DMERC A Medicare News

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The enclosed information was current at the time of publication. Please visit our Web site for recent updates.

Articles are identified by area of interest as follows: DRU = Drugs, GEN = General, MOB = Mobility/Support Surfaces, O&P = Orthotics & Prosthetics, OXY =Oxygen, PEN = Parenteral/Enteral Nutrition, SPE = Specialty Items, VIS = Vision

This bulletin should be shared with all health care practitioners and managerial members of the provider/supplier staff. Bulletins are available at no cost from our Web site at *www.umd.nycpic.com*.

CMS CENTERS for MEDICARE & MEDICAID SERVICES

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

HealthNow HealthNow New York Inc.

Cover Story

To All DMERC A Suppliers

Due to the July 1, 2006, transition to the Durable Medical Equipment Medicare Administrative Contractor (DME MAC) for Jurisdiction A, National Heritage Insurance Company (NHIC), this is the last bulletin that the Region A Durable Medical Equipment Regional Carrier (DMERC A) will publish. Therefore, please be sure to read the following articles:

- HealthNow New York Electronic Data Interchange (EDI) Contingency Plan
- Note for Fiscal Year 2006 Bulletin Subscribers
- Accessing DMERC A Web Site Information
- New Mailing Addresses for Jurisdiction A

Also, visit the NHIC Web site at ***www.medicarenhic.com/dme/index.shtml*** for additional information regarding the DME MAC transition.

DMERC A has been pleased to serve the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) supplier community in Region A.

Billing/Finance

Important News…

Releasing the Payment Floor

As a result of the transition of the Durable Medical Equipment (DME) workload from HealthNow Region A DMERC to the National Heritage Insurance Company (NHIC) Jurisdiction A DME MAC on July 1, 2006, HealthNow plans to release the payment floor to clear out all pending payments to suppliers. HealthNow will begin reducing the payment floor by one day, each day starting May 23, 2006, for paper claims, and June 6, 2006, for electronic claims. This plan will enable HealthNow to bring the payment floor to zero by June 21, 2006. Please refer to the NHIC Web site, ***www.medicarenhic.com/dme/index.shtml***, for information regarding the reinstitution of the payment floor.

News from CMS…

DME MAC NEWS #1 - DME Medicare Administrative Contractors' Implementation - Information for Suppliers

MLN Matters Number: SE0628
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Related CR Transmittal #: N/A
Effective Date: N/A
Implementation Date: N/A

The following information affects suppliers that bill Medicare durable medical equipment regional carriers (DMERCs) for their services, especially suppliers in the states of **Kentucky**, **Maryland**, **Virginia**, **West Virginia**, and the **District of Columbia**.

Key Points

The Centers for Medicare & Medicaid Services (CMS), in consultation with the current DMERCs, has begun a process to transition work from DMERCs to the new Durable Medical Equipment (DME) Medicare Administrative Contractors (MACs) in a way that presents the least disruption to the DME supplier community. This process will be especially helpful to the suppliers in Kentucky, Maryland, and the District of Columbia, which soon will be serviced by a different Medicare contractor. (See the "Background" section of this article for a brief explanation of why CMS is transitioning to DME MACs.)

The decisions regarding the transition to the DME MACs include the following:

- Two DME MACs (National Heritage Insurance Company, Inc. (NHIC) and AdminaStar Federal) will each assume full responsibility for the work of their respective geographic jurisdiction on July 1, 2006.
- These two new DME MACs have established Web pages that will be updated regularly with implementation

information, contact numbers, and email addresses. The contractors' Web pages are:

- NHIC: ***www.medicarenhic.com/dme/index.shtml***
- AdminaStar: ***www.adminastar.com/Providers/DMERC/ContractorReform/ContractorReform.html***

- There will be no need for DME suppliers currently enrolled in the Medicare fee-for-service program to re-enroll or obtain a new supplier number. Enrollment information will transfer to the new DME MACs.
- Current Electronic Data Interchange (EDI) Support for each DME region/jurisdiction has been extended until at least September 30, 2006.
- DME MACs will continue to support all DME free billing software packages.
- Although suppliers in Kentucky, Maryland, and the District of Columbia may continue to submit electronic claim transactions to the DME contractor that currently services them and have the claims redirected to the appropriate DME MAC, CMS encourages suppliers to connect to the DME MAC that will service them effective July 1.
- Connection to the servicing DME MAC will be required to receive all electronic output, including electronic remittance advices.
- Suppliers in Kentucky or those in the states that will be serviced by NHIC **must** complete a new copy of the Authorization Agreement for Electronic Funds Transfer and submit it to your new DME MAC if you wish to continue to receive Medicare payments via electronic funds transfer (EFT) effective July 1. Please see your DME MAC's Web page for specifics.
- Suppliers connected to multiple regions will need to understand regional-specific file retrieval options, including how to retrieve remittance advice files.
- Please refer to MLN Matters article SE0540 for more information regarding remittance advice and to MLN Matters article SE0611 for information regarding Medicare Remit Easy Print (MREP) software you may use to print Medicare's electronic remittances. These articles are available at ***www.cms.hhs.gov/MLNMattersArticles/downloads/SE0540.pdf*** and ***www.cms.hhs.gov/MLNMattersArticles/downloads/SE0611.pdf*** on the CMS Web site.
- New suppliers who want to conduct EDI transactions with Medicare should enroll with the appropriate DME contractor using standard enrollment forms and processes. (Please refer to links below.)
- The implementation of DME MACs for Jurisdictions C and D has been delayed pending resolution by CMS of a formal protest of those awards. Because of this delay, suppliers providing services to Medicare beneficiaries in Virginia and West Virginia will continue to be serviced by AdminaStar until further notice. Once the protest is resolved and the new DME MAC for Jurisdiction C can be implemented, it will take over the work for Virginia and West Virginia.

Background

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (P.L. 108-173) allows CMS to take appropriate steps to transition from contracts under Section 1842(a) of the Social Security Act to contracts with MACs under Section 1874A. The changes to Medicare's administration of the fee-for-service program (Medicare Contracting Reform) are designed to increase the efficiency of Medicare's claim processing and related functions. They will benefit Medicare providers and Medicare's enrollee population. For more information on Medicare Contracting Reform and plans for the acquisition and implementation of MACs, please see MLN Matters article SE0624 at ***www.cms.hhs.gov/MLNMattersArticles/downloads/SE0624.pdf*** on the CMS Web site, or visit the Medicare Contracting Reform Web page at ***www.cms.hhs.gov/MedicareContractingReform/*** on the CMS Web site.

On January 6, 2006, CMS announced the following:

- The DME MAC contract for Jurisdiction A (Connecticut, Delaware, District of Columbia, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, and Vermont) was awarded to National Heritage Insurance Company (NHIC).
- The DME MAC contract for Jurisdiction B (Illinois, Indiana, Kentucky, Michigan, Minnesota, Ohio, and Wisconsin) was awarded to AdminaStar Federal, Inc.
- The DME MAC contract for Jurisdiction C (Alabama, Arkansas, Colorado, Florida, Georgia, Louisiana, Mississippi, New Mexico, North Carolina, Oklahoma, Puerto Rico, South Carolina, Tennessee, Texas, U.S. Virgin Islands, Virginia, and West Virginia) was awarded to Palmetto GBA, LLC.
- The DME MAC contract for Jurisdiction D (Alaska, American Samoa, Arizona, California, Guam, Hawaii, Idaho, Iowa, Kansas, Missouri, Montana, Nebraska, Nevada, North Dakota, Northern Mariana Islands, Oregon, South Dakota, Utah, Washington, and Wyoming) was awarded to Noridian Administrative Services.
- A protest of the DME MAC awards for Jurisdictions C and D was filed with the Government Accountability Office (GAO) in January 2006. Until GAO issues a decision (due May 4, 2006) on the protest, any activity associated with the contract awards for administration of MAC Jurisdictions C and D is on hold.

Additional Information

For additional information about Medicare Contracting Reform, and specifically the DME MAC transition process, please refer to ***www.cms.hhs.gov/MedicareContractingReform/*** on the CMS Web site.

For information about Medicare Provider-Supplier Enrollment, please refer to ***www.cms.hhs.gov/MedicareProviderSupEnroll/*** on the CMS Web site. Form CMS-855S, Medicare Federal Health Care Provider/Supplier Enrollment Application, can be found at ***www.cms.hhs.gov/cmsforms/downloads/cms855s.pdf*** on the CMS Web site.

SE0540, CMS Releases New Educational Guide on Remittance Advice (RA) Notices, is located at ***www.cms.hhs.gov/MLNMattersArticles/downloads/SE0540.pdf*** on the CMS Web site. SE0611, Medicare Remit Easy Print (MREP) Software, is available at ***www.cms.hhs.gov/MLNMattersArticles/downloads/SE0611.pdf*** on the CMS Web site. SE0624, Assignment of Physicians and Providers to the Medicare Administrative Contractors (MACs), can be viewed at ***www.cms.hhs.gov/MLNMattersArticles/downloads/SE0624.pdf*** on the CMS Web site. This last article provides an overview of the Medicare Contracting Reform process as it applies to providers and suppliers.

To find the toll-free telephone number for your Medicare contractor, please refer to ***www.cms.hhs.gov/MedlearnProducts/downloads/CallCenterTollNumDirectory.pdf*** on the CMS Web site.

Assignment of Physicians, Providers, and Suppliers to the Medicare Administrative Contractors (MACs)

MLN Matters Number: SE0624
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Related CR Transmittal #: N/A
Effective Date: N/A
Implementation Date: N/A

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

Key Points

The Centers for Medicare & Medicaid Services (CMS) is implementing significant changes to the Medicare fee-for-service program's administrative structure. This Medicare Contracting Reform (MCR) will:

- Integrate and simplify the administration of Medicare Parts A and B with primary A/B Medicare Administrative Contractors (MACs) which will process both Part A and Part B claims for the fee-for-service benefit;
- Make contracting dynamic, competitive, and performance-based, resulting in more accurate claims payments and greater consistency in payment decisions; and
- Centralize information, creating a platform for advances in the delivery of comprehensive care.

Under MCR, there will be 23 MACs with no national MAC. These new MACs will include:

- Fifteen primary A/B MACs to serve the majority of all types of providers for Part A and Part B;
- Four specialty MACs to serve home health and hospice providers; and
- Four specialty MACs to serve durable medical equipment (DME) suppliers.

MACs will serve as the primary point of contact for provider enrollment, Medicare coverage and billing requirements training for providers, and the receipt, processing, and payment of Medicare fee-for-service claims for Medicare providers' respective jurisdictions. Medicare providers will be assigned to the local designated MAC based on their geographic location to the MAC which has jurisdiction for that benefit category and location.

Note: Please be aware that in the event that your current FI does not win the contract to serve the area where you are located, you will be required to be reassigned to the MAC that has won the jurisdiction for your area.

The new MAC jurisdictions will be more similar to each other in size than the existing FI and carrier jurisdictions. The workload allocation and the number of fee-for-service beneficiaries and providers in each MAC jurisdiction will be reasonably balanced. The

jurisdictions of the eight specialty MACs will overlay the boundaries of the fifteen primary A/B MAC jurisdictions.

Background

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (P.L. 108-173) allows CMS to take appropriate steps to transition from agreements under Section 1816 of the Social Security Act to contracts with MACs under Section 1874A. The changes to Medicare's administration are designed to increase the efficiency of Medicare's claims processing and related functions. They will benefit Medicare providers and Medicare's enrollee population.

Additional Information

During the initial implementation phase (2005-2011) of the Medicare fee-for-service administrative contracting reform, CMS intends to issue Requests for Proposals (RFPs) to compete and award contracts for 23 MACs (four DME and four Home Health/Hospice MACs and 15 primary A/B MACs). The transition to the MAC administrative structure will be implemented through a series of acquisition cycles (9-12 months from solicitation to award). The subsequent workload transition to the new MAC system is projected to take 6-13 months after contract award.

Medicare's MAC Jurisdictions

Jurisdiction	States Included in Jurisdiction	Procurement Schedule	
	Specialty MAC Jurisdictions (DME and Home Health/Hospice)	RFP Issuance	Award Date
A	Connecticut, Delaware, District of Columbia, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, and Vermont	DME March 2005	DME Jan. 2006
B	Illinois, Indiana, Kentucky, Michigan, Minnesota, Ohio, and Wisconsin		
C	Alabama, Arkansas, Colorado, Florida, Georgia, Louisiana, Mississippi, New Mexico, North Carolina, Oklahoma, Puerto Rico, South Carolina, Tennessee, Texas, U.S. Virgin Islands, Virginia, and West Virginia	Home Health/ Hospice Sept. 2007	Home Health/ Hospice Sept. 2008
D	Alaska, American Samoa, Arizona, California, Guam, Hawaii, Idaho, Iowa, Kansas, Missouri, Montana, Nebraska, Nevada, North Dakota, Northern Mariana Islands, Oregon, South Dakota, Utah, Washington, and Wyoming		

Jurisdiction	States Included in Jurisdiction	Procurement Schedule	
Jurisdiction	Primary A/B MAC Jurisdictions	RFP Issuance	Award Date
1	American Samoa, California, Guam, Hawaii, Nevada, and Northern Mariana Islands	Sept. 2006	Sept. 2007
2	Alaska, Idaho, Oregon, and Washington	Sept. 2006	Sept. 2007
3	Arizona, Montana, North Dakota, South Dakota, Utah, and Wyoming	Sept. 2005	June 2006
4	Colorado, New Mexico, Oklahoma, and Texas	Sept. 2006	Sept. 2007
5	Iowa, Kansas, Missouri, and Nebraska	Sept. 2006	Sept. 2007
6	Illinois, Minnesota, and Wisconsin	Sept. 2007	Sept. 2008
7	Arkansas, Louisiana, and Mississippi	Sept. 2006	Sept. 2007
8	Indiana and Michigan	Sept. 2007	Sept. 2008
9	Florida, Puerto Rico, and U.S. Virgin Islands	Sept. 2007	Sept. 2008
10	Alabama, Georgia, and Tennessee	Sept. 2007	Sept. 2008
11	North Carolina, South Carolina, Virginia, and West Virginia	Sept. 2007	Sept. 2008
12	Delaware, District of Columbia, Maryland, New Jersey, and Pennsylvania	Sept. 2006	Sept. 2007
13	Connecticut and New York	Sept. 2006	Sept. 2007
14	Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont	Sept. 2007	Sept. 2008
15	Kentucky and Ohio	Sept. 2007	Sept. 2008

For additional information about the MCR process, please refer to ***www.cms.hhs.gov/MedicareContractingReform/*** on the CMS Web site. Change Request (CR) 4002, transmittal 670, "Realignment of States and Medicare Claims Processing Workload from DMERC Regions A, B, C, and D to the DME MAC Jurisdictions A, B, C, and D," discusses phase 1 of the MAC acquisition and transition schedule. It can be found at ***www.cms.hhs.gov/transmittals/downloads/R670CP.pdf*** on the CMS Web site.

