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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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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LEGEND

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

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Additional Provider Education for Upcoming Changes in Payment for Oxygen Equipment and Capped Rentals for Durable Medical Equipment (DME) Based on the Deficit Reduction Act (DRA) of 2005 (MM5370)

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

MLN Matters Number: MM5370
Related CR Release Date: November 24, 2006
Related CR Transmittal #: R1120CP

Related Change Request (CR) #: 5370
Effective Date: January 1, 2007
Implementation Date: January 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.

Background

Recent legislative changes mandated by sections 5101(a) and 5101(b) of the Deficit Reduction Act (DRA) of 2005 require changes to the way Medicare makes payment for certain items of DME. The DRA provisions and associated regulations will begin to impact capped rental claims as of February 2007. The purpose of this article and related CR 5370 is to provide DME suppliers with an explanation of how these changes will impact them.

Key Points for Suppliers

Payments for Capped Rental DME

- Section 5101(a) revises the payment rules in accordance with the DRA and states that after 13 months the beneficiary owns the capped rental DME item, and after that time, Medicare pays for reasonable and necessary maintenance and servicing (i.e., for parts and labor not covered by a supplier's or manufacturer's warranty) of the item.
- The beneficiary may not, as in years past, choose to continue to rent the item and leave the supplier with the title to the item. The title transfer must occur on the first day after the last rental month. The provision applies to items for which the first rental month occurs on or after January 1, 2006.
- This provision does not affect parenteral nutrition (PEN) pumps, because PEN is not considered to be a capped rental DME, but rather is covered under the prosthetic benefit.
- Beneficiaries may still elect to obtain power-driven wheelchairs on a lump-sum purchase agreement basis. Should the beneficiary choose not to obtain the power-driven wheelchair on a lump sum purchase basis, title to the wheelchair will still transfer to the beneficiary after 13 continuous rental months have been paid.
- Capped rental items furnished to beneficiaries prior to January 1, 2006 will continue to be paid under the payment rules in effect prior to the DRA changes.

Payments for Oxygen Equipment

- Section 5101(b) of the DRA specifically provided that Medicare will continue to pay for oxygen contents (i.e. oxygen, regardless of modality) for beneficiary-owned stationary or portable gaseous or liquid systems. Payment for oxygen contents will continue to be made as long as the oxygen remains medically necessary.
- Section 5101 (B) of the DRA limits the total number of continuous rental months for which Medicare will pay for oxygen equipment to 36 months. After the 36th month, the supplier must transfer title to the equipment to the beneficiary on the first day of the last rental month. The supplier must follow applicable state and federal laws when transferring title to the beneficiary.
- The DRA further stipulates that payment for reasonable and necessary maintenance and servicing of beneficiary-owned oxygen equipment will be made for parts and labor that are not covered by a supplier's or manufacturer's warranty. This provision is effective January 1, 2006.
- For beneficiaries who were receiving oxygen equipment on December 31, 2005, the 36-month rental period begins on January 1, 2006, regardless of how many months rental has been paid prior to January 1, 2006.

Additional Provider Education for Upcoming Changes in Payment for Oxygen Equipment and Capped Rentals for Durable Medical Equipment (DME) Based on the Deficit Reduction Act (DRA) of 2005 (MM5370) (Continued)

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.

The official instruction, CR5370, issued to your Medicare DMERC or DME MAC may be viewed by going to **http://www.cms.hhs.gov/Transmittals/downloads/R1120CP.pdf** on the CMS web site.

In addition, you can find a related MLN Matters article, MM5010 at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5010.pdf** on the CMS website.

Annual Update of HCPCS Codes Used for Home Health Consolidated Billing Enforcement (MM5356)

NEWS FLASH - Flu Shot Reminder - Flu season is here! Medicare patients give many reasons for not getting their flu shot, including-"It causes the flu; I don't need it; it has side effects; it's not effective; I didn't think about it; I don't like needles!" The fact is that out of the average 36,000 people in the U.S. who die each year from influenza and complications of the virus, greater than 90 percent of deaths occur in persons 65 years of age and older. You can help your Medicare patients overcome these odds and their personal barriers through patient education. Talk to your Medicare patients about the importance of getting 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. 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.

MLN Matters Number: MM5356
Related CR Release Date: October 27, 2006
Related CR Transmittal #: R1082CP

Related Change Request (CR) #: 5356
Effective Date: January 1, 2007
Implementation Date: January 2, 2007

Provider Types Affected

Physicians, suppliers, and providers who bill Medicare contractors (Fiscal Intermediaries (FIs), Carriers, Durable Medical Equipment Regional Carriers (DMERC), regional home health intermediaries (RHHIs), and DME Medicare Administrative Contractors (DME MACs) and Part A/B Medicare Administrative Contractors (A/B MACs)) for medical supply or therapy services.

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of Healthcare Common Procedure Codes System (HCPCS) codes subject to the consolidated billing provision of the Home Health Prospective Payment System (HH PPS). This article provides the annual HH consolidated billing update effective January 1, 2007. Affected providers may note the changes in the table listed within this article or consult the instruction issued to the Medicare contractors as listed in the *Additional information* section of this article.

Background

Section 1842(b)(6) of the Social Security Act (SSA) requires that payment for home health services provided under a home health plan of care be made to the home health agency (HHA.) As a result, billing for all such items and services is to be made by a single HHA overseeing that plan. This HHA is known as the primary agency for HH PPS for billing purposes. Services appearing on this list that are submitted on claims to Medicare contractors will not be paid separately on dates when a beneficiary for whom such a service is being billed is in a home health episode (i.e., under a home health plan of care administered by an HHA). Exceptions include the following:

- Therapies performed by physicians
- Supplies incidental to physician services; and
- Supplies used in institutional settings.

Medicare periodically publishes Routine Update Notifications, which contain updated lists of non-routine supply and therapy codes that must be included in HH consolidated billing. The lists are always updated annually, effective January 1, as a result of changes in HCPCS codes that Medicare also publishes annually. This list may also be updated as frequently as quarterly if required by the creation of new HCPCS codes during the year.

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Annual Update of HCPCS Codes Used for Home Health Consolidated Billing Enforcement (MM5356) (Continued)

Key Points

CR5356 provides the annual HH consolidated billing update effective January 1, 2007. The following tables describe the HCPCS codes and the specific changes to each that this notification is implementing on January 2, 2007.

Table 1: Non Routine Supplies

Code	Description	Action	Replacement Code or Code being Replaced
A4213	Syringe, Sterile, 20 CC or Greater	Add	
A4215	Needle, Sterile, Any Size, Each	Add	
A4348	Male External Catheter with Integral Collection Compartment, Extended Wear, Each (e.g., 2 per month)	Delete	
A4359	Urinary Suspensory without Leg Bag	Delete	
A4244	Alcohol or Peroxide, per Pint	Add	
A4245	Alcohol Wipes, per Box	Add	
A4246	Betadine or Phisohex Solution, per Pint	Add	
A4247	Betadine or Iodine Swabs/Wipes, per Box	Add	
A4461	Surgical Dressing Holder, Non-reusable, Each	Add	Replaces code: A4462
A4462	Abdominal Dressing Holder, Each	Delete	Replacement code: A4461 and A4463
A4463	Surgical Dressing Holder, Reusable, Each	Add	Replaces code: A4462
A4932	Rectal Thermometer, Reusable, Any Type, Each	Add	
A6412	Eye Patch, Occlusive, Each	Add	

Table 2: Therapies

Code	Description	Action	Replacement Code or Code being Replaced
97020	Application Microwave	Delete	Replacement Code: 97024
97024	Application of a Modality to One or More Areas: Diathermy (e.g., Microwave)	Redefine	Replaces code: 97020

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Annual Update of HCPCS Codes Used for Home Health Consolidated Billing Enforcement (MM5356) (Continued)

Code	Description	Action	Replacement Code or Code being Replaced
97504	Orthotic(s) Fitting and Training, Upper Extremity(ies), Lower Extremity(ies), and/or Trunk, Each 15 Minutes	Delete	Replacement code: 97760
97520	Prosthetic Training, Upper and/or Lower Extremity(ies), Each 15 Minutes	Delete	Replacement code: 97761
97703	Checkout for Orthotic/Prosthetic Use, Established Patient, Each 15 Minutes	Delete	Replacement code: 97762
97760	Orthotic(s) Management and Training (Including Assessment and Fitting when not Otherwise Reported), Upper Extremity(s), Lower Extremity(s) and/or Trunk, Each 15 Minutes	Add	Replaces code: 97504
97761	Prosthetic Training, Upper and/or Lower Extremity(s), Each 15 Minutes	Add	Replaces code: 97520
97762	Checkout for Orthotic/Prosthetic Use, Established Patient, Each 15 Minutes	Add	Replaces code: 97703

Additional Information

If you have questions, please contact your Medicare FI, carrier, A/B MAC, DMERC, RHHI, 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 CR please see the official instruction issued to your Medicare FI, carrier, A/B MAC, DMERC, RHHI, or DME MAC. That instruction may be viewed by going to **http://www.cms.hhs.gov/Transmittals/downloads/R1082CP.pdf** on the CMS web site.

