DME MAC Jurisdiction A Resource

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

Table of Contents

September 2006
Number 1

Cover Story

Billing/Finance

CMS CENTERS for MEDICARE & MEDICAID SERVICES

This bulletin should be shared with all healthcare practitioners and managerial members of the physician/supplier staff. Bulletins are available at no cost from our website at **www.medicarenhic.com**

Table of Contents

EDI Services

HIPAA Information

General Information

Program Inquiries

Outreach & Education

Web Site Resources

LEGEND

DRU Drugs	**O&P** Orthotics & Prosthetics	**PT** Physical Therapy
GEN General	**OXY** Oxygen	**SPE** Specialty Items
MOB Mobility/Support Surfaces	**PEN** Parenteral/Enteral Nutrition	**VIS** Vision

September 2006

Welcome to the first issue of the DME MAC Jurisdiction A Medicare Resource.

NHIC, Corp. is pleased to serve you as the Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) for Jurisdiction A, effective July 1, 2006. NHIC, Corp. will provide its services for Medicare beneficiaries and Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) suppliers in DME MAC Jurisdiction A , which includes Connecticut, Delaware, District of Columbia, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, and Vermont.

This newsletter will be issued quarterly and will contain all the Medicare notices and information you are accustomed to receiving. It is developed and published by the NHIC, Corp. Outreach and Education Team. We are very pleased that Amy Capece, Liz Daniels, Judie Roan and Mindy Schuler have joined NHIC, Corp. to continue their role in providing you with the educational support that you need for Medicare program billing. In fact, Liz, Judy and Mindy's title of Outreach Specialist (formerly known as Ombudsman) highlight their focus on education.

NHIC, Corp. wants to thank you for your support during the transition and start-up period. Our teams in Customer Service, Claims Processing, Appeals, and Outreach and Education are all focused on accurate and timely service to you and the Medicare beneficiaries of Jurisdiction A. We are excited to be the DME MAC and we will listen to your concerns and suggestions to continue to improve our operations and service to you.

NHIC, Corp. looks forward to working with the DME MAC Jurisdiction A supplier community.

Thank you,

Andrew Conn

NHIC, Corp. DME MAC Project Manager

Please join the NHIC, Corp. DME mailing List!

Visit

http://www.medicarenhic.com/

and select DME Mailing List in the Upper Left hand corner.

A/B MAC NEWS #1 - First Contract for a Part A/Part B Medicare Administrative Contractor (MAC) To Be Awarded in Near Future (SE 0642)

MLN Matters Number: SE0642
Related CR Release Date: N/A
Related CR Transmittal #: N/A
Related Change Request (CR) #: N/A
Effective Date: N/A
Implementation Date: N/A

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

Provider Types Affected
All Medicare physicians, providers, and practitioners that bill Medicare fiscal intermediaries (FIs) or carriers for their services, especially those in the states of Arizona, Montana, North Dakota, South Dakota, Utah and Wyoming

Background
Section 911 of the Medicare Modernization Act (MMA) requires the Secretary to implement Medicare Contracting Reform by 2011. The law mandates that CMS conduct full and open competitions, in compliance with general federal contracting rules, for the work currently handled by fiscal intermediaries and carriers in administering the Medicare fee-for-service program.

Medicare Contracting Reform will:
- Improve administrative services within the fee-for-service claims processing environment by reducing the number of contracts, focusing on correct claims payment and creating performance incentives related to timeliness, accuracy, and quality of services to CMS and to providers of services to Medicare beneficiaries;
- Lead to more efficiency and greater accountability among companies performing claims administration and provider education, and services by promoting competition and basing awards on good performance;
- Generate operational savings to the federal government and taxpayers through consolidation and competition of large and high value contracts

With Medicare Contracting Reform, providers of health care in the original Medicare program can expect:
- Better educational and training resources on correct claims submission, Medicare coverage rules, and Medicare payment rules;
- Easier communications with a single A/B MAC serving as the point-of-contact for both Part A and Part B claims administration and payment;
- Increased payment accuracy and consistency in payment decisions resulting from CMS' increased focus on financial management by MACs; and
- An opportunity for input in evaluation of their MAC's performance through satisfaction surveys conducted by CMS.

Key Points for Providers
CMS soon will announce the result of the first full and open competition for a Part A/Part B Medicare Administrative Contractor (A/B MAC) conducted as part of the agency's Medicare Contracting Reform implementation strategy. This award will be for a single fee-for-service claims processing contract that will combine the workloads for a multi-state jurisdiction currently serviced both by FIs and carriers.

This first A/B MAC award will be for Jurisdiction 3, which includes the states of Arizona, Montana, North Dakota, South Dakota, Utah and Wyoming. Jurisdiction 3 represents three percent of the national fee-for-service Medicare claims volume.

With this contract award, CMS will begin to achieve efficiencies and administrative savings through the consolidation of the traditional cost-reimbursable contracts and by implementing improved contracting processes quickly.

The Request for Proposal (RFP) for the Jurisdiction 3 A/B MAC was released in September 2005. Full implementation of the new contractor is scheduled for July 2007. CMS will work with the current carriers and FIs in Jurisdiction 3, whose contracts will end with the MAC implementation, to ensure a smooth transfer of records and information to the new Jurisdiction 3 A/B MAC.

The carriers and FIs whose contracts will end are Montana Blue Cross Blue Shield, Wyoming Blue Cross, Arizona Blue Cross, and Noridian Administrative Services. CMS recognizes with gratitude the strong commitment by these corporations to serving the Medicare program for more than 40 years.

The Jurisdiction 3 A/B MAC contract award will be the first of 15 A/B MAC contracts. Each of these contracts will be for the administration of both the Medicare Part A and Part B benefits in a specified geographic jurisdiction of the country. (See the *Additional Information* section of this article for the web page containing a map showing the 15 jurisdictions.) All 15 contracts are to be awarded, and all A/B MACs are to be operational, by October 2011.

CMS has extensive experience in overseeing the successful transfer of Medicare claims processing work from one contractor to another. The agency is committed to ensuring that the implementation of the new A/B MAC environment will be as seamless as possible for the Medicare providers and beneficiaries.

CMS will devote full resources and manage the A/B MAC contract implementation so as to ensure continuity, accuracy, and timeliness in claims processing and issuance of payments. In Jurisdiction 3, CMS plans to implement the new A/B MAC contract by transferring the claims processing workload from the current contractors incrementally (rather than all at once) to ensure that neither providers nor beneficiaries will be adversely affected.

A/B MAC NEWS #1 - First Contract for a Part A/Part B Medicare Administrative Contractor (MAC) To Be Awarded in Near Future (SE 0642) (Continued)

Additional Information
Information on the Jurisdiction 3 A/B MAC procurement, including the scope of work to be performed, is available on the Federal Business Opportunities web site at **http://www1.fbo.gov/spg/HHS/HCFA/AGG/CMS%2D2005%2D0016/Attachments.html**

A map displaying the 15 A/B MAC jurisdictions is available on the Medicare Contracting Reform web site at **http://www.cms.hhs.gov/MedicareContractingReform/05_A_BMACJurisdictions.asp#TopOfPage** on the CMS web site. Individual fact sheets and data on each jurisdiction are also available there.

Suppliers may want to consult *MLN Matters* article SE0628 to see how Medicare Contracting Reform affects durable medical equipment regional carriers (DMERCs). That article is available at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0628.pdf** on the CMS web site.

Claim Form - Additional Requirements Necessary to Implement the Revised Healt Insurance Claim Form CMS-1500 (CR 5060)

MLN Matters Number: MM5060
Related CR Release Date: July 28, 2006
Related CR Transmittal #: R1010CP
Related Change Request (CR) #: 5060
Effective Date: January 1, 2007
Implementation Date: January 2, 2007

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

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

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

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

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

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

Claim Form - Additional Requirements Necessary to Implement the Revised Health Insurance Claim Form CMS-1500 (CR 5060) (Continued)

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

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

Billing Guidelines

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

if

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

Additional Information

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

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

Legacy identifiers are pre-NPI provider identifiers such as:

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

Additional NPI-Related Information

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

The change log which lists the various changes made to the Form CMS-1500 (0805) version can be viewed at the NUCC Web site at **http://www.nucc.org/images/stories/PDF/change_log.pdf**.

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

CR4293, Transmittal Number 899, "Revised Health Insurance Claim Form CMS1500," provides contractor guidance for implementing the revised Form CMS-1500 (08-05). It can be found at **http://www.cms.hhs.gov/transmittals/downloads/R899CP.pdf** on the CMS web site.

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

CR5060 is the official instruction issued to your carrier or DMERC regarding changes mentioned in this article, MM5060. CR 5060 may be found by going to **http://www.cms.hhs.gov/Transmittals/downloads/R1010CP.pdf** on the CMS web site.

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

Contractor Instruction - Revised Health Insurance Claim Form CMS-1500 (CR 5060)

CMS is implementing the revised Form CMS-1500, (**http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5060.pdf**) which accommodates the reporting of the National Provider Identifier (NPI). The Form CMS-1500 (08-05) version will be effective January 1, 2007, but will not be mandated for use until April 2, 2007, and some additional requirements have been added. (CR 5060)

Claim Status Category Code and Claim Status Code Update (CR 5137)

MLN Matters Number: MM5137
Related CR Release Date: June 23, 2006
Related CR Transmittal #: R987CP
Related Change Request (CR) #: 5137
Effective Date: October 1, 2006
Implementation Date: October 2, 2006

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

Provider Types Affected
Physicians, providers, and suppliers who submit Health Care Claim Status Transactions to Medicare contractors (carriers, durable medical equipment regional carriers (DMERCs), fiscal intermediaries (FIs), and regional home health intermediaries (RHHIs))

Provider Action Needed
Impact to You
This article is based on Change Request (CR) 5137, which provides the October 2006 updates of the Claim Status Codes and Claim Status Category Codes for use by Medicare contractors (carriers, DMERCs, FIs, and RHHIs).

What You Need to Know
Medicare contractors are to use codes with the "**new as of 10/06**" designation and prior dates, and they must inform affected providers of the new codes. CR5137 applies to Chapter 31 of the *Medicare Claims Processing Manual*, Section 20.7 - Health Care Claim Status Category Codes and Health Care Claims Status Codes for Use with the Health Care Claim Status Request and Response ASC X12N 276/277.

What You Need to Do
Please refer to the *Background* section of this article for further details.

Background
Claim Status Category codes indicate the general category of a claim's status (accepted, rejected, additional information requested, and so on). Further detail is provided by the Claim Status Code(s).

Under the Health Insurance Portability and Accountability Act (HIPAA), all payers (including Medicare) must use Claim Status Category and Claim Status codes approved by a recognized code set maintainer (instead of proprietary codes) to explain any status of a claim(s) sent in the Version 004010X093A1 Health Care Claim Status Request and Response transaction.

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

The updated Claim Status Category and Claim Status codes list is posted three times a year (after each Health Care Code Maintenance Committee X12 trimester meeting) at the Washington Publishing Company web site at **http://www.wpc-edi.com/codes**. At this web site, select "Claim Status Codes" or "Claim Status Category Codes" to access the updated code list. Included in the code lists are specific details, including the date when a code was added, changed or deleted. All code changes approved in June 2006 are to be listed to this web site approximately thirty (30) days after the meeting concludes. For this update, Medicare will begin using the codes in place as of October 2006 in claim status responses issued on or after October 2, 2006.

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

Additional Information
For complete details, please see CR5137, the official instruction issued to your Medicare carrier/DMERC or FI/RHHI regarding changes mentioned in this article. CR5137 may be found at **http://www.cms.hhs.gov/Transmittals/downloads/R987CP.pdf** on the CMS web site.

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

Redetermination requests must be mailed, not faxed to NHIC, Corp.

Collection of Fee-for-Service Payments Made During Periods of Managed Care Enrollment (Previously CR2801 Program Memorandum Transmittal AB-03-101) - Manualization (CR 5105)

MLN Matters Number: MM5105 Revised
Related CR Release Date: July 3, 2006
Related CR Transmittal #: R100FM
Related Change Request (CR) #: 5105
Effective Date: October 1, 2003
Implementation Date: June 26, 2006

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

Note: This article was revised on July 6, 2006, to reflect revisions made to CR5105, which CMS released on July 3, 2006. The Transmittal number, CR release date, and web address for accessing CR5105 have been changed. In addition, some references to MA (Medicare Advantage) have been changed to refer to managed care plans. All other information remains the same.

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

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

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

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

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

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

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

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

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

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

Collection of Fee-for-Service Payments Made During Periods of Managed Care Enrollment (Previously CR2801 Program Memorandum Transmittal AB-03-101) - Manualization (CR 5105) (Continued)

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

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

In summary, CMS issued CR 5105 to:
- Ensure that any fee-for-service claims that were approved for payment erroneously are submitted to the normal collection process used by the Medicare contractors (carriers, DMERCs, FIs, and RHHIs) for overpayments; and
- Instruct Medicare contractors to follow the instructions outlined in the *Medicare Financial Management Manual* (Publication 100-06, Chapter 3, Section 190), which is included as part of CR5105. Instructions for accessing CR5105 are in the *Additional Information* section of this article.

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

Additional Information
For complete details, please see the official instruction issued to your carrier, DMERC, intermediary, or RHHI regarding this change. That instruction may be viewed at **http://www.cms.hhs.gov/Transmittals/downloads/R100FM.pdf** on the CMS web site.

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

Competitive Acquisition Program (CAP) for Part B Drugs and Biologicals (JSMTDL-06475)

Visit **http://www.cms.hhs.gov/CompetitiveAcquisforBios/02_infophys.asp#TopOfPage** and scroll to the bottom of the page to download the Beneficiary Fact Sheet for the Competitive Acquisition Program (CAP) for Part B Drugs and Biologicals. Physicians who elect to participate in the CAP are required to provide the CAP Beneficiary Fact Sheet to Medicare beneficiaries who are receiving certain Part B physician-administered drugs.

CPT - New Current Procedural Terminology (CPT) Code (CR 4222)

MLN Matters Number: MM4222
Related CR Release Date: April 21, 2006
Related CR Transmittal #: R910CP
Related Change Request (CR) #: 4222
Effective Date: July 1, 2005
implementation Date: October 2, 2006

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

Provider Types Affected
All Medicare providers

CPT - New Current Procedural Terminology (CPT) Code (CR 4222) (Continued)

Provider Action Needed
Impact to You
Effective July 1, 2005, Medicare carriers and intermediaries must use the new Current Procedural Terminology (CPT) code 90714 (Tetanus and diphtheria toxoids (Td) adsorbed, preservative free, for use in individuals seven years or older, for intramuscular use) for services previously billed under CPT code 90718.

What You Need to Know
Effective for services on or after July 1, 2005, if you do not use the new Current Procedural Terminology (CPT) code, 90714, reimbursements may be impacted. CR4222 provides notification of this new CPT code for tetanus and diphtheria toxoids (see table below).

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

Background
Effective July 1, 2005, the following vaccine CPT code is being added to the CPT system.

CPT Code	Short Descriptor	Long Descriptor
90714	Td vaccine no prsrv>/=7 im	Tetanus and diphtheria toxoids (td) adsorbed, preservative free, for use in individual seven years or older, for intramuscular use

Note: Your carriers and fiscal intermediaries will assign the CPT code (90714) to status indicator "E" in the Medicare Physician Fee Schedule Database. Deductible and coinsurance apply.

Effective July 1, 2005:
- CPT code 90718 is used for the tetanus and diphtheria toxoids (Td) vaccine absorbed for use in an individual seven years or older, for intramuscular use; and
- CPT 90714 is used for the tetanus and diphtheria toxoids (Tg) vaccine absorbed, preservative free, for use in individuals seven years or older, for intramuscular use.

Additional Information
Medicare will not search its files to retract payment for claims already paid or to retroactively pay claims. However, carriers/intermediaries will adjust claims brought to their attention.

The official instruction issued to your carrier/intermediary is available at **http://www.cms.hhs.gov/Transmittals/downloads/R910CP.pdf** on the CMS web site.

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

DME Fee Schedule Amounts for Transcutaneous Electrical Joint Stimulation Device System (Healthcare Common Procedure Coding System (HCPCS) Code E0762) (JSM 06557)

In accordance with Transmittal 928, July Quarterly Update for 2006 DMEPOS Fee Schedule, DMEPOS fee schedule files containing fee schedule amounts for HCPCS code E0762 were released to contractors to pay claims with dates of service on or after January 1, 2006. In order to allow for additional time to address technical concerns raised regarding the calculation of fee schedule amounts for code E0762, we are revising these files to remove the fee schedule amounts for code E0762. Until further notice, contractors should determine the Medicare allowed payment amounts for claims submitted using HCPCS code based on their individual consideration of each claim. This code remains in the DME category for inexpensive or routinely purchased items in accordance with Transmittal 928.

DME Fee Schedule Amounts for Transcutaneous Electrical Joint Stimulation Device System (Healthcare Common Procedure Coding System (HCPCS) Code E0762) (JSM 06557) (Continued)

IN — Inexpensive and Routinely Purchased

HCPCS	Mod1	Mod2	Category	State	Fee
E0762	NU		IN	CT	$934.63
E0762	NU		IN	DC	$1,099.56
E0762	NU		IN	DE	$1,099.56
E0762	NU		IN	MA	$934.63
E0762	NU		IN	MD	$1,099.56
E0762	NU		IN	ME	$934.63
E0762	NU		IN	NH	$934.63
E0762	NU		IN	NJ	$1,099.56
E0762	NU		IN	NY	$934.63
E0762	NU		IN	PA	$1,099.56
E0762	NU		IN	RI	$934.63
E0762	NU		IN	VT	$934.63
E0762	RR		IN	CT	$93.47
E0762	RR		IN	DC	$109.96
E0762	RR		IN	DE	$109.96
E0762	RR		IN	MA	$93.47
E0762	RR		IN	MD	$109.96
E0762	RR		IN	ME	$93.47
E0762	RR		IN	NH	$93.47
E0762	RR		IN	NJ	$109.96
E0762	RR		IN	NY	$93.47
E0762	RR		IN	PA	$109.96
E0762	RR		IN	RI	$93.47
E0762	RR		IN	VT	$93.47
E0762	UE		IN	CT	$700.95
E0762	UE		IN	DC	$824.65
E0762	UE		IN	DE	$824.65
E0762	UE		IN	MA	$700.95
E0762	UE		IN	MD	$824.65
E0762	UE		IN	ME	$700.95
E0762	UE		IN	NH	$700.95
E0762	UE		IN	NJ	$824.65
E0762	UE		IN	NY	$700.95
E0762	UE		IN	PA	$824.65
E0762	UE		IN	RI	$700.95
E0762	UE		IN	VT	$700.95

Drugs - Average Sales Price Files

The July 2006 quarterly update for the Average Sales Price (ASP) Medicare Part B Drugs pricing file has been posted on the Centers for Medicare and Medicaid Services (CMS) Web site at
http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/02_aspfiles.asp#TopOfPage

Drugs - July 2006 Quarterly Average Sales Price (ASP) Medicare Part B Dru Pricing File, Effective July 1, 2006, and Revisions to January 2006 and Apri 2006 Quarterly ASP Medicare Part B Drug Pricing Files (CR 5110)

MLN Matters Number: MM5110 Revised
Related CR Release Date: June 9, 2006
Related CR Transmittal #: R974CP

Related Change Request (CR) #:5110
Effective Date: July 1, 2006
Implementation Date: July 3, 2006

Note: This article was revised on July 17, 2006, to include an additional web address in the "Additional Information" section. This address houses Part B Drug information and the quarterly ASP Medicare Drug Pricing Files.

