DME MAC Jurisdiction A Resource

FOCUSED INFORMATION for MEDICARE DME MAC SUPPLIERS in CT, DE, DC, ME, MD, MA, NH, NJ, NY, PA, RI, & VT

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December 2006
Number 2

Billing/Finance

EDI Services

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

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2007 Annual Update of HCPCS Codes for Skilled Nursing Facility (SNF) Consolidated Billing (CB) (MM5283)

MLN Matters Number: MM5283
Related CR Release Date: September 29, 2006
Related CR Transmittal #: R1068CP
Related Change Request (CR) #: 5283
Effective Date: January 1, 2007
Implementation Date: January 2, 2007

Provider Types Affected
Physicians, providers, and suppliers submitting claims to Medicare carriers, durable medical equipment regional carriers (DMERCs) or DME Medicare Administrative Contractors (DME MACs), and fiscal intermediaries (FIs) for services provided to Medicare beneficiaries in SNFs

Provider Action Needed
Impact to You
This article is based on Change Request (CR) 5283, which provides the 2007 annual update of HCPCS Codes for SNF CB and how the updates affect edits in Medicare claims processing systems.

What You Need to Know
CR5283 provides updated to HCPCS codes that will be used to revise CWF edits to allow carriers and FIs to make appropriate payments in accordance with policy for SNF CB in the *Medicare Claims Processing Manual* (Publication 100-04), Chapter 6, Section 110.4.1 for carriers and Chapter 6, Section 20.6 for FIs.

What You Need to Do
See the *Background* and *Additional Information* sections of this article for further details regarding this update.

Background
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 non-covered stay. Changes to Healthcare Common Procedure Coding System (HCPCS) codes and Medicare Physician Fee Schedule designations are used to revise these edits to allow carriers, DMERCs/DME MACs, and FIs to make appropriate payments in accordance with policy for SNF CB contained in the *Medicare Claims Processing Manual*. These edits only allow services that are excluded from CB to be separately paid by carriers and\or FIs.

- **For physicians and providers billing carriers:** By the first week in December 2006, new code files will be posted at **http://www.cms.hhs.gov/SNFConsolidatedBilling/** on the CMS web site.
- **For those providers billing FIs:** By the first week in December 2006, new Excel® and PDF files will be posted at **http://www.cms.hhs.gov/SNFConsolidatedBilling/** on the CMS web site.

Note: It is **important and necessary** for the provider community to view the "General Explanation of the Major Categories" PDF file located at the bottom of each year's FI update listed at **http://www.cms.hhs.gov/SNFConsolidatedBilling/** on the CMS web site in order to understand the Major Categories including additional exclusions not driven by HCPCS codes.

Implementation
The implementation date for CR5283 is January 2, 2007.

Additional Information
For complete details, please see the official instruction issued to your carrier, DMERC, DME MAC or intermediary regarding this change. That instruction may be viewed at **http://www.cms.hhs.gov/Transmittals/downloads/R1068CP.pdf** on the CMS web site.

If you have any questions, please contact your carrier, DMERC, DME MAC, or intermediary at their toll-free number, which may be at **http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip** on the CMS web site.

Additional Requirements Necessary to Implement the Revised Health Insurance Claim Form CMS-1500 (MM5060)

NEWS FLASH - Do you have your NPI? National Provider Identifiers (NPIs) will be required on claims sent on or after May 23, 2007. Every health care provider needs to get an NPI. Learn more about the NPI and how to apply for an NPI by visiting http://www.cms.hhs.gov/NationalProvIdentStand/ on the CMS web site.

MLN Matters Number: MM5060 Revised
Related CR Release Date: September 15, 2006
Related CR Transmittal #: R1058CP
Related Change Request (CR) #: 5060
Effective Date: January 1, 2007
Implementation Date: January 2, 2007

Note: Page 3 of this article was revised on October 13, 2006, to reflect that the appropriate NPI must be entered in certain fields on Form CMS-1500. Previously, the article incorrectly stated the NPI of the billing provider. All other information remains the same.

Provider Types Affected
Physicians and suppliers who bill Medicare carriers including durable medical equipment regional carriers (DMERCs) for their services using the Form CMS-1500.

Key Points
- The Centers for Medicare & Medicaid Services (CMS) is implementing the revised Form CMS-1500, which accommodates the reporting of the National Provider Identifier (NPI).
- The Form CMS-1500 (08-05) version will be effective January 1, 2007, but will not be mandated for use until April 2, 2007.
- During this transition time there will be a dual acceptability period of the current and the revised forms.
- A major difference between Form CMS-1500 (08-05) and the prior form CMS-1500 is the **split provider identifier fields**.
- The split fields will enable NPI reporting in the fields labeled as NPI, and corresponding legacy number reporting in the unlabeled block above each NPI field.
- There will be a period of time where both versions of the CMS-1500 will be accepted (08-05 and 12-90 versions). The dual acceptability timeline period for Form CMS-1500 is as follows:

January 2, 2007 - March 30, 2007	Providers can use either the current Form CMS-1500 (12-90) version or the revised Form CMS-1500 (08-05) version. **Note:** Health plans, clearinghouses, and other information support vendors should be able to handle and accept the revised Form CMS-1500 (08-05) by January 2, 2007.
April 2, 2007	The current Form CMS-1500 (12-90) version of the claim form is discontinued; only the revised Form CMS-1500 (08-05) is to be used. **Note:** All **rebilling** of claims should use the **revised** Form CMS-1500 (08-05) from this date forward, even though earlier submissions may have been on the current Form CMS-1500 (12-90).

Background
Form CMS-1500 is one of the basic forms prescribed by CMS for the Medicare program. It is only accepted from physicians and suppliers that are excluded from the mandatory electronic claims submission requirements set forth in the Administrative Simplification Compliance Act, Public Law 107-105 (ASCA), and the implementing regulation at 42 CFR 424.32. The CMS-1500 form is being revised to accommodate the reporting of the National Provider Identifier (NPI).

Note that a provision in the HIPAA legislation allows for an additional year for small health plans to comply with NPI guidelines. Thus, small plans may need to receive legacy provider numbers on coordination of benefits (COB) transactions through May 23, 2008. CMS will issue requirements for reporting legacy numbers in COB transactions after May 22, 2007.

In a related Change Request, CR4023, CMS required submitters of the Form CMS-1500 (12-90 version) to continue to report Provider Identification Numbers (PINs) and Unique Physician Identification Numbers (UPINs) as applicable.

There were no fields on that version of the form for reporting of NPIs in addition to those legacy identifiers. Change Request 4293 provided guidance for implementing the revised Form CMS-1500 (08-05). This article, based on CR 5060, provides additional Form CMS-1500 (08-05) information for Medicare carriers and DMERCs, related to validation edits and requirements.

Billing Guidelines
- When the NPI number is effective and required (May 23, 2007, although it can be reported starting January 1, 2007), claims will be **rejected** (in most cases with reason code 16 - "claim/service lacks information that is needed for adjudication") in tandem with the appropriate remark code that specifies the missing information,

  if

Additional Requirements Necessary to Implement the Revised Health Insurance Claim Form CMS-1500 (MM5060) (Continued)

- The appropriate **NPI is not entered** on Form CMS-1500 (08-05) in items:
  - **24J** (replacing item 24K, Form CMS-1500 (12-90));
  - **17B** (replacing item 17 or 17A, Form CMS-1500 (12-90));
  - **32a** (replacing item 32, Form CMS-1500 (12-90)); and
  - **33a** (replacing item 33, Form CMS-1500 (12-90)).

Additional Information

When the NPI Number is Effective and Required (May 23, 2007)

To enable proper processing of Form CMS-1500 (08-05) claims and to avoid claim rejections, please be sure to enter the correct identifying information for any numbers entered on the claim.

Legacy identifiers are pre-NPI provider identifiers such as:

- PINs (Provider Identification Numbers)
- UPINs (Unique Physician Identification Numbers)
- OSCARs (Online Survey Certification & Reporting System numbers)
- NSCs (National Supplier Clearinghouse numbers) for DMERC claims.

Additional NPI-Related Information

Additional NPI-related information can be found at **http://www.cms.hhs.gov/NationalProvIdentStand/** on the CMS web site.

The change log which lists the various changes made to the Form CMS-1500 (08-05) version can be viewed at the NUCC Web site at **http://www.nucc.org/images/stories/PDF/change_log.pdf**.

MLN Matters article MM4320, "Stage 1 Use and Editing of National Provider Identifier Numbers Received in Electronic Data Interchange Transactions via Direct Data Entry Screen, or Paper Claim Forms," can be found at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4320.pdf** on the CMS web site.

CR4293, Transmittal Number 899, "Revised Health Insurance Claim Form CMS-1500," provides contractor guidance for implementing the revised Form CMS-1500 (08-05). It can be found at **http://www.cms.hhs.gov/transmittals/downloads/R899CP.pdf** on the CMS web site.

MLN Matters article MM4023, "Stage 2 Requirements for Use and Editing of National Provider Identifier (NPI) Numbers Received in Electronic Data Interchange (EDI) Transactions, via Direct Data Entry (DDE) Screens, or Paper Claim Forms," can be found at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4023.pdf** on the CMS web site.

CR5060 is the official instruction issued to your carrier or DMERC regarding changes mentioned in this article, MM5060. CR 5060 may be found by going to **http://www.cms.hhs.gov/Transmittals/downloads/R1058CP.pdf** on the CMS web site.

Please refer to your local carrier or DMERC if you have questions about this issue. To find their toll free phone number, please go to: **http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip** on the CMS web site.

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Collection of Fee-for-Service Payments Made During Periods of Managed Care Enrollment (Previously CR2801 Program Memorandum Transmittal AB-03-101) (MM5105)

NEWS FLASH - Do you have your NPI? National Provider Identifiers (NPIs) will be required on claims sent on or after May 23, 2007. Every health care provider needs to get an NPI. Learn more about the NPI and how to apply for an NPI by visiting http://www.cms.hhs.gov/NationalProvIdentStand/ on the CMS web site.

MLN Matters Number: MM5105 Revised
Related CR Release Date: August 25, 2006
Related CR Transmittal #: R106FM
Related Change Request (CR) #: 5105
Effective Date: October 1, 2003
Implementation Date: June 26, 2006

Note: This article was revised on August 28, 2006, to reflect revisions made to CR5105, which CMS released on August 25, 2006. The Transmittal number, CR release date, and web address for accessing CR5105 have been changed. All other information remains the same.

Provider Types Affected
Physicians, providers, and suppliers submitting fee-for-service claims to Medicare carriers, durable medical equipment regional carriers (DMERCs), fiscal intermediaries (FIs), and/or regional home health intermediaries (RHHIs) for services furnished to Medicare beneficiaries enrolled in Medicare Advantage (MA) Organizations.

Impact on Providers
This article is based on Change Request (CR) 5105, which was issued to manualize the process that ensures that any duplicate payments for services rendered to Medicare beneficiaries are collected. CR5105 ensures that any fee-for-service claims that were approved for payment during a period when the beneficiary was enrolled in a Managed Care Organization are submitted to the normal collection process used by the Medicare contractors (carriers/DMERCs/FIs) for overpayments.

Background
The Centers for Medicare & Medicaid Services (CMS) pays for a beneficiary's medical services more than once when a specific set of circumstances occurs. When CMS data systems recognize a beneficiary has enrolled in a MA Organization, the MA Organization receives capitation payments for the Medicare beneficiary. In some cases, enrollments with retroactive payments are processed.

The result is that Medicare may pay for the services rendered during a specific period twice:
- First, for the specific service that was paid by the fee-for-service Medicare contractor to the provider; and
- Second, by the MA Payment Systems in the monthly capitation rate paid to the MA plan for the beneficiary.

Overview of the MA plan Enrollment Process
When an MA plan enrollment is processed retroactively:
- Fee-for-service claims with dates of service that fall under the managed care plan enrollment period are identified by Medicare's Common Working File (CWF); and
- An Informational Unsolicited Response (IUR) record is created.

In essence, the retroactive enrollment triggers a search for fee-for-service claims that were incorrectly paid for services rendered when the beneficiary was covered by the managed care plan. If such claims are found, the system generates an adjustment and initiation by Medicare systems of overpayment recovery procedures. The current policy/procedures, as outlined in CR2801 (Transmittal AB-03-101, dated July 18, 2003) and CR 5105, dictates that:
- Claims paid in error (due to enrollment or disenrollment corrections) will be adjusted; and
- Medicare contractors will initiate overpayment recovery procedures.

Note: CR 2801 (Transmittal AB-03-101, dated July 18, 2003) can be found at **http://www.cms.hhs.gov/Transmittals/Downloads/AB03101.pdf** on the CMS web site:

Because of the inherent retroactivity in the enrollment process, (e.g., beneficiaries can enroll in plans up to the last day of the month, and the effective date would be the first of the following month), the CWF may receive this information after the enrollment is effective. For this reason, these kinds of adjustments occur routinely.

A variety of the CMS systems issues over the past 18 months have prompted CMS to recently synchronize MA enrollment and disenrollment information for the period September 2003 to April 2006. As a result, providers may have claims that were affected by this synchronization. For details of the impact of this synchronization on providers, please see *MLN Matters article*, SE0638, which is available at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0638.pdf** on the CMS web site.

When claims are identified as needing payment recovery, the related remittance advice for the claim adjustment will indicate Reason Code 24, which states: "Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan." Upon receipt, providers are to contact the managed care plan for payment.

Collection of Fee-for-Service Payments Made During Periods of Managed Care Enrollment (Previously CR2801 Program Memorandum Transmittal AB-03-101) (MM5105) (Continued)

- Providers who bill carriers will be alerted by their carrier (via letter or alternate method) of the following:
  - That the beneficiary was in a managed care plan on the date of service;
  - That the provider should bill the managed care plan;
  - What the plan identification number is; and
  - Where to find the plan name and address associated with the plan number on the CMS web site.
- For providers who bill FIs, the adjustment will occur automatically and information on which plan to contact must be determined through an eligibility inquiry or by contacting the beneficiary directly.

Note: To associate plan identification numbers with the plan name, go to **http://www.cms.hhs.gov/HealthPlansGenInfo/claims_processing_20060120.asp#TopOfPage** on the CMS web site.

In summary, CMS issued CR5105 to:
- Ensure that any fee-for-service claims that were approved for payment erroneously are submitted to the normal collection process used by the Medicare contractors (carriers, DMERCs, FIs, and RHHIs) for overpayments; and
- Instruct Medicare contractors to follow the instructions outlined in the *Medicare Financial Management Manual* (Publication 100-06, Chapter 3, Section 190), which is included as part of CR5105. Instructions for accessing CR5105 are in the *Additional Information* section of this article.

Implementation
The implementation date for the instruction is June 26, 2006.

Additional Information
For complete details, please see the official instruction issued to your carrier, DMERC, intermediary, or RHHI regarding this change. That instruction may be viewed at **http://www.cms.hhs.gov/Transmittals/downloads/R106FM.pdf** on the CMS web site.

Also, if you have any questions, please contact your carrier/DMERC/intermediary/RHHI at their toll-free number, which may be found at **http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip** on the CMS web site.

Correction to Skilled Nursing Facility (SNF) Consolidated Billing (CB) Coding File (MM5103)

NEWS FLASH - Sign up now for the listserv appropriate for you at http://www.cms.hhs.gov/apps/mailinglists/. Get your Medicare news as it happens!

MLN Matters Number: MM5103
Related CR Release Date: August 18, 2006
Related CR Transmittal #: R1032CP
Related Change Request (CR) #: 5103
Effective Date: April 1, 2001
Implementation Date: September 18, 2006

Provider Types Affected
Physicians and providers billing Medicare carriers for SNF services to Medicare beneficiaries

What You Need to Know
Because claims for the procedure codes in Table 1 below have been processing incorrectly, carriers will begin reopen and reprocess affected claims, when brought to their attention.

Background
CMS has become aware that claims for the procedure codes listed below, have not been processing correctly. In order to ensure that you receive payment for these procedure codes, CR 5103, from which this article is taken, instructs Medicare carriers to reopen and reprocess these claims, when brought to the carrier's attention.

Correction to Skilled Nursing Facility (SNF) Consolidated Billing (CB) Coding File (MM5103) (Continued)

Table 1, shown below, displays the procedure codes (and applicable claim dates of service) subject to the overriding of the SNF consolidated billing edit. When brought to their attention, carriers will use the SNF consolidated billing override code to bypass the edits and adjust claims (claims with the dates of service as shown, **and processed prior to July 3, 2006**) to pay appropriately for these procedure codes.

Table 1
Procedure Codes Subject Reopening and Reprocessing*

Code		Date of Service
54150 90471 90472	92977 93790	On or after April 1, 2001
0019T		On or after January 1, 2002
90871 90918 90919	90920 90921 92617	On or after January 1, 2003
G0345 J9395 L6697 L6698 L7181	36818 44137 90467 90468	On or after January 1, 2005
G0375 G0376		On or after March 22, 2005
G0372		On or after October 25, 2005

*All processed prior to July 3, 2006

Additional Information
You can find more information about the correction to the skilled nursing facility (SNF) consolidated billing (CB) coding file by going to CR5103, located at **http://www.cms.hhs.gov/Transmittals/downloads/R1032CP.pdf** on the CMS web site.

