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

December 2007
Number 6

Billing/Finance

Electronic Data Interchange

General Information

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/dme/**

NHIC, Corp.

Table of Contents

National Provider Identifier

Outreach & Education

Web Site Resources

LEGEND

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

MLN Matters Disclaimer
These articles were prepared as a service to the public and are not intended to grant rights or impose obligations. These articles may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

Correction to Revised HCPCS Codes Relating to Immune Globulin (this CR rescinds and fully replaces CR 5635) (MM5741)

MLN Matters Number: MM5741
Related CR Release Date: October 5, 2007
Related CR Transmittal #: R1350CP
Related Change Request (CR) #: 5741
Effective Date: July 1, 2007
Implementation Date: November 5, 2007

Provider Types Affected
Physicians, providers and suppliers who bill Medicare contractors (carriers; Fiscal Intermediaries (FI); Medicare Administrative Contractors (A/B MACs); and Durable Medical Equipment Medicare Administrative Contractors (DME MACs)) for Immune Globulin.

What You Need to Know
CR 5741, from which this article is taken, rescinds and fully replaces CR 5635, which revised Healthcare Common Procedure Coding System (HCPCS) codes relating to immune globulin. **(Basically, the information in this article restates what was in CR5635 (and related *MLN Matters* article MM5635), except CR5741 emphasizes that this does apply to suppliers billing Medicare DME MACs.)** CR 5741 announces that on and after July 1, 2007:

- Code J1567 (injection, immune globulin, intravenous, non-lyophilized (e.g. liquid), 500 mg) **is no longer payable by Medicare.**
- It is being replaced by the following codes, which are effective for payment on July 1, 2007: **Q4087** (Octagam Injection), **Q4088** (Gammagard Liquid Injection), **Q4091** (Flebogamma Injection), and **Q4092** (Gamunex Injection).
- In addition, two new codes are payable for services on or after July 1, 2007:
  - **Q4089** (Rhophylac injection). *Note that currently, Rhophylac® is the only product that should be billed using code **Q4089**. If other products under the FDA approval for Rhophylac® become available, code **Q4089** would be used to bill for such products.*
  - **Q4090** (HepaGam B injection). *Note that currently, HepaGam B™, when given intramuscularly, is the only product that should be billed using code **Q4090.** If other products under the FDA's approval for HepaGam B™ IM become available, code **Q4090** would be used to bill for such products. HepaGam B™ when given intravenously should be billed using an appropriate Not Otherwise Classified code in the absence of a specific HCPCS code.*
- As described in CR 5428, contractors will pay for preadministration-related services (G0332) associated with IVIG administration when Q4087, Q4088, Q4091, or Q4092 is billed in lieu of J1567.

Make sure that your billing staffs are aware of these Immune Globulin HCPCS code changes.

Background
CR 5741, from which this article is taken, rescinds and fully replaces CR 5635 (released June 1, 2007). CR 5741 announces that effective July 1, 2007, Medicare will no longer pay for HCPCS code J1567 (injection, immune globulin, intravenous, non-lyophilized (e.g. liquid), 500 mg). In its place, effective July 1, 2007, codes Q4087, Q4088, Q4091, Q4092, and two new codes (Q4089, Q4090) become effective for payment. Table 1, below, displays these codes and their descriptions.

Correction to Revised HCPCS Codes Relating to Immune Globulin (this CR rescinds and fully replaces CR 5635) (MM5741) (Continued)

Table 1
HCPCS Code Changes for Immune Globulin
Effective July 1, 2007

Code	Short Description	Long Description
Status: Not Payable by Medicare on or after July 1, 2007		
J1567	Immune globulin, liquid	Injection, immune globulin, intravenous, non-lyophilized (e.g. liquid), 500 mg
Status: Payable for services on or after July 1, 2007		
Q4087	Octagam Injection	Injection, immune globulin (Octagam), intravenous, non-lyophilized (e.g. liquid), 500 mg
Q4088	Gammagard Liquid Injection	Injection, immune globulin (Gammagard Liquid), intravenous, non-lyophilized (e.g. liquid), 500 mg
Q4091	Flebogamma Injection	Injection, immune globulin (Flebogamma), intravenous, non-lyophilized (e.g. liquid), 500 mg
Q4092	Gamunex Injection	Injection, immune globulin (Gamunex), intravenous, non-lyophilized (e.g.liquid), 500 mg
Status: New/Payable for services on or after July 1, 2007		
Q4089	Rhophylac injection	Injection, Rho(D) immune globulin (human), (Rhophylac), intramuscular or intravenous, 100 iu
Q4090	HepaGam B injection	Injection, hepatitis B immune globulin (HepaGam B), intramuscular, 0.5 ml

Additional Information
You can find the official instruction issued to your Medicare contractor about the revised HCPCS codes relating to Immune Globulin by going to CR5741, located at **http://www.cms.hhs.gov/Transmittals/downloads/R1350CP.pdf** on the CMS website.

You might also want to look at CR 5428 (Medicare Payment for Pre-administration-Related Services Associated with IVIG Administration-Payment Extended through CY 2007). The *MLN Matters* article (MM5428) associated with that CR is available at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5428.pdf** on the CMS website.

If you have any questions, please contact your carrier, FI, A/B MAC, 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 website.

Please join the NHIC, Corp. DME MAC A ListServe! Visit
http://www.medicarenhic.com/dme/
and select "Join the DME MAC A ListServe"

Important Guidance on the New CMS-1500 and UB-04 Forms (SE0729)

MLN Matters Number: SE0729
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 providers using the new forms CMS-1500 or UB-04 to bill Medicare contractors (carriers, fiscal intermediaries (FI), or Medicare Administrative Contractors MACs)) for services provided to Medicare beneficiaries.

What You Need to Know
This *MLN Matters* article, SE0729, provides you valuable information about the new CMS 1500 and UB-04 forms.

Background
CMS Form 1500 Version 08-05
In 2006, the Centers for Medicare & Medicaid Services (CMS) introduced the revised Form CMS-1500 (08-05). This new version of the form, revised to accommodate the reporting of the National Provider Identifier (NPI), was developed through a collaborative effort headed up by the National Uniform Claim Committee (NUCC), which is chaired by the American Medical Association (AMA), in consultation with the CMS.

The committee includes representation from key provider and payer organizations, as well as standards setting organizations, one healthcare vendor, and the National Uniform Billing Committee (NUBC). As such, the committee is intended to have an authoritative voice regarding national standard data content and data definitions for non-institutional health care claims in the United States.

Although CMS prefers that you submit all claims to Medicare electronically, the Administrative Simplification Compliance Act Public Law 107-105 (ASCA) and the implementing regulation at 42 CFR 424.32 provide for exceptions to the mandatory electronic claim submission requirement. Therefore, Medicare will receive, and process, paper claims (using the new [08-05] version of the CMS-1500 form) only from physicians and suppliers who are excluded from the mandatory electronic claims submission requirements.

CMS began accepting the revised form CMS-1500 in January 1, 2007, planning to discontinue the older version on April 1, 2007; however formatting issues forced CMS to extend this date to July 2, 2007. At that time, CMS began returning the 12-90 version of the form. While the Government Printing Office (GPO) is not yet in a position to accept and fill orders for the revised CMS-1500 form, CMS' research indicates the form is widely available for purchase from print vendors.

For assistance in locating the form, you can contact the NUCC at **http://www.nucc.org/**, or you might consider using local print media directories to search for print vendors, contacting other providers to inquire on their source for the form, or searching for "CMS-1500 (08-05)" or "CMS-1500 08/05" on the internet to locate online print vendors. You should ask for samples before ordering to ensure that the formatting is correct.

Some important details in completing the new CMS-1500 form are as follow:

- If you previously populated boxes 17a (referring provider), 24j (rendering provider), and 33 (billing provider) with your legacy number, you should now begin using your NPI also.
- The billing provider NPI goes in box 33a. In addition, if the billing provider is a group, then the rendering provider NPI must go in box 24j. If the billing provider is a solo practitioner, then box 24j is always left blank. A referring provider NPI goes in box 17b.
- If the information in block 33 (billing) is different than block 32 (service facility), you should populate block 32 with the address information.

You can learn more about the new version of the CMS-1500 by reading *MLN Matters* article MM5060 (Additional Requirements Necessary to Implement the Revised Health Insurance Claim Form CMS-1500), released September 15, 2006. You can find that article at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5060.pdf**

UB-04 Information
At its February 2005 meeting, the National Uniform Billing Committee (NUBC) approved the UB-04 (CMS-1450) as the replacement for the UB-92. The UB-04, the basic form that CMS prescribes for the Medicare program, incorporates the National Provider Identifier (NPI) taxonomy, and additional codes; and is only accepted from institutional providers 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.

Effective March 1, 2007, institutional claim filers such as hospitals, SNFs, hospices, and others were to have begun using the UB-04, with a transitional period between March 1, 2007, and May 22, 2007 (during which time either the UB-92 or the UB-04 may have been used). On and after May 23, 2007: 1) The UB-92 has become no longer acceptable (even as an adjustment claim); and 2) All institutional paper claims must be submitted on the UB-04.

Important Guidance on the New CMS-1500 and UB-04 Forms (SE0729) (Continued)

You should note that while most of the data usage descriptions and allowable data values have not changed on the UB-04, many UB-92 data locations have changed and, in addition, bill type processing will change. Some details of the form follow:

- The UB-04 (Form CMS-1450) is a uniform institutional provider bill suitable for billing multiple third party payers. A particular payer, therefore, may not need some of the data elements.
- When filing, you should retain the copy designated "Institution Copy" and submit the remaining copies to your Medicare contractor, managed care plan, or other insurer.
- Instructions for completing inpatient and outpatient claims are the same unless otherwise noted.
- If you omit any required data, your contractor will either ask you for them or obtain them from other sources and will maintain them on its history record. It will not obtain data that are not needed to process the claim.
- Data elements in the CMS uniform electronic billing specifications are consistent with the UB-04 data set to the extent that one processing system can handle both. The definitions are identical, although in some situations, the electronic record contains more characters than the corresponding item on the form because of constraints on the form size not applicable to the electronic record. Further, the revenue coding system is the same for both the Form CMS-1450 and the electronic specifications.
- For the UB-04, the billing provider's NPI is entered in Form Locator (FL) 56. The attending provider's NPI is entered in FL76. The operating provider's NPI is entered in FL77. Up to 2 other provider NPIs can be entered in FL78 and FL79.

You can find more information about the UB-04 (Form CMS-1450) by reading *MLN Matters* article MM5072 (Uniform Billing (UB-04) Implementation - UB-92 Replacement), released November 3, 2006. You can find that article at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5072.pdf**. The CR, from which that article was taken, contains a copy of the UB-04 form (front and back) in PDF format, a crosswalk between the UB-04 and the UB-92, and the revised portion of the *Medicare Claims Processing Manual*, Chapter 25 (Completing and Processing the CMS 1450 Data Set), Sections 70 (Uniform Bill - Form CMS-1450 (UB-04)) and 71 (General Instructions for Completion of Form CMS-1450 (UB-04)). These sections contain very detailed instructions for completing the form.

For assistance in obtaining UB-04s you can contact the NUBC at **http://www.nubc.org/**

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

Quarterly October 2007 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files (MM5710)

MLN Matters Number: MM5710
Related CR Release Date: September 12, 2007
Related CR Transmittal #: R1334CP
Related Change Request (CR) #: 5710
Effective Date: October 1, 2007
Implementation Date: October 1, 2007

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

Provider Action Needed
This article is based on Change Request (CR) 5710, which informs Medicare providers of the availability of the October 2007 Average Sales Price (ASP) drug pricing file for Medicare Part B drugs as well as the revised January 2007, April 2007, July 2007 and October 2006 ASP payment files (**if CMS determines that revisions are necessary to the latter files**). CR5710 also advises Medicare providers that ASP Not Otherwise Classified (NOC) files will be available for retrieval from the CMS ASP webpage as well as the revised January 2007, April 2007, July 2007 and October 2006 ASP NOC files (**if CMS determines that revisions are necessary to the latter files**). Providers should make certain that your billing staffs are aware of these changes.

Background
The Medicare Modernization Act of 2003 (MMA; Section 303(c)) revised the payment methodology for Part B covered drugs that are not paid on a cost or prospective payment basis. Starting January 1, 2005, many of the drugs and biologicals not paid on a cost or prospective payment basis are paid based on the average sales price (ASP) methodology, and pricing for compounded drugs is performed by the local Medicare contractor. Additionally, beginning 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 Outpatient Prospective Payment System (OPPS), will be paid based on the ASP methodology.

Quarterly October 2007 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files (MM5710) (Continued)

The ASP methodology is based on quarterly data submitted to the Centers for Medicare & Medicaid Services (CMS) by manufacturers, and CMS supplies Medicare contractors (carriers, DME MACs, FIs, A/B MACs, and/or RHHIs) with the ASP drug pricing files for Medicare Part B drugs on a quarterly basis. CMS also posts these files to its website at **http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/**.

As announced in late 2006, CMS has been working further to ensure that more accurate and, as appropriate, separate payment is made for single source drugs and biologicals under Section 1847A of the Social Security Act. As part of this effort, CMS reviewed how the terms "single source drug," "multiple source drug," and "biological product" are made operational in the context of payment under section 1847A. For the purposes of identifying "single source drugs" and "biological products" subject to payment under section 1847A, generally CMS (and its contractors) will utilize a multi-step process. CMS will consider:

- The Food and Drug Administration (FDA) approval,
- Therapeutic equivalents as determined by the FDA, and
- The date of first sale in the United States.

For a biological product (as evidenced by a new FDA Biologic License Application or other relevant FDA approval) or a single source drug (that is, not a drug for which there are two or more drug products that are rated as therapeutically equivalent in the most recent FDA Orange Book) first sold in the United States after October 1, 2003, the payment limit under Section 1847A for that biological product or single source drug will be based on the pricing information for products produced or distributed under the applicable FDA approval. As appropriate, a unique HCPCS code will be assigned to facilitate separate payment. Separate payment may also be made operational through use of existing specific HCPCS codes or "not otherwise classified" HCPCS codes.

For 2007, a separate fee of $0.152 per International Unit (I.U.) of blood clotting factor furnished is payable when a separate payment for the blood clotting factor is made. The furnishing fee will be included in the payment amounts on the quarterly ASP pricing files.

ASP Methodology

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 (106%) of the ASP. Beginning January 1, 2006, payment allowance limits are paid based on 106 percent (106%) of the ASP for the following:

- ESRD drugs (when separately billed by freestanding and hospital-based ESRD facilities), and
- Specified covered outpatient drugs, and drugs and biologicals with pass-through status under the OPPS.

Exceptions are summarized as follows:

- The payment allowance limits for blood and blood products (other than blood clotting factors) that are not paid on a prospective payment basis are 95 percent (95%) of the average wholesale price (AWP) as reflected in the published compendia. The payment allowance limits will be updated on a quarterly basis. Blood and blood products furnished in the hospital outpatient department are paid under OPPS at the amount specified for the APC to which the product is assigned.
- 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 (95%) of the AWP reflected in the published compendia as of October 1, 2003, unless the drug is compounded or the drug is furnished incident to a professional service. **The payment allowance limits were not updated in 2007**. Payment allowance limits for infusion drugs furnished through a covered item of durable medical equipment (DME) that were not listed in the published compendia as of October 1, 2003, (i.e., new drugs) are 95 percent (95%) of the first published AWP unless the drug is compounded or the drug is furnished incident to a professional service.
- The payment allowance limits for influenza, Pneumococcal and Hepatitis B vaccines are 95 percent of the AWP as reflected in the published compendia except where the vaccine is furnished in a hospital outpatient department and, then, is paid at reasonable cost.
- The payment allowance limits for drugs and biologicals that are not included in the ASP Medicare Part B Drug Pricing File or Not Otherwise Classified (NOC) Pricing File, other than new drugs that are produced or distributed under a new drug application (or other application) approved by the FDA, are based on the published wholesale acquisition cost (WAC) or invoice pricing, except under OPPS where the payment allowance limit is 95 percent of the published AWP. The payment limit is 100 percent of the lesser of the lowest-priced brand or median generic WAC. For 2006, the blood clotting furnishing factor of $0.146 per I.U. is added to the payment amount for the blood clotting factor when the blood clotting factor is not included on the ASP file. For 2007, the blood clotting furnishing factor of $0.152 per I.U. is added to the payment amount for the blood clotting factor when the blood clotting factor is not included on the ASP file.
- The payment allowance limits for new drugs and biologicals that are produced or distributed under a new drug application (or other new application) approved by the FDA and that are not included in the ASP Medicare Part B Drug Pricing File or Not Otherwise Classified (NOC) Pricing File are based on 106 percent of the WAC, or invoice pricing if the WAC is not published, except under OPPS where the payment allowance limit is 95 percent of the published AWP. This policy applies only to new drugs that were first sold on or after January 1, 2005.

Quarterly October 2007 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files (MM5710) (Continued)

- The payment allowance limits for radiopharmaceuticals are not subject to ASP. Medicare contractors determine payment limits for radiopharmaceuticals based on the methodology in place in November 2003 in the case of radiopharmaceuticals furnished in other than the hospital outpatient department. Radiopharmaceuticals furnished in the hospital outpatient department are paid charges reduced to cost by the hospital's overall cost to charge ratio.

On or after September 18, 2007, the October 2007 ASP file will be available for download from the CMS ASP website. If CMS determines that revisions are needed to the January 2007, April 2007, July 2007, and October 2006 ASP payment files, those revised files will also be available for retrieval from the CMS ASP webpage. The payment limits included in the revised ASP and NOC payment files supersede the payment limits for these codes in any publication published prior to this document. The CMS ASP webpage is located at **http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/** on the CMS website. These quarterly files are applicable to claims based on dates of service as shown in the following table:

Payment Allowance Limit Revision Date	Applicable Dates of Service for Claims Processed or Reprocessed on or after October 1, 2007
October 2006	October 1, 2006 through December 31, 2006
January 2007	January 1, 2007 through March 31, 2007
April 2007	April 1, 2007 through June 30, 2007
July 2007	July 1, 2007 through September 30, 2007
October 2007	October 1, 2007 through December 31, 2007

Note: *The absence or presence of a HCPCS code and its associated payment limit does not indicate Medicare coverage of the drug or biological. Similarly, the inclusion of a payment limit within a specific column does not indicate Medicare coverage of the drug in that specific category. The local Medicare contractor processing the claim will make these determinations.*

Drugs Furnished During Filling or Refilling an Implantable Pump or Reservoir

Physicians (or a practitioner described in the Social Security Act (Section 1842(b) (18) (C); **http://www.ssa.gov/OP_Home/ssact/title18/1842.htm** may be paid for filling or refilling an implantable pump or reservoir when it is medically necessary for the physician (or other practitioner) to perform the service. Medicare contractors must find the use of the implantable pump or reservoir 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 safely and effectively. Payment for drugs furnished incident to the filling or refilling of an implantable pump or reservoir is determined under the ASP methodology as described above. Note that pricing for compounded drugs is done by your local Medicare contractor.