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

Provider Types Affected
Physicians, providers, and suppliers who submit Part A or Part B Fee-for-Service claims to Medicare contractors (fiscal intermediaries (FIs) including regional home health intermediaries (RHHIs), and carriers including durable medical equipment regional carriers (DMERCs)) for services.

Provider Action Needed
Impact to You
CR5110 provides notice of the updated payment allowance limits for Medicare Part B drugs, effective July 1, 2006 through September 30, 2006, as well as revised payment files for the January 2006, and April 2006 Quarterly ASP Medicare Part B Drug Pricing Files.

What You Need to Know
Certain Medicare Part B drug payment limits have been revised and the Centers for Medicare & Medicaid Services (CMS) updates the payment allowance quarterly. The revised payment limits included in the revised ASP and Not Otherwise Classified (NOC) payment files supersede the payment limits for these codes in any publication published prior to CR5110.

What You Need to Do
Make certain that your billing staffs are aware of this change.

Background
According to Section 303(c) of the Medicare Modernization Act of 2004 (MMA), CMS will update the payment allowances for Medicare Part B drugs on a quarterly basis.

As mentioned in previous articles (see MM4319 at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4319.pdf**), beginning January 1, 2005, Part B drugs (that are not paid on a cost or prospective payment basis) are paid based on **106 percent** of the average sales price (ASP).

Pricing for compounded drugs is performed by the local Medicare contractor.

ESRD Drugs
Additionally, in 2006, all ESRD drugs furnished by both independent and hospital-based ESRD facilities, as well as specified covered outpatient drugs, and drugs and biologicals with pass-through status under the OPPS, are paid based on the ASP methodology.

The ASP methodology is based on quarterly data submitted to CMS by manufacturers. CMS will supply Medicare contractors with the ASP drug pricing files for Medicare Part B drugs on a quarterly basis.

Beginning January 1, 2005, the payment allowance limits for Medicare Part B drugs and biologicals that are not paid on a cost or prospective payment basis are 106 percent of the ASP.

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

Exceptions
There are exceptions to these general rules and those exceptions are outlined in MLN Matters article MM4319, which can be viewed at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4319.pdf** on the CMS website.

With regard to the exceptions listed in MM4319, note that the payment allowance limits for infusion drugs furnished through a covered item of durable medical equipment on or after January 1, 2005, will continue to be 95 percent of the AWP reflected in the published compendia as of October 1, 2003, unless the drug is compounded.

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

Drugs - July 2006 Quarterly Average Sales Price (ASP) Medicare Part B Dru Pricing File, Effective July 1, 2006, and Revisions to January 2006 and Apri 2006 Quarterly ASP Medicare Part B Drug Pricing Files (CR 5110) (Continued)

Drugs Furnished During Filling or Refilling an Implantable Pump or Reservoir
Physicians (or other authorized practitioners) may be paid for filling or refilling an implantable pump or reservoir when it is medically necessary for the physician (or other practitioner) to do so. Payment for drugs furnished incident to the filling or refilling of an implantable pump or reservoir, is determined under the ASP methodology.

Note that the use of the implantable pump or reservoir must be found medically reasonable and necessary in order to allow payment for the professional service to fill or refill the implantable pump or reservoir and to allow payment for drugs furnished incident to the professional service.

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

How the ASP Is Calculated
The ASP is calculated using data submitted to CMS by manufacturers on a quarterly basis and each quarter:
- The revised January 2006 payment allowance limits apply to dates of service January 1, 2006, through March 31, 2006.
- The revised April 2006 payment allowance limits apply to dates of service April 1, 2006, through June 30, 2006.
- The July 2006 payment allowance limits apply to dates of service July 1, 2006, through September 30, 2006.

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

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

Additional Information
The *Medicare Claims Processing Manual*, Publication 100-04, Chapter 17, Drugs and Biologicals, contains information that is pertinent to MM5110. It is located at **http://www.cms.hhs.gov/manuals/downloads/clm104c17.pdf** on the CMS web site.

Quarterly Part B Drug Pricing files and information are also available at **http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice** on the CMS web site.

CR5110 is the official instruction issued to your Medicare carrier/FI/RHHI/DMERC regarding changes mentioned in this article. CR5110 may be found at **http://www.cms.hhs.gov/Transmittals/downloads/R974CP.pdf** on the CMS web site.

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

Drugs - National Council for Prescription Drug Program (NCPDP) Coordination of Benefits (COB) Workaround Instructions (CR 4290)

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

Note: This article was revised on July 7, 2006 to change the reference on page 2 to state ***Patient Location field (307-C7) equals "1" (Home)***. It had stated ***"Patient Location field (307-C7) is not "1" (Home)***. All other information remains unchanged.

Provider Types Affected

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

Drugs - National Council for Prescription Drug Program (NCPDP) Coordination of Benefits (COB) Workaround Instructions (CR 4290) (Continued)

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

Key Points
The following information is important for trading partners regarding the NCPDP version 5.1 batch standard 1.1 for COB crossover purposes:

- Drugs will always be paid as mandatory assignment.
- Health Insurance Claim (HIC) numbers will always be passed in the "Patient ID" field (332-CY) with a "99" (Other) qualifier in the Patient ID Qualifier field (331-CX).
- For eligibility file-based crossovers, the "Cardholder ID" field (302-C2) in the "Insurance Segment" will contain the beneficiary's policy number as submitted on the carriers eligibility file.
- When the "Patient Location" field (307-C7) **equals** "1" (Home), the Supplier Name and Address will be populated in lieu of the Facility Name and Address in the 500-byte-free formatted field

Additional Information
CR4290 is the official instruction issued to your DMERC regarding this change. CR4290 may be found by going to **http://www.cms.hhs.gov/Transmittals/downloads/R845CP.pdf** on the CMS web site.

Please refer to your local DMERC if you have questions about this issue. To find their toll free phone number, go to **http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.pdf**

Fee Schedule -July Quarterly Update for 2006 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule (CR5017)

MLN Matters Number: MM5017 Revised
Related CR Release Date: April 28, 2006
Related CR Transmittal #: R928CP
Related Change Request (CR) #: 5017
Effective Date: July 1, 2006
Implementation Date: July 3, 2006

Note: This article was revised on June 2, 2006, to show that codes K0734-K0737 are added to the fee schedule file and are effective for claims submitted with dates of service on or after July 1, 2006, not January 1, 2006.

Provider Types Affected
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 DMEPOS Fee Schedule

Provider Action Needed
This article is based on Change Request (CR) 5017 and provides specific information regarding the quarterly update for the July 2006 DMEPOS Fee Schedule.

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

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

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).

Fee Schedule -July Quarterly Update for 2006 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule (CR5017) (Continued)

Changes Made in the Update
Changes made in this update include the following:

The fee schedule amounts for the following HCPCS codes are added to the fee schedule file as part of this update and are effective for claims with dates of service on or after January 1, 2006:

L0624, L0629, L0632, L0634, L2034, L2387, L3671, L3672, L3673, L3702, L3763, L3764, L3765, L3766, L3905, L3913, L3919, L3921, L3933, L3935, L3961, L3967, L3971, L3973, L3975, L3976, L3977, L3978, L5703, L5858, L5971, L6621, L6677, L6883, L6884, L6885, L7400, L7401, L7402, L7403, L7404, L7405, E1238, E1812, E2291, E2292, E2293, E2294

The fee schedule amounts for HCPCS code **K0733**, *Power wheelchair accessory, 12 to 24 amp hour sealed lead acid battery, each (e.g., gel cell, absorded glass mat)* are added to the fee schedule file on July 1, 2006, and is effective for claims with dates of service on or after July 1, 2006.

The fee schedule amounts for HCPCS code **E0762**, *Transcutaneous electrical joint stimulation device system, includes all accessories*, are added to the fee schedule file on July 1, 2006, and are effective for claims submitted with dates of service on or after January 1, 2006. In addition, the payment category for code **E0762** is being revised to move the joint stimulation device from the DME payment category for capped rental items to the DME payment category for inexpensive and routinely purchased items, effective July 1, 2006.

The fee schedule amounts for HCPCS codes **L6694** and **L6698** are added to the fee schedule file on July 1, 2006, and are effective for claims with dates of service on or after January 1, 2005.

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

Code E0705 (Transfer Board or Device, Any Type, Each) was added to the HCPCS effective January 1, 2006. The payment category for E0705 is being revised to the inexpensive and routinely purchased payment category and the fee schedule amounts for previous HCPCS code E0972 will be crosswalked to code E0705 for use in paying claims with dates of service on or after January 1, 2006.

The fee schedules for HCPCS code **K0606** (Automatic External Defibrillator, With Integrated Electrocardiogram Analysis, Garment Type) are added to the fee schedule file on July 1, 2006, and are effective for claims submitted with dates of service on or after January 1, 2006.

The fee schedule amounts for HCPCS code **E1812** (Dynamic Knee, Extension/Flexion Device with Active Resistance Control) are added to the fee schedule file on July 1, 2006, and are effective for claims submitted with dates of service on or after January 1, 2006.

As part of this update, the common working file category for HCPCS code **B4185** will be switched from CWF category 9 to CWF category 20, effective January 1, 2006. B4185 was added to the HCPCS on January 1, 2006, to replace codes B4184 and B4186 and describes parenteral nutrients (CWF category 20) as opposed to enteral nutrients (CSF category 9).

Per CR4267, the following four adjustable wheelchair cushions codes are added to the HCPCS, effective July 1, 2006:
- **K0734** - Skin Protection Wheelchair Seat Cushion, Adjustable, Width Less Than 22 Inches, Any Depth
- **K0735** - Skin Protection Wheelchair Seat Cushion, Adjustable, Width 22 Inches or Greater, Any Depth
- **K0736** - Skin Protection and Positioning Wheelchair Seat Cushion, Adjustable, Width less than 22 Inches, Any Depth.
- **K0737** - Skin Protection and Positioning Wheelchair Seat Cushion, Adjustable, Width 22 Inches or Greater, Any Depth.

(See the MLN Matters article at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4267.pdf** on the CMS web site.)

The fee schedule amounts for the above codes, K0734, K0735, K0736, and K0737, are added to the fee schedule file on July 1, 2006 and are effective for claims submitted with dates of service on or after July 1, 2006.

HCPCS codes A6531 and A6532 were added to the HCPCS January 1, 2006, to replace L8110 and L8120; therefore, all billing and payment requirements for HCPCS codes L8110 and L8120 crosswalk directly to A6531 and A6532, including the requirement to bill modifier AW when items are furnished for use as surgical dressings (see transmittal AB-03-100).

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

Additional Information
The official instruction issued to your intermediary, carrier, or DMERC regarding this change can be found at **http://www.cms.hhs.gov/Transmittals/downloads/R928CP.pdf** on the 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: **http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.pdf** on the CMS web site.

Fee Schedule - Revised 2006 Durable Medical Equipment Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule Files - Correction (SE 0650)

MLN Matters Number: SE0650
Related CR Release Date: N/A
Related CR Transmittal #: N/A
Related Change Request (CR) #: N/A
Effective Date: N/A
Implementation Date: N/A

NEWS FLASH - Attention Physicians, Suppliers, and Providers!
Sign up now for the listserv(s) appropriate for you at http://www.cms.hhs.gov/apps/mailinglists/.
Get your Medicare news as it happens!

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

Background
The purpose of this Special Edition article is to **alert providers to the revision to the fee schedule regarding DME Fee Schedule Amounts for** Transcutaneous Electrical Joint Stimulation Device System Healthcare Common Procedure Coding System (HCPCS) **Code E0762**.

Key Points
- In accordance with Transmittal 928 (CR5017), July Quarterly Update for 2006 DMEPOS Fee Schedule, DMEPOS fee schedule files, which included fee schedule amounts for HCPCS code E0762 were released for claims with dates of service on or after January 1, 2006. (There is an MLN Matters article associated with CR5017 at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5017.pdf** on the CMS site.)
- To allow for additional time to address technical concerns raised regarding the calculation of fee schedule amounts for code E0762, the Centers for Medicare & Medicaid Services (CMS) is revising the files to remove the fee schedule amounts for code E0762.
- Until further notice, Medicare contractors (carriers, FIs, DMERCs and DME MACs) will determine the Medicare allowed payment amount for claims submitted using a HCPCS code based on their individual consideration of each claim. This code remains in the DME category for inexpensive or routinely purchased items in accordance with Transmittal 928.

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

Transmittal 928 can be found at **http://www.cms.hhs.gov/Transmittals/downloads/R928CP.pdf** on the CMS web site.

ICD-9-CM - Medicare Contractor Annual Update of the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) (CR 5142)

MLN Matters Number: MM5142
Related CR Release Date: June 23, 2006
Related CR Transmittal #: R990CP
Related Change Request (CR) #: 5142
Effective Date: October 1, 2006
Implementation Date: October 2, 2006

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

Provider Types Affected
Physicians, suppliers, and providers billing Medicare contractors (carriers, durable medical equipment regional carriers (DMERCs), and fiscal intermediaries (FIs) including regional home health intermediaries (RHHIs))

Provider Action Needed
Impact to You
Medicare has issued the annual update of the *International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)* to Medicare contractors. This update will apply for claims with service dates on or after October 1, 2006, as well as discharges on or after October 1, 2006, for institutional providers.

What You Need to Know
An ICD-9-CM code is required for all professional claims, e.g., physicians, non-physician practitioners, independent clinical diagnostic laboratories, occupational and physical therapists, independent diagnostic testing facilities, audiologists, ambulatory surgical centers (ASCs), and for all institutional claims, but is **not required** for ambulance supplier claims.

ICD-9-CM - Medicare Contractor Annual Update of the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) (CR 5142) (Continued)

What You Need to Do
Be ready to use the updated codes on October 1, 2006. Please refer to the *Background* and *Additional Information* sections of this article for further details regarding this instruction.

Background
This instruction is a reminder that Medicare carriers, DMERCs, FIs, and RHHIs will use the annual *International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)* coding update effective for:
- Dates of service on or after October 1, 2006; and
- Discharges on or after October 1, 2006 for institutional providers

Effective for dates of service on and after October 1, 2004, CMS no longer provided a 90-day grace period for physicians, practitioners and suppliers to use in billing discontinued ICD-9-CM diagnosis codes on Medicare claims. The Health Insurance Portability and Accountability Act (HIPAA) requires that medical code sets be date-of-service compliant, and ICD-9-CM diagnosis codes are a medical code set (see CR 3094, dated February 6, 2004 at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3094.pdf** on the CMS web site.

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

Additional Information
Publication of ICD-9-CM Codes
- The Centers for Medicare & Medicaid Services (CMS) places the new, revised, and discontinued codes at **http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/07_summarytables.asp#TopOfPage** on the CMS web site. The update should be available at this site in June.
- The updated codes can also be viewed at the National Center for Health Statistics (NCHS) web site at: **http://www.cdc.gov/nchs/icd9.htm**. This posting should be available at this site in June.
- Providers are also encouraged to purchase a new ICD-9-CM book or CDROM on an annual basis.

The ICD-9-CM codes are updated annually as stated in the *Medicare Claims Processing Manual*, Pub. 100-04, Chapter 23 (Fee Schedule Administration and Coding Requirements), Section 10.2 (Relationship of ICD-9-CM Codes and Date of Service). Chapter 23 may be accessed at **http://www.cms.hhs.gov/manuals/downloads/clm104c23.pdf** on the CMS web site.

To view CR5142, the official instruction issued to your Medicare carrier/DMERC or FI/RHHI, regarding changes mentioned in this article. CR5142 may be found at **http://www.cms.hhs.gov/Transmittals/downloads/R990CP.pdf** on the CMS web site.

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

Medicare's Common Working File (CWF) Part C (Medicare Advantage Manage Care) Data Exchange and Data Display Changes (CR 5118)

MLN Matters Number: MM5118
Related CR Release Date: June 30, 2006
Related CR Transmittal #: R995CP
Related Change Request (CR) #: 5118
Effective Date: October 1, 2006
Implementation Date: October 2, 2006

NEWS FLASH - Attention Physicians and Suppliers! Sign up now to the PHYSICIANS-L or DMEPOS-SUPPLIERS-L at http://www.cms.hhs.gov/apps/mailinglists/. Get your Medicare news as it happens!

Provider Types Affected
Physicians, providers, and suppliers who provide services to Medicare beneficiaries enrolled under Medicare Part C

Impact on Providers
CR5118 provides notice that effective January 2006, Medicare Part C plan contract numbers can begin with a character other than an "**H**."

As a result of changes in the assignment of Medicare Part C plan contract numbers, the entire five-position alpha/numeric Medicare Part C plan contract number will be provided to the common working file (CWF), which is a key file used by Medicare systems to provide beneficiary information to providers.

Medicare's Common Working File (CWF) Part C (Medicare Advantage Manage Care) Data Exchange and Data Display Changes (CR 5118) (Continued)

Currently, the CWF places an "H" in front of the Part C plan number, since prior to January 1, 2006, all plan numbers began with an "H." Once this change is implemented, the correct and complete plan contract numbers will then be on the CWF and will be given to providers when they inquire about Medicare beneficiaries.