A complete historical listing of codes subject to HH consolidated billing can be found at **http://www.cms.hhs.gov/HomeHealthPPS/03_coding&billing.asp** on the CMS web site.

To review the Medicare regulations discussed in this article see the *Medicare Claims Processing Manual* Chapter 10, Section 10.1.25 at **http://www.cms.hhs.gov/manuals/downloads/clm104c10.pdf** on the CMS website.

Application Update to Medicare Deductible, Coinsurance and Premium Rates for 2007 (MM5345)

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

MLN Matters Number: MM5345
Related CR Release Date: October 27, 2006
Related CR Transmittal #: R41GI

Related Change Request (CR) #: 5345
Effective Date: January 1, 2007
Implementation Date: January 2, 2007

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 5345 which announces the 2007 Medicare rates and instructs your Medicare contractors to make necessary updates to their claims processing systems.

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Application Update to Medicare Deductible, Coinsurance and Premium Rates for 2007 (MM5345) (Continued)

Background

There are beneficiary-related costs for using certain services under Parts A and B of Medicare, typically in the form of deductibles, co-payments, and/or premium payments. Beneficiaries who use covered Part A services may be subject to deductible and coinsurance requirements. A beneficiary is responsible for an inpatient hospital deductible amount, which is deducted from the amount payable by the Medicare program to the hospital, for inpatient hospital services furnished in a spell of illness.

When a beneficiary receives such services for **more than 60 days** during a spell of illness, he or she is responsible for **a coinsurance amount equal to one-fourth** of the inpatient hospital deductible **per-day for the 61st-90th day** spent in the hospital.

An individual has 60 lifetime reserve days (LRDs) of coverage, which they may elect to use after the 90th day in a spell of illness. The coinsurance amount for these LRDs is equal to one-half of the inpatient hospital deductible.

For Skilled Nursing Facility (SNF) services furnished during a spell of illness, a beneficiary is responsible for a coinsurance amount equal to one-eighth of the inpatient hospital deductible per day for the 21st through the 100th day.

Most individuals **age 65 and older**, and many **disabled individuals under age 65**, are **insured for Health Insurance (HI) benefits without a premium payment**. The Social Security Act provides that certain aged and disabled persons who are not insured may voluntarily enroll, but are subject to the payment of a monthly premium.

Since 1994, voluntary enrollees may qualify for a reduced premium if they have 30-39 quarters of covered employment. When voluntary enrollment occurs more than 12 months after the date a person is initial eligibility to enroll, a 10 percent penalty is assessed for 2 years for every year they could have enrolled and failed to enroll in Part A.

Under **Supplementary Medical Insurance (SMI) or Part B**, all enrollees are **subject to a monthly premium**. Most SMI services are subject to an annual deductible and coinsurance (percent of costs that the enrollee must pay), which are set by statute. When SMI enrollment takes place more than **12 months after a person's initial enrollment** period, there is a permanent **10 percent increase in the premium** for each year the beneficiary could have enrolled and failed to enroll.

Medicare Part A for 2007

For Calendar Year (CY) 2007, the following rates are applicable for Medicare Part A Deductible, Coinsurance, and Premium amounts:

Deductible	$992.00 per benefit period
Coinsurance	$248.00 a day for days 61-90 in each period
	$496.00 a day for days 91-150 for each LRD used
	$124.00 a day in a SNF for days 21-100 in each benefit period
Premium	$410.00 per month for those who must pay a premium
	$451.00 per month for those who must pay both a premium and a 10 % increase
	$226.00 per month for those who have 30-39 quarters of coverage
	$248.60 per month for those who have 30-39 quarters of coverage and must pay a 10 % increase

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Application Update to Medicare Deductible, Coinsurance and Premium Rates for 2007 (MM5345) (Continued)

Medicare Part B for 2007
For CY 2007, the following rates are applicable for Medicare Part B Deductible and Coinsurance :

Deductible	$131.00 per year
Coinsurance	20 percent

CMS updates the Part B premium each year. These adjustments are made according to formulas set by statute. By law, the monthly Part B premium must be sufficient to cover 25 percent of the program's costs, including the costs of maintaining a reserve against unexpected spending increases. The federal government pays the remaining 75 percent.

Below are the annual Part B premium amounts from Calendar Year (CY) 1996 to 2006. For these years, and years prior to 1996, the Part B premium is a single established rate for all beneficiaries.

Year	Part B Premium		Year	Part B Premium		Year	Part B Premium
1996	$42.50		2000	$45.50		2004	$66.60
1997	$43.80		2001	$50.00		2005	$78.20
1998	$43.80		2002	$54.00		2006	$88.50
1999	$45.50		2003	$58.70			

Beginning on January 1, 2007, the Part B premium will be based on the income of the beneficiary. Below are the CY 2007 **Part B premium amounts <u>based on beneficiary income parameters</u>.**

	Income Parameters for Determining Part B Premium	
Premium/mon	**Individual Income**	**Combined Income (Married)**
$93.50	$80,000.00 or less	$160,000.00 or less
$105.80	$80,000.01 - $100,000.00	$160,000.01 - $200,000.00
$124.40	$100,000.01 - $150,000.00	$200,000.01 - $300,000.00
$142.90	$150,000.01 - $200,000.00	$300,000.01 - $400,000.00
$161.40	$200,000.01 or more	$400,000.01 or more

Implementation
The implementation date for CR5345 is January 2, 2007.

Additional Information
For complete details, please see the official instruction issued to your carrier, DMERC,DME MAC, intermediary, RHHI, or A/B MAC regarding this change. That instruction may be viewed at **http://www.cms.hhs.gov/Transmittals/downloads/R41GI.pdf** on the CMS web site.

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

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

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

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

Note: This article was revised on November 1, 2006 to change the reference made to the Medicare Program Integrity Manual. This should have reference **Section 5.9** and not Section 5.8. All other information remains the same.

Provider Types Affected

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

Background

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

Key Points

This article and CR5128 provide an update to Section 5.9 Evidence of Medical Necessity: Wheelchair and Power Operated Vehicle (POV) Claims of the *Medicare Program Integrity Manual.*

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

Implementation

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

Additional Information

The official instructions, CR5128, issued to your Medicare DMERC regarding this change can be found at **http://www.cms.hhs.gov/Transmittals/downloads/R157PI.pdf** on the CMS web site. The revised Section **5.9 Evidence of Medical Necessity: Wheelchair and Power Operated Vehicle (POV) Claims** of the *Medicare Program Integrity Manual* is attached to CR5128.

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

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

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Fee Schedule Update for 2007 for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) (MM5417)

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

MLN Matters Number: MM5417
Related CR Release Date: December 8, 2006
Related CR Transmittal #: R1125CP
Related Change Request (CR) #: 5417
Effective Date: January 1, 2007
Implementation Date: January 2, 2007

Provider Types Affected

Physicians, suppliers, and providers who bill Medicare contractors (Part A/B Medicare Administrative Contractors (A/B MACs), durable medical equipment regional carriers (DMERCs), DME Medicare administrative contractors (DME MACs), fiscal intermediaries (FIs), carriers, and/or regional home health intermediaries (RHHIs)), for services paid under the DMEPOS Fee Schedule.

Provider Action Needed

This article is based on Change Request (CR) 5417, and it provides specific information regarding the annual update for the 2007 DMEPOS Fee Schedule. Be sure billing staff are aware of this update.

Background

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

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

Payment on a fee schedule basis is required for:

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

Note: DMERCs and DME MACS will use the 2007 PEN fee schedule payment amounts to pay claims for items furnished from January 1, 2007 through December 31, 2007

Deleted HCPCS Codes

The following codes are being **deleted** from the HCPCS effective January 1, 2007, and are therefore being removed from the DMEPOS and PEN fee schedule files.

