DME MAC Jurisdiction A Resource

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

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June 2007
Number 4

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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.

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MLN Matters Disclaimer

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Billing/Finance

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

MLN Matters Number: MM5060 - *Revised*
Related CR Release Date: September 15, 2006
Related CR Transmittal #: R1058CP

Related Change Request (CR) #: 5060
Effective Date: January 1, 2007
Implementation Date: January 2, 2007

Note: This article was revised on February 9, 2007, to clarify the language in the first bullet point under "Billing Guidelines" on page 2. All other information remains the same.

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

Key Points

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

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

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

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

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

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

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

Billing Guidelines

- When the NPI number is effective (May 23, 2007, although it can be reported starting January 1, 2007) **and the billed service requires the submission of an NPI,** claims will be **rejected** (in most cases with reason code 16 - "claim/service lacks information that is needed for adjudication") in tandem with the appropriate remark code that specifies the missing information,
  if
- The appropriate **NPI is not entered** on Form CMS-1500 (08-05) in items:
  - **24J** (replacing item 24K, Form CMS-1500 (12-90));
  - **17B** (replacing item 17 or 17A, Form CMS-1500 (12-90));
  - **32a** (replacing item 32, Form CMS-1500 (12-90)); and
  - **33a** (replacing item 33, Form CMS-1500 (12-90)).

Additional Information

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

To enable proper processing of Form CMS-1500 (08-05) claims and to avoid claim rejections, please be sure to enter the correct identifying information for any numbers entered on the claim.
Legacy identifiers are pre-NPI provider identifiers such as:

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

Additional NPI-Related Information

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

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

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

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

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

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

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

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and select "Join the DME MAC A Listserve"

April Quarterly Update for 2007 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule (MM5537)

MLN Matters Number: MM5537 - *Revised*
Related CR Release Date: March 9, 2007
Related CR Transmittal #: R1203CP
Related Change Request (CR) #: 5537
Effective Date: January 1, 2007
Implementation Date: April 2, 2007

Note: This article was revised on February 9, 2007, to clarify the language in the first bullet point under "Billing Guidelines" on page 2. All other information remains the same.

Provider Types Affected
Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, Durable Medical Equipment Regional Carriers (DMERCs), 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 DMEPOS provided to Medicare beneficiaries.

Provider Action Needed
This article is based on Change Request (CR) 5537, which provides the April 2007quarterly update to the DMEPOS fee schedules in order to implement fee schedule amounts for new codes and to revise any fee schedule amounts for existing codes that were calculated in error. Be sure billing staff are aware of these changes.

Background
The DMEPOS fee schedules are updated on a quarterly basis in order to implement fee schedule amounts for new codes and to revise any fee schedule amounts for existing codes that were calculated in error. The quarterly updates process for the DMEPOS fee schedule is located in the *Medicare Claims Processing Manual* (Publication 100-04), Chapter 23, Section 60; **http://www.cms.hhs.gov/manuals/downloads/clm104c23.pdf**).

CR 5537 provides specific instructions regarding the April quarterly update for the 2007 DMEPOS fee schedule. Payment on a fee schedule basis is required for durable medical equipment (DME), prosthetic devices, orthotics, prosthetics, and surgical dressings by the Social Security Act (Sections 1834(a), (h), and (i)). Payment on a fee schedule basis is required for parenteral and enteral nutrition (PEN) by regulations contained in Title 42 of the Code of Federal Regulations (42 CFR 414.102).

Key Changes
The following are key changes in the April 2007 quarterly update of the DMEPOS fee schedule:

L8690 and L8691
The A/B MACs, Local Carriers, and FIs will adjust previously processed claims for L8690 (Auditory Osseointegrated Device, Includes All Internal and External Components) and L8691 (Auditory Osseointegrated Device, External Sound Processor, Replacement), with dates of service on or after January 1, 2007, if you resubmit such claims as adjustments.

Code E1002 (Wheelchair accessory, Power Seating System, Tilt Only)
Code E1002 was added to the Healthcare Common Procedure Coding System (HCPCS) effective January 1, 2004. The fee schedule amounts that were calculated and implemented for this code included systems with tilts less than 45 degrees from horizontal. As described in the November 2006 Policy Article for Wheelchair Options/Accessories, power tilt seating systems (falling under code E1002) must have the ability to tilt to greater than or equal to 45 degrees from horizontal. Therefore as part of this quarterly update, **the fee schedule amounts for code E1002 are being revised in order to remove pricing information for power seating systems with tilts less than 45 degrees.**

The DME MACs, and DMERCs will adjust previously processed claims for code E1002 with dates of service on or after January 1, 2007, if they are resubmitted as adjustments.

Code E2377 (Power Wheelchair Accessory, Expandable Controller, Including All Related Electronics and Mounting Hardware, Upgrade Provided at Initial Issue)
Code E2377 was added to the HCPCS effective January 1, 2007, for use in paying claims for upgraded expandable controllers and mounting hardware provided at initial issue. The fee schedule amounts for code E2377 do not include payment for the proportional joystick and electronics/cables/junction boxes necessary to upgrade from a non-expandable controller. **Suppliers need to submit claims for the upgraded proportional joysticks and electronics provided at initial issue for dates of service on or after January 1, 2007, using HCPCS code E2399.**

Further Changes for Power Wheelchairs
CMS is in the process of making refinements to the fee schedule amounts for several HCPCS codes for power wheelchairs to be implemented as part of the April quarterly update for the 2007 DMEPOS fee schedule. Additional instructions regarding these changes will be issued in the near future under separate cover.

Additional Information
The official instruction, CR 5537, issued to your carrier, intermediary, RHHI, A/B MAC, DMERC, or DME MAC regarding this change may be viewed at **http://www.cms.hhs.gov/Transmittals/downloads/R1203CP.pdf** on the CMS website.

If you have any questions, please contact your Medicare carrier, intermediary, RHHI, A/B MAC, DMERC, 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**.

April 2007 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing File, Effective April 1, 2007, and Revisions to the January 2007 Quarterly ASP Medicare Part B Drug Pricing Files (MM5517)

MLN Matters Number: MM5517
Related CR Release Date: March 16, 2007
Related CR Transmittal #: R1204CP

Related Change Request (CR) #: 5517
Effective Date: April 1, 2007
Implementation Date: April 2, 2007

Provider Types Affected

Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, Durable Medical Equipment Regional Carriers (DMERCs), 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

This article is based on Change Request (CR) 5517 which informs Medicare contractors to download the April 2007 Average Sales Price (ASP) drug pricing file for Medicare Part B drugs as well as the revised January 2007 ASP files.

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 OPPS, will be paid based on the ASP methodology.

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, DMERCs, DME MACs, FIs, A/B MACs, and/or RHHIs) with the ASP drug pricing files for Medicare Part B drugs on a quarterly basis.

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 determined in the same manner the payment allowance limits were determined on October 1, 2003. Specifically, the payment allowance limits for blood and blood products 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. **The payment allowance limits will not be 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.
- Payment allowance limits for influenza, Pneumococcal and Hepatitis B vaccines are 95 percent (95%) of the AWP as reflected in the published compendia except when the vaccine is furnished in a hospital outpatient department. When the vaccine is administered in the hospital outpatient department, the vaccine is paid at reasonable cost.
- The payment allowance limits for **drugs that are not included in the ASP Medicare Part B Drug Pricing File or Not Otherwise Classified (NOC) Pricing File** (other than new drugs that are produced or distributed under a new drug application approved by the Food and Drug Administration) are based on the published wholesale acquisition cost (WAC) or invoice pricing. In determining the payment limit based on WAC, the Medicare contractors follow the methodology specified in the *Medicare Claims Processing Manual* (Publication 100-04, Chapter 17, Drugs and Biologicals) for calculating the AWP but substitute WAC for AWP. The payment limit is 100 percent (100%) 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.

April 2007 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing File, Effective April 1, 2007, and Revisions to the January 2007 Quarterly ASP Medicare Part B Drug Pricing Files (MM5517) (Continued)

- The payment allowance limits for **new drugs that are produced or distributed under a new drug application approved by the Food and Drug Administration (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 (106%) of the WAC or invoice pricing, if the WAC is not published. This policy applies only to new drugs that were first sold on or after January 1, 2005.
- The payment allowance limits for **radiopharmaceuticals** are not subject to ASP. Radiopharmaceuticals furnished in the hospital outpatient department are paid charges reduced to cost by the hospital's overall cost to charge ratio.

On or after March 19, 2007, the revised January 2007 and April 2007 ASP files and ASP Not Otherwise Classified (NOC) files will be available for retrieval from the CMS ASP webpage, and 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 site. The revised 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
January 2007	January 1, 2007 through March 31, 2007.
April 2007	April 1, 2007 through June 30, 2007

Note: The absence or presence of a Healthcare Common Procedure Coding System (HCPCS) code, and its associated payment limit, does not indicate Medicare coverage of the drug or biological. Similarly, the inclusion of a payment limit within a specific column does not indicate Medicare coverage of the drug in that specific category. The 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.

Additional Information

For complete details, please see the official instruction issued to your carriers, DMERCs, DME MACs, FIs, A/B MACs, and/or RHHIs regarding this change. That instruction may be viewed at **http://www.cms.hhs.gov/Transmittals/downloads/R1204CP.pdf** on the CMS website.

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

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

Changes in Maintenance and Servicing Due to Deficit Reduction Act (DRA) Legislation for Capped Rentals and Oxygen Equipment (MM5461)

MLN Matters Number: MM5461
Related CR Release Date: February 2, 2007
Related CR Transmittal #: R1177CP

Related Change Request (CR) #: 5461
Effective Date: January 1, 2006
Implementation Date: July 2, 2007

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

Provider Action Needed
Suppliers of oxygen equipment and services need to be aware of changes in Medicare processes impacting maintenance and servicing of oxygen equipment for Medicare beneficiaries as described in this article.

Background
This article is based on Change Request (CR) 5461 and the purpose is to identify the Medicare payment method used for maintenance and servicing (M&S) for both capped rental items generally and for oxygen equipment in particular. Sections 5101(a) and 5101(b) of the DRA of 2005 mandate changes in the way Medicare makes payment for certain items of DME.

Section 5101(a) revises the payment rules for capped rental DME. After 13 months, the beneficiary owns the capped rental DME item and, after that time, Medicare pays for reasonable and necessary repairs and servicing (i.e., parts and labor not covered by a supplier's or manufacturer's warranty) of the item. The provision applies to beneficiaries renting an item for which the first rental month occurs on or after January 1, 2006.

For rentals prior ro January 1, 2006, Section 5101(b) limits the total number of continuous rental months for which Medicare will pay for oxygen equipment to 36 months. After the 36th month, the beneficiary will own the oxygen equipment. For beneficiary-owned gaseous or liquid oxygen systems, Medicare will continue to pay for the oxygen contents. In addition, Medicare will pay for reasonable and necessary repairs and servicing (i.e., parts and labor not covered by a supplier's or manufacturer's warranty) of beneficiary-owned equipment (including oxygen concentrators). This provision was effective January 1, 2006. For beneficiaries receiving oxygen equipment on or before December 31, 2005, the 36-month rental period begins on January 1, 2006.

CR5370 and the resulting MLN article preceded CR5461 and provides background explanations that detail the impact of the DRA. The web address for CR5370 is listed in the *Additional Information* section of this article.

Key Points
- **Capped Rental Items -** Payment will no longer be made every 6 months for Maintenance and Servicing (M&S) for capped rental items (with the exception of oxygen equipment as discussed in the next bullet point). However, once the beneficiary owns the capped rental item, Medicare will cover reasonable and necessary repairs and servicing.
- **Oxygen Equipment -** Payment may be made for M&S every 6 months, starting 6 months after the beneficiary owns the equipment. The payment for M&S will be paid in 15 minute intervals and shall not exceed 30 minutes. In addition, Medicare will cover reasonable and necessary repairs.
- Claims with the base HCPCS code for the oxygen equipment and the "MS" modifier for maintenance and servicing for oxygen equipment will be accepted for payment.
- Maintenance and servicing claims for oxygen equipment not to exceed 2 units (of E1340) every 6 months will be accepted for payment.
- The modifier "RP" will be accepted for replacement parts.
- Claims with HCPCS code E1399 and modifier "RP" if a specific replacement code is not available for billing will be accepted for payment.
- The following Medicare Summary Notice (MSN) messages for capped rental items where the title has been transferred to the beneficiary will be sent to beneficiaries:
  - Monthly rental payments can be made for up to 13 months from the first paid rental month or until the equipment is no longer needed, whichever comes first. After the 13 month of rental is paid, your supplier must transfer title of this equipment to you.
  - Medicare will pay for medically necessary maintenance and/or servicing as needed after the end of the 13th paid rental month.
- The following MSN messages for oxygen equipment where the title has been transferred to the beneficiary will be sent to beneficiaries, as appropriate:
  - "Medicare will pay for you to rent oxygen for up to 36 months (or until you no longer need the equipment). After Medicare makes 36 payments, your supplier must transfer title of this equipment to you, and you will own the equipment."
  - "Medicare will pay to maintain and service your oxygen equipment. This will start 6 months after the supplier transfers the title of the equipment to you."

Changes in Maintenance and Servicing Due to Deficit Reduction Act (DRA) Legislation for Capped Rentals and Oxygen Equipment (MM5461) (Continued)

- "Billing exceeds the rental months covered/approved by the payer."
- "Title of this equipment must be transferred to the patient."

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

For complete details regarding this Change Request (CR) please see the official instruction (CR5461) issued to your Medicare DME MAC or DMERC. That instruction may be viewed by going to **http://www.cms.hhs.gov/Transmittals/downloads/R1177CP.pdf** on the CMS website.

MLN article MM5370, which relates to CR5370, contains additional information regarding oxygen caps and is available at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5370.pdf** on the CMS website.

Common Billing Errors to Avoid when Billing Medicare Carriers (SE0712)

MLN Matters Number: SE0712
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 and providers billing Medicare carriers for services provided to Medicare beneficiaries

Provider Action Needed
This special edition article includes some general information regarding the most frequent errors that are found in claims submitted to Medicare carriers. The article is intended to help you correctly complete your Medicare claims so they will not be denied, rejected, or delayed because of incorrect or incomplete information.

Background
The Administrative Simplification Compliance Act and its implementing regulation (42 CFR 44.32, **http://www.gpoaccess.gov/cfr/retrieve.html**) require that all initial claims for reimbursement under Medicare be submitted electronically as of October 16, 2003 (except from small providers with limited exceptions).

All Medicare providers, except for small providers defined in regulation, must bill Medicare electronically. A "small provider" is defined in the Federal Register (42 CFR 424.32(d)(1)(vii), **http://www.gpoaccess.gov/cfr/retrieve.html**). To simplify, Medicare will consider all physicians, practitioners, facilities, or suppliers with fewer than 10 full time employees (FTEs) that bill a Medicare carrier or DMERC to be small. Providers that qualify as "small" automatically qualify for waiver of the requirement that their claims be submitted to Medicare electronically. Those providers are encouraged to submit their claims to Medicare electronically, but are not required to do so under the law. Small providers may elect to submit some of their claims to Medicare electronically, but not others. Submission of some claims electronically does not negate their small provider status nor obligate them to submit all of their claims electronically.

COMMON BILLING ERRORS
The following list includes common billing errors that you should avoid when submitting your claims to Medicare carriers:

- The patient cannot be identified as a Medicare patient. Always use the Health Insurance Claim Number (HICN) and name as it appears on the patient's Medicare card.
- Item 32 (and the electronic claim equivalent) requires you to indicate the place where the service was rendered to the patient including the name and address -including a valid ZIP code- for all services unless rendered in the patient's home. Please be advised that any missing, incomplete, or invalid information recorded in this required field will result in the claim being returned or rejected in the system as unprocessable. Any claims received with the word "SAME" in Item 32 indicating that the information is the same as supplied in Item 33 are not acceptable. (**Note:** *References to an item number, such as item 32, refer to paper claim forms. However, note that the whenever an article number is used in this article, the related concept and information required also applies to equivalent fields on electronic claims.*)
- The referring/ordering physician's name and UPIN were not present on the claim. Please keep in mind this information is required in Item 17 and 17a on all diagnostic services, including consultations. In addition, be aware of the new requirements for use of National Provider Identifiers (NPIs). To learn more about NPIs and how to obtain your NPI, see the *MLN Matters* article SE0679 at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0679.pdf** on the CMS web site. Also, see the *MLN Matters* articles SE0555, SE0659, and MM4203 for important information regarding CMS' schedule for implementing the NPI. The articles are at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0555.pdf**, **http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0659.pdf**, and **http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4023.pdf**, respectively.

Common Billing Errors to Avoid when Billing Medicare Carriers (SE0712) (Continued)

- Evaluation and management (E&M) procedure codes and the place of service do not match. An incorrect place of service is being submitted with the E&M procedure code. (**Example:** Procedure code 99283, which is an emergency room visit, is submitted with place of service 11, which is office).
- Please keep in mind, when billing services for more than one provider within your group, that you must put the individual provider number in Item 24k, as Item 33 can only accept one individual provider number. Also, please make sure the provider number on the claim is accurate and that it belongs to the group. (Also, remember that as of May 23, 2007, NPIs are to be used.)
- Diagnosis codes being used are either invalid or truncated. Diagnosis codes are considered invalid usually because an extra digit is being added to make it 5 digits. Please remember not all diagnosis codes are 5 digits. Please check your ICD-9-CM coding book for the correct diagnosis code.
- Procedure code/modifier was invalid on the date of service. Remember that, as of January 1, 2005, CMS no longer provides a 90-day grace period for billing discontinued CPT/HCPCS codes. (**Note:** *Please read the Medicare provider bulletins, especially at the end of each year, as Medicare list all the additions, deletions, and code changes for the following year.)*
- Claims are being submitted with deleted procedure codes. This information can also be found in the CPT Book. It is important to be using a current book.
- When Medicare is secondary, Item 11, 11a, 11b, and 11c must be completed.

BILLING TIPS

The following topics will assist you with correct billing and help you complete and submit error free claims:

A. Provider Numbers

Individual vs. Group PIN - Use the individual rendering provider identification number (PIN) on each detail line. Make sure the group number, when applicable, corresponds to the appropriate individual PIN. When a physician has more than one PIN (private practice, hospital, etc.), use the appropriate PIN for the services rendered. A rendering provider number, if not a solo number, must always belong to the group number that is billing. Electronic submitter ID numbers (not UPINs) should be entered in place of the PIN (group or individual). When billing any service to Medicare, if you have doubts as to which provider number to use, please verify with your carrier. (Remember to use NPIs on claims as of May 23, 2007.)