Background
CWF contains data indicating when a beneficiary is enrolled under a Medicare Part C contract. Medicare Part C contracts are Medicare Advantage Managed Care Plans that provide Part A and B benefits for beneficiaries enrolled under the contract. CWF receives this Part C data on a data feed from the Enrollment Database (EDB), another Medicare database. Effective January 1, 2006, Part C contract numbers can begin with a letter other than "H" and the Medicare CWF is being modified to handle this change, so correct numbers are sent to providers as part of beneficiary information.

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

The number that will appear on CWF will begin with "H." For the following 11 plans, the alpha prefix is actually an "R." Prior to October, when using the web page look-up tool, make sure to replace the "H" with an "R." The 11 plans are the following:

R3175	R5566	R5863
R5287	R5595	R5941
R5342	R5674	R9943
R5553	R5826	

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

Additional Information
CR5118 is the official instruction issued to your Medicare carrier/durable medical equipment regional carrier (DMERC) or fiscal intermediary (FI) regarding changes mentioned in this article. CR5118 may be found at **http://www.cms.hhs.gov/Transmittals/downloads/R995CP.pdf** on the CMS web site.

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

MSN - Quarterly Medicare Summary Notice (MSN) Printing Cycle (CR 5062)

MLN Matters Number: MM5062 Revised
Related CR Release Date: May 12, 2006

Related CR Transmittal #: R955CP

Related Change Request (CR) #: 5062
Effective Date: Carriers - June 12, DMERCs - July 1, FIs - September 1
Implementation Date: Carriers - June 12, DMERCs - July 3, FIs - Sept. 1

Note: This article was revised on May 24, 2006, to correct the implementation date for DMERCs. That date should have been July 3, 2006. The transmittal number also changed, since Transmittal R945 (dated May 12, 2006) was rescinded and replaced with Transmittal R955 (dated May 19, 2006). All other information remains the same.

Provider Types Affected
Physicians, providers, and suppliers submitting claims to Medicare carriers, durable medical equipment regional carriers (DMERCs), fiscal intermediaries (FIs), and/or regional home health intermediaries (RHHIs) for services provided to Medicare beneficiaries

MSN - Quarterly Medicare Summary Notice (MSN) Printing Cycle (CR 5062 (Continued)

Impact on Providers
This article is based on Change Request (CR) 5062, which instructs Medicare contractors (carriers, DMERCs, FIs, and RHHIs) to print and mail No-Pay Medicare Summary Notices (MSNs) on a quarterly schedule (rather than the current monthly schedule).

Background
Current Centers for Medicare & Medicaid Services (CMS) instructions require all Medicare contractors to issue a MSN to each beneficiary for whom a claim was processed during the last 30 days (possibly for services received more than 30 days ago) to inform the beneficiary of the disposition of all claims (i.e., a record of services received, the status of any deductibles, and appeal rights).

In an effort to reduce overall operating costs, CR5062 instructs your intermediary/carrier to change from their current monthly (30 day) No-Pay MSN mailing schedule to a quarterly (90 day) No-Pay MSN mailing schedule. All MSN information should continue to print; however, summations will occur on a quarterly basis as opposed to a monthly basis.

No-Pay MSNs are the standard, system-generated MSNs produced for beneficiaries in which Medicare did not issue payment to the beneficiary for the respective claim. Beneficiaries often need these MSNs in order to obtain payment from another payer/insurer.

In those situations where a No-Pay MSN is needed or lost by a beneficiary, they can request a No-Pay MSN by calling 1-800 Medicare. On-demand requests will be generated and mailed once the request is made.

In summary, CR5062 provides the following instructions:
- Beginning no later than October 1, 2006, Medicare contractors will issue No-Pay MSNs on a quarterly/90-day mailing cycle as opposed to the previous monthly/30-day mailing cycle;
- MSNs with checks will continue to be mailed out as processed; and
- If a beneficiary requests a monthly No-Pay MSN (as opposed to the quarterly MSN), then Medicare contractors must generate and mail out the MSN at the time of the request.

Implementation
The implementation date for the instruction is June 12, 2006, for carriers, July 1, 2006, for DMERCs, and September 1, 2006 for FIs.

Additional Information
For complete details, please see the official instruction issued to your carrier/intermediary regarding this change. That instruction may be viewed at **http://www.cms.hhs.gov/Transmittals/downloads/R945CP.pdf** on the CMS web site.

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

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

MSP - Full Replacement of and Rescinding Change Request (CR) 3504 - Modification to Online Medicare Secondary Payer Questionnaire (CR 4098)

MLN Matters Number: MM4098 Revised
Related CR Release Date: October 21, 2005
Related CR Transmittal #: 41

Related Change Request (CR) #: 4098
Effective Date: January 21, 2006
Implementation Date: January 21, 2006

Note: This article was revised on June 15, 2006, because CR4098, on which this article is based, has been superseded by CR5087. To view modifications to the online Medicare Secondary Payer Questionnaire that are effective as of September 11, 2006, please see MLN Matters article MM5087, available at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5087.pdf** on the CMS web site.

Provider Types Affected
Medicare providers who, upon inpatient or outpatient admissions of Medicare beneficiaries, use a questionnaire to determine other insurance coverage that may be primary to Medicare.

Provider Action Needed
Impact to You
CR4098 clarifies recent changes made to the "Medicare Secondary Payer Questionnaire."

What You Need to Know
This CR identifies all of the changes that were made to CR3504 ***and*** makes additional changes to the model questionnaire. These changes will assist providers in identifying other payers that may be primary to Medicare.

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

Background
The Centers for Medicare & Medicaid Services (CMS) received information that a prior instruction (CR3504) did not specifically mention all of the changes that were made to the "Medicare Secondary Payer (MSP) Questionnaire." CR4098 identifies all of the changes made as part of CR3504 and makes additional changes to the model questionnaire.

The *Medicare Secondary Payer Manual*, Chapter 3, Section 20.2.1, available as an attachment to CR4098, provides a model: "Admission Questions to Ask Medicare Beneficiaries."

The model contains questions that may be printed out and used as a guide to help identify other payers. (The website for accessing CR4098 is provided in the *Additional Information* section of this article.)

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

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

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

Additional Information
The official instructions issued to your Medicare carrier or intermediary regarding this change and the model questionnaire can be found at **http://www.cms.hhs.gov/transmittals/downloads/R41MSP.pdf** on the CMS web site.

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

MSP - Modifications to Online Medicare Secondary Payer Questionnaire: This CR Rescinds and Replaces CR4098 (CR 5087)

MLN Matters Number: MM5087
Related CR Release Date: June 9, 2006
Related CR Transmittal #: R53MSP
Related Change Request (CR) #: 5087
Effective Date: September 11, 2006
Implementation Date: September 11, 2006

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

Provider Types Affected
Medicare physicians/providers/suppliers that, upon providing services to a Medicare patient, use a questionnaire to determine other insurance coverage that may be primary to Medicare

Provider Action Needed
Impact to You
Questions have arisen over Part V of the model Medicare Secondary Payer Questionnaire.

What You Need to Know
CR5087 provides clarification regarding Part V, provides major revisions to other parts of the model Medicare Secondary Payer Questionnaire, and rescinds and replaces CR4098.

What You Need to Do
You should replace any previous versions of the model questionnaire with the new version, available as an attachment to CR5087.

Background
In 1980, Congress enacted provisions that made Medicare the secondary payer to certain additional primary plans (group health plans, workers' compensation plans, liability insurance, or no-fault insurance). To help you identify such Medicare Secondary Payer (MSP) situations, CMS has developed a model Medicare Secondary Payer Questionnaire (found in IOM 100.05 (Medicare Secondary Payer Manual) Chapter 3, Section 20.2.1). You can use this model questionnaire as a guide, at each inpatient and outpatient admission, to help identify other payers that may be primary to Medicare.

CR4098 (released October 21, 2005) made changes to this model questionnaire that have generated several questions, specifically regarding PART V (Disability). In response, CR 5087 (from which this article is taken) incorporates the changes that were made in CR 4098, modifies the changes previously made to PART V to address the questions that have arisen, and makes additional changes to other parts of the model questionnaire to improve the wording and sequencing of questions in these parts.

The changes to the model questionnaire are too numerous to list here. As such, please refer directly to the revised section in the *Medicare Secondary Payer (MSP) Manual*, Chapter 3 (MSP Provider, Physician, and Other Supplier Billing Requirements), Section 20.2.1 (Admission Questions to Ask Medicare Beneficiaries) which contains the complete, updated model questionnaire. The changes are identified in redline and italics.

Please keep in mind the following:
1. This questionnaire is a model. Other questions may be added to help identify other payers that may be primary to Medicare.
2. If you choose to use this model questionnaire, please be aware that it was developed to be used in sequence. The Instructions listed after the questions are to direct the patient to the next appropriate question to facilitate transition between questions.

Additional Information
You can find more information about the Medicare Secondary Payer Questionnaire by viewing CR5087 at **http://www.cms.hhs.gov/Transmittals/downloads/R53MSP.pdf**. Attached to the CR is the revised section of the *Medicare Secondary Payer (MSP) Manual*, Chapter 3 (MSP Provider, Physician, and Other Supplier Billing Requirements), Section 20.2.1 (Admission Questions to Ask Medicare Beneficiaries) which contains the complete, updated model questionnaire.

If you have any questions, please contact your carrier (including durable medical equipment regional carrier), fiscal intermediary, or regional home health intermediary at their toll-free number, which may be found at **http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.pdf** on the CMS web site.

Contractor Instruction - Modifications to Online Medicare Secondary Paye Questionnaire. This CR Rescinds and Replaces CR 4098 (CR 5087)

CMS is updating changes to the 'Medicare Secondary Payer Questionnaire' made in CR 4098 by issuing CR 5087. The revised MSP Questionnaire may be found in CR 5087 on the CMS website at:
http://www.cms.hhs.gov/transmittals/downloads/R53MSP.pdf CMS has asked NHIC, Corp. to remind suppliers:

Contractor Instruction - Modifications to Online Medicare Secondary Paye Questionnaire. This CR Rescinds and Replaces CR 4098 (CR 5087) (Continued)

- That the "MSP Questionnaire" is a model of the type of questions that may be asked to help identify Medicare Secondary Payer (MSP) situations
- That if suppliers choose to use the model questionnaire in its entirety, then this instruction (CR 5087) represents major revisions to the model questionnaire.
- We recommend that suppliers replace any previous versions of the model questionnaire with the new version.

National Provider Identifier (NPI) (JSM 06184)

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

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

NPI - Stage 2 National Provider Identifier (NPI) Changes for Transaction 835, and Standard Paper Remittance Advice, and Changes in Medicare Claims Processin Manual, Chapter 22 - Remittance Advice (CR 5081)

MLN Matters Number: MM5081
Related CR Release Date: June 30, 2006
Related CR Transmittal #: R996CP
Related Change Request (CR) #: 5081
Effective Date: October 1, 2006
Implementation Date: October 2, 2006

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

Provider Types Affected
All Medicare physicians, providers, suppliers, and billing staff who submit claims for services to Medicare contractors (fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), carriers, and durable medical equipment regional carriers (DMERCs) and durable medical equipment administrative contractors (DME MACs))

Background
This article instructs the Shared System Maintainers and FIs, RHHIs, carriers, and DMERCs/DME MACs how to report Medicare legacy numbers and NPIs on a Health Insurance Portability and Accountability Act (HIPAA) compliant Electronic Remittance Advice (ERA) - transaction 835, and Standard Paper Remittance (SPR) advice, any output using PC Print or Medicare Remit Easy Print (MREP) between October 2, 2006, and May 22, 2007.

The Centers for Medicare & Medicaid Services (CMS) has defined legacy provider identifiers to include OSCAR, National Supplier Clearinghouse (NSC), Provider Identification Numbers (PIN), National Council of Prescription Drug Plans (NCPDP) pharmacy identifiers, and Unique Physician Identification Numbers (UPINs). CMS's definition of legacy numbers does not include taxpayer identifier numbers (TIN) such as Employer Identification Numbers (EINs) or Social Security Numbers (SSNs).

Medicare has published CR4320 (**http://www.cms.hhs.gov/Transmittals/downloads/R204OTN.pdf**) instructing its contractors how to properly use and edit NPIs received in electronic data interchange transactions, via Direct Data Entry screens, or on paper claim forms.

Providers need to be aware that these instructions that impact contractors will also impact the content of their SPR, ERA, and their PC print and MREP software.

NPI - Stage 2 National Provider Identifier (NPI) Changes for Transaction 835, and Standard Paper Remittance Advice, and Changes in Medicare Claims Processin Manual, Chapter 22 - Remittance Advice (CR 5081) (Continued)

The following dates outline the regulations from January 2006 forward and are as follows:

- **January 3, 2006 - October 1, 2006**: Medicare rejects claims with only NPIs and no legacy number.
- **October 2, 2006 - May 22, 2007**: Medicare will accept claims with a legacy number and/or an NPI, and will be capable of sending NPIs in outbound transaction e.g., ERA
- **May 23, 2007 - Forward**: Medicare will only accept claims with NPIs. Small health plans have an additional year to be NPI compliant.

Medicare providers may want to be aware of the following Stage 2 scenarios so that they are compliant with claims regulations and receive payments in a timely manner.

Key Points
During Stage 2, if an NPI is received on the claim, it will be cross walked to the Medicare legacy number(s) for processing. The crosswalk may result in:

Scenario I:	Single NPI	cross walked to	Single legacy number
Scenario II:	Multiple NPIs	cross walked to	Single Medicare legacy number
Scenario III:	Single NPI	cross walked to	Multiple Medicare legacy numbers

Note: The Standard Paper Remittance for institutional providers would include NPI information at the claim level. NPI information for professional providers and suppliers would be sent at the service level.

CMS will adjudicate claims based upon Medicare legacy number(s) even when NPIs are received and validated. The Remittance Advice (RA) may be generated for claims with the same legacy numbers but and different NPIs. These claims with different NPIs will be rolled up and reported in a single RA accompanied by one check or electronic funds transfer (EFT).

During Stage 2, Medicare will report both the legacy number(s) and NPI(s) to providers enabling them to track payments and adjustments by both identifiers. The Companion Documents will be updated to reflect these changes and the updated documents will be posted at **http://www.cms.hhs.gov/ElectronicBillingEDITrans/11_Remittance.asp#TopOfPage** on the CMS web site.

Scenario I - Single NPI cross walked to single legacy number:

1. ERA: Under this scenario, use the TIN (EIN/SSN) at the Payee level as the Payee ID, and the legacy number in the REF segment as Payee Additional ID. Then add the NPI at the claim and/or at the service level, if needed.
2. SPR: Insert the legacy number at the header level and the NPI at the claim and/or at the service level. if needed.
3. PC Print Software: Show the legacy number at the header level and the NPI at the claim and/or at the service level, if needed.
4. MREP software: Show the legacy number at the header level and the NPI at the claim and/or at the service level, if needed.

Scenario II: Multiple NPIs cross walked to Single Medicare legacy number:

1. ERA: Under this scenario, use the TIN (EIN/SSN) at the Payee level as the Payee ID, and the legacy number in the REF segment as Payee Additional ID. Then add the specific NPIs at the claim and/or at the service level, if needed. The specific NPI associate with the claim(s)/service lines included in the ERA will need to be identified using additional information provided on the claim.
2. SPR: Insert the legacy number at the header level. Add the specific NPIs at the claim and/or at the service level, if needed.
3. PC Print Software: Show the legacy number at the header level and the specific NPI at the claim and/or at the service level, if needed.
4. MREP software: Show the legacy number at the header level and the specific NPI at the claim and/or at the service level, if needed.

Scenario III: Single NPI cross walked to Multiple Medicare legacy numbers:

1. ERA: Under this scenario, use the TIN (EIN/SSN) at the Payee level as the Payee ID, and the appropriate legacy number in the REF segment as Payee Additional ID. Then add the NPI at the claim and/or at the service level, if needed. (Under this scenario, if there are 50 claims with the same NPI and that NPI crosswalks to 5 legacy numbers, we will issue 5 separate RAs and 5 separate checks/EFTs per each legacy number.
2. SPR: Insert the appropriate legacy number at the header level and the NPI at the claim and/or at the service level, if needed.
3. PC Print Software: Show the appropriate legacy number at the header level and the NPI at the claim and/or at the service level, if needed.
4. MREP software: Show the appropriate legacy number at the header level and the NPI at the claim and/or at the service level, if needed.

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

NPI - Stage 2 National Provider Identifier (NPI) Changes for Transaction 835, and Standard Paper Remittance Advice, and Changes in Medicare Claims Processin Manual, Chapter 22 - Remittance Advice (CR 5081) (Continued)

Additional Information
The official instructions issued to your Medicare FI, Carrier, RHHI, DMERC, or DME MAC regarding this change can be found at **http://www.cms.hhs.gov/transmittals/downloads/R996CP.pdf** on the CMS web site. The revised sections of Chapter 22-Remittance Advice of the *Medicare Claims Processing Manual* is attached to CR5081

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

The MLN Matters article that provides additional information about Stage 1 Use of NPI is at the following address is available at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4320.pdf** on the CMS web site.

New Temporary "K" Code for Power Mobility Device (PMD) Batteries (CR 4253)

MLN Matters Number: MM4253
Related CR Release Date: February 1, 2006
Related CR Transmittal #: R823CP
Related Change Request (CR) #: 4253
Effective Date: July 1, 2006
Implementation Date: July 3, 2006

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

Provider Types Affected
Suppliers and providers billing Medicare durable medical equipment regional carriers (DMERCs) and/or fiscal intermediaries (FIs) for services related to power mobility devices.

Provider Action Needed
This article is based on Change Request (CR) 4253, which establishes a new temporary "K" code for PMD batteries.

Background
Effective July 1, 2006, a new "K" code will be established for a 12- to 24-hour battery for power mobility devices. Effective July 1, 2006, the following K code will be added to the system:

K Code	Descriptor
K0733	Power wheelchair accessory, 12 to 24 amp hour sealed lead acid battery, each. (e.g., gel cell, absorded glassmat)

Note: K codes describe temporary durable medical equipment (DME) and drug codes. Once these codes are approved for permanent inclusion into the Healthcare Common Procedure Coding System (HCPCS), they usually become "A", "E", of "J" codes:

- "A" codes - ambulance and transportation services; medical and surgical supplies; and administrative, miscellaneous and investigational services/supplies;
- "E" codes - DME such as walkers, hospital beds, infusion supplies, etc.; and
- "J" codes - injectable drugs that can be injected subcutaneously, intramuscularly or intravenously with the dosage injected indicated.