If you have any questions, please contact your carrier at their toll-free number, which may be found at **http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip**

Evidence of Medical Necessity: Wheelchair and Power Operated Vehicle (POV) Claims (Clarification of CR 3952, Transmittal # 128, dated October 28, 2005) (MM5128)

NEWS FLASH - Effective October 1, 2006, Medicare will only generate Health Insurance Portability and Accountability Act (HIPAA) compliant remittance advice - transaction 835 version 004010A1-to all electronic remittance advice receivers. For more details, see MLN Matters article SE0656 at http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0656.pdf

MLN Matters Number: MM5128 Revised
Related CR Release Date: August 25, 2006
Related CR Transmittal #: R157PI
Related Change Request (CR) #: 5128
Effective Date: June 5, 2006
Implementation Date: October 16, 2006

Note: This article was revised on August 28, 2006, to reflect changes made to CR5128 on August 25. The transmittal number, CR release date, implementation date, and web address for accessing CR5105 were revised. All other information remains the same.

Evidence of Medical Necessity: Wheelchair and Power Operated Vehicle (POV) Claims (Clarification of CR 3952, Transmittal # 128, dated October 28, 2005) (MM5128) (Continued)

Provider Types Affected
Providers prescribing Power Mobility Devices (PMDs) and suppliers billing Medicare durable medical equipment regional carriers (DMERCs) for PMDs

Background
This Change Request (CR) is a supplement to CR 3952. When CR 3952 was developed and issued, the final regulation had not been published. The final rule was published in the Federal Register on April 5, 2006, and was effective on June 5, 2006. CR5128 contains updated changes based on the final regulation that differ from CR 3952. The key points below outline the changes based on the final regulations that differ from CR 3952. (The web address for the MLN Matters article, MM3952, related to CR3952 is **http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3952.pdf** on the CMS web site.)

Key Points
This article and CR5128 provide an update to section 5.8 Evidence of Medical Necessity: Wheelchair and Power Operated Vehicle (POV) Claims of the *Medicare Program Integrity Manual.*

- Upon review, a written prescription for the PMD must be received by the supplier **within 45 days** after the face-to-face examination.
- For those instances of a recently hospitalized beneficiary, the written prescription must be received by the supplier **within 45 days** after the date of discharge from the hospital.
- The CMN for wheelchairs (signed or unsigned) is no longer needed for claims with a date of service on/after May 5, 2005 that are received on or after April 1, 2006.

Implementation
The implementation date for this instruction is October 16, 2006.

Additional Information
The official instructions, CR5128, issued to your Medicare DMERC regarding this change can be found at **http://www.cms.hhs.gov/Transmittals/downloads/R157PI.pdf** on the CMS web site. The revised section **5.8 Evidence of Medical Necessity: Wheelchair and Power Operated Vehicle (POV) Claims** of the *Medicare Program Integrity Manual* is attached to CR5128.

If you have questions, please contact your Medicare DMERC at their toll-free number, which may be found at **http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip**

Fee Schedule Updates

The 2006 fee schedules and subsequent updates are available via the "Fee Schedules" section of the Jurisdiction A Durable Medical Equipment Medicare Administrative Contractor (DME MAC A) Web site, **http://www.medicarenhic.com/dme/dmfees.shtml**. The following notices have been posted:

- New - 4th Quarter 2006 DMEPOS/PEN Fees
- Revised - 3rd Quarter 2006 DMEPOS/PEN Fees
- Revised - 2nd Quarter 2006 DMEPOS/PEN Fees
- Revised - 1st Quarter 2006 DMEPOS/PEN Fees
- Revised - 4th Quarter 2005 DMEPOS/PEN Fees
- Revised - 1st Quarter 2005 DMEPOS/PEN Fees

- New - October 2006 Drug Fees In Average Sales Price (ASP) File
- Revised - July 2006 Drug Fees In Average Sales Price (ASP) File
- Revised - April 2006 Drug Fees In Average Sales Price (ASP) File

- New - 4th Quarter 2006 Update: Oral Anti-cancer Drug Fees
- Revised - 3rd Quarter 2006 Update: Oral Anti-cancer Drug Fees
- Revised - 2nd Quarter 2006 Update: Oral Anti-cancer Drug Fees

Note: The January 1 fees for the current calendar year are posted as the "Jurisdiction A DME MAC 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.

Implementation of New Healthcare Common Procedure Coding System (HCPCS) Codes and Fee Schedule Amounts for Power Mobility Devices (PMDs) (JSM06688)

A recurring update notification regarding the October quarterly update for the 2006 Durable Medical Equipment Prosthetic, Orthotics, and Supplies (DMEPOS) fee schedule was issued on August 25, 2006, (Transmittal 1037, Change Request 5255). This transmittal included instructions for implementation on October 1, 2006, of HCPCS codes K0800 thru K0812 for power operated vehicles and K0813 thru K0899 for power wheelchairs and corresponding fee schedule amounts if applicable. The effective date for implementation of these codes and fee schedule amounts is being changed to November 15, 2006, to allow additional time for suppliers to prepare for these changes. Therefore, the instructions below replace those instructions listed in the policy section and business requirements of transmittal 1037.

The following codes are being added to the HCPCS on November 15, 2006, and are effective for claims with dates of service on or after November 15, 2006:

POWER OPERATED VEHICLES

K0800	K0801	K0802	K0806	K0807	K0808	K0812

POWER WHEELCHAIRS

K0813	K0825	K0837	K0850	K0859	K0871	K0891
K0814	K0826	K0838	K0851	K0860	K0877	K0898
K0815	K0827	K0839	K0852	K0861	K0878	K0899
K0816	K0828	K0840	K0853	K0862	K0879	
K0820	K0829	K0841	K0854	K0863	K0880	
K0821	K0830	K0842	K0855	K0864	K0884	
K0822	K0831	K0843	K0856	K0868	K0885	
K0823	K0835	K0848	K0857	K0869	K0886	
K0824	K0836	K0849	K0858	K0870	K0890	

The Centers for Medicare & Medicaid Services (CMS) is in the process of calculating fee schedule amounts for the above codes, where applicable, and these fee schedule amounts will be transmitted to contractors in addendum DMEPOS fee schedule files in the near future.

Suppliers should use the above HCPCS codes for all new PMD claims with dates of service on or after November, 15, 2006. For power operated vehicles furnished on a rental basis with dates of service prior to November 15, 2006, suppliers should continue to use code E1230. For power wheelchairs furnished on a rental basis prior to November 15, 2006, suppliers should continue to use codes K0010 thru K0014, as appropriate.

Suppliers should begin submitting HCPCS codes
K0800 through K0802,
K0806 through K0808,
K0812 through K0816,
K0820 through K0831,
K0835 through K0843,
K0848 through K0864,
K0868 through K0871,
K0877 through K0880,
K0884 through K0886,
K0890, K0891, K0898 and K0899, as appropriate, for all Power Mobility Device claims with dates of service on or after November 15, 2006.

Power mobility device claims with dates of service prior to November 15, 2006, shall use E1230, K0010, K0011, K0012, and K0014 as appropriate.

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 (MM4296)

MLN Matters Number: MM4296 Revised
Related CR Release Date: September 22, 2006
Related CR Transmittal #: R159PI

Related Change Request (CR) #: 4296
Effective Date: October 1, 2006
Implementation Date: October 2, 2006

Note: This article was revised on September 26, 2006, to reflect changes needed when CMS re-issued CR4296. CMS revised CR4296 to correct some language in sections 5.3, 5.11, and 5.12 of the *Medicare Program Integrity Manual.* Those sections are attached to CR4296. This article was revised to reflect the new CR release date, transmittal number, and Web address for accessing CR4296. All other information remains the same.

Provider Types Affected
Physicians, providers, and suppliers using CMNs and 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 received from October 1, 2006, through December 31, 2006, where claims for items requiring a 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 (CR4296) issued to your DMERC.

Background
CMNs provide a mechanism for suppliers of durable medical equipment (defined in 42 U.S.C. § 1395x(n)) and medical equipment and supplies (defined in 42 U.S.C. § 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 DME Information Forms (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 that 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 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

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 (MM4296) (Continued)

DMERC FORM	CMS FORM	ITEMS ADDRESSED
06.02B	848	Transcutaneous Electrical Nerve Stimulators (TENS)
07.02A	849	Seat Lift Mechanisms
9.02	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 Transiton Period

The following table identifies the newly revised CMNs that will be accepted during the transition period for claims from October 1, 2006, through December 31, 2006. As of January 1, 2007, these forms will become effective for claims for items requiring a 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 from October 1, 2006, through December 31, 2006. As of January 1, 2007, the new forms will become effective for claims for items requiring a 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
9.03	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 on or after October 1, 2006.

CMNs Eliminated

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

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

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 (MM4296) (Continued)

ATTENTION: 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 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 **http://www.cms.hhs.gov/Transmittals/downloads/R159PI.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 **http://www.cms.hhs.gov/apps/contacts/** on the CMS web site.

New Durable Medical Equipment Prosthetic, Orthotics, and Supplies (DMEPOS) Transcutaneous Electrical Nerve Stimulators (TENS) Certificate of Medical Necessity (CMN) for Purchases (MM5107)

NEWS FLASH - Do you have your NPI? National Provider Identifiers (NPIs) will be required on claims sent on or after May 23, 2007. Every health care provider needs to get an NPI. Learn more about the NPI and how to apply for an NPI by visiting http://www.cms.hhs.gov/NationalProvIdentStand/ on the CMS web site.

MLN Matters Number: MM5107
Related CR Release Date: October 6, 2006
Related CR Transmittal #: R166PI
Related Change Request (CR) #: 5107
Effective Date: October 2, 2006
Implementation Date: January 2, 2007

Provider Types Affected
Providers and suppliers using CMNs when billing Medicare durable medical equipment regional carriers (DMERCs) or DME Medicare Administrative Contractors (DME MACs) for the purchase of TENS.

Background
The Centers for Medicare & Medicaid Services (CMS) has recently developed improved CMNs that were approved by the Office of Management and Budget (OMB). The OMB approved form number for the CMS-848 is OMB# 0938-0679.

Key Points of CR 5107
- The revised Transcutaneous Electrical Nerve Stimulators (TENS) CMN will **only apply to purchases**.
- Beginning January 1, 2007, **CMNs** for **TENS rentals will not be required**. DMERCs and DME MACs will allow suppliers to submit a partially-completed unsigned TENS CMN for claims submitted on or after October 2, 2006, and ending on December 31, 2006.
- For more information regarding the revised CMN forms, see the MLN Matters article MM4296, which is available at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4296.pdf** on the CMS website.

Additional Information
The official instructions, CR 5107, issued to your Medicare DMERC/DME MAC regarding this change can be found at **http://www.cms.hhs.gov/Transmittals/downloads/R166PI.pdf** on the CMS website. The new CMN form is available at **http://www.cms.hhs.gov/cmsforms/downloads/CMS848.pdf** on the CMS site.

If you have questions, please contact your Medicare DMERC/DME MAC at their toll-free number which may be found on the CMS website at: **http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip**

Note: For More information see Outreach & Education Section article "Supplement to MM5107 - DMEPOS Transcutaneous Electrical Nerve Stimulators (TENS) Certificate of Medical Necessity (CMN) for Purchases: Form CMS-848 (MM5107)"

October 2006 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing File, Effective October 1, 2006, and Revisions to April 2006 and July 2006 Quarterly ASP Medicare Part B Drug Pricing Files (MM5270)

NEWS FLASH - Sign up now to the listserv appropriate for you http://www.cms.hhs.gov/apps/mailinglists/. Get your Medicare news as it happens!

MLN Matters Number: MM5270
Related CR Release Date: September 22, 2006
Related CR Transmittal #: R1066CP

Related Change Request (CR) #: 5270
Effective Date: October 1, 2006
Implementation Date: October 2, 2006

Note: This article was revised on September 25, 2006, to reflect changes to CR5270, which CMS re-issued on September 22, 2006. The article was revised, as was CR5270, to remove references to the revised January 2006 file. The CR transmittal number, release date, and Web address for accessing CR5270 were also changed. All other information remains the same.

Provider Types Affected
All Medicare providers who bill Medicare for Part B drugs

Provider Action Needed
Impact to You
Change Request (CR) 5270, upon which this article is based, provides notice of the updated payment allowance limits effective October 1, 2006, and revisions to the April 2006 and July 2006 quarterly 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 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
CR5270, upon which this article is based, provides the quarterly average sales price (ASP) Medicare Part B drug pricing file update for October 1, 2006, and also provides revisions to the April 2006 and July 2006 quarterly files.

Section 303(c) of the Medicare Modernization Act of 2003 (MMA) revised the payment methodology for Part B covered drugs that are not paid on a cost or prospective payment basis; and mandated that since January 1, 2005, drugs and biologicals not paid on a cost or prospective payment basis be paid based on the average sales price (ASP) methodology.

In the same way in 2006, all ESRD drugs furnished by both independent and hospital-based ESRD facilities; specified, covered outpatient drugs; and drugs and biologicals with pass-through status under the OPPS will be paid according to this ASP methodology, which is based on quarterly data submitted to CMS by manufacturers.

Note that MMA also requires CMS to update the payment allowance limits quarterly, which CR5270 does.

Beginning January 1, 2005, Part B drugs that are not paid on a cost or prospective payment basis) have been paid based on **106%** of the average sales price (ASP). Additionally, 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%** of the ASP.

There are exceptions to this general rule as summarized below.

1. Blood and Blood Products
Blood and blood products furnished in the hospital outpatient department are paid under the outpatient prospective payment system (OPPS) at the amount specified for the APC to which the product is assigned. Conversely, for blood and blood products, not paid on a prospective payment basis (with certain exceptions such as blood clotting factors), payment allowance limits are determined in the same manner used to determine them on October 1, 2003.

The payment allowance limits for blood and blood products are 95% of the Average Wholesale Price (AWP) as reflected in the published compendia. These payment allowance limits will be updated on a quarterly basis, along with the others.

2. Infusion Drugs
The payment allowance limits for infusion drugs, furnished through a covered item of durable medical equipment, on or after January 1, 2005, will continue to be 95% of the AWP reflected in the published compendia as of October 1, 2003, unless the drug is compounded. The payment allowance limits were not updated in 2006.

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

October 2006 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing File, Effective October 1, 2006, and Revisions to April 2006 and July 2006 Quarterly ASP Medicare Part B Drug Pricing Files (MM5270) (Continued)

3. Influenza, Pneumococcal and Hepatitis B vaccines
The payment allowance limits for influenza, Pneumococcal and Hepatitis B vaccines are 95% of the AWP as reflected in the published compendia except where the vaccine is furnished in a hospital outpatient department. In this latter instance, the vaccine is paid at reasonable cost.

4. Drugs not included in the ASP Medicare Part B Drug Pricing File or Not Otherwise Classified (NOC) Pricing File
The payment allowance limits for drugs that are not included in the ASP Medicare Part B Drug Pricing File or Not Otherwise Classified (NOC) Pricing File (other than new drugs that are produced or distributed under a new drug application approved by the Food and Drug Administration) are based on the published wholesale acquisition cost (WAC) or invoice pricing.

In determining the payment limit based on WAC, Medicare contractors (carriers, including durable medical equipment regional carriers (DMERCs), and fiscal intermediaries, including regional home health intermediaries (RHHIs)) follow the methodology in the *Medicare Claims Processing Manual* specified for calculating the AWP, but substitute WAC for AWP. (See Publication 100-04, Chapter 17, Drugs and Biologicals at **http://www.cms.hhs.gov/manuals/downloads/clm104c17.pdf** on the CMS web site.)

The payment limit is 100% of the lesser of the lowest brand or median generic WAC. And note that for 2006, when the blood clotting factor is not included on the ASP file, the blood clotting furnishing factor of $0.146 per I.U. is added to the blood clotting factor payment amount.

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.

1. New Drugs
The payment allowance limits for new drugs that are produced or distributed under a new drug application approved by the Food and Drug Administration and that are not included in the ASP Medicare Part B Drug Pricing File or Not Otherwise Classified (NOC) Pricing File are based on 106% of the WAC. This policy applies only to new drugs that were first sold on or after January 1, 2005. As mentioned above, for 2006, the blood clotting furnishing factor of $0.146 per I.U. is added to the payment amount for a new blood clotting factor when a new blood clotting factor is not included on the ASP file.

2. Radiopharmaceuticals
The payment allowance limits for radiopharmaceuticals are not subject to ASP. Radiopharmaceuticals furnished in the hospital outpatient department are paid charges reduced to cost by the hospital's overall cost to charge ratio. And your carrier/FI will determine payment limits for radiopharmaceuticals not furnished in the hospital outpatient department based on the methodology in place as of November 2003.

3. Drugs Furnished During Filling or Refilling an Implantable Pump or Reservoir
CR 5270 clarifies that payment for drugs furnished incident to the filling or refilling of an implantable pump or reservoir is determined under the ASP methodology, as described above. Your carrier or FI will develop the pricing for compounded drugs.

Physicians (or a practitioner described in Section 1842(b)(18)(C)) may be paid for filling or refilling an implantable pump or reservoir when it is medically necessary for them to perform the service. Your carrier/FI must find the use of the implantable pump or reservoir medically reasonable and necessary in order to allow payment for: 1) The professional service of filling or refilling the implantable pump or reservoir; and 2) For drugs furnished incident to the professional service.

If a physician (or other practitioner) is prescribing medication for a patient with an implantable pump, a nurse may refill the pump if: 1) The medication administered is accepted as a safe and effective treatment of the patient's illness or injury; 2) There is a medical reason that the medication cannot be taken orally; and 3) The nurse's skills are needed to infuse the medication safely and effectively.

Here are some important things you should remember.