"Zero-Filling" - Do not substitute zeros or a submitter identification number where a Medicare PIN, UPIN, or NPI is required.

B. Health Insurance Claim (HIC) Numbers

HIC Accuracy - Your carrier receives numerous claims that are submitted with invalid or incorrect HIC numbers. These claims require manual intervention and can sometimes result in beneficiaries receiving incorrect EOMB information. Please be certain the HIC number you are keying is entered correctly, and is also the HIC that belongs to the patient (based on what is on his/her Medicare card) for which you are billing.

HIC Format - A correct HIC number consists of 9 numbers immediately followed by an alpha suffix. Take special care when entering the HIC number for members of the same family who are Medicare beneficiaries. A husband and wife may have a HIC number that share the same Social Security numerics. However, every individual has their own alpha suffix at the end of the HIC number. In order to ensure proper claim payment, it is essential that the correct alpha suffix is appended to each HIC. *No hyphens or dashes should be used.*

"Railroad Retirees" - Railroad Retirement HIC numbers generally have two alpha characters as a prefix to the number. These claims should be billed to United Health Care Insurance Company, at this address:

Palmetto Government Benefit Administrators
Railroad Medicare Services
PO Box 10066
Augusta, GA 30999-0001

C. Name Accuracy

Titles should not be used as part of the name (e.g., Dr., Mr., Rev., M.D., etc.). Be sure to use the name as it appears on the patient's Medicare card.

Non-Medicare Claims - Do not send claims for non-Medicare beneficiaries to your Medicare carrier.

D. Complete Address

U.S. Postal Addressing Standards - It is very important to meet the U.S. Postal addressing standards. Patient and provider information must be correct. This is necessary so that checks and Medicare Summary Notices (MSNs) or remittance notices arrive at the correct destination. It is also to ensure the quickest service to your office.

- A deliverable address may contain both a street name and number or a street name with a Post Officer (P.O.) Box number.
- A P.O. Box by itself is acceptable.
- A Rural Route (RR) number must be with a box number. **Note:** It is incorrect to key P.O. in front of the box number when given with a rural route.
- A star route number is not a deliverable address. Use highway contract route (HC) instead of star route.

Common Billing Errors to Avoid when Billing Medicare Carriers (SE0712) (Continued)

- RD numbers are no longer valid. If there are rural routes still existing in your area, the correct number should be preceded by RR, then the box number.
- A box number or a RR number by itself is not deliverable.
- A street name without a number can not be delivered.
- Do not use % or any other symbol when denoting an "in care of" address. C/O is appropriate.
- As always, no commas, hyphens, periods, or other special characters should be used.

Nursing Home or Skilled Nursing Facility Address - For a facility such as a nursing home or skilled nursing facility, it is preferred that a street name and number be supplied. In some cases, this information is not available, but if it is, please use it. Please verify the accuracy of your address before you send this information.

Apartment Complex - An apartment complex (words such as apartments, towers, or complex indicate such) should contain a street address and an apartment number. Again, this information is not always available, but should always be used when it exists.

Development Center / Trailer Park - If a development center or trailer park is given, it should contain the street address and number, if that information is part of the complete address.

"No Street Address" (NSA) - NSA (No Street Address) **is not acceptable.** This is not a deliverable address.

Changes to Provider Address - Please notify your carrier in writing of any address changes for your office practice.

E. Diagnosis and Procedure Codes

Make sure you keep current with valid diagnosis and procedure codes. HIPAA requires that Medicare conform to these standard code sets reported codes must be valid as of the date of service. Remember that Medicare can no longer allow a grace period for using deleted codes.

Additional Information

Medicare Claims Processing Manual

The *Medicare Claims Processing Manual* (Publication 100-04) contains detailed instructions on Medicare's claims processes and detailed information on preparation and submission of claims. This manual is available at **http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage** on the CMS web site.

MLN Matters

MLN Matters is a series of articles that CMS prepares especially for providers. These articles provide information on new and/or deleted procedure and diagnosis codes, changes to the Medicare Physician Fee Schedule and other changes that impact physicians and providers. These articles are available at **http://www.cms.hhs.gov/MLNMattersArticles/** on the CMS website.

Listservs

Listservs are electronic mailing lists that CMS uses to get new information into the hands of physicians and providers as quickly as possible. To get your Medicare news as it happens, join the appropriate listserv(s) at **http://www.cms.hhs.gov/apps/mailinglists/** 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** 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**

Disclosure Desk Reference for Provider Contact Centers (MM5089)

MLN Matters Number: MM5089 - *Revised*
Related CR Release Date: July 21, 2006
Related CR Transmittal #: R16COM

Related Change Request (CR) #: 5089
Effective Date: October 1, 2006
Implementation Date: October 2, 2006

Note: This article was revised on May 7, 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
All physicians, providers, and suppliers billing Medicare

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Disclosure Desk Reference for Provider Contact Centers (MM5089) (Continued)

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

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

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

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

Insufficient or Inaccurate Requests

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

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

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

Beneficiary Authentication

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

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

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

Special Instances

Below are three special instances that you should know about.

Overlapping Claims

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

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

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

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

Pending Claims

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

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

Deceased Beneficiaries

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

Disclosure Desk Reference for Provider Contact Centers (MM5089) (Continued)

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

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

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

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

Extension for Acceptance of Form CMS-1500 (12-90) (MM5568)

MLN Matters Number: MM5568 - *Revised*
Related CR Release Date: March 19, 2007
Related CR Transmittal #: R1208CP
Related Change Request (CR) #: 5568
Effective Date: April 1, 2007
Implementation Date: April 2, 2007

Note: This article was revised on May 7, 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
Physicians, non physician practitioners and suppliers who submit claims for their services using the Form CMS-1500 to Medicare contractors (carriers, Part A/B Medicare Administrative Contractors (A/B MACs), durable medical equipment regional carriers (DMERCs), and/or DME Medicare Administrative Contractors (DME/MACs)). **Be aware that some of the new Form CMS-1500 (08-05) forms have been printed incorrectly. This article contains details on this issue.**

Background
Form CMS-1500 is one of the basic forms prescribed by the Centers for Medicare & Medicaid Services (CMS) for the Medicare program. It is only accepted from physicians and suppliers that are excluded from the mandatory electronic claims submission requirements set forth in the Administrative Simplification Compliance Act, Public Law 107-105 (ASCA), and the implementing regulation at 42 CFR 424.32. The Form CMS-1500 (12-90) was revised in July of 2006 to accommodate the reporting of the National Provider Identifier (NPI).

Recently it came to the attention of CMS that there are incorrectly formatted versions of the revised form being sold by print vendors. After reviewing the situation, CMS determined that the source files received from the authorized forms designer were improperly formatted. This resulted in the sale of printed forms and negatives which do not comply with the form specifications.

Therefore, CMS has decided to extend the acceptance period of the Form CMS-1500 (12-90) version beyond the original April 1, 2007 deadline while this situation is resolved. The specific formatting issue involves top and bottom margins only, but may not be isolated to only top and/or bottom.

Key Points of CR5568
- CR5568 states that the Form CMS-1500 (12-90) will continue to be accepted until CMS instructs otherwise.
- All Form CMS-1500 (08-05) forms received by Medicare contractors that are incorrectly formatted will be returned to the provider or supplier if the Medicare contractor is unable to scan the form with its Optical Character Reader scanning equipment. An incorrectly formatted form is one that is 1/4” or more off in the top, bottom, right, and/or left margins.

Extension for Acceptance of Form CMS-1500 (12-90) (MM5568) (Continued)

- The best way to identify the incorrect forms is by looking at the upper right hand corner of the form. If the tip of the red arrow above the vertically stacked word "CARRIER" is touching or close to touching the top edge of the form, then the form is not printed to specifications. There should be approximately 1/4" between the tip of the arrow and the top edge of the paper on properly formatted forms.
- Providers submitting the Form CMS-1500 (12-90) are only required to submit their legacy provider number on that form, since the CMS-1500 (12-90) cannot accommodate the NPI. ***It is important to note that this issue involves the paper claim form only, not the electronic claim format, which can accommodate the NPI. In addition, this situation does not affect the current NPI implementation date of May 23, 2007.***

Additional Information
To see the official instruction (CR5568) issued to your Medicare carrier, A/B MAC, DME MAC, or DMERC, go to **http://www.cms.hhs.gov/Transmittals/downloads/R1208CP.pdf** on the CMS web site.

To view the original communication from CMS regarding this issue, visit **http://www.cms.hhs.gov/ElectronicBillingEDITrans/downloads/1500%20problems.pdf** on the CMS site.

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

Important Medicare Notice Regarding the Revised Form CMS-1500 (CMS Message 2007-03-09)

In July 2006, the Form CMS-1500 (12-90) was revised by the National Uniform Claim Committee (NUCC) predominantly for the purpose of accommodating the National Provider Identifier. Since that time, the industry has been preparing for the implementation of the revised Form CMS-1500 (08-05). In September 2006, Medicare announced that it would implement the revised Form CMS-1500 (08-05) on January 1, 2007 with dual acceptability of both versions until March 31, 2007. Medicare further announced that beginning April 1, 2007, the only acceptable version of the form would be the Form CMS-1500 (08-05) and that the prior version, Form CMS-1500 (12-90), would be rejected.

It has recently come to our attention that there are incorrectly formatted versions of the revised form being sold by print vendors, specifically the Government Printing Office (GPO). After reviewing the situation, the GPO has determined that the source files they received from the NUCC's authorized forms designer were improperly formatted. This resulted in the sale of both printed forms and negatives which do not comply with the form specifications.

Given the circumstances, **CMS has decided to extend the acceptance period of the Form CMS-1500 (12-90) version beyond the original April 1, 2007 deadline** while this situation is resolved. Medicare contractors will be directed to continue to accept the Form CMS-1500 (12-90) until notified by CMS to cease. At present, we are targeting June 1, 2007 as that date. In addition, during the interim, contractors will be directed to return, not manually key, any Form CMS-1500 (08-05) forms received which are not printed to specification. By returning the incorrectly formatted claim forms back to you, we are able to make you aware of the situation which will allow you to begin communications with your form supplier.

The following will help you to properly identify which form is which. The old version of the form contains "Approved OMB-0938-0008 FORM CMS-1500 (12-90)" on the bottom of the form (typically on the lower right corner) signifying the version is the December 1990 version. The revised version contains "Approved OMB-0938-0999 FORM CMS-1500 (08-05)" on the bottom of the form signifying the version is the August 2005 version. The best way to identify if your CMS-1500 (08-05) version forms are correct is by looking at the upper right hand corner of the form. On properly formatted claim forms, there will be approximately a 1/4" gap between the tip of the red arrow above the vertically stacked word "CARRIER" and the top edge of the paper. If the tip of the red arrow is touching or close to touching the top edge of the paper, then the form is not printed to specifications.

Questions may be directed to Brian Reitz at **Brian.Reitz@cms.hhs.gov.**

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

INDEPENDENCE iBOT 4000 Mobility System (MM5372)

MLN Matters Number: MM5372
Related CR Release Date: February 23, 2007
Related CR Transmittal #: R65NCD
Related Change Request (CR) #: 5372
Effective Date: July 27, 2006
Implementation Date: April 2, 2007

Provider Types Affected

Providers and suppliers who bill Medicare durable medical equipment regional carriers (DMERCs) or durable medical equipment Medicare administrative contractors (DME MACs) for services to Medicare beneficiaries.

Key Points

- Effective for services performed on and after July 27, 2006, the Centers for Medicare & Medicaid Services (CMS) has determined that only the Standard Function of the INDEPENDENCE iBOT 4000 Mobility System meets the definition of DME under section 1861(n) of the Medicare program and is reasonable and necessary for beneficiaries who have a personal mobility deficit sufficient to impair their participation in mobility-related activities of daily living, e.g., toileting, feeding, dressing, grooming, bathing, in customary locations in the home.
- Effective for services performed on or after July 27, 2006, the 4-wheel, Balance, Stair, and Remote Functions of the INDEPENDENCE iBOT 4000 Mobility System do not meet the definition of DME under section 1861(n) of the Medicare program.

Background

This article and related change request (CR) 5372 alerts providers that a new Section 280.15 was added to the *Medicare National Coverage Determination (NCD) Manual* as a result of the July 27, 2006, NCD decision memo for the INDEPENDENCE iBOT 4000 Mobility System.

The change clarifies the coverage policy for this particular power mobility device. The addition to the coverage manual will indicate that CMS will provide coverage for the Standard Function of the INDEPENDENCE iBOT 4000 Mobility System, which meets the definition of DME under section 1861(n) of the Social Security Act, as a wheelchair used in the patient's home that is reasonable and necessary for beneficiaries who have a personal mobility deficit sufficient to impair their participation in mobility-related activities of daily living, e.g., toileting, feeding, dressing, grooming, bathing, in customary locations in the home.

Medicare uses an algorithmic process in determining the presence of a mobility deficit in Chapter 1, Part 4, Section 280.3 of the *Medicare NCD Manual*, which is available at **http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage** on the CMS site. This approach is also outlined in the *MLN Matters* article, MM3791, which is available at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3791.pdf** on the CMS site.

Implementation

Medicare DMERCs and DME MACs will implement CR5372 on April 2, 2007.

Additional Information

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

For complete details regarding this Change Request (CR), please see the official instruction issued to your DMERC or DME MAC. That instruction may be viewed by going to **http://www.cms.hhs.gov/Transmittals/downloads/R65NCD.pdf** on the CMS web site.

Medically Unlikely Edits (MUEs) (MM5495)

MLN Matters Number: MM5495
Related CR Release Date: March 9, 2007
Related CR Transmittal #: R1202CP
Related Change Request (CR) #: 5495
Effective Date: April 1, 2007
Implementation Date: April 2, 2007

Provider Types Affected

Physicians, suppliers, and providers who submit claims to 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)).

Background

In order to lower the Medicare fee-for-service paid claims error rate, the Centers for Medicare & Medicaid Services (CMS) established units of service edits referred to below as MUEs. The National Correct Coding Initiative (NCCI) contractor develops and maintains MUEs.

Medically Unlikely Edits (MUEs) (MM5495) (Continued)

- An MUE is defined as an edit that tests claim lines for the same beneficiary, Health Care Common Procedure Code System (HCPCS) code, date of service, and billing provider against a criteria number of units of service.
- For carrier claims, the MUEs will automatically deny or suspend claim line items containing units of service billed in excess of the MUE criteria and for FI claims, the MUEs will Return to Provider (RTP) claims that contain lines that have units of service that exceed an MUE criteria.

Key Points

- CR5495 announces the upcoming release of the next version of the MUEs, which is version 1.1.
- CR5495 states that Medicare carriers and A/B MACs will deny the entire claim line from non-institutional providers with units of service that exceed MUE criteria and pay the other services on the claims.
- FIs and A/B MACs will RTP claims from institutional providers with units of service that exceed MUE criteria.
- An appeal process will not be allowed for RTP'ed claims as a result of an MUE. Instead, providers should determine why the claim was returned, correct the error, and resubmit the corrected claim.
- Providers may appeal MUE criteria by forwarding a request the carrier or A/B MAC who, if they agree, will forward the appeal to the National Correct Coding Contractor.
- Excess **charges due to units of service greater than the MUE may not be billed to the beneficiary (this is a "provider liability"),** and this provision can neither be waived nor subject to an Advanced Beneficiary Notice (ABN).

Additional Information

For complete details regarding this Change Request (CR) please see the official instruction (CR5495) issued to your Medicare carrier, FI, A/B MAC, DME MAC, DMERC, or RHHI. That instruction may be viewed by going to **http://www.cms.hhs.gov/Transmittals/downloads/R1202CP.pdf** on the CMS website.

If you have questions, please contact your Medicare carrier, FI, 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.

Modification to the Model Medicare Redetermination Notice (MRN) (for partly or fully unfavorable redeterminations) and the Administrative Law Judge (ALJ) Filing Locations Where the Place of Service Was in Delaware, Kentucky, Puerto Rico, Virginia, &/or the US Virgin Islands. (MM5554)

MLN Matters Number: MM5554
Related CR Release Date: April 27, 2007
Related CR Transmittal #: R1229CP
Related Change Request (CR) #: 5554
Effective Date: July 2, 2007
Implementation Date: July 2, 2007

Provider Types Affected

Physicians, suppliers, and providers who submit claims to Medicare contractors (Fiscal intermediaries (FIs), carriers, Part A/B Medicare Administrative Contractors (A/B MACs), DME Medicare Administrative contractors (DME/MACs), durable medical equipment regional carriers (DMERCs), and/or regional home health intermediaries (RHHIs)).

Provider Action Needed

Impact to You

The Centers for Medicaid & Medicare Services (CMS) issued change request (CR) 5554 in order to modify the Reconsideration Request Form and to amend the ALJ filing locations.

What You Need to Know

Providers and suppliers do not need to resubmit documentation when requesting a Qualified Independent Contractor (QIC) reconsideration if the documentation was previously submitted as part of the redetermination process. This documentation is forwarded to the QIC as part of the case file utilized in the reconsideration process. Make certain that any additional evidence is submitted prior to the reconsideration decision. If all additional evidence is not submitted prior to issuance of the reconsideration decision, you will not be able to submit any new evidence to the ALJ or further appeal unless you can demonstrate good cause for withholding the evidence from the QIC.

Be aware that when the service was rendered in **Delaware, Kentucky, Virginia, Puerto Rico, and/or the US Virgin Islands,** the filing locations for ALJ requests are modified to identify the appropriate Office of Medicare Hearings and Appeals (OMHA) field office. All other jurisdictions remain unchanged.

What You Need to Do

Make certain that your billing staff or other staff that handle reconsideration requests for you are aware of these changes.

Modification to the Model Medicare Redetermination Notice (MRN) (for partly or fully unfavorable redeterminations) and the Administrative Law Judge (ALJ) Filing Locations Where the Place of Service Was in Delaware, Kentucky, Puerto Rico, Virginia, &/or the US Virgin Islands. (MM5554) (Continued)

Background
CR5554 is the official document that announces these changes in Medicare processes. Attached to this CR are three documents that assist with the appeals process:

- A sample form letter titled: Medicare Appeal Decision,
- A paper outlining Important Information About Your Appeal Rights, and
- A modified **Reconsideration Request Form** containing revised introductory instructions, as follows: "At a minimum, you must complete/include information for items 1, 2a, 6, and 7 but to help us serve you better, please include a copy of the redetermination notice you received with your reconsideration request."