Additional Information

To see the official instruction (CR5710) issued to your Medicare carrier, FI, A/B MAC, DME MAC, or RHHI. That instruction may be viewed by going to **http://www.cms.hhs.gov/Transmittals/downloads/R1334CP.pdf** on the CMS website.

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

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

Reasonable Charge Update for 2008 for Splints, Casts, Dialysis Supplies, Dialysis Equipment, and Certain Intraocular Lenses (MM5740)

MLN Matters Number: MM5740
Related CR Release Date: September 28, 2007
Related CR Transmittal #: R1344CP

Related Change Request (CR) #: 5740
Effective Date: January 1, 2008
Implementation Date: January 7, 2008

Provider Types Affected
Physicians, providers, and suppliers billing Medicare contractors (carriers, Fiscal Intermediaries, (FIs), Medicare Administrative Contractors (A/B MACs), and Durable Medical Equipment Medicare Administrative Contractors (DME MACs)) for splints, casts, dialysis equipment, and certain intraocular lenses.

Provider Action Needed
Affected providers may want to be certain their billing staffs know of these changes.

Background
For calendar year 2008, Medicare will continue to pay on a reasonable charge basis for splints, casts, dialysis supplies, dialysis equipment and intraocular lenses. For intraocular lenses, payment is only made on a reasonable charge basis for lenses implanted in a physician's office. For splints and casts, the Q-codes are to be used when supplies are indicated for cast and splint purposes. This payment is in addition to the payment made under the Medicare physician fee schedule for the procedure for applying the splint or cast.

Change Request (CR) 5740 provides instructions regarding the calculation of reasonable charges for payment of claims for splints, casts, dialysis supplies, dialysis equipment, and intraocular lenses furnished in calendar year 2008. Payment on a reasonable charge basis is required for these items by regulations contained in 42 CFR 405.501 at: **http://www.gpoaccess.gov/cfr/retrieve.html** on the Internet. The 2008 payment limits for splints and casts will be based on the 2007 limits that were announced in CR 5382 last year, increased by 2.7 percent, the percentage change in the consumer price index for all urban consumers for the 12-month period ending June 30, 2007. The *MLN Matters* article related to CR 5382 can be viewed at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5382.pdf** on the CMS website.

For intraocular lenses, payment is made **only on a reasonable charge basis for lenses implanted in a physician's office**. Change Request 5740 instructs your carrier, or A/B MAC to compute 2008 customary and prevailing charges for the V2630, V2631, and V2632 (Intraocular Lenses Implanted in a Physician's Office) using actual charge data from July 1, 2006, through June 30, 2007.

Carriers and A/B MACs will compute 2008 Inflation-Indexed Charge (IIC) amounts for the V2630, V2631, and V2632 that were not paid using gap-filled payment amounts in 2007.

DME MACs will compute 2008 customary and prevailing charges for the codes identified in the following tables using actual charge data from July 1, 2006, through June 30, 2007. For these same codes, they will compute 2008 IIC amounts for the codes identified in the following tables that were not paid using gap-filled amounts in 2007. These tables are:

Dialysis Supplies Billed With AX Modifier

A4216	A4217	A4248	A4244	A4245	A4246
A4247	A4450	A4452	A6250	A6260	A4651
A4652	A4657	A4660	A4663	A4670	A4927
A4928	A4930	A4931	A6216	A6402	

Dialysis Supplies Billed Without AX Modifier

A4653	A4671	A4672	A4673	A4674	A4680
A4690	A4706	A4707	A4708	A4709	A4714
A4719	A4720	A4721	A4722	A4723	A4724
A4725	A4726	A4728	A4730	A4736	A4737
A4740	A4750	A4755	A4760	A4765	A4766
A4770	A4771	A4772	A4773	A4774	A4802
A4860	A4870	A4890	A4911	A4918	A4929
E1634					

Reasonable Charge Update for 2008 for Splints, Casts, Dialysis Supplies, Dialysis Equipment, and Certain Intraocular Lenses (MM5740) (Continued)

Dialysis Equipment Billed With AX Modifier

E0210NU	E1632	E1637	E1639	

Dialysis Equipment Billed Without AX Modifier

E1500	E1510	E1520	E1530	E1540	E1550
E1560	E1570	E1575	E1580	E1590	E1592
E1594	E1600	E1610	E1615	E1620	E1625
E1630	E1635	E1636			

Carriers and A/B MACs will make payment for splints and casts furnished in 2008 based on the lower of the actual charge or the payment limits established for these codes. **Contractors** will use the 2008 reasonable charges or the attached 2008 splints and casts payment limits to pay claims for items furnished from January 1, 2008 through December 31, 2008. **Those 2008 payment limits are in Attachment A at the end of this article**.

Additional Information
Detailed instructions for Calculating:

- Reasonable charges are located in Chapter 23 (Section 80) of the *Medicare Claims Processing Manual*;
- Customary and prevailing charge are located in Section 80.2 and 80.4 of Chapter 23 of the *Medicare Claims Processing Manual*; and
- The IIC (Inflation Indexed Charge) are located in Section 80.6 of Chapter 23 of the *Medicare Claims Processing Manual*. The IIC update factor for 2008 is 2.7 percent.

You can find Chapter 23 of the *Medicare Claims Processing Manual* at **http://www.cms.hhs.gov/manuals/downloads/clm104c23.pdf** on the CMS website.

For complete details regarding this Change Request (CR) please see the official instruction (CR5740) issued to your Medicare FI, carrier, DME MAC, or A/B MAC. That instruction may be viewed by going to **http://www.cms.hhs.gov/transmittals/downloads/R1344CP.pdf** on the CMS website.

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

2007 Payment Limits for Splints and Casts

Code	Payment Limit	Code	Payment Limit
A4565	$7.38	**Q4025**	$32.45
Q4001	$42.01	**Q4026**	$101.30
Q4002	$158.81	**Q4027**	$16.23
Q4003	$30.18	**Q4028**	$50.66
Q4004	$104.49	**Q4029**	$24.81
Q4005	$11.12	**Q4030**	$65.31
Q4006	$25.08	**Q4031**	$12.41

Reasonable Charge Update for 2008 for Splints, Casts, Dialysis Supplies, Dialysis Equipment, and Certain Intraocular Lenses (MM5740) (Continued)

2007 Payment Limits for Splints and Casts (Continued)

Code	Payment Limit	Code	Payment Limit
Q4007	$5.58	**Q4032**	$32.65
Q4008	$12.54	**Q4033**	$23.14
Q4009	$7.43	**Q4034**	$57.56
Q4010	$16.72	**Q4035**	$11.57
Q4011	$3.71	**Q4036**	$28.79
Q4012	$8.36	**Q4037**	$14.12
Q4013	$13.52	**Q4038**	$35.37
Q4014	$22.81	**Q4039**	$7.08
Q4015	$6.76	**Q4040**	$17.68
Q4016	$11.40	**Q4041**	$17.16
Q4017	$7.82	**Q4042**	$29.30
Q4018	$12.47	**Q4043**	$8.59
Q4019	$3.91	**Q4044**	$14.66
Q4020	$6.24	**Q4045**	$9.96
Q4021	$5.78	**Q4046**	$16.03
Q4022	$10.44	**Q4047**	$4.97
Q4023	$2.91	**Q4048**	$8.02
Q4024	$5.22	**Q4049**	$1.82

Update to the Place of Service (POS) Code Set to Add a Code for Prison/Correctional Facility - VMS Only (MM5331)

MLN Matters Number: MM5331
Related CR Release Date: July 13, 2008
Related CR Transmittal #: R1288CP
Related Change Request (CR) #: 5331
Effective Date: July 1, 2006
Implementation Date: January 7, 2008

Provider Types Affected
Suppliers who bill Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for services provided in prison/correctional facility settings.

What you need to know
CR 5331, from which this article is taken, announces the addition of place of service (POS) code "09" for a prison/correctional facility setting.

Update to the Place of Service (POS) Code Set to Add a Code for Prison/Correctional Facility - VMS Only (MM5331) (Continued)

Background
As a Health Insurance Portability and Accountability Act of 1996 (HIPAA) covered entity, Medicare must comply with the statute's standards and implementation guides. The currently adopted professional implementation guide for the ASC X12N 837 standard requires that each electronic claim transaction include a Place of Service (POS) code from the POS code set that the Centers for Medicare & Medicaid Services (CMS) maintains. Further, as a payer, Medicare must be able to recognize, as valid, any code from the CMS-maintained, HIPAA-standard POS code set that appears on the HIPAA standard claim transaction.

This POS code set provides setting information that both Medicare and Medicaid need in order to appropriately pay their claims. Medicaid sometimes has a greater need for POS specificity than Medicare, and many of the new codes developed over the past few years have been developed to meet Medicaid's more specific needs. While Medicare does not always need this greater specificity in order to appropriately pay its claims, it nevertheless adjudicates claims with the new codes to ease coordination of benefits and to give Medicaid and other payers the setting information they require.

CR 5331, from which this article is taken, updates the current Medicare fee-for-service POS code set to add a new code (POS code "09") for prison/correctional facility and will implement the systems and contractor-level changes needed for Medicare to adjudicate claims with the new code.

Your DME MAC will develop the necessary policies to adjudicate claims containing this new code, and will accept it as valid. You should also be aware that your DME MAC must continue to comply with CMS current policy that, in most cases, does not allow payment for Medicare services in a penal institution. The addition of a POS code for a prison/correctional facility setting does not supersede this policy. (See *Medicare Claims Processing Manual* (100-04, Section 10.4, Chapter 1, available at **http://www.cms.hhs.gov/manuals/downloads/clm104c01.pdf** on the CMS website.)

The implementation of this change will be based on claims processed on or after January 7, 2008, even though the effective date shows July 1, 2006. The effective date is based on HIPAA requirements for non-medical data code sets, but the changes in CR5331 apply to claims Medicare processes on or after January 7, 2008.

Additional Information
You can find more information about the prison/correctional facility POS code update to the POS code set by going to CR 5331, located at **http://www.cms.hhs.gov/Transmittals/downloads/R1288CP.pdf** on the CMS website.

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

Fee Schedule Updates

The 2007 fee schedules and subsequent updates are available via the "Fee Schedules" section of the Jurisdiction A Durable Medical Equipment Medicare Administrative Contractor (DME MAC A) Web site, **http://www.medicarenhic.com/dme/dmfees.shtml**. The following notices have been posted:

- **There are no October Updates to the 2007 Jurisdiction A DME MAC Fee Schedule**
- October 2007 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing File
- July 2007 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing File Revised 10-01-2007
- April 2007 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing File Revised 10-01-2007
- January 2007 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing File Revised 10-01-2007
- 4th Quarter 2007 Update: Oral Anticancer Drug Fees

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

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

Alert Regarding the Transition of the Medigap Claim-Based Crossover Process (JSM07535)

The Centers for Medicare & Medicaid Services (CMS) has made a decision to delay the use of the new Coordination of Benefits Agreement (COBA) Medigap claim-based identifiers on incoming Part B claims or claims for durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) until October 1, 2007. This represents a change from previous CMS direction issued in accordance with Transmittal 283, Change Request (CR) 5662, and the accompanying *MLN Matters* Article.

Because of the CMS delay, physicians and other suppliers shall inform their billing vendors **not** to include any newly assigned 5-byte COBA Medigap claim-based identifiers, as referenced at **http://www.cms.hhs.gov/COBAgreement/Downloads/Medigap%20Claim-based%20COBA%20IDs%20for%20Billing%20Purpose.pdf**, on incoming Medicare claims before October 1, 2007. If participating providers or suppliers include the newly assigned COBA Medigap claim-based ID on incoming claims before October 1, 2007, Medicare will **not** cross the claims over to the Medigap insurer.

Providers that use PC-Ace or other free billing Medicare software need to ensure this product is updated to reflect the newly assigned 5-byte COBA Medigap claim-based IDs but must ensure that the new identifiers will not be applied on incoming Medicare claims before October 1, 2007.

Effective with October 1, 2007, and as specified in Transmittal 283, CR 5662, physicians and other suppliers that bill using paper forms, i.e., those granted an exception for billing electronically under the Administrative Simplification Compliance Act (ASCA), shall include the newly assigned 5-byte identifier (number will fall in the range 55000 through 59999) within item 9-D of incoming paper CMS-1500 claim forms. These providers should complete items 9A through 9D, in accordance with previous procedures, to ensure they will successfully trigger a Medigap claim-based crossover. Providers that are required to bill Medicare electronically using the Health Insurance Portability and Accountability Act (HIPAA) American National Standards Institute (ANSI) X12-N 837 professional claim shall include the newly assigned 5-byte only COBA Medigap claim-based ID (range=55000 to 59999) in field NM109 of the NM1 segment within the 2330B loop. Retail pharmacies that bill National Council for Prescription Drug Programs (NCPDP) batch claims to Medicare shall include the newly assigned Medigap identifier within field 301-C1 of the T04 segment of their incoming NCPDP claims.

Beginning October 1, 2007, Changes to Medigap & Automatic Crossover Trading Partner Identifiers/Listings

Beginning October 1, 2007, new 5-digit (range = 55000 to 59999) Coordination of Benefits Contractor Agreement (COBA) will replace Medigap/OCNA claim-based identifiers. Only those insurers who have obtained the new COBA IDs will be listed in the NHIC, Corp. DME MAC A COBA Assignment List. New COBA ID information will be added as it is made available. **Providers/Billers must use the old contractor-assigned numbers on the incoming DME MAC claims until Monday, October 1, 2007.**

The updated COBA Assignment List is available on the DME MAC A web site at **http://www.medicarenhic.com/dme/edi/references/COBA_Assignments.pdf.** Insurer identifiers/listings which have not been updated to the new format have been deleted from the list.

Providers/Billers are reminded not to use the new identifiers until Monday, October 1, 2007.

For more information visit:
Coordination of Benefits (COB) Overview on the CMS website:
http://www.cms.hhs.gov/cobagreement/

COB ID listings:
http://www.cms.hhs.gov/COBAgreement/Downloads/Medigap%20Claim-based%20COBA%20IDs%20for%20Billing%20Purpose.pdf

Related *MLN Matters* article:
http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5601.pdf

Clarification Concerning Provider Billing Procedures Related to the Transition of the Medigap claim-based Crossover Process to the Coordination of Benefits Contractor on October 1, 2007 (SE0743)

MLN Matters Number: SE0743
Related CR Release Date: N/A
Related CR Transmittal #: N/A
Related Change Request (CR) #: CR5601 and CR5662
Effective Date: October 1, 2007
Implementation Date: N/A

Provider Types Affected

Physicians and suppliers submitting claims to Part B Medicare contractors (including carriers, Medicare Administrative Contractors (A/B MACs), and durable medical equipment MACs (DME MACs).

Provider Action Needed

As instructed in *MLN Matters* article MM5601, all providers that bill their claims to Part B carriers, A/B MACs, or DMACs should, effective with October 1, 2007, begin to include a new Coordination of Benefits Agreement (COBA) Medigap 5-byte COBA ID (range 55000 to 59999) on incoming Medicare paper claims (CMS-1500), or incoming Health Insurance Portability and Accountability Act (HIPAA) 837 professional (version 4010A1), or National Council for Prescription Drug Programs (NCPDP) version 5.1 batch standard 1.1 claims to trigger crossovers to those Medigap insurers that are participating in the Centers for Medicare & Medicaid Services (CMS) new COBA Medigap claim-based process.

Providers should be including **only** the new 5-byte COBA Medigap claim-based ID on incoming Medicare claims effective October 1, 2007, for the purpose of triggering crossovers to those Medigap insurers that have been assigned a COBA Medigap claim-based ID that falls in the range of 55000 through 59999. The link to the Medigap Billing ID spreadsheet, which providers or their billing vendors should consult for this purpose, remains as **http://www.cms.hhs.gov/COBAgreement/Downloads/Medigap%20Claim-based%20COBA%20IDs%20for%20Billing%20Purpose.pdf** on the CMS website.

Though the number of entities that have requested COBA Medigap claim-based IDs is currently not very large, providers and their billing vendors should continue to consult this listing for purposes of noting changes. Please be assured the list is complete and accurate. Providers or their billing vendors should include only the Medigap COBA IDs on this list (range 55000 through 59999) on Medicare claims for purposes of triggering crossovers to Medigap insurers. Providers or their billing vendors should not include any of the eligibility file-based COBA IDs (ranges 00001-29999; 30000-54999; 60000-69999; 70000-79999; and 80000-89999) on inbound claims to Medicare.

Effective October 1, 2007, if a provider or its billing vendor files a Medicare claim with a COBA ID other than the COBA Medigap IDs on the above-referenced Medigap Billing ID list, Medicare will generate an MA-19 message on the provider's 835 electronic remittance advice (ERA) or other remittance advice in use. This message indicates: "Information was **not** sent to the Medigap insurer due to incorrect/invalid information you submitted concerning that insurer. Please verify your information and submit your secondary claim directly to that insurer."

As a reminder, all entities that participate in the COBA eligibility file-based crossover process or automatic complementary crossover process may be referenced at **http://www.cms.hhs.gov/COBAgreement/Downloads/Contacts.pdf** on the CMS website.

Providers should **not** contact those insurers or payers listed as participating in the automatic crossover process for purposes of determining whether CMS has assigned them a COBA Medigap claim-based ID. As aforementioned, providers or their billing vendors should also **not** utilize COBA ID information from this listing on their incoming Medicare claims for the purpose of triggering Medigap claim-based crossovers. **IMPORTANT:** Not every Medigap insurer is utilizing the automatic crossover process for the purpose of identifying **all** of its covered members or policyholders for crossover purposes and for receiving crossover claims for those Medicare beneficiaries. An example of this scenario is as follows: If the COBC was approached by a new Medigap insurer that specified that it needed to apply for a Medigap claim-based ID (range 55000 to 59999) for various segments of its covered membership, but will utilize the automatic complementary crossover process for the remainder of its Medigap membership, the COBC would, following execution of the COBA crossover agreement with the insurer, assign it two COBA IDs-one for automatic crossover (range 30000 to 54999 for automatic Medigap eligibility file-based crossover) and the other for Medigap claim-based crossover (55000 to 59999). Thus, this Medigap insurer would appear on **both** the listing of automatic crossover insurers as well as the Medigap Billing ID listing at the respective URL links on the COB website, referenced above.

Background

All supplemental insurers are required to sign a national COBA crossover agreement with CMS' Coordination of Benefits Contractor (COBC) if they participate in CMS' automatic complementary crossover (COBA eligibility file-based crossover) process **or** in the COBA Medigap claim-based crossover process. Providers should know that it is **never** their responsibility to request or obtain new Medigap 5-byte IDs for their patients' Medigap insurers through the signing of a national COBA crossover agreement.