The pricing category for K code **K0733** is "32" (inexpensive or routinely purchased items), and the type of service (TOS) includes "A" (Used DME), "P" (Lump Sum Purchase of DME, Prosthetics, Orthotics), and "R" (Rental of DME). In addition, the place of service (POS) for K code K0733 is listed in the following table:

Place of Service	Descriptor
04	Homeless Shelter
12	Patient's Home
13	Assisted Living Facility
14	Group Home

New Temporary "K" Code for Power Mobility Device (PMD) Batteries (CR 4253 (Continued)

Place of Service	Descriptor
33	Custodial Care Facility
54	Intermediate Care Facility/Mentally Retarded
55	Residential Substance Abuse Treatment Center
56	Psychiatric Residential Treatment Center

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

Additional Information
For complete details, please see the official instruction issued to your DMERC/intermediary regarding this change. That instruction may be viewed at **http://www.cms.hhs.gov/Transmittals/downloads/R823CP.pdf** on the CMS web site.

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

Non-Application of Deductible for Colorectal Cancer Screening Tests

MLN Matters Number: MM5127
Related CR Release Date: July 21, 2006
Related CR Transmittal #: R1004CP
Related Change Request (CR) #: 5127
Effective Date: January 1, 2007
Implementation Date: January 2, 2007

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

Provider Types Affected
Physicians and providers who provide colorectal cancer screening services to Medicare beneficiaries

Impact on Providers
Effective January 1, 2007, Medicare will waive the annual Medicare Part B deductible for colorectal cancer screening tests billed with the HCPCS codes listed in the following chart. While the deductible will be waived, and will not apply for colorectal cancer screening test services furnished on or after January 1, 2007, the Medicare Part B coinsurance still applies for these screening tests.

HCPCS Screening Code	Code Description
G0104	Colorectal cancer screening: Flexible sigmoidoscopy
G0105 G0121	Colorectal cancer screening: Colonoscopy on individual at high risk; Colorectal cancer screening: Colonoscopy on individual not meeting criteria for high risk
G0106	Colorectal cancer screening: Barium enema as an alternative to G0104, screening sigmoidoscopy
G0120	Colorectal cancer screening: Barium enema as an alternative to G0105, screening colonoscopy

Currently (prior to January 1, 2007, for colorectal cancer screening test services furnished before January 1, 2007), **the annual Medicare Part B deductible AND coinsurance apply to the above codes**.

Please note that the annual Medicare Part B deductible and coinsurance **do not apply** for the following tests.

- **G0107** (colon cancer screening; fecal occult blood tests (FOBT), 1-3 simultaneous determinations); and
- **G0328** (colon cancer screening; as an alternative to G0107; fecal occult blood test, immunoassay, 1-3 simultaneous determinations).

Non-Application of Deductible for Colorectal Cancer Screening Tests (Continued)

Background
This policy is directed by Section 5113 of the Deficit Reduction Act (DRA) of 2005. It amends Section 1833(b) of the Social Security Act (SSA) by eliminating the requirement of the annual Part B deductible for colorectal cancer screening tests furnished on or after January 1, 2007.

Additional Information
SE0613 "Colorectal Cancer: Preventable, Treatable, and Beatable: Medicare Coverage and Billing for Colorectal Cancer Screening" contains pertinent information. It can be found at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0613.pdf** on the Centers for Medicare & Medicaid Services (CMS) website. This special edition also includes links to other resources related to colorectal cancer screening and Medicare-covered preventive services.

The manual attachment to CR5127 (*Medicare Claims Processing Manual*, Chapter 18, "Preventive and Screening Services", Section 60.1 "Colorectal Cancer Screening; Payment") contains additional information about colorectal cancer screening. CR 5127 is the official instruction issued to your Medicare carrier or fiscal intermediary (FI) regarding changes mentioned in this article. CR 5127 may be found at **http://www.cms.hhs.gov/Transmittals/downloads/R1004CP.pdf** on the CMS web site.

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

Notice of New Interest Rate for Medicare Overpayments and Underpayments (CR 4076)

Medicare Regulation 42 CFR §405.378 provides for the assessment of interest at the higher of the current value of funds rate (one percent for calendar year 2005) or the private consumer rate as fixed by the Department of the Treasury. The Department of the Treasury has notified the Department of Health and Human Services that the private consumer rate has been changed to **12.625** percent as of July 19, 2006.

Period	**Interest Rate**
February 7, 2001 - April 25, 2001	14.125%
April 26, 2001 - August 6, 2001	13.75%
August 7, 2001 - October 30, 2001	13.25%
October 31, 2001 - January 31, 2002	13.25%
February 1, 2002 - May 7, 2002	12.625%
May 8, 2002 - August 7, 2002	11.75%
August 8, 2002 - November 18, 2002	12.625%
November 19, 2002 - February 10, 2003	11.25%
February 11, 2003 - April 27, 2003	10.75%
April 28, 2003 - August 10, 2003	11.625%
August 11, 2003 - November 2, 2003	12.125%
November 3, 2003 -February 3, 2004	12.00%
February 4, 2004 - May 6, 2004	12.00%
May 7, 2004 - August 8, 2004	11.875%
August 9, 2004 - November 11, 2004	11.75%
November 12, 2004 - February 7, 2005	12.00%
February 8, 2005 - April 24, 2005	11.875%
April 25, 2005 - July 21, 2005	12.00%
July 22, 2005 - November 2, 2005	12.00%
November 3, 2005 - January 24, 2006	12.25%
January 25, 2006 - April 23, 2006	11.875%
April 24, 2006 - July 18, 2006	12.125%

Payments - Deficit Reduction Act of 2005 - Nine Day Payment Hold (JSM/TDL-06549)

This message is a reminder for all providers and physicians who bill Medicare contractors for their services.

A brief hold will be placed on Medicare payments for all claims during the last 9 days of the Federal fiscal year (September 22 through September 30, 2006). These payment delays are mandated by section 5203 of the Deficit Reduction Act of 2005. No interest will be accrued and no late penalties will be paid to an entity or individual by reason of this one-time hold on payments. All claims held during this time will be paid on October 2, 2006.

This policy only applies to claims subject to payment. It does not apply to full denials, no-pay claims, and other non-claim payments such as periodic interim payments, home health requests for anticipated payments, and cost report settlements.

Please note that payments will not be staggered and no advance payments will be allowed during this 9-day hold.

For more information, please view the MLN Matters Article at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5047.pdf**.

Payments - Full Replacement of CR4349, Hold on Medicare Payments. CR4349 I Rescinded (CR 5047)

MLN Matters Number: MM5047 Revised
Related CR Release Date: May 10, 2006
Related CR Transmittal #: R944CP

Related Change Request (CR) #: 5047
Effective Date: September 22, 2006
Implementation Date: July 3, 2006

Note: This article was revised on May 11, 2006, to reflect a new CR release date, transmittal number, and CR5047 web address. These were changed to reflect that CR5047 was revised by CMS on May 10. All other information in the article remains the same.

Provider Types Affected
Providers and physicians who bill Medicare contractors (fiscal intermediaries (FIs) including regional home health intermediaries (RHHIs), and carriers) for their services

Key Points
- A brief hold will be placed on Medicare payments for ALL claims (e.g., initial claims, adjustment claims, and Medicare Secondary Payer (MSP) claims) for the last 9 days of the Federal fiscal year, i.e., September 22, 2006-September 30, 2006.
  - In essence, no payments on claims will be made from September 22-30, 2006. Providers need to be aware of these payment delays, which **are mandated by section 5203 of the Deficit Reduction Act (DRA) of 2006**.
  - Accelerated payments using normal procedures will be considered
- No interest will be accrued or paid, and no late penalty will be paid to an entity or individual for any delay in a payment by reason of this one-time hold on payments.
- **All** claims held as a result of this one-time policy that would have otherwise been paid on one of these 9 days will be paid on **October 2, 2006**.

Additional Information
This policy applies only to claims subject to payment. It does not apply to full denials and no-pay claims. It also does not apply to periodic interim payments, home health request for anticipated payments, cost reports settlements, and other non-claim payments.

Additionally, Medicare contractors will continue to apply the fourteen day electronic claim payment floor and the 29-day paper claim payment floor. On a case-by-case basis, Medicare FIs, RHHIs or carriers may make adjustments, after October 1, 2006, for extenuating circumstances raised by a provider. For example, adjustments may be made to not charge a provider interest on an overpayment for those days for which offsets could not be made due to the hold of payments required by this DRA provision.

Please note that:
- Payments will not be staggered; and
- No advance payments during the 9-day hold will be allowed.

CR5047 is the official instruction issued to your FI, RHHI, or carrier regarding changes mentioned in this article. CR5047 may be found by going to **http://www.cms.hhs.gov/Transmittals/downloads/R944CP.pdf** on the CMS web site.

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

Payments - Medicare Policy Regarding Collection of Fee-for-Service Payment Made During Periods of Managed Care Enrollment (SE 0638)

MLN Matters Number: SE0638
Related CR Release Date: N/A
Related CR Transmittal #: N/A
Related Change Request (CR) #: 5105
Effective Date: N/A
Implementation Date: N/A

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

Background
Once a Centers for Medicare & Medicaid Services (CMS) data system recognizes a beneficiary has enrolled in a MA Organization, the MA organization receives capitation payments for the beneficiary. In some cases, enrollments with retroactive dates are processed. The result is that Medicare may pay for the services rendered during a specific period twice; once for the specific service which was paid by the fee-for-service Medicare contractor and secondly by the MA Payment systems in the monthly capitation rate to the plan. Change Request 5105 and MLN Matters 5105 (see **http://www.cms.hhs.gov/MLNArticles/downloads/MM5105.pdf**) describe how CMS ensures that any fee-for-service claims that are approved for payment erroneously are adjusted and overpayments recovered by Medicare carriers and/or FIs.

A variety of CMS systems issues over the past 18 months prompted CMS to recently synchronize Medicare Advantage enrollment and disenrollment information. As a result, providers may have claims that were affected by this synchronization in one of two ways, both of which are addressed below.

Scenario 1. Claims Paid in Error
About 386,000 claims for about 100,000 beneficiaries enrolled in MA organizations have been identified as having been paid on a fee-for-service basis by FIs or carriers during this time. FIs and carriers will, over the next 6 months, adjust these claims and seek overpayments.

Where such an overpayment is recovered from a provider, the related remittance advice for the claim adjustment will indicate Reason Code 24 which states: "Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan". Upon receipt, providers are to contact the MA plan for payment.

Providers who bill carriers:

The carrier will alert you via letter or alternate method of the following:
- The beneficiary was in a MA plan on the date of service;
- You should bill the managed care plan;
- The plan identification number; and
- Where to find the plan name and address associated with the plan number on the CMS internet site.

Providers who bill FIs:
The adjustment will occur automatically, and information on which plan to contact must be determined through an eligibility inquiry or by contacting the beneficiary directly. To associate plan identification numbers with the plan name, go to **http://www.cms.hhs.gov/HealthPlansGenInfo/claims_processing_20060120.asp#TopOfPage** on the CMS web site.

The number that will appear on the contractor notices will begin with 'H'. For the following 11 plans, the alpha prefix is actually an 'R'. A technical correction will be made in CMS systems in October 2006. Prior to October, when using the web page look up tool, make sure to replace the 'H' with an 'R'. The 11 plans are:

- R3175
- R5287
- R5342
- R5553
- R5566
- R5595
- R5674
- R5826
- R5863
- R5941
- R9943

Payments - Medicare Policy Regarding Collection of Fee-for-Service Payment Made During Periods of Managed Care Enrollment (SE 0638) (Continued)

MA Plans have been notified:
MA plans know that the resynchronization may result in an increase in payment requests from providers who had claims previously paid, but subsequently overturned by fee-for-service FIs and carriers. Whenever CMS reverses fee-for-service payments as a result of confirmed retro-active enrollment in an MA plan, the provider must bill the MA plan. The plan adjudicates the claim and pays the claim at the plan's rate (if the provider is part of the network) or pays the provider at the fee-for-service rate if the provider is not part of the network. If the plan denies payment then the provider may bill the beneficiary. The Medicare beneficiary call center representatives at 1-800-MEDICARE have been trained to answer beneficiary inquiries that may arise in these situations.

Scenario 2. Claims Denied in Error
Because CMS has synchronized Medicare Advantage enrollment and disenrollment information, it is possible that fee-for-service claims were previously denied because the beneficiary was incorrectly identified as being a member of an MA plan. If a provider believes past claims have been denied in error due to problems in enrollment and disenrollment information, those claims can now be resubmitted. For any Part B services, the 10% reduction for timely filing will be waived.

Additional Information
For more information regarding the manualization of this policy, see the MLN Matters article at **http://www.cms.hhs.gov/MLNArticles/downloads/MM5105.pdf** on the CMS web site.

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

The ADMC form
(http://www.medicarenhic.com/dme/ADMC.pdf)
Contains mailing and fax information

Chapter 24 Update to the National Council for Prescription Drug Program (NCPDP) Narrative Portion of Prior Authorization Segment (CR 5092)

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

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

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

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

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

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

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

Chapter 24 Update to the National Council for Prescription Drug Program (NCPDP) Narrative Portion of Prior Authorization Segment (CR 5092) (Continued)

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

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

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

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

End of Contingency for Electronic Remittance Advice (ERA) - ACTION (SE 0656)

MLN Matters Number:SE0656
Related CR Release Date: N/A
Related CR Transmittal #: N/A
Related Change Request (CR) #: N/A
Effective Date: N/A
Implementation Date: N/A

NEWS FLASH - Attention Physicians and Providers! Medicare will delay claims payments during the last 9 days of fiscal year 2006 (September 22 through September 30). For complete details, see MLN Matters article 4349 at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4349.pdf Get your Medicare news as it happens!

Provider Types Affected
Providers and physicians who bill Medicare fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), and carriers, including durable medical equipment regional carriers (DMERCs)

Background
The purpose of this Special Edition article is to clarify for providers the information issued by the Centers for Medicare & Medicaid (CMS) regarding the date to end the contingency plan for ERAs.

Key Points
Effective October 1, 2006, Medicare will only generate Health Insurance Portability and Accountability Act (HIPAA) compliant remittance advice - transaction 835 version 004010A1 - to all electronic remittance advice receivers. In addition, CMS issued instructions in Change Request (CR) 5047 that required a one-time hold of Medicare payments for the period of September 22, 2006, to September 30, 2006, for claims that would have been paid during the last 9 business days of fiscal year 2006. (See the *MLN Matters* article on CR5047 at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5047.pdf** on the CMS web site.)

End of Contingency for Electronic Remittance Advice (ERA) - ACTION (SE 0656 (Continued)

CMS has further instructed that on or after October 1, 2006:
- Any ERA for claims that would be held per CR5047 or for any other reason shall be created in the HIPAA compliant format.
- Any duplicate remittance advice per provider request shall be created in the HIPAA compliant, if electronic, or paper format.

Current figures indicate that 99% of all ERA receivers (providers and other entities that receive the ERA on behalf of providers) are receiving a HIPAA compliant ERA format and they are unaffected by the end of the contingency plan. The remaining **1% of legacy ERA receivers need to transition to a HIPAA compliant ERA format** between now and October 1, 2006. The following are the **options available** to you as a legacy ERA receiver:
- Start receiving HIPAA compliant ERAs beginning on October 1, 2006.
- Request to switch to Standard Paper Remittance (SPR) advice.
  - If you are already receiving an SPR, and do not want to receive the HIPAA compliant ERA, notify your Medicare FI, DMERC, RHHI, or carrier to stop sending any ERA.
  - If providers are not currently receiving SPR, and do not wish to switch to HIPAA compliant ERA, notify your Medicare FI, DMERC, RHHI, or carrier that you would like to start receiving SPR and not receive any ERA.

There are tools available to providers to view and print the remittance advice information using free Medicare software (PC Print for institutional providers and Medicare Remit Easy Print (MREP) for professional providers and suppliers). These free software packages are 835 version 004010A1 compatible and will not work with any legacy ERA. Both software packages have important advantages over the SPR. Both packages can also be used to generate a hard copy remittance to be sent for secondary/tertiary billing, and for accounts receivable reconciliation. See the additional information section of this article for MREP details.

Additional Information
To learn about more MREP benefits, download the brochure available at **http://www.cms.hhs.gov/MLNProducts/downloads/remit_easy_print.pdf** on the CMS web site.

Or, you can view Special Edition MLN Matters article SE0611 at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0611.pdf** or a related MLN Matters article (MM4376) at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4376.pdf** on the CMS web site.

For more information about the MREP software and how to receive the HIPAA 835, please contact your FI, RHHI, carrier/DMERC. Medicare Part B Electronic Data Interchange (EDI) helpline phone numbers are available at **http://www.cms.hhs.gov/ElectronicBillingEDITrans/Downloads/MedicarePartBEDIHelpline.pdf** on the CMS web site. Those billing for Part A services can find the appropriate toll free number at **http://www.cms.hhs.gov/ElectronicBillingEDITrans/Downloads/MedicarePartAEDIHelpline.pdf** on the CMS web site.

HPTC - Update to the Healthcare Provider Taxonomy Codes (HPTC) Version 5.1 (CR4072)

Related Change Request (CR) #:4072
Related CR Release Date: September 30, 2005
Effective Date: October 30, 2005
Medlearn Matters Number: MM4072
Related CR Transmittal #: 694
Implementation Date: October 30, 2005

Provider Types Affected
Physicians, suppliers, and providers billing Medicare carriers, including Durable Medical Equipment Regional Carriers (DMERCs)

Provider Action Needed
Impact to You
This article is based on Change Request (CR) 4072, which includes details regarding the Version 5.1 HPTC update.

What You Need to Know
CR4072 advises your carrier and/or DMERC to obtain the Healthcare Provider Taxonomy Code list Version 5.1 and use it to update their internal HPTC tables to process your claim(s) correctly.

What You Need to Know
Please see the *Background* section of this article for further details regarding this update.