The revised filing locations for sending documentation for requesting ALJ hearings are as follows:

- **Cleveland, Ohio** is the filing location for services rendered in **Delaware and Kentucky,**
- **Arlington, Virginia** for services in **Virginia,** and
- **Miami, Florida** for services in **Puerto Rico and the US Virgin Islands.**

The following table lists the addresses of all filing locations along with the place of service.

HHS OMHA Field Office & Mailing Address	**Jurisdiction (Based on the place of service)**			
Cleveland, OH BP Tower & Garage 200 Public Square, Suite 1300 Cleveland, OH 44114-2316	Connecticut Maine Massachusetts New Hampshire Rhode Island Vermont	New York New Jersey Puerto Rico Virgin Islands	Pennsylvania *Delaware* West Virginia *Kentucky*	Illinois Indiana Ohio Michigan Minnesota Wisconsin
Miami, FL 100 SE 2nd Street, Suite 1700 Miami, FL 33131-2100	Alabama Florida Georgia Mississippi North Carolina South Carolina Tennessee	Arkansas Louisiana New Mexico Oklahoma Texas *Puerto Rico* *US Virgin Islands*		
Irvine, CA 27 Technology Drive, Suite 100 Irvine, CA 92618-2364	Iowa Kansas Missouri Nebraska	Colorado Montana North Dakota South Dakota Utah Wyoming	Arizona California Hawaii Nevada Guam Trust Territory of the Pacific Islands American Samoa	Alaska Idaho Oregon Washington
Arlington, VA 1700 N. Moore St., Suite 1600 Arlington, VA 22209	*Virginia* Maryland District of Columbia			

Modification to the Model Medicare Redetermination Notice (MRN) (for partly or fully unfavorable redeterminations) and the Administrative Law Judge (ALJ) Filing Locations Where the Place of Service Was in Delaware, Kentucky, Puerto Rico, Virginia, &/or the US Virgin Islands. (MM5554) (Continued)

Additional Information
For complete details regarding this Change Request (CR) please see the official instruction (CR5554) issued to your Medicare carrier, FI, A/B MAC, DME MAC, DMERC, or RHHI. That instruction may be viewed by going to **http://www.cms.hhs.gov/Transmittals/downloads/R1229CP.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.

New Durable Medical Equipment Prosthetic, Orthotics & Supplies (DMEPOS) Certificates of Medical Necessity (CMNs) and DME Medicare Administrative Contractor (MAC) Information Forms (DIFS) for Claims Processing (MM4296)

MLN Matters Number: MM4296 - *Revised*
Related CR Release Date: October 27, 2006
Related CR Transmittal #: R167PI
Related Change Request (CR) #: 4296
Effective Date: October 1, 2006
Implementation Date: October 2, 2006

Note: This article was revised on April 16, 2007, to reflect that the transition period for use of the new forms has been extended through June 30, 2007, per CR5571, which CMS released on April 13, 2007. Previously, this article was revised on October 28, 2006, to reflect changes made to CR4296. The key change is that the CR4296 applies to claims based on dates of service rather than dates of receipt. In addition, the CR release date, transmittal number, and Web address for accessing CR4296 were changed. All other information remains the same.

Provider Types Affected
Physicians, providers, and suppliers using CMNs and DIFs when billing to Medicare durable medical equipment regional carriers (DMERCs)

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

What You Need to Know
There is a transition period for claims for dates of service from October 1, 2006, through June 30, 2007, where claims for items requiring a CMN or DIF will be accepted with either the old or the new form. The improved forms also permit the use of a signature and date stamp.

What You Need to Do
Make certain that your billing staff is aware of the changes in Chapters 3 and 5 of the *Medicare Program Integrity Manual* that are outlined in this article. The new series of forms is available as part of the official instructions (CR4296) issued to your DMERC.

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

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

New Durable Medical Equipment Prosthetic, Orthotics & Supplies (DMEPOS) Certificates of Medical Necessity (CMNs) and DME Medicare Administrative Contractor (MAC) Information Forms (DIFS) for Claims Processing (MM4296) (Continued)

Claims Accepted During Transition Period

The following table identifies the CMNs for claims for services provided during the transition period from October 1, 2006, through June 30, 2007. (For services on or after July 1, 2007, the old forms will no longer be accepted.)

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

Newly Revised CMNs Accepted During Transition Period

The following table identifies the newly revised CMNs that will be accepted for services provided during the transition period for claims from October 1, 2006, through June 30, 2007. For services on or after July 1, 2007, these forms will become effective for claims for items requiring a CMN.

Noteworthy changes include changing the title of CMS-484 from Home Oxygen Therapy to Oxygen. In addition, the title of CMS-846 was changed from Lymphedema Pumps to Pneumatic Compression Devices.

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

New Durable Medical Equipment Prosthetic, Orthotics & Supplies (DMEPOS) Certificates of Medical Necessity (CMNs) and DME Medicare Administrative Contractor (MAC) Information Forms (DIFS) for Claims Processing (MM4296) (Continued)

New DIFs Accepted During Transition Period

The following table identifies the new DIFs that will also be accepted during the transition period for claims for services provided from October 1, 2006, through June 30, 2007. For services on or after July 1, 2007, the new forms will become effective for claims for items requiring a DIF.

Noteworthy changes include changing CMS-851 for Infusion Pumps to a CMS-10125, External Infusion Pump DIF.

In addition, CMS-852 for Parenteral Nutrition and CMS-853 for Enteral Nutrition were combined into a CMS-10126 Enteral and Parenteral Nutrition DIF.

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

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

CMNs Eliminated

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

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

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

Implementation

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

Additional Information

The official instructions issued to your DMERC regarding this change can be found at **http://www.cms.hhs.gov/Transmittals/downloads/R167PI.pdf** on the CMS web site. These instructions include copies of the new forms.

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

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

New Durable Medical Equipment, Prosthetics, Orthotics & Supplies (DMEPOS) Certificates of Medical Necessity (CMNs) and DME Information Forms (DIFS) for Claims Processing (MM5571)

MLN Matters Number: MM5571
Related CR Release Date: April 13, 2007
Related CR Transmittal #: R198PI

Related Change Request (CR) #: 5571
Effective Date: October 1, 2006
Implementation Date: July 2, 2007

Provider Types Affected
Physicians (when ordering DMEPOS) and suppliers using CMNs and DIFs when billing to Medicare durable medical equipment regional carriers (DMERCs) or DME Medicare Administrative contractors (DME/MACs).

Provider Action Needed
Impact to You
The Centers for Medicaid & Medicare Services (CMS) has developed improved CMNs and DIFs that are consistent with current medical practices and conform to Medicare guidelines. Through this process, CMS revised several CMNs and replaced three CMNs with two DIFs. **This information was previously communicated in *MLN Matters* article MM4296 (http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4296.pdf).**

What You Need to Know
The transition period has been extended for claims with dates of service from October 1, 2006, through June 30, 2007. During this transition period claims for items requiring a CMN or DIF will be accepted with either the old or the new form. **For dates of service on or after July 1, 2007, the old CMN/DIF forms will no longer be accepted.**

What You Need to Do
Be sure your staff are aware that the transition period for use of the new forms has been extended through June 30, 2007.

Background
CMNs provide a mechanism for suppliers of durable medical equipment, defined in 42 United States Code (U.S.C.) §1395x(n) and medical equipment and supplies defined in 42 U.S.C. §1395j(5), to demonstrate that the item they provide meets the minimal criteria for Medicare coverage.

CMNs contain section A through D. Sections **A and C are completed by the supplier** and Sections **B and D are completed by the physician.** A DME DIF is completed and signed by the supplier. It does not require a narrative description of equipment and cost or a physician signature. Contractors review the documentation provided on the CMNs and DIF.

Recap of MM4296 Information
As previously reported in *MLN Matters* article MM4296, the changes to the CMN forms have resulted in the following:

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

Claims Accepted During Transition Period
The following table identifies the old versions of the CMNs, which are acceptable for claims for services provided during the transition period from October 1, 2006, through June 30, 2007. (For services on or after July 1, 2007, the old forms will no longer be accepted.)

New Durable Medical Equipment, Prosthetics, Orthotics & Supplies (DMEPOS) Certificates of Medical Necessity (CMNs) and DME Information Forms (DIFS) for Claims Processing (MM5571) (Continued)

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

Newly Revised CMNs Accepted During Transition Period

The following table identifies the newly revised CMNs that will be accepted for services provided during the transition period for claims from October 1, 2006, through June 30, 2007. (These forms are available at **http://www.cms.hhs.gov/CMSForms/CMSForms/list.asp#TopOfPage**.) For services on or after July 1, 2007, these forms will become effective for claims for items requiring a CMN.

Noteworthy changes include changing the title of CMS-484 from Home Oxygen Therapy to Oxygen. In addition, the title of CMS-846 was changed from Lymphedema Pumps to Pneumatic Compression Devices.

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

New DIFs Accepted During Transition Period

The following table identifies the new DIFs that will also be accepted during the transition period for claims for services provided from October 1, 2006, through June 30, 2007. (These forms are available at **http://www.cms.hhs.gov/CMSForms/CMSForms/list.asp#TopOfPage**.) For services on or after July 1, 2007, the new forms will become effective for claims for items requiring a DIF.

New Durable Medical Equipment, Prosthetics, Orthotics & Supplies (DMEPOS) Certificates of Medical Necessity (CMNs) and DME Information Forms (DIFS) for Claims Processing (MM5571) (Continued)

Noteworthy changes include changing CMS-851 for Infusion Pumps to a CMS-10125, External Infusion Pump DIF.

In addition, CMS-852 for Parenteral Nutrition and CMS-853 for Enteral Nutrition were combined into a CMS-10126 Enteral and Parenteral Nutrition DIF. In addition, CMS-852 for Parenteral Nutrition and CMS-853 for Enteral Nutrition were combined into a CMS-10126 Enteral and Parenteral Nutrition DIF.

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

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

CMNs Eliminated

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

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

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

Additional Information

For complete details regarding this Change Request (CR) please see the official instruction (CR5571) issued to your Medicare DME MAC, or DMERC. This instruction may be viewed by going to **http://www.cms.hhs.gov/Transmittals/downloads/R198PI.pdf** on the CMS website.

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

For additional information about the new CMNs and DIFs, see the *MLN Matters* article MM4296, titled "New Durable Medical Equipment Prosthetic, Orthotics & Supplies (DMEPOS) Certificates of Medical Necessity (CMNs) and DME Medicare Administrative Contractor (MAC) Information Forms (DIFS) for Claims Processing" at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4296.pdf** on the CMS website.

CMS has established a dedicated National Provider Identifier web page that houses all NPI outreach information that CMS has prepared. Please visit **http://www.cms.hhs.gov/NationalProvIdentStand** for more information.

(JSM 06536)

New "K" Codes for Oral/Mask for Use with Continuous Positive Airway Pressure (CPAP) Device (MM5525)

MLN Matters Number: MM5525
Related CR Release Date: March 23, 2007
Related CR Transmittal #: R1210CP

Related Change Request (CR) #: 5525
Effective Date: July 1, 2007
Implementation Date: July 2, 2007

Provider Types Affected
Providers and suppliers submitting claims to Medicare contractors (fiscal intermediaries (FIs), Durable Medical Equipment Regional Carrier (DMERCs), DME Medicare Administrative Contractors (DME MAC)), for services to Medicare beneficiaries for CPAP.

Provider Action Needed
Be sure billing staff are aware that, effective July 1, 2007, three new "K" codes will be established for oral/mask for use with a CPAP device.

Background
This article is based on Change Request (CR) 5525 and you need to be aware that effective July 1, 2007, the following codes will be added to the system, i.e.:

K0553	Combination oral/nasal mask, used with continuous positive airway pressure device, each
K0554	Oral cushion for combination oral/nasal mask, replacement only, each
K0555	Nasal pillows for combination oral/nasal mask, replacement only, pair

Additional Information
If you have questions, please contact your Medicare FI, DME MAC, DMERC 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.

To see the official instruction (CR5525) issued to your Medicare FI, DME MAC, DMERC or A/B MAC, go to **http://www.cms.hhs.gov/Transmittals/downloads/R1210CP.pdf** on the CMS website.

Provider Education for Handling Issues Related to Deceased Providers (MM5508)

MLN Matters Number: MM5508 - *Revised*
Related CR Release Date: March 30, 2007
Related CR Transmittal #: R1216CP

Related Change Request (CR) #: 5508
Effective Date: May 23, 2007
Implementation Date: April 30, 2007

Note: This article was revised on May 7, 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
Those submitting claims on behalf of physicians and providers who died before obtaining a National Provider Identifier (NPI), where such submitted claims that were received by a Medicare contractor (carrier, Part A/B Medicare Administrative Contractors (A/B MAC), durable medical equipment (DMERC) and/or DME Medicare Administrative Contractors, (DME/MAC)) after May 23, 2007.

Background
This article and related Change Request (CR) 5508 addresses NPI issues related to deceased providers. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that the Secretary of the Department of Health and Human Services adopt standards providing for a standard unique health identifier for each health care provider for use in the healthcare system and to specify the purpose for which the identifiers may be used.

Provider Education for Handling Issues Related to Deceased Providers (MM5508) (Continued)

All entities covered under HIPAA must comply with the requirements of the NPI final rule no later than May 23, 2007. Among these requirements are the following:

- Any health care provider who is an entity covered under HIPAA must obtain an NPI.
- Health care providers meeting the definition of health care provider referenced in the NPI final rule but not covered entities are eligible to obtain NPIs as well.
- Health care providers covered under HIPAA must use NPIs to identify themselves and their subparts (if applicable) on all standard transactions adopted under HIPAA.

Because deceased providers may not have NPIs, this article discusses what representatives of those providers need to do in order to submit claims that need to be paid.

Key Points of CR5508

If an individual provider dies before obtaining an NPI, the following apply:

- A representative of the estate of a proprietor cannot apply for an NPI for that provider posthumously.
- If a provider dies before obtaining an NPI and claims for that provider are received by a Medicare contractor after May 23, 2007, and **Medicare (the Medicare contractor, the Medicare Online Survey and Certification Reporting System (OSCAR), of the National Supplier Clearinghouse (NSC)) has not been notified of the death, the claims will reject when received by Medicare due to the absence of the provider's NPI.**
- At that point, the claim submitter would be expected to contact the Medicare contractor to which the claims were submitted to discuss payment of the claims and report the provider's death. **Toll free number of the Medicare contractors are available at http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip on the CMS website.**
- The State in which a provider furnishes care will continue to be responsible for notification of Medicare of the death of a provider following existing procedures. Since some States send such notifications on a quarterly basis, CMS is implementing the following procedures to enable affected claims to be paid more promptly:
- Because Medicare will reject an electronic claim received without an NPI after May 23, 2007, in cases where the provider died prior to obtaining an NPI, the provider's representative will need to submit the claim on paper.
- A representative of the estate should then contact the claims processing contractor, who will notify the provider that they must submit the claims on paper and that they must annotate the claim to state that the provider is deceased in Item 19.

Additional Information

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

You may view the official instruction (CR5508) issued to your Medicare carrier, DME/MAC, DMERC and/or A/B MAC by going to **http://www.cms.hhs.gov/Transmittals/downloads/R1216CP.pdf** on the CMS website.

Update on CMS Actions to Reverse Invalid Overpayments Generated by Managed Care Informational Unsolicited Responses (MCIURs) - (Invalid MCIURs from the Common Working File (CWF)) (MM5507)

MLN Matters Number: MM5507
Related CR Release Date: January 26, 2007
Related CR Transmittal #: R262OTN

Related Change Request (CR) #: 5507
Effective Date: January 26, 2007
Implementation Date: April 26, 2007

Provider Types Affected

Physicians, suppliers, and providers who submit claims to Medicare contractors (fiscal intermediaries (FIs), carriers, Part A/B Medicare Administrative Contractors (A/B MACs), durable medical equipment regional carriers (DMERCs), and/or DME Medicare Administrative Contractors (DME/MACs)).

Update on CMS Actions to Reverse Invalid Overpayments Generated by Managed Care Informational Unsolicited Responses (MCIURs) - (Invalid MCIURs from the Common Working File (CWF)) (MM5507) (Continued)

Provider Action Needed
This article provides information regarding overpayment recovery actions that may be taken by your Medicare contractor and the circumstances that have caused these recovery actions. We estimate that between 150,000 - 300,000 claims may be affected by these actions. If, due to the conditions stated below, an overpayment recovery action has occurred for your claims, your Medicare contractor is in the process of correcting the payment. **You need not take any action at this time.** Because these actions will affect Medicare contractors in varying degrees, you should stay tuned to your Medicare contractor's web site for additional details.

Background
In *MLN Matters* article SE0681 (**http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0681.pdf**), the Centers for Medicare & Medicaid Services (CMS) advised providers of certain eligibility system issues related to managed care Medicare beneficiaries. In brief, article SE0681 alerted providers that, in some instances, Medicare may be recovering certain overpayments due to system updates on beneficiary eligibility. When such overpayments are identified, Medicare systems generate a managed care informational unsolicited response (MCIUR), which triggers the overpayment recovery.

During the week of December 17, 2006, Medicare systems were updated with some incorrect Managed Care enrollment data, which, in turn, caused the systems to create some incorrect MCIURs. Medicare files have now been corrected and CMS is working diligently with Medicare contractors to stop the invalid overpayment recoveries from occurring. In addition, where action to recover the overpayments has already occurred, CMS has instructed your contractor to reverse the action and reissue payment to you.

Key Points
- CR5507 states that recovery action should stop if it has been initiated and reversed if MCIURs have already effected a recovery.
- Physicians and other providers who bill Medicare contractors need not take any action since contractors will automatically make the necessary adjustments as CR5507 is implemented.
- Your contractor will post more detailed information on their web site as CR5507 is implemented.

Additional Information
If you have questions, please contact your Medicare carrier, FI, A/B MAC, DME MAC, and/or DMERC 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 issue, please see the official instruction (CR5507) issued to your Medicare carrier, FI, A/B MAC, DME MAC, and/or DMERC. That instruction may be viewed by going to **http://www.cms.hhs.gov/Transmittals/downloads/R262OTN.pdf** on the CMS web site.

Remittance Advice Remark Code (RARC) and Claim Adjustment Reason Code (CARC) Update (MM5456)

MLN Matters Number: MM5456
Related CR Release Date: January 26, 2007
Related CR Transmittal #: R1163CP
Related Change Request (CR) #: 5456
Effective Date: April 1, 2007
Implementation Date: April 2, 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), durable medical equipment regional carriers (DMERCs) and DME Medicare Administrative Contractors (DME MACs)) for services.