- The payment limits included in the revised ASP and NOC payment files supersede the payment limits for these codes in any publication published prior to this document.
- Pricing for compounded drugs is performed by your carrier/FI.
- The presence or absence or of a HCPCS code and its associated payment limit does not indicate Medicare coverage of the drug or biological. Similarly, the inclusion of a payment limit within a specific column does not indicate Medicare coverage of the drug in that specific category. The local Medicare contractor processing the claim will make these determinations.
- The October 2006 and revised April 2006 and July 2006 ASP drug pricing files for Medicare Part B drugs will be available via the CMS Data Center (CDC) for your carriers/FIs to download on or after September 19, 2006.
- You can also view the October 2006 and revised April 2006, and July 2006 ASP NOC drug pricing files for Medicare Part B drugs (on or after September 22, 2006) at **http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/02_aspfiles.asp#TopOfPage** on the CMS web site.

October 2006 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing File, Effective October 1, 2006, and Revisions to April 2006 and July 2006 Quarterly ASP Medicare Part B Drug Pricing Files (MM5270) (Continued)

Note that:

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

Additional Information
You can find the official instructions issued to your carrier/FI/RHHI/DMERC regarding this change by going to CR5270, located at **http://www.cms.hhs.gov/Transmittals/downloads/R1066CP.pdf** on the CMS web site. If you have any questions, please contact your carrier at their toll-free number, which may be found at **http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip** on the CMS web site.

October Quarterly Update for 2006 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule (MM5255)

NEWS FLASH - Effective October 1, 2006, Medicare will only generate the Health Insurance Portability and Accountability Act (HIPAA) compliant remittance advice - transaction 835 version 004010A1 - to all electronic remittance advice receivers. For more details, see MLN Matters article SE0656 at http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0656.pdf.

MLN Matters Number: MM5255
Related CR Release Date: August 25, 2006
Related CR Transmittal #: R1037CP
Related Change Request (CR) #: 5255
Effective Date: October 1, 2006
Implementation Date: October 2, 2006

Provider Types Affected
Physicians, suppliers, and providers billing Medicare carriers, including durable medical equipment (DME) regional carriers (DMERCs) and DME Medicare Administrative Contractors (DME MACs), and/or fiscal intermediaries (FIs), including regional home health intermediaries (RHHIs), for services paid under the DMEPOS Fee Schedule.

Background
This article and related CR5255 provide specific information regarding the quarterly update for the October 2006 DMEPOS Fee Schedule.

Key Points
Quarterly Update
The DMEPOS fee schedules are updated on a quarterly basis to:
- Implement fee schedule amounts for new codes; and
- Revise any fee schedule amounts for existing codes that were calculated in error.

Required Payment
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).

Codes Added to HCPCS
The following codes are being added to the Healthcare Common Procedure Coding System (HCPCS) on October 1, 2006, and are effective for claims with dates of service on or after October 1, 2006:
- Code K0738 (Portable Gaseous Oxygen System, Rental; Home Compressor Used To Fill Portable Oxygen Cylinders; Includes Portable Containers, Regulator, Flow meter, Humidifier, Cannula Or Mask, And Tubing) This code is to be used for billing and payment for oxygen transfilling equipment used in the beneficiary's home to fill portable gaseous oxygen cylinders.
- HCPCS codes K0800 through K0802, K0806 through K0808, K0812 through K0816, K0820 through K0831, K0835 through K0843, K0848 through K0864, K0868 through K0871, K0877 through K0880, K0884 through K0886, K0890, K0891, K0898 and K0899, as appropriate, for related Power Mobility Device claims.

The descriptions for these codes and other codes in this article may be found in CR5255 at **http://www.cms.hhs.gov/Transmittals/downloads/R1037CP.pdf** on the CMS web site.

October Quarterly Update for 2006 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule (MM5255) (Continued)

For power wheelchairs furnished on a rental basis with dates of service prior to October 1, 2006, use codes K0010, K0011, K0012, and K0014 as appropriate.

Claims for K0010, K0011, K0012 and K0014 with dates of service on or after October 1, 2006, if the claims are for purchase of initial rental of the item, will be rejected.

The fee schedules for HCPCS code E1238 (Wheelchair, Pediatric Size, Folding, Adjustable, Without Seating System) are being revised as part of this update to correct errors in calculation and are effective for dates of service on or after January 1, 2006.

Fee schedule amounts for codes E2620 and E2621 are being revised to correct fee schedule assignment errors for claims with dates of service on or after January 1, 2006.

The fee schedules for HCPCS code A7043 (Vacuum drainage bottle and tubing for use with implanted catheter) are being revised as part of this update to correct calculation errors and will be effective for dates of service on or after January 1, 2006.

Previously processed claims for codes E2620, E2621, A7043 and E1238 with dates of service on or after January 1, 2006, will be adjusted if they are resubmitted as adjustments.

The fee schedule for HCPCS code L8689 (External recharging system for implanted neurostimulator, replacement only) was revised. FIs and carriers will adjust previously processed claims for code L8689 with dates of service on or after January 1, 2006, if they are resubmitted as adjustments.

HCPCS code L8689 should only be used for external systems that recharge implanted batteries (i.e., external recharging of batteries that area inside the patient). Claims for replacements for other types of implanted neurostimulator battery charging systems should be submitted using L8699.

The fee schedules for HCPCS code L2232 (Addition to lower extremity orthosis, rocker bottom for total contact ankle foot orthosis, for custom fabricated orthosis only) are added to the fee schedule file on October 1, 2006, and are effective for new claims with dates of service on or after January 1, 2005

Codes H0049 (Alcohol And/Or Drug Screening) and H0050 (Alcohol And/Or Drug Services, Brief Intervention, Per 15 Minutes) are being added to the HCPCS on June 30, 2006, and will be available on January 1, 2007, for assignment by insurers in accordance with their programs and policies.

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

Additional Information
For complete details, please see the official instruction issued to your Medicare carrier, FI, RHHI, DMERC, or DME/MAC regarding this change. That instruction may be viewed by going to
http://www.cms.hhs.gov/Transmittals/downloads/R1037CP.pdf on the CMS web site.

If you have questions, please contact your Medicare carrier, DMERC, DME MAC, FI, or RHHI at their toll-free number which may be found at: **http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip** on the CMS web site.

PMD Fee Schedule Ceiling Amounts are Now Available (CMS Message 200610-02)

The PMD fee schedule ceiling amounts are now available on the CMS website at: **http://www.cms.hhs.gov/DMEPOSFeeSched/**.

The fee schedule amounts for all States will be available by October 3, 2006, in a public use file available at:
http://www.cms.hhs.gov/DMEPOSFeeSched/LSDMEPOSFEE/list.asp

As stated in an earlier announcement, the new PMD codes, fee schedule amounts and local coverage determinations (LCDs) were originally scheduled to take effect on October 1, 2006. In order to allow for additional time to prepare for implementation of the fee schedule amounts and LCDs, these changes will be effective on November 15, 2006.

Remittance Advice Remark Code (RARC) and Claim Adjustment Reason Code (CARC) Update (MM5212)

NEWS FLASH - Effective October 1, 2006, Medicare will only generate Health Insurance Portability and Accountability Act (HIPAA) compliant remittance advice-transaction 835 version 004010A1-to all electronic remittance advice receivers. For more details, see MLN Matters article SE0656 at http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0656.pdf. Get your Medicare news as it happens!

MLN Matters Number: MM5212
Related CR Release Date: August 18, 2006
Related CR Transmittal #: R1031CP
Related Change Request (CR) #: 5212
Effective Date: October 1, 2006
Implementation Date: October 2, 2006

Provider Types Affected
Providers, physicians, and suppliers who bill Medicare fiscal intermediaries (FIs), including regional home health intermediaries (RHHIs), Medicare carriers, including durable medical equipment regional carriers (DMERCs) and Durable Medical Equipment Medicare Administrative Contracts (DME MACs).

Provider Action Needed
Impact to You
The November 2005 through February 2006 updates have been posted for the X12N 835 Health Care Remittance Advice Remark Codes (RARCs) and the X12N 835 Health Care Claim Adjustment Reason codes (CARCs).

What You Need to Know
The Centers for Medicare & Medicaid Services (CMS) has developed a new web site located at **http://www.cmsremarkcodes.info/** on the CMS website, to provide information and help navigate the RARC database more easily. A helpful search tool is provided at this site if you need to find a specific category of code. This new website does not replace the Washington Publishing Company (WPC) web site, **http://www.wpc-edi.com/codes**, as the official site where the most current RARC list resides. Use the list posted at the **WPC web site** if there are any discrepancies between code text listed either on the new web site or in this article, and the code text provided on the WPC web site.

What You Need to Do
Please refer to the *Background* section of this article for a summary of the RARC and CARC code text changes.

Background
Among the codes sets mentioned in the Implementation Guide for transaction 835 (Health Care Claim Payment/Advice), the following two code sets must be used to report payment adjustments and related information for transaction 835 and the standard paper remittance advice for Medicare:
- Claim Adjustment Reason Code (CARC); and
- Remittance Advice Remark Code (RARC).

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

Both of these code sets are updated three times a year, and Medicare issues recurring Change Requests (CRs) that capture the changes in these code sets that have been approved in the previous four months.

Summary of Current Updates (November 1, 2005 - February 28, 2006 Changes)
Remark Code (RARC) Changes
New: The following code table reflects new remark codes:

New Code	Current Narrative
N365	This procedure code is not payable. It is for reporting/information purposes only.
N366	Requested information not provided. The claim will be reopened if the information previously requested is submitted within one year after the date of this denial notice.
N367	The claim information has been forwarded to a Health Savings Account processor for review.
N368	You must appeal the determination of the previously adjudicated claim.
N369	Alert: Although this claim has been processed, it is deficient according to state legislation/regulation.

Modified: Remark Code **MA02** was modified effective December 29, 2005. Its modified narrative is:

> "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."

This modification is effective January 1, 2006, and was implemented on or before May 17, 2006.

Deactivated: Code **MA03** was deactivated effective October 1, 2006. Remark code MA02 may be used instead.

Remittance Advice Remark Code (RARC) and Claim Adjustment Reason Code (CARC) Update (MM5212) (Continued)

Reason Code (CARC) Changes
New: The following table reflects new reason codes:

New Code	Current Narrative	New as of:
193	Original payment decision is being maintained. This claim was processed properly the first time.	February 2006
194	Payment adjusted when anesthesia is performed by the operating physician, the assistant surgeon or the attending physician.	February 2006
195	Payment denied/reduced due to a refund issued to an erroneous priority payer for this claim/service.	February 2006

Implementation Date
These code changes will be applied by your Medicare carrier/DMERC/FI/RHHI by October 2, 2006.

Additional Information
CR5212 is the official instruction issued to your Medicare carrier/DMERC/FI/RHHI regarding changes mentioned in this article. CR5212 may be found at **http://www.cms.hhs.gov/Transmittals/downloads/R1031CP.pdf** on the CMS web site.

For more information on the process used to update these two codes sets, see the MLN Matters article, MM44314, available at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4314.pdf** on the CMS web site.

If you have questions please contact your local Medicare carrier/DMERC/FI/RHHI at their toll-free number, which may be found at **http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip** on the CMS web site.

Revised CMS-1500 Claim Form (MM4293)

MLN Matters Number: MM4293 Revised
Related CR Release Date: March 31, 2006
Related CR Transmittal #: R899CP

Related Change Request (CR) #: 4293
Effective Date: See shaded note box below.
Implementation Date: October 2, 2006

Note: This article was revised on August 25, 2006, by adding this statement directing readers to view article MM5060 at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5060.pdf** for more current information on the effective dates for using Form CMS-1500 (08/05). The dates in the MM5060 article supersede the dates in this article and MM5060 conforms with CR5060, which is available at **http://www.cms.hhs.gov/transmittals/downloads/R1010CP.pdf**.

Provider Types Affected
Physicians, providers, and suppliers who are excluded from the mandatory electronic claims submission requirements and submit claims to Medicare carriers using the CMS-1500 paper claim form

Important Points to Remember
CR4293 describes the claim form **CMS-1500 (12-90)** that is being revised to accommodate the reporting of the National Provider Identifier (NPI) and will then be named **CMS-1500 (08-05)**. The following timeline outlines the schedule for using the revised CMS-1500 claim form:

- October 1, 2006: Health plans, clearinghouses, and other information support vendors should be ready to handle and accept the revised CMS-1500 (08/05) claim form.
- October 1, 2006 - January 31, 2007: Providers can use either the current CMS-1500 (12/90) version or the revised CMS-1500 (08/05) version of the claim form.
- February 1, 2007: The current CMS-1500 (12/90) version of the claim form is discontinued; only the revised CMS-1500 (08/05) form is to be used. All rebilling of claims should use the revised CMS-1500 (08/05) form from this date forward, even though earlier submissions may have been on the current CMS-1500 (12/90) claim form.

Revised CMS-1500 Claim Form (MM4293) (Continued)

Background
The Form CMS-1500 form answers the needs of many health insurers. It is the basic form prescribed by the Centers for Medicare & Medicaid Services (CMS) for the Medicare program and is accepted only from physicians and suppliers that are excluded from the mandatory electronic claims submission requirements set forth in the Administrative Simplification Compliance Act, Pub.L. 107-105 (ASCA), and the implementing regulation at 42 CFR 424.32.

The CMS-1500 (12-90) claim form is being revised to accommodate the reporting of the National Provider Identifier (NPI). The intent of the new form is to best accommodate the NPI with minimal changes to the current claim form. The CMS-1500 (08-05) version will be effective October 1, 2006, but will not be mandated for use until February 1, 2007. Therefore, there will be a period when the current and the revised forms will both be acceptable.

The change log that lists the various changes made to the CMS-1500 (08-05) version can be viewed at the National Uniform Claim Committee (NUCC) web site at **http://www.nucc.org/images/stories/PDF/change_log.pdf**.

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

Additional Information
The official instructions issued to your Intermediary regarding this change can be found at **http://www.cms.hhs.gov/Transmittals/downloads/R899CP.pdf** on the CMS web site.

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

You may also wish to review MLN Matters articles:

- **SE0555**, "Medicare's Implementation of the National Provider Identifier (NPI): The Second in the Series of Special Edition MLN Matters Articles on NPI- Related Activities" available at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0555.pdf** on the CMS web site; and/or
- **SE0528**, "CMS Announces the National Provider Identifier (NPI) Enumerator Contractor and Information on Obtaining NPIs" available at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0528.pdf** on the CMS web site.

Remember
that you can fax
your immediate offset requests
http://www.medicarenhic.com/dme/forms/offsetrequest.pdf

Chapter 24 Update to the National Council for Prescription Drug Program (NCPDP) Narrative Portion of Prior Authorization Segment (MM5092)

MLN Matters Number: MM5092
Related CR Release Date: May 26, 2006
Related CR Transmittal #: R958CP

Related Change Request (CR) #: 5092
Effective Date: August 28, 2006
Implementation Date: August 28, 2006

Provider Types Affected
Providers and suppliers billing Medicare durable medical equipment regional carriers (DMERCs) for locally prepared medication that contains compound ingredients.

Background
The Centers for Medicare & Medicaid Services (CMS) require providers to adhere to electronic data interchange (EDI) requirements for Medicare. Certain informational modifiers are required to identify compound ingredients in locally prepared medication. The NCPDP format does not currently support reporting modifiers in the compound segment. Therefore, the narrative portion in the prior authorization segment is being used to report these modifiers.

Key Points
This article and Change Request (CR) 5092 provides an update to Chapter 24 Section 40.3 (NCPDP Narrative Portion of Prior Authorization Segment). This article and CR 5092 also identify the additional modifiers needed for coordination of benefits (COB). Therefore, the narrative portion in the prior authorization segment is being used to report these modifiers.

The following must be entered in positions 001-003 of the narrative (Example, MMN or MNF). Starting at position 355, indicate the two-byte ingredient number followed by the two-position modifier:

CMN	Indicates that the Supporting documentation that follows is Medicare required CMN or DIF information
CAN	Indicates that the Supporting documentation that follows is Medicare required CMN or DIF and narrative information
CFA	Indicates that the Supporting documentation that follows is Medicare required CMN or DIF information and Facility Name and Address
CSA	Indicates that the Supporting documentation that follows is Medicare required CMN or DIF information and Supplier Name and Address
CNF	Indicates that the Supporting documentation that follows is Medicare required CMN or DIF information, narrative information, and Facility Name and Address
CNS	Indicates that the Supporting documentation that follows is Medicare required CMN or DIF information, narrative information, and Supplier Name and Address
FAC	Indicates that the Supporting documentation that follows is Medicare required Facility Name and address
FAN	Indicates that the Supporting documentation that follows is Medicare required Facility Name and Address and narrative information
SAC	Indicates that the Supporting documentation that follows is Medicare required Supplier Name and address
SAN	Indicates that the Supporting documentation that follows is Medicare required Supplier Name and Address and narrative information
NAR	Indicates that the Supporting documentation that follows is Medicare required Narrative Information
MMN	Indicates that the Supporting documentation that follows is Medicare modifier Information and CMN or DIF information
MNA	Indicates that the Supporting documentation that follows is Medicare modifier information, CMN or DIF information and narrative information
MFA	Indicates that the Supporting documentation that follows is Medicare modifier information, CMN or DIF information and Facility Name and Address
MNF	Indicates that the Supporting documentation that follows is Medicare modifier information, CMN or DIF information, narrative information and Facility Name and Address
MAC	Indicates that the Supporting documentation that follows is Medicare modifier information and Facility Name and Address
MAN	Indicates that the Supporting documentation that follows is Medicare modifier information, narrative information and Facility Name and Address

Chapter 24 Update to the National Council for Prescription Drug Program (NCPDP) Narrative Portion of Prior Authorization Segment (MM5092) (Continued)

MFA	Indicates that the Supporting documentation that follows is Medicare modifier information, narrative information and Facility Name and Address
MNS	Indicates that the Supporting documentation that follows is Medicare modifier information, CMN or DIF information, narrative information and Supplier Name and Address
MSC	Indicates that the Supporting documentation that follows is Medicare modifier information, and Supplier Name and Address
MSN	Indicates that the Supporting documentation that follows is Medicare modifier information, narrative information and Supplier Name and Address
MAR	Indicates that the Supporting documentation that follows is Medicare modifier information and narrative information
MOD	Indicates that the Supporting documentation that follows is Medicare modifier information

Implementation
The implementation date for this instruction is August 28, 2006.