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

MLN Matters Number: MM4177 Revised
Related Change Request (CR) #: 4177
Related CR Release Date: November 10, 2005
Related CR Transmittal #: R752CP
Effective Date: April 1, 2006
Implementation Date: April 3, 2006
Note: This article was rescinded on March 21, 2006, because Change Request (CR) 4177 was rescinded. A new CR will be released on this issue in the future.

Rescind Change Request (CR) 4177- Eliminate the Use of Surrogate UPINs (OTH000) on Medicare Claims

MLN Matters Number: MM5019
Related Change Request (CR) #: 5019
Related CR Release Date: March 31, 2006
Related CR Transmittal #: R145PI
Effective Date: April 1, 2006
Implementation Date: April 3, 2006

The following information affects physicians, non-physician practitioners, suppliers, and providers billing Medicare carriers, durable medical equipment regional carriers (DMERCs), fiscal intermediaries (FIs), or regional home health intermediaries (RHHIs) for diagnostic, radiology, consultation services, and equipment.

Provider Action Needed

This article is based on Change Request (CR) 5019, which rescinds CR 4177. CR 4177 eliminated the use of the surrogate Unique Physician Identification Number (UPIN) OTH000 on claims submitted by billers, suppliers, physicians, and non-physician practitioners. CR 5019 instructs Medicare contractors to discontinue all work to eliminate the use of the surrogate UPIN "OTH000" in claims processing and continue to use surrogate UPIN "OTH000" for submitted claims and other internal purposes.

Background

The Social Security Act (Section 1833(q); ***www.ssa.gov/OP_Home/ssact/title18/1833.htm***) requires that:

- All physicians meeting the definition of a physician (Section 1861(r); ***www.ssa.gov/OP_Home/ssact/title18/1861.htm***) must have a UPIN, **and**
- All claims for services ordered or referred by one of these physicians must include the names and UPINs of the ordering/referring physician.

Currently, durable medical equipment (DME) suppliers, physicians, and non-physician practitioners are allowed to use a surrogate UPIN to bill for the following:

- Diagnostic services;
- Radiology services;
- Consultation services; and
- Durable medical equipment.

CR 4177 (Transmittal R752CP, dated November 10, 2005) instructed Medicare affiliated contractors (carriers, DMERCs, FIs, and RHHIs) not to accept the surrogate UPIN "OTH000" on Medicare claims submitted by billers, suppliers, physicians, and non-physician practitioners. However, because of the possibility that this will adversely impact the ability of providers to bill the Medicare program, the Centers for Medicare & Medicaid (CMS) is rescinding CR 4177.

Surrogate UPINs are intended to be used during an interim period when an UPIN has been requested but has not yet been received. Currently, DME suppliers, physicians, and non-physician practitioners are allowed to use a surrogate UPIN to bill for:

- Diagnostic services;
- Radiology services;
- Consultation services; and
- Durable medical equipment.

CR 5019 instructs your Medicare contractor(s) to:

- Discontinue all work to eliminate the use of the surrogate UPIN "OTH000" in claims processing; and
- Continue to use surrogate UPIN "OTH000" for submitted claims and other internal purposes.

Implementation

The implementation date for CR 5019 is April 3, 2006.

Additional Information

For complete details, please see the official instruction issued to your carrier/DMERC/FI/RHHI regarding this change. That instruction may be viewed at ***www.cms.hhs.gov/Transmittals/downloads/R145PI.pdf*** on the CMS Web site. Inquirers can obtain providers' UPINs at ***www.upinregistry.com/***.

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

Revised Health Insurance Claim Form CMS-1500

The Form CMS-1500 (12-90) is being revised to accommodate the reporting of the National Provider Identifier (NPI). The work to complete this effort was

headed up by the National Uniform Claim Committee (NUCC) of which the Centers for Medicare & Medicaid Services (CMS) is a voting member. The intent of the NUCC's efforts was to best accommodate the NPI with minimal changes to the current claim form. Once the draft claim form was completed, it was subjected to two public comment periods to solicit industry feedback on the proposed changes to the form. The end result of the NUCC's work and the public comment period is the Form CMS-1500 (08-05) version.

The Form 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 dual acceptability period of the current and the revised forms. In order to accommodate the dual acceptability period, there will be a need for both forms to be approved for use by the Office of Management and Budget (OMB). There are currently two clearance packages at OMB. The first package is a renewal of the current Form CMS-1500 (12-90) version, and the other is a new collection of the Form CMS-1500 (08-05) version. The OMB number for the Form CMS-1500 (12-90) version is 0938-0008. The new Form CMS-1500 (08-05) collection will receive a brand new OMB collection number upon approval. The OMB renewal and approval are both expected between March and April 2006. The following is the Form CMS-1500 form timeline:

- October 1, 2006: Health plans, clearinghouses, and other information support vendors should be ready to handle and accept the revised Form CMS-1500 (08/05).
- October 1, 2006 - January 31, 2007: Providers can use either the current Form CMS-1500 (12/90) version or the revised Form CMS-1500 (08/05) version.
- February 1, 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. 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).

The official instructions issued to your durable medical equipment regional carrier (DMERC) and carrier regarding this change can be found at ***www.cms.hhs.gov/Transmittals/downloads/R899CP.pdf*** on the CMS Web site.

Revised CMS-1500 Claim Form

MLN Matters Number: MM4293
Related Change Request (CR) #: 4293
Related CR Release Date: March 31, 2006
Related CR Transmittal #: R899CP
Effective Date: October 1, 2006
Implementation Date: October 2, 2006

The following information affects 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

Change Request (CR) 4293 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.

Background

The 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 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 ***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 ***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 ***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 ***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 ***www.cms.hhs.gov/MLNMattersArticles/downloads/SE0528.pdf*** on the CMS Web site.

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

Medlearn Matters Number: MM4296 Revised
Related Change Request (CR) #: 4296
Related CR Release Date: March 2, 2006
Related CR Transmittal #: R142PI

Effective Date: October 1, 2006
Implementation Date: October 2, 2006
Note: This article was revised on March 3, 2006, to reflect changes to Change Request (CR) 4296, which the Centers for Medicare & Medicaid Services (CMS) revised on March 2. The CR release date, transmittal number, and Web address have been revised, but no other changes were made to the article. Please note, however, that the revised CR 4296 states that "New forms located at *www.cms.hhs.gov/CMSForms/CMSForms/list.asp#TopOfPage* will not be available until the end of summer…" However, you can find copies of the forms at the end of CR 4296 located at *www.cms.hhs.gov/Transmittals/downloads/R142PI.pdf* on the CMS Web site.

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

Provider Action Needed

Impact to You

CMS has developed improved CMNs and DIFs, and consequently, there are changes to the forms.

What You Need to Know

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

What You Need to Do

Make certain that your billing staff is aware of the changes in Chapters 3 and 5 of the Medicare Program Integrity Manual that are outlined in this article. The new series of forms is available as part of the official instructions (CR 4296) issued to your DMERC.

Background

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

- Medicare Program Integrity Manual, Chapter 5, Items and Services Having Special DME Review

Considerations, has been revised.

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

Claims Accepted During Transition Period

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

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

Newly Revised CMNs Accepted During Transition Period

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

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

New DIFs Accepted During Transition Period

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

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

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

CMNs Eliminated

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

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

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

Implementation

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

Additional Information

The official instructions issued to your DMERC regarding this change can be found at ***www.cms.hhs.gov/Transmittals/downloads/R142PI.pdf*** on the CMS Web site. These instructions include copies of the new forms.

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

2006 Jurisdiction List

MLN Matters Number: MM4363
Related Change Request (CR) #: 4363
Related CR Release Date: March 24, 2006
Related CR Transmittal #: R893CP
Effective Date: June 26, 2006
Implementation Date: June 26, 2006

The following information affects physicians, providers, and suppliers who submit claims to Medicare durable medical equipment regional carriers (DMERCs) and Part B local carriers.

Provider Action Needed

Impact to You

Change Request (CR) 4363 provides notice of the spreadsheet containing the annual updated list of Healthcare Common Procedure Coding System (HCPCS) for DMERC and Part B local carrier jurisdictions.

What You Need to Know

The Excel spreadsheet containing these codes is available within the official instructions (CR 4363) issued to your DMERC contractor and Part B carrier, which may be viewed at ***www.cms.hhs.gov/Transmittals/downloads/R893CP.pdf***. The list will also be available at ***www.cms.hhs.gov/center/dme.asp*** on the Centers for Medicare & Medicaid Services (CMS) Web site.

What You Need to Do

The above codes are updated on an annual basis. Be sure your billing staff is aware of these changes.

Background

The HCPCS is updated annually to reflect changes in medical practice and the provision of health care. CMS provides a file containing updated HCPCS codes to Medicare carriers, DMERCs, and intermediaries, and to Medicaid State Agencies, 60 to 90 days before the implementation of the annual update.

CMS publishes a recurring update notification annually to notify the DMERCs and Part B carriers that the list has been updated and is available on the CMS Web site. Both the DMERCs and the local carriers publish this list to educate providers as to which contractor - the DMERC or local Part B carrier - to bill for codes provided on that list.

Implementation

The implementation date for this instruction is June 26, 2006.

Additional Information

The official instructions issued to your DMERC and carrier regarding this change can be found at ***www.cms.hhs.gov/Transmittals/downloads/R893CP.pdf*** on the CMS Web site.

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

Hospital Billing for Take-Home Drugs

Medlearn Matters Number: MM4301
Related Change Request (CR) #: 4301
Related CR Release Date: March 3, 2006
Related CR Transmittal #: R882CP
Effective Date: July 1, 2006
Implementation Date: July 3, 2006

The following information affects hospitals that submit claims for take-home oral anti-cancer drugs, take-home oral anti-emetic drugs, and immunosuppressive drugs not included in a procedure performed in the hospital.

Provider Action Needed

For oral anti-cancer, oral anti-emetic, and immunosuppressive take-home drug claims that cover more than a single day's supply, hospitals, including critical access hospitals (CAHs), must:

- Bill multi-day supplies of take-home oral anti-cancer, oral anti-emetic, and immunosuppressive drugs to the appropriate durable medical equipment regional carrier (DMERC);

- Bill their fiscal intermediary (FI) for outpatient services when the service includes an oral anti-cancer drug, oral anti-emetic drug, or immunosuppressive drug, so long as no more than one day's drug supply (i.e., only today's) is given to the beneficiary, and the beneficiary receives additional services;
- Bill the associated supplying and dispensing fees on the **same** claim as the drug. Claims for a supplying fee or a dispensing fee **not** billed on the same claim as the drug that was supplied or dispensed will be denied; and
- Bill all take-home inhalation drugs to the appropriate DMERC, unless the drug is an integral part of a hospital procedure (inpatient or outpatient).

  The appropriate DMERC for claim filing is the DMERC having jurisdiction for the region in which the beneficiary resides. Hardcopy claims submitted to an improper jurisdiction, i.e., to a DMERC other than the region in which the beneficiary resides, will be denied. Electronic claims that are sent to the wrong DMERC will be redirected to the correct DMERC.

Please also note that:

- Immunosuppressive drugs and supplying fees provided by a dialysis facility in the state of Washington are paid by the FI.
- When a beneficiary in a hospital or skilled nursing facility (SNF) noncovered stay, or a hospital/SNF inpatient that has exhausted benefits (type of bill (TOB) 12x or 22x, respectively) is given a covered oral anti-cancer or anti-emetic drug, or a covered immunosuppressive drug, the hospital or SNF should bill its regular FI.
- Payment to hospitals is dependent on the applicable payment mechanism for the type of hospital (reasonable cost for Tax Equity & Fiscal Responsibility Act of 1982 (TEFRA) hospitals and CAHs, and ambulatory payment classifications (APCs) for hospitals subject to the hospital outpatient prospective payment system (OPPS)).

Background

This article is related to Change Request (CR) 4301. It clarifies and provides new instructions for hospitals about billing the appropriate DMERC for take-home oral anti-cancer drugs, take-home oral anti-emetic drugs, and immunosuppressive drugs (as well as the associated supplying fees) not included in a procedure performed in the hospital. It is effective July 1, 2006, for claims from hospitals. Chapter 17, Drugs and Biologicals (Sections 80.2.2 and 90.4), of the Medicare Claims Processing Manual was updated to reflect these changes. The article also relates to CR 2488, Program Memorandum (PM) Transmittal A-02-123, dated December 13, 2002, which instructed hospitals to bill the appropriate DMERC for immunosuppressive drugs and supplying fees furnished to transplant patients. That transmittal may be viewed at ***www.cms.hhs.gov/Transmittals/downloads/A02123.pdf*** on the Centers for Medicare & Medicaid Services (CMS) Web site.

Take-Home Drugs versus Drugs Provided to Hospital Inpatients and Outpatients

To separate take-home drugs covered under Part B from drugs provided to hospital inpatients and outpatients, and to permit appropriate payment for drugs included in hospital procedures, CMS is requiring all hospitals to bill the appropriate DMERC for certain take-home drugs. When hospitals dispense drugs to Medicare beneficiaries for take-home use, they are functioning as retail pharmacies and billing should be as a retail pharmacy, using the national drug code (NDC) number of the drug and the National Council for Prescription Drug Programs (NCPDP) electronic format.

There is a supplying fee associated with these drugs. However, **only** the DMERC will pay this fee to a hospital outpatient department. Claims billed to the local FI for outpatients will **not** be paid the supplying fee. The **only** way a hospital can receive the supplying fee is to bill the appropriate DMERC for the supplying fee and the drug and, if applicable, any administration fee. Hospitals **must** bill the appropriate DMERC for the take-home drugs specified in CR 4301 (e.g., multi-day supplies of oral anti-cancer drugs, oral anti-emetic drugs, and immunosuppressive drugs, as well as their associated supplying fees). Supplying fees **must** be billed on the **same** claim as the drug.

Additional Information

Supplier Number

Hospitals that do **not** have a supplier number for billing the DMERC should complete a CMS-855S form and obtain a supplier number from the National Supplier Clearinghouse (NSC). There are two ways to obtain a supplier number from the NSC:

- Hospitals can call the NSC directly at 866-238-9652 and request an application form. The NSC will send them a CMS-855S. Once the hospital has completed the CMS-855S, it should be submitted as soon as possible to the NSC at the address indicated on the form.