Provider Action Needed
CR 5456, from which this article is taken, announces the latest update of X12N 835 Health Care Remittance Advice Remark Codes and X12N 835 and 837 Health Care Claim Adjustment Reason Codes, effective April 2, 2007. Be sure billing staff are aware of these changes.

Background
Two code sets-the reason and remark code sets-must be used to report payment adjustments in remittance advice transactions. The reason codes are also used in some coordination-of-benefits (COB) transactions. The RARC list is maintained by the Centers for Medicare & Medicaid Service (CMS), and used by all payers; and additions, deactivations, and modifications to it 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.

Remittance Advice Remark Code (RARC) and Claim Adjustment Reason Code (CARC) Update (MM5456) (Continued)

Both code lists are updated three times a year, and are posted at **http://wpc-edi.com/codes**. **The lists at the end of this article summarize the latest changes to these lists, as announced in CR 5456, effective on and after April 1, 2007.**

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**. 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.

Additional Information

You can see the official instruction issued to your FI/carrier/DMERC/RHHI regarding these latest RARC and claim adjustment reason code updates by going to CR 5456, located at **http://www.cms.hhs.gov/Transmittals/downloads/R1163CP.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 web site.

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

X12N 835 Remittance Advice Remark Code Changes

New Codes

Code	Current Narrative	Medicare Initiated
N373	It has been determined that another payer paid the services as primary when they were not the primary payer. Therefore, we are refunding to the payer that paid as primary on your behalf. **Note: (New Code 12/1/06)**	No
N374	Primary Medicare Part A insurance has been exhausted and a Part B Remittance Advice is required. **Note: (New Code 12/1/06)**	No
N375	Missing/incomplete/invalid questionnaire/information required to determine dependent eligibility. **Note: (New Code 12/1/06)**	No
N376	Subscriber/patient is assigned to active military duty, therefore primary coverage may be TRICARE. **Note: (New Code 12/1/06)**	No
N377	Payment adjusted based on a processed replacement claim. **Note: (New Code 12/1/06)**	No
N378	Missing/incomplete/invalid prescription quantity. **Note: (New Code 12/1/06)**	No
N379	Claim level information does not match line level information. **Note: (New Code 12/1/06)**	No

Remittance Advice Remark Code (RARC) and Claim Adjustment Reason Code (CARC) Update (MM5456) (Continued)

Modified Codes

Code	Current Narrative	Modification Date
M143	The provider must update license information with the payer. **Note: (Modified 12/1/06)**	12/01/06
N181	Additional information is required from another provider involved in this service. **Note: (New Code 2/28/03. Modified 12/1/06)**	12/01/06
N361	Payment adjusted based on multiple diagnostic imaging procedure rules **Note: (New Code 11/18/05. Modified 12/1/06)**	12/01/06
There are NO deactivated codes		

NOTE II: Some remark codes may provide information that may not necessarily supplement the explanation provided through a reason code and in some cases another/other remark code(s) for an adjustment. Newly created informational codes will have "Alert" in the text to identify them as informational rather than explanatory codes. 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 needs to be communicated but not as default codes.

X12 N 835 Health Care Claim Adjustment Reason Codes

New Codes

Code	Current Narrative	Notes
197	Payment denied/reduced for absence of precertification/authorization **Note: New as of 10/06**	New as of 10/06
198	Payment denied/reduced for exceeded, precertification/authorization **Note: New as of 10/06**	New as of 10/06
199	Revenue code and Procedure code do not match. **Note: New as of 10/06**	New as of 10/06
200	Expenses incurred during lapse in coverage **Note: New as of 10/06**	New as of 10/06
201	Workers Compensation case settled. Patient is responsible for amount of this claim/service through WC "Medicare set aside arrangement" or other agreement. (Use group code PR). **Note: New as of 10/06**	New as of 10/06

Remittance Advice Remark Code (RARC) and Claim Adjustment Reason Code (CARC) Update (MM5456) (Continued)

Modified Codes

Code	Current Narrative	Notes
42	Charges exceed our fee schedule or maximum allowable amount. **Note: Changed as of 10/06. This code will be deactivated on 6/1/2007.**	Modified as of 10/06 Effective 6/1/2007
45	Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability). **Note: Changed as of 10/06**	Modified as of 10/06 Effective 6/1/2007 **Note: This code replaces code 42 (above) on June 1, 2007.**
62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization. **Note: Changed as of 2/01 and 10/06. This code will be deactivated on 4/1/2007.**	Modified as of 10/06
97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated **Note: Changed as of 2/99 and 10/06.**	Modified as of 10/06
107	Claim/service adjusted because the related or qualifying claim/service was not identified on this claim. **Note: Changed as of 6/03 and 10/06.**	Modified as of 10/06
136	Claim adjusted based on failure to follow prior payer's coverage rules. (Use Group Code OA). **Note: Changed as of 6/00 and 10/06.**	Modified as of 10/06
196	Claim/service denied based on prior payer's coverage determination. **Note: New as of 6/06. Changed 10/06. This code will be deactivated on 2/1/2007, beginning on that date, value 136 will be used.**	Modified as of 10/06
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). **Note: Changed as of 10/06**	Modified as of 10/06
B15	Payment adjusted because this service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. **Note: Changed as of 2/01 and 10/06.**	Modified as of 10/06
D17	Claim/Service has invalid non-covered days. **Note: This code will be deactivated on 2/1/2007 and code 16 will then be used with appropriate claim payment remark code [M32, M33].**	Modified as of 10/06
D18	Claim/Service has missing diagnosis information. **Note: This code will be deactivated on 2/1/2007 and then code 16 will be used with appropriate claim payment remark code [MA63, MA65].**	Modified as of 10/06

Remittance Advice Remark Code (RARC) and Claim Adjustment Reason Code (CARC) Update (MM5456) (Continued)

Code	Current Narrative	Notes
D19	Claim/Service lacks Physician/Operative or other supporting documentation **Note: This code will be deactivated on 2/1/2007 and code 16 will be used with appropriate claim payment remark code [M29, M30, M35, M66].**	Modified as of 10/06
D20	Claim/Service missing service/product information. **Note: This code will be deactivated on 2/1/2007 and code 16 will be used with appropriate claim payment remark code [M20, M67, M19, MA67].**	Modified as of 10/06
D21	This (these) diagnosis(es) is (are) missing or are invalid **Note: New as of 6/05. This code will be deactivated on 2/1/2007.**	Modified as of 10/06

Requirement for Providing Route of Administration Codes for Erythropoiesis Stimulating Agents (ESAs) (MM5480)

MLN Matters Number: MM5480 - *Revised*
Related CR Release Date: March 30, 2007
Related CR Transmittal #: R1212CP

Related Change Request (CR) #: 5480
Effective Date: January 1, 2007
Implementation Date: June 29, 2007

Note: This article was revised on April 30, 2007, to replace one of the HCPCS codes on page 2 (Q4055) with J0886. All other information is the same.

Provider Types Affected
Physicians, providers, and suppliers who bill Medicare contractors (carriers, including durable medical equipment regional carriers (DMERCs) and DME Medicare administrative contractors (DME MACs), fiscal intermediaries (FIs),including regional home health intermediaries (RHHIs), and Medicare administrative contractors (MACs)) for providing ESA administration services to Medicare end stage renal disease (ESRD) beneficiaries.

What You Need to Know
CR 5480, from which this article is taken, instructs all providers and suppliers on the voluntary reporting of route of administration modifiers on claims for Erythropoiesis Stimulating Agents (ESAs) for ESRD beneficiaries. Route of administration modifiers were published and effective January 1, 2007, for reporting on Medicare claims submitted on or after February 1, 2007, for dates of service on or after January 1, 2007. Please see the *Background* section for details.

Background
Current claims processing requirements do not allow you to report the method of administering Erythropoiesis Stimulating Agents (ESA) - such as epoetin alfa (EPO) and darbepoetin alfa (Aranesp) - to treat your end stage renal disease (ESRD) patients who are anemic. However, in order to study the efficacy of both intravenous administration and subcutaneous administration methods of ESA administration, the Centers for Medicare and Medicaid Services (CMS) will begin requesting you to voluntarily report modifiers, which will indicate the method of ESA administration.

Specifically, CR 5480, from which this article is taken, announces that, effective for claims submitted on or after *February 1, 2007* (with dates of services on or after *January 1, 2007*), all providers and suppliers who bill for administering ESA to ESRD beneficiaries (Healthcare Common Procedure Coding System (HCPCS) codes Q4081, J0882, or J0886) are encouraged to include:

- Modifier JA on the claim to indicate an intravenous administration or
- Modifier JB to indicate a subcutaneous administration.

Requirement for Providing Route of Administration Codes for Erythropoiesis Stimulating Agents (ESAs) (MM5480) (Continued)

You should be aware that in the future, this reporting of the route of ESA administration will be a requirement, and additional instructions will be issued at that time. But until then, a claim for an ESA that does not report the route of administration will not be returned to the provider, and will be paid the same as a claim that does report the route of administration. Also, be aware that renal dialysis facilities whose claims include charges for ESA administration by both methods should report them in separate lines in order to identify the number of administrations provided by each method.

Additional Information
You can find more information about route of administration codes for Erythropoiesis Stimulating Agents (ESAs) by going to CR 5480, located at **http://www.cms.hhs.gov/Transmittals/downloads/R1212CP.pdf** on the CMS website. As attachments to this CR, you will find updated *Medicare Claims Processing Manual*, Chapter 8 (Outpatient ESRD Hospital, Independent Facility, and Physician/Supplier Claims), Section 60.2.3.1 (Requirement for Providing Route of Administration Codes for Erythropoiesis Stimulating Agents (ESAs)); and Chapter 17 (Drugs and Biologicals), Section 80.11(Requirements for Providing Route of Administration Codes for Erythropoiesis Stimulating Agents (ESAs)).

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.

Revisions to Form CMS-1500 Submission Requirements (MM5489)

MLN Matters Number: MM5489
Related CR Release Date: March 30, 2007
Related CR Transmittal #: R1215CP
Related Change Request (CR) #: 5489
Effective Date: April 1, 2007
Implementation Date: April 30, 2007

Provider Types Affected
Physicians, non-physician practitioners, and suppliers who bill Medicare contractors (Part A/B Medicare Administrative Contractors (A/B MACS), carriers, durable medical equipment regional contractors (DMERCS) and DME Medicare Administrative Contractors (DME MACs) for their services using the Form CMS-1500.

Background
The Form CMS-1500 answers the needs of many health insurers. It is the basic form prescribed by the Centers for Medicare & Medicaid Services (CMS) for the Medicare and Medicaid programs for claims from physicians and suppliers. The language contained in the *Medicare Claims Processing Manual*, Chapter 26, regarding the Form CMS-1500 is being updated to reflect current processing guidelines and incorporate recent data collection decisions made by CMS.

Key Points
CR5489 makes the following updates to the CMS-1500 requirements:

- The requirement to submit the provider's Social Security Number in Box 25 has been removed;
- The requirement to report the PIN of the Skilled Nursing Facility in Box 23 has been removed; and
- Clarification language was added to Box 17a, indicating the qualifier 1G precedes the Unique Physician Identification Number (UPIN).

In addition, language has been added regarding the completion of Item 25 (the provider of service or supplier federal tax identification number). Medicare providers are not required to complete this item for crossover claim purposes, since the Medicare contractor will retrieve the tax identification information from their internal provider file for inclusion on the Coordination of Benefits (COB) outbound claim. However, tax identification information is used in the determination of accurate National Provider Identification (NPI) reimbursement. Thus, reimbursement of claims submitted without tax identification information may be delayed.

Additional Information
CR5489 is the official instruction issued to your Medicare contractor. That instruction may be viewed by going to **http://www.cms.hhs.gov/Transmittals/downloads/R1215CP.pdf** on the CMS website. The revised Chapter 26, section 10.4, of the *Medicare Claims Processing Manual* is attached to CR5489.

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

Revisions to Incomplete or Invalid Claims Instructions Necessary to Implement the Revised Health Insurance Claim Form CMS-1500 (Version 8/05) (MM5391)

MLN Matters Number: MM5391 - *Revised*
Related CR Release Date: February 23, 2007
Related CR Transmittal #: R1187CP

Related Change Request (CR) #: 5391
Effective Date: May 23, 2007
Implementation Date: May 23, 2007

Note: This article was revised on May 8, 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
Physicians and suppliers submitting claims to Medicare contractors (carriers, Durable Medical Equipment Regional Carriers (DMERCs), 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 based on Change Request (CR) 5391 which revises the *Medicare Claims Processing Manual* (Publication 100-04; Chapter 1, Section 80.3.2) relating to the handling of incomplete and invalid claims to reflect the changes in reporting items for the National Provider Identifier (NPI) on the revised Form CMS-1500 version 08/05 and updates the references to remark codes in the instructions and revises the instructions to indicate what is consistent with Health Insurance Portability and Accountability Act (HIPAA) guidelines. Affected providers should assure their billing staff are aware of NPI reporting requirements. These changes apply to claims received on or after May 23, 2007.

Background
The Centers for Medicare & Medicaid Services Form 1500 (CMS-1500; Health Insurance Claim Form) has been revised to accommodate the reporting of the National Provider Identifier (NPI). The revised form is designated as Form CMS-1500 (8/05). The revisions to CMS-1500 include additional items for the reporting of the NPI. The manual revisions also include items that have already been implemented through the Competitive Acquisition of Part B Drugs and Biologicals (CAP) through the following Change Requests (CRs):

- CR4064 at **http://www.cms.hhs.gov/Transmittals/Downloads/R777CP.pdf**, and *MLN Matters* article MM4064 at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4064.pdf**;
- CR4306 at **http://www.cms.hhs.gov/transmittals/downloads/R841CP.pdf**;
- CR4309 at **http://www.cms.hhs.gov/transmittals/downloads/R866CP.pdf**; and *MLN Matters* article MM4309 at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4309.pdf**;
- CR5079 at **http://www.cms.hhs.gov/transmittals/downloads/R1055CP.pdf**; and
- CR5259 at **http://www.cms.hhs.gov/transmittals/downloads/R1034CP.pdf**.

As a result of the revisions included in the Form CMS-1500 (8/05), the incomplete and invalid claims instructions are being updated to reflect the appropriate items in which the NPI will be reported.

CR 5391 instructs Medicare contractors (carriers, DMERCs, DME MACs, and A/B MACs):

- To make all necessary changes to their internal business processes to enable the return of claims as unprocessable that do not report an NPI when required in a provider name segment or another provider identification segment in an electronic or a CMS-1500 (08/05) paper claim. See the *Medicare Claims Processing Manual* (Pub. 100-04), Chapter One (Sections 80.3.2.1.1 through 80.3.2.1.3) included as an attachment to CR5391, and the Health Care Claim Professional 837 Implementation Guide (**http://www.wpc-edi.com/**) for further information.
- To use the appropriate remittance advice remark codes provided in the *Medicare Claims Processing Manual*, Chapter One, (Pub. 100-04), Chapter One, Sections 80.3.2.1.1 through 80.3.2.1.3, when returning claims as unprocessable.
- To not search their internal files:
  - To correct a missing or inaccurate NPI on a Form CMS-1500(8/05) or on an electronic claim.
  - To correct missing or inaccurate information required for HIPAA compliance for claims governed by HIPAA.

Additional Information
For complete details, please see the official instruction issued to your Medicare contractor (carrier, DMERC, A/B MAC, or DME MAC) regarding this change. That instruction may be viewed at
http://www.cms.hhs.gov/Transmittals/downloads/R1187CP.pdf on the CMS website.

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

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:

- 2007 Jurisdiction A DME MAC Fee Schedule (Revised 4-02-07)
- April Updates to the 2007 Jurisdiction A DME MAC Fee Schedule
- April 2007 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing File
- January 2007 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing File - Revised 04-01-2007
- 2nd Quarter 2007 Update: Oral Anticancer Drug Fees
- 1st Quarter 2007 Update: Oral Anticancer Drug Fees - Revised 04-01-2007
- Revised Fee Schedule Amounts for HCPCS Codes K0813-K0864 - Revised 04-01-2007

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

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.

Accreditation Information for Suppliers of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) (SE0713)

MLN Matters Number: SE0713 - *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 April 23, 2007, to reinforce the need for suppliers to be accredited in order to be awarded a contract under this program. All other information remains the same.

Provider Types Affected
All suppliers of durable medical equipment (DME) that wish to participate in the Medicare DMEPOS program.

Provider Action Needed
This Special Edition (SE) article, SE0713, provides the information that DME suppliers need to comply with Section 302(b)(1) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). That MMA section requires the Secretary of the Department of Health and Human Services (HHS) to establish and implement quality standards for DMEPOS suppliers. All DMEPOS suppliers wishing to bill Medicare for DMEPOS provided to Medicare patients must comply with these standards to receive Medicare Part B payments. In addition, Section 1847 (b)(2)(A)(i) of the Social Security Act requires DMEPOS suppliers meet these standards before being awarded a contract under the upcoming Medicare DMEPOS Competitive Bidding Program.

Background
Section 302 of the MMA required the Secretary to establish and implement quality standards for suppliers of DMEPOS. All suppliers of DMEPOS must comply with the quality standards in order to receive Medicare Part B payments and to retain a supplier billing number. Covered items include (Section 1834 (a) (13 and (h) (4)):

- Medical supplies;
- Home dialysis supplies and equipment;
- Therapeutic shoes;
- Parenteral and enteral nutrient, equipment and supplies;
- Electromyogram devices;
- Salivation devices;
- Blood products;
- Transfusion medicine; and
- Prosthetic devices, orthotics.

The standards will be applied prospectively and are published at **http://www.cms.hhs.gov/CompetitiveAcqforDMEPOS** on the Centers for Medicare & Medicaid Services (CMS) website. Also, note that Section 1847(b)(2)(A)(i) of the Act requires DMEPOS suppliers to meet the quality standards before being awarded a contract under the Medicare DMEPOS Competitive Bidding Program.

Please note that suppliers must be accredited or be pending accreditation to submit a bid. CMS cannot accept a bid from any supplier that is not accredited or has not applied for accreditation. Additionally, suppliers 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 must be accredited before this date in order to be awarded a contract.** Suppliers should apply for accreditation immediately to allow adequate time to process their applications.