Additional Information
The official instructions, CR5092, issued to your Medicare DMERC regarding this change can be found at **http://www.cms.hhs.gov/Transmittals/downloads/R958CP.pdf** on the CMS web site. The revised section *40.3 National Council for Prescription Drug Program Claim Requirements of the Medicare Claims Processing Manual* is attached to CR5092.

If you have questions, please contact your Medicare DMERC at their toll-free number which may be found at: **http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.pdf** on the CMS web site.

Electronic Data Interchange (EDI) Media Changes (CR5225)

CMS Manual System
Pub 100-04 Medicare Claims Processing
Transmittal 1081

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)
Date: OCTOBER 20, 2006
Change Request 5225

NOTE: *Transmittal 1077, dated October 13, 2006 is rescinded and replaced by Transmittal 1081, dated October 20, 2006, to correct the implementation date from January 16, 2007 to April 2, 2007. The implementation date has been revised. All other information remains the same.*

Subject: Electronic Data Interchange (EDI) Media Changes

I. SUMMARY OF CHANGES: Some contractors permitted providers to submit EDI claims via fax-imaging, diskette, tape, or similar storage media. The CMS has determined that use of such media is not cost effective and must be terminated.

New / Revised Material
Effective Date: April 1, 2007
Implementation Date: April 2, 2007

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	Chapter / Section / Subsection / Title
R	24/30/30.2/Media

Electronic Data Interchange (EDI) Media Changes (CR5225) (Continued)

30.2 - Media
(Rev. 1077, Issued: 10-20-06; Effective: 04-01-07, Implementation Dates: 04-02-07)
An EDI transaction is defined by its initial manner of receipt. Depending upon the capability of a carrier, DMERC, or FI and the details as negotiated between carrier/DMERC/FI and electronic claim submitters, an electronic claim could be submitted via central processing unit (CPU) to CPU transmission, dial up frame relay, direct wire (T-1 line or similar), or personal computer modem upload or download (also see §30.3).

When counting electronic claims for workload reporting, the contractor includes data on all bills received for initial processing from providers (including all RHCs) directly or indirectly through another FI, etc. It also includes data on demand bills and no-pay bills submitted by providers with no charges and/or covered days/visits. See § 90 of this chapter for information about application of the claims payment floor when a claim is submitted electronically in a non-HIPAA compliant format.

Carriers, DMERCs, and FIs are not permitted to classify the following as electronic claims for CROWD reporting, for payment floor or Administrative Simplification Compliance Act (ASCA, see section 90) mandatory electronic claim submission purposes:

- Bills received from providers if they are incomplete, incorrect, or inconsistent, and consequently returned for clarification. Individual controls are not required for these bills;
- Adjustment bills (FIs only);
- Misdirected bills transferred to another carrier, DMERC, or FI;
- HHA bills where no utilization is chargeable and no payment has been made, but which have been requested only to facilitate record keeping processes (There is no CMS requirement for HHAs to submit no payment non-utilization chargeable bills.);
- Bills paid by an HMO and processed by the contractor; and
- Transactions submitted on diskettes, CDs, DVDs or similar storage media that should only be accepted as part of a disaster recovery process.

Carriers, DMERCs, DME MACs, A/B MACs, and FIs are no longer permitted to accept claims via fax-imaging, tape/diskette/similar storage media. Carriers, DMERCs, DME MACs, A/B MACs, and FIs are to assist billers using such media to transition to more efficient electronic media, such as the free Medicare claim submission or commercially available software that are considered to be more cost effective.

End Of Contingency For Electronic Remittance Advice

Effective October 1, 2006, Medicare will send only HIPAA compliant electronic remittance advice (ANSI 4010A1 835) to all electronic remittance advice receivers. Medicare will stop sending ERA in any version other than the standard ANSI 4010A1 format. Any other format (e.g., NSF) will automatically be converted over to the standard HIPAA version effective October 1, 2006. A provider education article related to these instructions is available at:
http://www.cms.hhs.gov/MLNMattersArticles/downloads/se0656.pdf.

If you do not wish to be converted to the ANSI 4010A1 format you must notify Medicare in writing that you would like to start receiving SPR and not receive any ERA before October 1, 2006.

Remember, free software is available from Medicare that allows you to view and print your ERA identical to that of the SPR. For more information please refer to the following link: **http://www.medicarenhic.com/edi/sub_spotlight.shtml**.

Please be sure that you have the most updated version of the IVR Guide and IVR Call Flow in your office, both can be found at **http://www.medicarenhic.com/dme/contacts.shtml**

Ending the Contingency Plan for Remittance Advice (RA) and Charging for PC Print, Medicare Remit Easy Print (MREP), and Duplicate RAs (MM5308)

NEWS FLASH - Do you have your NPI? National Provider Identifiers (NPIs) will be required on claims sent on or after May 23, 2007. Every health care provider needs to get an NPI. Learn more about the NPI and how to apply for an NPI by visiting http://www.cms.hhs.gov/NationalProvIdentStand/ on the CMS web site.

MLN Matters Number: MM 5308
Related CR Release Date: September 22, 2006
Related CR Transmittal #: R1063CP
Related Change Request (CR) #: CR 5308
Effective Date: October 1, 2006
Implementation Date: October 23, 2006

Provider Types Affected
Physicians, providers and suppliers submitting claims to A/B Medicare Administrative Contractors (A/B MACs) carriers, Durable Medical Equipment Regional Carriers (DMERCs), DME Medicare Administrative Contractors (DME MACs), Fiscal Intermediaries (FIs), and/or Regional Home Health Intermediaries (RHHIs) for services provided to Medicare beneficiaries.

Impact on Providers
This Change Request (CR) updates the *Medicare Claims Processing Manual* (Publication 100-04) for ending the contingency plan for Electronic Remittance Advice (ERA), and instructs contractors about charging for PC Print, Medicare Remit Easy Print (MREP), and duplicate Remittance Advice (RA).

Background
This article is based on Change Request (CR) 5308 which

- Updates the *Medicare Claims Processing Manual* (Chapters 22 and 24) to include the end of the contingency period for Electronic Remittance Advice (ERA) effective October 1, 2006; and
- Provides instructions to Medicare contractors (A/B MACs, carriers, DMERCs, DME MACs, FIs, and RHHIs) regarding charging for:
  - Generating and mailing provider requested duplicate remittance advices (RAs). There is no current CMS instruction for contractors to charge for generating duplicate remittance advice (when provider has already been sent a remittance advice - either in electronic or paper format) and mailing in case of paper remittance advice. Therefore, CR 5308 informs Medicare Contractors that they are now allowed to charge to recoup their cost to generate a duplicate RA if the request comes from a provider or any entity working on behalf of the provider.
  - Making PC Print or Medicare Remit Easy Print software available to providers by CD/DVD or any other means when the requested software is available for free to download. Contractors may charge up to $25.00 for each mailing to cover their cost(s).

Under the Health Insurance Portability and Accountability Act (HIPAA) of 1996, an ERA sent to a provider **on or after October 16, 2003** is required to be a standard HIPAA compliant ERA, and the ERA standard adopted under HIPAA was ANSI ASC X12N transaction 835, Version 004010A1.

CMS implemented a contingency plan (as of October 16, 2003) to continue to accept and send HIPAA-compliant and non HIPAA-compliant transactions from/to trading partners beyond October 16, 2003, for a limited time.

CMS ended the contingency period <u>for claims</u> in **October 2005**, and in a Joint Signature Memorandum (JSM/TDL-06518) issued on June 28, 2006, CMS instructed Medicare contractors that it **is ending the contingency period <u>for ERAs</u>** on **September 30, 2006**.

CR 5308 instructs Medicare Contractors that, on or after October 1, 2006, all ERAs must be provided in the standard HIPAA (ANSI ASC X12N 835 version 004010A1) format.

Implementation
The implementation date for CR5308 is October 23, 2006.

Additional Information
For complete details, please see the official instruction issued to your A/B MAC, carrier, intermediary regarding this change. That instruction may be viewed at **http://www.cms.hhs.gov/Transmittals/downloads/R1063CP.pdf** on the CMS web site. The revised sections of the Medicare Claims Processing Manual are attached to CR5308.

If you have any questions, please contact your carrier, intermediary, or A/B MAC at their toll-free number, which may be found on the CMS web site at: **http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip**

Medicare Remit Easy Print (MREP) Version 1.9 is now available for download! (JSM07001)

Version 1.9 includes many improvements, including the latest version of the Claim Adjustment Reason Codes and the Remittance Advice Remark Codes, as well as:

- The MREP Remittance Advice has been modified to accommodate the presence of an NPI value at the 2110 loop and when the submitted (2110.SVC07) and paid units (2110.SVC05) of service are present and differ. Also, when claim line Remittance Advice Remark Code(s) (RARC) are present, they display further into the right on the second line of the claim line.
- The MREP Remittance Advice that is printed from the Claim Detail tab has been modified so that heading information is printed on multiple pages (when multiple pages are present)
- The user has the option to print or suppress the glossary of Remittance Advice Remark Codes (RARCs) and Claim Adjustment Reason Codes (CARCs) involved with a particular MREP Remittance Advice, when printed from the Claim Detail tab. **Note:** When the user elects to print the glossary of RARCs and CARCs, they will continue to print on a separate page from the remittance advice.
- An MREP Help online system has been incorporated into the MREP software to give the user the opportunity to look up information regarding the functionality (i.e. reports, search function, etc.) of the software rather than referring to the MREP User Guide.
- A user has the capability to automatically import 835v4010A1 remit files when the MREP application is invoked.
- The list of Remittance Advices that display in the top half portion of the MREP main screen has been modified to include a new field, Payee ID (1000B.N104).
- The Search Tab has been modified to allow the user to search on a Rendering NPI value (2110.REF02 value when 2110.REF01 = HPI).
- The following reports are new or have been updated:
  - Other Adjustments Report: This **new** report displays claims that have Late filing and Interest, and the remittance advices that have Withholding and Forwarding Balances.
  - Non-COB Claims Report: This **new** report displays claims that did not cross over. These claims do not have the value of 19, 20 or 21 in the 2100.CLP02 data field.
  - Coinsurance Report: This **new** report only displays those claim lines that have coinsurance dollar amounts greater than zero. It also displays either the Rendering NPI or the Rendering Provider Number.
  - Adjusted Service Line(s), Deductible Service Line(s), Coinsurance Service Line(s), Deductible/Co-Insurance Service Line(s) and Denied Service Line(s) Reports: These existing reports have been modified to display either the Rendering NPI or the Rendering Provider Number.

Corrected Issues

- The MREP software has been updated so that when a user chooses to resize his/her screen, the screen resizes correctly.
- The MREP software is being updated to correctly account for the dollar amounts in the claim and remit total adjustments when a CR and/or PR group code is present.

In addition, there are changes to the MREP User Guide including a *"What's New"* section with the improvements included in this version. After this October update, annual MREP updates are anticipated to be every July. Remember you can save time and money by taking advantage of **FREE** Medicare Remit Easy Print software available to view and print the HIPAA compliant 835!

Medicare Secondary Payer Edit M384

EFFECTIVE SEPTEMBER 29, 2006 , EDIT CODE M384 REINSTATED TO "CLAIM DELETE".

The 837 4010A1 implementation guides require that claims submitted for secondary payment include any adjustment amounts from the primary payer and contain standard claim adjustment reason codes to explain adjudication decisions made by the primary payer. Although Medicare does not currently use adjustment information from the primary payer to adjudicate Medicare Secondary Payer (MSP) claims, there is a possibility that a tertiary payer receiving the claim from Medicare can require this data.

Medicare Secondary Payer Edit M384 (Continued)

To comply with the ANSI 4010A1 implementation guide and to ensure that accurate adjustment information is made available to a tertiary insurance, Medicare implemented new pre-pass edit code M384 in July to reject claims when the primary payer paid amounts and the primary payer adjusted amounts did not equal the billed amount at the claim level. However, due to complaints to the Centers for Medicare & Medicaid Services (CMS) about out of balance situations and issues caused by this edit, CMS instructed carriers to set this edit code to "informational" until further notice.

After analyzing all the information, CMS has determined there is no evidence that issues exist with the primary payer Explanation of Benefits (EOBs) not balancing. Therefore, edit code M384 is being activated as "CLAIM DELETE" effective **September 29, 2006**. This means that MSP claims submitted electronically will have to balance or edit code M384 will set.

- **M384**- edit will set if the amount of 2320/AMT02 (claim level primary paid amount) plus the sum of loop 2320/CAS03, CAS06, CAS09, CAS12, CAS 15 and CAS18(claim level adjustment amounts) plus the sum of loop 2430/CAS03, CAS06, CAS09, CAS12, CAS 15 and CAS18 (line level adjustment amounts) does not equal the total of 2300/CLM02 (claim submitted charge amount).

Remember, adjustment information should be reported at either the claim level or at the service line level, but not both. Providers should only report adjustment amounts from the primary payer **once**, preferably at the service level unless the adjustment applies to the entire claim or the primary payer does not itemize the adjustments at the service level. If adjustments are repeated at both the claim and service line level, pre-pass edit M384 will set as the balancing logic will include the amounts from the header and detail CAS segments in it's calculation.

National Council for Prescription Drug Programs (NCPDP) Coordination of Benefits (COB) Companion Document Update (MM5080)

NEWS FLASH - Effective October 1, 2006, Medicare will only generate Health Insurance Portability and Accountability Act (HIPAA) compliant remittance advice-transaction 835 version 004010A1-to all electronic remittance advice receivers. For more details, see MLN Matters article SE0656 at http://www.cms.hhs.gov/MLNMattersArticles/downloads/SEO656.pdf.

MLN Matters Number: MM5080
Related CR Release Date: May 26, 2006
Related CR Transmittal #: R227OTN
Related Change Request (CR) #: 5080
Effective Date: June 26, 2006
Implementation Date: August 28, 2006

Provider Types Affected
Suppliers who submit claims to Medicare durable medical equipment regional carriers (DMERCs) and Medicare trading partners for prescription drugs provided to Medicare beneficiaries for coordination of benefits.

Background
This article and Change Request 5080 provide a One-Time Notification to DMERCs with a revised NCPDP companion document. Most current trading partners cannot accept the NCPDP version 5.1 batch standard 1.1 for COB crossover purposes due to a lack of data elements they consider essential within the transaction. The revised companion document provides workaround instructions to give current trading partners these data elements.

Key Points
The following information is important for trading partners regarding the instructions in the companion document for the workaround of the NCPDP version 5.1 batch standard 1.1 for COB crossover purposes:

- The 15-digit Internal Control Number (ICN)/Claim Control Number (CCN) that identifies a Medicare processed claim will appear in field 330-CW- (Alternate ID) within the "Claim Segment" portion of the NCPDP COB file. (**Note:** Bytes 16-19 will contain spaces.) The ICN will enable the trading partner to determine that an adjustment to an original claim occurred, since adjustments necessitate a change to the ICN.
- A Patient Assignment of Benefits Indicator default value of "Y" will be included in field 330-CW (Alternate ID) in byte 20.
- Per CMS regulations, drugs will always be paid by Medicare as mandatory assignment.
- The HICN will always be passed in "Patient ID" (field 332-CY with a "99-other" qualifier in field 331-CX Patient Id qualifier). The "Cardholder ID" (field 302-C2 carried within the "Insurance Segment") will contain the beneficiary's policy number; on claim based Medigap crossovers; that was sent on the inbound transaction in the Alternate-Id (field 330-CW carried within the "Claim Segment").
- For non-claim based Medigap crossovers, the "Cardholder ID" (field 302-C2 carried within the "Insurance Segment") will contain the beneficiary's policy number as submitted on the carrier's eligibility file.
- For Medicaid crossovers, the "Cardholder ID" (field 302-C2 carried within the "Insurance Segment") will contain the beneficiary's Medicaid policy number as submitted on the carrier's eligibility file.

National Council for Prescription Drug Programs (NCPDP) Coordination of Benefits (COB) Companion Document Update (MM5080) (Continued)

- If the beneficiary's policy number is not available, the "Cardholder ID" (field 302-C2 carried within the "Insurance Segment") will contain the beneficiary's HICN.
- The retail pharmacy's (supplier) name and address will be populated in lieu of the Facility Name and Address in the 500-byte-free formatted field when the 'Patient Location' field (307-C7) equals "1" (home).
- Values have been added to the Prior Authorization Segment Supporting Documentation Field 498-PP (Medicare Mapping)

Implementation
The implementation date for this instruction is August 28, 2006.

Additional Information
The official instructions issued to your Medicare DMERC regarding this change can be found at **http://www.cms.hhs.gov/Transmittals/downloads/R227OTN.pdf** on the CMS web site. The companion document to supplement the NCPDP Version 5.1 Batch Transaction Standard1.1 Billing Request for exchanges with Medicare DMERCs is attached to CR5080.

Note that the missing data elements in the NCPDP version 5.1 batch standard 1.1 were addressed in CR4290. To view the MLN Matters article related to CR4290 go to **http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4290.pdf** on the CMS web site.

If you have questions, please contact your Medicare DMERC at their toll-free number, which may be found at **http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.pdf** on the CMS web site.