- Alternatively, hospitals may go to ***www.cms.hhs.gov/MedicareProviderSupEnroll/01_overview.asp*** on the CMS Web site and download the CMS-855S in Adobe Acrobat format. The application can be completed as a hardcopy and submitted to the NSC.

Once a hospital has its supplier number, the hospital can proceed to bill the appropriate DMERC using the NCPDP - Telecommunication Version 5.1 and Batch Standard 1.1 - Retail Pharmacy Claims. This is the Health Insurance Portability & Accountability Act of 1996 (HIPAA) approved telecommunication format for billing drugs. Alternatively, in exceptional circumstances, a hardcopy CMS-1500 may be used. In both cases, the actual drug **must** be listed by NDC, and the claim **must** show the units given to the beneficiary. The DMERC will provide specific instructions to hospitals on billing requirements.

Relevant Links

CR 2488, Program Memorandum (PM) Transmittal A-02-123, dated December 13, 2002, Hospital Billing for Immunosuppressive Drugs Furnished to Transplant, can be found at ***www.cms.hhs.gov/Transmittals/downloads/A02123.pdf*** on the CMS Web site. CR 4301 is the official instruction issued to your FI or DMERC regarding the changes mentioned in this article. CR 4301 may be found by going to ***www.cms.hhs.gov/Transmittals/downloads/R882CP.pdf*** on the CMS Web site. The revised portions of the Medicare Claims Processing Manual, which provide full details of these changes, are attached to CR 4301.

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

Payment for Power Mobility Device (PMD) Claims

MLN Matters Number: MM4372 Revised
Related Change Request (CR) #: 4372
Related CR Release Date: March 10, 2006
Related CR Transmittal #: R215OTN
Effective Date: January 1, 2006
Implementation Date: No later than March 24, 2006
Note: This article was revised on March 24, 2006, to emphasize that providers submitting claims on or after April 1, 2006, must bill the E/M and the G0372 code on the same claim.

The following information affects physicians, providers, and non-physician practitioners billing Medicare carriers, durable medical equipment regional carriers (DMERCs), regional home health intermediaries (RHHIs), and/or fiscal intermediaries (FIs) for power mobility devices (PMDs) and services related to prescribing PMDs.

Important Points to Remember

Options for Submitting G0372 and E/M Codes

Providers billing a Medicare carrier have the following options for submitting the G0372 code and the E/M code during January 1, 2006, through March 31, 2006:

- Submit the G0372 code and E/M now on the same claim. Payment for these claims will be held through March 31, 2006.
- Hold all claims containing the G0372 code until after March 31, 2006.
- Submit the E/M service now, and bill the G0372 code after March 31, 2006. The E/M service will be paid now. Note that this is not intended to require that Medicare FIs or carriers split claims submitted with both the E/M and G0372 code. Rather, the physician/provider may choose to submit two separate claims for the individual services.

Providers submitting claims on or after April 1, 2006, must bill the E/M and the G0372 code on the same claim.

Critical access hospitals (CAHs) billing the FI under Method II have the following options from January 1, 2006, through July 2, 2006, for submitting the G0372 code and the E/M code:

- Submit the G0372 and E/M now on the same claim. Payment for these claims will be held by the FI through July 2, 2006.
- Hold all claims containing the G0372 code until after July 2, 2006.
- Submit the E/M service now, and bill the G0372 code after July 2, 2006. The E/M service will be paid now. Note that this is not intended to require the FIs or carriers to split claims submitted with both the E/M and G0372 code. Rather, the physician or treating practitioner may choose to submit two separate claims for the individual services.

Method II CAHs submitting claims on or after July 2, 2006, must bill the E/M and the G0372 code on the same claim.

Background

The Centers for Medicare & Medicaid Services (CMS) published an interim Final Rule on PMDs to conform its regulations to Section 302(a)(2)(E)(iv) of the Medicare Modernization Act (MMA), which is codified at Section 1834(a)(1)(E)(iv) of the Social Security Act (SSA). The effective date of the rule was October 25, 2005. For PMDs, the MMA mandated that:

- A face-to-face examination of the individual be conducted by a physician, a physician assistant, a nurse practitioner, or a clinical nurse specialist; and
- That payment may **not** be made for a motorized or power wheelchair unless the physician or treating practitioner has written a prescription for the item.

By defining the practitioners allowed to conduct the face-to-face examination, it also effectively removed the current requirement that a beneficiary must be seen by a specialist in physical medicine, orthopedic surgery, neurology, or rheumatology in order to get a power-operated vehicle (POV).

Submission of Medical Record and Prescription

Apart from the MMA requirements, the other key change made by this regulation is a requirement that the physician or treating practitioner **must** submit pertinent parts of the medical record (in lieu of the certificate of medical necessity (CMN)), along with the prescription, to the durable medical equipment (DME) supplier within 30 days of the face-to-face examination. A separate add-on payment (an add-on payment to the office visit billed with the code of G0372) was established by the rule to recognize the additional physician work and resources required for submitting pertinent parts of the medical record.

Payment for the history and physical examination is made through the appropriate evaluation and management (E&M) code along with the add-on payment (G0372), which goes to the local Medicare FI or carrier. The PMD claim will go to the local DMERC.

Appropriations Act

Title II, Section 222, of the Departments of Labor, Health and Human Services, and Education and Related Agencies Appropriations Act, 2006 (H.R. 3010) (the Appropriations Act) was signed into law on December 30, 2005. It states, in part:

> **SEC. 222.** None of the funds made available under this Act may be used to implement or enforce the interim Final Rule published in the Federal Register by the Centers for Medicare & Medicaid Services on August 26, 2005, (70 Fed. Reg. 50940) prior to April 1, 2006.

Although this section of the Appropriations Act does not allow federal funds to implement or enforce the rule, CMS believes that this section does not affect the validity of the rule. Therefore, CMS is instructing DMERCs and/or DME Program Safeguard Contractors (PSCs) that, between January 1, 2006, to April 1, 2006, contractors will **only** pay PMD claims that satisfy the requirements of Section 1834(a)(1)(E)(iv) of the SSA.

Based on the Appropriations Act, CMS is instructing FIs and carriers to hold claims that contain G0372. These claims must be held through March 31, 2006. Carriers will begin to release physician claims for processing on April 3, 2006.

Implementation

The implementation date for this instruction is no later than two weeks after release of Change Request (CR) 4372 or March 24, 2006.

Additional Information

For additional information regarding PMDs, you may want to review the following MLN Matters articles:

- MM4121: MMA - New G Code for Power Mobility Devices (PMDs), ***www.cms.hhs.gov/MLNMattersArticles/downloads/MM4121.pdf***
- MM3952: MMA - Evidence of Medical Necessity: Power Wheelchair and Power Operated Vehicle (POV)/Power Mobility Device (PMD) Claims, ***www.cms.hhs.gov/MLNMattersArticles/downloads/MM3952.pdf***

The official instructions issued to your carrier, DMERC, FI, or RHHI regarding this change can be found at ***www.cms.hhs.gov/Transmittals/downloads/R215OTN.pdf*** on the CMS Web site.

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

Coverage and Billing for Ultrasound Stimulation for Nonunion Fracture Healing

Medlearn Matters Number: MM4085
Related Change Request (CR) #: 4085
Related CR Release Date: January 20, 2006
Related CR Transmittal #: R816CP
Effective Date: April 27, 2005
Implementation Date: April 3, 2006

The following information affects physicians, suppliers, and providers billing Medicare fiscal intermediaries (FIs), including regional home health intermediaries (RHHIs), for Ultrasound Stimulation for Nonunion Fracture Healing.

Provider Action Needed

Impact to You

This article is based on Change Request (CR) 4085, which supplements CR 3836 - Coverage and Billing Requirements for Ultrasound Stimulation for Nonunion Fracture Healing.

What You Need to Know

Effective for services performed on or after April 27, 2005, ultrasonic osteogenic stimulators are covered as medically reasonable and necessary for the treatment of nonunion bone fractures prior to surgery. Please note that there have been changes made to CR 3836 business requirements. These changes are discussed in the "Additional Information" section of this article. All other material and information remain the same as in the original CR 3836.

What You Need to Do

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

Background

The Centers for Medicare & Medicaid Services (CMS) determined that evidence is adequate to conclude that it is reasonable and necessary to use non-invasive ultrasound stimulation for the treatment of nonunion bone fractures prior to surgical intervention. Therefore, effective for services performed on or after April 27, 2005, ultrasonic osteogenic stimulators are covered as medically reasonable and necessary for the treatment of nonunion bone fractures prior to surgery.

Coverage and Billing for Ultrasound Stimulation for Nonunion Fracture Healing

An ultrasonic osteogenic stimulator is a non-invasive device that emits low-intensity, pulsed ultrasound. This device is applied to the surface of the skin at the fracture site, and ultrasound waves are emitted via a conductive coupling gel to stimulate fracture healing.

Note: Ultrasonic osteogenic stimulators are not to be used concurrently with other non-invasive osteogenic devices.

Coverage Requirements

Effective for dates of service on and after April 27, 2005, ultrasonic osteogenic stimulators are covered as medically reasonable and necessary for the treatment of nonunion bone fractures prior to surgical intervention. In demonstrating nonunion fractures, CMS expects a minimum of **two** sets of radiographs, obtained prior to starting treatment with the osteogenic stimulator, separated by a minimum of 90 days. Each radiograph set must include multiple views of the fracture site, accompanied with a written interpretation by a physician stating that there has been no clinically significant evidence of fracture healing between the two sets of radiographs.

For further coverage information, please refer to the Medicare National Coverage Determinations Manual (Pub.100-03), Chapter 1, Section 150.2, which can be found at ***www.cms.hhs.gov/manuals/downloads/ncd103c1_Part2.pdf*** on the CMS Web site.

Note: Hospitals should note that there are no covered services for ultrasonic osteogenic stimulation for which hospitals can be paid by the FI. Thus, hospitals cannot bill for ultrasonic osteogenic stimulators.

Bill Types When Billing RHHIs

When billed to RHHIs, ultrasonic osteogenic stimulators must be billed on type of bill (TOB) 32X, 33X, or 34X and are payable under the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule.

Note: Ultrasonic osteogenic stimulators must be in the patient's home health plan of care if billed on TOBs 32X or 33X.

Billing Instructions When Billing Medicare Carriers

Effective for dates of service on or after April 27, 2005, carriers will allow payment for ultrasonic osteogenic stimulators with the following Current Procedural Terminology (CPT) code:

- **20979** - Low-intensity ultrasound stimulation to aid bone healing, non-invasive (non-operative).

Billing Instructions for Durable Medical Equipment Regional Carriers (DMERCs) and RHHIs

Effective for dates of service on or after April 27, 2005:

- DMERCs and RHHIs will allow payment for ultrasonic osteogenic stimulators with the following Healthcare Common Procedure Coding System (HCPCS) codes:
  - **E0760** for low-intensity ultrasound (include modifier "KF"); or
  - **E1399** for other ultrasound stimulation (include modifier "KF").
- RHHIs will:
  - Pay for ultrasonic osteogenic stimulators only when services are submitted on TOBs 32X, 33X, or 34X;
  - Pay home health agencies (HHAs) on TOBs 32X, 33X, and 34X for ultrasonic osteogenic stimulators on the DMEPOS fee schedule.

Note: Medicare carriers, FIs, and RHHIs will adjust claims with dates of service on and after April 27, 2005, if brought to their attention.

Implementation

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

Additional Information

Some of the differences between CR 3836 and the new CR 4085 include the following:

- A modifier is not needed when billing code 20979 to a carrier as a result of CR 4085.
- Modifier "KF" is now to be used when billing code E0760 or code E1399 to a DMERC or RHHI.

For complete details, please see the official instruction issued to your carrier/DMERC/FI/RHHI regarding this change. That instruction may be viewed at ***www.cms.hhs.gov/Transmittals/downloads/R816CP.pdf*** on the CMS Web site.

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

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

Medlearn Matters Number: MM4335
Related Change Request (CR) #: 4335
Related CR Release Date: March 3, 2006
Related CR Transmittal #: R880CP
Effective Date: January 1, 2006
Implementation Date: April 3, 2006

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

Provider Action Needed

This article is based on Change Request (CR) 4335 and provides specific information regarding the April quarterly update for the 2006 DMEPOS Fee Schedule.

Background

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

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

Payment on a fee schedule basis is required for:

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

Changes made in this update include the following:

- The fee schedule amounts for Healthcare Common Procedure Coding System (HCPCS) code **K0730**, Controlled dose inhalation drug delivery system, were added to the fee schedule file on April 1, 2006, and are

effective for claims with dates of service on or after April 1, 2005. If processed claims for code K0730 with dates of service on or after April 1, 2005, are resubmitted as adjustments after April 1, 2006, carriers and DMERCs will adjust the claims.

- The fee schedule amounts for HCPCS code **E1010**, Wheelchair accessory, addition to power seating system, power leg elevation system, including leg rest, were inadvertently dropped from the January fee schedule file and are being added back to the file as part of the April 2006 update.
- The payment categories for codes **E0471** and **E0472** are being revised to move Respiratory Assist Devices from the DME category for frequently serviced items to the DME payment category for capped rental items, effective on April 1, 2006.

Implementation

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

Additional Information

The official instructions issued to your intermediary, carrier, or DMERC regarding this change can be found at ***www.cms.hhs.gov/Transmittals/downloads/R880CP.pdf*** on the Centers for Medicare & Medicaid Services (CMS) Web site.

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

Denial of Claims Not Timely Filed

Medlearn Matters Number: MM4041
Related Change Request (CR) #: 4041
Related CR Release Date: February 2, 2006
Related CR Transmittal #: R830CP
Effective Date: July 1, 2006
Implementation Date: July 3, 2006

The following information affects providers billing fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), carriers, and durable medical equipment regional carriers (DMERCs) for services provided to Medicare beneficiaries.

Provider Action Needed

Impact to You

This article is based on information contained in Change Request (CR) 4041, which clarifies that a determination relating to the untimely submission of a Medicare claim by a provider or supplier is **not** an initial determination and **cannot** be appealed.

What You Need to Know

Claims that are filed after the "timely filing period" will be denied as specified in the Medicare Claims Processing Manual, Publication 100-04, Chapter 1, Section 70.1. When a claim is denied because it was filed after the timely filing period, the denial will **not** constitute an "initial determination." As such, the determination that a claim was not filed timely **cannot** be appealed.

What You Need to Do

Be aware of the time limits for filing Medicare claims and the consequences of untimely filing.