In *MLN Matters* article, MM5662, CMS informed its affected provider community that, during June through August 2007, its COBC would assign a new 5-byte COBA Medigap claim-based identifier (range=55000 to 59999) to a Medigap insurer after it has signed a national crossover agreement with the COBC. Despite repeated outreach communications to the health insurance industry, not all Medigap insurers have, as instructed, contacted the COBC to specify which approach, among three available options, they will exercise to ensure continued receipt of crossover claims on and after October 1, 2007.

Clarification Concerning Provider Billing Procedures Related to the Transition of the Medigap claim-based Crossover Process to the Coordination of Benefits Contractor on October 1, 2007 (SE0743) (Continued)

The three (3) options available to each Medigap insurer for addressing its receipt of Medicare crossovers remain as follows:

- If applicable, continue to participate **fully** in the automatic crossover process (or COBA eligibility file-based crossover process) and discontinue use of any claim-based Medigap IDs;
- Continue to participate in part in the automatic crossover process for a segment of the insurer's covered membership but request a COBA Medigap claim-based ID through the COBC to address crossovers for the remaining segments; or
- Request a new COBA Medigap claim-based crossover ID through the COBC, with the understanding that the Medigap insurer would prefer **not** to participate in the automatic crossover process.

To be clear, if a Medigap insurer is currently participating **fully** in the automatic (or COBA eligibility file-based) crossover process, it merely needs to inform the COBC of this decision. Upon doing so, that Medigap insurer will experience no disruption in its receipt of crossover claims. Based upon its most recent review of trending, CMS has noted that the vast majority of the larger, more commonly known Medigap insurers, which were already participating **fully** in the Medicare automatic crossover process, have informed CMS and the COBC that they plan to continue to participate fully in the automatic crossover process for purposes of fulfilling their mandatory Medigap crossover payment responsibilities on behalf of their Medigap policyholders. In other words, the majority of the larger, more commonly known Medigap insurers have exercised option #1, above.

Additional Information

You can find *MLN Matters* articles MM5061 and MM5662 at
http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5601.pdf and
http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5662.pdf on the CMS website.

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

Electronic Funds Transfer Standardizations and Revisions to the Medicare Claims Processing Manual (Chapter 24) (MM5586)

MLN Matters Number: MM5586
Related CR Release Date: July 9, 2007
Related CR Transmittal #: R1284CP

Related Change Request (CR) #: 5586
Effective Date: July 1, 2007
Implementation Date: October 1, 2007

Provider Types Affected

Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, DME Medicare Administrative Contractors (DME MACs), Fiscal Intermediaries (FIs), Part A/B Medicare Administrative Contractors (A/B MACs), and/or Regional Home Health Intermediaries (RHHIs)) for services provided to Medicare beneficiaries.

Provider Action Needed

Impact to You

This article is based on Change Request (CR) 5586 which revises the *Medicare Claims Processing Manual,* Chapter 24 (General Electronic Data Interchange (EDI) and EDI Support Requirements, Electronic Claims and Coordination of Benefits Requirements, Mandatory Electronic Filing of Medicare Claims).

What You Need to Know

Effective July 1, 2007, your Medicare contractor will conduct Administrative Simplification Compliance Act (ASCA) reviews annually of at least 20% of providers submitting CMS 1500 paper claims who were not already reviewed in the past 2 years and found to have fewer than 10 FTEs employed by the practice. In addition, contractors will insure that the addenda record is sent with the Medicare claim payment when an ACH format is used to transmit an EFT payment to a financial institution but the remittance advice is separately transmitted to a provider. This will assist with reconciliation of the payment and the information that explains the payment. The EFT format will be the National Automated Clearinghouse Association (NACHA) format CCP - Cash Concentration/Disbursement plus Addenda (CCD+) (ACH) as mentioned in the X12N 835 version 004010A1 implementation guide.

What You Need to Do

See the Background and Additional Information Sections of this article for further details regarding these changes.

Electronic Funds Transfer Standardizations and Revisions to the Medicare Claims Processing Manual (Chapter 24) (MM5586) (Continued)

Background
Change Request (CR) 5586 provides the following revisions to the *Medicare Claims Processing Manual* (Chapter 24, Sections 40.7 and Section 90.5.3) regarding electronic funds transfer (EFT) and the identification of providers to be reviewed.

Contractor Roles in Administrative Simplification Compliance Act (ASCA) Reviews and Identification of Providers to be Reviewed
Each carrier, DME MAC and B MAC (not FIs or RHHIs at this time) conducts an ASCA review annually of 20% of those providers still submitting CMS 1500 paper claims. Medicare contractors will not select a provider for a quarterly review if:

- A prior quarter review is underway and has not yet been completed for that provider;
- The provider has been reviewed within the past two years, determined to be a "small" provider as fewer than 10 FTEs are employed in that practice and there is no reason to expect the provider's "small" status will change within two years of the start of the prior review; or
- Fewer than 30 paper claims were submitted by the provider to Medicare during the prior quarter.

Electronic Funds Transfer (EFT)
Although EFT is not mandated by the Health Insurance Portability and Accountability Act (HIPAA), EFT is the required method of Medicare payment for all providers entering the Medicare program for the first time and any existing providers, not currently receiving payments by EFT, who are submitting a change to their existing enrollment data. Providers must submit a signed copy of Form CMS-588 (Electronic Funds Transfer Authorization Agreement) to their Carriers, DME MACs, A/B MACs, FIs, and/or RHHIs. For changes of information, DME MACs will verify the authorized official on the CMS-855 form. In addition, Medicare contractors will not approve any requests to change the payment method from EFT to check.

Carriers, DME MACs, A/B MACs, FIs and RHHIs must use a transmission format that is both economical and compatible with the servicing bank. If the money is traveling separately from an X12 835 transaction, then the NACHA format CCP (Cash Concentration/Disbursement plus Addenda -CCD+) is used to make sure that the addenda record is sent with the EFT, because providers need the addenda record to re-associate dollars with data. Carriers, DME MACs, A/B MACs, FIs, and RHHIs must:

- Transmit the EFT authorization to the originating bank upon the expiration of the payment floor applicable to the claim, and
- Designate a payment date (the date on which funds are deposited in the provider's account) of two business days later than the date of transmission.

Note: *Medicare contractors will not approve any requests to change payment method from EFT to check.*

Additional Information
The official instruction, CR5586, issued to your carrier, intermediary, RHHI, A/B MAC, or DME MAC regarding this change may be viewed at **http://www.cms.hhs.gov/Transmittals/downloads/R1284CP.pdf** on the CMS website.

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

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

New Healthcare Provider Taxonomy Code List Effective October 2007

Effective October 1, 2007, the new **Healthcare Provider Taxonomy Codes (HPTC)** set list will be available from the Washington Publishing Company (WPC) website at **http://www.wpc-edi.com/codes/taxonomy**.

Newly approved codes **may not be used prior to the effective date** and terminated codes may not be used after the specified termination date. Although updates may be posted on the WPC Web page up to 3 months prior to the effective date, changes are not effective until October 1, 2007. To avoid delays in the processing of your claims, please ensure you are using only the latest HPTC set list.

If you have any questions regarding the new HPTC, please contact the DME MAC Jurisdiction A EDI Support Staff at **866-563-0049**.

Remittance Advice Remark Code (RARC) and Claim Adjustment Reason Code (CARC) Update (MM5721)

MLN Matters Number: MM5721
Related CR Release Date: September 28, 2007
Related CR Transmittal #: R1345CP

Related Change Request (CR) #: 5721
Effective Date: October 1, 2007
Implementation Date: October 1, 2007

Provider Types Affected
Physicians, providers, and suppliers who submit claims to Medicare contractors (carriers, fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), Part A/B Medicare Administrative Contractors (A/B MACs), and DME Medicare Administrative Contractors (DME MACs)) for services

Provider Action Needed
CR 5721, from which this article is taken, announces the latest update of X12N 835 Health Care RARCs and X12N 835 and 837 Health Care CARCs, effective October 1, 2007. Be sure billing staff are aware of these changes.

Background
For transaction 835 (Health Care Claim Payment/Advice) and standard paper remittance advice, there are two code sets - Claim Adjustment Reason Code (CARC) and Remittance Advice Remark Code (RARC) - that must be used to report payment adjustments, appeal rights, and related information. Additionally, for transaction 837 coordination-of-benefits (COB), CARC must be used. These code sets are updated on a regular basis. Medicare contractors must use only currently valid codes, and make the necessary changes on a regular basis as per this recurring code update CR or the specific CR that describes the change in policy that resulted in the code change.

The RARC list is maintained by the Centers for Medicare & Medicaid Service (CMS), and used by all payers. Additions, deactivations, and modifications to the list may be initiated by both Medicare and non-Medicare entities. The health care claim adjustment reason code list is maintained by a National Code Maintenance Committee that meets when X12 meets for their trimester meetings to make decisions about additions, modifications, and retirement of existing reason codes.

As mentioned earlier in CR 5634, at least one remark code must be used with the following 5 CARCs:

16 - Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)

17 - Payment adjusted because requested information was not provided or was insufficient/incomplete. At least one Remark Code must be provided. (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)

96 - Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)

125 - Payment adjusted due to a submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)

A1 - Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)

Both code lists are updated three times a year, and are posted at **http://wpc-edi.com/codes** on the Internet. Please note that in order to synchronize with the CARC update schedule, the RARC list will be updated in early November, March and July instead of the current schedule of early December, April and August. **The lists at the end of this article summarize the latest changes to these lists, as announced in CR 5721, to be effective on and after October 1, 2007 for Medicare.**

CMS has also developed a new tool to help you search for a specific category of code and that tool is at **http://www.cmsremarkcodes.info** on the CMS website. Note that this website does not replace the WPC site and, should there be any discrepancies between this site and the WPC site, consider the WPC site to be correct.

Remittance Advice Remark Code (RARC) and Claim Adjustment Reason Code (CARC) Update (MM5721) (Continued)

Additional Information

You can see the official instruction issued to you're A/B MAC, FI, carrier, DME MAC, or RHHI regarding these latest RARC and claim adjustment reason code updates by going to CR 5721, located at **http://www.cms.hhs.gov/transmittals/downloads/R1345CP.pdf** on the CMS website.

For additional information about Remittance Advice, please refer to *Understanding the Remittance Advice (RA): A Guide for Medicare Providers, Physicians, Suppliers, and Billers* at **http://www.cms.hhs.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf** on the CMS website.

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.zip** on the CMS website.

Remittance Advice Remark Code changes

New Remark Codes

Code	Current Narrative	Medicare Initiated
N380	The original claim has been processed, submit a corrected claim.	No
N381	Consult our contractual agreement for restrictions/billing/payment information related to these charges.	No
N382	Missing/incomplete/invalid patient identifier.	No
N383	Services deemed cosmetic are not covered	No
N384	Records indicate that the referenced body part/tooth has been removed in a previous procedure.	No
N385	Payment has been adjusted because notification of admission was not timely according to published plan procedures.	No
N386	This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at **http://www.cms.hhs.gov/mcd/search.asp**. If you do not have web access, you may contact the contractor to request a copy of the NCD.	Yes
N387	You should submit this claim to the patient's other insurer for potential payment of supplemental benefits. We did not forward the claim information.	Yes

Remittance Advice Remark Code (RARC) and Claim Adjustment Reason Code (CARC) Update (MM5721) (Continued)

Modified Remark Codes

The following codes have been identified as "Informational" codes, and modified to add the word "Alert" in front of the current text.

M4	MA15	N59	N155	N353
M6	MA18	N84	N156	N355
M9	MA19	N85	N162	N358
M17	MA26	N88	N177	N360
M27	MA28	N89	N183	N363
M32	MA44	N130	N185	N364
M39	MA45	N132	N187	N367
M70	MA59	N133	N189	
M118	MA62	N134	N196	
MA01	MA68	N136	N202	
MA07	MA72	N137	N210	
MA08*	MA77	N138	N211	
MA10	N1	N139	N215	
MA13	N21	N140	N220	
MA14	N23	N154	N352	

*Code MA08 text has been modified further as follows:

Old Text for MA08	New Text for MA08
You should also submit this claim to the patient's other insurer for potential payment of supplemental benefits. We did not forward the claim information as the supplemental coverage is not with a Medigap plan, or you do not participate in Medicare.	**Alert:** Claim information was not forwarded because the supplemental coverage is not with a Medigap plan, or you do not participate in Medicare.

NOTES: *Some remark codes may only provide general information that may not necessarily supplement the specific explanation provided through a reason code and in some cases another/other remark code(s) for an adjustment. Codes that are "Informational" will have "Alert" in the text to identify them as informational rather than explanatory codes. These informational codes should be used only if specific information about adjudication (like appeal rights) needs to be communicated. An example of an informational code:*

N369 Alert: Although this claim has been processed, it is deficient according to state legislation/regulation.

The above information is sent per state regulation but does not explain any adjustment. These informational codes should be used only if specific information about adjudication (like appeal rights) needs to be communicated but not as default codes.

Deactivated Remark Codes

Code	Current Narrative	Notes
N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.	Deactivated effective 10/1/07. Consider using Reason Code 45
N361	Payment adjusted based on multiple diagnostic imaging procedure rules	Deactivated effective 10/1/07. Consider using Reason Code 59

Remittance Advice Remark Code (RARC) and Claim Adjustment Reason Code (CARC) Update (MM5721) (Continued)

X12 N Health Care Claim Adjustment Reason Code Changes

Explanation of Start, Last Modified, and Stop

- **Start** - Every code has a start date. This is the date when the code was first available in the code list.
- **Last Modified** - When populated, this is the date of the code list release when the definition of the specific code was last modified by the committee. This date represents a point when the definition changed from one wording to another.
- **Stop** - When populated, this date identifies that the code can no longer be used in original business messages after that date. The code can only be used in derivative business messages (messages where the code is being reported from the original business message). For example, a CARC with a stop date of 02/01/2007 would not be able to be used by a health plan in a CAS segment in a claim payment/remittance advice transaction (835) dated after 02/01/2007 as part of an original claim adjudication. The code would still be able to be used after 02/01/2007 in derivative transactions, as long as the original usage was prior to 02/01/2007. Derivative transactions include: secondary or tertiary claims (837) from the provider or health plan to a secondary or tertiary health plan, an 835 from the original health plan to the provider as a reversal of the original adjudication. The deactivated code is usable in these derivative transactions because they are reporting on the valid usage (pre-deactivation) of the code in a previously generated 835 transaction.

New Reason Codes

Code	Current Narrative	Notes
202	Payment adjusted due to non-covered personal comfort or convenience services.	Start: 02/28/2007
203	Payment adjusted for discontinued or reduced service.	Start: 02/28/2007
204	This service/equipment/drug is not covered under the patient's current benefit plan	Start: 02/28/2007
205	Pharmacy discount card processing fee	Start: 07/09/2007
206	NPI denial - missing	Start: 07/09/2007
207	NPI denial - Invalid format	Start: 07/09/2007 Stop: 05/23/2008
208	NPI denial - not matched	Start: 07/09/2007
209	Per regulatory or other agreement, the provider cannot collect this amount from the patient. However, this amount may be billed to subsequent payer. Refund to patient if collected. (Use Group code OA)	Start: 07/09/2007
210	Payment adjusted because pre-certification/authorization not received in a timely fashion	Start: 07/09/2007
211	National Drug Codes (NDC) not eligible for rebate, are not covered.	Start: 07/09/2007

Remittance Advice Remark Code (RARC) and Claim Adjustment Reason Code (CARC) Update (MM5721) (Continued)

Modified Reason Codes

Code	Current Narrative	Notes
59	Charges are adjusted based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.)	Start: 01/01/1995 Last Modified: 02/28/2007
197	Payment adjusted for absence of recertification/authorization. This change effective 1/1/2008: Payment adjusted for absence of precertification/authorization/notification.	Start: 10/31/2006 Last Modified: 07/09/2007
115	Payment adjusted as procedure postponed or canceled. This change effective 1/1/2008: Payment adjusted as procedure postponed, canceled, or delayed.	Start: 01/01/1995 Last Modified: 07/09/2007
85	Interest amount. This change effective 1/1/2008: Patient Interest Adjustment (Use Only Group code PR) Notes: only use when the payment of interest is the responsibility of the patient	Start: 01/01/1995 Last Modified: 07/09/2007

Deactivated Reason Codes

Code	Current Narrative	Notes
A2	Contractual adjustment. Notes: Use Code 45 with Group Code 'CO' or use another appropriate specific adjustment code. The "Stop" date of 1/1/2008 may change.	Start: 01/01/1995 Stop: 01/01/2008 Last Modified: 02/28/2007
207	NPI denial - Invalid format	Start: 07/09/2007 Stop: 05/23/2008

In addition, CR5721 contains a comprehensive list of deactivated reason codes. These codes have been deactivated prior to publication of CR5721 and have been included in previous CRs. Because of a policy change, the deactivation date may have moved from a specific version to a specific date. Contractors will not use any of these codes in any original business messages, but these codes may be used in derivative business messages (messages where the code is being reported from the original business message). This list can be viewed by accessing CR5721 at the Web address cited in the "Additional Information" section (above) of this article.

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

Remittance Advice Remark Code (RARC) and Claim Adjustment Reason Code (CARC) Updates 10/01/2007

Effective October 1, 2007 Change Request (CR) 5721 announces the release of the Remittance Advice and Claim Adjustment Reason Code updates. The complete list of reason codes is available from Washington Publishing, visit their website at **http://www.wpc-edi.com/codes**

For information on the new codes, modified codes, and deactivated codes that are involved in this update, you can review CR 5721 at: **http://www.cms.hhs.gov/transmittals/downloads/R1345CP.pdf**

If you have any further questions regarding the reason code updates you can contact customer service at: **866-419-6458**

Transitioning the Mandatory Medigap ("Claim-Based") Crossover Process to the Coordination of Benefits Contractor (COBC) (MM5601)

MLN Matters Number: MM5601 - Revised
Related CR Release Date: August 31, 2007
Related CR Transmittal #: R1332CP

Related Change Request (CR) #: 5601
Effective Date: October 1, 2007
Implementation Date: October 1, 2007

Note: *This article was revised on September 3, 2007, to reflect changes CMS made to CR5601, which was re-issued on August 31, 2007. The CR transmittal number, release date, and the web address for accessing CR5601 were revised in this article. All other information remains the same.*

Provider Types Affected
Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, DME Medicare Administrative Contractors (DME MACs), and/or Part A/B Medicare Administrative Contractors (A/B MACs)), for services provided to Medicare beneficiaries.