A4348	L0100	L6740	L6825	L6872
A4359	L0110	L6745	L6830	L6873
A4462	L3902	L6750	L6835	L6875
A4632	L3914	L6755	L6840	L6880
E0164	L6700	L6765	L6845	L7010
E0166	L6705	L6770	L6850	L7015
E0180	L6710	L6775	L6855	L7020
E0701	L6715	L6780	L6860	L7025
E0977	L6720	L6790	L6865	L7030
E0997 thru E0999	L6725	L6795	L6867	L7035
E2320	L6730	L6800	L6868	
K0090 thru K0097	L6735	L6806 thru L6809	L6870	
K0099				

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Fee Schedule Update for 2007 for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) (MM5417) (Continued)

Added HCPCS

The HCPCS codes listed below are being **added to the HCPCS** on January 1, 2007:

A4461	A9279	L1001	L6703
A4463	E0676	L3806	L6704
A4559	E0936	L3808	L6706
A4600	E2373 thru E2377	L3915	L6707 thru L6709
A4601	E2381 thru E2396	L5993	L7007 thru L7009
A8000	K0733 thru K0737	L5994	L8690
A8001		L6611	L8691
A8002		L6624	L8695
A8003		L6639	
A8004			

Payment Rates for Oxygen and Oxygen Equipment

As part of this fee schedule update, the Centers for Medicare & Medicaid Services (CMS) is implementing national monthly payment rates for oxygen and oxygen equipment effective for claims with dates of service on or after January 1, 2007. The 2007 national monthly payment rates are listed in the table below. As a result of these changes, CMS is revising the fee schedule amounts for codes E1405 and E1406. Since 1989, the fees for E1405 and E1406 have been established based on a combination of the Medicare payment amounts for stationary oxygen equipment and nebulizer codes E0585 and E0570, respectively.

As part of these changes, suppliers must submit claims with both the code for stationary oxygen contents (E0441 or E0442) and the code for portable oxygen contents (E0443 or E0444) when billing for payment for furnishing both stationary and portable oxygen contents for beneficiary-owned gaseous or liquid stationary and portable oxygen equipment.

HCPCS Codes	Amount	Class
E0424, E0439, E1390, and E1391	$198.40	Stationary Oxygen Equipment (including stationary concentrator, liquid and gaseous equipment) and Oxygen Contents (stationary and portable)
E0431 and E0434	$31.79	Portable Equipment Only (gaseous or liquid tanks)
E1392 and K0738	$51.63	Oxygen Generating Portable Equipment (OGPE) Only
E0441 and E0442	$77.45	Oxygen Contents for Beneficiary-Owned Stationary Gaseous or Liquid Oxygen Equipment
E0443 and E0444	$77.45	Oxygen Contents for Beneficiary-Owned Portable Gaseous or Liquid Oxygen Equipment

The fee schedules for HCPCS code E0461 (Volume Control Ventilator, Without Pressure Support Mode, May Include Pressure Control Mode, Used with Non-Invasive Interface (E.G. Mask)) are being revised as part of this update to correct calculation errors and are effective for dates of service on or after January 1, 2007.

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Fee Schedule Update for 2007 for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) (MM5417) (Continued)

Gap-Fill Items

The Medicare DMERCS and DME MACs will gap-fill base fee schedule amounts for each State in their region for the following new and revised HCPCS codes that will be subject to the DMEPOS fee schedules in 2007:

- Inexpensive or routinely purchased DME for codes A8002, A8003, A8004, E2373, E2374, E2375, E2376, E2377, E2388, E2389, E2390, E2391, E2392, E2393, E2394, E2395
- Capped rental DME codes of E0639 and E0640
- Prosthetics and Orthotics codes of L1001, L3806, L3808, L3915, L5993, L5994, L6611, L6624, L6639
- Surgical Dressings codes of A4463
- DME supplies codes of A4559

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 (CR5417) issued to your Medicare A/B MAC, DMERC, DME MAC, FI, RHHI, or carrier. That instruction may be viewed by going to **http://www.cms.hhs.gov/Transmittals/downloads/R1125CP.pdf** on the CMS web site.

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
- Fee Schedule Amounts for HCPCS Codes K0827, K0829 and K0864 - Revised 12-29-2006
- Fee Schedule Amounts for HCPCS Codes K0813-K0864 - Revised 12-20-2006
- 2006 DMEPOS Fee Schedule for New Power Mobility Device Codes - Effective 11-15- 2006

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

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

Please join the NHIC, Corp. DME MAC A ListServe!

Visit

http://www.medicarenhic.com/dme/

and select

“Join the DME MAC A ListServe”

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Infrared Therapy Devices (MM5421)

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

MLN Matters Number: MM5421
Related CR Release Date: December 15, 2006
Related CR Transmittal #: R1127CP and R62NCD
Related Change Request (CR) #: 5421
Effective Date: October 24, 2006
Implementation Date: January 16, 2007

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.

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,
  - 880.00-887.79,
  - 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.

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Infrared Therapy Devices (MM5421) (Continued)

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/R1127CP.pdf** on the CMS site.

January 2007 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing File, Effective January 1, 2007, and Revisions to April 2006, July 2006 and October 2006 Quarterly ASP Medicare Part B Drug Pricing Files (MM5413)

NEWS FLASH - 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 .

MLN Matters Number: MM5413
Related CR Release Date: December 15, 2006
Related CR Transmittal #: R1129CP
Related Change Request (CR) #: 5413
Effective Date: January 1, 2007
Implementation Date: January 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) 5413 which informs Medicare contractors to download the January 2007 Average Sales Price (ASP) drug pricing file for Medicare Part B drugs as well as the revised January 2006, April 2006, July 2006, and October 2006 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.

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January 2007 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing File, Effective January 1, 2007, and Revisions to April 2006, July 2006 and October 2006 Quarterly ASP Medicare Part B Drug Pricing Files (MM5413) (Continued)

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 where the vaccine is furnished in a hospital outpatient department. Where 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* (Pub. 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.
- 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 December 19, 2006, the revised April, July and October 2006 and January 2007 ASP file 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 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
April 2006	April 1, 2006 through June 30, 2006.
July 2006	July 1, 2006 through September 30, 2006.
October 2006	October 1, 2006 through December 31, 2006.
January 2007	January 1, 2007 through March 31, 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 shall make these determinations.

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January 2007 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing File, Effective January 1, 2007, and Revisions to April 2006, July 2006 and October 2006 Quarterly ASP Medicare Part B Drug Pricing Files (MM5413) (Continued)

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. 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/R1129CP.pdf on the CMS web site.

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 web site at:
http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip.

Medically Unlikely Edits (MUEs) (MM5402)

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

MLN Matters Number: MM5402
Related CR Release Date: December 8, 2006
Related CR Transmittal #: R178PI

Related Change Request (CR) #: 5402
Effective Date: January 1, 2007
Implementation Date: January 2, 2007

Provider Types Affected
Physicians, suppliers, and providers who bill Medicare fiscal intermediaries (FIs), carriers, Part A/B Medicare Administrative Contractors (A/B MACs), durable medical equipment regional carriers (DMERCs), 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.

- 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.
- The MUEs will auto-deny claim line items containing units of service billed in excess of the MUE criteria or Return to Provider (RTP) claims that contain lines that have units of service that exceed an MUE criteria.

Key Points
- CR5402 states that Medicare contractors will deny the claim line or RTP claims with units of service that exceed MUE criteria and pay the other services on the claim as part of initial claims processing activities.
- The MUEs that will be implemented by this notice are based on anatomic considerations. CMS believes that most MUEs based on anatomic considerations are not controversial, but CMS will allow and require an appeals process for those claim line items that are denied as a result of an MUE edit.
- An appeals process will not be allowed or required for claims that are RTP'ed as a result of an MUE edit. Instead, providers should resubmit corrected claims.
- This set of MUEs that is based on anatomical considerations addresses approximately 2,800 codes.
- 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).

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Medically Unlikely Edits (MUEs) (MM5402) (Continued)

Additional Information
If you have questions, please contact your Medicare FI, Carrier or A/B MAC, DMERC, 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.