HPTC - Update to the Healthcare Provider Taxonomy Codes (HPTC) Version 5.1 (CR4072) (Continued)

Background
The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that submitted data, which is part of a named code set, be valid data from that code set. Claims with invalid data are noncompliant. Because healthcare provider taxonomy is a named code set in the American National Standards Institute (ANSI) X12N 837 Professional Implementation Guide, Medicare carriers, including DMERCs, must validate the inbound taxonomy codes against their internal HPTC tables.

The HPTC is an external non-medical data code set designed for use in classifying healthcare providers in an electronic environment according to provider type, or practitioner specialty. HPTCs are scheduled to be updated twice per year (April and October).

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

- Free Adobe PDF download; and
- Available for purchase, an electronic representation of the list, which will facilitate the automatic loading of the code set.

CR4072 advises your carrier and/or DMERC to use the most cost effective means to obtain the Version 5.1 HPTC list and update their HPTC tables as necessary.

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

Additional Information
To summarize the changes in Version 5.1, the following taxonomy codes are added:
- 170300000X
- 171000000X
- 1710I1002X
- 1710I1003X

For complete details, please see the official instruction issued to your carrier/DMERC regarding this change at **http://www.cms.hhs.gov/transmittals/** on the CMS web site. From that web page, look for CR 4072 in the CR NUM column on the right, and click on the file for that CR.

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

Medicare Remit Easy Print (MREP) Update (CR 5032)

MLN Matters Number: MM5032
Related CR Release Date: April 28, 2006
Related CR Transmittal #: R927CP
Related Change Request (CR) #: 5032
Effective Date: October 1, 2006
Implementation Date: October 2, 2006

Provider Types Affected
Physicians, suppliers, and providers billing Medicare carriers, including durable medical equipment regional carriers (DMERCs), for services provided to Medicare beneficiaries.

Provider Action Needed
Impact to You
This article is based on Change Request (CR) 5032 which advises providers to use Medicare Remit Easy Print (MREP) software to read and print the Health Insurance Portability and Accountability Act (HIPAA) compliant electronic remittance advice (RA) for accounts reconciliation and crossover claims submission to secondary/tertiary payers.

What You Need to Know
CR5032 also includes instructions for Medicare's system maintainer (VIPS) to update MREP software with additional functionalities, and directs carriers and DMERCs to test and communicate to the end users about the software update.

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

Medicare Remit Easy Print (MREP) Update (CR 5032) (Continued)

Background
The Centers for Medicare & Medicaid Services (CMS) developed Medicare Remit Easy Print (MREP) software as a tool providers can use to read and print an electronic remittance advice (RA) in a human readable format. The format is based on the current Standard Paper Remittance (SPR) format. Providers who use the MREP software package can:

- Print paper documentation that can be used to reconcile accounts receivable; and
- Create document(s) that can be included with claim submissions to Coordination of Benefits (COB) payers.

The MREP software became available on October 11, 2005, to providers (Part B and DMERC) through their respective Medicare carrier/DMERC, and it was updated this year in April and July.

CR5032 further encourages providers to use the MREP software to read and print the Health Insurance Portability and Accountability Act (HIPAA) compliant electronic RA for accounts reconciliation and crossover claims submissions to secondary/tertiary payers.

CMS created a process to receive suggestions from providers, Medicare Contractors, and CMS staff in order to continuously improve and enhance MREP's functionality and effectiveness. A summary listing of the improvements to be implemented in the October 2006, update of MREP is included in the *Additional Information* section of this article.

Note: This update to MREP software includes suggestions for improvements received before the cut off date of March 15, 2006.

Beginning June 1, 2006, Medicare contractors and DMERCs (and later DMACs) will start suppressing the issuance of standard paper remittance advices (SPRs) to providers/suppliers, billing agents, clearing houses, or other entities representing providers, who also have been receiving electronic remittance advice (ERA) transactions for 45 days or more. MREP is an option for providers to print their own remittances at their own computer.

After the October 2006 update, annual updates of MREP will be provided every October unless a critical error affecting production needs to be corrected. The software will also be updated three times a year to implement the Claim Adjustment Reason and Remittance Advice Remark code changes.

See Special Edition MLN Matters article at http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0627.pdf on the CMS web site for options for providers affected by this change.

Implementation
The implementation date for CR5032 is October 2, 2006. Your carrier/DMERC will post a notice to their web site on or after October 2, 2006, to alert you that the new version of the MREP software is available for download and that the software includes the latest version of the Claim Adjustment Reason Codes and Remittance Advice Remark Codes.

Additional Information
For complete details, please see the official instruction issued to your carrier/DMERC regarding this change. That instruction may be viewed at **http://www.cms.hhs.gov/Transmittals/downloads/R927CP.pdf** on the CMS web site.

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

List of Improvements to be Implemented in October 2006

Synopsis of Change
A provider would like to have the Provider ID added after the Payee Name. This way, when they have multiple providers and provider locations, they can sort them easier. The Provider ID will be displayed after the Payee Name on the MREP Main Page.
New report/listing of accounts NOT FORWARDED to supplemental or crossovers.
A new report is added to show "Late Filing."
A new report will be created showing only those items with coinsurance.
Print reason/remark codes on same page as Remittance; or, can there be a check box that will either print the codes or not? The MREP software is being changed to include a check box to allow the user to have the remit print with or without the reason/remark codes.
The program should automatically import the 835 file. CMS is looking into this possibility or identifying and displaying the 835 file and path.
Searchable "Help" menu and Index. The analysis is underway to determine the appropriate level of a help facility.

Suppression of Standard Paper Remittance Advice (JSM 06586)

If you applied for a waiver allowing for the receipt of both the electronic remittance advice (ERA) and standard paper remittance advice (SPR), please note that this waiver extension ends on October 1, 2006. For more information, please refer to MLN Matters article SE0627 (**http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0627.pdf**) on the CMS website.

Please be sure that you have the most updated version of the IVR Guide in you office

http://www.medicarenhic.com/dme/contacts/dmeivrguide_0706.pdf

Eligibility - Rules Governing Provider/Clearinghouse Protection of Medicare Beneficiary Eligibility Information (CR 5138)

MLN Matters Number: MM5138
Related CR Release Date: June 23, 2006
Related CR Transmittal #: R991CP

Related Change Request (CR) #: 5138
Effective Date: July 24, 2006
Implementation Date: July 24, 2006

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

Provider Types Affected
Physicians, providers, suppliers, and clearinghouses who bill Medicare fiscal intermediaries (FIs), carriers, regional home health intermediaries (RHHIs), and durable medical equipment regional carriers (DMERCs), and who use the HIPAA 270/271 beneficiary eligibility transaction data in a real-time environment via the Centers for Medicare & Medicaid Services (CMS) AT&T communication Extranet

Background
CMS is committed to maintaining the integrity and security of health care data in accordance with applicable laws and regulations. Disclosure of Medicare beneficiary eligibility data is restricted under the provisions of the Privacy Act of 1974 and the Health Insurance Portability and Accountability Act of 1996 (HIPAA.)

This article is a reminder to physicians/providers/suppliers of the importance of protecting Medicare beneficiary information and to use it only for authorized purposes. Be sure all your representatives and employees who have authorized access to this information are aware of the importance of protecting that information as well.

Key Points of CR5138
Change Request (CR) 5138 reiterates the responsibilities of users in obtaining, disseminating, and using beneficiary's Medicare eligibility data. The following key points outline those responsibilities:

EDI Enrollment
The Medicare electronic data interchange (EDI) enrollment process must be executed by each physician/provider/supplier that submits/receives EDI either directly to or from Medicare or through a third party, such as a clearinghouse.

Each physician/provider/supplier that uses EDI, either directly or through a billing agent or clearinghouse to exchange EDI transactions with Medicare, must sign the EDI Enrollment Form and submit it to the carrier, DMERC, or FI with whom EDI transactions will be exchanged before any transaction is conducted.

Physicians/providers/suppliers should remember that they agreed to use sufficient security procedures (including compliance with all provisions of the HIPAA security regulations) to ensure that all transmissions of information are authorized and all beneficiary-specific data is protected from improper access. Acting on behalf of the beneficiary, physicians/providers/suppliers/users of Medicare data are expected to use and disclose protected health information according to the CMS regulations. The HIPAA Privacy Rule mandates the protection and privacy of all health information.

Authenticating Data Elements for HIPAA 270/271 Eligibility Data
Authenticating data elements for HIPAA 270/271 Eligibility Data must be provided by the inquirer (physician, provider, supplier, or other authorized third party) prior to the release of any beneficiary-specific eligibility information and must include:
- Beneficiary last name (must match the name on the Medicare card);
- Beneficiary first name or first initial (must match the information on the Medicare card);
- Assigned Medicare Claim Number (also referred to as the Health Insurance Claim Number (HICN) including both alpha and numerical characters; and
- Date of birth.

Medicare Beneficiary as First Source of Health Insurance Eligibility Information
The Medicare beneficiary should be your first source of health insurance eligibility information. When scheduling a medical appointment for a Medicare beneficiary, remind them to bring, on the day of their appointment, all health insurance cards showing their health insurance coverage. This will not only help you determine who to bill for services rendered, but also provide you with the proper spelling of the beneficiary's first and last name and identify their Medicare Claim Number as reflected on the Medicare Health Insurance card. It is important to use the name as shown on the Medicare card.

If the beneficiary has Medicare coverage but does not have a Medicare Health Insurance card, encourage them to contact the Social Security Administration at 1-800-772-1213 to obtain a replacement Medicare Health Insurance card. Those beneficiaries receiving benefits from the Railroad Retirement Board (RRB) can call 1-800-808-0772 to request a replacement Medicare Health Insurance card from RRB.

Eligibility - Rules Governing Provider/Clearinghouse Protection of Medicare Beneficiary Eligibility Information (CR 5138) (Continued)

Authorized Purposes for Requesting Medicare Beneficiary Eligibility Information
In conjunction with the intent to provide health care services to a Medicare beneficiary, authorized purposes include the following:

- Verify eligibility for Part A or Part B of Medicare;
- Determine beneficiary payment responsibility with regard to deductible/co-insurance;
- Determine eligibility for services such as preventive services;
- Determine if Medicare is the primary or secondary payer;
- Determine if the beneficiary is in the original Medicare plan or a Part C plan (Medicare Advantage); and
- Determine proper billing.

Medicare eligibility data is only to be used for the business of Medicare; such as preparing an accurate Medicare claim or determining eligibility for specific services.

In order to obtain access to eligibility data, as a physician/provider/supplier you will be responsible for the following:

- Before you request Medicare beneficiary eligibility information and at all times thereafter, you will ensure sufficient security measures to associate a particular transaction with the particular employee.
- You will cooperate with CMS or its agents in the event that CMS has a security concern with respect to any eligibility inquiry.
- You will promptly inform CMS or one of CMS's contractors (your carrier/DMERC/RHHI/FI) in the event you identify misuse of "individuallyidentifiable" health information accessed from the CMS database.
- Each eligibility inquiry will be limited to requests for Medicare beneficiary eligibility data with respect to a patient currently being treated or served by you, or who has contacted you about treatment or service, or for whom you have received a referral from a health care provider that has treated or served that patient.

Note: Medicare health benefit beneficiary eligibility inquiries are monitored. Providers identified as demonstrating aberrant behavior (e.g., high inquiry error rate or high ratio of eligibility inquires to claims submitted) may be contacted to verify proper use of the system, made aware of educational opportunities, or when appropriate referred for investigation of possible fraud and abuse or violation of HIPAA privacy law.

Criminal Penalties' Provisions

Remember that a number of statutes provide for severe criminal and civil penalties for misuse of information, including:

1. **Tading Partner Agreement Violation**
   42 U.S.C. 1320d-6 authorizes criminal penalties against a person who, "knowingly and in violation of this part ... (2) obtains individually identifiable health information relating to an individual; or (3) discloses individually identifiable health information to another person."

   Offenders shall "(1) be fined not more than $50,000, imprisoned not more than 1 year, or both; (2) if the offense is committed under false pretenses, be fined not more than $100,000, imprisoned not more than 5 years, or both; and (3) if the offense is committed with intent to sell, transfer, or use individually identifiable health information for commercial advantage, personal gain, or malicious harm, be fined not more than $250,000, imprisoned not more than 10 years, or both."

2. **False Claim Act**
   Under the False Claims Act, **31 U.S.C. §§ 3729-3733**, those who knowingly submit, or cause another person or entity to submit, false claims for payment of government funds are liable for three times the government's damages plus civil penalties of $5,500 to $11,000 per false claim.

3. **Health Insurance Portability and Accountability Act of 1996 (HIPAA)**
   HHS may impose civil money penalties on a covered entity of $100 per failure to comply with a Privacy Rule requirement. That penalty may not exceed $25,000 per year for multiple violations of the identical Privacy Rule requirement in a calendar year...A person who knowingly obtains or discloses individually identifiable health information in violation of HIPAA faces a fine of $50,000 and up to one-year imprisonment. The criminal penalties increase to $100,000 and up to five years imprisonment if the wrongful conduct involves false pretenses, and to $250,000 and up to ten years imprisonment if the wrongful conduct involves the intent to sell, transfer, or use individually identifiable health information for commercial advantage, personal gain, or malicious harm. Criminal sanctions will be enforced by the Department of Justice.

Implementation
The implementation date for this instruction is July 24, 2006.

Additional Information
CR5138, the official instructions issued to your Medicare FI, carrier, RHHI, and DMERC regarding this change, can be found at **http://www.cms.hhs.gov/Transmittals/downloads/R991CP.pdf** on the CMS web site. The revised section Chapter 31-ANSI X12N Formats Other than Claims or Remittance of the Medicare Claims Processing Manual is attached to CR5138.

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

NPI - Information for Providers - Announcement of a Dedicated National Provider Identifier (NPI) Web Page with HIPAA Information (JSMTDL 06536)

The Centers for Medicare and Medicaid Services (CMS) has established a dedicated National Provider Identifier webpage that houses all NPI outreach information that CMS has prepared, as well as links to other NPI-related documents of interest to health care providers. The page also has information that is explicitly for use by Medicare enrolled providers so that Medicare's implementation information and expectations are available to enrolled providers
(**http://www.cms.hhs.gov/NationalProvIdentStand**)

CMS posted a document entitled, **"MEDICARE EXPECTATIONS ON DETERMINATION OF SUBPARTS BY MEDICARE ORGANIZATION HEALTH CARE PROVIDERS WHO ARE COVERED ENTITIES UNDER HIPAA"** on the NPI webpage at (**http://www.cms.hhs.gov/NationalProvIdentStand/Downloads/Medsubparts01252006.pdf**). This document addresses Medicare organization health care providers (Entity Type 2) who must determine if they have subparts that need to be uniquely identified in standard transactions (e.g., electronic claims transactions) with Medicare. This document **does not** address health care providers who are enrolled in Medicare as individual practitioners (such as physicians, physician assistants, nurse practitioners, and others, including health care providers who are sole proprietors). In terms of NPI assignment, an Individual is an Entity Type 1 (Individual) and is eligible for a single NPI.

Remittance Advice - Ending the HIPAA Contingency for Remittance Advice (SE 0646)

MLN Matters Number: SE0646
Related CR Release Date: N/A
Related CR Transmittal #:
Related Change Request (CR) #: N/A
Effective Date: N/A
Implementation Date: N/A

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

Provider Types Affected
All providers and suppliers who bill Medicare contractors (carriers, including durable medical equipment regional carriers (DMERCs), DME Medicare Administrative Contractors (DME MACs), and fiscal intermediaries (FIs), including regional home health intermediaries (RHHIs))

What You Need to Know
Effective October 1, 2006, Medicare will send only HIPAA-compliant Electronic Remittance Advice (ERA) transactions (transaction 835 version 004010A1) to all electronic remittance advice receivers.

Background
In 2003, the Centers for Medicare & Medicaid Services (CMS) addressed compliance with the HIPAA transaction and code sets, and encouraged health plans (such as Medicare) to:

- Intensify their efforts toward compliance;
- Assess the readiness of their provider communities; and
- Determine the need to implement contingency plans to maintain the flow of payments while continuing toward compliance.

Consistent with that guidance, Medicare has aggressively worked with providers to achieve HIPAA compliance. Effective October 16, 2003, in order to ensure the continuation of normal program operations, CMS implemented a contingency plan through which Medicare continued to accept and send both HIPAA-compliant and non-HIPAA transactions from/to trading partners.

CMS ended the contingency plan that addressed **inbound** claims on October 1, 2005, and at that time began denying non-compliant electronic claims.

Now, CMS is moving to end the contingency plan for Electronic Remittance Advice (ERA) transactions. Currently, 99% of all Electronic Remittance Advice (ERA) receivers (providers, clearinghouses, billing agencies, and others who receive ERAs on behalf of providers) are receiving the HIPAA compliant ERA.

Further, the overall compliance rate for all Medicare providers in May, 2006, was 96%. (The rate for professional providers was 97% and for institutional providers was 93%.)

Therefore, CMS announces that, effective October 1, 2006, it will end the contingency plan for the remittance advice transaction.

Remittance Advice - Ending the HIPAA Contingency for Remittance Advice (SE 0646) (Continued)

After that date, your carriers, FIs, DMERCs, DME MACs, and RHHIs will send only HIPAA-compliant remittance advice (transaction 835) to all electronic remittance advice receivers. In doing so, Medicare will stop sending electronic remittance advice in any version other than the standard HIPAA version (835 version 004010A1), or in any other format (e.g., NSF).

Additional Information

You can find more information about HIPAA at **http://www.cms.hhs.gov/HIPAAGenInfo/** on the CMS web site.

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

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

CMS Mailing Lists Fact Sheet (JSM06504)

Do you want up-to-date information from CMS? Then you should review the CMS Mailing Lists Fact Sheet available from the MLN Matters website. The fact sheet can be obtained by downloading it from the following url: **http://www.cms.hhs.gov/MLNProducts/downloads/MailingLists_FactSheet.pdf**.

Hardcopies can also be ordered by going to the MLN Products Ordering Page at: **http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5** and then click on the first item under 'Informational Resource s'. NHIC, Corp. encourages providers to distribute the mailing lists at all association meetings and events.