The quality standards are separated into two sections and have three appendices, as follows:

- Section I includes the business standards that apply to all suppliers and focus on standards for administration, financial management, human resource management, consumer services, performance management product safety, and information management.
- Section II contains product-specific service standards, including intake, delivery and setup, training and instruction of the beneficiary and/or their caregiver, and follow-up service.
- Appendix A deals with respiratory equipment, supplies, and services.
- Appendix B deals with manual wheelchairs and power mobility devices, including complex rehabilitation and assistive technology.
- Appendix C deals with custom fabricated, custom fitted and custom made orthotics, prosthetic devices, somatic, ocular and facial prosthetics, and therapeutic shoes and inserts.

Accreditation Information for Suppliers of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) (SE0713) (Continued)

In order to participate in Medicare Part B, DMEPOS suppliers will need to be accredited and in compliance with these standards. The accreditation will be phased in and to accommodate the suppliers who wish to participate in the Medicare Competitive Bidding Program for DMEPOS, CMS will require accreditation organizations to prioritize their surveys of suppliers to accredit suppliers in the selected Metropolitan Statistical Areas (MSAs) where the Bidding Program will begin. To provide additional information on the accreditation surveys, suppliers should note that:

- All surveys are performed on site at the supplier location.
- All surveys are unannounced.
- Accreditation cannot be transferred upon merger, acquisition or sale - CMS, the National Supplier Clearinghouse (NSC) and the Accreditation organization must be notified when these events occur.
- The Accreditation organization and the NSC will be coordinating efforts so that the supplier number can be revoked when accreditation is revoked.

Status of Accreditations

- Almost 5,000 suppliers are already accredited (329 of those are in the 20 MSAs proposed in the NPRM for the Competitive Bidding Program).
- 1,000 surveys have been scheduled since the start of 2007.
- Ten (10) Accreditation Organizations were deemed by CMS in Nov. 2006. Those organizations are listed at **http://www.cms.hhs.gov/CompetitiveAcqforDMEPOS/downloads/DMEPOS_Accreditation_Organizations.pdf** on the CMS website.

Suppliers can contact the deemed accrediting organizations directly based on the information provided at that website.

Additional Information

The CMS complete listing of all DME resources is available at **http://www.cms.hhs.gov/center/dme.asp** on the CMS website.

The CMS webpage for the Competitive Bidding Program is **http://www.cms.hhs.gov/CompetitiveAcqforDMEPOS**.

Change in the Amount in Controversy Requirement for Federal District Court Appeals (MM5518)

MLN Matters Number: MM5518
Related CR Release Date: March 30, 2007
Related CR Transmittal #: R1211CP

Related Change Request (CR) #: 5518
Effective Date: January 1, 2007
Implementation Date: July 2, 2007

Provider Types Affected

Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, Durable Medical Equipment Regional Carriers (DMERCs), 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

This article is based on Change Request (CR) 5518 which notifies Medicare contractors of an increase in the Amount in Controversy Required to sustain Federal District Court appeal rights beginning January 1, 2007.

Background

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 provides for an annual reevaluation, beginning in 2005, of the dollar amount in controversy required for an Administrative Law Judge (ALJ) hearing or Federal District Court review. **Therefore, CR5518 updates the *Medicare Claims Processing Manual* (Pub. 100-04, Chapter 29, Sections 330.1 and 345.1) to announce the Amount in Controversy Requirements for ALJ or Federal District Court Appeals during 2007.**

The amount remaining in controversy requirement for ALJ hearing requests made before January 1, 2006 was $100. The amount in controversy requirement increased to $110 for requests made on or after January 1, 2006. **CR 5518 announces that for ALJ hearing requests made on or after January 1, 2007, the amount that must remain in controversy did not change and remains at $110.**

The amount remaining in controversy requirement for Federal District Court review prior to January 1, 2006, was $1.000. That amount increased to $1,090 on or after January 1, 2006. **CR 5518 announces that for Federal District Court review requests made on or after January 1, 2007, the amount that must remain in controversy is increased to $1,130.**

Change in the Amount in Controversy Requirement for Federal District Court Appeals (MM5518) (Continued)

Additional Information
The official instruction, CR 5518, issued to your carrier, intermediary, RHHI, A/B MAC, DMERC, or DME MAC regarding this change may be viewed at **http://www.cms.hhs.gov/Transmittals/downloads/R1211CP.pdf** on the CMS website.

If you have any questions, please contact your Medicare carrier, intermediary, RHHI, A/B MAC, DMERC, 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**.

Differentiating Mass Adjustments from Other Types of Adjustments and Claims for Crossover Purposes and Revising the Detailed Error Report Special Provider Notification Letters (MM5472)

MLN Matters Number: MM5472 - *Revised*
Related CR Release Date: February 28, 2007
Related CR Transmittal #: R1189CP

Related Change Request (CR) #: 5472
Effective Date: July 1, 2007
Implementation Date: July 2, 2007

Note: This article was revised on March 1, 2007, to reflect changes made to CR5472, which CMS revised on February 28, 2007. The CR transmittal number, release date, and Web address for accessing CR5472 have been revised. All other information remains the same.

Provider Types Affected
Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, Durable Medical Equipment Regional Carriers (DMERCs), 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) 5472 which implements changes to Medicare contractor systems so that their claim transmissions to the Coordination of Benefits Contractor (COBC) for mass adjustments and other kinds of adjustments may be differentiated from all other types of claims sent for crossover.

What You Need to Know
This will be accomplished through modifications to the 837 COB flat files and National Council for Prescription Drug Programs (NCPDP) Part B drug claim files, all of which are transmitted to the COBC on a daily basis.

Through CR5472, Medicare contractors' systems will be modified so that the COBC Detailed Error Report information that is printed on the outgoing special provider notification letters/report that you receive when claims will not be crossed over due to claim data errors will be modified to also include the error/trading partner rejection code and accompanying description. These changes to the special provider letters should enable your billing service to determine why claims that were previously selected by Medicare for crossover were not actually crossed over.

Without these changes, CMS would be unable to isolate mass adjustment claims as part of the national COBA crossover process. This change corrects a problem that the Centers for Medicare & Medicaid Services (CMS) encountered as part of its implementation of the Deficit Reduction Act (DRA). Also, providers would continue to be unaware of the specific reasons as to why their patients' claims were not crossed over.

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

Background
All Medicare contractors currently send processed claims, for which Medicare systems show the beneficiary has other insurance to the COBC for crossover under the national Coordination of Benefits Agreement (COBA) program.

The Centers for Medicare & Medicaid Services (CMS) requires a method whereby its Coordination of Benefits Contractor (COBC) can differentiate among the various categories of adjustment crossover claims including:
- Mass adjustments - Medicare physician fee schedule (MPFS),
- Mass adjustments - other, and
- All other adjustments.

Differentiating Mass Adjustments from Other Types of Adjustments and Claims for Crossover Purposes and Revising the Detailed Error Report Special Provider Notification Letters (MM5472) (Continued)

Having the ability to differentiate among the various categories of adjustment crossover claims will enable CMS (and the COBC) to better address the kinds of contingencies that arise with the passage of legislation such as the Deficit Reduction Act, which mandate changes for Medicare that can affect claims already processed.

CR5472 instructs that the COBC Detailed Error Report process be modified to ensure that the contractor-generated special provider letters which are created and sent in accordance with CR 3709 contain the specific Claredi rejection code returned for the claim along with its description. (See the *MLN Matters* article at **http://www.cms.hhs.gov/mlnMattersArticles/downloads/MM3709.pdf** for information on CR3709.)

Providers may wish to contact their billing agent/vendor to obtain a better understanding of these error codes and accompanying descriptions, which, in turn, explains why their patients' claims were not crossed over successfully. In addition, providers should notify their billing agent/vendor when they receive special provider letters or reports stating why their patients' claims were not crossed over.

Additional Information
The official instruction, CR5472, issued to your carrier, FI, RHHI, A/B MAC, DMERC, or DME MAC regarding this change may be viewed at **http://www.cms.hhs.gov/Transmittals/downloads/R1189CP.pdf** on the CMS website. Attached to CR5472, you will find the new chapter of the *Medicare Claims Processing Manual* explaining in detail the new special mass adjustment process for COB. In addition, you will also find revised chapters for other portions of that manual, which discuss the COB process.

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

Infrared Therapy Devices (MM5421)

MLN Matters Number: MM5421 - *Revised*
Related CR Release Date: February 9, 2007
Related CR Transmittal #: R1183CP and R62NCD

Related Change Request (CR) #: 5421
Effective Date: October 24, 2006
Implementation Date: January 16, 2007

Note: This article was revised on February 9, 2007, to correct the range of ICD-9 codes shown in bold print on page 2. The range is 880.00-887.7. Originally, CR5421 and the related article incorrectly showed 880.00-887.79 for that range. The CR transmittal number, release date, and Web address for accessing CR5421 are also revised, but all other information remains the same.

Provider Types Affected
Physicians, suppliers, and providers who submit claims to Medicare carriers, Part A/B Medicare Administrative Contractors (A/B MACs), durable medical equipment regional carriers (DMERCs), DME Medicare administrative contractors (DME/MACs), fiscal intermediaries (FIs), and/or regional home health intermediaries (RHHIs), for the use of infrared therapy devices for treatment of diabetic and/or non-diabetic peripheral sensory neuropathy, wounds and/or ulcers of the skin and/or subcutaneous tissues in Medicare beneficiaries.

Impact on Providers
This article is based on Change Request (CR) 5421. Effective for services performed on or after October 24, 2006, the Centers for Medicare & Medicaid Services (CMS) has made a National Coverage Determination (NCD) stating the use of infrared and/or near-infrared light and/or heat, including monochromatic infrared energy (MIRE), **is non-covered for the treatment,** including symptoms such as pain arising from these conditions, of diabetic and/or non-diabetic peripheral sensory neuropathy, wounds and/or ulcers of the skin and/or subcutaneous tissues in Medicare beneficiaries.

Background
The use of infrared therapy devices has been proposed for a variety of disorders, including treatment of diabetic neuropathy, other peripheral neuropathy, skin ulcers and wounds, and similar related conditions, including symptoms such as pain arising from these conditions. A wide variety of devices are currently available. Previously there was no NCD concerning the use of infrared therapy devices, leaving the decision to cover or not cover up to local Medicare contractors.

Infrared Therapy Devices (MM5421) (Continued)

The following requirements are in effect as of October 24, 2006

- **Effective for services performed on or after October 24, 2006,** infrared therapy devices, HCPCS codes E0221 (infrared heating pad system) and A4639 (infrared heating pad replacement) **are non-covered** as DME or PT/OT services when used for the treatment of diabetic and/or non-diabetic peripheral sensory neuropathy, wounds, and/or ulcers of the skin and/or subcutaneous tissues.
- Claims will be denied with CPT 97026 (infrared therapy incident to or as a PT/OT benefit) and HCPCS E0221 or A4639, if they are accompanied by the following ICD-9 codes:
  - 250.60-250.63,
  - 354.4, 354.5, 354.9,
  - 355.1-355.4,
  - 355.6-355.9
  - 356.0, 356.2-356.4, 356.8-356.9,
  - 357.0-357.7,
  - 674.10, 674.12, 674.14, 674.20, 674.22, 674.24,
  - 707.00-707.07, 707.09-707.15, 707.19,
  - 870.0-879.9,
  - 880.00-887.7,
  - 890.0-897.7, or
  - 998.31-998.32.
- Note that denial of infrared therapy claims for the indications listed above applies to all settings, and affects Types of bills (TOBs) 12X, 13X, 22X, 23X, 34X, 74X, 75X and 85X.
- If you submit a claim for one of the non-covered services, your patient will receive the Medicare Summary Notice (MSN) message stating "This service was not covered by Medicare at the time you received it". The Spanish translation is: "Este servicio no estaba cubierto por Medicare cuando usted lo recibió."
- If you submit a claim for one of the non-covered services you will receive a remittance advice notice that reads: Claim Adjustment Reason Code 50, "These are non-covered services because this is not deemed a 'medical necessity' by the payer."
- Physicians, physical therapists, occupational therapists, outpatient rehabilitation facilities (ORFs), comprehensive outpatient rehabilitation facilities (CORFs), home health agencies (HHAs), and hospital outpatient departments should note that **you are liable** if the service is performed, unless the beneficiary signs an Advanced Beneficiary Notice (ABN).
- DME suppliers and HHA be aware that you are liable for the devices when they are supplied, unless the beneficiary signs an ABN.

Additional Information

If you have questions, please contact your Medicare A/B MAC, FI, DMERC, DME/MAC, RHHI or carrier 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 (CR5421) issued to your Medicare A/B MAC, FI, DME MAC, RHHI, or carrier. There are actually two transmittals associated with CR5421. The first is the national coverage determination transmittal, located at **http://www.cms.hhs.gov/Transmittals/downloads/R62NCD.pdf** on the CMS website. In addition, there is a transmittal related to the *Medicare Claims Processing Manual* revision, which is at **http://www.cms.hhs.gov/Transmittals/downloads/R1183CP.pdf** on the CMS site.

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

Initial Supplier Registration for Competitive Bidding Program for DMEPOS is Now Open (SE0717)

MLN Matters Number: SE0717
Related CR Release Date: N/A
Related CR Transmittal #: N/A

Related Change Request (CR) #: 5574
Effective Date: N/A
Implementation Date: N/A

Provider Types Affected
All suppliers of durable medical equipment (DME) that wish to participate in the Medicare Competitive Bidding Program for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS).

Provider Action Needed
Impact to You
Suppliers wishing to participate in the program must register and obtain a user identification (USER ID) number and password in order to submit their bids electronically to Medicare.

What You Need to Know
Without the USER ID and password, suppliers will not be able to submit electronic, on-line bids. Further, incorrect information could delay issuance of your USER ID and password.

What You Need to Do
Register for the USER ID early in order to confirm that correct information is on file with Medicare and the National Supplier Clearinghouse (NSC) so you can avoid any delays in submitting bids. The *Background* and *Additional information* sections of this article provide important information about the registration process.

Background
The Centers for Medicare & Medicaid Services (CMS) will be using an on-line system to accept bids for the Medicare DMEPOS Competitive Bidding Program. To take advantage of this opportunity, bidders must first complete an on-line registration process. The name of the on-line registration program is the Individuals Authorized Access to CMS Computer Services (IACS) system. To complete the initial registration and obtain a USER ID and password, please go to **https://applications.cms.hhs.gov**. The on-line registration will be available up to 14 days prior to the close of the bidding window.

The process will require the supplier to have its authorizing official, the person identified in Section 15 on the CMS-855S application form, register and receive a USER ID and password. The authorized official's information must match the information on file at the NSC.

If an organization has one authorizing official but many NSC numbers, the organization needs to submit only one (1) registration request to obtain access to the IACS system. During the registration process, the bidding organization will have to report one of its NSC numbers-the correspondence address associated with that NSC number will be used for mailing the IACS system USER ID and Password.

If an organization has multiple authorizing officials for the same NSC number, only one authorizing official needs to obtain access to the IACS system.

An authorizing official only needs one USER ID and password in order to submit bids for every company for which he/she was listed as such on the CMS-855S.

Potential registrants should first read the CMS document entitled, "Individuals Authorized Access to CMS Computer Services (IACS): Competitive Bid Submission System/Durable Medical Equipment (CBSS/DME) User Guide." You may view this guide on the Competitive Bidding Implementation Contractor's (CBIC) website at **http://www.dmecompetitivebid.com/cbic/cbic.nsf/(pages)/home**. If you have any questions about the initial registration process, please contact the Competitive Bidding Implementation Contractor's helpdesk at 1-877-577-5331. The helpdesk will be available Monday - Friday 6:00 a.m. - 9:00 p.m. prevailing Eastern Standard Time and on Saturday 9:00 a.m. - 3:00 p.m. prevailing Eastern Standard Time.

Suppliers are required to register through IACS and get USER IDs and passwords before access to the CBSS/DME will be granted. The bidding window is not scheduled to open until late April 2007; however, suppliers planning to bid are strongly urged to register now, so any issues with USER IDs and passwords can be resolved before the bidding window opens. The issues could include:

- Incorrect authorized official information maintained by the National Supplier Clearinghouse (NSC) as identified in Section 15 of your CMS-855S.
- Incorrect authorized official Date of Birth or Social Security number.
- NSC number does not match the Authorizing Official information.
- Incorrect correspondence address maintained by the NSC as listed on your CMS-855S in Section 2A.2.

Initial Supplier Registration for Competitive Bidding Program for DMEPOS is Now Open (SE0717) (Continued)

The USER ID and password will be mailed to the authorized official if his/her submitted information matches exactly the data on file for last name, date of birth, Social Security number and supplier number. The USER ID and password will be delivered in 2 separate mailings to the authorized official at the correspondence address (Section 2A.2) listed on the CMS 855S.

It can take up to 15 days for the NSC to correct authorized official information. Correcting a correspondence address can take up to 45 days. These timeframes for correcting NSC data may be longer depending on the number of requests received by the NSC. This underscores the need to start early.

Important Note: For added security, when suppliers use their USER IDs and passwords to access the Competitive Bid Submission System for the first time, they will need to complete a brief authentication process. The information required for this process must also match the information in the National Supplier Clearinghouse file. If you successfully completed the initial registration and received your USER ID and password, please enter your information exactly as you did for initial registration when completing the Competitive Bid Submission System authentication process. Failure to do so may delay your ability to use the system.

Additional Information
Detailed instructions on how to register for CMS Application Access can be found in the Guide at **http://www.dmecompetitivebid.com/cbic/cbic.nsf/(pages)/home**.

Remember that **this first step is the registration to gain access** to on-line bidding materials-it is not the actual bidding process.

The Competitive Bidding Implementation Contractor (CBIC) Help Desk can help you with any problems or questions you have regarding the IACS registration process. The Help Desk number is 1-877-577-5331.

You may also want to review a related *MLN Matters* article that covers accreditation requirements for suppliers wishing to participate in the Competitive Bidding Program. That article, SE0713, is available at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0713.pdf** on the CMS website.

Periodically, you may also want to visit **http://cms.hhs.gov/CompetitiveAcqforDMEPOS/01_overview.asp** to stay abreast of developments for this program.

Invalid Skilled Nursing Facility (SNF) Informational Unsolicited Responses (IURs) from Medicare's Common Working File (CWF) System (MM5587)

MLN Matters Number: MM5587
Related CR Release Date: April 27, 2007
Related CR Transmittal #: R274OTN
Related Change Request (CR) #: 5587
Effective Date: April 27, 2007
Implementation Date: July 2, 2007

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

Provider Action Needed
Impact to You
Medicare systems may have inadvertently rejected outpatient, Part B, and DME claims that overlapped periods of a SNF stay by a beneficiary, whose Medicare SNF benefits were exhausted and for whom a non-pay SNF claim was submitted to Medicare.