For complete details regarding CR 5402 please see the official instruction issued to your Medicare FI, Carrier or A/B MAC. That instruction may be viewed by going to **http://www.cms.hhs.gov/Transmittals/downloads/R178PI.pdf** on the CMS web site.

MMA - Reopenings and Revisions of Claim Determinations and Decisions (MM4147)

MLN Matters Number: MM4147
Related CR Release Date: September 29, 2006
Related CR Transmittal #: R1069CP

Related Change Request (CR) #: 4147
Effective Date: November 29, 2006
Implementation Date: November 29, 2006

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

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

Provider Action Needed
Impact to You
This article, based on Change Request (CR) 4147, notifies you about changes to the *Medicare Claims Processing Manual*, which ensure that claims with **clerical errors (which include minor errors and omissions)** should be processed as "**reopenings**" and not as "**appeals**."

What You Need to Know
All reopenings are conducted at the discretion of your Medicare contractor and are therefore not appealable. Your Part A Medicare contractor may continue to handle some errors through the claim adjustment process. The Centers for Medicare & Medicaid Services (CMS) has added "Missing data items, such as provider number or missing date of service" to the definition of clerical errors. Note that clerical errors are limited to errors in form and content, and that omissions do not include failure to bill for certain items or services. Please note that third party payor errors DO NOT constitute clerical errors.

What You Need to Do
Please refer to the *Additional Information* section of this article and to the information in the manual attachment to CR4147 (Pub. 100-04, The *Medicare Claims Processing Manual*, Chapter 34, Section 10) for detailed and updated information regarding reopenings. Please note also that this information replaces what was previously found in Chapter 29, Section 90 of The *Medicare Claims Processing Manual*.

Background
The Medicare claim appeals process was amended by the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), and by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). Section 937 of MMA requires the establishment of a process for the correction of minor errors and omissions that do not necessitate the use of the formal appeals process.

Additional Information
"A reopening is a remedial action taken to change a final determination or decision that resulted in either an overpayment or an underpayment, even though the determination or decision was correct based on the evidence of record." (Pub. 100-04, The *Medicare Claims Processing Manual*, Chapter 34, Section 10)If your reopening request is denied, you may not appeal the contractor's refusal to reopen but you can appeal the original claim denial as long as the timeframe to request an appeal has not expired. **Requesting a reopening does not toll the timeframe to request an appeal.** If a reopening results in a revised determination, new appeal rights will be afforded on that revised determination. Not all reopenings result in a revised determination. Some important points to note about reopenings as a result of these changes are as follows:

- Medicare contractors will not use reopenings as an appeal when a formal appeal is not available.
- Medicare contractors may conduct a reopening to revise an initial determination or redetermination. Medicare Secondary Payer (MSP) beneficiary or provider/supplier recovery claims are not reopening actions except where the recovery claim is a MSP provider/supplier recovery claim. All other MSP beneficiary or provider /supplier recovery claims are initial determinations.

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MMA - Reopenings and Revisions of Claim Determinations and Decisions (MM4147) (Continued)

- If a claim is suspended for medical review, a request for additional documentation (ADR) may be required to make a determination. If no response is received within the specified timeframes, the medical review department will likely deny the service as not reasonable and necessary based on lack of documentation. In such cases, if appealed with the requested documentation, the Medicare contractor will perform a reopening instead of an appeal. The reopenings will be performed by the medical review department.
- For Part A Medicare, there are a limited number of clerical errors that can be corrected through the reopening process. Many FIs are handling the correction of errors through the submission of an adjustment or corrected claim. FIs who are handling errors through adjustments will continue to do so.
- Medicare contractors will accept reopening requests only if they are made in writing or over the telephone. Please note that the telephone reopenings process is not required for fiscal intermediaries.
- Medicare contractors will ask the providers or suppliers to fax in the proof to support changes and error correction, when necessary.
- In cases where the issue is: (1) too complex to be handled over the phone or (2) there is a need for additional medical documents, the Medicare contractor will inform the party that their request cannot be processed over the phone. In such instances, the contractor will advise the requestor to file their request in writing.
- Medicare contractors will require the following three items from the caller, prior to conducting a telephone reopening: (1) provider/ physician/supplier name & ID # or NSC #; (2) Beneficiary last name & first initial; and (3) Medicare HICN. **NOTE: Items must match exactly.**

CR4147 is the official instruction issued to your FI/RHHI, carrier, DMERC, or DME MAC regarding changes mentioned in this article. CR 4147 may be found by going to **http://www.cms.hhs.gov/Transmittals/downloads/R1069CP.pdf** on the CMS website.

For additional information relating to the Medicare appeals process, you may wish to refer to Chapter 29 of the *Medicare Claims Processing Manual*, which is available at **http://www.cms.hhs.gov/manuals/downloads/clm104c29.pdf.**

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

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 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 December 31, 2006, where claims for items requiring a CMN or DIF will be accepted with either the old or the new form. The improved forms also permit the use of a signature and date stamp.

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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)

What You Need to Do

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

Background

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

The changes to the CMN forms have resulted in the following:

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

Claims Accepted During Transition Period

The following table identifies the CMNs for claims for services provided during the transition period from October 1, 2006, through December 31, 2006. (For services on or after January 1, 2007, the old forms will no longer be accepted.)

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

Newly Revsed CMNs Accepted During Transiton 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 December 31, 2006. For services on or after January 1, 2007, these forms will become effective for claims for items requiring a CMN.

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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)

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 December 31, 2006. For services on or after January 1, 2007, the new forms will become effective for claims for items requiring a DIF.

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

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

DME MAC FORM	CMS FORM	ITEMS ADDRESSED
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

ALERT: 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.

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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)

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.

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

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

MLN Matters Number: MM5107 Revised
Related CR Release Date: October 31, 2006
Related CR Transmittal #: R168PI
Related Change Request (CR) #: 5107
Effective Date: October 2, 2006
Implementation Date: January 2, 2007

Note: This article was revised on November 1, 2006, to reflect changes CMS made to CR5107 to clarify the transition period. In addition, the article has some specific information for completing CMNs during this transition period.

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

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

Key Points of CR 5107
- The revised Transcutaneous Electrical Nerve Stimulators (TENS) CMN will **only apply to purchases.**
- Beginning January 1, 2007, **CMNs** for **TENS rentals will not be required.** DMERCs and DME MACs will allow suppliers to submit a partially-completed unsigned TENS CMN for claims submitted on or after October 2, 2006, and ending on December 31, 2006.

For more information regarding the revised CMN forms, see the MLN Matters article MM4296, which is available at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4296.pdf** on the CMS website. Note that you must use the old CMN forms for this transition period (dates of service on or after October 1, 2006, and ending on December 31, 2006). Also, note the following:

- Enter the date of service (i.e., the delivery date) in the "initial" date field in Section A of the CMN.
- Enter all other information in Section A fields that are required currently.
- Enter 99 in the "Est. Length of Need" field in Section B.
- Enter the primary diagnosis in the "diagnosis Codes" field in CMN Section B.
- Enter "D" as the answer to questions 1, 3, and 6 of Section B of the CMN.
- Enter "5" as the answer to question 5 of Section B.
- The answers to questions 2 and 4 of Section B may be left blank.

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

- You may leave section C as blank.
- In Section D of the CMN, enter a "yes" in the "Physician's Signature" field and enter the delivery date in the "Signature Date" field.
- For hardcopy CMNs, only complete Section A and leave other sections blank.

Additional Information
The official instructions, CR 5107, issued to your Medicare DMERC/DME MAC regarding this change can be found at **http://www.cms.hhs.gov/Transmittals/downloads/R168PI.pdf** on the CMS website. The new CMN form is available at **http://www.cms.hhs.gov/cmsforms/downloads/CMS848.pdf** on the CMS site.

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

Payment by DME MACs and DMERCs for the Administration of Part D Vaccines (MM5486)

NEWS FLASH - 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

MLN Matters Number: MM5486
Related CR Release Date: December 29, 2006
Related CR Transmittal #: R1146CP
Related Change Request (CR) #: 5486
Effective Date: January 1, 2007
Implementation Date: January 29, 2006

Provider Types Affected
Medicare-enrolled pharmacies who bill Durable Medical Equipment Regional Carriers (DMERCs) or Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for administration of Part D vaccines to Medicare beneficiaries.

What You Need to Know
CR 5486, from which this article was taken, implements the payment policy for the administration of Part D-covered vaccines furnished by Medicare-enrolled pharmacies.

