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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CMS CENTERS for MEDICARE & MEDICAID SERVICES

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

NHIC, Corp.

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

Additional Common Working File (CWF) Editing for Skilled Nursing Facility (SNF) Consolidated Billing (CB) (MM5624)

MLN Matters Number: MM5624 - Revised
Related CR Release Date: July 13, 2007
Related CR Transmittal #: R1289CP
Related Change Request (CR) #: 5624
Effective Date: April 1, 2001
Implementation Date: January 7, 2008

Note: This article was revised on July 17, 2007, to reflect a correction made to CR5624. The implementation date was changed to January 7, 2008. All other information remains the same.

Provider Types Affected
Physicians, providers, and suppliers who bill Medicare carriers, Medicare Administrative Contractors (A/B MAC), or Durable Medical Equipment Medicare Administrative Contractors (DME MAC) for services provided to Medicare beneficiaries in SNF stays.

What Providers Need to Know
Effective for dates of service on or after April 1, 2001, CR 5624, from which this article is taken, instructs Medicare carriers, A/B MACs, and DME MACs to bypass certain current SNF consolidated billing (CB) Part B and Part B/DMEMAC edits in order to enable the identification of periods when SNF CB edits should not be applied.

Background
CR 5624 instructs Medicare carriers, A/B MACs, and DME MACs (effective April 1, 2001) to bypass SNF CB Part B and Part B/DMEMAC edits when certain inpatient claims are present on Medicare's history.

These revisions will allow Medicare SNF CB editing to take into account periods of SNF stays that are non-covered by Medicare Part A when services should be payable outside of CB by the Medicare Part B contractor.

Note: CR 5624 does not change the policy for SNF CB. It adjusts Medicare's claims systems to be in line with current policy.

Medicare contractors (carrier, A/B MAC, or DME MAC) will re-open and re-process inappropriately denied claims for dates of service on or after April 1, 2001 through January 1, 2008 when you bring such claims to their attention. You should contact your Medicare contractor to have claims re-processed that you feel were erroneously subject to these consolidated billing edits, and denied. The change will be implemented on January 7, 2008 and claims will be processed correctly as of that date.

Additional Information
You can find the official instruction, CR5624, issued to your carrier, A/B MAC, or DME MAC on the CMS website at **http://www.cms.hhs.gov/Transmittals/downloads/R1289CP.pdf**. As an attachment to CR5624, you will find updated *Medicare Claims Processing Manual* (100-04), Chapter 6 (SNF Inpatient Part A Billing), Sections 110.2.2 (A/B Crossover Edits), 110.2.4 (Edit for Ambulance Services), and 110.2.5 (Edit for Clinical Social Workers (CSWs)).

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**.

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

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

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

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

This article was revised on May 8, 2007, to add this statement that Medicare FFS has announced a contingency plan regarding the May 23, 2007 implementation of the NPI. For some period after May 23, 2007, Medicare FFS will allow continued use of legacy numbers on transactions; accept transactions with only NPIs; and accept transactions with both legacy numbers and NPIs. For details of this contingency plan, see the *MLN Matters* article, MM5595, at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5595.pdf** on the CMS website.

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

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

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

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

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

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

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

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

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

Additional Information

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

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

Legacy identifiers are pre-NPI provider identifiers such as:

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

Additional NPI-Related Information

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

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

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

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

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

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

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

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

MLN Matters Number: SE0712 - Revised
Related CR Release Date: N/A
Related CR Transmittal #: N/A
Related Change Request (CR) #: N/A
Effective Date: N/A
Implementation Date: N/A

This article was revised on May 7, 2007, to add this statement that Medicare FFS has announced a contingency plan regarding the May 23, 2007 implementation of the NPI. For some period after May 23, 2007, Medicare FFS will allow continued use of legacy numbers on transactions; accept transactions with only NPIs; and accept transactions with both legacy numbers and NPIs. For details of this contingency plan, see the *MLN Matters* article, MM5595, at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5595.pdf on the CMS website.