What You Need to Know
This problem may have affected some of your claims processed by Medicare from October 2, 2006 until January 29, 2007, when Medicare systems were fixed.

What You Need to Do
You need not take any action as your Medicare contractor will take steps to adjust any claims affected and to reverse or stop any payment recovery actions. See the *Background* section for more details.

Background
Providers need to be aware that the Centers for Medicare & Medicaid Services (CMS) has identified an issue with processing outpatient, Part B, and DME claims for beneficiaries who are in a SNF, but whose Medicare coverage for the SNF stay has ended. In October of 2006 Change Request (CR) 4292 (Benefits Exhaust and No-Payment for Medicare FIs and SNFs) was implemented. CR4292 (see *Additional Information* section for the CMS website address of CR4292) mandated that providers submit ALL SNF non-pay claims after benefits were exhausted to allow CMS to track the beneficiary's benefit period.

Invalid Skilled Nursing Facility (SNF) Informational Unsolicited Responses (IURs) from Medicare's Common Working File (CWF) System (MM5587) (Continued)

Medicare system changes relating to CR4292 caused outpatient, Part B, and DME paid claims that overlap non-pay SNF claims to be rejected. **This is an error and your Medicare contractor will adjust claims or payment recovery actions resulting from this problem.** The CWF coding change to fix this problem was effective and in production on January 29, 2007 and CWF will provide a list of claims to the applicable contractors to allow for corrections and payment to be made to providers.

Key Points
CMS has directed Medicare contractors to correct any claims that were adjusted as a result of the problem with implementation of CR4292.

- Any providers whose claims were impacted will be paid any payment recovered to include any interest charged.
- Where the payment recovery has not occurred, the Medicare contractor will stop such action.

Additional Information
For complete details regarding this CR please see the official instruction (CR5587) issued to your Medicare carrier, FI, A/B MAC, DME MAC, DMERC, or RHHI. That instruction may be viewed by going to **http://www.cms.hhs.gov/Transmittals/downloads/R274OTN.pdf** on the CMS website.

If you have questions, please contact your Medicare carrier, FI, A/B MAC, DME MAC, DMERC, 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 *MLN Matters* article for CR4292, *Benefits Exhaust and No-Payment for Medicare FIs and SNFs*, can be viewed at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4292.pdf** on the CMS website.

Part C Plan Type Display on the Medicare's Common Working File (CWF) - CR5538 rescinds and fully replaces CR 5349 (MM5538)

MLN Matters Number: MM5538
Related CR Release Date: April 13, 2007
Related CR Transmittal #: R1219CP

Related Change Request (CR) #: 5538
Effective Date: July 1, 2007
Implementation Date: July 2, 2007

Provider Types Affected
Physicians, providers, and suppliers who access Medicare beneficiary eligibility data through CWF eligibility screens (e.g. HUQA, HIQA, HIQH, ELGA, ELGB, ELGH).

Provider Action Needed
Be aware of the expanded list of MA Plan Type Descriptions that are being displayed by Medicare's CWF system. Being aware of the MA plan type is crucial, especially for those beneficiaries who are enrolled in Private Fee-For-Service (PFFS) plans. A plan directory, which is quite descriptive, is now available at **http://www.cms.hhs.gov/MCRAdvPartDEnrolData/**.

Background
The CWF displays information on the Medicare Part C (now known as Medicare Advantage) contract number in which a beneficiary is enrolled, including the plan type description associated with the contract, and currently, CWF displays the label "HMO" for these contracts. In many of these cases, the "HMO" label is incorrect because the list of possible plan type descriptions has grown much larger since the creation of the Medicare Advantage (MA) programs.

This situation has especially become problematic for Medicare beneficiaries who are enrolled in MA Private Fee-for-Service (PFFS) contracts because PFFS contracts are labeled as "HMO" in CWF. Consequently, some providers are not recognizing that they can offer services to those beneficiaries enrolled in a MA PFFS contract.

Part C Plan Type Display on the Medicare's Common Working File (CWF) - CR5538 rescinds and fully replaces CR 5349 (MM5538) (Continued)

To address this issue, the Health Plan Management System (HPMS) will modify the existing HMO address file exchange process with CWF in order to supply the list of available contract numbers and their corresponding plan type descriptions. With this new data, CWF can correctly display one of the following plan type descriptions: HMO, PPO, POS, Indemnity, or FFS Demo. The following table provides additional information to providers regarding these plan type descriptions:

Plan Type Description	Brief Guidance on Treating Patient	Additional Information
HMO	Call plan for authorization.	Managed Care plan with a provider network. Limited or no out-of-network coverage with the exception of emergency services.
PPO	You may treat the patient.	Has a network of providers. In return for higher cost sharing, members can go out of the plan network for all plan services, including supplemental benefits.
POS	You may treat the patient subject to plan rules. Contact the plan for details.	A limited out-of-network option offered by HMO plans. Contact plan for details.
Indemnity	You may treat the patient.	If this is a PFFS plan, you must follow the PFFS plan's terms and conditions of payment. If this is a Medical Savings Account (MSA) plan, the member may pay you directly.
FFS Demo	You may treat the patient.	Beneficiaries remain in original Medicare and are entitled to all fee-for-service benefits. There are no changes to Medicare FFS billing instructions or claims processing.

Additional Information
The official instruction, CR5538, issued to your carrier, intermediary, RHHI, A/B MAC, DMERC, or DME MAC regarding this change may be viewed at **http://www.cms.hhs.gov/Transmittals/downloads/R1219CP.pdf** on the CMS website.

If you have any questions, please contact your Medicare carrier, intermediary, RHHI, A/B MAC, DMERC, 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**.

Program Instructions Designating the Competitive Bidding Areas and Product Categories Included in the CY 2007 DMEPOS Competitive Bid Program (MM5574)

MLN Matters Number: MM5574
Related CR Release Date: April 3, 2007
Related CR Transmittal #: R1218CP
Related Change Request (CR) #: 5574
Effective Date: April 2, 2007
Implementation Date: April 9, 2007

Provider Types Affected

Section 1847 of the Social Security Act requires the Secretary of the Department of Health and Human Services (HHS) to establish and implement programs for certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) under which competitive bidding areas are established throughout the United States for the furnishing of certain competitively priced items and services for which payment is made under Part B (the Medicare DMEPOS Competitive Bidding Program"). **Suppliers who bill Medicare for DMEPOS must be aware of this program.**

Program Instructions Designating the Competitive Bidding Areas and Product Categories Included in the CY 2007 DMEPOS Competitive Bid Program (MM5574) (Continued)

Provider Action Needed
This article and Change Request (CR) 5577, recently released by the Centers for Medicare & Medicaid Services (CMS), provide an overview of the DMEPOS Competitive Bidding Program that will be implemented in 2008, 2009, and thereafter. **Suppliers who bill Medicare for DMEPOS must be aware of this program.**

Background
Section 1847 of the Social Security Act requires Medicare to establish and implement programs under which competitive bidding areas are established throughout the United States for contract award purposes for the furnishing of certain competitively priced items for which payment is made under Medicare Part B (the "Medicare DMEPOS Competitive Bidding Program"). Competitive bidding provides a way to harness marketplace dynamics to create incentives for suppliers to provide quality items in an efficient manner, at a reasonable cost to the Medicare beneficiaries while producing significant savings to the Medicare program.

Section 1847(a)(1)(A) of the Act requires that competitive bidding programs be established and implemented in areas throughout the United States. Section 1847(a)(1)(B) of the Act provides the Centers for Medicare & Medicaid Services (CMS) with the authority to phase-in competitive bidding programs so that the competition under the programs occurs in 10 of the largest Metropolitan Statistical Areas (MSAs) in 2008; 70 additional MSAs in 2009; and additional areas after 2009.

The CMS will conduct competitive bidding programs in which certain suppliers will be awarded contracts to provide certain DMEPOS items to Medicare beneficiaries. Suppliers must submit bids for items that fall within product categories for which they want to be considered for selection as a contract supplier.

The Medicare DMEPOS Competitive Bidding Program will apply to a variety of DMEPOS product categories. The product categories will be comprised of products identified by individual Healthcare Common Procedure Coding System (HCPCS) codes. Contract suppliers will be selected from the suppliers that have the lowest bids and that meet all relevant Medicare program requirements.

The MSAs, product categories and HCPCS codes for each product category are available at **http://www.cms.hhs.gov/CompetitiveAcqforDMEPOS/01_overview.asp** on the CMS website.

Exceptions to this program may be granted for items and services for which the application of competitive acquisition is not likely to result in significant savings or to permit continuity of an existing relationship between a beneficiary and supplier with respect to furnishing either a rental item or oxygen. The statute also allows CMS to exempt certain areas from the program, such as rural areas or areas with low population density within urban areas that are not competitive, unless there is a significant national market for mail order for a particular item or service.

Additional Information
To view the official instruction, CR5574 issued to your Medicare contractor, go to **http://www.cms.hhs.gov/Transmittals/downloads/R1218CP.pdf** on the CMS website.

Information on the final rule is available by going to **http://www.cms.hhs.gov/CompetitiveAcqforDMEPOS/02_regsnotices.asp** on the CMS site. Once there, click on the download for CMS-1270-F.

If you have questions or need assistance regarding competitive bidding, contact the Competitive Bidding Program Helpline at 1-877-577-5331 or use the "Contact Us" feature at **http://www.dmecompetitivebid.com** on the Web.

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

CMS News Flash

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

NPI: Get It. Share It. Use It.
The Centers for Medicare & Medicaid Services (CMS) announced that it is implementing a contingency plan for covered entities (other than small health plans) who will not meet the May 23, 2007, deadline for compliance with the National Provider Identifier (NPI) regulations under the Health Insurance Portability and Accountability Act (HIPAA) of 1996. Details are contained in a CMS document entitled, *"Guidance on Compliance with the HIPAA National Provider Identifier (NPI) Rule."* To view this guidance, visit **http://www.cms.hhs.gov/NationalProvIdentStand/Downloads/NPI_Contingency.pdf** on the CMS website. Applying for an NPI is fast, easy and free. Visit the National Plan/Provider Enumeration System (NPPES) website at **https://nppes.cms.hhs.gov/**.

Flu Shot Reminder
As a respected source of health care information, patients trust their doctors' recommendations. If you have Medicare patients who haven't yet received their flu shot, help protect them by recommending an annual influenza and a one time pneumococcal vaccination. Medicare provides coverage for flu and pneumococcal vaccines and their administration. And don't forget to immunize yourself and your staff. Protect yourself, your patients, and your family and friends. Get Your Flu Shot. Remember - Influenza vaccination is a covered Part B benefit. Note that influenza vaccine is NOT a Part D covered drug. For more information about Medicare's coverage of adult immunizations and educational resources, go to CMS's website:
http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0667.pdf

Flu Shot Reminder
It's Not Too Late to Give and Get the Flu Shot!
The peak of flu season typically occurs between late December and March; however, flu season can last until May. Protect yourself, your patients, and your family and friends by getting and giving the flu shot. Each office visit presents an opportunity for you to talk with your patients about the importance of getting an annual flu shot and a lifetime pneumococcal vaccination. Remember - influenza and pneumococcal vaccination and their administration are covered Part B benefits. Note that influenza and pneumococcal vaccines are NOT Part D covered drugs. For more information about Medicare's coverage of adult immunizations and educational resources, go to CMS' website:
http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0667.pdf

Flu Shot Reminder
It's Not Too Late to Get the Flu Shot. We are in the midst of flu season and a flu vaccine is still the best way to prevent infection and the complications associated with the flu. But re-vaccination is necessary each year because the flu viruses change each year. Encourage your Medicare patients who haven't already done so to get their annual flu shot and don't forget to immunize yourself and your staff. Protect yourself, your patients, and your family and friends. Get Your Flu Shot. It's Not Too Late! Remember - Influenza vaccination is a covered Part B benefit. Note that influenza vaccine is NOT a Part D covered drug. For more information about Medicare's coverage of adult immunizations and educational resources, go to CMS's website: **http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0667.pdf**

PQRI Information Available
A new CMS webpage dedicated to providing information on the Physician Quality Reporting Initiative (PQRI) is now available.

On December 20, 2006, the President signed the Tax Relief and Health Care Act of 2006 (TRHCA). Section 101 under Title I authorizes the establishment of a physician quality reporting system by CMS. CMS has titled the statutory program the Physician Quality Reporting Initiative. For more information, visit **http://www.cms.hhs.gov/pqri** on the CMS website.

Medicare Physician Fee Schedule Fact Sheet
The *Medicare Physician Fee Schedule Fact Sheet,* which provides general information about the Medicare Physician Fee Schedule, is now available in print format. To place an order for the fact sheet, visit the Medicare Learning Network at **http://www.cms.hhs.gov/mlngeninfo** on the Centers for Medicare & Medicaid Services website and select "MLN Product Ordering Page" under the "Related Links Inside CMS" Section.

Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals educational video program
An Overview of Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals educational video program, provides information on Medicare-covered preventive services, risk factors associated with various preventable diseases, and highlights the importance of prevention, detection, and early treatment of disease. The program is an excellent resource to help physicians, providers, suppliers, and other health care professionals learn more about preventive benefits covered by Medicare. Running approximately 75 minutes in length, the program is suitable for individual viewing or for use in conjunction with a conference or training session. To order your copy today, go to the Medicare Learning Network Product Ordering page at **http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5** on the CMS website. Available in DVD or VHS format.

CMS News Flash (Continued)

Medicare Advantage (MA) plan
If you have questions regarding the plan of a specific Medicare patient enrolled in a Medicare Advantage (MA) 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 Centers for Medicare & Medicaid Services (CMS) website. CMS updates this site on a monthly basis.

Medicare Guide to Rural Health Services
The *Medicare Guide to Rural Health Services: Information for Providers, Suppliers, and Physicians (Second Edition),* which provides rural information pertaining to rural health facility types, coverage and payment policies, and rural provisions under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 and the Deficit Reduction Act of 2005 is now available in downloadable format at **http://www.cms.hhs.gov/MLNProducts/downloads/MedicareRuralHealthGuide.pdf**

Inpatient Rehabilitation Facility Prospective Payment System Fact Sheet
The *Inpatient Rehabilitation Facility Prospective Payment System Fact Sheet,* which provides information about Inpatient Rehabilitation Facility Prospective Payment System rates and classification criterion, is now available in downloadable format on the CMS Medicare Learning Network Publications Page located at
http://www.cms.hhs.gov/MLNProducts/downloads/IRFPPSFactSheet0307.pdf

DMEPOS Competitive Bidding Program Final Regulation
The Centers for Medicare & Medicaid Services (CMS) has announced that the Medicare Durable Medical Equipment Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program Final Regulation is now on display at the Office of the Federal Register. CMS has also announced the first 10 metropolitan areas in which competition will occur as well as the first items to be competitively bid. Visit the CMS Website at **http://www.cms.hhs.gov/competitiveacqfordmepos/** to view the rule and obtain additional information.

DMEPOS Competitive Bidding Program Final Regulation
The Medicare Durable Medical Equipment Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program Final Regulation is now available. CMS has also announced the first 10 metropolitan areas in which competition will occur as well as the first items to be competitively bid. Visit the CMS Website at **http://www.cms.hhs.gov/competitiveacqfordmepos/** to view the rule and get more information.

Medicare Fee-For-Service (FFS) Contingency Plan Announced!
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/**.

Updating Supplier Records

If you have moved, or are planning to move, and have not yet sent in a "Change of Information" form (CMS-855S), be sure to notify the National Supplier Clearinghouse (NSC) of your new address immediately. Any changes or updates to supplier addresses, telephone numbers (including area code changes), or tax information **must** be reported in writing to the NSC **within 30 days** after such changes have taken place.

If you wait, your payments can be suspended. When an item is sent to a supplier's "Pay To" address and is returned by the U.S. Postal Service noting "Do Not Forward" (DNF), the Jurisdiction A Durable Medical Equipment Medicare Administrative Contractor (DME MAC A) places a DNF code on the supplier's file. The DNF code suspends payments for that supplier number. The supplier **must** then verify their address with the NSC in writing.

Note: A request to change your address should not be sent to DME MAC A since we cannot change supplier files.

For instructions on the completion and mailing of CMS-885S, visit the CMS Forms website at
http://www.cms.hhs.gov/CMSForms/CMSForms/list.asp to download the Form.

Failure to provide the updated information is grounds for denial or revocation of a Medicare billing number.

Claims Submitted With Only a National Provider Identifier (NPI) During the Stage 2 NPI Transition Period (MM5378)

MLN Matters Number: MM5378 - *Revised*
Related CR Release Date: November 13, 2006
Related CR Transmittal #: R249OTN
Related Change Request (CR) #:5378
Effective Date: October 1, 2006
Implementation Date: November 20, 2006

Note: This article was revised on May 4, 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
Physicians, providers, and suppliers who conduct HIPAA standard transactions, such as claims and eligibility inquiries, with Medicare.

Provider Action Needed
Impact to You
Beginning October 1, 2006 and until further notice, claims that you submit containing only an NPI will be returned you as unprocessable if a properly matching legacy number cannot be found.

What You Need to Know
From the beginning of Medicare's Stage 2 NPI transition period on October 1, 2006 and until further notice, you should submit both NPIs and legacy provider numbers on your Medicare claims to ensure that they are properly processed.. During this period, claims submitted with only a NPI that Medicare systems are unable to properly match with a legacy number (e.g., PIN, OSCAR number), may be rejected, and you will be required to resubmit the claim with the appropriate legacy number.

What You Need to Do
You should make sure that when submitting Medicare claims with dates of service on or after October 1, 2006, your billing staff submit both your NPI and legacy provider numbers until further notice from CMS.

Background
As previously announced, the Centers for Medicare & Medicaid Services (CMS) plans to begin testing new software it has been developed to use the NPI in the existing Medicare fee-for-service claims processing systems. (Remember that you will be required to submit claims and other HIPAA transactions with only an NPI beginning on May 23, 2007).

During the Stage 2 NPI transition period of October 1, 2006, through May 22, 2007, Medicare will accept claims having only NPIs (as well as those having only legacy provider numbers); however in CR 5378, from which this article is taken, CMS recommends that during this period you submit claims using:

- The provider's legacy number, such as a Provider Identification Number (PIN), NSC number, OSCAR number or UPIN; or
- Both the provider's NPI and legacy number.