Options for Providers/Suppliers Affected by CR4376: Suppression of Standard Paper Remittance Advice (SPR) to Providers and Suppliers Also Receiving Electronic Remittance Advice (ERA) for 45 Days or More (SE0627)

MLN Matters Number: SE0627
Related CR Release Date: N/A
Related CR Transmittal #: N/A
Related Change Request (CR) #: N/A
Effective Date: N/A
Implementation Date: N/A

Provider Types Affected
Physicians, suppliers, qualified non-physician practitioners, and other providers billing Medicare carriers, including durable medical equipment regional carriers (DMERCs)

Provider Action Needed
Impact to You
This Special Edition reminds providers that as of June 1, 2006, if you have been receiving **both** an Electronic Remittance Advice (ERA), either directly from your Medicare carrier/DMERC or indirectly from a clearinghouse, billing agent, or other entity representing you, **and** a Standard Paper Remittance (SPR) from your carrier/DMERC for 45 days or more, that **you will no longer be mailed an SPR** by your carrier/DMERC, in accordance with Change Request (CR) 4376. This article outlines some of the options available to providers who will no longer receive the SPR directly from their carrier/DMERC.

What You Need to Know
Are you receiving an ERA? Make sure you know if and how you receive the ERA. You may be receiving your ERA directly from your carrier/DMERC or you may be receiving your ERA indirectly through a billing agent, clearinghouse, or other entity representing you. No matter how you receive your ERA, if you are also receiving an SPR from your carrier/DMERC in addition to receiving an ERA for 45 days or more, after June 1, 2006, your carrier/DMERC will no longer mail you an SPR. **If you still need both, take appropriate action now.**

What You Need to Do
If you need the SPR, take action **NOW** so you can avoid any business disruption associated with the June 1, 2006, cutoff of the SPR. If your clearinghouse, billing agent, or other entity cannot offer a way (e.g. print software) for you to receive or generate a paper remittance, it may be beneficial to explore other options.

Options for Providers/Suppliers Affected by CR4376: Suppression of Standard Paper Remittance Advice (SPR) to Providers and Suppliers Also Receiving Electronic Remittance Advice (ERA) for 45 Days or More (SE0627) (Continued)

Determine which of the following scenarios represents your situation:

1. **You are receiving the ERA directly from your carrier in the HIPAA-compliant 835 format:** Use the Medicare Remit Easy Print (MREP) software. MREP requires that you import ERAs in the HIPAA-compliant 835 format. (**NOTE:** 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.) (See the *Additional Information* section of this article for further information.) MREP is **free** software that allows you to:
   - Print the ERA for individual or multiple selected claims in a format mirroring the SPR, so you can forward your remittance to secondary/tertiary payers;
   - Easily navigate and view remittance information;
   - Quickly access claim information;
   - Print and export useful reports about ERAs including denied, adjusted, and deductible service lines;
   - Receive the latest version of Claim Adjustment Reason and Remittance Advice Remark Code sets, three times a year;
   - Archive, restore, and delete imported ERAs; and
   - Eliminate physical filing and storage space needs.
2. **You are receiving a HIPAA-compliant 835 from a billing agent, clearinghouse, or other entity**: Use MREP or software offered by the billing agent, clearinghouse, or other entity representing you to view and print your paper remittance advice.
3. **You are receiving the ERA directly in a format that is not the HIPAA-compliant 835 format:** Transition to the HIPAA-compliant 835 format now, so you can begin using MREP. CMS ended the contingency plan for non-HIPAA claims, i.e., 837 transaction, in 2005. CMS will be ending the contingency plan for the non-HIPAA remittance advice, i.e., the 835, next.
4. **You are receiving an ERA that is not the HIPAA-compliant 835 format from your billing agent, clearinghouse, or other entity representing you and they do not offer software or other means that allows you to view and print your remittance advice:** Work with them so that they will send you a HIPAA-compliant 835, so you can use MREP.
5. **You have a need for the paper remittance advice and your clearinghouse, billing agent, or other entity representing you is receiving the ERA on your behalf, but does not currently forward the ERA to you:** Work with your clearinghouse, billing agent, or other entity to receive the ERA and use MREP. This may be your situation if the clearinghouse, billing agent, or other entity representing you receives the ERA for you, but until now there has been no business reason to forward the ERA to you.

Background
CMS has an initiative for moving to a more electronic transaction environment and reducing the cost associated with producing and mailing the paper remittances sent by CMS contractors. The *Medicare Claims Processing Manual*, Chapter 22, Section 40.1, Remittance Advice, describes the instructions issued by CMS to carriers and DMERCs. The section instructs carriers and DMERCs to eliminate SPRs to those providers/suppliers who were receiving ERA transactions for 45 days or more.

Implementation
The implementation date is June 1, 2006

Additional Information
To learn about more MREP benefits, download the brochure available at **http://www.cms.hhs.gov/MLNProducts/downloads/remit_easy_print.pdf** on the CMS web site. Or, you can view Special Edition MLN Matters article SE0611 at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0611.pdf** or a related MLN Matters article (MM4376) at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4376.pdf** on the CMS web site.

For more information about the MREP software and how to receive the HIPAA 835, please contact your carrier/DMERC. Medicare Part B Electronic Data Interchange (EDI) helpline phone numbers are available at **http://www.cms.hhs.gov/ElectronicBillingEDITrans/** on the CMS web site.

If you have other questions, please contact your Medicare carrier/DMERC at their toll-free number, which may be found at **http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.pdf** on the CMS web site.

The official instructions (CR4376) issued to your carrier/DMERC regarding this change can be found at **http://www.cms.hhs.gov/transmittals/downloads/R885CP.pdf** on the CMS web site.

Please have your supplier number and the beneficiary's HIC and DOB ready when you call customer service.

Communications Infrastructure Testing (CR 5336)

Background
The Centers for Medicare and Medicaid Services (CMS) is working to ensure that its communications infrastructure can reach providers/suppliers in the event of a regional or national disaster. It is important that at such times providers/suppliers can be reached with critical information in a timely fashion. As the DME MAC for Jurisdiction A our relationship with the Medicare providers/suppliers is a key component of this infrastructure. In order to strengthen the level of emergency preparedness, CMS will be working with all contractors in providing ways to test our communications infrastructure in the near future.

DME MAC Jurisdiction A ListServes
The DME MAC Jurisdiction A listserves are a simple way to remain informed of critical information in case of either a regional or national emergency. The DME General Interest listserve is currently used to notify subscribers via email of important and time-sensitive Medicare program information, upcoming provider education and training events, and other important announcements or messages. The General listserve will also be used for the purpose of communicating critical information in the event of a regional or national emergency. It is important for you to subscribe to this listserve. An online sign up form for the DME MAC Jurisdiction A listserves can be found at **http://ui.constantcontact.com/d.jsp?m=1101306329206&p=oi**

Do You Have a Back Up?
In order to ensure that critical information is received by you and your staff, we, along with CMS, recommend that all providers/suppliers have **an alternate contact subscribed to the listserve as a backup**. In times of emergency, critical information can slip through the cracks when the primary listserve subscriber is unable to receive the message, and having an alternate contact can help to ensure that all critical information can properly be distributed.

IVR Update

Beginning on Monday October 2, 2006 there were several new updates to the Interactive Voice Response (IVR) System due to the new disclosure desk reference that was effective (CR5089). NHIC, Corp. has updated the IVR manual and it is now available on our Web site.

Changes to the IVR include:

Beneficiary Eligibility

- Per the Centers of Medicare and Medicaid Services (CMS), providers must now enter in the beneficiary's first initial and first 6 letters of the last name. They can either speak this information or they can use their touchtone pad. CMS has removed the requirement for providers to enter in the beneficiary's gender. Providers must enter their provider #, Health Insurance Claim (HIC) #, date of birth and beneficiary name.
- The IVR will be able to give detailed information about Medicare Secondary Payer (MSP) records including the effective dates along with the name and address of the plan. There is also a date of service compare function that will allow providers to check a previous date of service. If the MSP information is not available in the IVR, the IVR will prompt the provider to contact the beneficiary.
- The IVR will be able to give the effective dates, plan #, name and address of Medicare Advantage (HMO) plans. This update however will not allow providers to check a previous date of service like it does for MSP. Customer Service Representatives (CSRs) will respond to an inquiry regarding a terminated Medicare Advantage/HMO plan. If the information is not available in the IVR, the IVR will prompt the provider to contact the beneficiary.
- **Same or similar** - Under the CMN status menu option, the provider is now required per CMS to query for specific HCPCS to check for same or similar. Per CMS, the IVR can search for an exact match, but not similar. So the providers will have to check each HCPCS in a similar category. For example; if the provider is going to provide a K0001 wheelchair, they would need to check for K0001, K0003, K0004, etc... individually. Obviously the beneficiary does not need to be on the line for this. The provider can check in the IVR for CMNs and dummy CMNs in Jurisdiction A and the Common Working File (CWF). Currently, the IVR only offers information on Oxygen and PEN, but staring 10/2/06, it will be able to check for anything that would have a CMN or a dummy CMN. **CSRs will no longer handle calls on same or similar from the providers, unless the HIC# cannot be accessed in the IVR**.
- The IVR will now be able to give out a date of death if the provider specifically asks for it. The IVR will also now release entitlement dates and other eligibility information when there is a date of death on file.
- The IVR will also be able to give out how much of the deductible has been met.

IVR Update (Continued)

Claim Status

- Providers will now need to verify the beneficiary name in the same way that is done in the eligibility menu.

Complete instructions on using the DME MAC A IVR can be accessed on our Web site at **http://www.medicarenhic.com/dme/contacts.shtml**. The *DME IVR Guide* is a step by step guide through the DME IVR and the *DME IVR Call Flow* is a visualization of the menu system.

Medicare Provider Feedback Town Hall Meeting (SE0666)

NEWS FLASH - Sign up now to the listserv appropriate for you at http://www.cms.hhs.gov/apps/mailinglists/. Get your Medicare news as it happens!

MLN Matters Number: SE0666
Related CR Release Date: N/A
Related CR Transmittal #: N/A
Related Change Request (CR) #: N/A
Effective Date: N/A
Implementation Date: N/A

Provider Types Affected
Physicians, suppliers, and providers billing Medicare carriers, fiscal intermediaries (FIs), durable medical equipment regional carriers (DMERCs), DME Medicare Administrative Contractors (DME MACs), and regional home health intermediaries (RHHIs), for services to Medicare beneficiaries

Background
The purpose of this Special Edition (SE) article is to alert individual Medicare Fee-for-Service (FFS) providers and suppliers that a town hall meeting soliciting their opinions is scheduled. CMS recognizes and values the importance of medical associations, individual provider and supplier perspectives and looks forward to providing this town hall meeting as a feedback venue.

Key Points
- The Centers for Medicare & Medicaid Services (CMS) will convene a Town Hall meeting on September 20, 2006, from 2:00 p.m. until 4:00 p.m. (Eastern Daylight Time).
- The meeting will be held in the CMS auditorium located at 7500 Security Boulevard, Baltimore, Maryland 21244 and by teleconference.
- Those wishing to participate via teleconference may dial **1-877-357-7851** and use conference ID number **2323964**.
- Individuals wishing to participate, either in person or via teleconference, must complete the online registration at **http://registration.intercall.com/menu.php?short_name=cms2. For in person attendance, be sure to register prior to 5:00 p.m. EDT on September 18, 2006, to assure access to the building. You must also present a photo ID, preferably a driver's license to gain access to the meeting in person.**
- The meeting will provide CMS with an open and public venue to interact with individual Medicare physicians, providers and suppliers and obtain their feedback on a variety of Medicare policy and operational issues.
- All physicians, providers, and suppliers who participate in the Medicare program, including hospitals, home health agencies, and their third party billers, are invited to attend this meeting.

Additional Information
If you have questions, please contact your Medicare carrier, DMERC, DME MAC, FI, or RHHI at their toll-free number which may be found at **http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip** on the CMS website.

Medicare Survey Finds Overall Satisfaction In Contractor-Provider Relationship (JSM07009)

The vast majority of Medicare health care providers are satisfied with the customer service, claims processing and educational activities provided by the Medicare fee-for-service contractors, according to a new survey conducted by the Centers for Medicare & Medicaid Services (CMS).

Medicare Survey Finds Overall Satisfaction In Contractor-Provider Relationship (JSM07009) (Continued)

The first Medicare Contractor Provider Satisfaction Survey (MCPSS) was designed to garner objective, quantifiable data on provider satisfaction with the fee-for-service (FFS) contractors that process and pay Medicare claims. The MCPSS revealed that 85 percent of respondents rated their contractors between 4 and 6 on a 6-point scale.

The survey was sent early this year to more than 25,000 randomly selected providers, including physicians, suppliers, health care practitioners and institutional facilities that serve Medicare beneficiaries across the country. MCPSS will be administered on an annual basis to measure satisfaction with key services performed by the 42 FFS contractors that process and pay more than $280 billion in Medicare claims each year.

"Our partnerships with physicians and hospitals - the full scope of health providers - is so important that we are measuring their satisfaction with contractors' service levels and hold the contractors to high performance standards," said CMS Administrator Mark B. McClellan, M.D., Ph.D. "The new survey aids us in working with Medicare contractors which, in turn, will help us be more effective in dealing with our providers nationwide."

The survey focused on the seven business functions of the provider contractor relationship provider communications, provider inquiries, claims processing, appeals, provider enrollment, medical review, and provider audit and reimbursement. Respondents were asked to rate their contractors using a scale of 1 to 6 on each of the business functions, with "1" representing "not at all satisfied" and "6" representing "completely satisfied."

For all contractor types, key predictors for satisfaction were the handling of provider questions and claims processing. The specific composite scores by contractor type are:

- Regional home health intermediaries received an average score of 4.79
- Part A fiscal intermediaries received 4.71
- Part B carriers received 4.52
- Durable medical equipment regional carriers received 4.43

Among those who interact with fiscal intermediary contractors, the most satisfied providers are rural health centers and skilled nursing facilities, both with 4.73, followed by end stage renal disease treatment facilities with 4.59, and hospitals with 4.57.

For those interacting with carrier contractors, the most satisfied providers are ambulance (4.66) and physicians (4.61), followed by labs (4.50) and licensed practitioners (4.40).

"Provider feedback is a critical component of the evaluation and enhancement process in our effort to get the best possible contractor performance," Dr. McClellan said. "These results from our first year survey will set the baseline so we may identify trends and address issues in the future. The survey enables CMS to make valid comparisons of provider satisfaction between contractors and, over time, improvements to the Medicare program."

In January, the 2007 MCPSS will be distributed to a new sample of Medicare providers. The views of each provider in the survey are important because they represent many other organizations similar in size, practice type and geographical location.

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. 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.

Further information about the MCPSS is available at **http://www.cms.hhs.gov/MCPSS/**

Medicare Contractor Provider Satisfaction Survey (MCPSS) Fact Sheet (JSM07009)

Survey Overview

The Medicare Contractor Provider Satisfaction Survey (MCPSS) is designed to garner objective, quantifiable data on provider satisfaction with the performance of Medicare fee-for-service (FFS) claims payment contractors. Specifically, the survey enables the Centers for Medicare & Medicaid Services (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. Results from the first survey implementation are now available.

The contractors will begin to use the insights gleaned from the MCPSS to make changes to their systems and procedures. CMS will use the findings as a benchmark for monitoring future trends as well as to improve its oversight and increase efficiency of the Medicare program.

Medicare Contractor Provider Satisfaction Survey (MCPSS) Fact Sheet (JSM07009) (Continued)

The Results

For the 2006 administration of MCPSS, CMS provided to the public an array of findings, such as provider satisfaction by contractor type; satisfaction with contractor group by provider type; business function scores by contractor and provider type; and individual contractor composite scores. In addition to their composite scores, contractors received aggregate scores for each business function.

- In general, **Medicare providers are highly satisfied with their contractors**. The MCPSS revealed that **85 percent of the respondents rated their contractors between 4 and 6 on a 6-point scale**
- For all contractor types, key predictors for satisfaction were the handling of provider questions and claims processing
- Specific **composite scores by contractor type** are as follows:
  - Regional Home Health Intermediaries (RHHIs) received a composite score of 4.79
  - Fiscal Intermediaries (FIs) received 4.71
  - Carriers received 4.52
  - Durable Medical Equipment Regional Carriers (DMERCs) received 4.43
- Among those who **interact with FI contractors**, the **most satisfied providers are Rural Health Centers (RHC) and Skilled Nursing Facilities (SNF), both with 4.73**, followed by **End Stage Renal Disease (ESRD) providers (4.59) and Hospitals (4.57)**
- With respect to **interacting with Carrier contractors, the most satisfied providers are Ambulance (4.66) and Physicians (4.61), followed by Labs (4.50) and Licensed Practitioners (4.40)**
- The survey also looked at both the effect of the volume of claims as well as how the score for each business function related to overall satisfaction - neither of which had a measurable impact on satisfaction across all provider types

Survey Background

Purpose & Goals

- Purpose: Obtain **quantifiable data** to enable CMS to measure provider satisfaction with the performance of Medicare contractors
- Three **primary goals**:
  - Satisfy Medicare Modernization Act (2003) requirements to measure provider satisfaction levels
  - Provide feedback from providers to contractors so they may implement process improvement initiatives
  - Establish a uniform measure of provider satisfaction with contractor performance

Survey Administration

- First national administration queried more than **25,000 randomly selected providers** (physicians, healthcare practitioners, and facilities) out of the 1.2 million who serve Medicare beneficiaries
- Survey included all 42 Medicare Fee For Service contractors
- Questions focused on **seven business functions of the provider contractor relationship**: provider communications, provider inquiries, claims processing, appeals, provider enrollment, medical review, provider audit and reimbursement
- Respondents were asked to rate their contractors using a scale of 1 to 6 on each of the business functions, with "1" representing "not at all satisfied" and "6" representing "completely satisfied"

Looking Ahead: A Call to Action

The 2007 MCPSS will be distributed to a new sample of Medicare providers in January. CMS urges all Medicare providers who are selected to participate in the MCPSS to complete and return their surveys. The views of every provider asked to participate are very important to the success of this study, as each one represents many other organizations that are similar in size, practice type and geographical location.