Background

The Centers for Medicare & Medicaid Services (CMS) issued a technical correction to the June 30, 2005, Federal Register, Interim Final Rule, "Medicare Program: Changes to the Medicare Claims Appeal Procedures (42 CFR Parts 401 and 405)," that clarified that a determination regarding the untimely submission of a Medicare claim is **not** an initial determination and **cannot** be appealed. Specifically, 42 CFR Section 405.926(n) indicates that a determination that a provider or supplier failed to submit a claim timely or failed to submit a timely claim, despite being requested to do so by the beneficiary or the beneficiary's subrogee, is **not** an initial determination and **cannot** be appealed.

CR 4041 informs all Medicare providers of the above technical correction to the June 30, 2005, Interim Final Rule, "Medicare Program: Changes to the Medicare Claims Appeal Procedures," and revises the Medicare Claims Processing Manual, Publication 100-04, Chapter 1 (General Billing Requirements), Sections 70.4 and 70.8.6 to incorporate these changes.

Additional Information

For complete details, including the revised sections of the Medicare Claims Processing Manual and a table that illustrates the timely filing limit for dates of service in each calendar month, please see the official instruction issued to your carriers, FIs, DMERCs, or RHHIs

regarding this change. That instruction may be viewed by going to ***www.cms.hhs.gov/Transmittals/downloads/R830CP.pdf*** on the CMS Web site.

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

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

MLN Matters Number: SE0617
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Related CR Transmittal #: N/A
Effective Date: N/A
Implementation Date: N/A

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

Provider Action Needed

Based on comments received during provider open door forums and community meetings, the Centers for Medicare & Medicaid Services (CMS) has amended the payment methodology for the Recovery Audit Contractors (RACs) to include payment for the identification of Medicare underpayments.

Background

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), Section 306, directs the Secretary of the U.S. Department of Health and Human Services (HHS) to demonstrate the use of RACs under the Medicare Integrity Program in: 1) identifying underpayments and overpayments; and 2) recouping overpayments under the Medicare program (for services for which payment is made under Part A or Part B of Title XVIII of the Social Security Act).

Update

The RACs are paid on a contingency basis; that is, the RACs receive a portion of what they identify and collect. Beginning with underpayments identified on or after March 1, 2006, the RACs will receive an equivalent percentage for all underpayment and overpayment identifications. The RACs will use the same methodologies of automated and complex reviews to identify potential Medicare underpayments.

Important Things Providers Need to Know About the Underpayment Identification Portion of the RAC Demonstration

- The RAC may request a medical record for an underpayment determination. However, the medical record request letter will not indicate if the medical record is being requested for overpayment or underpayment review. When responding to a medical record request from the RAC, the provider may attach his/her own opinion regarding an underpayment. However, the findings from the RAC may differ from that of the provider.
- Upon identification of a potential underpayment, the RAC will forward the claim and all supporting documentation to the appropriate Medicare fiscal intermediary, carrier, or durable medical equipment regional carrier (DMERC) for their review. An underpayment identification will not be final unless the fiscal intermediary, carrier, or DMERC agrees with the identification. The RAC or the fiscal intermediary, carrier, or DMERC will NOT ask the provider to correct and resubmit the claim. Under the RAC demonstration, the RAC contractors have no authority to make refunds. Therefore, once the underpayment has been validated by the appropriate fiscal intermediary, carrier, or DMERC, the RAC will send the provider written notice of the underpayment determination. This notice will include claim and beneficiary details.
- The RACs do not have the authority to review unsolicited cases from providers where underpayment is thought to have occurred. Outside of the RAC program, if a provider feels he/she has received an underpayment, he/she may resubmit a corrected claim if the timely filing limit has not yet passed.
- The provider does not have any official appeals rights in relation to an underpayment determination. The provider may utilize the RAC rebuttal process and discuss the underpayment determination with the RAC. If the provider disagrees with the RAC that an underpayment exists, the RAC will defer to the billing provider's judgment.

Definition of an Underpayment

For purposes of the RAC demonstration, a Medicare underpayment is defined as those lines or payment groups (APC, RUG) on a claim that were billed at a low level of payment but should have been billed at a higher level of payment. The RAC will review each claim line or payment group and consider all possible

occurrences of an underpayment in that one line or payment group. If changes to the diagnosis, procedure, or order of diagnoses would change a line or payment group on the claim from a low level of payment to a higher level of payment (and the medical record supports such a change), an underpayment exists. Service lines or payment groups that a provider failed to include on a claim are **not** considered underpayments for the purposes of this demonstration.

Note: CMS has excluded the review of physician evaluation and management codes relevant to the level of an office visit or the medical necessity of the level of office visit from the RAC demonstration. This includes the review of overpayments and underpayments.

Examples of an Underpayment

The following **are** considered underpayments:

- The provider billed for 15 minutes of therapy when the medical record clearly indicates 30 minutes of therapy was provided. (This provider type is paid based on a fee schedule that pays more for 30 minutes of therapy than for 15 minutes of therapy.)
- The provider billed for a particular service and the amount the provider was paid was lower than the amount on the CMS physician fee schedule.
- A diagnosis/condition was left off the Minimum Data Set (MDS), but appears in the medical record. Had this diagnosis or condition been listed on the MDS, a higher payment group would have been the result.
- The physician submitted a claim for a surgical procedure using a code for a simpler procedure when in fact the procedure was a more complex one, such as in the case of skin repair which can be billed at a simple, intermediate, or complex level depending upon size and complexity.

The following **are not** considered underpayments:

- The medical record indicates that the provider performed additional services such as an electrocardiogram (EKG), but did not bill for the service.
- The provider billed for 15 minutes of therapy when the medical record clearly indicates 30 minutes of therapy was provided; however, the additional minutes do not affect the grouper or the pricer. (This provider type is paid based on a prospective payment system that does not pay more for this much additional therapy.)
- The medical record indicates that the provider implanted a particular device for which a device Average Projected Cost (APC) exists (and is separately payable over and above the service APC), but the provider did not bill for the device APC.

Questions concerning the RAC demonstration may be directed to a special email address CMS has established specifically for the demonstration: **cmsrecoveryauditdemo@cms.hhs.gov**.

Additional Information

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

Find out more about the MMA at ***www.cms.hhs.gov/MMAUpdate/*** on the CMS Web site.

News from DMERC A…

Fee Schedule Updates

The 2006 fee schedules and supplementary updates are available via the "Fee Schedules" section of the Region A Durable Medical Equipment Regional Carrier (DMERC A) Web site, ***www.umd.nycpic.com/dmfees.html***. The following updates have been posted:

- 2006 Parenteral and Enteral Fees - Revised 04-04-06
- 1st Quarter 2006 Update: Oral Anticancer Drug Fees - Revised 03-31-06
- 2nd Quarter 2006 Update: Oral Anticancer Drug Fees
- 4th Quarter 2005 Update: Oral Anticancer Drug Fees - Revised 4-4-06
- 3rd Quarter 2005 Update: Oral Anticancer Drug Fees - Revised 4-4-06
- 2nd Quarter 2005 Update: Oral Anticancer Drug Fees - Revised 4-4-06
- 1st Quarter 2005 Update: Oral Anticancer Drug Fees - Revised 4-4-06

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

- 2nd Quarter 2006 Fee For K0730

Note: The January 1 fees for the current calendar year are posted as the "Region A DMERC Fee Schedule" for that particular year, and these files are **not** changed throughout the year. Rather, separate notices are posted

as fee revisions/updates become available. Please be sure you are viewing the appropriate file/notice for the item and date of service.

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

Important Update: ADMC Requests

Beginning June 1, 2006, Advance Determination of Medicare Coverage (ADMC) requests should be sent directly to the Region A Program Safeguard Contractor (PSC) at the following address:

TriCenturion
Attention: ADMC Region A
7909 Parklane Road
Suite 190
Columbia, SC 29223

Or, fax requests to the PSC at 803-419-6080. Please specifically state, "**ADMC Request for Region A**," when submitting via mail or fax to ensure requests are processed accurately.

DMERC A Additional Documentation Transition Process

Effective June 1, 2006, the Region A Durable Medical Equipment Regional Carrier (DMERC A) will **no** longer accept hardcopy additional documentation for claims processing. If documentation is submitted in hardcopy, it will be appropriately discarded. This is due to the transition to the Durable Medical Equipment Medicare Administrative Contractor (DME MAC) for Jurisdiction A, effective July 1, 2006.

Providers will need to utilize the NTE fields (2300 and 2400) to submit all information pertinent to their claims. The note segment is limited to 80 characters at the claim level and each line level, so providers should not include any wording that does not relate to the items and services being billed. If claims that require additional information for adjudication are submitted with nothing documented in the NTE fields (e.g., repairs), these claims will be denied. DMERC A will not send development letters for these claims.

The "Suggested Abbreviations When Reporting Additional Documentation Notations in the ANSI and NCPDP Formats" (***www.umd.nycpic.com/edidocfiles.html#Abbrev***) is available to assist providers when submitting additional documentation in electronic claims. This "suggested list" of abbreviations contains the most common types of documentation and notations submitted to DMERC A. Please refer to this reference tool to avoid unnecessary denials.

Additional Fax Documentation Workflow Changes

Effective July 1, 2006, the HealthNow Region A Durable Medical Equipment Regional Carrier (DMERC A) process described as the "Additional Documentation Fax Process" will be discontinued. Along with the elimination of this process, this document outlines the **changes** to the current claims submission instructions for services (such as K0108) for which suppliers fax supporting documentation to HealthNow today.

These changes are consistent with recent documentation requirements detailed in Local Coverage Determination (LCD) 11473 (Wheelchairs Options/Accessories). The **March 1, 2006, update** to this LCD states:

> The medical necessity for all options and accessories must be documented in the patient's medical record and be available to the DMERC on request. This documentation might include information on why the patient needs the item, the patient's diagnosis, the patient's abilities and limitations as they relate to the equipment (e.g., degree of independence/dependence, frequency and nature of the activities the patient performs, etc.), the duration of the condition, the expected prognosis, and past experience using similar equipment.

To compare, the previous version of this policy stated:

> When billing option/accessory codes as a replacement (modifier RP), documentation of the medical necessity for the item, make and model name of the wheelchair base it is being added to, and the date of purchase of the wheelchair must be submitted with the claim.
>
> When code K0108 is billed, the claim must include a narrative description of the item, the manufacturer, the model name or number (if applicable), and information justifying the medical necessity for the item. If a formal

wheelchair evaluation has been performed, it would be appropriate to include this information as documentation.

This change recognizes that fact that suppliers are required to retain all required supporting documentation and provide it to Durable Medical Equipment Medicare Administrative Contractors (DME MACs) and/or Program Safeguard Contractor (PSC) upon request.

This procedural update **does not change** any existing documentation requirements detailed in current LCDs. What does change is the need to **submit** hardcopy medical backup documentation with the claim.

The example below is for K0108, however, these instructions would be for any of the Not Otherwise Classified (NOC) codes for which the "Additional Documentation Fax Process" is used today.

Instructions

If a claim is billed with a K0108 (wheelchair component or accessory, not otherwise specified) the below information is required.

1. If multiple miscellaneous accessories are provided, each should be billed on a separate claim line using code K0108.
2. A description of the item, and the brand name, make/model and part number (if applicable), up to 80 characters. This would be listed in the detail NTE field. Use abbreviations when needed. You can abbreviate the brand name by using just the first five (5) letters if needed. Do not abbreviate the model/part number.

   Example: TOGGLE SWITCH.MFR PRIDE MD#FRMASMB272 REPLCMNT
   46 characters could be further abbreviated to "RPL toggle MFR PRIDE MD FRMASMB272" 33 characters
3. The date of purchase and the Healthcare Common Procedure Coding System (HCPCS) code and description of the beneficiary-owned equipment.

   The Claim NTE field could be used to reference this to free up space in the detail NTE **if needed**, or the detail NTE would be used. If this information is entered in the Claim NTE field, the National Heritage Insurance Company (NHIC, the DME MAC for Jurisdiction A) processors **will** be able to view the narrative.

   Example: Repairs to PT owned PRIDE JAZZY PTO PWC PUR 04162003 (49 characters)

   This information only needs to be referenced once per claim. Therefore, if the claim is for the above **plus** E1340 (labor) and you include the information as described below, it would not be needed on any of the K0108 lines applicable to that beneficiary-owned equipment.

Repairs

E1340 - Labor charges

While your medical records will contain detailed descriptions of the repairs made, the information needed on the claim is a statement that this service is for repairs to beneficiary-owned equipment and the date of purchase and the HCPCS code or description for beneficiary-owned equipment.

Example: Repairs to PT owned PRIDE JAZZY PTO PWC PUR 04162003 (49 characters)

All other required supporting medical documentation would be retained in your files.

Please note that should it be necessary for the DME MAC and/or PSC to obtain additional documentation, the claim will be developed with an ADR (Additional Documentation Request).

NHIC will continue the use of the HealthNow abbreviation list (DMERC A's "Suggested Abbreviations When Reporting Additional Documentation Notations in the ANSI and NCPDP Formats") and welcomes your suggestions for additions to the list. Let us know of common abbreviations you use that you would like to see on the list. The Abbreviation Listing is a reference tool for you and your staff, and we want it to be as useful as possible.

EDI Services

News from CMS…

Medicare to Stop Mailing Standard Paper Remittance (SPR) for Those Providers/Suppliers Also Receiving the Electronic Remittance Advice (ERA)

Beginning June 1, 2006, the standard paper remittance (SPR) received through the mail will **no** longer be available to providers/suppliers who also receive an electronic remittance advice (ERA), whether the ERA is received directly or through a billing agent, clearinghouse, or other entity representing a provider/supplier. In response to the provider/supplier communities continued need for SPRs, the Centers for Medicare & Medicaid Services (CMS) has developed **free** software, called Medicare Remit Easy Print (MREP), that gives providers/suppliers a tool to read and print a remittance advice (RA) from the Health Insurance Portability and Accountability Act (HIPAA)-compliant Health Care Claim Payment/Advice (835) file. The MREP software was designed to incorporate new functionality to save providers/suppliers time and money. The paper output generated by MREP is similar to the SPR format. CMS has worked with other payers to insure their acceptance of the SPR generated by the MREP software for Coordination of Benefit claim submission. Additionally, CMS has worked with clearinghouses to assure similar software is available to read and print an ERA for those providers/suppliers that utilize clearinghouse services. We encourage providers/suppliers currently receiving the ERA, who don't use software to read and print RAs from these files, to begin using MREP or other similar software before the June 1, 2006, cutoff. Please go to ***www.umd.nycpic.com/dmedi_mrep.html*** for further information regarding MREP software. We appreciate your continued cooperation as the Medicare program moves toward a more electronic environment.