Provider Types Affected

Physicians and providers billing Medicare carriers for services provided to Medicare beneficiaries

Provider Action Needed

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

Background

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

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

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

COMMON BILLING ERRORS

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

- The patient cannot be identified as a Medicare patient. Always use the Health Insurance Claim Number (HICN) and name as it appears on the patient's Medicare card.
- Item 32 (and the electronic claim equivalent) requires you to indicate the place where the service was rendered to the patient including the name and address -including a valid ZIP code- for all services unless rendered in the patient's home. Please be advised that any missing, incomplete, or invalid information recorded in this required field will result in the claim being returned or rejected in the system as unprocessable. Any claims received with the word "SAME" in Item 32 indicating that the information is the same as supplied in Item 33 are not acceptable. (**NOTE:** *References to an item number, such as item 32, refer to paper claim forms. However, note that the whenever an item number is used in this article, the related concept and information required also applies to equivalent fields on electronic claims*.)
- The referring/ordering physician's name and UPIN were not present on the claim. Please keep in mind this information is required in Item 17 and 17a on all diagnostic services, including consultations. In addition, be aware of the new requirements for use of National Provider Identifiers (NPIs). To learn more about NPIs and how to obtain your NPI, see the *MLN Matters* article SE0679 at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0679.pdf** on the CMS web site. Also, see the *MLN Matters* articles SE0555, SE0659, and MM4203 for important information regarding CMS' schedule for implementing the NPI. The articles are at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0555.pdf**, **http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0659.pdf**, and **http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4023.pdf**, respectively.
- Evaluation and management (E&M) procedure codes and the place of service do not match. An incorrect place of service is being submitted with the E&M procedure code. (Example: Procedure code 99283, which is an emergency room visit, is submitted with place of service 11, which is office).
- Please keep in mind, when billing services for more than one provider within your group, that you must put the individual provider number in Item 24k, as Item 33 can only accept one individual provider number. Also, please make sure the provider number on the claim is accurate and that it belongs to the group. (Also, remember that as of May 23, 2007, NPIs are to be used.)
- Diagnosis codes being used are either invalid or truncated. Diagnosis codes are considered invalid usually because an extra digit is being added to make it 5 digits. Please remember not all diagnosis codes are 5 digits. Please check your ICD-9-CM coding book for the correct diagnosis code.
- Procedure code/modifier was invalid on the date of service. Remember that, as of January 1, 2005, CMS no longer provides a 90-day grace period for billing discontinued CPT/HCPCS codes. (**Note:** *Please read the Medicare provider bulletins, especially at the end of each year, as Medicare list all the additions, deletions, and code changes for the following year*.)
- Claims are being submitted with deleted procedure codes. This information can also be found in the CPT Book. It is important to be using a current book.
- When Medicare is secondary, Item 11, 11a, 11b, and 11c must be completed.

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

BILLING TIPS

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

A. Provider Numbers

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

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

B. Health Insurance Claim (HIC) Numbers

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

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

"Railroad Retirees" - Railroad Retirement Board (RRB) HIC numbers generally have two alpha characters as a prefix to the number. These claims should be billed to the RRB carrier, at this address:

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

C. Name Accuracy

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

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

D. Complete Address

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

- A deliverable address may contain both a street name and number or a street name with a Post Officer (P.O.) Box number.
- A P.O. Box by itself is acceptable.
- A Rural Route (RR) number must be with a box number. Note: It is incorrect to key P.O. in front of the box number when given with a rural route.
- A star route number is not a deliverable address. Use highway contract route (HC) instead of star route.
- RD numbers are no longer valid. If there are rural routes still existing in your area, the correct number should be preceded by RR, then the box number.
- A box number or a RR number by itself is not deliverable.
- A street name without a number can not be delivered.
- Do not use % or any other symbol when denoting an "in care of" address. C/O is appropriate.
- As always, no commas, hyphens, periods, or other special characters should be used.