Provider Action Needed
Impact to You
This article is based on Change Request (CR) 5601, which outlines the Centers for Medicare & Medicaid Services (CMS) systematic requirements for the transitioning of its mandatory Medigap ("claim-based") crossover process from its Part B contractors to the COBC. During the period from June through September 2007, CMS' Coordination of Benefits Contractor (COBC) will sign national crossover agreements with Medigap claim-based crossover insurers and will assign new 5-digit Coordination of Benefits (COBA) Medigap claim-based crossover identifiers to these entities for inclusion on incoming Medicare claims. CMS is also preparing a separate change request (CR 5662) that includes the website where provider billing staffs may go to obtain the listing of new COBA Medigap claim-based identifiers for purposes of initiating Medigap claim-based crossovers. Within the next few weeks, following the issuance of CR 5662, providers will also receive more detailed information regarding this change via their Medicare contractors' provider newsletters/bulletins and websites.

What You Need to Know
October 1, 2007 is the effective date for completing the transition of the Medigap crossover process to the COBC. At that time, CMS will then only support the Health Insurance Portability and Accountability Act (HIPAA) American National Standards Institute (ANSI) X-12N 837 professional COB (version 4010-A1) claim format **and National Council for Prescription Drug Programs (NCPDP) version 5.1 batch standard 1.1 claim format for such crossovers**. As CMS' COBC assigns the new COBA Medigap claim-based ID to the Medigap insurers, it will populate this information on its COB website so that provider billing staffs may access it for purposes of including the new identifiers on incoming Medicare Part B claims, claims for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS), and NCPDP Part B drug claims. By October 1, 2007, providers will exclusively be including the new identifiers on incoming claims to initiate Medigap claim-based crossovers.

What You Need to Do
During June through September, 2007, CMS will gradually be moving Medigap insurers to the new process. Be certain that your billing staffs are aware of these changes and that claims are sent to Medicare contractors in a timely and correct manner.

Background
Currently, in accordance with §1842(h)(3)(B) of the Social Security Act and §4081(a)(B) of Public Law 100-203 (the Omnibus Budget Reconciliation Act of 1987), Part B contractors, including carriers and Medicare Administrative Contractors (MACs), and Durable Medical Equipment Medicare Administrative Contractors (DME MACs) transfer participating provider claims to Medigap insurers if the beneficiary has assigned rights to payment to the provider and if other claims filing requirements are met. This form of claims transfer is commonly termed "Medigap claims-based crossover." One of the "other" claims filing requirements for Medigap claim-based crossover is that the participating provider must include an Other Carrier Name and Address (OCNA) or N-key identification number on the incoming electronic claim to trigger the crossing over of the claim.

Transitioning the Mandatory Medigap ("Claim-Based") Crossover Process to the Coordination of Benefits Contractor (COBC) (MM5601) (Continued)

Key Points of CR5601

- Be aware that during the transition period from June through September 2007 the COBC will assign new 5-byte claim-based Coordination of Benefits Agreement (COBA) IDs to the Medigap insurers on a graduated basis throughout the three month period prior to the actual transition. Until CMS' COBC assigns a new 5-digit COBA Medigap claim-based ID to a Medigap insurer, Medicare will continue to accept the older contractor-assigned OCNA or N-key identifiers for purposes of initiating Medigap claim-based crossovers. During June through September 2007, the affected contractors will also continue to cross claims over as normal to their Medigap claim-based crossover recipients. CMS will be regularly apprising the affected Medicare contractors when the COBC has assigned new COBA Medigap claim-based IDs to the Medigap insurers and will post this information on its COB website so that contractors **may direct providers to that link for purposes of obtaining regular updates**.
- Effective with claims filed to Medicare on October 1, 2007:
  - All participating providers that have been granted a billing exception under the Administrative Simplification Compliance Act (ASCA) should enter CMS' newly assigned COBA Medigap claim-based identifier (ID) within block 9-D of the incoming CMS-1500 claim for purposes of triggering Medigap claim-based crossovers.
  - All other participating providers shall enter the newly assigned COBA Medigap claim-based ID, left-justified and followed by spaces, within the NM109 portion of the 2330B loop of the incoming HIPAA ANSI X12-N 837 professional claim **and** within field 301-C1 of the T04 segment on incoming National Council for Prescription Drug Programs (NCPDP) claims for purposes of triggering Medigap claim-based crossovers.
- Providers will need to make certain that claims are submitted with the appropriate identifier that begins with a "5" and contains "5" numeric digits.
- Be mindful that claims for Medigap claim-based crossovers shall feature a syntactic editing of the incoming COBA claim-based Medigap ID to ensure that the identifier begins with a "5" and contains 5 numeric digits. If your claim does not follow the appropriate format, Medicare will continue to adjudicate your claim as normal but will notify you via the Electronic Remittance Advice (ERA) and the beneficiary via the Medicare Summary Notice (MSN) that the information reported was insufficient to cause the claim to be crossed over.
- Your Medicare contractor's screening process will also continue to verify that you participate with Medicare and that the beneficiary has assigned benefits to you as the provider.
- If the claim submitted to the Medicare contractor indicates that (1) the claim contained an invalid claim-based Medigap crossover ID, **the Medicare contractor** will send the following standard message to you, the provider.
  - "Information was **not** sent to the Medigap insurer due to incorrect/invalid information you submitted concerning the insurer. **Please verify your information and submit your secondary claim directly to that insurer."**
- In addition, in these cases, if CMS' Common Working File (CWF) system determines that the beneficiary was identified for crossover on a Medigap insurer's eligibility file, the CWF system will suppress crossover to the Medigap insurer whose information was entered on the incoming claim.
- Also, the Medicare contractor will include the following message on the beneficiary's MSN in association with the claim: (MSN #35.3):
  - "A copy of this notice will not be forwarded to your Medigap insurer because the Medigap information submitted on the claim was incomplete or invalid. Please submit a copy of this notice to your Medigap insurer."
- **REMEMBER:** As CMS's COBC assigns new 5-digit COBA Medigap claim-based identifiers to Medigap insurers, participating providers will be expected to include the new 5 digit identifier on incoming crossover claims for purposes of triggering claim-based Medigap crossovers. Additionally, effective with **October 1, 2007, Medigap claim-based crossovers will occur exclusively through the COBC in the HIPAA ANSI X12-N 837 professional claim format (version 4010A1 or more current standard) and NCPDP claim format.**

Additional Information

For complete details regarding this Change Request (CR) please see the official instruction (CR5601) issued to your Medicare carrier, A/B MAC, or DME MAC. That instruction may be viewed by going to **http://www.cms.hhs.gov/Transmittals/downloads/R1332CP.pdf** on the CMS website.

If you have questions, please contact your Medicare carrier, A/B MAC, 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 website.

2008 Annual Update of HCPCS Codes for Skilled Nursing Facility (SNF) Consolidated Billing (CB) for the Common Working File (CWF), Medicare Carriers and Fiscal Intermediaries (FIs) (MM5696)

MLN Matters Number: MM5696
Related CR Release Date: August 17, 2007
Related CR Transmittal #: R1317CP

Related Change Request (CR) #: 5696
Effective Date: January 1, 2008
Implementation Date: January 7, 2008

Provider Types Affected
Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, durable medical equipment Medicare Administrative Contractors (DME MACs), Part A/B Medicare Administrative Contractors (Part A/B MACs) and fiscal intermediaries (FIs)) for services provided to Medicare beneficiaries in SNFs.

Provider Action Needed
Impact to You
This article is based on Change Request (CR) 5696, which provides the 2008 annual update of HCPCS Codes for SNF CB and how the updates affect edits in Medicare claims processing systems.

What You Need to Know
CR5696 provides updates to HCPCS codes that will be used to revise CWF edits to allow carriers and FIs to make appropriate payments in accordance with policy for SNF CB in the *Medicare Claims Processing Manual*, Chapter 6, Section 110.4.1 for carriers and Chapter 6, Section 20.6 for FIs.

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

Background
Medicare's claims processing systems currently have edits in place for claims received for beneficiaries in a Part A covered SNF stay as well as for beneficiaries in a non-covered stay. Changes to Healthcare Common Procedure Coding System (HCPCS) codes and Medicare Physician Fee Schedule designations are used to revise these edits to allow carriers, A/B MACs, DME MACs, and FIs to make appropriate payments in accordance with policy for SNF CB contained in the *Medicare Claims Processing Manual*. These edits only allow services that are excluded from CB to be separately paid by Medicare contractors.

Physicians and providers are advised that, by the first week in December 2007, new code files will be posted to the at **http://www.cms.hhs.gov/SNFConsolidatedBilling/** on the CMS website. Institutional providers note that this site will include new Excel® and PDF format files.

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

Additional Information
The official instruction, CR5696, issued to your Medicare contractor regarding this change can be found at **http://www.cms.hhs.gov/Transmittals/downloads/R1317CP.pdf** on the CMS website.

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

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

Claim Status Category Code and Claim Status Code Update (MM5687)

MLN Matters Number: MM5687
Related CR Release Date: July 23, 2007
Related CR Transmittal #: R1314CP

Related Change Request (CR) #: 5687
Effective Date: January 1, 2008
Implementation Date: January 7, 2008

Provider Types Affected
Physicians, providers, and suppliers who submit Health Care Claim Status Transactions to Medicare contractors (carriers, Medicare administrative contractors (A/B MACs), durable medical equipment Medicare administrative contractors (DME MACs), fiscal intermediaries (FIs), and regional home health intermediaries (RHHIs)).

Provider Action Needed
Impact to You
This article is based on Change Request (CR) 5687, which provides the January 2008 updates of the Claim Status Codes and Claim Status Category Codes for use by Medicare contractors (carriers, A/B MACs, DME MACs, FIs, and RHHIs).

What You Need to Know
Effective January 1, 2008, Medicare contractors are to use codes posted on July 9, 2007, at the **http://www.wpc-edi.com/codes** Website. 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 discusses these codes in more detail. You may review section 20.7 at: **http://www.cms.hhs.gov/manuals/downloads/clm104c31.pdf** on the Centers for Medicare & Medicaid Services (CMS) website.

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

Background
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. These codes indicate the general category of a claim's status (accepted, rejected, additional information requested, and so on).The national Code Maintenance Committee maintains the Claim Status Category and Claim Status codes.

The national Code Maintenance Committee meets at the beginning of each X12 trimester meeting (February, June, and October) and makes decisions about additions, modifications, and retirement of existing codes. The codes sets are available at **http://www.wpc-edi.com/content/view/180/223/.** This page has previously been referenced by the following URL address: **http://www.wpc-edi.com/codes**. Included in the code lists are specific details, including the date when a code was added, changed, or deleted.

All code changes approved during the June 2007 committee meeting were posted on that site on July 9, 2007. One of the decisions made during this June meeting by this Maintenance Committee was to allow the industry more lead time for implementation of code changes. At least 6 months lead time will be allowed for industry implementation of all Claim Status-related code changes as well as Claim Adjustment Reason Code changes (the same committee maintains these code sets). As result, **changes approved in June 2007 will be effective January 1, 2008.**

Additional Information
For complete details regarding this Change Request (CR) please see the official instruction (CR5687) issued to your Medicare FI, carrier, DME MAC, RHHI or A/B MAC. That instruction may be viewed by going to **http://www.cms.hhs.gov/Transmittals/downloads/R1314CP.pdf** on the CMS website.

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

Remember that you can fax your immediate offset requests
http://www.medicarenhic.com/dme/dme_forms.shtml

Clarification About the Medical Privacy of Protected Health Information (SE0726)

MLN Matters Number: SE0726
Related CR Release Date: N/A
Related CR Transmittal #: N/A
Related Change Request (CR) #: N/A
Effective Date: N/A
Implementation Date: N/A

Provider Types Affected
Physicians, providers, and suppliers who bill Medicare contractors (carriers, durable medical equipment Medicare Administrative Contractors (DME MACs), fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), and/or Part A/B Medicare Administrative Contractors (A/B MACs) for services provided to Medicare beneficiaries.

Provider Action Needed
The purpose of this Special Edition (SE) article, SE0726, is be sure that heath care providers are aware of the helpful guidance and technical assistance materials the U.S. Department of Health and Human Services (HHS) has published to clarify the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), specifically, the educational material below. Remind individuals within your organization of:

- the Privacy Rule's protections for personal health information held by providers and the rights given to patients, who may be assisted by their caregivers and others, and
- that providers are permitted to disclose personal health information needed for patient care and other important purposes.

HHS Privacy Guidance
HHS' educational materials include a letter to healthcare providers with the following examples to clarify the Privacy Rule:

HIPAA does not require patients to sign consent forms before doctors, hospitals, or ambulances can share information for treatment purposes:
Providers can freely share information with other providers where treatment is concerned, without getting a signed patient authorization or jumping through other hoops. Clear guidance on this topic can be found in a number of places:

- Review the answers to frequently asked questions (FAQs) in the "Treatment/Payment/Health Care Operations" subcategory, or search the FAQs on a likely word or phrase such as "treatment." The link to the FAQs may be found at **http://www.hhs.gov/hipaafaq/** on the HHS website.
- Consult the Fact Sheet, "Uses and Disclosures for Treatment, Payment, and Health Care Operations," which is at **http://www.hhs.gov/ocr/hipaa/guidelines/sharingfortpo.pdf** on the HHS website.
- Review the "Summary of the HIPAA Privacy Rule" at **http://www.hhs.gov/ocr/privacysummary.pdf** on the HHS website.

HIPAA does not require providers to eliminate all incidental disclosures:

- The Privacy Rule recognizes that it is not practicable to eliminate all risk of incidental disclosures. That is why, in August 2002, HHS adopted specific modifications to that Rule to clarify that incidental disclosures do not violate the Privacy Rule when providers and other covered entities have common sense policies which reasonably safeguard and appropriately limit how protected health information is used and disclosed.
- OCR guidance explains how this applies to customary health care practices, for example, using patient sign-in sheets or nursing station whiteboards, or placing patient charts outside exam rooms. At the HHS/OCR website, see the FAQs in the "Incidental Uses and Disclosures" subcategory; search the FAQs on terms like "safeguards" or "disclosure"; or review the Fact Sheet on "Incidental Disclosures". The fact sheet is at **http://www.hhs.gov/ocr/hipaa/guidelines/incidentalud.pdf** on the HHS website.

HIPAA does not cut off all communications between providers and the families and friends of patients:

- Doctors and other providers covered by HIPAA can share needed information with family, friends, or with anyone else a patient identifies as involved in his or her care as long as the patient does not object.
- The Privacy Rule also makes it clear that, unless a patient objects, doctors, hospitals and other providers can disclose information when needed to notify a family member, or anyone responsible for the patient's care, about the patient's location or general condition.
- Even when the patient is incapacitated, a provider can share appropriate information for these purposes if he believes that doing so is in the best interest of the patient.
- Review the HHS/OCR website FAQs **http://www.hhs.gov/hipaafaq/notice/488.html** in the sub-category "Disclosures to Family and Friends."

HIPAA does not stop calls or visits to hospitals by family, friends, clergy or anyone else:

- Unless the patient objects, basic information about the patient can still appear in the hospital directory so that when people call or visit and ask for the patient, they can be given the patient's phone and room number, and general health condition.
- Clergy, who can access religious affiliation if the patient provided it, do not have to ask for patients by name.
- See the FAQs in the "Facility Directories" at **http://www.hhs.gov/hipaafaq/administrative/** on the HHS website.

HIPAA does not prevent child abuse reporting:
Doctors may continue to report child abuse or neglect to appropriate government authorities. See the explanation in the FAQs on this topic, which can be found, for instance, by searching on the term "child abuse;" or review the fact sheet on "Public Health" that can be reviewed at **http://www.hhs.gov/ocr/hipaa/guidelines/publichealth.pdf** on the HHS website.

Clarification About the Medical Privacy of Protected Health Information (SE0726) (Continued)

HIPAA is not anti-electronic:
Doctors can continue to use e-mail, the telephone, or fax machines to communicate with patients, providers, and others using common sense, appropriate safeguards to protect patient privacy just as many were doing before the Privacy Rule went into effect. A helpful discussion on this topic can be found at **http://www.hhs.gov/hipaafaq/providers/smaller/482.html** on the HHS website.

Additional Information
The HHS complete listing of all HIPAA medical privacy resources is available at **http://www.hhs.gov/ocr/hipaa/** on the HHS website.

For a full list of educational materials, visit **http://www.hhs.gov/ocr/hipaa/assist.html** on the HHS website.

CMS Extends the Bid Submission, Registration, and Accreditation Deadlines for the First Round of the Medicare DMEPOS Competitive Bidding Program (CMS Message 2007-07-27)

The Centers for Medicare & Medicaid Services (CMS) is extending the bid submission, registration, and accreditation deadlines for the first round of the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding Program.

Note: *All bids are now due by 9:00 p.m. prevailing Eastern Time on September 25, 2007. Suppliers that have already submitted their bids may revise and resubmit their bids until the new deadline. Suppliers that resubmit bids must submit a new certification statement.*

- On May 15, 2007, CMS issued a request for bids for the first round of the Medicare DMEPOS competitive bidding program. The original due date was 9:00 p.m. prevailing Eastern Time on July 13, 2007. **All bids are now due by 9:00 p.m. prevailing Eastern Time on September 25, 2007.**
- Suppliers interested in bidding must first register and receive a User ID and Password before they can access the internet-based bid submission system. Registration opened on April 9, 2007. The original registration deadline was June 30, 2007. CMS has reopened registration. **The registration deadline is now August 27, 2007.**
- Suppliers must be accredited or be pending accreditation to submit a bid and will need to be accredited to be awarded a contract. The accreditation deadline for the first round of competitive bidding was originally August 31, 2007. **The accreditation deadline is now October 31, 2007.**
- CMS is revising the contract periods. The original contract period for mail order diabetic supplies was April 1, 2008 - December 31, 2009. The contract period for all other first round product categories was April 1, 2008 - March 31, 2011. **The contract period for mail order diabetic supplies is now July 1, 2008 - March 31, 2010. The contract period for all other first round product categories is now July 1, 2008 - June 30, 2011.**
- CMS is providing a targeted period to address suppliers' remaining questions on the competitive bidding program. To help ensure that answers are available as soon as possible, please e-mail your questions to the Competitive Bidding Implementation Contractor (CBIC) no later than August 10, 2007. The e-mail address is **cbic.admin@palmettogba.com.**
- There are revised customer service hours at the Competitive Bidding Implementation Contractor (CBIC). Effective immediately, the CBIC help desk will be available to assist you from 9 a.m. until 9 p.m. EST, Monday through Friday. You may call the help desk at **877-577-5331.**

For more information on the program, please visit **http://www.dmecompetitivebid.com**

HHS and DOJ Announce Initiative to Fight Infusion Fraud Therapy (CMS Message 2007-08-21)

Today, Health and Human Services Secretary (HHS) Mike Leavitt announced an initiative designed to protect Medicare beneficiaries from fraudulent providers of infusion therapy. This two-year project will focus on preventing deceptive providers from operating in South Florida. Providers will be required to reapply to be a qualified Medicare infusion therapy provider.