Timeline:

- 2nd National administration: January 2007
- Contractor Reports: July 2007
- Final Reports: July 2007

For more information and survey results, please contact:

CMS:

- Gladys Valentin, 4107861620, **Gladys.Valentin@cms.hhs.gov**
- Colette Shatto, 4107866932, **Colette.Shatto@cms.hhs.gov**

Westat (the survey research firm hired to administer MCPSS):

- Contractor Helpline: Lauren Shrader, 18887217104, **mcpss@westat.com**
- Provider Helpline: Joshua Rubin, 18888633561, **mcpss@westat.com**

Or visit: **http://www.cms.hhs.gov/MCPSS/**

Medicare Contractor Provider Satisfaction Survey (JSM07009)

Centers for Medicare & Medicaid Services MCPSS Frequently Asked Questions September 2006

1. **When was the 2006 Medicare Contractor Provider Satisfaction Survey (MCPSS) conducted?**
   Survey notification packets were mailed in waves between January and February, and responses were received via mail, web, fax and phone through May.

2. **Who was surveyed in the 2006 Medicare Contractor Provider Satisfaction Survey (MCPSS)?**
   The 2006 sample included more than 25,000 providers - those physicians, healthcare practitioners and facilities who serve Medicare beneficiaries across the country. This group reliably represents the national community of 1.2 million Medicare providers.

   Specifically, CMS considered the following for the randomly selected sample:
   a. Physicians
   b. Licensed practitioners
   c. Hospitals
   d. Skilled nursing facilities
   e. Rural health clinics
   f. Home health agencies
   g. Federally qualified health centers (FQHC)
   h. Hospices
   i. End-stage renal disease (ESRD) facilities
   j. Durable medical equipment (DME) suppliers
   k. Ambulance service providers
   l. Other Part A and Part B providers

3. **What did CMS ask in 2006 Medicare Contractor Provider Satisfaction Survey (MCPSS)?**
   CMS queried respondents on the seven business functions of the provider-contractor relationship:
   a. Provider communications
   b. Provider inquiries
   c. Claims processing
   d. Appeals
   e. Provider enrollment
   f. Medical review
   g. Provider audit and reimbursement
   Respondents were asked to rate their contractors using a scale of 1 to 6 on each of the business functions, with "1"representing"not at all satisfied"and "6" representing "completely satisfied."

4. **What are the results of the 2006 Medicare Contractor Provider Satisfaction Survey (MCPSS)?**
   Contractors received an overall composite score, a score on each business function and a score for each of the provider types they serve. CMS provided to the public a series of program-wide findings, such as provider satisfaction by contractor type; satisfaction with contractor group by provider type; and business function scores by contractor and provider type.
   - In general, Medicare providers are highly satisfied with their contractors. At least 85 percent of the respondents rated their contractors between 4.0 and 6.0 on a 6-point scale
   - For all contractor types, key predictors for satisfaction were the handling of provider questions and claims processing
   - Specific composite scores by contractor type are as follows:
     - Regional Home Health Intermediaries (RHHIs) received a composite score of 4.79
     - Fiscal Intermediaries (FIs) received a 4.71
     - Carriers received 4.52
     - Durable Medical Equipment Regional Carriers (DMERCs) received 4.43
   - Among those who interact with FI contractors, the most satisfied providers are Rural Health Centers (RHC) (4.73) and Skilled Nursing Facilities (SNF) (4.73), followed by End Stage Renal Disease (ESRD) providers (4.59) and Hospitals (4.57)
   - With respect to interacting with Carrier contractors, the most satisfied providers are Ambulance (4.66) and Physicians (4.61), followed by Labs (4.50) and Licensed Practitioners (4.40)

5. **Where can I find a summary of all the results of the 2006 Medicare Contractor Provider Satisfaction Survey (MCPSS)?**
   The public report is available via **http://www.cms.hhs.gov/MCPSS**.

6. **Did the 2006 Medicare Contractor Provider Satisfaction Survey (MCPSS) consider varying claims volumes among providers?**
   The survey looked at the effect of the volume of claims on the score for each business function and on overall satisfaction - neither of which had a measurable effect on provider satisfaction.

7. **How will CMS use the results of the 2006 Medicare Contractor Provider Satisfaction Survey (MCPSS)?**
   CMS will use the findings as a benchmark for monitoring future trends as well as to improve its oversight and increase the efficiency of the Medicare program. A scientifically-sound, objective method for measuring provider satisfaction enables CMS to make improvements over time to the Medicare program.

Medicare Contractor Provider Satisfaction Survey (JSM07009) (Continued)

8. **Why is CMS conducting the Medicare Contractor Provider Satisfaction Survey (MCPSS)?**
   CMS is conducting the MCPSS to achieve three primary goals:
   - Satisfy Medicare Modernization Act (2003) requirements to measure provider satisfaction levels
   - Provide feedback from providers to contractors so they may implement process improvement initiatives
   - Establish a uniform measure of provider satisfaction with contractor performance
9. **When will the next Medicare Contractor Provider Satisfaction Survey (MCPSS) be conducted?**
   The 2007 MCPSS will be administered to a new sample of Medicare providers in January. CMS urges all Medicare providers who are selected to participate in the MCPSS to complete and return their surveys. The views of every provider asked to participate are very important to the success of this study, as each one represents many other organizations that are similar in size, practice type and geographical location. For more information and survey results, visit **http://www.cms.hhs.gov/MCPSS/**.
10. **Who do I contact for questions or to comment on the Medicare Contractor Provider Satisfaction Survey (MCPSS)?**
    Either submit questions or comments via email at mcpss@westat.com or call 1-888-863-3561. CMS will review all questions and comments.
11. **Are there Spanish versions of the Medicare Contractor Provider Satisfaction Survey (MCPSS)?**
    Yes. CMS developed a Spanish language version of the 2006 survey instrument and all related survey materials and will do so again in 2007.
12. **Will CMS survey the same providers every year in the Medicare Contractor Provider Satisfaction Survey (MCPSS)?**
    No. CMS will randomly select a new sample each year. The survey data is reliable only if the respondents are randomly selected and all Medicare provider types are represented (see Question 2). In some cases, where contractors serve a relatively small population of providers, providers sampled in 2006 may be sampled again in 2007.

DME MAC A's Gift Policy

During the holiday season, people often like to show their appreciation with gifts. Occasionally, we at the Jurisdiction A Durable Medical Equipment Medicare Administrative Contractor (DME MAC A) receive gifts such as candy, fruit baskets, and flowers from beneficiaries, providers, and their billing staffs, in appreciation and thanks for our customer service. While we greatly appreciate the generosity of such gifts, we are unable to accept them. As part of our Code of Conduct, DME MAC A has a zero tolerance policy regarding gifts - we cannot accept any. If you would like to express your thanks for service you have received from DME MAC A's representatives, we welcome notes or letters of appreciation in place of gifts.

2007 Jurisdiction A DME MAC Holiday Schedule

The Jurisdiction A Durable Medical Equipment Medicare Administrative Contractor (DME MAC A) will be observing the following holidays in 2007:

Holiday	2007 NHIC Holiday Schedule
New Year's Day Holiday	Monday, January 1
Martin Luther King Jr. Birthday	Monday, January 15
Memorial Day	Monday, May 28
Independence Day	Wednesday, July 4
Labor Day	Monday, September 3
Veteran's Day	Monday, November 12
Thanksgiving	Thursday, November 22
Day after Thanksgiving	Friday, November 23
Day before Christmas	Monday, December 24
Christmas Holiday	Tuesday, December 25

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

Announcing the new Centers for Medicare & Medicaid Services (CMS) Web page dedicated to providing all the latest NPI news for Fee-For-Service (FFS) Medicare providers! Visit **http://www.cms.hhs.gov/NationalProvIdentStand/** on the Web!

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

Correction of Business Requirement 4320.19 as Contained in CR4320 Regarding National Provider Identifier Information (MM5217)

NEWS FLASH - Sign up now to the listserv appropriate for you at http://www.cms.hhs.gov/apps/mailinglists/. Get your Medicare news as it happens!

MLN Matters Number: MM5217
Related CR Release Date: August 18, 2006
Related CR Transmittal #: R235OTN

Related Change Request (CR) #: 5217
Effective Date: January 1, 2006
Implementation Date: November 20, 2006

Provider Types Affected
Physicians, providers, and suppliers who submit claims to Medicare contractors (carriers, including durable medical equipment regional carriers (DMERCs) and DME Medicare administrative contractors (DME MACs), fiscal intermediaries (FIs), and regional home health intermediaries (RHHIs))

Impact on Providers
This article is based on change request CR5217, which instructs your Medicare carrier/DMERC/DME MAC, or FI/RHHI to provide specific National Provider Identifiers (NPIs) for those providers identified in electronic claims, such as a billing, pay-to, rendering or other provider, that have already obtained NPIs.

Prior to May 23, 2007, providers should report the Medicare legacy identifiers of those providers enrolled to submit claims to Medicare, as well as their NPI.

Note: Pending Medicare implementation of the UB-04 and the revised CMS-1500, providers are not to report NPIs on the current paper claim forms.

If not already available, the following information will be posted on your local Medicare contractor's web site, or included in provider newsletters from your local Medicare contractor:

- Adjustments to edits to be applied when an NPI is included in an electronic data interchange (EDI) transaction; and
- Actions that can be taken by claim and 276 submitters to avoid rejection of their transactions as result of these edits, and information about how to correct and resubmit a transaction if the transactions are rejected as result of these edits.

Additional Information
CR4320, "Stage 1 Use and Editing of National Provider Identifier Numbers Received in Electronic Data Interchange Transactions, via Direct Data Entry Screens, or on Paper Claim Forms" can be located at **http://www.cms.hhs.gov/transmittals/downloads/R204OTN.pdf** on the CMS web site.

MM4320, the similarly titled Medicare Learning Network (MLN) article associated with CR4320, is found at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4320.pdf** on the CMS web site.

CR5217 is the official instruction issued to your Medicare carrier/DMERC/DME MAC/FI/RHHI regarding changes mentioned in this article. CR5217 may be found at **http://www.cms.hhs.gov/Transmittals/downloads/R235OTN.pdf** on the CMS web site.

If you have questions, please contact your local Medicare carrier/DMERC/DME MAC/FI/RHHI at their toll-free number, which may be found at **http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip** on the CMS web site.

Important Changes to NPI Implementation

Beginning October 2, 2006, Medicare will begin accepting claims with a legacy Medicare provider number and/or an NPI. Although you will have the option of submitting your claims with the NPI number only, we strongly urge that you continue to use your Medicare legacy number in addition to the NPI on all your claims. Providing your legacy Medicare number on all claims will allow system verification between your Medicare number and NPIs supplied by the NPI enumerator. Failure to include your Medicare legacy number, may result in delays or rejections to the adjudication of your claims.

To comply with all NPI requirements effective October 2, 2006, the following edit codes will set if the field requirements are not met.

EDIT	LOOP/DATA ELEMENT	NAME	DESCRIPTION	EDIT LOGIC
M010	2010AA REF01	Billing Provider Reference Identification Qualifier	Medicare Prov Qualifier (1C) missing	Edit is set if segment with 1C qualifier is missing on the 2010AA REF01 or 2010AB REF01, or the NM108 is not XX in the 2010AA or the 2010AB
M012	2010AA REF02	Billing Provider Additional Identifier	Billing Prov not on file	Edit is set if BPRV or BNPI not on PCF. **NOTE:** Edit performs when 2010AA REF01 = 1C qualifier or the 2010AA NM108 = XX.
M013	2010AA REF02	Billing Provider Additional Identifier	Submitter/ billing Prov not on file	Edit is set if the submitter/BPROV or the submitter/BNPI is not on PCF. **NOTE:** Perform this edit for the submitter/billing provider combination of 1000A/NM109 and the BPROV 2010AA/REF02 with 2010AA/REF01 = 1C. Or the 1000A/NM109 and the BNPI 2010AA/NM109 with 2010AANM108 is XX.
M017	2010AB REF02	Pay-To-Provider Identifier	Prov not on file	Edit is set if PRV or the PNPI not on PCF. **NOTE:** Perform edit if 2010AA REF01 is not 1C and 2010AB REF01 = 1C or if the 2010AA NM108 is not XX and the 2010AB NM108 = XX.
M340	2010AA REF01	Billing Provider Secondary Identifier	Required Element Missing	Set the edit when the value in NM108 is equal to XX and there is a REF01 within the same loop containing the qualifier 1C or 1G and the value is not found on the MCS PIN/NPI Crosswalk file. **NOTE:** If PIN is not received edit only validates NPI on crosswalk.
M341	2010AB REF01	Pay-To Provider Secondary Identifier	Required Element Missing	Set the edit when the value in NM108 is equal to XX and there is a REF01 within the same loop containing the qualifier 1C or 1G and the value is not found on the MCS PIN/NPI Crosswalk file. **NOTE:** If PIN is not received edit only validates NPI on crosswalk.
M342	2310A REF01	Referring Provider Secondary Identifier	Required Element Missing	Set the edit when the value in NM108 is equal to XX and there is a REF01 within the same loop containing the qualifier or 1G and the value is not found on either the MCS PIN/NPI or the Other/NPI Crosswalk files. **NOTE:** If Surrogate UPIN is received edit only validates NPI is on the crosswalk.
M343	2310B REF01	Rendering Provider Secondary Identifier	Required Element Missing	Set the edit when the value in NM108 is equal to XX and there is a REF01 within the same loop containing the qualifier 1C or 1G and the value is not found on the MCS PIN/NPI Crosswalk file. **NOTE:** If PIN is not received edit only validates NPI on crosswalk.

Important Changes to NPI Implementation (Continued)

EDIT	LOOP/DATA ELEMENT	NAME	DESCRIPTION	EDIT LOGIC
M344	2310C REF01	Purchase Service Provider Secondary Identifier	Required Element Missing	Set the edit when the value in NM108 is equal to XX and there is a REF01 within the same loop containing the qualifier 1C or 1G and the value is not found on either the MCS PIN/NPI or the Other/NPI Crosswalk files. **NOTE:** If PIN is not received edit only validates NPI on crosswalk.
M345	2310D REF01	Service Facility Provider Secondary Identifier	Required Element Missing	Set the edit when the value in NM108 is equal to XX and there is a REF01 within the same loop containing the qualifier 1C or 1G and the value is not found on either the MCS PIN/NPI or the Other/NPI Crosswalk files. **NOTE:** If PIN is not received edit only validates NPI on crosswalk.
M346	2310E REF01	Supervising Provider Secondary Identifier	Required Element Missing	Set the edit when the value in NM108 is equal to XX and there is a REF01 within the same loop containing the qualifier or 1G and the value is not found on either the MCS PIN/NPI or the Other/NPI Crosswalk files. **NOTE:** If Surrogate UPIN is received edit only validates NPI is on the crosswalk.
M347	2420A REF01	Rendering Provider Secondary Identifier	Required Element Missing	Set the edit when the value in NM108 is equal to XX and there is a REF01 within the same loop containing the qualifier 1C or 1Gand the value is not found on the MCS PIN/NPI Crosswalk file. **NOTE:** If PIN is not received edit only validates NPI on crosswalk.
M348	2420B REF01	Purchased Service Provider Secondary Identifier	Required Element Missing	Set the edit when the value in NM108 is equal to XX and there is a REF01 within the same loop containing the qualifier 1C or 1G. and the value is not found on either the MCS PIN/NPI or the Other/NPI Crosswalk files. **NOTE:** If PIN is not received edit only validates NPI on crosswalk.
M349	2420D REF01	Supervising Provider Secondary Identifier	Required Element Missing	Set the edit when the value in NM108 is equal to XX and there is a REF01 within the same loop containing the qualifier or 1G and the value is not found on either the MCS PIN/NPI or the Other/NPI Crosswalk files. **NOTE:** If Surrogate UPIN is received edit only validates NPI is on the crosswalk.
M350	20420E REF01	Ordering Provider Secondary Identifier	Required Element Missing	Set the edit when the value in NM108 is equal to XX and there is a REF01 within the same loop containing the qualifier or 1G and the value is not found on either the MCS PIN/NPI or the Other/NPI Crosswalk files. **NOTE:** If Surrogate UPIN is received edit only validates NPI is on the crosswalk.
M351	2420F REF01	Referring Provider Secondary Identifier	Required Element Missing	Set the edit when the value in NM108 is equal to XX and there is a REF01 within the same loop containing the qualifier 1C or 1G and the value is not found on either the MCS PIN/NPI or the Other/NPI Crosswalk files. **NOTE:** If Surrogate UPIN is received edit only validates NPI is on the crosswalk.