During calendar year 2007, you may be paid under Medicare Part B for the administration of a Part D-covered vaccine furnished to a Medicare beneficiary during 2007 only if you are enrolled with the National Supplier Clearinghouse and the beneficiary is enrolled in Part D.

Background
Section 202(b) of the Tax Relief and Health Care Act of 2006 (TRHCA) establishes a permanent policy for, and resolves any potential ambiguity about, payment by Medicare for administration of Part D-covered vaccines, beginning with 2008. The payment policy for services furnished by physicians and other practitioners was implemented in a previous Change Request (CR 5459), and CR 5486 implements the payment policy for the administration of Part D-covered vaccines furnished by Medicare-enrolled pharmacies.

Specifically, effective January 1, 2008, the administration of a Part D-covered vaccine is included in the definition of "covered Part D drug" under the Part D statute. Until this effective date, Section 202(a) of TRHCA provides for a transition policy (**in effect for 2007 only**) which permits payment under Medicare Part B for administration of a Part D-covered vaccine. For this 2007 transition period, payment will be made under Part B for the administration of a covered Part D vaccine "as if it were the administration of a vaccine described in section 1861(s)(10)(B) [hepatitis B vaccine.]"

Since payment for administration of a hepatitis B vaccine requires the application of Part B coinsurance and deductible, and involves other statutory requirements such as assignment; these requirements also apply (during 2007) to a payment for the administration of a Part D-covered vaccine. Moreover, payment under Part B for administration of a Part D-covered vaccine is available only if 1) On the date of service, the pharmacy is enrolled as such with the National Supplier Clearinghouse; and 2) The Medicare beneficiary, to whom the Part D-covered vaccine is furnished, is enrolled in a Part D Prescription Drug Plan.

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Payment by DME MACs and DMERCs for the Administration of Part D Vaccines (MM5486) (Continued)

Here are some details that you should know:

1. **Neither this CR nor CR 5459 addresses payment for a Part D-covered vaccine itself. Payment for Part D-covered vaccines is made solely by participating Part D Prescription Drug Plans.**
2. You should use G code (G0377: *Administration of vaccine for Part D drug*) for the administration of Part D-covered vaccines in 2007. The Part B allowed charge for this code (effective for 2007) is $19.33. Thus, the Medicare payment would be 80% of that amount or $15.46, assuming the beneficiary's Part B deductible is met. The beneficiary would pay $3.87 as a coinsurance payment, plus any Part B deductible payment that may be due.
3. Claims must be submitted in the 837 or the CMS 1500 paper form, billed with Indicator 05 -Pharmacy, and indicating the Place of Service (POS) as either home or pharmacy.
4. The Administration of Part D vaccine claims is subject to mandatory assignment. Your DMERC/DME MACs will therefore ensure that you accept assignment for claims associated with the administration of a Part D vaccine; and if you should submit a claim for G0377 as unassigned, will process that claim as though it were assigned. Further, since beneficiaries can not submit assigned claims, beneficiary-submitted claims for the administration under the Tax Relief and Health Care Act of 2006 legislation can not be paid.
5. You must retain in your records the physician orders/prescription of record for claims associated with the administration a Part D vaccine.
6. DMERCs/DME MACs will return/reject claims for the administration of a Part D vaccine with dates of service after December 31, 2007, and they will use existing Medicare Summary Notice and remittance advice messages for claims associated with the administration of a vaccine.
7. Note that the implementation date for this change is January 29, 2007 in Medicare systems. Thus, your DMERC or DME MAC may not actually process any 2007 claims for payment until that date.

Additional Information

CR5486 is the official instruction issued to your DMERC/DME MAC and you can find CR 5486 at **http://www.cms.hhs.gov/Transmittals/downloads/R1146CP.pdf** on the CMS website.

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

Reasonable Charge Update for 2007 for Splints, Casts, Dialysis Supplies, Dialysis Equipment, and Certain Intraocular Lenses (MM5382)

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

MLN Matters Number: MM5382
Related CR Release Date: November 24, 2006
Related CR Transmittal #: R1118CP
Related Change Request (CR) #: 5382
Effective Date: January 1, 2007
Implementation Date: January 2, 2007

Provider Types Affected

Physicians, suppliers and providers billing Medicare carriers, durable medical equipment regional carriers (DMERCs), DME Medicare Administrative Contractors (DME MACs), or Part A/B Medicare Administrative Contractors (A/B MACs) for splints, casts, dialysis supplies, dialysis equipment, and certain intraocular lenses.

Provider Action Needed

Physicians, suppliers and providers billing Medicare carriers, durable medical equipment regional carriers (DMERCs), DME Medicare Administrative Contractors (DME MACs), or Part A/B Medicare Administrative Contractors (A/B MACs) for splints, casts, dialysis supplies, dialysis equipment, and certain intraocular lenses. Providers may want to be sure their billing staff knows of these changes.

Background

Payment continues to be made on a reasonable charge basis for splints, casts, dialysis supplies, dialysis equipment and intraocular lenses in calendar year 2007 as required by regulations contained in 42 CFR 405.501 (**http://www.gpoaccess.gov/cfr/retrieve.html**).

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Reasonable Charge Update for 2007 for Splints, Casts, Dialysis Supplies, Dialysis Equipment, and Certain Intraocular Lenses (MM5382) (Continued)

For splints and casts, Q-codes are to be used when supplies are indicated for cast and splint purposes. Current Procedural Terminology (CPT) codes should be used as indicated in the CPT section "Application of Casts and Strapping" for the specified CPT procedure codes in the 29XXX series. This payment is in addition to the payment made under the physician fee schedule for the procedure for applying the splint or cast.

For intraocular lenses, payment is only made on a reasonable charge basis for lenses implanted in a physician's office. Change Request (CR) 5282 instructs your carrier, DMERC, DME MAC, or A/B MAC to compute 2007 customary and prevailing charges for the V2630, V2631, and V2632 (Intraocular Lenses Implanted in a Physician's Office) using actual charge data from July 1, 2005, through June 30, 2006.

Carriers, and A/B MACs will compute 2007 Inflation-Indexed Charge (IIC) amounts for the V2630, V2631, and V2632 that were not paid using gap-filled payment amounts in 2006.

DMERCs and DME MACs will compute 2007 customary and prevailing charges for the codes identified in the following tables using actual charge data from July 1, 2005, through June 30, 2006. For these same codes, they will compute 2007 IIC amounts for the codes identified in the following tables that were not paid using gap-filled amounts in 2006. These tables are:

Dialysis Supplies Billed With AX Modifier

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

Dialysis Supplies Billed Without AX Modifier

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

Dialysis Equipment Billed With AX Modifier

E0210NU	E1632	E1637	E1639

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Reasonable Charge Update for 2007 for Splints, Casts, Dialysis Supplies, Dialysis Equipment, and Certain Intraocular Lenses (MM5382) (Continued)

Dialysis Equipment Billed Without AX Modifier

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

Carriers and A/B MACs will make payment for splints and casts furnished in 2007 based on the lower of the actual charge or the payment limits established for these codes. **Carriers, DMERCs and DME Medicare Administrative Contractors (MACs)** to will use the 2007 reasonable charges or the same payment limits to pay claims for items furnished from January 1, 2007 through December 31, 2007. **Those 2007 payment limits are in the table at the end of this article.**

Additional Information

Instructions for calculating:

- Reasonable charges are located in chapter 23 (section 80) of the *Medicare Claims Processing Manual* (Pub. 100-04);
- Customary and prevailing charge are locate in section 80.2 and 80.4 of chapter 23 of the *Medicare Claims Processing Manual* (Pub 100-04); and
- The IIC (Inflation Indexed Charge) are located in section 80.6 of chapter 23 of the *Medicare Claims Processing Manual* (Pub. 100-04). The IIC update factor for 2007 is 4.3 percent.

You can find chapter 23 of the *Medicare Claims Processing Manual* (Pub. 100-04) at the following CMS website: **http://www.cms.hhs.gov/manuals/downloads/clm104c23.pdf**

For complete details, please see the official instruction issued to your carrier, DMERC, DME MAC, or A/B MAC regarding this change. That instruction may be found at **http://www.cms.hhs.gov/Transmittals/downloads/R1118CP.pdf** on the CMS website.