"HHS continues to work with the Department of Justice (DOJ) to protect the public and Medicare by stopping fraud before it happens," Secretary Leavitt said. "This demonstration project works to bar unlawful infusion therapy providers from entering the Medicare billing system." The new infusion therapy demonstration follows similar demonstration projects previously announced by HHS.

The Centers for Medicare & Medicaid Services (CMS) will now require infusion providers who operate in several South Florida counties to immediately resubmit applications to be a qualified Medicare infusion therapy provider. Those who fail to reapply within 30 days of receiving a notice to reapply from CMS will have their Medicare billing privileges revoked. Infusion therapy providers that fail to report a change in ownership; have owners, partners, directors or managing employees who have committed a felony, or no longer meet each and every provider enrollment requirement will have their billing privileges revoked.

The DOJ is supporting HHSs new controls through a surge in prosecutions for health care fraud in South Florida. In May, the DOJ and HHS announced the work of a multi-agency team of federal, state and local investigators designed specifically to combat Medicare fraud through the use of real-time analysis of Medicare billing. Since implementing the "phase one" Strike Force in Miami last March, DOJ prosecutors working with Assistant U.S. Attorneys from the Southern District of Florida have filed 47 indictments charging 65 individuals and/or entities with health care fraud in schemes that collectively billed Medicare more than $345 million. The Strike Force has convicted 26 defendants to date; 23 by plea agreement and three have been convicted in jury trials.

To view the HHS Press Release on this topic visit the HHS Web site at
http://www.hhs.gov/news/press/2007pres/08/pr20070820a.html

To view the HHS Fact Sheet on this topic visit the HHS Web site at
http://www.hhs.gov/news/facts/infusiontherapy.html

Note: *All HHS press releases, fact sheets and other press materials are available at* ***http://www.hhs.gov/news***

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

Medicare Clinical Trial Policy (CTP) (MM5719)

MLN Matters Number: MM5719
Related CR Release Date: September 7, 2007
Related CR Transmittal #: R74NCD
Related Change Request (CR) #: 5719
Effective Date: July 9, 2007
Implementation Date: October 9, 2007

Provider Types Affected
All physicians, providers, and suppliers who submit claims related to clinical trials to Medicare contractors (carriers, Medicare Administrative Contractors (A/B MACs), durable medical equipment Medicare Administrative Contractors (DME/MACs), fiscal intermediaries (FIs), and regional home health intermediaries (RHHIs)).

Provider Action Needed
Impact to You
This article is based on Change Request (CR) 5719, which implements two changes to the 2000 clinical trial policy by: (1) modifying for clarity the language describing coverage of an investigational item/service in the context of a clinical trial, and, (2) adopting coverage with evidence development (CED). The remainder of the 2000 clinical trials policy continues without change.

CR 5719 states that for items and services furnished on and after July 9, 2007, the routine costs of a clinical trial include all items and services that are otherwise generally available to Medicare beneficiaries (i.e., there exists a benefit category, it is not statutorily excluded, and there is not a national non-coverage decision) that are provided in either the experimental or the control arms of a clinical trial. The investigational item or service itself is excluded, *unless otherwise covered outside of the clinical trial.*

What You Need to Know
In addition, the National Coverage Determination (NCD) is revised to add coverage with evidence development (CED). CED is for items and services in clinical research trials for which there is some evidence of significant medical benefit, but for which there is insufficient evidence to support a "reasonable and necessary" determination. CED is determined through the NCD process, and conditional upon meeting standards of patient safety and clinical evidence, items and services not otherwise covered would be considered "reasonable and necessary" in the context of a clinical trial. Coverage determined under CED is implemented via subsequent NCDs, CRs, and *MLN Matters* articles specific to the coverage issue.

What You Need to Do
Make certain your billing staffs are aware of these changes. Medicare contractors will adjust claims processed prior to the implementation date of this change if you bring such claims to their attention.

Background
On June 7, 2000, the President of the United States issued an executive memorandum directing the Secretary of Health and Human Services to "explicitly authorize [Medicare] payment for routine patient care costs and costs due to medical complications associated with participation in clinical trials." In keeping with the President's directive, the Centers for Medicare & Medicaid Services (CMS) engaged in defining the routine costs of clinical trials and identifying the clinical trials for which payment for such routine costs should be made. On September 19, 2000, CMS implemented its initial Clinical Trial Policy through the NCD process. On July 10, 2006, CMS opened a reconsideration of its NCD on clinical trials in the *NCD Manual*, section 310.1. CR5719 communicates the findings resulting from that analysis.

Additional Information
To see the official instruction (CR5719) issued to your Medicare FI, carrier, DME/MAC, RHHI or A/B MAC, visit **http://www.cms.hhs.gov/transmittals/downloads/R74NCD.pdf** on the CMS website.

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

Reasons for Provider Notification of Medicare Claims Disputed/Rejected by Supplemental Payers/Insurers (SE0728)

MLN Matters Number: SE0728
Related CR Release Date: N/A
Related CR Transmittal #: N/A
Related Change Request (CR) #: N/A
Effective Date: N/A
Implementation Date: N/A

Provider Types Affected
Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, fiscal intermediaries (FIs), Medicare Administrative Contractors (A/B MACs), and durable medical equipment MACs (DME MACs).

Provider Action Needed
Effective for claims processed on or after July 1, 2007, when claims crossed over by Medicare to a supplemental payer/insurer are rejected or disputed by that insurer, Medicare will add a standardized message to the notification to the provider. That message will be in the form of a Dispute Reason Code, which will explain why the supplemental insurer disputed the claim. Be sure your billing staff is aware of these codes, as described later in this article, and is ready to take corrective action, as appropriate.

Reasons for Provider Notification of Medicare Claims Disputed/Rejected by Supplemental Payers/Insurers (SE0728) (Continued)

Background

In *MLN Matters* article, MM3709, the Centers for Medicare & Medicaid Services (CMS) describes the notification process to Medicare providers when Medicare claims that should automatically cross to a supplemental payer/insurer-are not crossed over due to claim data errors. The notification is mailed to the correspondence address that is submitted by the provider, along with all other Medicare enrollment data, and is maintained by CMS' Medicare contractors. (MM3709 may be referenced at: **http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3709.pdf** on the CMS website.)

There are also situations where provider notifications are sent **after** the claim has crossed to the supplemental payer/insurer. This occurs in situations where the insurer may not be able to process the Medicare claim for supplemental payment and, therefore, rejects or disputes the claim back to CMS' Coordination of Benefits Contractor (COBC). When these situations occur, the COBC transmits a report containing the "disputed" claims to the Medicare contractor, which then notifies the provider, through a special automated correspondence, that the claim was not crossed automatically.

Beginning in July 2007, provider notifications will include standardized language for claims that have been disputed by the supplemental payer/insurer and the dispute has been accepted by the COBC. The standardized language will read: "Claim rejected by other insurer," and it will include a reason code. The following is a list of the reason codes that may be contained in the standardized language and the definition of each:

Dispute Reason Codes:

- 000100 - Duplicate Claim
- 000110 - Duplicate Claim (within the same ISA - IEA loop)
- 000120 - Duplicate claim (within the same ST-SE loop)
- 000200 - Claim for Provider ID/State should have been excluded
- 000300 - Beneficiary not on eligibility file
- 000400 - Reserved for future use
- 000500 - Incorrect claim count
- 000600 - Claim does not meet selection criteria
- 000700 - HIPAA Error
- 009999 - Other

When Medicare providers receive this notification, they may need to take appropriate action to obtain payment from the supplemental payer/insurer for all Dispute Reason Codes **except** for 000100, 000110, 000120, and 000400.

Additional Information

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

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

Revision to Medicare Publication 100-09, Chapter 3 - Provider Inquiries and Chapter 6 - Provider Customer Service Program Updates (MM5597)

MLN Matters Number: MM5597 - Revised
Related CR Release Date: July 13, 2007
Related CR Transmittal #: R20COM

Related Change Request (CR) #: 5597
Effective Date: May 23, 2007
Implementation Date: July 30, 2007

Note: *This article was revised on July 16, 2007, to reflect changes that CMS made to CR5597. The transmittal number, CR release date, and the Web address for accessing CR5597 were changed. All other information remains the same.*

Provider Types Affected
All physicians, suppliers, and providers who submit written inquiries to, or contact the toll-free lines at, their Medicare contractors [fiscal intermediaries (FIs), carriers, Part A/B Medicare Administrative Contractors (A/B MACs), DME Medicare Administrative Contractors (DME/MACs), and/or regional home health intermediaries (RHHIs).

Provider Action Needed
CR5597 contains a number of revisions to the *Medicare Contractor Beneficiary and Provider Communications Manual*, including changes for authenticating providers who make inquiries of Medicare contractors. Due to the Medicare fee-for-service contingency plan for the National Provider Identifier (NPI), the NPI will not be a required authentication element for general provider telephone and written inquiries until the date that the Centers for Medicare & Medicaid Services (CMS) requires it to be on all claim transactions. In this contingency environment, the provider transaction access number (PTAN) is your current legacy provider identification number. Your PTAN, which may be referred to as your legacy number by some Medicare fee-for-service provider contact centers (PCCs), will be the required authentication element for all inquiries to Interactive Voice Response (IVR) systems, customer service representatives (CSRs), and written inquiry units. **While the authentication rules are part of CR5597, for complete details about these rules under the Medicare NPI contingency plan, see *MLN Matters* article SE0721**, which you will find at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0721.pdf** on the CMS website.

The remainder of this article provides information on the highlights of changes announced in CR5597.

Background
CR5597 modifies *Medicare Contractor Beneficiary and Provider Communications Manual*, Publication 100-09. These changes are summarized as follows:

Overlapping Claims - New Rules
- Medicare often receives multiple claims for the same beneficiary with the same or similar dates of service. An overlap occurs when the date of service or billing period of one claim seems to conflict with the date on another claim, indicating that one of the claims may be incorrect.
- When an inquiry regarding an overlapping claim is received, only the Medicare contractor initially contacted by the provider can authenticate the provider. The provider will be authenticated by verifying the name, PTAN/ legacy number or NPI, beneficiary name, Health Insurance Claim Number (HICN), and date of service for post-claim information, or date of birth for pre-claim information. Authentication does not need to be repeated when the second contractor is contacted.
- Contractors shall release overlapping claim information whether a provider inquires about a claim that was rejected for overlapping information, or if the provider found overlapping information when checking eligibility for a new admittance.
- For specific information regarding the resolution of claims rejected by Medicare's Common Working File (CWF) system, refer to the *Medicare Claims Processing Manual*, Chapter 27, §50 at **http://www.cms.hhs.gov/manuals/downloads/clm104c27.pdf** on the CMS website.

Information Available on the IVR
- **USE THE IVR whenever possible.** Providers should be aware that if a request for claim status or eligibility is received by a CSR or written inquiry correspondent and the requested information is available on the IVR, the CSR/correspondent will probably encourage you to use the self-service options that are available.
- If at any time during a telephone inquiry, you request information that can be found on the IVR the CSR will most likely refer you back to the IVR.

Information Available on the Remittance Advice (RA)
- **USE THE RA whenever possible.** If a CSR or written inquiry correspondent receives an inquiry about information that is available on an RA, the CSR/correspondent will discuss with the inquirer how to read the RA in order to independently find the needed information. The CSR/correspondent will inform the inquirer that the RA is necessary in order to answer any specific questions for which the answers are available on the RA. Providers should also be aware that any billing staff or representatives that make inquiries on his/her behalf will need to have a copy of the RA.
- To make your job easier you may use the Medicare Remit Easy Print (MREP) software. Information about MREP is available at: **http://www.cms.hhs.gov/AccesstoDataApplication/02_MedicareRemitEasyPrint.asp** on the CMS website.
- Providers may also take advantage of national training materials available to educate themselves and their representatives about reading an RA. The national training materials include the MLN product, *Understanding the Remittance Advice: A Guide for Medicare Providers, Physicians, Suppliers, and Billers* which is available at **http://www.cms.hhs.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf** on the CMS website.

Revision to Medicare Publication 100-09, Chapter 3 - Provider Inquiries and Chapter 6 - Provider Customer Service Program Updates (MM5597) (Continued)

- Also available is a website that serves as a resource allowing providers to check the definitions of *Claim Adjustment Reason Codes and Remittance Advice Remark Codes.* This information is available at **http://www.wpc-edi.com/products/codelists/alertservice** on the Washington Publishing Company website.
- There is a web-based training course, *Understanding the Remittance Advice for Professional Providers*, which is available at: **http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5** on the CMS website. The course provides continuing education credits and contains general information about RAs, instructions to help interpret the RA received from Medicare and reconcile it against submitted claims, instructions for reading Electronic Remittance Advices (ERAs) and Standard Paper Remittance Advices, and an overview of the MREP software that Medicare provides free to providers for viewing ERAs.

Authentication of Beneficiary Elements - additions to current rules

CR5597 contains, within its attachments, a detailed table showing the data elements that are released in response to provider inquiries for beneficiary information. A key new provision allows Medicare contractors to release abdominal aortic aneurysm screening information to providers. CR5597 is available at **http://www.cms.hhs.gov/Transmittals/downloads/R20COM.pdf** on the CMS website.

Additional Key Points of CR5597

- Medicare's CSRs have the discretion to end a provider telephone inquiry if the caller places them on hold for two minutes or longer. Where possible, the CSR will give prior notice that a disconnection may occur.
- If a provider requests a copy of the Report of Contact made during a telephone response to a written inquiry, Medicare contractors will send you a letter detailing the discussion. This letter may be sent to you by e-mail or fax, if you request, unless the details include specific beneficiary or claim related information.
- When your Medicare contractor schedules a training event for which there is a charge for attendance and you register and pay, but are unable to attend, you may be entitled to a refund of some or all of your payment. But, to receive such a refund, **you must notify the contractor before the event.**

Additional Information

For complete details regarding this Change Request (CR) please see the official instruction (CR5597) issued to your Medicare carrier, FI, A/B MAC, DME MAC, or RHHI. That instruction may be viewed by going to **http://www.cms.hhs.gov/Transmittals/downloads/R20COM.pdf** on the CMS website.

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

The 2007 Medicare Contractor Provider Satisfaction Survey (MCPSS) Shows Positive Results for Medicare's Fee-for-Service Contractors (SE0733)

MLN Matters Number: SE0733
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 billing the Medicare program.

Provider Action Needed

No action is needed. This article is informational only and provides a summary of the findings from the second annual survey by Medicare to assess provider satisfaction with service from Medicare contractors (carriers, fiscal intermediaries (FIs), Medicare Administrative Contractors (MACs), and Durable Medical Equipment Medicare Administrative Contractors (DME MACs)).

Background

The Centers for Medicare & Medicaid Services (CMS) reports that most Medicare health care providers continue to find satisfaction with the services provided by Medicare contractors.

The Medicare Contractor Provider Satisfaction Survey (MCPSS), recently conducted by CMS for the second year, is designed to garner objective, quantifiable data on provider satisfaction with the fee-for-service contractors that process and pay Medicare claims. The survey revealed that 85 percent of respondents rated their contractors between 4 and 6 on a 6-point scale, with "1" representing "not at all satisfied" and "6" representing "completely satisfied." The national average score for 2007 is 4.56.

The 2007 Medicare Contractor Provider Satisfaction Survey (MCPSS) Shows Positive Results for Medicare's Fee-for-Service Contractors (SE0733) (Continued)

Contractors received an overall composite score for the seven business functions of the provider-contractor relationship: provider communications, provider inquiries, claims processing, appeals, provider enrollment, medical review, and provider audit and reimbursement. For all contractor types, a contractor's handling of provider inquiries surpassed claims processing as the key predictor of a provider's satisfaction. CMS has provided contractors information for process improvement based on individual MCPSS results.

The MCPSS was sent early this year to more than 36,000 randomly selected providers, including physicians, suppliers, health care practitioners and institutional facilities that serve Medicare beneficiaries across the country. The survey was expanded this year to include hospice locations and federally qualified health centers.

The full results of the 2007 survey are now available at **http://www.cms.hhs.gov/MCPSS** on the CMS website.

In January 2008, the next MCPSS will be distributed to a new sample of Medicare providers. The views of each provider in the survey are important because they represent many other organizations similar in size, practice type and geographical location. If you are one of the providers randomly chosen to participate in the 2008 MCPSS implementation, you have an opportunity to help CMS improve service to all providers.

Additional Information
Remember, your Medicare contractor is available to assist you in providing services to Medicare beneficiaries and in being reimbursed timely for those services. Whenever you have questions, contact your contractor at their toll free number, which is available at **http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip** on the CMS website.

Timeliness Standards for Processing 'Other-Than-Clean' Claims (MM5513)

MLN Matters Number: MM5513
Related CR Release Date: July 20, 2007
Related CR Transmittal #: R1312CP
Related Change Request (CR) #: 5513
Effective Date: January 1, 2008
Implementation Date: January 7, 2008

Provider Types Affected
Providers and suppliers submitting claims to Medicare contractors (Fiscal Intermediaries (FIs), Part A/B Medicare Administrative Contractors (A/B MACs), DME Medicare Administrative Contractors (DME MACs), and/or Regional Home Health Intermediaries (RHHIs)) for services provided to Medicare beneficiaries.

Provider Action Needed
Impact to You
This article is based on Change Request (CR) 5513 which implements requirements for timeliness standards for processing other-than-clean claims. The article is informational in nature and requires no action on your part.

What You Need to Know
The Centers for Medicare & Medicaid Services (CMS) published instructions in a separate transmittal to implement requirements for all carriers and Medicare Administrative Contractors (MACs) for timeliness standards for processing other-than-clean claims, and CR5513 implements those same requirements for FIs, A/B MACs, DME MACs, and RHHIs, effective for claims received on or after January 1, 2008.

What You Need to Do
See the Background and Additional Information Sections of this article for further details regarding these requirements.

Background
The Social Security Act (Section 1869(a)(2); **http://www.ssa.gov/OP_Home/ssact/title18/1869.htm**) mandates that Medicare process all "other-than-clean" claims and notify the provider/supplier filing such claims of the determination within 45 days of receiving such claims. The Social Security Act (Section 1869; **http://www.ssa.gov/OP_Home/ssact/title18/1869.htm**) further defines the term "clean claim" as meaning "a claim that has no defect or impropriety (including any lack of any required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payment from being made on the claim under this title." Claims that do not meet the definition of "clean" claims are "other-than-clean" claims, and they require investigation or development external to the contractor's Medicare operation on a prepayment basis.

A Medicare contractor should process all "other-than-clean" claims and notify the provider and beneficiary of their determination within 45 calendar days of receipt. (See *Medicare Claims Processing Manual*, Publication 100-4, Chapter 1, Section 80.2.1 for the definition of "receipt date" and for timeliness standards for clean claims; **http://www.cms.hhs.gov/manuals/downloads/clm104c01.pdf**)

Timeliness Standards for Processing 'Other-Than-Clean' Claims (MM5513) (Continued)

However, when the Medicare contractor develops the 'other-than-clean' claim by asking the provider/supplier or beneficiary for additional information, the Medicare contractor should cease counting the 45 calendar days on the day that the Medicare contractor sends the development letter to the provider/supplier and/or beneficiary. Upon receiving the materials requested in the development letter from the provider/supplier and/or beneficiary, the Medicare contractor should resume counting the 45 calendar days.