Disclosure Desk Reference for Provider Contact Centers (CR 5089)

MLN Matters Number: MM5089
Related CR Release Date: July 21, 2006
Related CR Transmittal #: R16COM
Related Change Request (CR) #: 5089
Effective Date: October 1, 2006
Implementation Date: October 2, 2006

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

Provider Types Affected
All physicians, providers, and suppliers billing Medicare

Provider Action Needed
Impact to You
When you call or write a Medicare fee-for-service provider contact center (PCC) to request beneficiary protected health information, the PCC staff, in order to comply with the requirements of the Privacy Act of 1974 and the Health Insurance Portability and Accountability Act, will authenticate your identity prior to disclosure.

What You Need to Know
CR5089 revises *Medicare Contractor Beneficiary and Provider Communications Manual*, Chapter 3, Section 30, and Chapter 6, Section 80, to update the guidance to PCCs for authenticating providers who call or write to request beneficiary protected health information, and to clarify the information they may disclose after authentication.

What You Need to Do
Be prepared to supply the required authentication information when contacting a PCC to request protected health information.

Background
In order to protect the privacy of Medicare beneficiaries and to comply with the requirements of the Privacy Act of 1974 and the Health Insurance Portability and Accountability Act, customer service staff at Medicare PCCs must first authenticate the identity of providers/staff that call or write to request beneficiary protected health information before disclosing it to the requestor.

CR5089, from which this article is taken, completely revises Section 30 in Chapter 3 and Section 80 in Chapter 6 of the *Medicare Contractor Beneficiary and Provider Communications Manual* (Publication 100-9). It updates the PCC Disclosure Desk Reference, the main purpose of which is to protect the privacy of Medicare beneficiaries by ensuring that protected health information is disclosed to providers only when appropriate, to include:

- Guidance for authenticating providers who call or write to request beneficiary protected health information; and
- Clarification of the information that may be disclosed after authentication of writers and callers.

Please note that while new subsections have been added to each chapter/section, this reflects reformatting and revision of existing information rather than new requirements.

Below is the authentication guidance that the PCCs will be using:

Telephone Inquiries
Provider Authentication

CSR Telephone Inquiries - Through May 22, 2007, Customer Service Representatives (CSR) will authenticate providers using provider number and provider name.

Interactive Voice Response (IVR) Telephone Inquiries - Through May 22, 2007, IVRs will authenticate providers using only the provider number.

Note: See "Final Note" below to learn more about provider authentication after May 22, 2007

Disclosure Desk Reference for Provider Contact Centers (CR 5089) (Continued)

Written Inquiries
Provider Authentication

Through May 22, 2007, for written inquiries, PCCs will authenticate providers using provider number and provider name.

Note: See "Final Note" below to learn more about provider authentication after May 22, 2007.

At this point, there are some specific details about provider authentication in written inquiries of which you should be aware.

There is one exception for the requirement to authenticate a written inquiry. An inquiry received on the provider's official letterhead (including e-mails with an attachment on letterhead) will meet provider authentication requirements (no provider identification number required) if the provider's name and address are included in the letterhead and clearly establish the provider's identity.

Further, if multiple addresses are on the letterhead, authentication is considered met as long as one of the addresses matches the address that Medicare has on record for that provider. Thus, make sure that your written inquiries contain all provider practice locations or use the letterhead that has the address that Medicare has on record for you.

Also, please note that requests submitted via fax on provider letterhead will be considered to be written inquiries and are subject to the same authentication requirements as those received in regular mail. However, for such fax (and also for e-mail) submissions, even if all authentication elements are present, the PCC will not fax or e-mail their responses back to you.

Rather, they will send you the requested information by regular mail, or respond to these requests by telephone. In either of these response methods, or if they elect to send you an automated e-mail reply (containing no beneficiary-specific information), they will remind you that such information cannot be disclosed electronically via email or fax and that, in the future, you should send a written inquiry through regular mail or use the IVR for beneficiary-specific information.

And lastly, inquiries received without letterhead, including hardcopy, fax, e-mail, pre-formatted inquiry forms, or inquiries written on Remittance Advice (RAs) or Medicare Summary Notices (MSNs), will be authenticated the same as written inquiries, (explained above) using provider name and the provider number.

Insufficient or Inaccurate Requests
You should also understand that for any protected health information request in which the PCC determines that the authentication elements are insufficient or inaccurate, you will have to provide complete and accurate input before the information will be released to you.

Such requests that are submitted in written form and those on pre-formatted inquiry forms, will be returned in their entirety by regular mail, with a note stating that the requested information will be supplied upon submission of all authentication elements, and identifying which elements are missing or do not match the Medicare record.

Alternatively, if you sent the request by e-mail (containing no protected health information), the PCC may return it by e-mail, or may elect to respond by telephone to obtain the rest of the authentication elements.

Beneficiary Authentication
Regardless of the type of telephone inquiry (CSR or IVR) or written inquiry, PCCs will authenticate four beneficiary data elements before disclosing any beneficiary information:

1) Last name;
2) First name or initial;
3) Health Insurance Claim Number; and
4) Either date of birth (eligibility, next eligible date, Certificate of Medical Necessity (CMN)/Durable Medical Equipment Medicare Administrative Contractor Information Form (DIF) [pre-claim]) **or** date of service (claim status, CMN/DIF [post-claim]).

Please refer to the disclosure charts attached to CR5089 for specific guidance related to these data elements as well as details on the beneficiary information that will be made available in response to authenticated inquiries. CR5089 is available at **http://www.cms.hhs.gov/Transmittals/downloads/R16COM.pdf** on the CMS web site.

Special Instances
Below are three special instances that you should know about.

Overlapping Claims
Overlapping claims (multiple claims with the same or similar dates of service or billing period) occur when a date of service or billing period conflicts with another, indicating that one or the other may be incorrect.

Sometimes this happens when the provider is seeking to avoid have a claim be rejected, for example:

- When some End State Renal Disease (ESRD) facilities prefer to obtain the inpatient hospital benefit days for the month, prior to the ESRD monthly bill being generated, thus allowing the facility to code the claim appropriately and bill around the inpatient hospital stay/stays; or
- Skilled nursing facility and inpatient hospital stays.

Disclosure Desk Reference for Provider Contact Centers (CR 5089) (Continued)

These situations fall into the category of disclosing information needed to bill Medicare properly, and information can be released as long as all authentication elements are met.

Pending Claims
A pending claim is one that is being processed, or has been processed and is pending payment. CSRs can provide information about pending claims, including Internal Control Number (ICN), pay date/amount or denial, as long as all authentication requirements are met.

Providers should note, however, that until payment is actually made or a remittance advice is issued, the information provided could change.

Deceased Beneficiaries
Although the Privacy Act of 1974 does not apply to deceased individuals, the HIPAA Privacy Rule concerning protected health information applies to individuals, both living and deceased. Therefore, PCCs will comply with authentication requirements when responding to requests for information related to deceased beneficiaries.

Final Note: More information will be provided in a future MLN Matters article about authentication on and after May 23, 2007, the implementation date for the National Provider Identifier on NPI.

Additional Information
You can find more information about Provider Contact Center guidelines concerning authentication by going to **http://www.cms.hhs.gov/Transmittals/downloads/R16COM.pdf** on the CMS web site.

Attached to that CR, you will find the updated *Medicare Contractor Beneficiary and Provider Communications Manual* (Publication 100.09), Chapter 3 (Provider Inquiries), Section 30 (Disclosure of Information); and Chapter 6 (Provider Customer Service Program), Section 80 (Disclosure of Information).

If you have any questions, please contact your carrier, durable medical equipment (DME) regional carrier, DME Medicare Administrative Contractor (DME MAC), fiscal intermediary, or regional home health intermediary at their toll-free number, which may be found at **http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip** on the CMS web site.

Drugs - Medicare Part B versus Part D Drug Coverage Determinations (SE 0652)

MLN Matters Number: SE0652
Related CR Release Date: N/A
Related CR Transmittal #: N/A
Related Change Request (CR) #: N/A
Effective Date: N/A
Implementation Date: N/A

NEWS FLASH - Attention Physicians and Providers! Medicare will delay claims payments during the last 9 days of fiscal year 2006 (September 22 through September 30). For complete details, see MLN Matters article MM4349 at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4349.pdf Get your Medicare news as it happens!

Provider Types Affected
Physicians, pharmacists, providers, health care professionals, suppliers, and their staff

Impact on Providers
This Special Edition article is being provided by the Centers for Medicare & Medicaid Services (CMS) to assist physicians, providers, other prescribers, and pharmacists to understand the CMS' recommended approach to simplifying and expediting the coverage determination process for Medicare Part B versus Part D.

Affected physicians, pharmacists, providers, and their staff may also wish to review *MLN Matters* article number SE0570, which provides a good summary of Medicare's drug coverage under Parts A, B, and D of Medicare. That article is available at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0570.pdf** on the CMS web site.

Background
Part B - Medical Insurance
Medicare Part B covers drugs that are:
- Not usually self-administered; and
- Furnished and administered as part of a physician service.

Drugs - Medicare Part B versus Part D Drug Coverage Determinations (SE 0652 (Continued)

Medicare Part B covers other selected drugs, such as the following:

- Drugs requiring administration via a piece of covered durable medical equipment (DME), such as a nebulizer or infusion pump in the home (because the law specifies "in the home" this coverage is generally not available in nursing facilities);
- Immunosuppressive drugs for people who had a Medicare covered transplant;
- Hemophilia clotting factors;
- Antigens;
- Intravenous immune globulin provided in the home;
- Certain oral anti-cancer and oral anti-emetic drugs;
- Erythropoietin for people with end stage renal disease (ESRD);
- Certain vaccines [Influenza, Pneumococcal, and (for intermediate- to high-risk individuals) Hepatitis B]; and
- Parenteral nutrition for people with a permanent dysfunction of their digestive tract.

Regional differences in Part B drug coverage policies can occur in the absence of a national coverage decision. For more information on local coverage determinations, go to **http://www.cms.hhs.gov/coverage** on the CMS web site.

Part D - Prescription Drug Insurance

Part D-covered drugs are defined as:

- Drugs available only by prescription, approved by the FDA, and used for a medically accepted indication which are not covered under part B (or Part A)

Certain drugs or classes of drugs (or their medical uses) are excluded by law from Part D coverage. These exclusions include the following:

- Benzodiazepines;
- Barbiturates;
- Drugs for anorexia, weight loss, or weight gain;
- Drugs used to promote fertility;
- Drugs used for cosmetic purposes or for hair growth;
- Drugs used for symptomatic relief of cough and colds;
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparation products;
- Non-prescription drugs; and
- Drugs for which the manufacturer seeks to require as a condition of purchase that associated tests and monitoring services be purchased exclusively from the manufacturer or its designee.
- Drugs for the treatment of sexual or erectile dysfunction (beginning in 2007 for Medicare Part D beneficiaries)

For more detailed information about Part B drugs and Part D coverage, please refer MLN Matters article SE0570 or to the detailed report at **http://www.cms.hhs.gov/PrescriptionDrugCovContra/Downloads/BvsDCoverage_07.27.05.pdf** on the CMS web site. This report provides excellent detail on the overall issue of Part B and Part D drugs.

Recommended Process to Expedite Part B versus Part D Coverage Determinations

Plans may rely on physician information included with the prescription, such as diagnosis information (e.g., to determine if the prescription is related to a Medicare covered transplant) or location of administration (e.g., to determine if the prescription is being dispensed for a beneficiary in a nursing home) to the same extent they rely on similar information acquired through documentation from physicians on prior authorization forms. Assuming the indication on the script is sufficient to make the coverage determination, there is no need in such cases to require additional information to be obtained from the physician.

To the extent that the plan requires their contracted pharmacies to report the information provided on the prescription to assist in the determination of Part B versus Part D coverage, the plan may rely on the pharmacist's report of appropriate information to make the coverage determination under Part D. For example, for cases in which prednisone is prescribed for a condition other than immunosuppression secondary to a Medicare-covered transplant, and this is indicated on the prescription, a plan may authorize the pharmacy to dispense the drug under Part D without seeking further information from the prescribing physician.

PDPs are prohibited from paying for drugs that are covered under Part B. Certain drugs such as prednisone are covered under Part B when they are used to prevent organ rejection for a patient who has had a Medicare covered transplant. When a plan gets a prescription for prednisone, they must have a process by which they can verify that the prednisone is being used for a disease which would not trigger Part B coverage. Initially the plans instituted cumbersome prior authorizations procedures which required that the prescriber fill out a prior authorization form and send the form to the plan. In order to simplify the process CMS has instructed the plans that if a prescription is written for a B/D drug and the prescription has written on it the words "Part D" and a part D diagnosis such as "contact dermatitis" the prescription should be filled.

CMS is not requiring physicians to fill out prescriptions in the manner described below; instead, it is suggested as a way to save time and bypass what may be a burdensome process of completing a prior authorization form and faxing it back.

Drugs - Medicare Part B versus Part D Drug Coverage Determinations (SE 0652 (Continued)

For example, prednisone used for immunosuppression following Medicare covered transplants or methotrexate used for cancer would be Part B drugs for these diagnoses, but they would be *Part D* drugs if they were used to treat rheumatoid arthritis.

Using the CMS guidance outlined above, if prednisone is prescribed for rheumatoid arthritis:
- The Diagnosis is "Rheumatoid Arthritis;"
- The Statement of Status is "for Part D."

The information recommended by CMS for inclusion on the written prescription for prednisone prescribed for Rheumatoid Arthritis is *"Rheumatoid Arthritis for Part D*.

Note: This clarification should not be construed to indicate that a Part D plan may not impose prior authorization or other procedures to ensure appropriate coverage under the Medicare drug benefit.

The Part D Plan is ultimately responsible for making the Part D coverage determination. However, CMS believes that the Part D plan will have met appropriate due diligence standards without further contacting a physician if:
- Necessary and sufficient information is provided on the prescription; and
- The contracted pharmacy is able to communicate this information to the plan in order to make the coverage determination.

CMS is preparing additional guidance to assist plans, pharmacies, and physicians in operationalizing these Part B versus Part D coverage determinations.

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 the following CMS web sites:
http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0570.pdf
http://www.cms.hhs.gov/PrescriptionDrugCovContra/downloads/DueDiligenceQA_03.24.06.pdf
http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/Downloads/PartBandPartDdoc_07.27.05.pdf

Enrollment - Announcing the Release of the Revised CMS-855 Medicare Enrollment Applications (SE0632)

MLN Matters Number: SE0632
Related CR Release Date: N/A
Related CR Transmittal #: N/A
Related Change Request (CR) #: N/A
Effective Date: N/A
Implementation Date: N/A

Provider Types Affected
All Medicare physicians, providers, and suppliers

Background
On **May 1, 2006**, the Centers for Medicare & Medicaid Services (CMS) issued the revised CMS-855 Medicare enrollment applications. **Providers and suppliers should begin to use the new Medicare enrollment applications immediately**. Initially, these applications will be available only from the CMS provider enrollment web site. The link for that CMS web site is listed in the *Additional Information* section of this article.

Over the last year, CMS has received numerous comments and suggestions regarding the proposed revisions to the Medicare enrollment applications. CMS reviewed the comments and adopted many of the suggested revisions. Also, CMS incorporated a number of enhancements and changes (see *Key Points* below) to clarify the enrollment process and to reduce the burden imposed on the provider and supplier communities.

Key Points
This Special Edition outlines the significant revisions to the Medicare enrollment applications and they are as follows:

Enhancements
- Improved the application's aesthetics via a more visually appealing format, larger font, clarified headings, and the use of plain language;

Enrollment - Announcing the Release of the Revised CMS-855 Medicare Enrollment Applications (SE0632) (Continued)

- Revised cover page to include instructions that help applicants submit the correct enrollment application, inform applicants where to mail the application, and provide information on the documents that must be furnished with the enrollment application;
- Added tips on how to avoid delays in the enrollment process; and
- Redesigned Section 17 (Supporting Documentation) to make it easier for providers and suppliers to know which documents must be submitted with an enrollment application.

Significant Changes
- Require the submission of the National Provider Identifier (NPI) and a copy of the NPI notification furnished by the National Plan and Provider Enumeration System with each enrollment application;
- Require that providers and suppliers complete the Authorization Agreement for Electronic Funds Transfer (CMS-588) when initially enrolling or - if they are currently not receiving payments via EFT - making a change to their enrollment information; and,
- Removed Sections 9 (Electronic Claims Submission Information), 10 (Staffing Companies), and 11 (Surety Bonds) from the application. In addition, information regarding overpayments no longer must be submitted.

Application-Specific Changes for Physicians and Non-Physician Practitioners (CMS-855I)
- A sole proprietor who incorporates (and who is the sole owner of that business) only needs to complete the CMS 855I form. In the past, such suppliers had to complete the CMS 855B, CMS 855I and CMS 855R. However, the person will still need to report information about the practice, such as the legal business name and adverse legal history.

Application-Specific Changes for Clinics/Group Practices and Certain Other Suppliers (CMS-855B)
- Removed the requirement to collect crew member and certain vehicle information from ambulance companies **in Attachment 1 of the application**.
- Revised the Independent Diagnostic Testing Facility information contained in Attachment 2 of the application.

Application-Specific Changes for Institutional Providers (CMS-855A)
- Eliminated questions dealing with fiscal intermediary preferences. This change implements section 911(d) (2) (B) of the Medicare Modernization Act. See MLN Matters article SE0582 at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0582.pdf** for further information.

Additional Information
For additional information regarding the Medicare enrollment process, including the mailing address and telephone number for the carrier or FI serving your area, visit **http://www.cms.hhs.gov/MedicareProviderSupEnroll** on the CMS web site.

Special Edition article SE0612 contains helpful information about the Medicare enrollment process. You may review the article on the CMS web site at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0612.pdf** on the CMS site.

Enrollment - Facilitating Your Medicare Enrollment (SE 0634)

MLN Matters Number: SE0634
Related CR Release Date: N/A
Related CR Transmittal #: N/A
Related Change Request (CR) #: N/A
Effective Date: N/A
Implementation Date: N/A

Provider Types Affected
All Medicare physicians, providers, and suppliers

Background
On May 1, 2006, the Centers for Medicare & Medicaid Services (CMS) issued the revised CMS-855 Medicare enrollment applications. **Providers and suppliers should begin to use the new Medicare enrollment applications immediately.** Initially, these applications will be available only from the CMS provider enrollment web site. The link for that CMS web site is listed in the *Additional Information* section of this article.