Suppression of Standard Paper Remittance Advice (SPR) to Providers and Suppliers Also Receiving Electronic Remittance Advice (ERA) for 45 Days or More

Medlearn Matters Number: MM4376
Related Change Request (CR) #: 4376
Related CR Release Date: March 10, 2006
Related CR Transmittal #: R885CP
Effective Date: March 15, 2006
Implementation Date: June 1, 2006

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

Provider Action Needed

Impact to You

Change Request (CR) 4376 provides notice that beginning June 1, 2006, carriers and DMERCs will stop sending standard paper remittance (SPR) advices to you (or a billing agent, clearinghouse, or other entity representing you) if you have been receiving 835s or electronic remittance advice (ERA) transactions, either directly or through a billing agent, clearinghouse, or other entity representing you, for 45 days or more.

What You Need to Know

If you need a paper copy of a remittance advice for accounts reconciliation or to forward to secondary/tertiary payers, be aware that the Centers for Medicare & Medicaid Services (CMS) has developed software that gives you a tool to view and print an 835 in a readable format locally on your computer. This software is called Medicare Remit Easy Print (MREP). See the "Additional Information" section of this article to learn how to access MREP software. Your clearinghouse may also offer software that allows you to view and print your remittance advice.

What You Need to Do

Make certain that your billing staffs are aware of these changes. Try MREP software to view and print your own remittance and see the benefits for yourself. Or, check with your clearinghouse to see if it provides similar software.

Background

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.

MREP was developed in response to comments CMS received from the provider/supplier community that they need a paper document for accounts reconciliation and claim submission for secondary/tertiary payments. Providers/suppliers who use the MREP software package have the ability to print paper remittances and

reports that can be used to reconcile accounts receivable, as well as to create document(s) that can be included with claim submissions to secondary/tertiary payers. The output of MREP is similar to the current SPR format. Benefits of using MREP software include the ability to:

Save Time and Money
You can print remittance information directly from your computer the day the Health Insurance Portability and Accountability Act (HIPAA) 835 is available. No more time is spent waiting for the mail.

Create and Print Special Reports
With MREP, you can run, export, or print several useful reports including:

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

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

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

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

Note: MREP software will be revised three times per year to accommodate Claim Adjustment Reason and Remittance Advice Remark Code set changes. You can sign up to be notified automatically when a new version of MREP is available at your carrier's/DMERC's Web site.

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

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

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

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

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

Implementation
The implementation date for this instruction is June 1, 2006.

Additional Information
To learn about more MREP benefits, download the brochure available at ***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 ***www.cms.hhs.gov/MLNMattersArticles/downloads/SE0611.pdf*** on the CMS Web site.

If you have questions, please contact your Medicare carrier/DMERC at their toll-free number, which may be found at ***www.cms.hhs.gov/MedlearnProducts/downloads/CallCenterTollNumDirectory.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 telephone numbers are available at ***www.cms.hhs.gov/ElectronicBillingEDITrans/*** on the CMS Web site.

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

Options for Providers/Suppliers Affected by CR 4376: Suppression of Standard Paper Remittance Advice (SPR) to Providers and Suppliers Also Receiving Electronic Remittance Advice (ERA) for 45 Days or More

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

The following information affects 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.

Determine which of the following scenarios represents your situation:

1. **You are receiving the ERA directly from your carrier in the Health Insurance Portability and Accountability Act (HIPAA)-compliant 835 format:** Use the Medicare Remit Easy Print (MREP) software.[1] MREP requires that you import ERAs in the HIPAA-compliant 835 format. (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 an 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. The Centers for Medicare & Medicaid Services (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 an 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 ***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 ***www.cms.hhs.gov/MLNMattersArticles/downloads/SE0611.pdf*** or a related MLN Matters article (MM4376) at ***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 telephone numbers are available at ***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 ***www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.pdf*** on the CMS Web site.

The official instructions (CR 4376) issued to your carrier/DMERC regarding this change can be found at ***www.cms.hhs.gov/transmittals/downloads/R885CP.pdf*** on the CMS Web site.

[1]This software was developed by CMS for use by Medicare providers/suppliers to view and print an HIPAA-compliant Medicare 835. Medicare has no liability and takes no responsibility for any other use of this software.

Update to Chapter 24 (EDI Support Requirements) of the Medicare Claims Processing Manual to Show New CMS Web Site URL References

MLN Matters Number: MM4398
Related Change Request (CR) #: 4398
Related CR Release Date: April 7, 2006
Related CR Transmittal #: R900CP
Effective Date: May 8, 2006
Implementation Date: July 7, 2006

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

Background

This article, based on Change Request (CR) 4398, highlights the fact that the ***www.cms.hhs.gov*** Web site has been completely redesigned. Currently, Chapter 24 of the Medicare Claims Processing Manual contains Uniform Resource Locators (URLs) that no longer direct the user to the new CMS Web site. If used, the following message will appear: "We're sorry. The page you requested cannot be found. CMS has recently launched a Web site redesign and many addresses have changed." This instruction updates the URLs that are currently in Chapter 24, removes the URLs that no longer apply, and replaces them with the new URLs.

Key Points

The key new Web addresses are as follows:

- ***www.cms.hhs.gov/ElectronicBillingEDITrans/01_Overview.asp*** is the new address for accessing and downloading the CMS electronic data interchange (EDI) instructions.
- The X12N 837 implementation guide (IG) version 4010A1 for Institutional (I) and Professional (P) claims is now at ***www.cms.hhs.gov/ElectronicBillingEDITrans/08_HealthCareClaims.asp*** on the CMS Web site.
- The implementation guide for coordination of benefits (COB) with other payers is at ***www.cms.hhs.gov/ElectronicBillingEDITrans/12_COB.asp*** on the CMS Web site.
- The National Council for Prescription Drug Programs (NCPDP) Telecommunications Standard Specifications and IG version 5.1 and Batch Standard 1.1 for retail prescription drug claims (billed to Medicare DMERCs only) and COB are at ***www.cms.hhs.gov/ElectronicBillingEDITrans/08_HealthCareClaims.asp*** on the CMS Web site.
- The X12 835 IG version 4010A1 for Remittance Advice is at ***www.cms.hhs.gov/ElectronicBillingEDITrans/11_Remittance.asp*** on the CMS Web site.
- The X12 276/277 IG version 4010A1 for Claim Status Inquiry and Response is located at ***www.cms.hhs.gov/ElectronicBillingEDITrans/10_ClaimStatus.asp*** on the CMS Web site.
- Information on the X12 270/271 IG version 4010A1 transactions for Beneficiary Eligibility Inquiry and Response are at ***www.cms.hhs.gov/ElectronicBillingEDITrans/09_Eligibility.asp*** on the CMS Web site.
- Health Insurance Portability and Accountability Act (HIPAA) IG "companion documents" are available at ***www.cms.hhs.gov/ElectronicBillingEDITrans*** on the CMS Web site. Once at that site, select the specific transaction desired from the left side of the screen, and you will then get a link to the companion document at the bottom of the page for that transaction.

Additional Information

The official instructions issued to your carrier or intermediary regarding this change can be found at ***www.cms.hhs.gov/Transmittals/downloads/R900CP.pdf*** on the CMS Web site.

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

News from DMERC A…

Suppression of Standard Paper Remittance Advice (SPR) to Providers and Suppliers Also Receiving Electronic Remittance Advice (ERA)

Beginning June 1, 2006, carriers and durable medical equipment regional carriers (DMERCs) will stop sending Standard Paper Remittance (SPR) advices to you (or a billing agent, clearinghouse, or other entity representing you) if you have been receiving Electronic Remittance Advice (ERA) transactions for 45 days or more, either directly or through a billing agent, clearinghouse, or other entity representing you.

Once the SPR is suppressed, it is even more critical to remember that submitters are expected to access the Region A Durable Medical Equipment Regional Carrier (DMERC A) Bulletin Board System (BBS) on a daily basis to retrieve the Electronic Media Claims (EMC) Transmission Reports and ERA. It is also expected that submitters will be equally prompt in reviewing them and requesting DMERC A Electronic Data Interchange (EDI) Help Desk Services on a timely basis, if these services are needed. These files are available for 15 calendar days only and are then permanently deleted. Information on reports retrieval from the BBS can be found at ***www.umd.nycpic.com/ElectronicClaimsTransmissionReport020106.pdf*** on the DMERC A Web site.

In response to the provider/supplier community's continued need for remittance advices (RAs) in

hardcopy, the Centers for Medicare & Medicaid Services (CMS) has developed **free** software, called Medicare Remit Easy Print (MREP), that gives providers/suppliers a tool to print an RA from the Health Insurance Portability and Accountability Act (HIPAA)-compliant HealthCare Claim Payment/Advice (American National Standards Institute (ANSI) 835) file. MREP is designed to incorporate new functionality to save providers/suppliers time and money. The paper output generated by MREP is similar to the SPR format. CMS has worked with other payers to insure their acceptance of the SPR generated by the MREP software for Coordination of Benefit (COB) claim submission. More information on ERAs and MREP can be found at ***www.umd.nycpic.com/dmedi_mrep.html*** on the DMERC A Web site.

Use of New Carrier Number for Electronic Claims Submitted to HealthNow for Processing by NHIC

Effective **Wednesday, June 28, 2006**, submitters, billing services, and clearinghouses who submit electronic claims directly to Jurisdiction A must use the carrier number for National Heritage Insurance Company (NHIC), the new Durable Medical Equipment Medicare Administrative Contractor (DME MAC). The carrier number for the HealthNow Region A Durable Medical Equipment Regional Carrier (DMERC A), 00811, will no longer be valid. The new carrier number for NHIC is **16003**. The carrier number, also known as the Receiver ID, is located in four places in an American National Standards Institute (ANSI) 837 claim file, and also in National Council for Prescription Drug Programs (NCPDP) claim files.

ExpressPlus users should check the HealthNow DMERC A Web site (***www.umd.nycpic.com/ediupdates.html***) often for updates and announcements. Submitters using any other software must contact their vendor for assistance with this change.

Remember that this change must not occur before **Wednesday, June 28, 2006**. If any claims are received with **16003** before **Wednesday, June 28, 2006**, or with 00811 after **Tuesday, June 27, 2006**, the claims will reject on the front end.

HealthNow New York Electronic Data Interchange (EDI) Contingency Plan

Due to the delay in implementation of a common DME MAC EDI Front End system, HealthNow New York has developed a contingency plan to support Electronic Medicare Claims (EMC) transmissions for the DME MAC Jurisdiction A (National Heritage Insurance Company (NHIC)) for the period of July 1, 2006, through September 30, 2006.

What HealthNow will continue to support:

- Electronic Claims Submission (see chart)
- Return of file transmission and editing reports (see chart)
- Electronic Remittance Advices (ERAs) (see chart)
- EDI Technical Help Desk services (telephone, fax, email) for **front end functions only**
- Distribution and support of Medicare low cost billing software (ExpressPlus)
- Enrollment and testing of new submitters
- Ongoing updates and maintenance of submitter profiles and systems setup

Function	Current Region A States	Current MD & D.C. *(Note)*
Submit ANSI 837 & NCPDP Claims	• Continue to submit to HealthNow New York • Misdirected claims will be transferred to correct Region/ Jurisdiction based on address of Beneficiary	• Continue to submit to former Region OR enroll and submit to HealthNow New York • Misdirected claims will be transferred to correct Region/Jurisdiction based on address of Beneficiary
Retrieve transmission and translator edit reports	Continue to retrieve from HealthNow New York	Continue to retrieve from former Region
Retrieve VMS Edit Reports	Continue to retrieve from HealthNow New York	• Continue to retrieve from former Region • For claims that are transferred to Jurisdiction A, enroll with HealthNow New York to receive second VMS Edit report
Retrieve ERAs	Continue to retrieve from HealthNow New York	Enroll with HealthNow New York to retrieve from Jurisdiction A
Submit 276 Claims Status Inquiries and Receive 277 Responses	Continue to submit/retrieve from HealthNow New York	Enroll with HealthNow New York to submit/retrieve

Note: Submitters for MD and D.C. claims who are already enrolled with Region A may submit claims to either Region and will retrieve reports from the Region to which the claims were submitted. ERAs will be retrieved from Region A.

What will move from HealthNow New York EDI Services to NHIC support on July 1, 2006:

- VPIQ for On-Line Claims Status and Eligibility Inquiries
- Electronic Funds Transfer (EFT)
- Acquisition and support of the Medicare Remit Easy Print (MREP) software for management of ERAs
- Assistance with VMS Front End Edits and Errors related to Coverage Guidelines, Billing Practices, and Medical Policy
- Enforcement of Administrative Simplification Compliance Act (ASCA) Requirements for Health Insurance Portability and Accountability Act (HIPAA)-compliant Claims Submission

Joint HealthNow New York and NHIC efforts:
EDI education and outreach will be conducted cooperatively, including Web site postings, ListServe messages, and supplier publications. Information and EDI forms currently available on the HealthNow Web site will be available on the NHIC DME Web site.

Note: For additional information on durable medical equipment (DME) electronic claims submissions, please refer to the National Heritage Insurance Company (NHIC) Web site at *www.medicarenhic.com/dme/index.shtml*.

HIPAA Information

News from CMS…

Termination of the Existing Eligibility File-Based Crossover Process at All Medicare Contractors

Medlearn Matters Number: MM4231
Related Change Request (CR) #: 4231
Related CR Release Date: December 9, 2005
Related CR Transmittal #: 198
Effective Date: January 9, 2006
Implementation Date: January 9, 2006

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

Provider Action Needed

Impact to You

This article is based on Change Request (CR) 4231, which informs Medicare contractors (carriers, DMERCs, FIs, and RHHIs) about their responsibilities regarding the discontinuance of the current eligibility file-based crossover process effective January 3, 2006. The impact of CR 4231 is primarily on the Centers for Medicare & Medicaid Services (CMS) trading partners as defined later in this article. The article is primarily informational for providers.

What You Need to Know

CMS will discontinue the current eligibility file-based crossover process effective January 3, 2006, and CR 4231 outlines the processes that Medicare contractors must follow when trading partners request a waiver to enable them to move into crossover production with the CMS Coordination of Benefits Contractor (COBC) beyond January 3, 2006.

What You Need to Do

This article is informational only for providers, so they may be aware of the potential for changes in how their claims are forwarded to CMS trading partners for coordination of benefits activities. See the "Background" section of this article for further details regarding the termination of the existing eligibility file-based crossover process.