Example: *A Medicare contractor receives a claim on June 1st, but does not send a development letter to the provider/supplier/ and/or beneficiary until June 5th. In this example, 5 of the 45 allotted calendar days will have already passed before the Medicare contractor requested the additional information. Upon receiving the information back from the provider/supplier and/or beneficiary, the Medicare contractor has 40 calendar days left to process the claim and notify the individual that filed the claim of the payment determination for that claim.*

Medicare contractors should follow existing procedures relative to both 1) the length of time the provider/supplier and/or beneficiary is afforded the opportunity to return information requested in the development letters and 2) situations where the provider/supplier and or beneficiary does not respond.

This timeliness standard does not apply:

- Where the Social Security Administration blocks a beneficiary's Health Insurance Claim Number (HIC);
- Where there is a problem with the beneficiary's record in Medicare's files **are not subject to this instruction**;
- Where the claim is rejected by the translator software;
- Where CMS instructs Medicare contractors to hold certain claims for processing, e.g., while system changes are being made to handle such claims correctly; or
- To claims submitted by a hospice and these claims are to be processed per instructions in the *Medicare Claims Processing Manual* (Chapter 1, Section 50.2.3; **http://www.cms.hhs.gov/manuals/downloads/clm104c01.pdf**)

Additional Information

The official instruction, CR5513, issued to your FI, RHHI, A/B MAC, or DME MAC regarding this change may be viewed at **http://www.cms.hhs.gov/Transmittals/downloads/R1312CP.pdf** on the CMS website.

If you have any questions, please contact your FI, RHHI, A/B MAC, 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 website.

CMS News Flash

- **Rejected Claims Reminder** - Fee-for-Service Medicare claims can be rejected by Medicare contractors (carriers, intermediaries (FIs), and Medicare Administrative Contractors (MACs)) for a variety of reasons including: incorrect billing information, terminated provider, the beneficiary is not eligible for Medicare or the claim was sent to the wrong contractor. If a provider has questions about a claim rejected by an FI/carrier or MAC, the provider should contact the contractor directly. It is never appropriate to direct the beneficiary who received the service billed on the claim to the 1-800-Medicare toll free line to resolve a claim rejection.
- If you treat a Medicare Advantage enrolled beneficiary and you have questions about their Medicare Advantage Plan, you may wish to contact that plan. A plan directory and MA claims processing contact directory are available at **http://www.cms.hhs.gov/MCRAdvPartDEnrolData/** on the CMS website. CMS updates this site on a monthly basis.
- The Centers for Medicare & Medicaid Services (CMS) is extending the bid submission deadline for the first round of the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding Program. All bids are due by 9:00 p.m. prevailing Eastern Time on July 27, 2007. The contract period for mail order diabetic supplies is April 1, 2008 - December 31, 2009. The contract period for all other first round product categories is April 1, 2008 - March 31, 2011. Suppliers must be accredited or have pending accreditation to submit a bid and will need to be accredited to be awarded a contract. The accreditation deadline for the first round of competitive bidding is August 31, 2007. Suppliers should apply for accreditation immediately to allow adequate time to process their applications. Suppliers interested in bidding must have first registered to receive a User ID and Password before they could access the internet-based bid submission system. Suppliers who did not register cannot submit bids. The registration deadline was June 30, 2007. For more information on the program as well as bidding and accreditation information, please visit **http://www.dmecompetitivebid.com or http://www.cms.hhs.gov/CompetitiveAcqforDMEPOS**.

CMS News Flash (Continued)

- A new preventive services brochure entitled *Adult Immunizations*, ICN# 006435, is now available on the Centers for Medicare & Medicaid Services (CMS) Medicare Learning Network (MLN). This tri-fold brochure provides health care professionals with an overview of Medicare's coverage of influenza, pneumococcal, and hepatitis B vaccines and their administration. The brochure is available at **http://www.cms.hhs.gov/MLNProducts/downloads/Adult_Immunization.pdf** on the CMS website.
- **National Provider Identifier (NPI) News** - During this testing and implementation phase for the NPI, providers should pay close attention to information from health plans and clearinghouses to understand how claims are being processed and what providers should be doing to assure no disruption in payment. Providers should also ensure that the information they are submitting on a claim is what is being transmitted to each health plan by the billing vendors or clearinghouses who may be submitting the claims on their behalf. Additional information can be found at **http://www.cms.hhs.gov/NationalProvIdentStand/** on the CMS website.
- The May 2007 version of the *Quick Reference Information: Medicare Preventive Services* laminated chart is now available to order or download from the Medicare Learning Network. To order, go to the "MLN Product Ordering Page" located at **http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5** or to view online, go to **http://www.cms.hhs.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf** on the CMS Website.
- The 2nd Edition of The Guide to *Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals* is now available in downloadable format from the Centers for Medicare & Medicaid Services, Medicare Learning Network (MLN). This comprehensive guide provides fee-for-services health care providers and suppliers with coverage, coding, billing and reimbursement information for preventive services and screenings covered by Medicare. This guide gives clinicians and their staff the information they need to help them in recommending Medicare-covered preventive services and screenings that are right for their Medicare patients and provides information needed to effectively bill Medicare for services furnished. To view online, go to **http://www.cms.hhs.gov/MLNProducts/downloads/mps_guide_web-061305.pdf** on the CMS website.
- Since May 29, 2007, Medicare Fiscal Intermediaries, as well as Part B CIGNA Idaho and Tennessee, have been validating National Provider Identifiers (NPIs) and Legacy Provider Identifier pairs submitted on claims against the Medicare NPI Crosswalk. Between the period of September 3, 2007 and October 29, 2007, all other Part B carriers and DME MACS will begin to turn on edits to validate the NPI/Legacy pairs submitted on claims. If the pair is not found on the Medicare NPI crosswalk, the claim will reject. Medicare contractors have been instructed to inform providers at a minimum of seven days prior to turning on the edits to validate the NPI/Legacy pairs against the Crosswalk.
- *Understanding the Remittance Advice: A Guide for Medicare Providers, Physicians, Suppliers, and Billers* serves as a resource on how to read and understand a Remittance Advice (RA). Inside the guide, you will find useful information on topics such as the types of RAs, the purpose of the RA, and the types of codes that appear on the RA. To order your copy today, go to the Medicare Learning Network Product Ordering page at **http://www.cms.hhs.gov/MLNProducts** on the CMS website.

DME MAC A's Gift Policy

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

Remember that you can fax your immediate offset requests
http://www.medicarenhic.com/dme/dme_forms.shtml

NHIC, Corp. DME MAC A 2008 Holiday Schedule

The Jurisdiction A Durable Medical Equipment Medicare Administrative Contractor (DME MAC A) will be observing the following holidays in 2008:

Tuesday, January 1	New Year's Day
Monday, January 21	Martin Luther King Day
Monday, February 18	George Washington's Birthday
Monday, May 26	Memorial Day
Friday, July 4	Independence Day
Monday, September 1	Labor Day
Monday, October 13	Columbus Day
Tuesday, November 11	Veteran's Day
Thursday, November 27	Thanksgiving Day
Thursday, December 25	Christmas Day

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

Delete References to Required Reporting of the National Provider Identifier (NPI) on or after May 23, 2007 and Revise to a "When Effective" Date (MM5678)

MLN Matters Number: MM5678
Related CR Release Date: August 31, 2007
Related CR Transmittal #: R1328CP

Related Change Request (CR) #: 5678
Effective Date: October 1, 2007
Implementation Date: October 1, 2007

Provider Types Affected
Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, DME Medicare Administrative Contractors (DME MACs), and Part A/B Medicare Administrative Contractors (A/B MACs)) for services provided to Medicare beneficiaries.

Provider Action Needed
This article is informational in nature and is based on Change Request (CR) 5678 which updates Chapter 80 of the *Medicare Claims Processing Manual* to delete references to the May 23, 2007 mandatory date for entry of the National Provider Identifier (NPI) on claims. The effective date for providers to use only the NPI on Medicare claims will be officially announced at a later date, as previously communicated to providers in the *MLN Matters* article corresponding to CR5595. That article is available at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5595.pdf** on the CMS website.

Background
The National Provider Identifier (NPI) final rule, published in the Federal Register on January 23, 2004 **(http://www.access.gpo.gov/su_docs/fedreg/a040123c.html**; Health and Human Services Department Rules), established the standard for a unique identifier for each health care provider for use in health care transactions. Medicare contractors were to be required to enter NPI in certain items and fields of paper claim forms and electronic equivalents on or after May 23, 2007.

However, on April 2, 2007, the Department of Health and Human Services (DHHS) provided guidance regarding contingency planning for the implementation of the NPI. For some time after May 23, 2007, Medicare Fee for Service (FFS) will allow continued use of legacy numbers (Unique Physician Identification Numbers (UPINs) and Provider Identification Numbers (PINs)), as well as accepting transactions with only NPIs. The effective date for providers to use only the NPI only on claims and to cease entering UPINs and PINs will be officially announced at a later date, as previously communicated to providers in the *MLN Matters* article corresponding to CR5595. That article is available at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5595.pdf** on the CMS website. This article reflects CR5678, which simply amends Chapter 80 of the *Medicare Claims Processing Manual* to reflect that the use of the NPI will be mandated for Medicare FFS claims at a future date.

Additional Information
The official instruction, CR5678, issued to your carrier, A/B MAC, or DME MAC regarding this change may be viewed at **http://www.cms.hhs.gov/Transmittals/downloads/R1328CP.pdf** on the CMS website.

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

Please join the NHIC, Corp. DME MAC A ListServe! Visit
http://www.medicarenhic.com/dme/
and select "Join the DME MAC A ListServe"

Discontinuance of the Unique Physician Identification Number (UPIN) Registry (MM5584)

MLN Matters Number: MM5584 - Revised
Related CR Release Date: September 14, 2007
Related CR Transmittal #: R222PI

Related Change Request (CR) #: 5584
Effective Date: May 29, 2007
Implementation Date: June 29, 2007

Note: *This article was revised on September 17, 2007, to reflect changes made to CR5584, which CMS re-issued on September 14, 2007. The article was revised to show that the UPIN Registry website and lookup functionality will be available through May 23, 2008. Information was added regarding the release of information, including NPIs, via the NPPES. The CR transmittal number, Web address for accessing CR5584, and the CR release date were also changed. All other information remains the same.*

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

Provider Action Needed
Impact to You
This article is based on Change Request (CR) 5584 which announces that the Centers for Medicare & Medicaid Services (CMS) will discontinue assigning Unique Physician Identification Numbers (UPINs) on June 29, 2007.

What You Need to Know
The National Provider Identifier (NPI) is a requirement of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and the NPI will replace the use of UPINs and other existing legacy identifiers. (However, CMS recently announced a contingency plan that allows for use of legacy numbers for some period of time beyond May 23, 2007. Under the Medicare FFS contingency plan, UPINs and surrogate UPINs may still be used to identify ordering and referring providers and suppliers until further notice.) Information on that contingency plan is at **http://www.cms.hhs.gov/NationalProvIdentStand/downloads/NPI_Contingency.pdf** on the CMS site.)

What You Need to Do
If you do not have an NPI, you should obtain one as soon as possible. Applying for an NPI is fast, easy and free by going to the National Plan and Provider Enumeration System (NPPES) website at **https://nppes.cms.hhs.gov/**. See the Background and Additional Information Sections of this article for further details.

Background
The Centers for Medicare & Medicaid Services (CMS) was required by law to establish an identifier that could be used in Medicare claims to uniquely identify providers/suppliers who order services for Medicare patients or who refer Medicare patients to physicians and certain other suppliers. The UPIN was established to meet this requirement. CMS assigns UPINs to those physicians and eligible suppliers who are permitted by Medicare to order or refer in the Medicare program. Medicare claims for services that were ordered or for services that resulted from referrals must include UPINs to identify the providers/suppliers who ordered the services or made the referral.

On January 23, 2004, the Secretary of Health and Human Services published a Final Rule in which the Secretary adopted a standard unique health identifier to identify health care providers in transactions for which the Secretary has adopted standards (known as HIPAA standard transactions). This identifier is the National Provider Identifier (NPI). The NPI will replace all legacy provider identifiers that are used in HIPAA standard transactions, including the UPIN, to identify health care providers. All HIPAA covered entities (health plans, health care clearinghouses, and those health care providers who transmit any data electronically in connection with a HIPAA standard transaction) are required by that regulation to begin using NPIs in these transactions no later than May 23, 2007 (small health plans have until May 23, 2008). Medicare is also requiring the use of NPIs in paper claims no later than May 23, 2007, but see the note in the following box regarding the May 23, 2007 implementation by Medicare.

Important Note: *Effective May 23, 2007, Medicare FFS is establishing a contingency plan for implementing the National Provider Identifier (NPI). In this plan, as soon as Medicare considers the number of claims submitted with an NPI for primary providers (Billing, pay-to and rendering providers) is sufficient, Medicare (after advance notification to providers) will begin rejecting claims without an NPI for primary providers, perhaps as early as July 1, 2007. For more information on this contingency plan, please visit the NPI dedicated website at* ***http://www.cms.hhs.gov/NationalProvIDentStand/****. This contingency plan does not affect CMS plans to discontinue assigning UPINs on June 29, 2007 or to disable the UPIN "look-up" functionality as of May 23, 2008.*

The CMS discontinued assigning UPINs on June 29, 2007, but CMS will maintain its UPIN public "look-up" functionality and Registry website (**http://www.upinregistry.com/**) through May 23, 2008. In addition, CMS published the NPPES Data Dissemination Notice (CMS-6060-N) in the Federal Register on May 30, 2007. This Notice describes the policy by which information, to include NPIs, may be disseminated by CMS from the National Plan and Provider Enumeration System (NPPES).

Discontinuance of the Unique Physician Identification Number (UPIN) Registry (MM5584) (Continued)

Additional Information

For additional information regarding NPI requirements and use, please see *MLN Matters* articles, MM4023 (**http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4023.pdf**) titled *Requirements for Use and Editing of National Provider Identifier (NPI) Numbers Received in Electronic Data Interchange Transactions, via Direct Data Entry Screens or Paper Claim Forms,* and MM4293 (**http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4293.pdf**) titled *Revised CMS-1500 Claim Form*, which describes the revision of claim form CMS-1500 (12-90) to accommodate the reporting of the National Provider Identifier (NPI) and renamed CMS-1500 (08-05).

The official instruction, CR5584, issued to your carrier, intermediary, RHHI, A/B MAC and DME MAC regarding this change may be viewed at **http://www.cms.hhs.gov/Transmittals/downloads/R222PI.pdf** on the CMS website.

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

Lifting the National Provider Identifier (NPI) Crosswalk Bypass Logic (JSM07508)

Since October 2, 2006, providers have been encouraged to submit both the NPI and Medicare legacy identifier (PIN or NSC) on their claims. During this timeframe providers were **not** penalized for invalid NPI/legacy ID combinations.

Effective **October 29, 2007**, NHIC, Corp. DME MAC Jurisdiction A, will begin editing the NPI/legacy ID combinations for validity against the NPI crosswalk file. Where a match cannot be located on the crosswalk, claims will be rejected or returned to the provider.

When the claim is returned, a provider should first verify that the correct NPI was submitted. If correct, you will need to verify that your legacy identifier (PIN or NSC) number corresponds with the information on file with the National Plan and Provider Enumeration System (NPPES). NPPES data may be checked on line at **https://nppes.cms.hhs.gov**.

If your NPPES information is correct and you have included and matched ALL Medicare legacy identifiers with a corresponding NPI in NPPES, but you are experiencing provider identifier problems with your claims that contain an NPI, you may need to submit a Medicare enrollment application (i.e., the CMS-855). Please contact the DME MAC A Customer Service department at 866-419-9458 if you need more information in this circumstance.

More information and education on the NPI may be found at the CMS NPI page, **http://www.cms.hhs.gov/NationalProvIdentStand** on the CMS website. Also, providers can apply for an NPI online at **https://nppes.cms.hhs.gov**.

Note: *Don't disrupt your cash flow! DME MAC A is strongly encouraging submitters to send a small batch of claims with an **NPI only** to validate that the legacy selected to match with the NPI is correct. This would be a helpful tool and should be done as soon as possible upon receipt of this notification to detect problems early without affecting your cash flow.*

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

Medicare Fee for Service (FFS) National Provider Identifier (NPI) Final Implementation (MM5728)

MLN Matters Number: MM5728
Related CR Release Date: October 5, 2007
Related CR Transmittal #: R1349CP

Related Change Request (CR) #: 5728
Effective Date: No later than May 23, 2008
Implementation Date: January 7, 2008 and April 7, 2008

Provider Types Affected
Physicians, providers, and suppliers who submit any HIPAA standard transactions to Medicare contractors (carriers, Fiscal Intermediaries, (FIs), including Regional Home Health Intermediaries (RHHIs), Medicare Administrative Contractors (A/B MACs), and DME Medicare Administrative Contractors (DME MACs))

Provider Action Needed
Impact to You
This article is based on CR5728, which describes the policy change brought about as a result of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, that requires issuance of a unique national provider identifier (NPI) to each physician, supplier, and other provider of health care who conducts HIPAA standard electronic transactions.

What You Need to Know
Once CMS ends its' NPI contingency, the legacy number will NOT be permitted on any inbound electronic and outbound electronic transaction (there are exceptions to the 835 remittance advice (see CR5452)). Medicare contractors will begin rejecting claims, electronic, including direct data entry, that contain legacy provider numbers for any primary provider instead of or in addition to the NPI number. The following HIPAA transactions are also affected:

- X12N 276/277 Claim Status Inquiry/Response - (see CR5726 for details.)
- X12N 837 Coordination of Benefits (COB) - NPI only will be sent on the 837 coordination of benefits. Legacy numbers are not allowed. An exception will exist for claims that have not cleared the system by the date that CMS ends its NPI contingency plan. Such claims may contain the legacy number and, therefore, the COB transaction will also include the legacy number.

What You Need to Do
No later than May 23, 2008, providers should ensure that all HIPAA transactions sent to Medicare contractors contain only valid NPI numbers (no legacy provider numbers.)

Background
The Health Insurance Portability and Accountability Act (HIPAA) of 1996 required issuance of a unique national provider identifier (NPI) to each physician, supplier, and other provider of health care who conducts HIPAA standard electronic transactions. The Centers for Medicare & Medicaid Services (CMS) began to issue NPIs on May 23, 2005. CMS has been allowing transactions adopted under HIPAA to be submitted with a variety of identifiers. They are:

- NPI only;
- Medicare legacy only; or
- NPI and legacy combination.