Key Points
This Special Edition provides additional information regarding the submission of a Medicare enrollment application.

All Provider Enrollment Applications
To ensure timely processing of your application, make certain to completely fill out the application and provide all required supporting documentation at the time of filing.

Enrollment - Facilitating Your Medicare Enrollment (SE 0634) (Continued)

Section 17 of the Medicare enrollment application lists the types of supporting documentation that you will need to submit with your enrollment application. In addition to providing the documentation previously required, all applicants are required to:

- Submit their National Provider Identifier (NPI) and a copy of the NPI notification furnished by the National Plan and Provider Enumeration System with each enrollment application; and
- Complete the Authorization Agreement for Electronic Funds Transfer (CMS588) when initially enrolling or - if they are currently not receiving payments via EFT - making a change to their enrollment information.

To obtain a list of specific supporting documentation that you must submit with your enrollment application, contact the designated Medicare fee-for-service contractor serving your area before submitting your application.

Contractor Request for Additional Information
At any time during the enrollment process, your carrier or FI may request documentation to support or validate information that you have reported on your application. Applicants are responsible for providing this documentation in a timely manner. Failure to provide documentation in a timely manner may delay your enrollment into the Medicare program.

Applications Received Through June 2, 2006
Medicare contractors will continue to accept the 11/2001 version of the Medicare enrollment applications through June 2, 2006, as long as the application is complete and contains the NPI notification from NPPES. In addition, providers and suppliers who choose to use the 11/2001 version of the 855 will be required to complete and submit Section 1 or Section 4 (completed by the provider) of the 04/06 version of the CMS-855. Providing this information will ensure that Medicare is able to link existing Medicare identification number(s) to the NPI that the provider or suppliers plan to use for billing purposes.

Specifically, Section 1 must be completed by Physician Assistants and providers reassigning all of their benefits, as this is where NPI data is reported. All other providers must furnish the NPI and Medicare Identification Number in Section 4 of the CMS-855; this is the only data that must be reported in Section 4.

Applications Received On or After June 5, 2006
All applications received on or after June 5, 2006, must be filed using the 04/06 version of the CMS-855 and contain all supporting documentation, including the NPI notification and the CMS-588.

Additional Information
For additional information regarding the Medicare enrollment process, including the mailing address and telephone number for the carrier or FI serving your area, visit **http://www.cms.hhs.gov/MedicareProviderSupEnroll** on the CMS web site.

Special Edition article SE0612 and SE0632 contain helpful information about the Medicare enrollment process. You may review the article on the CMS web site at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0612.pdf**, and **http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0632.pdf,** respectively, on the CMS site.

MMA - Coverage for Home Use of Oxygen Included in Clinical Trials (CR 4389)

MLN Matters Number: MM4389
Related CR Release Date: May 26, 2006
Related CR Transmittal #: R57NCD and R961CP
Related Change Request (CR) #: 4389
Effective Date: March 20, 2006
Implementation Date: October 3, 2006

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

Provider Types Affected
Providers, physicians, and suppliers who bill Medicare regional home health intermediaries (RHHIs) and/or durable medical equipment regional carriers (DMERCs) for home use of oxygen services

Key Points

- On March 20, 2006, the Centers for Medicare & Medicaid Services (CMS) announced a National Coverage Determination (NCD) covering the home use of oxygen for Medicare beneficiaries who are enrolled in a CMS approved clinical trial sponsored by the National Heart, Lung & Blood Institute (NHLBI), with arterial oxygen partial pressure measurements from 56 to 65 mmHg, or whose oxygen saturation is at or above 89%.
- Please note that this decision does not change coverage for the home use of oxygen provided outside the clinical trials currently identified in Pub. 100-03, the NCD Manual, Chapter 1, Part 4, Section 240.2, Home Use of Oxygen (Please see Additional Information section below for link to CR4389.)

MMA - Coverage for Home Use of Oxygen Included in Clinical Trials (CR 4389 (Continued)

- Your RHHI or DMERC will continue to make local determinations of reasonable and necessary services (based on existing guidance provided by CMS policy) for medically accepted home uses of oxygen that are not addressed in section 240.2, Home Use of Oxygen of the NCD manual.

Billing Guidelines

- Beginning March 20, 2006, to be paid for the home use of oxygen (in the above described situation), the patient must be participating in an approved clinical trial and this must be reflected on the Medicare claim.
- To report this on a claim to a DMERC, use **modifier "QR"** when reporting the home use of oxygen furnished during an approved clinical trial identified by CMS and sponsored by the NHLBI, for fee-for-service (FFS) beneficiaries who have arterial oxygen partial pressure measurements from 56 to 65 mmHg, or oxygen saturation at or above 89%. When modifier QR is attached to a HCPCS code, it generally means the service is part of a CMS-related clinical trial, demonstration or study.
- For claims submitted to RHHIs, use condition code 30 and ICD-9-CM diagnosis code of V70.7 in the second diagnosis code position for reporting home use of oxygen furnished during an approved clinical trial for beneficiaries (in FFS or under a Medicare Advantage (MA) plan) who have arterial oxygen partial pressure measurements from 56 to 65mmHg or oxygen saturation at or above 89%.
- Healthcare Common Procedure Coding System (HCPCS) codes recognized as clinical trial codes for home use of oxygen when the modifier "QR" (DMERC claims) or when condition code 30 and ICD-9-CM diagnosis code of V70.7 are present in the second diagnosis code (RHHI claims) include:
  - E0424, E0425, E0430, E0431, E0434, E0435, E0439, E0440, E0441, E0442, E0443, E0444, E0445, E1390, E1391, E1405, E1406, E1392, A4575, A4606, A4608, A4615, A4616, A4617, A4619, A4620, A7525, A9900, E0455, E0555, E0580, E1353, and E1355.
  - Providers and suppliers should note that any accessory codes listed above are included in the base oxygen fee and are not separately payable under the current policy.
  - Note that Medicare will apply applicable coinsurance for MA plan beneficiaries when reporting home use of oxygen furnished during an approved clinical trial.
- Additionally, you must use the Oxygen Certificate of Medical Necessity (CMN) (CMN, Form CMS-484, also known as the DMERC 484.2) for claims submitted for the approved clinical trial for the home use of oxygen. Subsequent claims will be paid based upon the initial date and status of the initial CMN.
- Clinical trial services claims under MA plans shall continue to be billed separately from non-clinical trial services.

Additional Information

Additional information about this policy can be found in the following manual sections attached to the two transmittals for CR4389.

- The NCD can be found in transmittal 57, CR4389, at **http://www.cms.hhs.gov/Transmittals/downloads/R57NCD.pdf** on the CMS web site.
- Claims processing instructions are available in Transmittal 961, CR4389, which is available at **http://www.cms.hhs.gov/Transmittals/downloads/R961CP.pdf** on the CMS site.

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

MMA - Payment for Islet Cell Transplantation in NIH-Sponsored Clinical Trials (CR5740)

MLN Matters Number: MM5140
Related CR Release Date: June 16, 2006
Related CR Transmittal #: R986CP

Related Change Request (CR) #: 5140
Effective Date: May 1, 2006
Implementation Date: July 31, 2006

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

Provider Types Affected

Physicians, suppliers, and providers billing Medicare contractors (carriers and fiscal intermediaries (FIs))

MMA - Payment for Islet Cell Transplantation in NIH-Sponsored Clinical Trials (CR5740) (Continued)

Provider Action Needed
Impact to You
The Centers for Medicare & Medicaid Services (CMS) is updating the modifier used for claims for islet cell transplantation and for routine follow-up care related to the transplantation in NIH-sponsored clinical trials.

What You Need to Know
Please note that effective for islet cell transplantation and routine follow-up services related to the islet cell transplantation on or after **May 1, 2006, the QV modifier is no longer valid. The QR modifier** (item or service provided in a Medicare-specified study) **will replace the QV modifier for services on or after May 1, 2006**

What You Need to Do
Refer to the *Background* and *Additional Information* sections of this article for more information. Be ready to use the new QR modifier for payment of islet cell transplantation and routine follow-up care when appropriate.

Background
As a result of section 733 of the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) (P.L. 108-173), for services performed/ discharges on or after October 1, 2004, Medicare covers islet cell transplantation for patients with Type I diabetes who are participating in an NIH-sponsored clinical trial. The islet cell transplantation may be done alone or in combination with kidney transplantation.

Additional Information
Effective for services on or after **May 1, 2006**, Medicare will **accept the QR modifier** for payment on claims for patients who participate in an NIH-sponsored clinical trial in conjunction with:

- Islet cell transplantation; and
- Routine follow-up care related to islet cell transplantation, when:
  - Performed in an outpatient department of a hospital; and
  - Billed on type of bill (TOB) 13X or 85X.

For additional information, please refer to MM3385, "MMA-Billing Requirements for Islet Cell Transplantation for Beneficiaries in a National Institutes of Health (NIH) Clinical Trial," which can be found at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3385.pdf** on the CMS web site. Also, refer to the *Medicare National Coverage Determinations Manual*, publication 100-03, Chapter 1, Part 4, Section 260.3.1 "Islet Cell Transplantation in the Context of a Clinical Trial (Effective October 1, 2004)," located at **http://www.cms.hhs.gov/manuals/downloads/ncd103c1_Part4.pdf** on the CMS web site.

CR5140 is the official instruction issued to your Medicare carrier or FI regarding changes mentioned in this article, and the manual attachment to CR5140, the *Medicare Claims Processing Manual*, Publication 100-4, Chapter 32, "Billing Requirements for Special Services," Section 70 "Billing Requirements for Islet Cell Transplantation for Beneficiaries in a National Institutes of Health (NIH) Clinical Trial." CR5140 may be found at **http://www.cms.hhs.gov/Transmittals/downloads/R986CP.pdf** on the CMS web site.

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

Contractor Instruction - Modifier Update for Islet Cell Transplantation in Nationa Institutes of Health (NIH) Clinical Trials (IOM Pub. 100-04, Chap. 32, Sec. 70) (CR 5140)

Medicare has covered islet cell transplantation only for patients with Type I diabetes who are participating in an NIH sponsored clinical trial since October 1, 2004. The islet cell transplant may be done alone or in combination with a kidney transplant. Islet recipients will also need immunosuppressant therapy to prevent rejection of the transplanted islet cells. Routine follow-up care will be necessary for each trial patient.

Since that date, physicians used modifier **QV** (item or service provided as routine care in a Medicare qualifying clinical trial). Effective May 1, 2006, physicians must use modifier **QR** (item or service provided in a Medicare specified study) for all claims for islet cell transplantation and routine follow-up care related to this service.

Preventive - Medicare Provides Coverage for Many Preventive Services and Screenings (SE 0630)

MLN Matters Number: SE0630
Related CR Release Date: N/A
Related CR Transmittal #: N/A

Related Change Request (CR) #: N/A
Effective Date: N/A
Implementation Date: N/A

Note: This article was revised on June 30, 2006, to remove references to the "Flu Billing" Videos, which are no longer available on the CMS web site.

Provider Types Affected
All Medicare fee-for-service physicians, providers, suppliers, and other health care professionals who provide and bill for preventive services and screenings provided to Medicare beneficiaries.

Provider Action Needed
This article serves as a reminder that we need your help to ensure that Medicare beneficiaries receive the preventive services they need. Become familiar with the preventive services and screenings covered by Medicare. Help the Centers for Medicare & Medicaid Services (CMS) spread the news about the many preventive services and screenings covered by Medicare.

Talk with your Medicare patients about preventive services and screenings and encourage use of those services, where appropriate. Order and use the educational products developed by CMS to educate your staff about these benefits. The information found in these products will also help you communicate with your patients about Medicare preventive benefits.

Introduction
Medicare provides coverage for many diseases that are preventable through immunization or amendable through early detection, treatment, and lifestyle changes. This Special Edition MLN Matters article informs health care professionals about the preventive services and screenings covered by Medicare and highlights the educational and informational products developed by CMS for health care professionals to promote awareness and increase appropriate utilization of these services.

Medicare provides coverage for the following preventive services and screenings (subject to certain eligibility and other limitations):

- Adult Immunizations
  - Influenza (Flu)
  - Pneumococcal Polysaccharide Vaccine (PPV)
  - Hepatitis B Virus (HBV)
- Bone Mass Measurements
- Cancer Screenings
  - Breast (Mammography)
  - Cervical & Vaginal (Pap Test & Pelvic Exam)
  - Colorectal
  - Prostate
- Cardiovascular Disease Screening
- Diabetes Screening, and
  - Self-Management Training
  - Medical Nutrition Therapy
  - Supplies
- Glaucoma Screening
- Initial Preventive Physical Exam (IPPE) ("Welcome to Medicare" Physical Exam)
- Smoking and Tobacco-Use Cessation Counseling Services

CMS needs your help to get the word out about the many preventive services and screenings covered by Medicare. Each of these benefits presents an opportunity for health care professionals to help Medicare beneficiaries learn if they have an increased risk of developing certain diseases.

CMS recognizes the crucial role that health care professionals play in promoting, providing, and educating Medicare patients about preventive services and screenings. As a trusted source, your recommendation is the most important factor in increasing the use of appropriate preventive services.

Talk to your Medicare patients about the benefits of preventive medicine, detecting disease earlier when outcomes are best, reducing infectious disease, and improving the quality of their lives.

Educational Products and Informational Resources for Health Care Professionals
CMS has developed a variety of educational products to:

- Help increase your awareness of Medicare's coverage of disease prevention and early detection;
- Provide you with information and tools to help you communicate with your Medicare patients about these potentially life saving benefits for which they may be eligible; and
- Give you resources to help you effectively file claims.

Print products may be ordered, free of charge, from the Medicare Learning Network (MLN). All print products are available to download and view on line and may be reprinted or redistributed as needed. Some print products are only available as a download and will be notated as such.

Product Ordering Instructions
To order a product, free of charge, click here:
Order Product: **http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5**

Preventive - Medicare Provides Coverage for Many Preventive Services and Screenings (SE 0630) (Continued)

You may click on title of the publications below to view them online in the MLN Matters article on the CMS website at: http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0630.pdf.

Brochures

The Medicare Preventive Services Brochure Series for Physicians, Providers, Suppliers, and Other Health Care Professionals - This series of tri-fold brochures provides an overview of Medicare's coverage for preventive services and screenings including the new benefits: diabetes and cardiovascular disease screenings and the initial preventive physical examination (IPPE). (See *Expanded Benefits* brochure)

- ***Adult Immunizations [PDF 279KB]***
- ***Bone Mass Measurements [PDF 269KB]***
- ***Cancer Screenings [PDF 295KB]***
- ***Expanded Benefits [PDF 255KB]***
- ***Glaucoma Screening [PDF 242KB]***
- ***Smoking and Tobacco-Use Cessation Counseling Services [PDF, 562KB]*** (available in download only at this time)

Guides

The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals [PDF 2MB] - This guide provides information on Medicare's preventive benefits including coverage, frequency, risk factors, billing and reimbursement. (May 2005; See the Errata Sheet for corrections identified since May 2005 printing.)

Determining a Medicare Beneficiary's Eligibility for Medicare Preventive Services [PDF 304KB] - This guide provides information on interpreting the Medicare beneficiary preventive services "next eligible date" data and is intended to supplement the educational materials already available for the HIQA, HIQH, HUQA, ELGA, ELGB and ELGH eligibility inquiry screens used to access Common Working File (CWF) records. (September 2005; Available in download only)

Medicare Preventive Services CD ROM

Medicare Preventive Services Resources for Physicians, Providers, Suppliers, and Other Health Care Professionals -This CD ROM contains The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals; six brochures: 1) Expanded Benefits, 2) Glaucoma Screenings, 3) Cancer Screenings,4) Bone Mass Measurements, 5) Adult Immunizations, and 6) Smoking and Tobacco-Use Cessation Counseling Services; and a Quick Reference Information: Medicare Preventive Services chart.

These resources are useful for Medicare fee-for-service physicians, providers, suppliers, and other health care professionals that bill Medicare for preventive services. (See Errata Sheets for corrections identified since May 2005 printing of these products; See product ordering instructions above.)

Quick Reference Information Chart

Quick Reference Information: Medicare Preventive Services [PDF 74KB] -This two-sided laminated chart gives a quick reference to Medicare's preventive services and screenings, identifying coding requirements, eligibility, frequency parameters, and copayment/coinsurance and deductible information for each benefit. (May 2005; See Errata Sheet for corrections identified since May 2005 printing.)

Web-Based Training Courses

Web-Based Training Modules (WBTs) - Three web-based training courses covering coding, billing, coverage and reimbursement for Medicare preventive services and screenings. (To access these WBT courses, go to the MLN Products web page at **http://www.cms.hhs.gov/MLNProducts/**, scroll to the bottom of the page to "Links Inside CMS" and click on Web-based Training Modules

Web Page

MLN Preventive Services Web Page - This Medicare Learning Network (MLN) web page, for Medicare fee-for-services health care professionals, provides links to all of the provider/supplier specific preventive services educational and informational products mentioned in this article.

Other Useful Provider Resources

Other useful provider resources include the following:

Prevention Toolkit - This online toolkit contains resources that you may find useful when talking to your patients about Medicare preventive benefits.

Immunizations Toolkit - This online toolkit contains printable resources that nursing home providers can use to help improve the influenza and pneumococcal immunization rates among their residents, staff, and volunteers.

CMS Prevention Web Pages

CMS has created individual web pages for each of the preventive services and screenings covered by Medicare. For additional information visit **http://www.cms.hhs.gov/home/medicare.asp** and scroll down to the Prevention section.

Preventive - Medicare Provides Coverage for Many Preventive Services and Screenings (SE 0630) (Continued)

Medicare Learning Network (MLN)
The Medicare Learning Network (MLN) is the brand name for official CMS educational products and information for Medicare fee-for-service providers. For additional information visit the Medicare Learning Network's web page at **http://www.cms.hhs.gov/MLNGenInfo** on the CMS website.

We encourage you to order and use these provider specific products to:
- Increase your awareness of preventive services covered by Medicare;
- Equip you to talk with your patients about Medicare-covered preventive services and encourage utilization of these potentially life saving benefits; and
- Help you file preventive services claims more effectively.

Please Note: These products have been developed for you, the health care professional. Provider-specific products are not meant for distribution to Medicare beneficiaries. See below for where to obtain beneficiary specific information.