Background

CMS has been testing its national Coordination of Benefits Agreement (COBA) consolidated crossover process with over 120 trading partners starting in July 2004. During this time, CMS and its COBC have brought the Health Insurance Portability and Accountability Act (HIPAA) American National Standards Institute (ANSI) X12N 837 Coordination of Benefits (COB) claim files into high degrees of compliancy with the Version 4010A1 837 Institutional and Professional Claim Implementation Guides. Starting in June 2005, CMS has been moving trading partners into crossover production with the COBC, and this trend has recently been accelerating.

Note: "Trading Partner" is defined as an issuer of an insurance policy that supplements Medicare or a state agency responsible for administration of Title XIX of the Social Security Act. It is also defined as a federal agency, or contractor thereof, that administers and provides health care benefits for its eligible beneficiaries or an entity working under contract with a self-insured employer plan or an insurer to adjudicate claims and perform other insurance functions. A trading partner does not include entities that merely receive, route, and/or translate files, such as health care clearinghouses, network service vendors, data transmission services, and billing services. CMS and its COBC may, however, transmit crossover claims to trading partners through one of these entities.

CMS recently provided guidance to all Medicare contractors (carriers, DMERCs, FIs, and RHHIs) regarding the discontinuance of the existing eligibility file-based crossover process effective December 31, 2005 (JSM-06026) and described a waiver process that trading partners who will not be moving into COBA crossover production by December 31, 2005, must follow. In addition, CR 4231 is being issued to:

- Clarify all Medicare contractor requirements as they relate to the discontinuance of the existing eligibility file-based crossover process; and
- Update the end date for the existing Medicare eligibility file-based crossover process to January 3, 2006, for Medicare contractor purposes.

This will enable the Medicare contractors to initiate the termination process for those trading partners that have not moved to COBA production by December 31, 2005.

Note: The "eligibility file" is the data file provided by the trading partner containing the records required to identify Medicare beneficiaries for purposes of receiving Medicare Part A and B crossover claims and reporting existing prescription drug coverage by the trading partner.

CMS Medicare contractors will **not** cross claims over to trading partners beyond January 3, 2006, pursuant to signed crossover agreements and the submission of COB eligibility files. As of January 3, 2006, CMS' COBC will exclusively cross over all claims to trading partners in the HIPAA ANSI X12N 837 COB (version 4010A1) formats via the COBA eligibility file-based crossover process, unless:

1. Medicare contractors have submitted waiver requests to CMS on behalf of their current trading partners no later than December 16, 2005 (Note: Trading partners would need to have submitted these requests to the Medicare contractors no later than December 7, 2005), and
2. CMS has approved the trading partners' waiver requests in advance of January 3, 2006. (Note: CMS plans to reach a decision on all waiver requests no later than December 21, 2005, unless late waiver requests must be addressed.)

Termination Process Notifications to Trading Partners That Have Not Requested a Waiver

All Medicare contractors will begin the termination of the existing eligibility file-based crossover process with each individual trading partner that has not requested and received a waiver no sooner than January 3, 2006.

Impact on Mandatory Medigap ("Claim-Based") Crossovers

The January 3, 2006, end date does **not** apply to mandatory Medigap ("claim-based") crossovers, which are authorized by the Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203, Section 4081(a)(B)) and currently supported by Part B and DMERC contractors.

Implementation

The implementation date for this instruction is January 9, 2006.

Additional Information

For complete details, please see the official instruction issued to your carrier/DMERC/intermediary regarding this change. That instruction may be viewed at ***www.cms.hhs.gov/transmittals/downloads/R198OTN.pdf*** on the CMS Web site.

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

General Information

News from CMS…

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

Medlearn Matters Number: SE0602 Revised
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Related CR Transmittal #: N/A
Effective Date: January 3, 2006
Implementation Date: January 3, 2006
Note: This article was revised on March 17, 2006, to show the data collection period will continue through April 2006.

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

Provider Action Needed

Impact to You

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

What You Need to Know

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

What You Need to Do

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

Background

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

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

It contains a total of 76 questions and takes approximately 21 minutes to complete. The target date to respond is approximately three weeks after receipt of the notification packet. CMS will analyze the data and release a summary report in July that will be made available on the Internet. Each contractor will also receive an individual report on their performance in June. The MCPSS will be conducted on an annual basis.

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

Additional Information

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

Announcing a New Name for Medicare's Provider Education Articles - MLN Matters

MLN Matters Number: SE0620
Related Change Request (CR) #: N/A
Related CR Release Date: N/A

Related CR Transmittal #: N/A
Effective Date: N/A
Implementation Date: N/A

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

Background

The Medicare Learning Network is pleased to announce a new name for our very popular provider education articles. To more closely associate these articles with the Medicare Learning Network, i.e., the official educational information source for Medicare Fee-for-Service (FFS) providers, the articles previously known as "Medlearn Matters" articles will now be known as "MLN Matters" articles (the MLN standing for "Medicare Learning Network"). You will also notice a new logo at the top of the articles indicating the name change. The Centers for Medicare & Medicaid Services (CMS) knows that you have come to rely on these articles to help you more easily understand new or changed Medicare policy and to help you gain quick access to accurate Medicare program information.

The articles can now be accessed from ***www.cms.hhs.gov/MLNMattersArticles*** on the CMS Web site. If you have previously bookmarked the "Medlearn Matters" page, please update your bookmark to the new Uniform Resource Locator (URL). We hope that you will continue to utilize these articles that are always prepared with the affected provider audience in mind.

In conjunction with the above referenced change, the URLs for the Medicare Learning Network (MLN) Web pages have also been changed. You can reach our MLN Web pages from the cms.hhs.gov main page - just click on "Outreach and Education." The full URLs to access the various MLN sections on the CMS Web site are:

MLN General Information - ***www.cms.hhs.gov/MLNGenInfo***

MLN Products - ***www.cms.hhs.gov/MLNProducts***

Additional Information

Also, note that if you know the specific number of an article you are after, such as SE0620, you can go directly to the specific URL for an article by using the format below. For example, the Web site for SE0620 is ***www.cms.hhs.gov/MLNMattersArticles/downloads/SE0620.pdf***. For any other article, just substitute its number for the SE0620 in this URL to go directly to the Portable Document Format (PDF) version of the article on the CMS Web site.

Please note: The related links on the Region A Durable Medical Equipment Regional Carrier (DMERC A) Web site have been updated to reflect the changes within this article.

New Information for All Medicare Participating Providers in Pennsylvania

In late January, we [the Centers for Medicare & Medicaid Services (CMS)] informed you that many Medicare beneficiaries who also have Medicaid coverage from the state of Pennsylvania (also known as "full benefit dual eligibles" or "dual eligibles") have been enrolled into Medicare "Special Needs Plans" (SNPs) and coverage began January 1, 2006. These Medicare SNPs (listed below) are managed care plans operated by the same organization that provided these beneficiaries' Medicaid managed care coverage and provide Medicare-covered services (including Medicare prescription drug coverage) and other health care services to the dually eligible population.

In our January message, we asked that you continue to see your Medicare patients, even if you do not participate in any or all of these plans' networks, during a special transition or "grace period" that was scheduled to end on March 31, 2006. This period has since been extended until **June 30, 2006**, to allow beneficiaries additional time to either change to in-network providers or to disenroll from their SNP and return to Medicare fee-for-service (FFS) or to enroll in another Medicare Advantage plan.

1) Until **June 30, 2006**, you may provide Medicare-covered services to these individuals and submit a claim to your patient's Medicare SNP even though you do not participate in its network. The SNP is required to pay you the Medicare FFS rate or billed charge, whichever is lower, for any Medicare-covered services provided during the period beginning January 1, 2006, and ending on **June 30, 2006**.

2) You may sign up to be a participating provider with the plan, should you so desire. You should contact the plan for further details about becoming a participating provider.

3) Your dual eligible patients may disenroll from the SNP and return to original (FFS) Medicare or choose a different Medicare managed care plan at any time. You should feel free to refer them to one of the organizations listed at the end of this letter for advice about what plan is best for them.

CMS has worked closely with the SNPs to clarify their obligations to continue to pay for services provided by out-of-network providers through **June 30, 2006**, and to ensure that these "transition policies" are appropriately disseminated throughout their organizations. If you have any questions about these policies, or encounter any difficulties receiving payment for care provided during this time period, please contact the appropriate plan at the numbers listed below. You may also contact CMS' Philadelphia Regional Office at 215-861-4154 if you encounter problems with this process or with signing up to be a participating provider with a plan. Please feel free to duplicate this mailing and share it with your colleagues.

The SNPs sent a notice to all affected beneficiaries in February, explaining their enrollment options and clarifying plan transition policies, and recently, sent a second notice to these beneficiaries informing them that they now have until **June 30, 2006**, to exercise these options without being limited in their choice of providers. (A copy of this notice is attached.) As the notice explains, these beneficiaries may disenroll from their SNP by calling the plan directly at the number included below, or by calling 1-800-MEDICARE (1-800-633-4227). TYY users should call 1-877-486-2048. Staff at 1-800-MEDICARE will also help them to enroll in a Medicare Prescription Drug Plan to make sure that they retain Medicare prescription drug coverage.

Please note: Since it may take several days for a beneficiary's disenrollment to appear in CMS' systems, we ask that you accept as proof of disenrollment a letter from CMS or the SNP confirming the disenrollment request and the effective date.

List of Medicare Special Needs Plans

AmeriHealth 65
Member Services: 1-800-645-3965
Provider Services: 1-888-850-9200

Gateway Health Plan
Member Services: 1-800-685-5209
Provider Services: 1-800-685-5205

Health Partners
Member Services General: 1-800-553-0784
Medicare Specific: 1-888-667-7367
Provider Services: 1-888-991-9023

Keystone 65 Complete
Member Services: 1-800-645-3965
Provider Services: 1-888-850-9200

UPMC Health Plan
Members and Providers: 1-800-606-8648

Unison Health Plan
Member Services: 1-800-290-4009
Provider Services: 1-800-600-9007

Resources to Help Dual Eligibles Choose Another Plan

Medicare
1-800-MEDICARE (1-800-633-4227)
TYY 1-877-486-2048

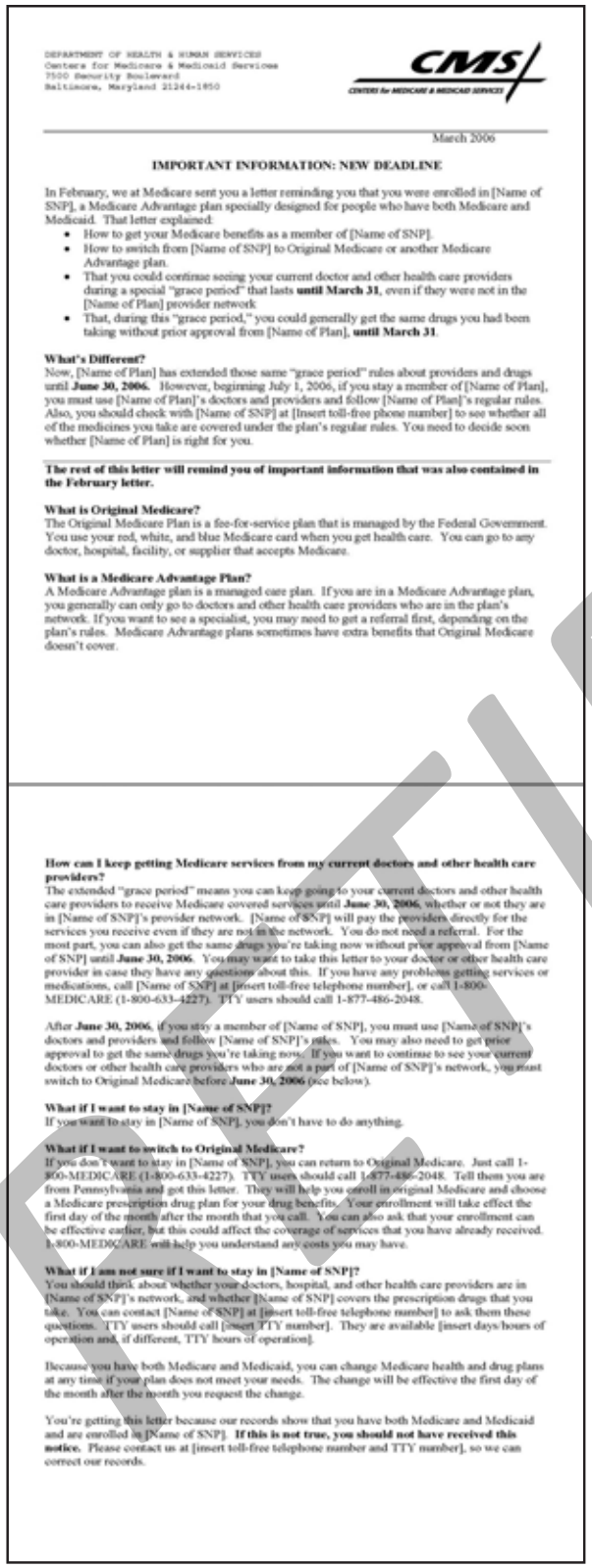
APPRISE
1-800-783-7067

Other Organizations to Help Dual Eligibles

Pennsylvania Health Law Project
1-800-274-3258

Community Legal Services
(for Philadelphia Residents)
215-227-2400

(See next page for copy of beneficiary notice.)



DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

March 2006

IMPORTANT INFORMATION: NEW DEADLINE

In February, we at Medicare sent you a letter reminding you that you were enrolled in [Name of SNP], a Medicare Advantage plan specially designed for people who have both Medicare and Medicaid. That letter explained:

- How to get your Medicare benefits as a member of [Name of SNP].
- How to switch from [Name of SNP] to Original Medicare or another Medicare Advantage plan.
- That you could continue seeing your current doctor and other health care providers during a special "grace period" that lasts **until March 31**, even if they were not in the [Name of Plan] provider network.
- That, during this "grace period," you could generally get the same drugs you had been taking without prior approval from [Name of Plan], **until March 31**.

What's Different?
Now, [Name of Plan] has extended those same "grace period" rules about providers and drugs until **June 30, 2006.** However, beginning July 1, 2006, if you stay a member of [Name of Plan], you must use [Name of Plan]'s doctors and providers and follow [Name of Plan]'s regular rules. Also, you should check with [Name of SNP] at [Insert toll-free phone number] to see whether all of the medicines you take are covered under the plan's regular rules. You need to decide soon whether [Name of Plan] is right for you.

The rest of this letter will remind you of important information that was also contained in the February letter.

What is Original Medicare?
The Original Medicare Plan is a fee-for-service plan that is managed by the Federal Government. You use your red, white, and blue Medicare card when you get health care. You can go to any doctor, hospital, facility, or supplier that accepts Medicare.