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

2007 Payment Limits for Splints and Casts

Code	Payment Limit	Code	Payment Limit
A4565	$7.19	Q4025	$31.60
Q4001	$40.91	Q4026	$98.64
Q4002	$154.63	Q4027	$15.80
Q4003	$29.39	Q4028	$49.33
Q4004	$101.74	Q4029	$24.16
Q4005	$10.83	Q4030	$63.59
Q4006	$24.42	Q4031	$12.08
Q4007	$5.43	Q4032	$31.79
Q4008	$12.21	Q4033	$22.53
Q4009	$7.23	Q4034	$56.05
Q4010	$16.28	Q4035	$11.27
Q4011	$3.61	Q4036	$28.03

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Reasonable Charge Update for 2007 for Splints, Casts, Dialysis Supplies, Dialysis Equipment, and Certain Intraocular Lenses (MM5382) (Continued)

Code	Payment Limit	Code	Payment Limit
Q4012	$8.14	Q4037	$13.75
Q4013	$13.16	Q4038	$34.44
Q4014	$22.21	Q4039	$6.89
Q4015	$6.58	Q4040	$17.22
Q4016	$11.10	Q4041	$16.71
Q4017	$7.61	Q4042	$28.53
Q4018	$12.14	Q4043	$8.36
Q4019	$3.81	Q4044	$14.27
Q4020	$6.08	Q4045	$9.70
Q4021	$5.63	Q4046	$15.61
Q4022	$10.17	Q4047	$4.84
Q4023	$2.83	Q4048	$7.81
Q4024	$5.08	Q4049	$1.77

Remittance Advice Remark Code and Claim Adjustment Reason Code Update (MM5346)

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

MLN Matters Number: MM5346
Related CR Release Date: October 27, 2006
Related CR Transmittal #: R1087CP
Related Change Request (CR) #: 5346
Effective Date: January 1, 2007
Implementation Date: January 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 5346, 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 January 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 transactions.

The remittance advice remark code 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.

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Remittance Advice Remark Code and Claim Adjustment Reason Code Update (MM5346) (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 5346, effective on and after January 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 remittance advice remark code and claim adjustment reason code updates by going to CR 5346, located at **http://www.cms.hhs.gov/Transmittals/downloads/R1087CP.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**

Remittance Advice Remark Code Changes

Code	New/ Modified/ Deactivated/ Retired	Current Narrative	Comment
N370	New	Billing exceeds the rental months covered/approved by the payer.	Medicare initiated
N371	New	Alert: title of this equipment must be transferred to the patient. *	Medicare initiated
N372	New	Only reasonable and necessary maintenance/service charges are covered.	Medicare initiated
MA02	Modified	If you do not agree with this determination, you have the right to appeal. You must file a written request for an appeal within 180 days of the date you receive this notice.	Modified effective 8/1/06
M114	Modified	This service was processed in accordance with rules and guidelines under the Competitive Bidding Demonstration Project. If you would like more information regarding this project, contact your local contractor.	Modified effective 8/1/06
N199	Modified	Additional payment/recoupment approved based on payer-initiated review/audit.	Modified effective 8/1/06
There are no deactivated remittance advice remark code changes			

NOTE: Some remark codes may provide only information. They may not necessarily supplement the explanation provided through a reason code, or, 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. For example, this informational code is sent per state regulation, but does not explain any adjustment:

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

These informational codes will be used only if specific information needs to be communicated but not as default codes.

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Remittance Advice Remark Code and Claim Adjustment Reason Code Update (MM5346) (Continued)

Reason Code Changes

Code	New/ Modified/ Deactivated/ Retired	Current Narrative	Comment
196	New	Claim/service denied based on prior payer's coverage determination	New as of June, 2006
16	Modified	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	Modified as of February, 2002 and June, 2006
17	Modified	Payment adjusted because requested information was not provided or was insufficient/incomplete. Additional information is supplied using the remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	Modified as of February, 2002 and June, 2006
96	Modified	Non-covered charge(s). This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	Modified as of February, 2002 and June, 2006
125	Modified	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	Modified as of February, 2002 and June, 2006
43	Retired	Gramm-Rudman reduction.	Modified as of June, 06, and deactivated on July 1, 2006

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)

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Returning Paper Claims Received From Clearinghouses (MM5341)

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

MLN Matters Number: MM5341
Related CR Release Date: November 3, 2006
Related CR Transmittal #: R247OTN
Related Change Request (CR) #: 5341
Effective Date: January 1, 2007
Implementation Date: January 2, 2007

Provider Types Affected

All Medicare providers who submit paper claims to clearinghouses for filing with Medicare

Provider Impact

If a clearinghouse submits claims for you on paper (rather than electronically) your payments may be affected. The Administrative Simplification Compliance Act (ASCA) requires that claims a clearinghouse submits to Medicare on your behalf must be submitted electronically. When your carrier or fiscal intermediary (FI) identifies that a clearinghouse has submitted a claim for you on paper, they will return the claim unprocessed to the clearinghouse.

Background

Section 3 of the Administrative Simplification Compliance Act (ASCA), PL 107-105; the implementing regulation at 42 CFR 424; and the *Medicare Claims Processing Manual* Chapter 24, Section 90-90.6 and its exhibits all require (except in limited situations) that you submit claims to Medicare electronically. And, while ASCA regulations do allow you (as a provider) to submit some, or all, claims on paper in very specific and limited instances; HIPAA covered entities (other than providers) are not eligible for an exemption from these electronic Medicare claim submission requirements.

CR 5341, from which this article is taken, addresses claims that your clearinghouse submits to Medicare on your behalf. To be specific, if you contract with a clearinghouse to send claims to Medicare for you, they are required to submit these claims electronically.

But this being said, there is evidence that some clearinghouses are routinely submitting paper claims without the providers' knowledge. You should be aware that your carriers and FIs, having identified that a provider's clearinghouse has submitted your claims in paper form, will return them back to the clearinghouse without action.

Additional Information

The official instruction (CR5341) issued to your Medicare contractor (carriers, durable medical equipment regional carrier (DMERC), DME Medicare Administrative Contractor (DME MAC), fiscal intermediary (FI), or Part A/B Medicare Administrative Contractor (A/B MAC)) regarding paper claims that they receive from clearinghouses is located at **http://www.cms.hhs.gov/Transmittals/downloads/R247OTN.pdf** on the CMS website.

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

Revisions to Procedures to Establish Good Cause and Qualified Independent Contractor (QIC) Jurisdictions (MM5386)

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

MLN Matters Number: MM5386
Related CR Release Date: December 22, 2006
Related CR Transmittal #: R1136CP
Related Change Request (CR) #: 5386
Effective Date: January 1, 2007
Implementation Date: April 2, 2007

Provider Types Affected

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

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Revisions to Procedures to Establish Good Cause and Qualified Independent Contractor (QIC) Jurisdictions (MM5386) (Continued)

Background

The purpose of CR 5386 is to notify providers and suppliers of the restructured **Part B/DME QIC** jurisdictions. Under the new jurisdictions, three QICs will process reconsiderations as follows:

- Two QICs will process reconsiderations of carrier and A/B MAC re-determinations effective November 15, 2006 for contractors that process claims in the North jurisdiction and January 1, 2007 for contractors that process claims in the South jurisdiction. Your contractor will reference the appropriate QIC in the Medicare Redetermination Notice (MRN). In order to expedite your request for appeal, please make sure you follow the instructions on your MRN regarding where to submit your request for reconsideration. If you have already submitted a reconsideration request with the incumbent QIC, please do not submit a duplicate request.; and
- The third QIC will process all reconsiderations of DMERC and DME MAC re-determinations effective December 1, 2006.

Key Points

- Your contractor will reference the appropriate QIC with jurisdiction in the redetermination letter.
- One QIC will process all reconsiderations of DME claims.
- There are two QIC jurisdictions for Part B claims: a North jurisdiction and a South jurisdiction.
  - **The North** QIC jurisdiction includes the following states: Alaska, Arizona, Maine, Vermont, New Hampshire, Massachusetts, Rhode Island, District of Columbia, New York, Pennsylvania, New Jersey, Delaware, Maryland, Ohio, Kentucky, Indiana, Illinois, Michigan, Wisconsin, Minnesota, Missouri, Iowa, Washington, Oregon, Nevada, Idaho, Wyoming, Montana, California, Utah, Kansas, Nebraska, North Dakota, South Dakota, Hawaii, American Samoa, Guam, and the Northern Marianas Islands.
  - **The South** QIC jurisdiction is comprised of the following states: Colorado, Connecticut, New Mexico, Texas, Oklahoma, Arkansas, Louisiana, Mississippi, Tennessee, Alabama, Georgia, Florida, North Carolina, South Carolina, Virginia, West Virginia, Puerto Rico, and Virgin Islands.