Important Changes to NPI Implementation (Continued)

EDIT	LOOP/DATA ELEMENT	NAME	DESCRIPTION	EDIT LOGIC
M379	2010AA REF02	Billing Provider Additional Identifier	Invalid Value	Edit is set if the 2010AA and the 2010AB do not contain a REF01 of 1C. The 2010AA REF01 does contain: EI and the EIN is not on the PIN/NPI Crosswalk file for the NPI in the 2010AA NM109 OR SY and the SSN is not on the PIN/NPI Crosswalk file for the NPI in the 2010AA NM109
M380	2010AB EF02	Pay-To Provider Secondary Identification	Invalid Value	Edit is set if the 2010AA and the 2010AB do not contain a REF01 of 1C and the 2010AA does not contain NM108 of XX. The 2010AB REF01 does contain: EI and the EIN is not on the PIN/NPI Crosswalk file for the NPI in the 2010AA NM109 OR SY and the SSN is not on the PIN/NPI Crosswalk file for the NPI in the 2010AA NM109
M381	2310B REF02	Rendering Provider Secondary Identifier	Invalid Value	Edit is set if the 2310B does not contain a REF01 of 1C. The 2310B REF01 does contain: EI and the EIN is not on the PIN/NPI Crosswalk file for the NPI in the 2310B NM109 OR SY and the SSN is not on the PIN/NPI Crosswalk file for the NPI in the 2310B NM109 OR The 2010AA or 2010AB REF01 of EI and the EIN is not on the PIN/NPI Crosswalk file for the NPI in the 2310B NM109
M382	2420A REF02	Rendering Provider Secondary Identifier	Invalid Value	Edit is set if the 2420A does not contain a REF01 of 1C. The 2420A REF01 does contain: EI and the EIN is not on the PIN/NPI Crosswalk file for the NPI in the 2420A NM109 OR SY and the SSN is not on the PIN/NPI Crosswalk file for the NPI in the 2420A NM109 OR The 2010AA or 2010AB REF01 of EI and the EIN is not on the PIN/NPI Crosswalk file for the NPI in the 2420A NM109
M387	1000B NM109	Receiver Primary Identifier	Invalid Value	Edit is set if the 2010AA and the 2010AB do not contain a REF01 of 1C. The contractor number found in the 1000B NM109 is not found on the PIN/NPI Crosswalk file for the NPI in the 2010AA NM109 or the 2010AB NM109 when the NM108 is XX

Important Guidance Regarding National Provider Identifier (NPI) Usage in Medicare Claims (SE0659)

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MLN Matters Number: SE0659
Related CR Release Date: N/A
Related CR Transmittal #: N/A
Related Change Request (CR) #:N/A
Effective Date: N/A
Implementation Date: N/A

Provider Types Affected
Physicians, providers, and suppliers who conduct HIPAA standard transactions, such as claims and eligibility inquiries

Provider Action Needed
Impact to You
You must report your NPI correctly on all electronic data interchange (EDI) transactions that you submit, as well as on paper claims you send to Medicare and telephone Interactive Voice Response (IVR) queries by no later than May 23, 2007, or your transactions will be rejected.

What You Need to Know
Carriers have reported errors on claims (see *Background*, below) that will impact your payment when you begin to submit NPIs. Although not mandated until May 23, 2007, providers are currently allowed to submit NPIs in Medicare transactions other than paper claims. NPI will be accepted on the revised paper claim CMS-1500 (0805) and UB-04 forms early in 2007.

What You Need to Do
Make sure that your billing staffs are using your NPI correctly when they submit your claims for services provided to Medicare beneficiaries or submit electronic beneficiary or claim status queries to Medicare.

Background
All HIPAA covered healthcare providers who would either bill Medicare; render care to Medicare beneficiaries; order durable medical equipment, supplies, or services for beneficiaries; refer beneficiaries for other health care services; act as an attending physician when a beneficiary is hospitalized; prescribe covered retail prescription drugs for beneficiaries; operate on beneficiaries; or could otherwise be identified on a claim submitted to Medicare for payment must obtain an NPI. This applies whether providers are **individuals** (such as physicians, nurses, dentists, chiropractors, physical therapists, or pharmacists) or **organizations** (such as hospitals, home health agencies, clinics, nursing homes, residential treatment centers, laboratories, ambulance companies, group practices, managed care organizations, suppliers of durable medical equipment, pharmacies, etc.) must obtain an NPI for use to identify themselves in HIPAA standard transactions.

Although the NPI requirement applies by law to covered entities such as healthcare providers, healthcare clearinghouses, and health plans in the U.S. when exchanging electronic transactions for which a national standard has been adopted under HIPAA, HIPAA permits healthcare plans to elect to require reporting of NPIs in paper claims and for non-HIPAA transaction purposes. Medicare will also require NPIs for identification of all providers listed on the UB-04 institutional paper claim form and of physicians and suppliers listed on the revised CMS-1500 (08-05) professional paper claim form by May 23, 2007.

Medicare will reject paper claims received after May 22, 2007 that do not identify each provider, physician or supplier listed on a paper or electronic claim with an NPI. Medicare will also begin to require an NPI in Interactive Voice Response (IVR) queries effective May 23, 2007.

Retail pharmacies are required to use the NCPDP format adopted as a HIPAA standard for submission of prescription drug claims to Medicare. Since that format permits entry of only one provider identifier each for a pharmacy and the physician who prescribed the medication, retail pharmacies that use the NCPDP HIPAA format can use either their National Supplier Clearinghouse (NSC) number or their NPI to identify themselves, and either the Unique Provider Identification Number (UPIN) or the NPI to identify the prescribing physician prior to May 23, 2007.

May 23, 2007 and later, only an NPI may be reported for identification of pharmacies and prescribing physicians. NCPDP claims received by Medicare after May 22, 2007 that lack an NPI for either the pharmacy or the prescribing physician will be rejected.

This being said, Medicare carriers and fiscal intermediaries (FIs) have reported receiving X12 837-P (professional) and X12-837-I (institutional) claims containing errors that will result in claim rejection, and/or processing delays, if they continue to occur once NPI reporting begins.

Some of the errors seen by Medicare carriers include the following:

Incorrect information in the 2010A/A Billing Provider Loop in X12 837-P Claims
Prior to May 23, 2007, carriers will reject claims when the NPI in a loop does not belong to the owner of the Provider Identification Number (PIN) or UPIN that should also be reported in REF02 of the same loop, or if the name and address of the provider in that loop do not correlate with either the NPI, PIN or UPIN in the same loop. The same edits will also be applied to NPIs when received on paper claims prior to May 23, 2007.

Important Guidance Regarding National Provider Identifier (NPI) Usage in Medicare Claims (SE0659) (Continued)

Carriers have also detected claims where the rendering physician's or supplier's NPI is reported in the 2010A/A NM1 segment when the claim was submitted by a group to which the physician belongs or the home office of a chain to which a supplier belongs. The 2010A/A loop of an 837-P claim must contain the identifier that applies to the groups/chains (NPI entity 2) that submitted the claims. This rule also applies to identification of the billing provider on a paper claim. Information concerning a billing agent or a healthcare clearinghouse may never be reported in the billing provider loop for a Medicare claim.

To prevent this error, you must report the rendering physician's or supplier's NPI in the NM109 data element in the rendering provider claim level loop (2310B), unless multiple services were furnished by different members of the group/chain. If multiple rendering providers were involved, the information for each must be reported in the service level 2420A loop along with the service(s) each of them rendered.

To facilitate claim processing prior to May 23, 2007, you should also report the rendering provider(s) PIN(s) as the REF02 data element with 1C in REF01 in that same rendering provider loop (2310B for the claim or 2420A for individual services, as applicable).

Reporting of the Pay-to Address in the Billing Provider (2010A/A) Loop
Once NPI reporting begins, carriers will reject claims when the pay-to-address, if different than the actual practice location address, is in the 2010A/A (billing provider) loop, rather than in the 2010A/B (pay-to-provider) loop.

When groups or organizations submit claims, and the billing and the pay-to providers are different individuals or entities, the pay-to information must always be reported in the 2010A/B loop and the billing provider information in the 2010A/A loop.

Reporting of the Name and Address of a Billing Provider in the 2010A/A Loop of an X12 837-I (Institutional) Electronic Claim
FIs will reject claims in which the billing provider and the rendering provider are different entities, and you report the billing provider's name and address in the 2010A/A loop of an X12 837-I (institutional) electronic claim, and the OSCAR number of the rendering provider in that same loop.

If the home office of a chain has obtained one NPI for all facilities it owns, or one of a chain's facilities bills for all (or other) facilities owned by that chain, or a hospital bills for its special units, the home office, hospital or other facility submitting those claims is considered a form of billing agent for Medicare purposes.

In this instance, you must identify the specific provider, for whom the claim is being submitted, as the billing provider for that claim. If a provider that furnished the care had a separate OSCAR number than the entity submitting its claims, the provider that furnished the care must be identified in the billing provider loop. You must also report the name of the facility for whom the claim is being submitted, that facility's address, and should report applicable NPI (when obtained prior to May 23, 2007), as well as the Medicare OSCAR number assigned to that provider in the 2010A/A (billing provider) loop of the claim.

If the home office, hospital or other entity that prepared the claim is to be sent payment for the claim, you must report the name and address, and should report the NPI if issued, and the applicable OSCAR number associated with that entity in the 2010A/B (pay-to-provider) loop prior to May 23, 2007.

However, you should note that Medicare will not issue payment to a third party for a provider solely as result of completion of the 2010A/B loop of an electronic claim. The facility that furnished the care, or the established owner of that facility, must have indicated on their 855 provider enrollment form filed when that facility enrolled in Medicare (or via a subsequent 855 used to update enrollment information) that payments for that facility are to be issued to that home office, hospital, other facility or an alternate third party.

Additional Information

For those providers still permitted to submit any paper claims under the restrictions imposed by the Administrative Simplification Compliance Act, Medicare plans to begin accepting paper claims on the revised CMS-1500 (08-05 version) beginning January 2, 2007 (allowing you to report a provider's NPI as well as the applicable PIN or UPIN); and on the revised UB-04 (CMS-1450) form beginning March 1, 2007 (allowing you to report a provider's NPI as well as the applicable OSCAR or UPIN). Medicare carriers plan to reject "old" CMS-1500 forms received after March 31, 2007, and FIs plan to reject UB-92 forms received after April 30, 2007. **Note**: Medicare does not accept NPIs on the "old" versions of the CMS-1500 or UB-92 forms. There are no fields on those forms designed for NPI reporting.

CMS highly recommends that for electronic or paper Medicare claims that you submit during the transition period to full NPI implementation on May 23, 2007, you include both the NPI and the Medicare legacy identifier of each provider for whom you report information.

- When you report an NPI on a claim sent to a carrier for a referring, ordering, purchased service or supervising physician, or for a provider listed in the service facility locator loop, use a UPIN as the Medicare legacy identifier. Furthermore, if any of those physicians are not enrolled in Medicare, and the claim is being submitted prior to May 23, 2007, you should report OTH000 as the UPIN.

Important Guidance Regarding National Provider Identifier (NPI) Usage in Medicare Claims (SE0659) (Continued)

- When you report an NPI on a claim sent to an FI for an attending, operating or other physician, or in the service facility locator loop (when those loops apply), you should also report the provider's UPIN. And as above, you may report OTH000 as the surrogate UPIN if any of those providers is not enrolled in Medicare, and the claim is being submitted prior to May 23, 2007.
- Finally, when you report an NPI for a billing, pay-to, or rendering provider identified on a claim sent to a carrier, you should also report the valid Medicare PIN that applies to that physician or supplier. Additionally, you should always report an OSCAR number for each billing, pay-to, or possibly a service facility locator loop provider identified on a claim sent to an FI, as well as the NPI if issued to each of those providers, prior to May 23, 2007.

Remember that failure to report information as described here may result in delayed processing or rejection of your claims.

You can find more information about the National Provider Identifier (NPI) by going to the NPI page at **http://www.cms.hhs.gov/apps/npi/01_overview.asp** on the CMS Website. In addition, if you have any questions on the NPI, you may call your carrier or FI at their toll-free number, which may be found at **http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip** on the CMS web site.

Modification of National Provider Identifier (NPI) Editing Requirements in CR4023 and an Attachment to CR4320 (MM5229)

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MLN Matters Number: MM5229
Related CR Release Date: August 18, 2006
Related CR Transmittal #: R234OTN

Related Change Request (CR) #: 5229
Effective Date: October 1, 2006
Implementation Date: October 2, 2006

Provider Types Affected
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) (or durable medical equipment Medicare administrative contractors (DME MACs) if appropriate)

Provider Action Needed
Impact to You
This article is based on CR5229, which corrects certain business requirements from CR4023 that relate to edits for National Provider Identifiers (NPIs) and provider legacy identifiers when reported on claims, particularly for **referring/ordering or other secondary providers**, effective October 1, 2006 and later. Additionally, CR5229 revises Attachment 1 to CR4320.

What You Need to Know
Some of those business requirements erroneously assumed that any provider for whom information is reported in a claim, including a referring/ordering or other secondary provider, would need to be enrolled in Medicare and therefore listed in the Medicare Provider Identifier Crosswalk. This is not always the case. CR5229 modifies those business requirements.

What You Need to Do
These modifications will enable correct processing of affected claims in October 2006 and later, and will avoid the unnecessary rejection of many claims that involve a referring/ordering or other secondary provider. Please refer to the *Background* section of this article and to CR5229 for additional important information regarding these modifications.

Background
The Medicare Learning Network (MLN) articles, MM4023 and MM4320 which are based on CR4023 and CR4320 respectively, contain important information about the stages of the NPI implementation process. Some of this information is updated in the current article. The links to these articles are located in the *Additional Information* section of this article.

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 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 to accept applications for, and to issue NPIs on May 23, 2005. Applications can be made by mail and online at **https://nppes.cms.hhs.gov**.

During Stage 2 of the NPI implementation process (October 2, 2006 - May 22, 2007), Medicare will utilize a Medicare Provider Identifier Crosswalk between NPIs and legacy identifiers to validate NPIs received in transactions, assist with population of NPIs in Medicare data center provider files, and to report NPIs on remittance advice (RA) and coordination of benefit (COB) transactions.

Modification of National Provider Identifier (NPI) Editing Requirements in CR4023 and an Attachment to CR4320 (MM5229) (Continued)

Primary and Secondary Providers
Providers, for NPI provider identifier editing purposes, are categorized as either "primary" or "secondary" providers. Primary providers include billing, pay-to, and rendering providers. Primary providers are required to be enrolled in Medicare for the claim to qualify for payment.

Secondary providers are all other providers for which data could be reported on an institutional (837-I) or professional (837-P), free billing software or direct data entry (DDE) claim, or on a revised CMS-1500 or a UB-04 (once those paper claims are accepted by Medicare). Since the UB-92, the currently used CMS-1500, and the HIPAA NCPDP format do not allow reporting of both NPIs and legacy identifiers, information on secondary providers in those claims is not included in the following requirements. **Secondary providers may be enrolled, but are not required to be enrolled in Medicare** (unless they plan to bill or be paid by Medicare for care rendered to Medicare beneficiaries).

Secondary Provider Claims
Claims Submitted with NPI and Medicare Legacy Identifier:
During Stage 2, claim submitters should submit a provider's Medicare legacy identifier whenever reporting an NPI for a provider. Failure to report a Medicare legacy number for a provider enrolled in Medicare could result in a delay in processing of the claim. When an NPI and a legacy identifier are reported for a provider, Medicare contractors will apply the same edits to those numbers that would have been applied if that provider was a primary provider . (See MM4023.)

There are two exceptions:
1. A Medicare contractor cannot edit a surrogate Unique Provider Identification Number (sometimes called a dummy UPIN, such as OTN000). Despite its name, a surrogate is not actually unique for a specific provider.
2. Only a National Supplier Clearinghouse (NSC) identification number or a UPIN should ever be reported as the legacy numbers on a claim sent to a DMERC/DME MAC. If a carrier Provider Identification Number (PIN) is reported as a legacy identifier with an NPI, DMERCs/DME MACs will edit as if the NPI was the only provider identifier reported for that provider.

Claims Submitted with NPI Only:
The NPI is edited to determine if it meets with the physical requirements of the NPI (10 digits, begins with a 1, 2, 3, or 4, and the check digit in the 10th position is correct), and whether there is a Medicare Provider Identifier Crosswalk entry for that NPI.

If the NPI is located in the Crosswalk:
- The Taxpayer Identification Number (TIN) (Employer Identification Number (EIN) or Social Security Number (SSN) and legacy identifier will be sent to the trading partner in addition to the NPI if coordination of benefits (COB) applies.
- However, only the TIN will be forwarded to the COB payer if there is more than one legacy identifier associated with the same NPI in the Medicare Provider Identifier Crosswalk because it may be difficult to know which Medicare legacy identifier applies to that claim.

If the NPI is not located in the Crosswalk:
- No supplemental identifier can be reported to a COB payer.
- However, the claim **will not be rejected** if the NPI for a referring/ordering provider or another secondary provider cannot be located in the Medicare Provider Identifier Crosswalk, with one exception. Reporting of a Medicare legacy identifier other than a surrogate UPIN signifies a provider is enrolled in Medicare. If a Medicare legacy identifier is reported and cannot be located in the Crosswalk, the claim will be rejected, regardless of whether an NPI was reported for that provider.

Claims (including UB-92 or the current CMS-1500 paper claims) submitted with Medicare Legacy Identifier Only
- A Medicare contractor may, but is not reqired to check a legacy number against the Medicare Provider Identifier Crosswalk.
- As at present, claims will be rejected if any Medicare legacy identifier reported on a claim does not meet the physical requirements (length, if numeric or alphanumeric as applicable) for that type of Medicare provider identifier.

COB and Medigap Trading Partners
Legacy identifiers will not be reported to these trading partners for secondary providers if they are not submitted on the claim sent to Medicare, are surrogate UPINs or if the provider is not enrolled in Medicare. If not enrolled, a legacy identifier or a TIN cannot be sent for a"secondary" provider because Medicare would not have issued a legacy identifier to or collected a TIN from that provider.