What is a Medicare Advantage Plan?
A Medicare Advantage plan is a managed care plan. If you are in a Medicare Advantage plan, you generally can only go to doctors and other health care providers who are in the plan's network. If you want to see a specialist, you may need to get a referral first, depending on the plan's rules. Medicare Advantage plans sometimes have extra benefits that Original Medicare doesn't cover.

How can I keep getting Medicare services from my current doctors and other health care providers?
The extended "grace period" means you can keep going to your current doctors and other health care providers to receive Medicare covered services until **June 30, 2006**, whether or not they are in [Name of SNP]'s provider network. [Name of SNP] will pay the providers directly for the services you receive even if they are not in the network. You do not need a referral. For the most part, you can also get the same drugs you're taking now without prior approval from [Name of SNP] until **June 30, 2006**. You may want to take this letter to your doctor or other health care provider in case they have any questions about this. If you have any problems getting services or medications, call [Name of SNP] at [insert toll-free telephone number], or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

After **June 30, 2006**, if you stay a member of [Name of SNP], you must use [Name of SNP]'s doctors and providers and follow [Name of SNP]'s rules. You may also need to get prior approval to get the same drugs you're taking now. If you want to continue to see your current doctors or other health care providers who are not a part of [Name of SNP]'s network, you must switch to Original Medicare before **June 30, 2006** (see below).

What if I want to stay in [Name of SNP]?
If you want to stay in [Name of SNP], you don't have to do anything.

What if I want to switch to Original Medicare?
If you don't want to stay in [Name of SNP], you can return to Original Medicare. Just call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. Tell them you are from Pennsylvania and got this letter. They will help you enroll in original Medicare and choose a Medicare prescription drug plan for your drug benefits. Your enrollment will take effect the first day of the month after the month that you call. You can also ask that your enrollment can be effective earlier, but this could affect the coverage of services that you have already received. 1-800-MEDICARE will help you understand any costs you may have.

What if I am not sure if I want to stay in [Name of SNP]?
You should think about whether your doctors, hospital, and other health care providers are in [Name of SNP]'s network, and whether [Name of SNP] covers the prescription drugs that you take. You can contact [Name of SNP] at [insert toll-free telephone number] to ask them these questions. TTY users should call [insert TTY number]. They are available [insert days/hours of operation and, if different, TTY hours of operation].

Because you have both Medicare and Medicaid, you can change Medicare health and drug plans at any time if your plan does not meet your needs. The change will be effective the first day of the month after the month you request the change.

You're getting this letter because our records show that you have both Medicare and Medicaid and are enrolled in [Name of SNP]. **If this is not true, you should not have received this notice.** Please contact us at [insert toll-free telephone number and TTY number], so we can correct our records.

Access to the Part D Drug Benefit in Long-Term Care Settings

Medlearn Matters Number: SE0614
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Related CR Transmittal #: N/A
Effective Date: N/A
Implementation Date: N/A

The following information affects skilled nursing facilities (SNFs) and nursing homes with Medicare residents.

Impact on Providers

To simplify access to the Part D drug benefit in the long-term care (LTC) setting, the Centers for Medicare & Medicaid Services (CMS) recommends that providers take steps to clearly differentiate those drugs which may qualify as Part B drugs and those which may qualify as Part D drugs.

Important Points to Remember

CMS released the following information via the Minimum Data Set (MDS) submission system's Welcome Page on March 14, 2006:

Drugs Administered Through a Part B Covered Item of Durable Medical Equipment (DME), Such as a Nebulizer or Pump

Medicare Part B **only** covers the above categories of drugs when used in conjunction with Part B covered DME in the patient's home. For those LTC facilities that do not qualify as a patient's home, CMS recommends for the above categories of drugs that the following be **included in the written order**:

- The diagnosis and indication for the drug, **and**
- A statement of status such as "Nursing Home Part D"

Note: See the Web site listed at the end of this document for more information regarding the definition of a home.

Certain Infusion and Injectable Drugs

Medicare Part B covers injectable and infusible drugs that are not usually self-administered and that are furnished incident to a physician's service. If an LTC facility, rather than a physician, furnishes and administers these drugs to a patient who is not in a Medicare Part A stay, **CMS recommends including a statement of status such as "Administered by Facility, Nursing Home Part D."**

Certain Oral and Immunosuppressive Drugs

At this time, Part B covers three categories of drugs: oral anti-cancer, oral anti-emetic, and immunosuppressive drugs listed below under certain circumstances. This does not represent an exhaustive list of Part B covered drugs. It is possible for the list of drugs covered by Part B to change over time.

The following are immunosuppressive drugs for transplants paid for by Medicare:

Cyclophosphamide - Oral	Cyclosporine - Oral
Cyclosporine - Parenteral	Daclizumab - Parenteral
Lymphocyte Immune Globulin, Antithymocyte Globulin - Parenteral	Methotrexate - Oral
Methylprednisolone - Oral	Methylprednisolone Sodium Succinate - Injection
Muromonab-Cd3 - Parenteral	Mycophenolate Acid - Oral
Mycophenolate Mofetil - Oral	Oral Azathioprine
Parenteral Azathioprine	Prednisolone - Oral
Prednisone - Oral	Sirolimus - Oral
Tacrolimus - Oral	Tacrolimus - Parenteral

The following are the oral anti-cancer drugs paid for by Medicare Part B:

Busulfan Capecitabine	Cyclophosphamide
Etoposide	Melphalan
Methotrexate	Temozolomide

The following are oral anti-emetics paid for by Medicare when prescribed for use within 48 hours of chemotherapy, except as noted below:

3 Oral Drug Combination of: (1) Aprepitant; (2) A 5-HT3 Antagonist (Q0166, Q0179, Q0180); and (3) Dexamethasone	Chlorpromazine Hydrochloride
Diphenhydramine Hydrochloride	Dolasetron Mesylate (Q0180) (Within 24 Hours)
Dronabinol	Granisetron Hydrochloride (Q0166) (Within 24 Hours)
Hydroxyzine Pamoate	Ondansetron Hydrochloride (Q0179)
Perphenazine	Prochlorperazine Maleate - Oral
Promethazine Hydrochloride	Thiethylperazine Maleate
Trimethobenzamide Hydrochloride	

For these categories of drugs, CMS recommends including in the written prescription the diagnosis and the indication as well as the statement of status as "Part B" (for above indications) or for "Part D" (for all other indications). For example, Methotrexate for rheumatoid arthritis should have the diagnosis specified and the designation "Part D" added to the prescription.

While this guidance does **not** guarantee payment or coverage, following the process may help pharmacists respond more readily to additional information to support Part D or Part B coverage and facilitate processing by the appropriate plan.

Note: This Special Edition information does **not** supersede any existing guidance concerning documentation for Part B prescriptions.

Additional Information

For more detailed information on Part B versus Part D coverage, see ***www.cms.hhs.gov/PrescriptionDrugCovGenIn/Downloads/PartBandPartDdoc_07.27.05.pdf*** on the CMS Web site. A comprehensive list of links to agency-wide Part D resources for physicians is available at ***www.cms.hhs.gov/center/provider.asp***, scroll to "Part D Tools for Health Care Professionals."

As always, the source for Part D information for Fee-For-Service (FFS) providers is located on the Medicare Learning Network's drug coverage page at ***www.cms.hhs.gov/MedlearnProducts/23_DrugCoverage.asp*** on the CMS Web site.

Instructions for Provider Notification Regarding Streamlined Drug Coverage Materials for Health Care Professionals, a New Fact Sheet and Script for Recent Audio Conference

MLN Matters Number: SE0619 Revised
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Related CR Transmittal #: N/A
Effective Date: March 3, 2006
Implementation Date: N/A
Note: This article was revised to contain Web addresses that conform to the new Centers for Medicare & Medicaid Services (CMS) Web site and to show they are now MLN Matters articles. The Web address for the fact sheet, under the "Transition Policy Fact Sheet" subsection of the "Key Points" section, was also changed. All other information remains the same.

The following information affects providers, physicians, and suppliers and their staff who prescribe medications for Medicare patients.

Key Points

CMS has developed three new products as part of the Medicare Prescription Drug Coverage (Part D) campaign for health care professionals:

Consolidated List of Links
A consolidated list of links to resources for prescribers is located at ***www.cms.hhs.gov/center/provider.asp*** on the CMS Web site. At this Web page, offices can get access to direct telephone numbers to a Medicare drug plan's coverage determination staff, as well as to obtain model forms that will help speed this process.

Educational information for Fee-For-Service (FFS) providers is always available through our Medicare Learning Network drug coverage page at ***www.cms.hhs.gov/MLNProducts/23_DrugCoverage.asp*** on the CMS Web site.

Transition Policy Fact Sheet
A new fact sheet regarding the new transition policy, as well as the exceptions and appeals process for Medicare prescription drug coverage, is available for use in prescriber offices. This resource fact sheet provides ready links to tools that will streamline the prescribing process under the new coverage.

CMS continues to work with groups representing physicians, pharmacists, patients, and Part D plans to simplify and standardize the information that physicians need to provide to plans. The fact sheet is at ***www.cms.hhs.gov/MLNProducts/downloads/Part_D_Resource_Fact_sheet_revised.pdf*** on the CMS Web site.

An Important Message for Providers Regarding Medicare Part D from CMS Administrator Dr. Mark McClellan
Dr. McClellan's message to providers describes the steps CMS is taking to implement the new Medicare prescription drug coverage. Dr. McClellan also discusses helpful resources for providers. Streaming video of this message is available at ***media.cms.hhs.gov/cms/McClellanPartDProvider.wmv*** on the CMS Web site.

Telephone Conference Training Session
A PowerPoint presentation and audio replay of a recent telephone conference training session is available entitled, "Working with Plan Formularies: Transition Supplies, Prior Authorization, Quantity Limits, Step Therapy, and Exceptions." This training session is geared towards guiding office staff through the exceptions process. These materials are located at ***media.cms.hhs.gov/cms/partner03022006.wma*** on the CMS Web site.

Other Special Edition Articles
Other Special Edition articles regarding the prescription drug program include, but are not limited to, the following:

- SE0618 - "2006 Standard Medicare Prescription Drug Coverage: Understanding Costs to Beneficiaries," available at ***www.cms.hhs.gov/MLNMattersArticles/downloads/SE0618.pdf*** on the CMS Web site.
- SE0603 - "Medicare Prescription Drug Coverage: Essential Information and Resources for Prescribing Health Care Professionals - The Eleventh in the MLN Matters Series on the New Prescription Drug Plans," available at ***www.cms.hhs.gov/MLNMattersArticles/downloads/SE0603.pdf*** on the CMS Web site.
- SE0557 - "Clarification on Part D and Fee-for-Service (FFS) Providers," available at ***www.cms.hhs.gov/MLNMattersArticles/downloads/SE0557.pdf*** on the CMS Web site.
- SE0502 - "The Facts for Providers Regarding the Medicare Prescription Drug Program," is available at ***www.cms.hhs.gov/MLNMattersArticles/downloads/SE0502.pdf*** on the CMS Web site.

Cultural Competency: A National Health Concern

MLN Matters Number: SE0621
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Related CR Transmittal #: N/A
Effective Date: N/A
Implementation Date: N/A

This article is for informational purposes only and does not affect Medicare billing processes.

Background

The increasing diversity of the racial, ethnic, and linguistic composition of the U.S. challenges providers as they strive to deliver health care services. Cultural and language differences between patients and providers may generate miscommunication of critical health care information, a lack of compliance with prescribed treatment or medication, or other factors that negatively influence clinical situations and health

outcomes. The existence of racial and ethnic disparities in health has been well documented by organizations such as the Institute of Medicine and the Agency for Healthcare Research and Quality.

Cultural competency, or the ability of health care providers to work effectively with colleagues and patients in cross-cultural situations, is a vital component of professional competence. Culturally competent practice can offer a variety of benefits to health care providers and their organizations, including:

- Improved patient care and satisfaction
- Decreased malpractice risk
- Enhanced operational efficiency
- Increased compliance with state and federal regulations
- Reduction in health disparities

Highlights of the Centers for Medicare & Medicaid Services' (CMS') Activities to Address Health Disparities

To ensure that providers are prepared for the challenges they face to deliver the right care to every person every time, CMS' Quality Improvement Organizations (QIOs) are working with health care providers to become more effective and culturally aware of how they provide care to diverse populations. As part of a national initiative, QIOs are recruiting health providers to participate in a FREE online (Web-based) program, "A Family Physician's Practical Guide to Culturally Competent Care," to ensure that Medicare providers are prepared to effectively serve the increasingly diverse patient population. QIOs have adopted the guide as the "Program of Choice" for health care provider cultural competency education. The guide is an innovative educational product designed to equip health care providers with the cultural and linguistic competencies required to improve the quality of care for minority, immigrant, and ethnically diverse communities.

"A Family Physician's Practical Guide to Culturally Competent Care" is anchored in the three themes of the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care and serves a key initiative in helping the Department of Health and Human Services' Office of Minority Health to achieve its mission of "improving the health of racial and ethnic minority populations' through the development of effective health policies and programs that help to eliminate disparities in health care."

"A Family Physician's Practical Guide to Culturally Competent Care" is a case study-based curriculum, featuring video vignettes and a diverse group of providers and clinic staff at a fictional practice setting that reinforce learning points throughout the modules. Participants can also share their reactions to the case studies in an online bulletin-board feature. This program was designed with the busy health care provider in mind, offering "anytime, anywhere" continuing education credit in an engaging and innovative format. This curriculum is available to all health care providers at ***www.thinkculturalhealth.org***. The program is accredited for Continuing Medical Education (CME) credits for physicians and Continuing Education Units (CEUs) for nurses and pharmacists.

Please visit ***www.thinkculturalhealth.org*** to access the free accredited continuing education program, "A Family Physician's Practical Guide to Culturally Competent Care," and to view updates about the nursing program.

Additional Information

To access the free program, "A Family Physician's Practical Guide to Culturally Competent Care," please visit ***www.thinkculturalhealth.org***. The National Standards for CLAS in Health Care are available at ***www.omhrc.gov/templates/browse.aspx?lvl=2&lvlID=15***.

For more information about the QIO cultural competency initiative, please visit ***www.qsource.org/uqiosc/***. Additional information about the Office of Minority Health is available at ***www.omhrc.gov/***.