On April 2, 2007, the Department of Health and Human Services (DHHS) provided guidance to covered entities regarding contingency planning for the implementation of the NPI. As long as a health plan is compliant, meaning they can accept and send NPIs on electronic transactions, they may establish contingency plans to facilitate the compliance of their trading partners. As a compliant health plan, Medicare fee for service (FFS) established a contingency plan on April 20, 2007, that followed this guidance. CR5728 directs Medicare contractors to begin rejecting HIPAA inbound claims when directed by CMS, if they contain legacy provider identifiers.

Since paper claims are not HIPAA transactions, these requirements do not apply to paper claims, however, providers should not submit legacy numbers on paper claims once CMS ends its NPI contingency plan.

Additional Information
The official instruction, CR5728, issued can be found at **http://www.cms.hhs.gov/Transmittals/downloads/R1349CP.pdf** on the CMS website.

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

Remember that you can fax your immediate offset requests
http://www.medicarenhic.com/dme/dme_forms.shtml

Medicare's Implementation of the National Provider Identifier (NPI): The Second in the Series of Special Edition MLN Matters Articles on NPI-Related Activities (SE0555)

MLN Matters Number: SE0555 - Revised
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 August 7, 2007, to delete a reference to the NPI viewlet, which is no longer available on the CMS website. Previously, the article was revised on May 18, 2007, to add this statement that Medicare FFS has announced a contingency plan regarding the May 23, 2007 implementation of the NPI. For some period after May 23, 2007, Medicare FFS will allow continued use of legacy numbers on transactions; accept transactions with only NPIs; and accept transactions with both legacy numbers and NPIs. For details of this contingency plan, see the MLN Matters article, MM5595, at* ***http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5595.pdf*** *on the CMS website.*

Provider Types Affected
Providers and suppliers who conduct HIPAA standard transactions, such as claims and eligibility inquiries. In addition, organizations or associations that represent providers and plan to obtain NPIs for those providers should take note of this article.

Part 1: Information That Applies to All Providers

Background
All healthcare providers are eligible to receive NPIs. All HIPAA covered healthcare providers, whether they are **individuals** (such as physicians, nurses, dentists, chiropractors, physical therapists, or pharmacists) or **organizations** (such as hospitals, home health agencies, clinics, nursing homes, residential treatment centers, laboratories, ambulance companies, group practices, health maintenance organizations, suppliers of durable medical equipment, pharmacies, etc.) must obtain an NPI for use to identify themselves in HIPAA standard transactions. Once enumerated, a provider's NPI will not change. The NPI remains with the provider regardless of job or location changes.

Note: *HIPAA covered entities such as providers completing electronic transactions, healthcare clearinghouses, and large health plans, must use* ***only*** *the NPI to identify covered healthcare providers in standard transactions by* ***May 23, 2007****. Small health plans must use* ***only*** *the NPI by* ***May 23, 2008****.*

Obtaining and Sharing Your NPI
Providers and suppliers may now apply for their NPI on the National Plan and Provider Enumeration System (NPPES) web site, **https://nppes.cms.hhs.gov**. The NPPES is the only source for NPI assignment.

The NPI will replace healthcare provider identifiers in use today in standard healthcare transactions by the above dates. The application and request for an NPI does not replace the enrollment process for health plans. Enrolling in health plans authorizes you to bill and be paid for services.

Healthcare providers should apply for their NPIs as soon as it is practicable for them to do so. This will facilitate the testing and transition processes and will also decrease the possibility of any interruption in claims payment. Providers may apply for an NPI in one of three ways:

- An easy web-based application process is available at **https://nppes.cms.hhs.gov**.
- A paper application may be submitted to an entity that assigns the NPI (the Enumerator). A copy of the application, including the Enumerator's mailing address, is available at **https://nppes.cms.hhs.gov**. A copy of the paper application may also be obtained by calling the Enumerator at 1-800-465-3203 or TTY 1-800-692-2326.
- With provider permission, an organization may submit a request for an NPI on behalf of a provider via an electronic file.

Knowing the NPI Schedule of Your Health Plans and Practice Management System Companies
Providers should be aware of the NPI readiness schedule for each of the health plans with which they do business, as well as any practice management system companies or billing companies (if used). They should determine when each health plan intends to implement the NPI in standard transactions and keep in mind that each health plan will have its own schedule for this implementation. Your other health plans may provide guidance to you regarding the need to submit both legacy numbers and NPIs.

Providers should submit their NPI(s) on standard transactions only when the health plan has indicated that they are ready to accept the NPI. Providers should also ensure that any vendors they use will be able to implement the NPI in time to meet the compliance date. also ensure that any vendors they use will be able to implement the NPI in time to meet the compliance date.

Medicare's Implementation of the National Provider Identifier (NPI): The Second in the Series of Special Edition MLN Matters Articles on NPI-Related Activities (SE0555) (Continued)

Sharing Your NPI

Once providers have their NPI(s), they should protect them. Covered providers must share their NPI with any entity that would need it to identify the provider in a standard transaction. For example, a referring physician must share their NPI with the provider that is billing for the service. Other entities the provider should consider sharing their NPI with are:

- Any provider with which they do business (e.g., pharmacies);
- Health plans with which they conduct business; and
- Organizations where they have staff privileges.

Note: *We understand that providers have many questions related to EFI or bulk enumeration, NPPES Data Dissemination, and the Medicare subparts policy. We have included information currently available on these key topics in this article and will continue to provide updates, as more information becomes available.*

Electronic File Interchange (EFI) - Formerly Known as Bulk Enumeration

The Centers for Medicare & Medicaid Services (CMS) is in the process of putting into place a mechanism that will allow for bulk processing of NPI applications. EFI allows an organization to send NPI applications for many healthcare providers, with provider approval, to the NPPES within a single electronic file. For example, a large group practice may want to have its staff handle the NPI applications for all its members. If an organization/provider employs all or a majority of its physicians and is willing to be considered an EFI submitter, EFI enumeration may be a good solution for that group of providers.

The EFI Steps

Once EFI is available, concerned entities will follow these steps:

- An organization that is interested in being an EFI organization will log on to an EFI home page (currently under construction) on the NPPES web site (**https://nppes.cms.hhs.gov**) and download a certification form.
- The organization will send the completed certification form to the Enumerator to be considered for approval as an EFI organization (EFIO).
- Once notified of approval as an EFIO, the entity will send files in a specified format, containing NPI application data, to the NPPES.
- Providers who wish to apply for their NPI(s) through EFI must give the EFIO permission to submit their data for purposes of applying for an NPI.
- Files containing NPI application data, sent to NPPES by the EFIO, will be processed. NPI(s) will be assigned and the newly assigned NPI(s) will be added to the files submitted by the EFIO.
- The EFIO will then download the files containing the NPI(s) and will notify the providers of their NPI(s). An EFIO may also be used for updates and deactivations, if the providers agree to do so.

National Plan and Provider Enrollment System (NPPES) Data Dissemination Policy

CMS expects to publish a notice regarding its approach to NPI data dissemination in the coming months. The notice will propose the data dissemination strategy and processes. The approach will describe the data that CMS expects to be available from the NPPES, in compliance with the provisions of the Privacy Act, the Freedom of Information Act, the Electronic FOIA Amendments of 1996, the NPPES System of Records Notice, and other applicable regulations and authorities.

Crosswalks

Each health plan may create its own crosswalk, to cross check NPI and legacy identifiers. To that end, CMS stresses the importance of healthcare providers entering all of their current identification numbers onto their NPI application to facilitate the building of the crosswalks.

Subparts of a Covered Organization

Covered-organization healthcare providers (e.g., hospitals, suppliers of durable medical equipment, pharmacies, etc.) may be made up of components (e.g., an acute care hospital with an ESRD program) or have separate physical locations (e.g., chain pharmacies) that furnish health care, but are not themselves legal entities. The Final NPI rule calls these entities "**subparts**" to avoid confusion with the term healthcare "components" used in HIPAA privacy and security rules. Subparts cannot be individuals such as physicians, e.g., group practices may have more than one NPI, but individual members of that group practice by definition are not and cannot be "subparts."

The NPI was mandated to identify each healthcare provider, not each service address at which health care is furnished. Covered organization providers must designate as subparts (according to the guidance given in the NPI Final Rule) any component(s) of themselves or separate physical locations that are not legal entities and that conduct their own standard transactions. Covered organizations/providers must obtain NPI(s) for their subparts, or instruct the subparts to obtain their own NPIs. The subparts would use their NPIs to identify themselves in the standard transactions they conduct.

Medicare's Implementation of the National Provider Identifier (NPI): The Second in the Series of Special Edition MLN Matters Articles on NPI-Related Activities (SE0555) (Continued)

The NPI Final Rule also gives covered organizations/providers the ability to designate subparts should there be other reasons for doing so. Federal regulations or statutes may require healthcare providers to have unique billing numbers in order to be identified in claims sent to federal health programs, such as Medicare.

In some cases, healthcare providers who need billing numbers for federal health programs are actually components of covered healthcare providers. They may be located at the same address as the covered organization provider or they may have a different address.

In situations where such federal regulations or statutes are applicable, the covered organization providers would designate the components as subparts and ensure that they obtain NPI(s) in order to use them in standard transactions. The NPI will eventually replace the billing numbers in use today.

What Providers Can Do to Prepare for NPI Implementation

- Watch for information from the health plans with which you do business on the implementation/testing of NPIs in claims, and, eventually, in other standard transactions.
- Check with your billing services, vendors, and clearinghouses about NPI compliance and what you need to do to facilitate the process.
- Review laws in your state to determine any conflicts or supplements to the NPI. For example, some states require the NPI to be used on paper claims.
- Check in your area for collaborative organizations working to address NPI implementation issues on a regional basis among the physicians, hospitals, laboratories, pharmacies, health plans, and other impacted parties.

Part 2: Information That Applies to Medicare Fee-For-Service (FFS) Providers Only

All Medicare providers are reminded that they will be required to use the NPI ***in Medicare claims transactions***.

NPI Transition Plans for Medicare FFS Providers

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

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

Medicare's Implementation of the National Provider Identifier (NPI): The Second in the Series of Special Edition MLN Matters Articles on NPI-Related Activities (SE0555) (Continued)

Crosswalk
The Medicare health plan is preparing a crosswalk to link NPI and Medicare legacy identifiers exclusively for Medicare business, which should enable Medicare to continue claims processing activities without interruption. NPI(s) will be verified to make sure that they were actually issued to the providers for which reported. Medicare will use the check digit to ensure the NPI(s) are valid.

Subparts Policy
CMS is currently developing policy on how Medicare providers should identify Medicare subparts. Further details will be provided when this policy is finalized.

Resources for Additional Information
Coming Soon: CMS is developing a MLN web page on NPI for Medicare FFS providers, which will house all Medicare fee for service educational resources on NPI, including links to all *MLN Matters* articles, frequently-asked-questions, and other information. CMS will widely publicize the launch of this web page in the coming weeks.

You may wish to visit **http://www.cms.hhs.gov/NationalProvIdentStand/01_Overview.asp** regularly for the latest information about the NPI.

You may go to **http://www.cms.hhs.gov/hipaa/hipaa2/support/tools/decisionsupport/CoveredEntityFlowcharts.pdf** to access a tool to help establish whether one is a covered entity under the administrative simplifications of HIPAA.

The Federal Register notice containing the NPI Final Rule is available at **http://www.cms.hhs.gov/NationalProvIdentStand/Downloads/NPIfinalrule.pdf** on the CMS web site.

There are some non-CMS Web sites that have information on NPI-related issues. While CMS does not necessarily endorse those materials, there may be information and tools available that might be of value to you.

You may also find some industry implementation recommendations and white papers on the NPI at **http://www.wedi.org**, which is the site of the Workgroup for Electronic Data Interchange (WEDI).

NPI: NPPES Data & New Data Dissemination Training Module Now Available (CMS Message 2007-09-13)

The NPI Registry and the downloadable file are now available. To view the Registry, visit **https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do** on the web. The downloadable file is available at **http://nppesdata.cms.hhs.gov/cms_NPI_files.html** on the web.

Additionally, the final module in the NPI Training Package is now available. Module 4, Data Dissemination, is now available at **http://www.cms.hhs.gov/NationalProvIdentStand/Downloads/NPI_Module4_Data_Dissemination.pdf** on the CMS website. This module describes the policy by which CMS will make certain NPPES data available, as well as the data CMS is disclosing.

As always, more information and education on the NPI can be found through the CMS NPI page **http://www.cms.hhs.gov/NationalProvIdentStand** on the CMS website. Providers can apply for an NPI online at **https://nppes.cms.hhs.gov** or can call the NPI enumerator to request a paper application at 1-800-465-3203. Having trouble viewing any of the URLs in this message? If so, try to cut and paste any URL in this message into your web browser to view the intended information.

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

NPI: The Importance of Reporting Medicare Legacy Numbers in NPPES (CMS Message 2007-08-08)

Information for Medicare Providers Regarding the Importance of Reporting Legacy Numbers in NPPES

The reporting of legacy numbers in the "Other Provider Identifier"/"Other Provider Identifier Type Code" fields in the National Plan and Provider Enumeration System (NPPES) will assist Medicare in successfully creating linkages between providers' NPIs and the identifiers that Medicare has assigned to them (such as PINs).

You should be aware that if you remove your legacy numbers from the "Other Provider Identifier"/"Other Provider Identifier Type Code" fields, linkages that Medicare has established using the reported Medicare legacy numbers will be broken and your Medicare claims could be rejected.

Not sure what an NPI is and how you can get it, share it and use it? As always, more information and education on the NPI can be found through the CMS NPI page **http://www.cms.hhs.gov/NationalProvIdentStand** on the CMS website. Providers can apply for an NPI online at **https://nppes.cms.hhs.gov** or can call the NPI enumerator to request a paper application at 1-800-465-3203.

Special National Provider Identifier (NPI) Message to Clearinghouses and Billing Services (CMS Message 2007-10-04)

Potential Issues Related to Clearinghouse and Billing Service Practices

As part of efforts to fully implement the NPI, Medicare FIs, carriers, and A/B MACs have begun calling providers who are not sending their NPI on claims or are sending incorrect NPI information. It has come to CMS' attention that:

- Some Clearinghouses may be stripping the National Provider Identifier (NPI) off the claim prior to its submission to Medicare for claims processing. Clearinghouses may be adding the NPI back onto the Remittance Advice, so that providers are unaware that NPIs are being removed prior to being sent forward.
- Some billing services (or "key" shops) are not putting the NPI on the claim, contrary to provider instructions.
- Some clearinghouses are not forwarding, to providers, carrier NPI informational claim error messages designed to help the provider understand the problems Medicare is encountering in attempts to crosswalk the NPI to legacy identifiers.

Medicare Contractors are turning on edits to begin validating the NPI/legacy pair against the Medicare NPI Crosswalk. If the pair on the claim is not found on the crosswalk, the claim will reject. Stripping the NPI submitted by a provider from the claim adversely affects Medicare provider incentive cash flow, payers that receive crossover claims, and the efforts of Medicare to fully implement NPI.

If you are a Clearinghouse or billing service that is stripping or not sending the NPI, Medicare would like to better understand the reasons behind this practice as well as the expected timeframe during which this will continue to occur. Therefore, we ask those willing to discuss this problem with CMS staff to please contact Aryeh Langer at **Aryeh.langer@cms.hhs.gov** or Nicole Cooney at **Nicole.cooney@cms.hhs.gov** before October 10, 2007.

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

Stage 3 National Provider Identifier (NPI) Changes for Transaction 835, and Standard Paper Remittance Advice (RA) (MM5452)

MLN Matters Number: MM5452 - Revised
Related CR Release Date: September 21, 2007
Related CR Transmittal #: R1343CP

Related Change Request (CR) #: 5452
Effective Date: July 2, 2007
Implementation Date for DME suppliers: July 2, 2007
Implementation Date for other providers: April 7, 2008

Note: *This article was revised on September 21, 2007, to reflect a change made to the implementation dates in CR5452. For DME suppliers billing DME MACs, the implementation date remains the same. For other providers who bill Medicare carriers, fiscal intermediaries, including Regional Home Health Intermediaries, and/or Part A/B Medicare Administrative Contractors (A/B MACs), the implementation date is now April 7, 2008. The CR transmittal date, number, and Web address for accessing CR5452 were also changed. All other information remains the same.*

Provider Types Affected
Physicians, providers, and suppliers who conduct Health Insurance Portability and Accountability Act (HIPAA) standard transactions, such as claims and eligibility inquiries, with Medicare.

Provider Action Needed
Impact to You
Be aware that Stage 3 of the NPI implementation is nearing. This article discusses impact of the NPI Stage 3 implementation on remittance advice transactions.

What You Need to Know
Make sure you have your NPI, know how to use it, and are prepared to receive it back in your remittance advice processes.

What You Need to Do
Read the remainder of this article and be sure your staff are aware of how the NPI implementation impacts the remittance advice transactions you receive.

Background
This article discusses Stage 3 of Medicare's fee-for-service (FFS) processes for the NPI and reflects Medicare processing of claims submitted with NPIs. Submitted NPIs will be crosswalked to the Medicare legacy number(s) for processing. Medicare's internal provider files will continue to be based upon records established in relation to the legacy identifiers. The crosswalk may result in:

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

CMS will adjudicate Medicare FFS claims based upon a unique NPI/Legacy combination for Scenarios II and III, but the remittance advice, both electronic and paper, and any output using PC Print or Medicare Remit Easy Print (MREP) will have only NPI as the primary provider identification. The TIN will be used as the secondary identifier for the Payee. The NPI regulation permits continued use of Taxpayer Identification Number (TIN) for tax purposes if the implementation guide allows it.

The Companion Documents and Flat Files for both Part A and B will be updated to reflect these changes and the updated documents will be posted at **http://www.cms.hhs.gov/ElectronicBillingEDITrans/11_Remittance.asp** on the CMS website.

The following three scenarios refer to Medicare reporting of NPIs in remittance advice processes.

Note that current requirements concerning the reporting of provider names and addresses still apply.

Stage 3 National Provider Identifier (NPI) Changes for Transaction 835, and Standard Paper Remittance Advice (RA) (MM5452) (Continued)

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

- **Electronic Remittance Advice (ERA)** - Under this scenario, Medicare will report the NPI at the Payee level as the Payee primary ID, and the TIN (Employer Identification Number (EIN) Social Security Number (SSN) (EIN/SSN)) in the REF segment as Payee Additional ID. Medicare will report any relevant Rendering Provider NPI at the claim level if different from the Payee NPI. A/B MACs, carriers, DME MACs, and DMERCs, as appropriate, will also report relevant Rendering NPI(s) at the service line level if different from the claim level Rendering Provider NPI. Under this scenario, there will be one remittance advice, and one check/Electronic Funds Transfer (EFT) per NPI.
- **Standard Paper Remittance (SPR)** - Medicare will insert the appropriate Payee NPI at the header level. The ERA reporting requirements apply to the corresponding SPR fields. See above for additional note.
- **PC Print Software** - Medicare will show the Payee NPI at the header level and add the relevant Rendering Provider NPI at the claim level if different from the Payee NPI.
- **MREP Software** - Medicare will show the Payee NPI at the header level and add any relevant Rendering Provider NPI at the claim level if different from the Payee NPI, and any relevant Rendering NPI(s) at the service line level if different from the claim level Rendering Provider NPI.