Note: Until January 2, 2007, NPIs are not to be submitted on paper claims via CMS 1500 forms. Institutional providers are advised that the NPI will not be accepted on paper claims by FIs or A/B MACs until implementation of the UB-04 on May 23, 2007.

Until testing of Medicare's new software is complete, if you submit Medicare claims with only your NPI:

1) They may be processed and paid, or
2) If the Medicare systems are unable to properly match the incoming NPI with a legacy number (e.g., PIN, OSCAR number), they may be rejected, and you will be required to resubmit the claim with the appropriate legacy number.

Additional Information
The official instruction issued to your Medicare contractor on this issue, CR 5378, is available at **http://www.cms.hhs.gov/Transmittals/downloads/R249OTN.pdf** on the CMS website.

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

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

CMS Announces the National Provider Identifier (NPI) Enumerator Contractor and Information on Obtaining NPIs (SE0528)

MLN Matters Number: SE0528 - *Revised*
Related Change Request (CR) #: N/A
Related CR Release Date: N/A

Note: This article was revised on May 7, 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
All health care providers - Medicare and non-Medicare

Provider Action Needed
Learn about the NPI and how and when to apply for one.

Background
The Centers for Medicare & Medicaid Services (CMS) is pleased to announce the availability of a new health care identifier for use in the HIPAA standard transactions.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandated that the Secretary of Health and Human Services adopt a standard unique health identifier for health care providers. On January 23, 2004, the Secretary published a Final Rule that adopted the National Provider Identifier (NPI) as this identifier.

The NPI must be used by covered entities under HIPAA (generally, health plans, health care clearinghouses, and health care providers that conduct standard transactions). The NPI will identify health care providers in the electronic transactions for which the Secretary has adopted standards (the standard transactions) after the compliance dates. These transactions include claims, eligibility inquiries and responses, claim status inquiries and responses, referrals, and remittance advices.

The NPI will replace health care provider identifiers that are in use today in standard transactions. Implementation of the NPI will eliminate the need for health care providers to use different identification numbers to identify themselves when conducting HIPAA standard transactions with multiple health plans.

All health plans (including Medicare, Medicaid, and private health plans) and all health care clearinghouses must accept and use NPIs in standard transactions by May 23, 2007 (small health plans have until May 23, 2008). After those compliance dates, health care providers will use only their NPIs to identify themselves in standard transactions, where the NPI is required.

Important Note: While you are urged to apply for an NPI beginning May 23, 2005, the Medicare program is not accepting the NPI in standard transactions yet. Explicit instructions on time frames and implementation of the NPI for Medicare billing will be issued later in 2006.

NPI Enumerator Contract Awarded
Recently, the CMS announced the selection of Fox Systems, Inc. as the contractor, to be called the Enumerator, to perform the support operations for the NPI project.

Fox Systems, Inc. will process NPI applications from health care providers and operate a help desk to assist health care providers in obtaining their NPIs.

Who may apply for the NPI?
All health care providers including individuals, such as physicians, dentists, and pharmacists, and organizations, such as hospitals, nursing homes, pharmacies, and group practices are eligible to apply for and receive an NPI.

Note: All health care providers who transmit health information electronically in connection with any of the HIPAA standard transactions are required by the NPI Final Rule to obtain NPIs. This is true even if they use business associates such as billing agencies to prepare the transactions.

The NPI Application Process
Health care providers may begin applying for an NPI on May 23, 2005. Once the process begins, **it will be important to apply for your NPI** before the compliance date of May 2007 because health plans could require you to use your NPI before that date.

CMS Announces the National Provider Identifier (NPI) Enumerator Contractor and Information on Obtaining NPIs (SE0528) (Continued)

You will be able to apply for your NPI in one of three ways:

1. You may apply through an easy-to-use Web-based application process, beginning May 23, 2005. The web address will be **https://nppes.cms.hhs.gov/NPPES/Welcome.do**, but please note — the web site is not available until May 23, 2005.
2. Beginning July 1, 2005, you may complete a paper application and send it to the Enumerator. A copy of the application, including the Enumerator's mailing address (where you will send it) will be available on **https://nppes.cms.hhs.gov/NPPES/Welcome.do** or you can call the Enumerator to receive a copy. The phone number is 1-800-465-3203 or TTY 1-800-692-2326. But remember, paper applications may not be submitted until July 1, 2005.
3. With your permission, an organization may submit your application in an electronic file. This could mean that a professional association, or perhaps a health care provider who is your employer, could submit an electronic file containing your information and the information of other health care providers. This process will be available in the fall of 2005.

You may apply for an NPI using only one of these methods. When gathering information for your application, be sure that all of your information, such as your social security number and the Federal Employer Identification Number, are correct. Once you receive your NPI, safeguard its use.

If all information is complete and accurate, the Web-based process could result in you being issued a number within minutes. If there are problems with the information received, it could take longer. The paper application processing time is more difficult to estimate, depending on the information supplied in the application, the workload, and other factors.

The transition from existing health care provider identifiers to NPIs will occur over the next couple of years. Each health plan with which you conduct business, including Medicare, will notify you when it will be ready to accept NPIs in standard transactions like claims. You can expect to hear about the importance of applying for an NPI from a variety of sources. Be clear that you only have to apply for, and acquire, one NPI. Your unique NPI will be used for all standard transactions, Medicare and non-Medicare.

Please be particularly aware that applying for an NPI does not replace any enrollment or credentialing processes with any health plans, including Medicare.

Additional Information

For additional information on NPIs:

- Visit **http://www.cms.hhs.gov/NationalProvIdentStand/06_implementation.asp** on the CMS web site.
- Beginning May 23, 2005, visit **https://nppes.cms.hhs.gov/NPPES/Welcome.do** or call the Enumerator at 1-800-465-3203 or TTY 1-800-692-2326.
- For HIPAA information, you may call the HIPAA Hotline: 1-866-282-0659, or write to **AskHIPAA@cms.hhs.gov** on the web.

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

MLN Matters Number: SE0659 - *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 May 7, 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

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

Provider Action Needed

Impact to You

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

What You Need to Know

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

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

What You Need to Do

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

Background

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

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

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

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

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

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

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

Incorrect information in the 2010A/A Billing Provider Loop in X12 837-P Claims

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

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

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

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

Reporting of the Pay-to Address in the Billing Provider (2010A/A) Loop

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

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

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

Reporting of the Name and Address of a Billing Provider in the 2010A/A Loop of an X12 837-I(Institutional) Electronic Claim

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

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

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

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

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

Additional Information

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

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

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

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

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

Medicare Fee-For-Service (FFS) National Provider Identifier (NPI) Implementation Contingency Plan (MM5595)

MLN Matters Number: MM5595 - *Revised*
Related CR Release Date: April 24, 2007
Related CR Transmittal #:R1227CP

Related Change Request (CR) #: 5595
Effective Date: May 23, 2007
Implementation Date: May 23, 2007

Note: This article was revised on April 24, 2007, to reflect changes made to CR5595, which CMS re-issued on April 24. The article was changed to reflect in **bold print** on page 2 that "As long as covered entities, including health plans and covered health providers, continue to act in good faith to come into compliance, meaning they are working towards being able to accept and send NPIs, they may establish contingency plans to facilitate the compliance of their trading partners". The article also has a revised transmittal number, release date, and Web address for accessing CR5595. All other information remains the same.

Provider Types Affected
Physicians, providers, and suppliers who conduct HIPAA standard transactions, such as claims and eligibility inquiries, with Medicare contractors (carriers, Fiscal Intermediaries, (FIs), including Regional Home Health Intermediaries (RHHIs), Medicare Administrative Contractors (MACs), Durable Medical Equipment Regional Carriers (DMERCs), and DME Medicare Administrative Contractors (DME MACs))

Provider Action Needed
Impact to You
As early as July 1, 2007, Medicare fee for service (FFS) contractors may begin rejecting claims that do not contain an NPI for the primary providers.

What You Need to Know
CR 5595, from which this article is taken, announces that (effective May 23, 2007) Medicare fee for service (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.

What You Need to Do
If you have not yet done so, you should obtain your NPI now. You can apply on line at **https://nppes.cms.hhs.gov/** on the CMS website. You should also make sure that your billing staffs begin to include your NPI on your claims as soon as possible.

Background
The 1996 Health Insurance Portability and Accountability Act (HIPAA) required that each physician, supplier, and other health care provider conducting HIPAA standard electronic transactions, be issued a unique national provider identifier (NPI). CMS began to issue NPIs on May 23, 2005; and to date, has been allowing transactions adopted under HIPAA to be submitted with a variety of identifiers, including:

- NPI only,
- Medicare legacy only, or
- An 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 NPI implementation. **As long as covered entities, including health plans and covered health providers, continue to act in good faith to come into compliance, meaning they are working towards being able to accept and send NPIs, they may establish contingency plans to facilitate the compliance of their trading partners.** (You can find this guidance on the CMS website at: **http://www.cms.hhs.gov/NationalProvIdentStand/Downloads/NPI_Contingency.pdf**.)

In CR 5595, from which this article is taken, Medicare fee for service (FFS) announces that it is establishing a contingency plan that follows this DHHS guidance. 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.

After May 23, 2008, legacy numbers will NOT be permitted on ANY inbound or outbound transactions.

As part of this plan, Medicare FFS has been assessing health care provider submission of NPIs on claims. As soon as the number of claims submitted with an NPI for primary providers (Billing, pay-to and rendering providers) is determined sufficient (and following appropriate notice to providers), Medicare will begin rejecting claims that do not contain an NPI for primary providers following appropriate notification. (See *Important Information* below.)

In May 2007, Medicare FFS will evaluate the number of submitted claims containing a NPI. If this analysis demonstrates a sufficient number of submitted claims contain a NPI, Medicare will begin to reject claims without NPIs on July 1, 2007. If, however, there are not sufficient claims containing NPIs in the May analysis, Medicare FFS will assess compliance in June 2007 and determine whether to begin rejecting claims in August 2007.

Medicare Fee-For-Service (FFS) National Provider Identifier (NPI) Implementation Contingency Plan (MM5595) (Continued)

CMS also recognizes that the National Council of Prescription Drug Programs (NCPDP) format only allows for reporting of one identifier. Thus, NCPDP claims can contain either the NPI or the legacy number, but not both, until May 23, 2008.

In addition, in regards to the 835 remittance advice transactions and 837 Coordination of Benefits (COB) transactions, Medicare FFS will do the following until May 23, 2008:

- If a claim is submitted with an NPI, the NPI will be sent on the associated 835 remittance advice; otherwise, the legacy number will be sent on the associated 835.
- If a claim is submitted with an NPI, the associated 837 COB transaction will be sent with both the NPI and the legacy number; otherwise, only the legacy number will be sent.

By May 23, 2008, the X12 270/271 eligibility inquiry/response supported by CMS via the Extranet and Internet must contain the NPI.

Important Information

CR 5595 also provides specific important information that you should be aware of:

- Once a decision is made to require NPIs on claims, Medicare FFS will notify (in advance) providers and Medicare contractors about the date that claims without NPIs for primary providers will begin to be rejected. **That date will supersede all dates announced in previous CRs and *MLN Matters* articles.**
- In editing NPIs, Medicare considers billing, pay-to and rendering providers to be primary providers who must be identified by NPIs, or the claims will be rejected once the decision is made to reject.
- All other providers (including referring, ordering, supervising, facility, care plan oversight, purchase service, attending, operating and "other" providers) are considered to be secondary providers. Legacy numbers are acceptable for secondary providers until May 23, 2008. If a secondary provider's NPI is present, it will only be edited to assure it is a valid NPI.

Additional Information

You can read CR 5595 by visiting **http://www.cms.hhs.gov/Transmittals/downloads/R1227CP.pdf** on the CMS website. You can also learn more about the NPI at **http://cms.hhs.gov/NationalProvIdentStand/** 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.

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

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

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

Note: This article was revised on May 7, 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, physicians, and suppliers who bill Medicare fiscal intermediaries (FIs), including regional home health intermediaries (RHHIs), and Medicare carriers including durable medical equipment regional carriers (DMERCs) (or durable medical equipment Medicare administrative contractors (DME MACs) if appropriate)

Provider Action Needed

Impact to You

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

What You Need to Know

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

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

What You Need to Do

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

Background

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

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

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

Primary and Secondary Providers

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

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

Secondary Provider Claims

Claims Submitted with NPI and Medicare Legacy Identifier:

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

There are two exceptions:

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

Claims Submitted with NPI Only:

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

If the NPI is located in the Crosswalk:

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

If the NPI is not located in the Crosswalk:

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

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

Claims (including UB-92 or the current CMS-1500 paper claims) submitted with Medicare Legacy Identifier Only

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

COB and Medigap Trading Partners

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

837-I or 837-P version 4010A1 Claims

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

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

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

Implementation Date

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

Additional Information

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

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

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

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

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

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 2 National Provider Identifier (NPI) Changes for Transaction 835, and Standard Paper Remittance Advice, and Changes in Medicare Claims Processing Manual, Chapter 22 - Remittance Advice (MM5081)

MLN Matters Number: MM5081 - *Revised*
Related CR Release Date: June 30, 2006
Related CR Transmittal #: R996CP

Related Change Request (CR) #: 5081
Effective Date: October 1, 2006
Implementation Date: October 2, 2006

Note: This article was revised on May 7, 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
All Medicare physicians, providers, suppliers, and billing staff who submit claims for services to Medicare contractors (fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), carriers, and durable medical equipment regional carriers (DMERCs) and durable medical equipment administrative contractors (DME MACs))

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

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

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

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

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

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

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

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

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

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

Stage 2 National Provider Identifier (NPI) Changes for Transaction 835, and Standard Paper Remittance Advice, and Changes in Medicare Claims Processing Manual, Chapter 22 - Remittance Advice (MM5081) (Continued)

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

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

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

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

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

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

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

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

Implementation

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

Additional Information

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

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

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

Stage 2 Requirements for Use and Editing of National Provider Identifier (NPI) Numbers Received in Electronic Data Interchange Transactions, via Direct Data Entry Screens or Paper Claim Forms (MM4023)

MLN Matters Number: MM4023 - *Revised*
Related CR Release Date: November 3, 2005
Related CR Transmittal #: 190

Related Change Request (CR) #: 4023
Effective Date: April 1, 2006
Implementation Date: April 3, 2006

Note: This article was revised on August 25, 2006, by adding this statement directing readers to view article MM5060 at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5060.pdf** for more current information on the effective dates for using Form CMS-1500 (08/05). The dates in the MM5060 article supersede the dates in this article and MM5060 conforms with CR5060, which is available at **http://www.cms.hhs.gov/transmittals/downloads/R1010CP.pdf**. **Also, this article was revised on May 7, 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
Physicians, providers, and suppliers who submit claims for services to Medicare carriers, including durable medical equipment regional carriers (DMERCs) and fiscal intermediaries (FIs), to include regional home health intermediaries (RHHIs)

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

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

Background
The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires issuance of a unique national provider identifier (NPI) to each physician, supplier, and other provider of health care (45 CFR Part 162, Subpart D (162.402-162.414).

To comply with this requirement, the Centers for Medicare & Medicaid Services (CMS) began to accept applications for, and to issue NPIs, on May 23, 2005. Applications can be made by mail and also online at **https://nppes.cms.hhs.gov/NPPES/Welcome.do**.

NPI and Legacy Identifiers
The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty.

Beginning May 23, 2007 (May 23, 2008, for small health plans), the NPI must be used in lieu of legacy provider identifiers.
Legacy provider identifiers include:
- Online Survey Certification and Reporting (OSCAR) system numbers;
- National Supplier Clearinghouse (NSC) numbers;
- Provider Identification Numbers (PINs); and
- Unique Physician Identification Numbers (UPINs) used by Medicare.

They do not include taxpayer identifier numbers (TINs) such as:
- Employer Identification Numbers (EINs); or
- Social Security Numbers (SSNs).

Primary and Secondary Providers
Providers are categorized as either "primary" or "secondary" providers:
- **Primary providers** include billing, pay-to, rendering, or performing providers. In the DMERCs, primary providers include ordering providers.
- **Secondary providers** include supervising physicians, operating physicians, referring providers, and so on.

Crosswalk
During Stage 2, Medicare will utilize a Crosswalk between NPIs and legacy identifiers to validate NPIs received in transactions, assist with population of NPIs in Medicare data center provider files, and report NPIs on remittance advice (RA) and coordination of benefit (COB) transactions. Key elements of this Crosswalk include the following:
- Each primary provider's NPI reported on an inbound claim or claim status query will be cross-walked to the Medicare legacy identifier that applies to the owner of that NPI.
- The Crosswalk will be able to do a two-directional search, from a Medicare legacy identifier to NPI, and from NPI to a legacy identifier.
- The Medicare Crosswalk will be updated daily to reflect new provider registrations.

Stage 2 Requirements for Use and Editing of National Provider Identifier (NPI) Numbers Received in Electronic Data Interchange Transactions, via Direct Data Entry Screens or Paper Claim Forms (MM4023) (Continued)

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: ***(This is stage 2, the subject of CR4023)***	CMS systems will accept an existing legacy Medicare billing number and/or an NPI on claims. If there is any issue with the provider's NPI and no Medicare legacy identifier is submitted, the provider may not be paid for the claim. *Therefore, Medicare strongly recommends that providers, clearinghouses, and billing services continue to submit the Medicare legacy identifier as a secondary identifier.* Medicare will be capable of sending the NPI as primary provider identifier **and** legacy identifier as a secondary identifier in outbound claim, claim status response, remittance advice (electronic but not paper), and eligibility response electronic transactions.
May 23, 2007 - Forward:	CMS systems will only accept NPI numbers. Coordination of benefit transactions sent to small health plans will continue to carry legacy identifiers, if requested by such a plan, through May 22, 2007.

Claim Rejection

Claims will be rejected if:

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

Stage 2 Requirements for Use and Editing of National Provider Identifier (NPI) Numbers Received in Electronic Data Interchange Transactions, via Direct Data Entry Screens or Paper Claim Forms (MM4023) (Continued)

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

Additional Information

X12 837 Incoming Claims and COB

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

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

National Council of Prescription Drug Plans (NCPDP) Claims

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

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

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

Paper Claim Forms

The transition period for the revised CMS-1500 is currently scheduled to begin October 1, 2006 and end February 1, 2007. The transition period for the UB-04 is currently scheduled for March 1, 2007 - May 22, 2007.