Additional Information

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

For complete details regarding this Change Request (CR) please see the official instruction (CR5386) issued to your Medicare A/B MAC, FI, carrier, RHHI, DMERC or DME MAC. That instruction may be viewed by going to **http://www.cms.hhs.gov/Transmittals/downloads/R1136CP.pdf** on the CMS website.

For additional supporting information that details the general appeals process in initial determinations please see MLN Matters article MM4019 at: **http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4019.pdf** on the CMS website.

MLN Matters article MM3530, which can be found at: **http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3530.pdf** on the CMS website, provides a detailed explanation of the term *'vacate a dismissal'* as well as more background information about the second level of appeals process for Medicare Part A and Part B claims called 'reconsiderations.'

Rules of Behavior Governing Medicare Eligibility Inquiries (MM5431)

NEWS FLASH - 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

MLN Matters Number: MM5431
Related CR Release Date: January 8, 2007
Related CR Transmittal #: R1149CP
Related Change Request (CR) #: 5431
Effective Date: January 1, 2007
Implementation Date: April 2, 2007

Provider Types Affected

All providers and suppliers, including their third party billing agents or clearinghouses, who submit eligibility inquiries to Medicare

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Rules of Behavior Governing Medicare Eligibility Inquiries (MM5431) (Continued)

Provider Action Needed

Impact to You

The Centers for Medicare & Medicaid Services (CMS) is committed to maintaining the integrity and security of health care data in accordance with applicable laws and regulations. If you, or your biller, do not adhere to these rules of behavior and/or other CMS data privacy and security rules, you could incur revocation of access to the data as well as other penalties.

What You Need to Know

CR 5431, from which this article is taken, restates your responsibilities in obtaining, disseminating, and using beneficiary's Medicare eligibility data; and also delineates CMS' expectations for provider and clearinghouse use of the HIPAA 270/271 Extranet application.

What You Need to Do

Read the key points from CR 5431 in the Background section, below, and make sure that your staffs read the manual section (*Medicare Claims Processing Manual* (100-04), Chapter 31 (ANSI X12N Formats Other than Claims or Remittance), Section 10.3 (Eligibility Rules of Behavior), attached to CR5431. (See Additional Information, below, for instructions in locating CR5431.)

Background

Disclosure of Medicare beneficiary eligibility data is restricted under the provisions of the Privacy Act of 1974 and the Health Insurance Portability and Accountability Act of 1996 (HIPAA.)

CR 5431, upon which this article is based, restates your responsibilities in obtaining, disseminating, and using beneficiary's Medicare eligibility data; and outlines CMS' expectations for providers and clearinghouses who use the HIPAA 270/271 Extranet application.

In October 2005, CMS began offering to Medicare providers and clearinghouses, the HIPAA 270/271 beneficiary eligibility transaction, real-time, via the CMS AT&T communication Extranet; and in June 2006, began to pilot an internet application for eligibility information. Over time, this application will be available to an increasing number of Medicare providers.

Please keep in mind that the Medicare Electronic Data Interchange (EDI) Enrollment process (which collects the information needed to successfully exchange EDI transactions between Medicare and EDI trading partners, and establishes the data exchange expectations for both), must be executed by each provider that submits/receives EDI either directly to or from Medicare or through a third party (a billing agent or clearinghouse).

First, here are the key points, from the CR, that address your responsibilities in dealing with beneficiary eligibility data.

- The HIPAA Privacy Rule mandates the protection and privacy of all health information, and specifically defines the authorized uses and disclosures of "individually-identifiable" health information. CMS is committed to maintaining the integrity and security of health care data in accordance with the applicable laws and regulations.
- You should always remember that Medicare eligibility data is to be used for Medicare business only, and that providers and their staffs are expected to use, and disclose, this protected health information according to the CMS regulations.
- Authorized purposes for requesting beneficiary Medicare eligibility information include:
  - To verify eligibility, after screening the patient to determine Medicare Part A or Part B eligibility;
  - To determine beneficiary payment responsibility with regard to deductible/co-insurance;
  - To determine eligibility for services such as preventive services;
  - To determine if Medicare is the primary or secondary payer;
  - To determine if the beneficiary is in the original Medicare plan, Part C plan (Medicare Advantage) or Part D plan; and
  - To determine proper billing.

Conversely, examples of unauthorized purposes for requesting beneficiary Medicare eligibility information include:

- To determine eligibility for Medicare without screening the patient to determine if they are Medicare eligible; or
- To acquire the beneficiary's health insurance claim number.

In dealing with Medicare beneficiary eligibility information, you and your employees/staff must:

- Ensure sufficient security measures exist to associate a particular transaction with a particular staff member or employee before requesting the information;
- Cooperate with CMS or its agents in the event that CMS has a security concern with respect to any eligibility inquiry;
- Promptly inform CMS or one of CMS's contractors (e.g., your carrier, fiscal intermediary (FI), or Part A/B Medicare Administrative Contractor (A/B MAC)) if you identify misuse of "individually-identifiable" health information accessed from the CMS database; and
- Limit each inquiry for Medicare beneficiary eligibility data to that for a patient that you are currently treating/serving, or who has contacted you about treatment or service, or for whom you have received a referral from a health care provider that has treated or served that patient.

Rules of Behavior Governing Medicare Eligibility Inquiries (MM5431) (Continued)

Penalties

- HHS may impose civil money penalties on a HIPAA-covered entity of $100 per failure to comply with a Privacy Rule requirement (not to exceed $25,000 per year for multiple violations of the identical Privacy Rule requirement in a calendar year).
- Further, a person who knowingly obtains or discloses individually identifiable health information in violation of HIPAA or a trading partner agreement under 42 U.S.C 1320d-6 faces a fine of $50,000 and up to one-year imprisonment (increasing to $100,000 and up to five years imprisonment if the wrongful conduct involves false pretenses, and to $250,000 and up to ten years imprisonment if the wrongful conduct involves the intent to sell, transfer, or use individually identifiable health information for commercial advantage, personal gain, or malicious harm).
- Under the False Claims Act, anyone who knowingly submits, or causes another person or entity to submit, false claims for payment of government funds is liable for three times the government's damages plus civil penalties of $5,500 to $11,000 per false claim.

CR5431 also discusses CMS' expectations for providers and Clearinghouses who use the HIPAA 270/271 Extranet application. A synopsis of this discussion follows.

For Providers

In order to access and use this system, you will need to 1) Register, on line, in IACS (Individual Authorized Access to CMS Computer Services) and provide your social security number and e-mail address so that the system can identify you and communicate with you through email, if necessary; and 2) Adhere to basic desktop security measures and to the CMS computer systems security requirements in order to ensure the security of Medicare beneficiary personal health information.

You will also be required to adhere to the security requirements for users of CMS computer systems and to the basic desktop security measures to ensure the security of Medicare beneficiary personal health information. You must not:

- Disclose or lend your identification number and/or password to someone else. They are for your use only and serve as your electronic signature. This means that you may be held responsible for the consequences of unauthorized or illegal transactions.
- Browse or use CMS data files for unauthorized or illegal purposes.
- Use CMS data files for private gain or to misrepresent yourself or CMS.
- Make any disclosure of CMS data that is not specifically authorized.

As mentioned earlier, violation of these security requirements could result in termination of system access privileges and /or disciplinary/adverse action up to and including legal prosecution.

For Clearinghouses

CMS allows the release of eligibility data to third parties (providers' authorized billing agents or Clearinghouses) for the purpose of preparing an accurate Medicare claim or determining eligibility for specific services.

In order to receive such access on behalf of providers, billing agents/Clearinghouses must adhere to the following rules:

- Such entities may not submit an eligibility inquiry except as a health care provider's authorized, and through a business associate contract with the provider;
- Each provider that contracts with a billing agent/clearinghouse must sign a valid EDI Enrollment Form and be approved by a Medicare contractor before eligibility data can be sent to the third party;
- Each billing agent/clearinghouse must sign appropriate agreement(s) (i.e. Rules of Behavior, Trading Partner Agreement and Attestation Form) directly with CMS and/or one of CMS's contractors; and
- The billing agent/clearinghouse must be able to associate each inquiry with the provider or billing service making the inquiry.