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

- **ERA** - Under this scenario, Medicare will report the NPI at the Payee level as the Payee primary ID, and the TIN (EIN/SSN) in the REF segment as Payee Additional ID. Then add any relevant Rendering Provider NPI at the claim level if different from the Payee NPI. A/B MACs, carriers, DME MACs, and DMERCs, as appropriate, will add any relevant Rendering NPI(s) at the service line level if different from the claim level Rendering Provider NPI. Under this scenario, adjudication will be based on the unique combination of NPI/legacy number, and there would be multiple remittance advices, checks and/or EFTs based on that unique combination.
- **SPR** - Medicare will insert the appropriate NPI number at the header level. The ERA reporting requirements apply to the corresponding SPR fields. See above for additional note.
- **PC Print Software** - Same as Scenario I.
- **MREP Software** - Same as Scenario I.

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

- **ERA** - Under this scenario, Medicare will report the NPI at the Payee level as the Payee primary ID, and the TIN (EIN/SSN) in the REF segment as Payee Additional ID. Then, Medicare will add any relevant Rendering Provider NPI at the claim level if different from the Payee NPI. A/B MACs, carriers, DME MACs, and DMERCs, as appropriate, will add relevant Rendering NPI(s) at the service line level if different from the claim level Rendering Provider NPI. Under this scenario, adjudication will be based on the unique combination of NPI/legacy number, and there would be multiple remittance advices, checks and/or EFTs based on that unique combination.
- **SPR** - Insert the appropriate NPI number at the header level. The ERA reporting requirements apply to the corresponding SPR fields. See above for additional notes.
- **PC Print Software** - Same as Scenario I.
- **MREP Software** - Same as Scenario I.

Implementation

While these changes are effective for dates of service on or after July 2, 2007, the changes will be implemented as follows:

- For claims submitted to DMERCs and/or DME MACs, the changes will be implemented on July 1, 2007.
- For claims submitted to other Medicare contractors, the implementation will occur on **April 7, 2008**.

Additional Information

If you have questions, please contact your Medicare carrier, FI, Part A/B Medicare Administrative Contractors (A/B MAC), durable medical equipment regional carrier (DMERC), DME/MAC, and/or regional home health intermediary (RHHI), at their toll-free number which may be found at:
http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip on the CMS website.

For complete details regarding this Change Request (CR) please see the official instruction (CR5452) issued to your Medicare FI, RHHI, DMERC, DME/MAC, or A/B MAC. That instruction may be viewed by going to **http://www.cms.hhs.gov/Transmittals/downloads/R1343CP.pdf** on the CMS web site. The revised sections of Chapter 22 - Remittance Advice of the *Medicare Claims Processing Manual* are attached to CR5452.

Important ID Qualifier Information for Paper Claim Submitters

DME MAC A has received several calls regarding the use of the qualifiers that are currently required when submitting **legacy numbers** on the new CMS-1500 (08/05) claim form. The following instructions MUST be followed.

Block (Item) 17a - UPIN of the Referring/Ordering Physician
Enter the ID Qualifier **1G** in the smaller box followed by the CMS assigned UPIN of the referring/ordering physician in the larger box. The **1G** and UPIN must be submitted within the confines of the appropriate boxes. The UPIN may be reported on the CMS-1500 Form (08/05) until May 23, 2008, and MUST be reported if an NPI is not available.

Block (Item) 33b - ID Qualifier and PIN
Enter the ID qualifier **1C** followed by the PIN of the billing provider or group. Suppliers billing the DME MAC will use **1C** followed by the National Supplier Clearinghouse (NSC) number.

Note: *An invalid UPIN format will cause the claim to be rejected as unprocessable. When NPI is fully implemented, legacy numbers will no longer be accepted.*

For additional information regarding the new CMS-1500 (08/05) claim form, please refer to **http://www.cms.hhs.gov/nationalprovidentstand/**

Reminder of the Reasonable Useful Lifetime Guidelines

The Medicare guidelines regarding the replacement of Durable Medical Equipment, orthoses, eye prostheses and facial prostheses state that the reasonable useful lifetime requirements are determined by the contractor, but in no case, can it be less than five (5) years. The reasonable useful lifetime requirement is based on when the equipment was delivered to the patient. It is not based on the age of the piece of equipment. Replacement of an item during the reasonable useful lifetime of five years is covered if the item is lost, irreparably damaged, or the patient's medical condition changes (i.e., if the equipment that was originally provided no longer meets the patient's medical needs). Replacement of the item due to irreparable wear during the reasonable useful lifetime of five years is considered non-covered by Medicare.

Medicare will cover a replacement item for a beneficiary owned piece of equipment or if it is a capped rental item in certain cases where the equipment has been lost or irreparably damaged. Irreparable damage is a rare unexpected event (i.e., fire, flood, etc.) that is an exception to the reasonable useful lifetime guideline. Medicare will consider irreparable damage when an item is damaged beyond repair by a specific incident or accident. A physician's order and/or new Certificate of Medical Necessity (CMN) would be needed to reaffirm the medical necessity of the item.

Irreparable damage of an item must be distinguished and documented from irreparable wear. Irreparable wear is deterioration of an item due to day-to-day usage over time and an event cannot be identified that caused the deterioration. If a patient utilizes a power wheelchair on a daily basis and the drive motor in the power wheelchair breaks down within three years, a replacement chair would not be covered because there was no specific incident that could be identified that caused the motor to break down. This would be considered irreparable wear by Medicare. Medicare would cover a repair of the wheelchair up to, but not exceeding the cost of the replacement of the wheelchair.

When filing a Medicare claim for replacement equipment prior to the reasonable useful lifetime of five years, the RP modifier must be submitted on the claim. When billing with the RP modifier, documentation must be maintained in the beneficiary's files and be available upon request from the Durable Medical Equipment Medicare Administrative Contractor (DME MAC) or the Program Safeguard Contractor (PSC). The following documentation must be included, but is not limited to:

- Reason for replacement
- New CMN when required
- Medical records
- Police reports
- Written explanations from the beneficiary

These guidelines **do not** apply to breast prostheses or limb prostheses. Please refer to each individual Local Coverage Determination (LCD) and Policy Article on the TriCenturion Web site at **http://www.tricenturion.com** for the exceptions to the reasonable useful requirement of five years for these items.

Surgical Dressings Billing Reminder

Please refer to Tricenturion's Web site for the July 2007 article, "Surgical Dressings Widespread Probe Results HCPCS A6209-A6214" at **http://www.tricenturion.com/content/pcalpet.cfm**

Based on findings of this audit, suppliers are reminded to reference the following publications in regard to physician orders and documentation requirements.

- NHIC, Corp. *DME MAC A Supplier Manual*, Chapter 10, regarding "Documentation in the Patient's Medical Record" and "Supplier Documentation" which can be found at **http://www.medicarenhic.com/dme/dme_publications.shtml**
- The Documentation Requirements of the Local Coverage Determination (LCD) for Surgical Dressings are outlined below and can be found at **http://www.tricenturion.com/content/lcd_current_dyn.cfm**

The physician order must be on file and must specify the following:

- Type of dressing (e.g., hydrocolloid wound cover, hydrogel wound filler, etc.)
- Size of the dressing (if appropriate)
- Number/amount to be used at one time (if more than one)
- Frequency of dressing change
- Expected duration of need

A new order is needed:

- If a new dressing is added
- If the quantity of an existing dressing to be used is increased
  (Not routinely needed if the quantity of dressings used is decreased)
- At least every 3 months for each dressing being used even if the quantity used has remained the same or decreased

Necessary information to be obtained from the physician, nursing home, or home care nurse:

- Information defining the number of surgical/debrided wounds being treated with a dressing
- The reason for dressing use (e.g., surgical wound, debrided wound, etc.)
- Whether the dressing is being used as a primary or secondary dressing or for some non-covered use (e.g., wound cleansing)

Note: *The source of that information and date obtained must be documented in the supplier's records.*

Additional points to remember:
Current clinical information which supports the reasonableness and necessity of the type and quantity of surgical dressings provided **must** be present in the patient's medical records.

Evaluation of a patient's wound(s) **must** be performed at least on a monthly basis unless there is documentation in the medical record which justifies why an evaluation could not be done within this timeframe and what other monitoring methods were used to evaluate the patient's need for dressings.

Evaluation is expected on a more frequent basis (e.g., weekly) in patients in a nursing facility or in patients with heavily draining or infected wounds.

The evaluation may be performed by a nurse, physician or other health care professional.

This evaluation **must include** the following information for **each** wound:

- Type (e.g., surgical wound, pressure ulcer, burn, etc.)
- Location
- Size (length by width in cm.)
- Depth (in cm.)
- Drainage amount
- Any other relevant information

This information must be available upon request.

Supplier created forms are **not acceptable** as a substitution for the medical record.

For continuing educational opportunities, please visit the DME MAC A Events page at **http://www.medicarenhic.com/dme/dmerc_seminars.shtml** for upcoming webinars or seminars featuring this topic.

Remember that you can fax your immediate offset requests
http://www.medicarenhic.com/dme/dme_forms.shtml

Third Quarter 2007 - Top Claim Submission Errors

Claim submission errors (CSEs) are errors made on a claim that would cause the claim to reject upon submission to the Jurisdiction A Durable Medical Equipment Medicare Administrative Contractor (DME MAC). The top ten American National Standards Institute (ANSI) Claim Submission Errors for July through September 2007, are provided in the following chart.

Top Ten Claims Submission Errors	Number Received	Reason For Error
40022 - Procedure Code / Modifier Invalid	28,123	The procedure code and/or modifier used on this line is invalid.
40068 - Invalid / Unnecessary CMN Question	25,917	The question number entered is not valid for the DME MAC CMN you are sending.
40067 - Invalid / Unnecessary CMN Version Submit	11,386	Verify form number based on CMN submitted.
40076 - CMN Form Identifier Missing	10,953	The form identification code is incorrect.
20011 - Billing Provider Secondary ID Invalid	8,114	Secondary provider ID is invalid.
20269 - Pointer 1 Diagnosis Invalid	6,577	Diagnosis pointer is invalid.
20143 - Ordering Provider Secondary ID Invalid	6,444	The provider number or Unique Physician Identification Number (UPIN) is invalid.
40073 - Dates of Service Invalid with Procedure Code	5,877	The procedure code used is not valid for the dates of service used.
40014 - Ordering Provider Information Missing	5,124	The ordering provider information is missing. This should be included with every service line.
20025 - Subscriber ID Code Invalid	4,925	The qualifier identifying the subscriber is invalid.

Third Quarter 2007 - Top Claim Submission Errors (Continued)

In an effort to reduce other initial claim denials, the below information represents the top ten return/reject denials for the third quarter of 2007. Claims denied in this manner are considered to be unprocessable and have no appeal rights. An unprocessable claim is any claim with incomplete or missing, required information, or any claim that contains complete and necessary information, however, the information provided is invalid. Such information may either be required for all claims or required conditionally. The below chart reflects those claims that were accepted by the system and processed, however, were denied with a return/reject action code, which could have been prevented upon proper completion of claim information. This chart represents the top errors for claims processed from July through September 2007.

Claims Submission Errors (Return / Reject Denials)	CMS 1500 Form (or electronic equivalent) Entry Requirement	Number Received
CO 4 The procedure code is inconsistent with the modifier used or a required modifier is missing.	**Item 24D** - Enter the procedures, services or supplies using the Healthcare Common Procedure Coding System (HCPCS). When applicable, show HCPCS modifiers with the HCPCS code.	8,588
CO 16 M51 Claim service lacks information which is needed for adjudication. Missing / incomplete / invalid procedure codes(s) and/or rates.	**Item 24D** - Enter the procedures, services, or supplies using the HCPCS. When applicable show HCPCS modifiers with the HCPCS code.	6,707
CO 16 MA130 Claim service lacks information which is needed for adjudication. Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable.	**Item 11** - If other insurance is primary to Medicare, enter the insured's policy or group number. If no insurance primary to Medicare exists, enter "NONE."	5,024
CO 16, CO 207 N265, N286 Missing / incomplete / invalid ordering provider primary identifier.	**Item 17** - Enter the name of the referring or ordering physician, if the service or item was ordered or referred by a physician.	3,573
CO 16 N64 Claim / service lacks information which is needed for adjudication. The "from" and "to" dates must be different.	**Item 24A** - Enter the precise eight-digit date (MMDDCCYY) for each procedure, service, or supply in Item 24A.	3,099
CO 16 N280 Missing / incomplete / invalid pay to provider primary identifier	**Item 24J** - Enter the valid NPI (National Provider Identifier) or NSC (National Supplier Clearinghouse) number. The NPI must have the qualifier 1C followed by the NPI. The first digit of an NPI must be either 1, 2, 3, or 4.	1,987
CO 16 M51, N225, N29 Missing / incomplete / invalid procedure code(s).	**Item 24D** - Enter the procedures, services or supplies using the Healthcare Common Procedure Coding System (HCPCS). When applicable, show HCPCS modifiers with the HCPCS code.	889
CO 16 M76 Missing / incomplete/invalid diagnosis or condition.	**Item 21** - Claim/service lacks information which is needed for adjudication. Validate diagnosis prior to claim submission.	444
CO 16 M76, M81 You are required to code to the highest level of specificity. Missing / incomplete / invalid diagnosis or condition.	**Item 21** - Enter the patient's diagnosis/condition. All physician specialties must use an ICD-9-CM code number, coded to the highest level of specificity.	343
CO 16 MA114 Missing / incomplete / invalid information on where the services were furnished.	**Item 32** - Enter the name, address, and ZIP code of the facility if the services were furnished in a hospital, clinic, laboratory, or facility other than the patient's home or physician's office.	320

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

DME MAC A ListServes

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

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

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

Jurisdiction A DME MAC and PSC Affiliate Web Sites

Both the Jurisdiction A Durable Medical Equipment Medicare Administrative Contractor (DME MAC A) and Program Safeguard Contractor (PSC) maintain separate Web sites. Providers should visit the DME MAC A Web site (**http://www.medicarenhic.com/dme/**) for information regarding billing, educational updates and events, electronic data interchange (EDI), fee schedules, ListServes, What's New, etc. Online versions of our quarterly bulletins and the *DME MAC A Supplier Manual* are also available via this Web site.

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

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

Quarterly Provider Update

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

Supplier Manual News

The 2007 Edition of the *Jurisdiction A Durable Medical Equipment Medicare Administrative Contractor (DME MAC A) Supplier Manual* is available via the "Publications" section of our Web site at **http://www.medicarenhic.com/dme/dme_publications.shtml**. Once there, users can access the entire *DME MAC A Supplier Manual*, including revised chapters and archived revisions. The 2007 Edition is available to current suppliers via the DME MAC A Web site only, and newly-enrolled suppliers will continue to receive initial copies, as mandated by the Centers for Medicare & Medicaid Services (CMS). The option to request additional copies for a fee is not available to anyone at this time.

Updates/Corrections Made:
In October of 2007 **chapters 1, 2, 3, 4, 7, 8, 9, and 10** of the *DME MAC A Supplier Manual* were updated. A new chapter was also added during this time **creating an 11th chapter**. Suppliers who maintain hard copy manuals at their place of business need to discard the previously published pages and replace them with the revised ones. In order to avoid potential viewing and/or printing problems, be sure to follow the download instructions to access the revised pages.

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

For Your Notes

For Your Notes

The Durable Medical Equipment Medicare Administrative Contractor (DME MAC A) for Jurisdiction A will continue to offer our quarterly bulletin, the *DME MAC Jurisdiction A Resource*, in electronic format via our Web site, where copies can be printed free of charge. To access the bulletin, go to the "Publications" section of the DME MAC A Web site at ***http://www.medicarenhic.com/dme/dme_publications.shtml***. To be notified via email when bulletins are posted on our Web site, as well as the latest Medicare updates, subscribe to the DME MAC A ListServes, our electronic mailing lists. To subscribe, visit ***http://www.medicarenhic.com/dme/*** and click on "**Join the DME MAC A ListServe**".

For Suppliers without Internet Access: If you do not have Internet access and require the bulletin via hardcopy or CD-ROM*, you may subscribe to it for a fee. The annual subscription fee is $65.00 for hardcopy and $172.00 for CD-ROM. ***This subscription includes the four quarterly bulletins published during the calendar year of 2008 - March, June, September, and December.*** Complete this form and submit with payment, via check only, to the address listed below.

* The CD-ROM version of the bulletin is a Portable Document Format (PDF) file. To view PDFs, you must have Adobe® Acrobat® Reader® installed on your computer.

Name: _____ Provider # (NPI): _____

Mailing Address: _____ City: _____

_____ State: _____

_____ Zip: _____

Phone Number: _____

Reason for requesting a hardcopy of the *Resource:* _____

I wish to receive: Hardcopy - $65 per year ☐ CD-ROM - $172 per year ☐

By completing this form and signing below, I certify I do not have access to the Internet, or have some other technical barrier, preventing me from accessing the *DME MAC Jurisdiction A Resource* and therefore request I receive an annual hardcopy subscription. I understand I will have to renew my subscription annually before December 1st to continue receiving hardcopy of *DME MAC Jurisdiction A Resource*.

Enclose your check payable to: **NHIC, Corp.**

Mail your completed form with payment to: **NHIC, Corp.**
Cash Accounting / DME Subscription
75 Sgt William B Terry Drive
Hingham, MA 02043

Signature: _____ Date: _____

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

Outreach & Education
781-741-3950

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

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

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

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

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

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

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

Written Inquiry FAX: 781-741-3530

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

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

Administrative Law Judge (ALJ) Hearings:
HHS OMHA Mid-West Field Office
BP Tower, Suite 1300
200 Public Square
Cleveland, OH 44114-2316

Redetermination Requests FAX:
781-741-3118

Reconsiderations
RiverTrust Solutions, Inc.
P.O. Box 180208
Chattanooga, TN 37401-7208

For Overnight Deliveries:
RiverTrust Solutions, Inc.
P.O. Box 180208
Chattanooga, TN 37401-7208

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

EDI/EFT DME Enrollments Forms
PO Box 9185
Hingham, MA 02043-9185

National Supplier Clearinghouse
866-238-9652

SADMERC
877-735-1326

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

DME MAC Jurisdiction A Resource

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

December 2007
Number 6

Publication Information

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

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

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

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

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

NHIC, Corp.
an EDS Company
A CMS CONTRACTOR

75 Sgt. William B. Terry Drive
Hingham, MA 02043