Pending the start of submission of the revised CMS-1500 and the UB-04, **providers must continue to report legacy identifiers, and not NPIs, when submitting claims on the non-revised CMS-1500 and the UB-92 paper claim forms.**

Provider identifiers reported on those claim forms are presumed to be legacy identifiers and will be edited accordingly. "Old" form paper claims, received through the end of the transition period that applies to each form, may be rejected if submitted with an NPI.

Or, if they are not rejected-since some legacy identifiers were also 10-digits in length-could be incorrectly processed, preventing payment to the provider that submitted that paper claim.

Standard Paper Remits (SPRs)

The SPR FI and carrier/DMERC formats are being revised to allow reporting of both a provider's NPI and legacy identifier when both are available in Medicare's files. If a provider's NPI is available in the data center provider file, it will be reported on the SPR, even if the NPI was not reported for the billing/pay-to, or rendering provider on each of the claims included in that SPR. The revised FI and carrier/DMERC SPR formats are attached to CR4023:

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

Remit Print Software

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

Free Billing Software

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

In-Depth Information

Please refer to CR4023 for additional detailed NPI-related claim information about the following topics:

- Crosswalk
- X12 837 Incoming Claims and COB
- Non-HIPAA COB Claims
- NCPDP Claims
- DDE Screens
- Paper Claim Forms
- Free Billing Software
- X12 276/277 Claim Status Inquiry and Response Transactions

Stage 2 Requirements for Use and Editing of National Provider Identifier (NPI) Numbers Received in Electronic Data Interchange Transactions, via Direct Data Entry Screens or Paper Claim Forms (MM4023) (Continued)

- 270/271 Eligibility Inquiry and Response Transactions
- 835 Payment and Remittance Advice Transactions
- Electronic Funds Transfer (EFT)
- Standard Paper Remits (SPRs)
- Remit Print Software
- Claims History
- Proprietary Error Reports
- Carrier, DMERC, and FI Local Provider Files, including EDI System Access Security Files
- Med A and Med B Translators
- Other Translators
- Stages 3 and 4

CR4023, the official instruction issued to your FI/ regional home health intermediary (RHHI) or carrier/durable medical equipment regional carrier (DMERC) regarding this change, may be found by going to **http://www.cms.hhs.gov/transmittals/downloads/R190OTN.pdf** on the CMS web site.

You may also wish to review *MLN Matters* article SE0555, "Medicare's Implementation of the National Provider Identifier (NPI): The Second in the Series of Special Edition *MLN Matters* Articles on NPI-Related Activities," which is available at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/se0555.pdf** on the CMS website. This article contains further details on the NPI and how to obtain one.

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

CMS has established a dedicated National Provider Identifier web page that houses all NPI outreach information that CMS has prepared. Please visit **http://www.cms.hhs.gov/NationalProvIdentStand** for more information.

(JSM 06536)

Discontinuance of BP, BR, and BU Modifiers for Capped Rentals

The BP, BR, or BU modifiers are no longer necessary for capped rental periods that begin with an initial date of service that is on or after January 1, 2006. **Discontinue using the BP, BR, or BU modifier by March 23, 2007 to avoid claim denials. NHIC will manually remove the BP, BR or BU modifiers from affected capped rental items through March 22, 2007 to allow suppliers time to make necessary system changes.**

This change is due to the implementation of Section 5101 of the Deficit Reduction Act (DRA) of 2005. Under the DRA of 2005, DME MACs are required to limit capped rental payments to 13 rental months. Therefore, a rent/purchase option is no longer available for capped rental items. Please refer to Change Request 5010 (**http://www.cms.hhs.gov/transmittals/downloads/R918CP.pdf**) for further details on this change.

Note: Suppliers must continue to use these modifiers for capped rental periods with initial dates of service prior to January 1, 2006. Motorized wheelchairs and Parenteral and Enteral Nutrition (PEN) pumps are not affected by this change and should be billed as previously instructed.

First 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 January 2007 through March 2007, are provided in the following chart.

Top Ten Claims Submission Errors	Number Received	Reason For Error
40022 - Procedure Code / Modifier Invalid	47,787	The procedure code and/or modifier used on this line is invalid.
40068 - Invalid / Unnecessary CMN Question	26,692	The question number entered is not valid for the DME MAC CMN you are sending.
20011 - Billing Provider Secondary ID Invalid	12,409	Secondary provider ID is invalid.
40073 - Dates of Service Invalid with Procedure Code	11,865	The procedure code used is not valid for the dates of service used.
20269 - Pointer 1 Diagnosis Invalid	10,596	Diagnosis pointer is invalid.
40021 - Capped Rental K Modifier Missing	9,893	Required capped rental K modifier is missing from the claim.
20025 - Subscriber ID Code Invalid	7,715	The qualifier identifying the subscriber is invalid.
20143 - Ordering Provider Secondary ID Invalid	7,485	The provider number or Unique Physician Identification Number (UPIN) is invalid.
40037 - Service Date Greater Than Receipt Date	6,367	Service date is after the date the claim was received.
40014 - Ordering Provider Information Missing	6,114	The ordering provider information is missing. This should be included with every service line.

First 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 first 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 January through March 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.	31,836
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.	8,352
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."	4,500
CO 16 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.	3,730
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.	2,725
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.	1,452
CO 16 M77 Missing / incomplete / invalid place of service.	**Item 24B** - Enter the appropriate place of service code(s). Identify the location, using a place of service code, for each item used or service performed.	365

First Quarter 2007 - Top Claim Submission Errors (Continued)

Claims Submission Errors (Return/Reject Denials)	CMS 1500 Form(or electronic equivalent) Entry Requirement	Number Received
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.	339
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.	241
CO 16 M119 Missing / incomplete / invalid / deactivated / withdrawn National Drug Code (NDC).	**Item 24D** - Only Oral Anti-Cancer Drugs can be submitted with a National Drug Code for paper and ANSI claims. All other items must be billed with a HCPCS code in this field.	154

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.

Reopening vs. Redetermination

Suppliers should be aware of the difference between the Reopening process and the Redetermination process. A **reopening** is the process that allows suppliers to correct clerical errors or omissions without having to request a formal appeal. Clerical errors or minor errors are limited to errors in form and content. Omissions do not include failure to bill for certain items or services. A claim should be reopened within one year of the date on the Remittance Advice (RA). You must wait to make contact with the Reopening Department until after you have received a Remittance Advice (RA). No action can be taken until a final claim determination is rendered.

Examples of minor errors or omissions include:

- Mathematical or computational mistakes
- Transposed procedure or diagnostic codes
- Inaccurate data entry, such as units of service, place of service, modifiers
- Misapplication of a fee schedule
- Computer errors
- Denial of claims as duplicates which the supplier believes were incorrectly identified as a duplicate
- Incorrect data items, such as provider number, use of modifier, or date of service
- A valid change to a Certificate of Medical Necessity (CMN) that will not be accepted electronically on the front end.

Note: Reopenings of this type cannot be accepted via the telephone reopening process, therefore you must submit this type of reopening request (along with the CMN) using the fax or mail process. For further details on this particular issue please refer to the educational article titled *New Process for Certain Certificate of Medical Necessity (CMN) Rejections* (**http://www.medicarenhic.com/dme/dmeduc.shtml#newprocesscmn**)

Reopening vs. Redetermination (Continued)

A reopening may be requested in the following manner:

Verbally by Telephone	866-419-9458
In Writing via Fax	781-741-3914
In Writing by Mail	NHIC, Corp DME MAC Attn: Reopenings P.O. Box 9170 Hingham, MA 02043-9170

When requesting a reopening in writing via fax, please utilize the **Fax Reopening Cover Sheet**, which is available at **http://www.medicarenhic.com/dme/dme_forms.shtml**. If requesting a reopening in writing by mail, be sure to include all of the same information that is included on the Fax Reopening Cover Sheet.

When requesting a reopening by telephone, please be sure to have the following information available during the call:

- Your supplier number
- The Medicare Claim Control Number (CCN)
- Reason for denial
- Beneficiary name and Medicare health insurance claim number (HICN)
- Any additional information to support why you believe the decision is incorrect, including the details of what you believe is correct.

Some issues are more complicated and may not be resolved through the reopening process. Such issues may require more extensive research or medical staff consultation. The DME MAC reserves the right to decline a request for a reopening and advise one to submit a written redetermination request.

A **redetermination** is the first level of the appeals process that allows suppliers to request a formal review of a claim decision due to dissatisfaction of that decision. It is a second look at the claim and supporting documentation and is made by a different employee. The appellant must begin the appeal at the first level after receiving an initial determination. A party must file a request for redetermination within 120 days of the date of receipt of the Remittance Advice (RA).

Note: If an initial determination on a claim has not been made, there are not appeal rights on that claim.

A redetermination may be requested in the following manner:

In Writing via Fax	781-741-3118
In Writing by Mail	DME - Redeterminations P.O. Box 9150 Hingham, MA 02043-9150

When requesting a redetermination in writing, please utilize the **Medicare Redetermination Request Form - CMS 20027,** which is available at **http://www.medicarenhic.com/dme/dme_forms.shtml**. If this form is not used, the request for redetermination must contain the following elements:

- Beneficiary's name
- Medicare Health Insurance Claim Number (HICN)
- Name and address of the supplier of the item/service
- Date of initial determination
- The specific date(s) of service for which the initial determination was issued
- The specific service(s) and/or item(s) for which the redetermination is being requested
- The name and signature of the party or the representative of the party

Some redetermination requests may contain attachments. For example, if the RA is attached to the redetermination request that does not contain the dates of service on the cover and the dates of service are highlighted or emphasized in some manner on the attached RA, this is an acceptable redetermination request.

Reopening vs. Redetermination (Continued)

Note: Each submission of a completed Medicare Redetermination Request Form - CMS 20027 constitutes a **separate redetermination request,** therefore, please include all necessary documentation with each case. This includes a separate CMN (if applicable) for each form submitted.

Once the information is received, the Redetermination Department must render a decision on the request within 60 days of receipt with the exception of situations in which additional documentation is requested. Under this circumstance, the DME MAC has an additional 14 days to render a decision.

If a previous redetermination decision has been issued, a reconsideration must filed. In situations where a supplier or beneficiary requests a redetermination and the issue involves a minor error or omission, the DME MAC will treat the request as a reopening.

Submitting Refunds to NHIC, Corp. DME MAC for Jurisdiction A

In response to supplier questions, DME MAC A would like to remind you of the steps to follow when submitting refunds:

- For refunds as the result of a demand letter, the refund check must be submitted *with a copy of the demand letter* and mailed to:
  DM E - Accounting (Refund Checks)
  P.O. Box 9143
  Hingham, MA 02043-9143
- You may also fax requests for immediate offset to **781-741-3916**. Please include a copy of the demand letter and the Offset Request Form, which can be found at **http://www.medicarenhic.com/dme/dme_forms.shtml#Forms** on the DME MAC A Web site, requesting the immediate offset.

Note: In order to ensure that information is kept secured the hours of operation for the fax line are 8a.m. to 4p.m. Monday through Friday.

DME MAC A has recently implemented a process change to greatly reduce the instance of payment offset occurring when a refund check has recently been sent. However, because payment offset is initiated at 30 days from the date of the demand letter, please submit your refund (by mail or fax) in consideration of this 30 day timeframe.

It is very important that the demand letter copy be submitted with the refund check. If a refund check for an established account receivable is received without the demand letter copy, the check is initially classified as a voluntary refund. Since voluntary refunds are processed with a 60 day metric, an established debt could offset if the check is initially classified as a voluntary refund due to insufficient supporting documentation.

Voluntary Refunds: When submitting voluntary refunds for an overpayment situation complete the Overpayment Refund Form, which can be found at **http://www.medicarenhic.com/dme/dme_forms.shtml#Forms** on the DME MAC A Web site. Voluntary refunds can be mailed or faxed using the above contact information.

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

Supplier Call Center - Explanation of Level 1, Level 2 and Level 3 Customer Service Representatives (CSRs)

In response to customer questions about the call center structure, the following article provides background information and details about the tiered structure.

Effective July1, 2006 the DME MAC Jurisdiction A call center implemented CR 3376 **(Implementation of §921 of the Medicare Modernization Act (MMA) - Provider Customer Service Program**). You can access CR3376 and the related MLM Matters Article from the link below: **http://www.cms.hhs.gov/MLNMattersArticles/2004MMA/itemdetail.asp?itemID=CMS043763**

CR3376 was developed to strengthen and enhance Medicare's ongoing efforts associated with provider inquiries and education, and instructs that Contractors shall divide their telephone inquiry staff dedicated to responding to general provider inquiries into at least two levels of CSRs.

Level 1 CSR

- First level CSRs shall answer a wide range of basic questions that cannot be answered by the IVR or other interactive self-service technology.
- At a minimum, first level CSRs shall handle questions that do not require substantial research and easily can be answered during the initial call. Contractors must determine what types of inquiries are best answered by first level CSRs.
- Some examples of this level of inquiry may include:
  1. Eligibility, claims status or Medicare secondary payer (MSP) status inquiries not adequately handled by the IVR;
  2. Straight-forward claim denial questions that cannot be handled by the IVR;
  3. Questions with well-documented, nationally consistent and easily accessible answers.
- First level CSRs shall have the authority to refer more complex questions to second level CSRs.

This means that if a supplier has a question that cannot be answered through the IVR, the call will be answered by a CSR. It is important to note that the CSR taking your call could be either a Level 1 or Level 2 CSR.

As detailed above, it is the CSRs responsibility to refer more complex questions to the Level 2 CSR as needed.

Level 2 CSR

- Second level CSRs have more experience and expertise enabling them to answer more complex questions. These questions may include:
  1. Telephone inquiries concerning local coverage determinations not requiring referral to medical review
  2. Calls resulting in the need for simple claims adjustments that can be handled by telephone CSRs
  3. Dissatisfied callers who require a higher level of service.
- Contractors may organize second level CSRs in any configuration that best suits the nature of the inquiries received. Second level CSRs may serve as consultant subject matter experts for first level CSRs and, therefore, do not always have to speak directly to a provider.
- Second level CSRs may be used to answer first level CSR questions, if the workload demands. Second level CSRs may also handle callbacks. All callbacks shall be completed within 10 business days of the original inquiry and documented in the tracking system.
- Inquiries that require additional time or a yet higher degree of expertise and/or research shall be referred to the Provider Relations Research Specialists (PRRS).

Provider Relations Research Specialists (PRRS) (Level 3)

- The PRRS responds to the more complex provider questions including those related to coverage policy, coding, and payment policy. PRRS uses the full contractor resources (e.g., contractor medical director, contractor Web sites, bulletins, medical review staff, LPET staff, claims processing staff, etc), and CMS resources (Internet-Only Manual, contractor instructions, training packages, Medicare law and regulations, the **http://www.cms.hhs.gov** Web site, *MLN Matters* articles) when researching answers to complex inquiries.
- The PRRS receives its workload through referrals from the tiered process described above and though a similar process from Written Inquiries.
- The PRRS will refer global education topics to the Outreach and Education department as appropriate.
- The PRRS must provide clear and accurate written answers within 10 business days for at least 75 percent of cases referred by the telephone CSRs, 20 business days for 90 percent of cases referred by the telephone CSRs, and 45 business days for 100% of all cases (referred by telephone CSRs or from the general inquiries area).

This tiered structure is designed to improve accuracy, completeness, consistency and timeliness by ensuring that staff with the appropriate levels of expertise addresses supplier issues.

Upcoming Ask-the-Contractor Teleconference (ACT) Call

The NHIC, Corp. DME MAC A Outreach & Education Team is welcoming you to participate in our quarterly Ask-the-Contractor Teleconference calls on **Thursday, June 28, 2007**.

These calls serve to identify issues in a timely way, provide methods of sharing information, and are an excellent tool to listen to our customers. This is your opportunity to interact directly with the NHIC DME MAC on the topic of your choice.

The calls will last for one hour and will begin promptly at the scheduled time. No registration is needed; however the number of lines is limited.

We encourage all suppliers to participate!

Date: Thursday, June 28, 2007 **Time:** 10:00 AM EST **Topic:** DME MAC A General Q&A Session **Toll Free Access Number:** 888-730-9134 **Participant Code:** DME MAC	**Date:** Thursday, June 28, 2007 **Time:** 2:00 PM EST **Topic:** DME MAC A General Q&A Session **Toll Free Access Number:** 888-730-9134 **Participant Code:** DME MAC

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

DME MAC A Online Education Tutorials

NHIC, Corp. is working to offer our providers a wider variety of methods and technological tools to make education more readily available. Our goals are to provide flexible training that can fit anyone's schedule, and to reduce the amount of travel needed to attend NHIC educational activities. Education Online includes online tutorials and training courses available on demand, any time of the day. Each course is designed to proceed at your own pace. If you feel you missed something, you can go back and review the information at any time.

Note: The NHIC, Corp. Outreach and Education team is currently developing new tutorials and training courses. Once these materials have been developed they will be posted to the NHIC Online Education page at **http://www.medicarenhic.com/dme/dme-eduonline.shtml**, and the supplier community will be alerted regarding their completion by a DME MAC A General ListServe message. If you are not yet a subscriber to the DME MAC A General ListServe then sign up today by visiting **http://ui.constantcontact.com/d.jsp?m=1101306329206&p=oi**

Items new to the Online Education page:

- Commodes Billing (Approx: 14 minutes)
- Coordination of Benefits & Medicare Secondary Payer (Approx: 32 minutes)
- Refractive Lens (Vision) Billing (Approx: 25 minutes)
- DME MAC A Web site Navigation Guide

DME MAC A ListServes

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

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

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

Jurisdiction A DME MAC and PSC Affiliate Web Sites

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

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

Jurisdiction A DME MAC and PSC Affiliate Web Sites (Continued)

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

The Pulse of CMS

The Centers for Medicare & Medicaid Services (CMS) provided the Jurisdiction A Durable Medical Equipment Medicare Administrative Contractor (DME MAC A) with a copy of the Spring 2007 edition of "The Pulse of CMS." This quarterly regional publication, for health care professionals, is available via the "Educational Articles" section of the DME MAC A Web site at **http://www.medicarenhic.com/dme/dmeduc.shtml#pulse**.

Note: This is a Portable Document Format (PDF) file, therefore, please follow the PDF download instructions in order to properly view and/or print this publication.

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**. After accepting the CPT License Agreement, suppliers 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 hard copy manuals, 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 January of 2007 **all chapters** of the *DME MAC A Supplier Manual* were updated. 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.

For Your Notes

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

Outreach & Education
781-741-3950

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

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

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

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

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

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

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

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

June 2007
Number 4

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/**
- TriCenturion: **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

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