837-I or 837-P version 4010A1 Claims
Attachment 1 to CR4320 which is being revised as part of CR5229 addresses (among other issues), the identification of secondary providers for which the 837-I or 837-P version 4010A1 implementation guides only require reporting of an NPI or other identifier "if known." Unless there is a pre-existing Medicare instruction that mandates the reporting of a specific identifier for those "if known" types of providers, there is no requirement for entry of any identifier for those entities/individuals. If there is no such requirement, claims received that lack an identifier for those types of providers will not be denied.

Note that "secondary" providers such as a referring/ordering physician are not required to be enrolled in Medicare as a **condition for payment** of the services or supplies they order, furnish, supervise delivery of, etc. for beneficiaries **when those services are billed, paid-to or rendered by "primary" providers**. For example, Medicare could pay:

Modification of National Provider Identifier (NPI) Editing Requirements in CR4023 and an Attachment to CR4320 (MM5229) (Continued)

- A hospital for services ordered for a patient for inpatient hospital care when the admitting or attending physician is not enrolled in Medicare;
- Hospital surgery costs when the surgeon is not enrolled in Medicare; or
- A hospital when services are purchased from another provider "under arrangements" even if that other provider is not enrolled in Medicare.

Implementation Date
The implementation date for this instruction is October 2, 2006.

Additional Information
CR4320, issued February 1, 2006, "Stage 1 Use and Editing of National Provider Identifier Numbers Received in Electronic Data Interchange Transactions, via Direct Data Entry Screens, or on Paper Claim Forms" is located at **http://www.cms.hhs.gov/transmittals/downloads/R204OTN.pdf** on the CMS web site.

The associated MLN article (with the same title) MM4320, can be found at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4320.pdf** on the CMS web site.

CR4023, dated November 3, 2005, "Stage 2 Requirements for Use and Editing of National Provider Identifier (NPI) Numbers Received in Electronic Data Interchange (EDI) Transactions, via Direct Data Entry (DDE) Screens, or Paper Claim Forms" is located at **http://www.cms.hhs.gov/transmittals/downloads/R190OTN.pdf** on the CMS web site. MM4023, the associated MLN article, is located at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4023.pdf** on the CMS web site.

CR5229 is the official instruction issued to your Medicare carrier/DMERC (DME MAC if appropriate), FI/RHHI regarding changes mentioned in this article. CR5229 may be found at **http://www.cms.hhs.gov/Transmittals/downloads/R234OTN.pdf** on the CMS web site.

If you have questions, please contact your local Medicare carrier/DMERC (DME MAC if appropriate), or FI/RHHI at their toll-free number, which may be found at **http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip** on the CMS website.

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 (MM4023)

MLN Matters Number: MM4023 Revised
Related CR Release Date: November 3, 2005
Related CR Transmittal #: 190
Related Change Request (CR) #: 4023
Effective Date: April 1, 2006
Implementation Date: April 3, 2006

Note: This article was revised on August 25, 2006, by adding this statement directing readers to view article MM5060 at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5060.pdf** for more current information on the effective dates for using Form CMS-1500 (08/05). The dates in the MM5060 article supersede the dates in this article and MM5060 conforms with CR5060, which is available at **http://www.cms.hhs.gov/transmittals/downloads/R1010CP.pdf.**

Provider Types Affected
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 NPI in Stage 2 is October 1, 2006.

Background
The Health Insurance Portability and Accountability Act (HIPAA) of 1996 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).

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 (MM4023) (Continued)

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/NPPES/Welcome.do**.

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 cross-walked 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 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.

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 (MM4023) (Continued)

Stage	Medicare Implementation
October 2, 2006 - May 22, 2007: (This is stage 2, the subject of CR4023)	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 taxpayer identification number (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.

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 (MM4023) (Continued)

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 CR4023:
- 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 CR4023 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 EDI System Access Security Files
- Med A and Med B Translators
- Other Translators
- Stages 3 and 4

CR4023, 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 **http://www.cms.hhs.gov/transmittals/downloads/R190OTN.pdf** on the CMS web site.

You may also wish to review *MLN Matters* article SE0555, "Medicare's Implementation of the National Provider Identifier (NPI): The Second in the Series of Special Edition *MLN Matters* Articles on NPI-Related Activities," which is available at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/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 phone number, go to **http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.pdf** on the CMS web site.

Electronic Submission of Claims Involving a Break in Service

As a result of many inquiries regarding the electronic submission of break in service claims, NHIC, Corp. would like to provide clarification that will assist you with this type of submission.

It is important to understand the difference between a break in service and a break in billing. A break in service occurs when a beneficiary's condition improves to the point where the medical need is interrupted for at least 60 days and then is resumed. A break in billing occurs when a beneficiary is renting a piece of durable medical equipment and must enter a hospital or a skilled nursing facility requiring them to return the equipment even though they still have a medical need for it. In this situation, the facility is expected to provide the durable medical equipment to the beneficiary during their stay and the DME MAC may not be billed for the service.

When submitting a claim to NHIC, Corp. for an item in which a **break in service** has occurred, there is some specific information that is necessary to assist NHIC, Corp. in making a decision to allow for a new rental period or to continue the previous rental period. NHIC, Corp. strongly encourages suppliers to utilize the following instructions during claim submission:

Suggested abbreviations for the NTE (Note Segment):

BIS:	Break in Service
PUD:	Pick-up Date
DLD:	Delivery Date
PDX:	Previous Diagnosis Code
NDX:	New Diagnosis Code

List the following information utilizing the suggested abbreviations:

BIS PUD (MMDDYY) **DLD** (MMDDYY) **PDX** (ICD-9) **NDX** (ICD-9)

Example:
BIS PUD 010106 **DLD** 090506 **PDX** 379.31 **NDX** V43.1

In some cases, NHIC, Corp. may need to develop the claim and request additional information, however, the majority of break in service claims can be processed with the above information.

Reopenings are to correct processing or clerical errors. Medical necessity denials must be handled through the redetermination process.

NHIC, Corp. DME MAC Holds First PCOM Advisory Group Meeting

The Outreach and Education Team of the NHIC DME MAC for Jurisdiction A held its first Provider Communications (PCOM) Advisory Group meeting at the NHIC office in Hingham, MA on October, 12, 2006. During this meeting, it was announced that the name for the PCOM Advisory Group will be changing to the Provider Outreach and Education (POE) Advisory Group.

The purpose of the POE Advisory Group is to ensure targeted educational efforts are both meaningful and helpful to the provider community as a whole. Members of this group play a vital role in achieving this task. All previous DMERC A PCOM Advisory Group members were granted a new membership term with the NHIC DME MAC. In addition, several new members joined the group, representing the new Jurisdiction A territories of Maryland and the District of Columbia.

In addition to the Outreach and Education Team, participants at the first quarterly meeting included representatives from several NHIC DME MAC operational areas, the Centers for Medicare and Medicaid Services (CMS), billing services, state provider associations and individual provider organizations.

Topics discussed at the first meeting included:

- NHIC History and Part B Medicare Experience
- DME MAC Contract/Transition Issues
- EDI Transition, effective 10/01/06
- New Contractor Requirements under DME MAC Contract
  - New Education and Outreach Initiatives/Structure
  - New Customer Service Levels I, II and PRRS
  - Ask-the-Contractor Teleconference (ACT) calls
- POE Advisory Group Future Plans
- Web site and Publication Updates
- Interactive Voice Response (IVR) System
- Medicare Contractor Provider Satisfaction Survey (MCPSS)
- Comprehensive Error Rate Testing (CERT)
- Outreach and Education Efforts/Initiatives
- National Provider Identifier (NPI)
- New CMNs and DIFs (CR 4296)
- Capped Rental Changes (CR 5010)

The Outreach and Education Team was very pleased with the outcome of this first meeting. The meeting was extremely productive with excellent educational suggestions and interaction from the members. Minutes from this meeting and previous meetings conducted under the previous DMERC A contractor, are available on the NHIC DME MAC PCOM Advisory Group Web page at: **http://www.medicarenhic.com/dme/dmerc_PCOM.shtml.** In addition to the meeting minutes, this site contains supplementary information on the Advisory Group, which includes a list of members and instructions on becoming a member. Currently, there are membership openings for 2007 and the membership is free of charge. We welcome any interested parties in becoming a member!

Outreach and Education Events

The Outreach and Education Team has been off to a great start and very busy attending, exhibiting, and/or presenting at numerous events. The response from the supplier community through these events has been tremendous. Participation in the majority of these events included partnering with the other DME MACs/DMERC, the National Supplier Clearinghouse (NSC) and, on occasion, the Centers for Medicare and Medicaid Services (CMS), conducting presentations and hosting booths for the dissemination of educational information.

The following are the events we have contributed to during the past few months:

- The National Association of Chain Drug Stores (NACDS) Annual Conference, San Diego, CA
- Two Mid-Atlantic Medicare Symposiums, hosted by Trailblazers Part B, held in Delaware and Maryland
- The New England Medical Equipment Dealers (NEMED) Association Fall Membership and Educational Conference, Boxborough, MA
- The Maryland National Capital Homecare Association (MNCHA) Annual Home Care Conference, Towson, MD
- The MedTrade Convention, Atlanta, GA
- The Jersey Association of Medical Equipment Suppliers (JAMES) Annual Conference, Edison, NJ
- The New York State Chapter of the American Association of Orthotists and Prosthetists, East Elmhurst, NY
- The New England Chapter of the American Association of Orthotists and Prosthetists, Kennebunkport, ME
- The NHIC, Corp. Part B Medicare Fair III, Worcester, MA

Outreach and Education Events (Continued)

- The New Jersey Chapter of the American Academy of Orthotists and Prosthetists Annual Meeting, Atlantic City, NJ
- The Pennsylvania Orthotics and Prosthetics Society Annual Meeting, Harrisburg, PA

The Outreach and Education Team also hosted our first Ask-the-Contractor Teleconference (ACT) sessions in September, which consisted of general transition information and updates. The ACTs were well received with both sessions at full attendance capacity. Future ACTs will be held at least on a quarterly basis with various topics chosen based on suggestions and feedback we have received from our supplier community.

In the coming months, the Outreach and Education Team will be updating and developing our on-line tutorials and offering live on-line educational sessions. We will also be holding in-person seminars in the spring of 2007.

The Outreach and Education Team appreciates the terrific response, suggestions and feedback we receive at each of these events and we look forward to our upcoming events and interaction with our supplier community. We are always looking for new and efficient ways to reach our supplier community and welcome any suggestions you may have.

Be sure you are signed up for our ListsServe to stay informed of upcoming outreach and education opportunities and where our team will be next!

Supplement to MM5107 - DMEPOS Transcutaneous Electrical Nerve Stimulators (TENS) Certificate of Medical Necessity (CMN) for Purchases: Form CMS-848 (MM5107)

The Centers for Medicare and Medicaid Services (CMS) has recently developed improved certificates of medical necessity (CMNs) approved by the Office of Management and Budget (OMB). The OMB approved form number for Form CMS-848 is OMB #0938-0679. The revised Transcutaneous Electrical Nerve Stimulators (TENS) CMN **will only** apply to purchases. As of January 1, 2007, contractors **shall not** require a CMN for TENS rentals.

For rentals, contractors shall allow a transition period for the TENS CMNs submitted and entered **on or after October 2, 2006, through December 31, 2006**. Suppliers shall submit a partially-completed unsigned TENS CMN. Contractors shall not edit on this partially-complete TENS CMN. Claims tied to a TENS CMN will be accepted and processed based on the format of the CMN.

Follow the chart below in order to properly partially-complete the unsigned TENS CMN form for rentals during the transition period **on or after October 2, 2006, and ending on December 31, 2006**.

Note: Suppliers must use the old CMN forms for this transition period.

Section A:	• Enter the date of service (i.e., the delivery date) in the "Initial" date field; • Enter all information in required fields as is currently being done;
Section B:	• Enter 99 in the "Est. Length of Need" field; • Enter the primary diagnosis in the "diagnosis Codes" field; • Enter "D" as the answer to questions 1,3, and 6. Enter "5" as the answer to question 5. You may leave the answer to questions 2 and 4 blank.
Section C:	May leave blank,
Section D:	Enter a "yes" in the "Physician's Signature" field. Enter the delivery date in the "Signature Date" field.
Paper CMNs:	For hard copy CMNS, only complete section A. All other sections of the CMN should be left blank.

More information regarding the improved CMNs can be found within the *Medicare Program Integrity Manual* Chapter 5.3. The *Medicare Program Integrity Manual* can be found on the CMS Web site at **http://www.cms.hhs.gov/Manuals/IOM/list.asp** under Publication #100-08

DME MAC A ListServes

The Jurisdiction A Durable Medical Equipment Medicare Administrative Contractor (DME MAC A) ListServes are used to notify subscribers via email of important and time-sensitive Medicare program information and other important announcements or messages. All you need is Internet access and an email address.

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

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

Jurisdiction A DME MAC and PSC Affiliate Web Sites

Both the Jurisdiction A Durable Medical Equipment Medicare Administrative Contractor (DME MAC A) and Program Safeguard Contractor (PSC) maintain separate Web sites. Providers should visit the DME MAC A Web site (**http://www.medicarenhic.com/dme/**) 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 DME MAC A Web site (**http://www.medicarenhic.com/dme/dmprovlink.shtml**) or directly at **http://www.tricenturion.com/content/reg_ab_dme_psc_toc.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: **http://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 **http://www.tricenturion.com/content/lmrp_current_dyn.cfm**.

CMS has established a dedicated National Provider Identifier web page that houses all NPI outreach information that CMS has prepared.

Please visit

http://www.cms.hhs.gov/NationalProvIdentStand

for more information. (JSM 06536)

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 **http://www.cms.hhs.gov/QuarterlyProviderUpdates/**. CMS encourages you to bookmark this Web site and visit it often for this valuable information. To receive notification when regulations and program instructions are added throughout the quarter, sign up for the QPU ListServe at: **https://list.nih.gov/cgi-bin/wa?SUBED1=cms-qpu&A=1**

Web Site Satisfaction Survey

The Centers for Medicare & Medicaid Services (CMS) has contracted with ForeSee Results to conduct Web site satisfaction surveys on behalf of Medicare carriers. The purpose of the ForeSee Results Web site satisfaction survey is to obtain feedback from users of the Jurisdiction A Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Web site regarding content, usability, reliability, and overall satisfaction with the DME MAC A Web site.

The ForeSee Results Web satisfaction survey was implemented on the DME MAC A Web site on Friday, September 29, 2006. The survey will appear to users randomly, in a pop-up window while navigating the DME MAC A Web site. If you are selected to complete a survey, please take a moment to provide your feedback regarding the DME MAC A Web site. The information you provide is anonymous and will help us provide a Web site that meets your needs.

Be sure to visit the "What's New" section of our Web site at
http://www.medicarenhic.com/dme/dme_what's_new.shtml
for the latest information and updates regarding the
Medicare program and DME MAC A.

For Your Notes

For Your Notes

For Your Notes

Customer Service Telephone
Interactive Voice Response (IVR) System - 866-419-9458
Customer Service Representatives - 866-419-9458
TTY/TDD - 888-897-7539

Outreach & Education
781-741-3950

Claims Submissions

DME – Drug Claims
P.O. Box 9145
Hingham, MA 02043-9145

DME – Mobility/Support Surfaces Claims
P.O. Box 9147
Hingham, MA 02043-9147

DME – Oxygen Claims
P.O. Box 9148
Hingham, MA 02043-9148

DME – PEN Claims
P.O. Box 9149
Hingham, MA 02043-9149

DME – Specialty Claims
P.O. Box 9165
Hingham, MA 02043-9165

DME – ADS
P.O. Box 9170
Hingham, MA 02043-9170

Written Inquiries

DME – Written Inquiries
P.O. Box 9146
Hingham, MA 02043-9146

DME – MSP Correspondence
P.O. Box 9175
Hingham, MA 02043-9175

Written Inquiry FAX: 781-741-3530

Appeals

DME – Redeterminations
P.O. Box 9150
Hingham, MA 02043-9150

Redetermination Street Address for Overnight Mailings:
NHIC, Corp. DME MAC Jurisdiction A Appeals
75 William Terry Drive
Hingham, MA 02044

DME – Administrative Law Judge (ALJ) Hearings
P.O. Box 9144
Hingham, MA 02043-9144

Electronic Data Interchange Support Services

866-563-0049
9 a.m. - 5 p.m. EST Monday through Friday
Electronic Fund Transfers, VIPS Provider Inquiry System (VPIQ), Medicare Remit Easy Print (MREP) software and Administrative Simplification Compliance Act (ASCA) Letters

EDI/EFT DME Enrollments Forms
P.O. Box 9185
Hingham, MA 02043-9185

National Supplier Clearinghouse
866-238-9652

SADMERC
877-735-1326

Beneficiary Toll-Free Number
800-633-4227 (1-800-Medicare)

CMS CENTERS for MEDICARE & MEDICAID SERVICES

DME MAC Jurisdiction A Resource

INFORMATION for DME MAC SUPPLIERS in CT, DE, DC, ME, MD, MA, NH, NJ, NY, PA, RI & VT

December 2006
Number 2

Publication Information

NHIC, Corp. is the contractor for the Jurisdiction A DME MAC serving all of Connecticut, Delaware, District of Columbia, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island and Vermont.

Visit the following websites for more information:
- NHIC, Corp.: www.medicarenhic.com
- TriCenturon: www.tricenturion.com
- CMS: www.cms.hhs.gov

DME MAC Jurisdiction A Resource, together with occasional special releases, serves as legal notice to physicians and suppliers concerning responsibilities and requirements imposed upon them by Medicare law, regulations, and guidelines.

If you have any comments about *DME MAC Jurisdiction A Resource* or would like to make suggestions, please write to:

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