Preventive Benefit Information for Medicare Beneficiaries
Medicare beneficiaries can obtain information about Medicare preventive benefits by going to **http://www.medicare.gov/** and clicking on "Preventive Services.: They can also call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Telephone - New Site for Medicare Provider Service Toll Free Numbers (SE 0655)

MLN Matters Number: SE0655
Related CR Release Date: N/A
Related CR Transmittal #: N/A
Related Change Request (CR) #: N/A
Effective Date: N/A
Implementation Date: N/A

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

Provider Types Affected
All Medicare physicians, providers, and suppliers

Impact on Providers
This article is mainly for informational purposes and discusses a new and more convenient web address and site that houses toll-free numbers that physicians, providers, and suppliers can use to contact their Medicare contractor (carriers, including durable medical equipment (DME) regional carriers and DME Medicare administrative contractors (DME MACs), and fiscal intermediaries, including regional home health intermediaries (RHHIs).

Background
The Centers for Medicare & Medicaid Services (CMS) is pleased to announce to all Medicare physicians, providers, and suppliers a new and improved web site for accessing Medicare Contractor Provider Call Center toll-free number information. The new site is located at **http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip** on the CMS web site.

This change is a result of replacing the previous "Provider Call Center Toll-Free Numbers Directory" (with map) document with an Excel® file that contains all of the information previously available plus many improvements.

The original document proved difficult to update and download while keeping the functionality of the map intact. The new Excel's smaller file size allows for a significantly faster download, and the improved functionality, provided by the pull-down menus, makes more targeted contact information available while filtering the displays appearing on the screen.

Additionally, a "Coverage Area" column has been added to the original four columns of information (i.e., State Served, Call Center, Program, and Toll-Free Number) and each column has a menu allowing users to filter the information displayed on the screen. Selecting the menus to "ALL" resets the spreadsheet to display all available information.

Many of the existing MLN Matters articles contain links to the previous map document, which was **http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.pdf** on the CMS web site. As you can see, the new address is almost identical, except for the last three characters, "*pdf*," which are now "*zip*."

Please be aware that articles already housed on the MLN Matters pages will not be updated with the new link, except where such articles are revised in the future for other reasons. However, those providers who have been using the map document directory should already know where to find it within the CMS website and should, therefore, be able to locate the new document.

Telephone - New Site for Medicare Provider Service Toll Free Numbers (SE 0655 (Continued)

The directory is also prominent on all MLN pages and should be easy to find. In fact, now might be a good time to bookmark the new address or add it to your "Favorites" list:
http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip.

The new spreadsheet directory will be updated approximately once every three months-more often if necessary.

As previously mentioned, you can access the new file from all major MLN web pages, including the main section pages at:
http://www.cms.hhs.gov/MLNGenInfo/
http://www.cms.hhs.gov/MLNProducts/
http://www.cms.hhs.gov/MLNMattersArticles/
http://www.cms.hhs.gov/MLNEdWebGuide/

The new file can be downloaded directly from
http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip on the CMS web site.

CMS hopes you find this new site to be useful and we invite your comments and feedback on this and other Medicare Learning Network web-based products. You can provide such feedback by going to
http://questions.cms.hhs.gov/cgi-bin/cmshhs.cfg/php/enduser/site_fdbck.php on the CMS web site.

Remember the revised workflow for the former "Additional Faxed Documentation" process

http://www.medicarenhic.com/dme/articles/addfaxdoc_0606.htm

General Provider Education for Changes in the Payment for Oxygen Equipment and Capped Rentals for Durable Medical Equipment (DME) Due to the Deficit Reduction Act (DRA) of 2005 (CR 5010)

MLN Matters Number: MM5010
Related CR Release Date: April 28, 2006
Related CR Transmittal #: R918CP

Related Change Request (CR) #: 5010
Effective Date: May 30, 2006
Implementation Date: May 30, 2006

Provider Types Affected
Suppliers and providers billing Medicare durable medical equipment regional carriers (DMERCs) for oxygen equipment/services or other rentals of capped DME. Physicians treating Medicare patients using oxygen equipment or other rentals of capped DME may also want to be aware of this issue.

Background
Recent legislative changes mandated by Section 5101(a) and 5101(b) of the Deficit Reduction Act (DRA) of 2005 require changes to the DME claims processing systems.

The purpose of this article and related CR5010 are to provide DME suppliers with an explanation of how these changes will impact them.

Important Points to Remember
Changes in Capped Rentals for DME
Section 5101(a) of the DRA is effective for capped rental items for which the first rental month occurs on or after January 1, 2006.

- For claims with dates of service (DOS) on and after January 1, 2006, the DMERCs, and eventually their replacements, the Durable Medical Equipment Medicare Administrative Contractors (DME MACs), will limit the total number of months for which they make payment for capped rental DME to 13 months.
- After the DME MAC (or DMERC) has paid for 13 months for capped rental DME, title for the equipment will be transferred to the beneficiary.
- This policy applies only to beneficiaries who began a new DME capped rental period for dates of service on or after January 1, 2006.
- For claims with dates of services prior to January 1, 2006, current rules apply.

Changes Related to Payment for Oxygen Equipment:
- Section 5101(b) of he DRA establishes a 36 month (3 year) limit or cap on monthly payments for stationary and portable oxygen equipment. This cap applies to oxygen equipment furnished on or after January 1, 2006, and applies to all claims for the following list of HCPCS codes.

E0424 - Stationary gaseous oxygen system	E0431 - Portable gaseous oxygen system
E0434 - Portable liquid oxygen system	E0439 - Stationary liquid oxygen system
E1390 - Oxygen concentrator, single delivery port	E1391 - Oxygen concentrator, dual delivery port
E1392 - Portable oxygen concentrator	E1405 - Oxygen and water vapor enriching system with heated delivery
E1406 - Oxygen and water vapor enriching system without heated delivery	

- Payments for any of the above described items terminate after a period of continuous use of 36 months beginning on or after January 1, 2006. On the first day after the month for which the 36th monthly payment amount is made, the supplier must transfer title for the stationary and/or portable oxygen equipment to the beneficiary.
- On the same day that title for the equipment is transferred to the patient, **monthly payments can begin to be made for oxygen contents** used with patient-owned gaseous and liquid oxygen equipment.

The HCPCS codes for oxygen contents include the following:

EO441 - Stationary gaseous contents used with patient owned gaseous stationary system	E0442 - Stationary liquid contents used with patient owned liquid stationary system
E0443 - Portable gaseous contents used with patient owned gaseous portable system	E0444 - Portable liquid contents used with patient owned liquid portable system.

General Provider Education for Changes in the Payment for Oxygen Equipment and Capped Rentals for Durable Medical Equipment (DME) Due to the Deficit Reduction Act (DRA) of 2005 (CR 5010) (Continued)

Note: Medicare DMERCs will begin the 36-month count for beneficiaries that were already receiving oxygen therapy on January 1, 2006. Months prior to January 2006 will not be included in the 36-month count.

- DMERCs will pay for reasonable and necessary maintenance and servicing (i.e., parts and labor not covered by a supplier's or manufacturer's warranty) of beneficiary-owned equipment (including oxygen concentrators).
- Updates to the *Medicare Claims Processing Manual*, Publication 100-04, and the *Medicare Benefits Policy Manual*, Publication 100-02, related to CR5010 will be made at a later date to reflect these changes.

Use of HCPCS Modifiers
Additional program billing and claims processing instructions will be issued later this year. For now, suppliers should continue to use the KH, KI, and KJ modifiers in the manner as previously instructed for capped rental DME. These modifiers do not need to be submitted for oxygen or oxygen equipment claims. Suppliers should continue to use the BP, BR, and BU modifiers with respect to capped rental periods that began prior to January 1, 2006.

Implementation
The implementation date for this instruction is May 30, 2006.

Additional Information
The official instructions issued to your DMERC regarding this change can be found at **http://www.cms.hhs.gov/Transmittals/downloads/R918CP.pdf** on the CMS web site.

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

Therapy Services - Changes Conforming to Change Request 3648 (CR3648) fo Therapy Services (CR 4014)

MLN Matters Number: MM4014 Revised
Related CR Release Date: June 14, 2006
Related CR Transmittal #: R980CP and R55NCD
Related Change Request (CR) #: 4014
Effective Date: October 1, 2006
Implementation Date: October 2, 2006

Note: This article was revised on June 15, 2006, to reflect changes made to CR4014, which was re-issued on June 14, 2006. The transmittal number, CR release date (see above), and the Web address for viewing CR4014 were revised. All other information remains the same.

Provider Types Affected
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 therapy services.

Provider Action Needed
Impact to You
This article is based on Change Request (CR) 4014, which updates language in the *Medicare National Coverage Determinations Manual* (Publication 100-03) and the *Medicare Claims Processing Manual* (Publication 100-04) by changing the term "speech therapy" to "speech-language pathology."

What You Need to Know
To conform to changes in CR3648, CR4014 removes from the *Medicare Claims Processing Manual* (Publication 100-04) the requirement to include the date last seen by a physician for outpatient services provided by a physical or occupational therapist or speech-language pathologist. Requirements for therapy services incident to a physician have not been changed.

What You Need to Do
See the *Background* section of this article for further details regarding these changes.

Therapy Services - Changes Conforming to Change Request 3648 (CR3648) fo Therapy Services (CR 4014) (Continued)

Background
The Centers for Medicare & Medicaid Services (CMS) is updating language in the *Medicare National Coverage Determinations (NCD) Manual* (Publication 100-03) and the *Medicare Claims Processing Manual* (Publication 100-04) as follows: the term "speech therapy" is being changed to "speech-language pathology."

In addition, CMS is changing requirements in Chapter 1 of the *Medicare Claims Processing Manual* where therapists are to provide information on CMS-1500 (Health Insurance Claim Form) and the UB-92 claim form concerning the date last seen by the physician to conform with instructions in CR3648, Transmittal 36, dated June 24, 2005; subject: Publication 100-02, Chapter 15, Sections 220 and 230 Therapy Services. CR3648 can be found at **http://www.cms.hhs.gov/Transmittals/downloads/R36BP.pdf** on the CMS web site.

Health Insurance Portability and Accountability Act (HIPAA) guidelines require the following information only when it impacts the payer's adjudication process:
- Date last seen; and
- The Unique Provider Identification Number (UPIN) of the physician.

Medicare payment is not impacted by this information except when the service is provided "incident to" the services of a physicians or nonphysician practitioners (NPP), in which case it is required. CR4014 updates instructions in CR3648 (related to claims for services "incident to" a physician's/NPP's service) by acknowledging that:
- The "incident to" service can be identified only on prepay or postpay review;
- Manual review of all therapy claims is not required; and
- Incident to policies have not changed and still apply to therapy services.

CR4014 also clarifies selected business requirements in CR3648 to indicate that some contractor actions:
- Will occur on prepay or postpay review;

  For example, compare the following:
  Business Rule (BR) 3648.8 - Contractors shall pay for therapy services only when the service qualifies as a therapy service and the service is furnished by qualified professionals, or qualified personnel as defined in the manuals; with
  BR 4014.8 - On prepay or post pay review of outpatient therapy claims for services provided on or after July 25, 2005, contractors shall pay for **physical therapy and occupational therapy** services only when the service is furnished by qualified professionals, or qualified personnel as defined in the appropriate Medicare manuals.

- Should not be applied to services "incident to." (e.g., BR 3648.3 - Medicare contractors shall not deny therapy claims based on missing documentation of a visit to the physician on prepay or postpay review).

CR3648 omitted the requirement for a physician visit when therapy services are billed. This change omits the requirement that the physician visit be documented on the claim.

This change does not affect the requirements for services billed "incident to" a physician.

Therefore, when a therapy service is billed "incident to," the following requirements remain in effect because they are required by "incident to" policies:
- An initial physician visit (date last seen); and
- Identification of the ordering (and supervising) physicians/NPPs.

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

Additional Information
CR3648 (Transmittal 36 dated June 24, 2005, subject Pub. 100-02, Chapter 15, Sections 220 and 230 Therapy Services) can be reviewed at **http://www.cms.hhs.gov/manuals/pm_trans/R36BP.pdf** on the CMS web site.

The MLN Matters article, MM3648 can be viewed at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3648.pdf** on the CMS web site.

For complete details, please see the official instructions (CR4014) issued to your carrier/intermediary regarding this change. There are two transmittals for CR4014, the NCD, transmittal 55 is available at **http://www.cms.hhs.gov/Transmittals/downloads/R55NCD.pdf**. Transmittal 941 is the *Medicare Claims Processing Manual* update, which is available at **http://www.cms.hhs.gov/Transmittals/downloads/R980CP.pdf** on the CMS site.

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

The NHIC, Corp. DME MAC is pleased to announce the Outreach & Education Team

The primary responsibility of the Outreach & Education Team is to provide education, through various venues, to assure that suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) to Medicare beneficiaries are fully knowledgeable about the Medicare DME MAC program and provisions to ensure accurate, efficient claims processing. Several of the members of this team come to NHIC, Corp. from the previous Durable Medical Equipment Regional Carrier (DMERC) A contractor, bringing with them experience and knowledge as they continue to provide you with educational support.

Amy Capece was the former Manager for the DMERC A Program Education & Training department. Liz Daniels, Mindy Schuler and Judie Roan were former Ombudsmen, now referred to as Outreach Specialists to further emphasize the focus of the primary outreach and education responsibilities of these individuals. James Marko was the former Internet Communications Specialist, and Jim Hardiman worked for DMERC A for many years in various capacities within the systems and claims areas. Becky Magdycz is joining the team from the EDS Medicaid Provider Relations area, and in addition to her home state of Delaware, will be responsible for the newest territories to this jurisdiction, Maryland and the District of Columbia.

The Outreach Specialists coordinate with supplier associations/organizations, billing services, industry organizations, medical societies, the PCOM Advisory Group and individual suppliers to ensure targeted educational efforts are both meaningful and helpful to the supplier community as a whole.

The Outreach & Education Team should be contacted for:

- Educational Seminars/Workshops/On-line Training/Teleconferences
- Educational Materials/Publications/Web site
- Trade Shows/Association Meetings/Other Partnering Opportunities
- Ask-the-Contractor Teleconferences
- Provider Communications Advisory Group
- Complex/Global Issues Requiring Education

The Outreach & Education Team consists of the following individuals:

Manager:

Amy Capece
781-741-3942 or 570-332-6353

amy.capece@eds.com

Outreach Specialists:

Elizabeth (Liz) Daniels	-	Pennsylvania
James (Jim) Hardiman	-	New Jersey and New York City (Area Codes 212, 347, 646, 718, 917)
Rebekah (Becky) Magdycz	-	Delaware, Maryland, District of Columbia & Outside Jurisdiction A
Judie Roan	-	New England (CT, ME, MA, NH, RI & VT)
Mindy Schuler	-	New York (Area Codes 315, 516, 518, 585, 607, 631, 716, 845, 914)

Publications/Web Specialist:

James Marko

The Outreach & Education Team can be reached by calling **781-741-3950**

The NHIC,Corp. DME MAC Outreach & Education Team looks forward to working with the Jurisdiction A supplier community, as we focus on providing you with quality education and prompt communication to keep you well informed in this ever changing environment.

Be sure to sign-up for our ListServes and check our Web site regularly for the latest information and upcoming events. Also, look to the quarterly publication of the NHIC, Corp. *DME MAC Jurisdiction A Resource* for educational articles and information from the Outreach & Education Team.

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

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

for more information. (JSM 06536)

Quarterly Provider Update

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

Region A DMERC and PSC Affiliate Web Sites

Both the Jurisdiction A Durable Medical Equipment Medicare Administrative Contractor (DME MAC A) and Program Safeguard Contractor (PSC) maintain separate Web sites. Providers should visit the DME MAC A Web site (**http://www.medicarenhic.com/dme/**) for information regarding billing, educational updates and events, electronic data interchange (EDI), fee schedules, ListServes, what's new, etc. Providers can gain access to the PSC Web site via the "TriCenturion" link on the DME MAC A Web site (**http://www.medicarenhic.com/dme/dmprovlink.shtml**) or directly at **http://www.tricenturion.com/content/reg_ab_dme_psc_toc.cfm**. Providers should access the PSC Web site for information on Bulletins, Fraud and Abuse, Healthcare Common Procedure Coding System (HCPCS), Medical Policies, and Progressive Corrective Action/Local Provider Education & Training (PCA/LPET). Recent updates involving medical policy development, medical review, benefit integrity, or fraud alerts can be accessed by visiting the PSC "What's New" section at:
http://www.tricenturion.com/content/whatsnew_dyn.cfm

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

DME MAC A ListServe

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

What are the benefits of joining the DME MAC A ListServe? By joining, you will be the first to learn about upcoming educational opportunities and training events. You will also be the first to know when our quarterly bulletins and supplier manual revisions become available on our Web site.

Signing up for the DME MAC A ListServe gives you immediate email notification of important information on Medicare changes impacting your business. Subscribe today by visiting the **http://visitor.constantcontact.com/email.jsp?m=1101306329206**. Also, to receive email notification of medical policy updates and other important articles, subscribe to the Jurisdiction A Program Safeguard Contractor (PSC) ListServe by visiting:
http://www.palmettogba.com/registration.nsf/Push+Mail+Archive+Home?OpenForm

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

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

Outreach & Education
781-741-3950

Claims Submissions

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

DME – PEN Claims
P.O. Box 9146
Hingham, MA 02043-9149

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

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

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

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

Written Inquiries

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

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

Written Inquiry FAX: 781-741-3530

Appeals

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

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

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

Electronic Data Interchange Support Services
866-563-0049
9:00 a.m. to 5:00 p.m. EST Monday through Friday
Electronic Fund Transfers, VIPS Provider Inquiry System (VPIQ), Medicare Remit Easy Print (MREP) Software and Administrative Simplification Compliance Act (ASCA) Letters

National Supplier Clearinghouse
866-238-9652

SADMERC
877-735-1326

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

DME MAC Jurisdiction A Resource

INFORMATION for DME MAC SUPPLIERS in CT, DE, DC, ME, MD, MA, NH, NJ, NY, PA, RI & VT Septemter 2006
Number 1

Publication Information

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

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

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

DME MAC Jurisdiction A Resource Coordinator
Outreach & Education Publications
NHIC, Corp.
75 Sgt. William B. Terry Drive
Hingham, MA 02043

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