Additional Information

You can find more information about the rules of behavior with respect to obtaining, disseminating, and using beneficiary's Medicare eligibility data by going to CR 5431, located at **http://www.cms.hhs.gov/Transmittals/downloads/R1149CP.pdf** on the CMS website; and reading the attached *Medicare Claims Processing Manual* (100-04), Chapter 31 (ANSI X12N Formats Other than Claims or Remittance), Section 10.3 (Eligibility Rules of Behavior).

If you have any questions, please contact your carrier, fiscal intermediary (FI), regional home health intermediary (RHHI), A/B MAC, Durable Medical Equipment Regional Carrier (DMERC) or DME MAC at their toll-free number, which may be found at **http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip.**

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Annual Medicare Contractor Provider Satisfaction Survey: Make Your Voice Heard! (SE0702)

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

MLN Matters Number: SE0702
Related CR Release Date: N/A
Related CR Transmittal #: N/A
Related Change Request (CR) #: N/A
Effective Date: N/A
Implementation Date: N/A

Provider Types Affected
All Medicare FFS providers, especially those receiving the 2007 Medicare Contractor Provider Satisfaction Survey.

Provider Action Needed
The Centers for Medicare & Medicaid Services (CMS) is publishing this Special Edition (SE) article to alert providers that in early January 2007 CMS will disseminate the 2007 Medicare Contractor Provider Satisfaction Survey (MCPSS) to a new sample of Medicare providers. If you receive the survey, CMS encourages you to respond because your input is NEEDED and will be used to support claims processing improvement by Medicare fee-for-service (FFS) contractors and to reform the Medicare Program.

Background
The 2007 MPCSS survey is designed so that it **can be completed in about 15 minutes** and providers can submit their responses via a secure Web site, mail, fax, or over the telephone. CMS will ask providers to respond by February 2007.

The views of each provider in the survey are important because they represent many other organizations similar in size, practice type and geographical location.

The MCPSS focuses on seven major aspects of the provider-contractor relationship:
- Provider communications
- Provider inquiries
- Claims processing
- Appeals
- Provider enrollment
- Medical review
- Provider audit and reimbursement.

Respondents are asked to rate their experience working with Medicare FFS contractors using a scale of 1 to 6, with “1” representing “not at all satisfied” and “6” representing “completely satisfied.”

Additional Information
More information about the MCPSS and results of the 2006 survey are available at **http://www.cms.hhs.gov/MCPSS/** on the CMS website.

CMS Announces New Qualified Independent Contract (QIC) (JSM07037)

Effective December 1, 2006, a request for reconsideration must be filed to the following QIC contractor:

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

For overnight deliveries
801 Pine Street
Chattanooga, TN 37402

The request must be made in writing on the form CMS 20033 (available at **http://www.cms.hhs.gov/CMSForms/**) or must contain the following items:
- The beneficiary’s name;
- Medicare health insurance claim number;
- The specific service(s) and item(s) for which the reconsideration is requested and the specific date(s) of service;
- The name and signature of the party or representative of the party; and
- The name of the contractor that made the redetermination.

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CMS Announces New Qualified Independent Contract (QIC) (JSM07037) (Continued)

Any additional documentation, new information or medical evidence that may assist the QIC in reevaluating the claim(s) should be attached to the written reconsideration request. If no additional information is submitted, a decision will be made based on the documentation contained in the DME MAC/DMERC redetermination case file.

Note: To aid in the processing of your request and to avoid significant delays, a copy of the redetermination letter should accompany your reconsideration request.

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

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

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

MLN Matters Number: MM5378
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

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 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

Capped Rental Maintenance and Service Clarification

The following instruction applies to capped rental periods that began prior to January 1, 2006, if the beneficiary chose the rental option. These instructions are not applicable to capped rental periods beginning on or after January 1, 2006, due to the recent capped rental guideline changes in which beneficiaries no longer have the option to continue on a rental basis for capped rental equipment. Please refer to MM5010 on page 54 of the September 2006 *DME MAC Jurisdiction A Resource* for further information on the recent capped rental changes.

On occasion, a supplier may be faced with situations when not all fifteen rental months have been paid either due to timely filing or that some rental months have been recouped due to a beneficiary stay in a skilled nursing facility. In these situations, NHIC cannot waive the remaining rental months to allow for maintenance and service billing. All fifteen rental months must be paid in order to bill and be paid for maintenance and service on capped rental equipment.

For these circumstances, suppliers should bill a later date of service that is not during the skilled nursing facility stay and is not past timely filing. If the claim denies upon initial submission for an expired CMN, the supplier should submit an appeal and request that the CMN be extended to cover the dates of service in question.

Once all fifteen months are paid, the supplier can then bill for maintenance and service six months from the last paid rental month.

External Infusion Pump DME MAC Information Form

Published in collaboration with AdminaStar Federal **(http://www.adminastar.com/)**

The “Length of Need” is not listed or required on the paper copy of the CMS-10125 External Infusion Pump DIF. However, the “Length of Need” is required on the HIPAA compliant electronic claim in Loop 2400, segment CR3, element 03. Electronic claims transmitted without the length of need on the CMS-10125 may cause the entire claim file to reject on the electronic front end.

All Electronic Submitters should enter “99” as the “length of need” in the electronic format on the DME MAC Information Form (DIF) CMS-10125.

The value “99” should be listed for all electronic claims including those transmitted by the ExpressPlus software.

Please contact the NHIC, Corp. EDI helpdesk at **866-563-0049** with any questions.

New Process for Certain Certificate of Medical Necessity (CMN) Rejections

There are several situations when suppliers are required by medical policy to submit a new initial CMN, even though the previous CMN was for a lifetime length of need. The most common reason is for a break in service of at least sixty days with a change in medical condition. Due to the current processing system edits, a CMN will typically reject upon submission when a previous lifetime initial CMN is already on file, causing the claim(s) to deny. In the past, these denials were sent to the first level of appeals to have the CMN added or corrected in the processing system.

Effective immediately, NHIC, Corp. has implemented a new process for these types of denials to be handled as a claim reopening. This type of reopening, however, must be sent as a written request for reopening and **cannot** be done as a telephone reopening. Suppliers must submit a copy of the CMN along with a copy of the remittance advice and complete the clerical error section of the Reopening Fax Cover Sheet **(http://www.medicarenhic.com/dme/dme_forms.shtml#Forms).** The request(s) should be faxed to 781-741-3914 or mailed to:

NHIC, Corp. DME MAC
Attn: Reopenings
P.O. Box 9170
Hingham, MA 02043-9170

All requests are processed in the order of receipt with an expected response time within 60 days.

Once the CMN is corrected in the system for a particular beneficiary, any additional claims that denied for a missing or expired CMN can be resubmitted.

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Oral AntiCancer Drug Billing Reminder

Suppliers are reminded that most oral anticancer drugs should be billed with the full 11-digit National Drug Code instead of a HCPCS code in the ANSI format. A list of valid NDC numbers for covered oral anticancer drugs can be found on the SADMERC web site at **http://www.palmettogba.com/sadmerc**. Per the Oral Anticancer Drug medical policy, until a new NDC number is added to this list, suppliers must submit claims using code J8999.

Note: NDCs may be billed only when the drug is used as an oral anticancer drug.

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.

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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: **www2.palmettogba.com/cgi-bin/mojo/mojo.cgi**

Jurisdiction A DME MAC and PSC Affiliate Web Sites

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

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

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

Quarterly Provider Update

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

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The Pulse of CMS

The Centers for Medicare & Medicaid Services (CMS) provided the Jurisdiction A Durable Medical Equipment Medicare Administrative Contractor (DME MAC) with a copy of the Winter 2006 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 .**

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

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For Your Notes

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For Your Notes

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Customer Service Telephone

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

Outreach & Education

781-741-3950

Claims Submissions

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

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

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

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

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

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

Written Inquiries

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

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

Written Inquiry FAX: 781-741-3530

Appeals

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

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

Administrative Law Judge (ALJ) Hearings:
HHS OMHA Mid-West Field Office
BP Tower, Suite 1300
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INFORMATION for DME MAC SUPPLIERS in CT, DE, DC, ME, MD, MA, NH, NJ, NY, PA, RI & VT

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