Program Inquiries

News from CMS…

Changes to Chapter 29 - Appeals of Claims Decisions: Administrative Law Judge; Departmental Appeals Board; U.S. District Court Review

Medlearn Matters Number: MM4152
Related Change Request (CR) #: 4152
Related CR Release Date: February 17, 2006
Related CR Transmittal #: R862CP
Effective Date: May 1, 2005
Implementation Date: March 17, 2006

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

Background

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

The purpose of this article is to notify you about changes to the manual provisions that address Administrative Law Judge (ALJ), Departmental Appeals Board (DAB), and U.S. District Court review levels of appeal.

Key Points

Administrative Law Judge (ALJ) - The Third Level of Appeal

Parties to an appeal who are not satisfied with decisions made by the QIC at the second level of appeal (reconsideration), have the right to request an ALJ hearing as long as **all** of the ALJ hearing request requirements are met (see Medicare Claims Processing Manual, Chapter 29, Section 330 for details). Outlined below is some pertinent information about the ALJ level of the appeal process.

ALJ Hearing Amount in Controversy

Parties requesting an ALJ hearing **must** meet the amount in controversy requirements:

- The amount remaining in controversy requirement for requests made before January 1, 2006, is $100.
- The amount remaining in controversy will increase to $110 for requests made on or after January 1, 2006.
- Beginning in 2005, for requests made for an ALJ hearing or judicial court review, the dollar amount in controversy requirement will increase by the percentage increase in the medical care component of the consumer price index for all urban consumers (U.S. city average) for July 2003 to the July preceding the year involved. Any amount that is not a multiple of $10 will be rounded to the nearest multiple of $10.

Time Limits and Responsibilities

Decisions: The official ALJ decision is a signed copy of the ALJ decision. When issuing decisions, the ALJ will either:

- Issue a decision based on the request for ALJ hearing; or
- Issue an order of dismissal of the appellant's request for ALJ hearing.

Effectuation (No Agency Referral): Often, the ALJ's decision will require an effectuation action (payment of the claim) on the Medicare contractor's part. Contractors will effectuate ALJ decisions within 30 days of the receipt of the official ALJ decision if:

- The decision is partially or wholly favorable;
- The decision gives a specific amount to be paid; and
- There is no agency referral to the DAB.

Computation of the Amount (No Agency Referral): If the amount must be computed by the Medicare contractor, the decision must be effectuated within 30 days after the contractor computes the amount to be paid to the appellant. The computation should be done as soon as possible, but no later than 30 calendar days of the date of receipt of the official ALJ decision or effectuation notice.

Clarification (No Agency Referral): If clarification from the ALJ is necessary, then the date of the clarification is considered to be the final determination for purposes of effectuation.

If clarification is needed from the physician/supplier (e.g., splitting charges), this clarification should be requested as soon as possible and the amount payable should be computed within 30 calendar days after the receipt of the necessary clarification. The date of receipt of the clarification is considered to be the final determination for purposes of effectuation.

Departmental Appeals Board (DAB) - The Fourth Level of Appeal

The DAB evaluates requests for review and makes final decisions whether to review, or to decline to review, decisions of ALJs as well as orders of dismissal by ALJs.

DAB Effectuation Time Limits: DAB decisions requiring contractor effectuation must be initiated within 30 days of receipt of a DAB decision. Effectuation must be completed within 60 days.

U.S. District Court - The Fifth Level of Appeal
A party may request court review of the DAB's decision. Medicare contractors are **not** responsible for reviewing ALJ decisions issued by the Department of Health and Human Services (HHS) ALJs to determine if an agency referral is appropriate and will **not** accept a request for U.S. District Court review by a party.

Relevant Links

The official instruction issued to your fiscal intermediary (FI), including regional home health intermediaries (RHHIs), or carrier, including durable medical equipment regional carriers (DMERCs), regarding this change may be found by going to ***www.cms.hhs.gov/Transmittals/downloads/R862CP.pdf*** on the Centers for Medicare & Medicaid Services (CMS) Web site. The new sections of Chapter 29 of the Medicare Claims Processing Manual are attached to Change Request (CR) 4152.

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

Program Education & Training

Billing Reminder - Replacement Batteries for Medically Necessary Glucose Monitors

Effective for dates of service January 1, 2006, and after, there are four new codes (A4233, A4234, A4235, and A4236) for replacement batteries for medically necessary glucose monitors. In order for Medicare to consider payment for replacement batteries, it is necessary to include a statement that indicates that the beneficiary **owns** a glucose monitor.

This information should be included in the narrative field of an electronic claim or Item 19 of the CMS-1500 claim form.

Claim Submission Errors for the Second Quarter of Fiscal Year 2006

Claim submission errors (CSEs) are errors made on a claim that would cause the claim to reject upon submission to the Region A Durable Medical Equipment Regional Carrier (DMERC A). The top ten American National Standards Institute (ANSI) CSEs for January 1, 2006, through March 31, 2006, are provided in the following chart. The total number of ANSI errors for this period was **227,585**.

ANSI Error Number - Narrative (Total Errors)	Reason for Error
1) 40022 - Procedure Code/Modifier Invalid. (33,738 errors)	The procedure code and/or modifier used on this line is invalid.
2) 40068 - Invalid/Unnecessary Certificate of Medical Necessity (CMN) Question. (33,473 errors)	The question number entered is not valid for the DMERC CMN you are sending.
3) 40073 - Dates of Service Invalid with Procedure Code. (18,436 errors)	The procedure code used is not valid for the dates of service used.
4) 20269 - Pointer 1 Diagnosis Invalid. (15,847 errors)	Diagnosis pointer is invalid.
5) 20270 - Pointer 2 Diagnosis Invalid. (8,863 errors)	Diagnosis pointer is invalid.
6) 20011 - Billing Provider Secondary ID Invalid. (7,631 errors)	Secondary provider ID is invalid.
7) 40021 - Capped Rental K Modifier Missing. (7,596 errors)	The procedure code submitted requires a K modifier for adjudication.
8) 20025 - Subscriber ID Code Invalid. (5,972 errors)	The qualifier identifying the subscriber is invalid.
9) 20143 - Ordering Provider Secondary ID Invalid. (5,613 errors)	The provider number or Unique Physician Identification Number (UPIN) is invalid.
10) 40037 - Service Date Greater Than Receipt Date. (5,284 errors)	Service date is greater than date claim was received.

In an effort to reduce other initial claim denials, the below information represents the top ten return/reject denials for the second quarter of fiscal year 2006. Claims denied in this manner are considered to be unprocessable and **have no appeal rights**.

An unprocessable claim is any claim with incomplete or missing, required information, or any claim that contains complete and necessary information; however, the information provided is invalid. Such information may either be required for all claims or required

conditionally. Please refer to Chapter 1, Section 80.3.1, of Pub. 100-04, Medicare Claims Processing Manual.

Denial Code - Narrative (Total Claims Denied)	CMS-1500 Form Entry Requirement
1) CO 16 M51 Claim/service lacks information which is needed for adjudication. Missing/incomplete/invalid procedure code(s) and/or rates. (9,924 claims)	Item # - 24D.
2) M81 Patient's diagnosis in a narrative form is not provided on an attachment or diagnosis code(s) is truncated, incorrect, or missing; you are required to code to the highest level of specificity. (7,571 claims)	Item # - 21.
3) CO 16 M78 Claim/service lacks information which is needed for adjudication. Missing/incomplete/invalid Healthcare Common Procedure Coding System (HCPCS) modifier. (5,819 claims)	Item # - 24D.
4) CO 16 MA83 Claim/service lacks information which is needed for adjudication. Did not indicate whether we are the primary or secondary payer. (5,260 claims)	Item # - 11.
5) CO 16 MA102 Claim/service lacks information which is needed for adjudication. Missing/incomplete/invalid name or provider identifier for the rendering/referring/ordering/ supervising provider. (3,458 claims)	Item # - 17.
6) CO 16 MA82 Claim/service lacks information which is needed for adjudication. Missing/incomplete/invalid provider/supplier billing number/identifier or billing name, address, city, state, zip code, or telephone number. (3,112 claims)	Item # - 33.
7) CO 16 N64 Claim/service lacks information which is needed for adjudication. The "from" and "to" dates must be different. (2,769 claims)	Item # - 24A.
8) CO 16 MA114 Claim/service lacks information which is needed for adjudication. Missing/incomplete/invalid information on where the services were furnished. (488 claims)	Item # - 32.
9) CO 16 M77 Claim/service lacks information which is needed for adjudication. Missing/incomplete/invalid place of service. (308 claims)	Item # - 24B.
10) CO 16 M79 Claim/service lacks information which is needed for adjudication. Missing/incomplete/invalid charge. (287 claims)	Item # - 24F.

Make it a goal to reduce the number of CSEs by taking the extra time to review your claims before submission to ensure that **all** the required information is on **each** claim. Please take advantage of the information in the above charts, and share it with your colleagues!

Supplier Manual News

The 2003 edition of the Region A Durable Medical Equipment Regional Carrier (DMERC A) supplier manual was reprinted in September 2005. The **DMERC A Supplier Manual** is available via the "Publications" section of our Web site at ***www.umd.nycpic.com/dmprovpublcopy.html***. After accepting the CPT License Agreement, suppliers can access the entire manual, including revised chapters and archived revisions. The 2005 reprint is available to current suppliers via the DMERC A Web site, and newly-enrolled suppliers will receive their initial manuals on CD-ROM through mid-June 2006. The option to request additional copies for a fee is **no** longer available via the DMERC A Web site.

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

Revision 2005-04 (April 2006)

- Chapter 3 (Health Insurance Claim Form) - updated for the impending changes related to the National Provider Identifier (NPI) and the addition of place of service 01 (Pharmacy), as well as changes reflected in the Centers for Medicare & Medicaid Services (CMS) online manuals
- Chapter 4 (Electronic Data Interchange) - updated to reflect recent changes to the DMERC A electronic data interchange (EDI) processes
- Chapter 9 (Durable Medical Equipment) - updated to include additional information on the Advance Beneficiary Notice (ABN) and beneficiary signature requirements and to reflect recent changes to the Advance Determination of Medicare Coverage (ADMC) process and in the CMS online manuals

Revision 2005-05 (May 2006)

- Chapter 2 (Supplier Enrollment) - updated to emphasize standard 16
- Chapter 5 (Medicare Secondary Payer) - updated to reflect recent changes in the CMS online manuals and Web site references
- Chapter 6 (Pricing) - updated to reflect current CMS online manual Web site references
- Chapter 7 (System Outputs) - updated to remove extraneous language, to include current examples, and to reflect recent changes in the CMS online manuals and Web site references

(**Note**: The table of contents was also updated to reflect the changes to the above chapters.)

Suppliers who maintain hardcopy manuals at their place of business need to discard the previously published pages and replace them with the revised ones. Be sure to follow the download instructions to print the revised pages.

Note for Fiscal Year 2006 Bulletin Subscribers

Effective July 1, 2006, the Durable Medical Equipment Medicare Administrative Contractor (DME MAC) for Jurisdiction A will be National Heritage Insurance Company (NHIC). Suppliers who have paid for the fiscal year (FY) 2006 bulletin subscription with the Region A Durable Medical Equipment Regional Carrier (DMERC A) will receive their September 2006 bulletin from NHIC, since NHIC will honor the DMERC A FY2006 subscriptions. (NHIC will provide notification regarding the FY2007 bulletin subscription process.)

The bulletin published by NHIC will not have the same format as the DMERC A bulletin, however, the content will include all the educational articles and Centers for Medicare & Medicaid Services (CMS) notifications that suppliers will need for accurate Medicare billing. And, like the DMERC A bulletin, the NHIC quarterly bulletin will be available via their Web site.

Web Site Resources

News from CMS…

CMS Mailing Lists Fact Sheet

The Centers for Medicare & Medicaid Services (CMS) Electronic Mailing Lists (ListServes) can help you with your business! For more details, download the Fact Sheet from the following Uniform Resource Locator (URL):
www.cms.hhs.gov/MLNProducts/downloads/MailingLists_FactSheet.pdf

News from DMERC A…

Accessing DMERC A Web Site Information

Bulletins and other reference material published by the Region A Durable Medical Equipment Regional Carrier (DMERC A) will be transferred to the Durable Medical Equipment Medicare Administrative Contractor (DME MAC) for Jurisdiction A, National Heritage Insurance Company (NHIC), Web site at ***www.medicarenhic.com/dme/index.shtml***. Effective July 1, 2006, suppliers will access the NHIC Web site to view historical information from DMERC A as well as other durable medical equipment (DME) reference information, such as the Centers for Medicare & Medicaid Services (CMS) notices, MLN Matters articles, and billing instructions.

Note: The forms currently in use for DMERC A processes will be removed from our Web site as these functions reach their cutoff point for the DME MAC transition. These forms include the Advance Determination of Medicare Coverage (ADMC) Request, Extra Documentation Request (see the related articles within the "Billing/Finance" section of this publication), Fair Hearing Request, Overpayment Refund, and Request for Redetermination. Refer to the NHIC Web site for more information on how DME processes will be administered effective July 1, 2006.

Medical Review and Medical Policy Information

As they do currently, suppliers should access the Region (Jurisdiction) A Program Safeguard Contractor (PSC), TriCenturion, Web site (***www.tricenturion.com/content/psc_dmerc_reg_a.cfm***) 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 (prepay and post-pay), benefit integrity, or fraud alerts/investigations can be accessed by visiting the PSC "What's New" section at ***www.tricenturion.com/content/whatsnew_dyn.cfm***.

Please note: A new section, "Electronic Data Interchange (EDI) Transition and Contingency," has been added to the Region A Durable Medical Equipment Regional Carrier (DMERC A) Web site. Please take a few moments to visit this new section, and be sure to check it often, as information will be added as details are finalized for the EDI transition for the Durable Medical Equipment Medicare Administrative Contractor (DME MAC) contract and EDI contingency plan for the front end system.

New Mailing Addresses for Jurisdiction A

Effective June 23, 2006, suppliers within Jurisdiction A (Connecticut, Delaware, District of Columbia, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, and Vermont) will submit their durable medical equipment (DME) claims and correspondence to the following addresses:

DME - Accounting (Refund Checks)
P.O. Box 9143
Hingham, MA 02043-9143

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

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

DME - Written Inquiries
P.O. Box 9146
Hingham, MA 02043-9146
[*for Written Inquiries, Freedom of Information Act Requests*]

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

DME - Specialty Claims
P.O. Box 9165
Hingham, MA 02043-9165
[*for all other claim types, including orthotics, prosthetics, and wound*]

DME - ADS
P.O. Box 9170
Hingham, MA 02043-9170
[*for ADS Responses, when requested*]

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

Suppliers: This bulletin should be directed to your billing manager.

MEDICARE

DMERC A
P.O. Box 6800
Wilkes-Barre, PA 18773-6800

A CMS Contracted Carrier