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

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

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

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

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

Changes to Provider Address - Please notify your carrier via a CMS-855 form of any address changes for your office practice.

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

Additional Information

Medicare Claims Processing Manual

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

MLN Matters

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

Listservs

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

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

July 2007 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing File, Effective July 1, 2007, and Revisions to January 2007 and April 2007 Quarterly ASP Medicare Part B Drug Pricing Files (MM5646)

MLN Matters Number: MM5646 - Revised
Related CR Release Date: June 15, 2007
Related CR Transmittal #: R1270CP
Related Change Request (CR) #: 5646
Effective Date: July 1, 2007
Implementation Date: July 2, 2007

Note: This article was revised on June 25, 2007, to delete references in the title and elsewhere to a revised October 2006 ASP file. All other information is the same.

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 5646 which informs Medicare providers of the availability of the July 2007 Average Sales Price (ASP) drug pricing file for Medicare Part B drugs as well as the revised January 2007 and April 2007 ASP files. Providers should make certain that your billing staffs are aware of these changes.

Background

The Medicare Modernization Act of 2003 (MMA; Section 303(c)) revised the payment methodology for Part B covered drugs that are not paid on a cost or prospective payment basis. Starting January 1, 2005, many of the drugs and biologicals not paid on a cost or prospective payment basis are paid based on the average sales price (ASP) methodology, and pricing for compounded drugs is performed by the local Medicare contractor. Additionally, beginning in 2006, all ESRD drugs furnished by both independent and hospital-based ESRD facilities, as well as specified covered outpatient drugs, and drugs and biologicals with pass-through status under the OPPS, will be paid based on the ASP methodology.

July 2007 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing File, Effective July 1, 2007, and Revisions to January 2007 and April 2007 Quarterly ASP Medicare Part B Drug Pricing Files (MM5646) (Continued)

The ASP methodology is based on quarterly data submitted to the Centers for Medicare & Medicaid Services (CMS) by manufacturers, and CMS supplies Medicare contractors (carriers, 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. CMS also posts these files to its website at **http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/**.

As announced in late 2006, after carefully examining Section 1847A of the Social Security Act, as added by the Medicare Modernization Act of 2003, CMS has been working further to ensure that more accurate and, as appropriate, separate payment is made for single source drugs and biologicals under Section 1847A. As part of this effort, CMS reviewed how the terms "single source drug," "multiple source drug," and "biological product" are operationalized in the context of payment under section 1847A. For the purposes of identifying "single source drugs" and "biological products" subject to payment under section 1847A, generally CMS (and its contractors) will utilize a multi-step process. CMS will consider:

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

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

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

ASP Methodology

Beginning January 1, 2005, the payment allowance limits for Medicare Part B drugs and biologicals that are not paid on a cost or prospective payment basis are 106 percent (106%) of the ASP. Beginning January 1, 2006, payment allowance limits are paid based on 106 percent (106%) of the ASP for the following:

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

Exceptions are summarized as follows:

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

July 2007 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing File, Effective July 1, 2007, and Revisions to January 2007 and April 2007 Quarterly ASP Medicare Part B Drug Pricing Files (MM5646) (Continued)

- The payment allowance limits for new drugs and biologicals that are produced or distributed under a new drug application (or other new application) approved by the Food and Drug Administration and that are not included in the ASP Medicare Part B Drug Pricing File or Not Otherwise Classified (NOC) Pricing File are based on 106 percent of the WAC, or invoice pricing if the WAC is not published, except under OPPS where the payment allowance limit is 95 percent of the published AWP. This policy applies only to new drugs that were first sold on or after January 1, 2005.
- The payment allowance limits for radiopharmaceuticals are not subject to ASP. Medicare contractors determine payment limits for radiopharmaceuticals based on the methodology in place in November 2003 in the case of radiopharmaceuticals furnished in other than the hospital outpatient department. Radiopharmaceuticals furnished in the hospital outpatient department are paid charges reduced to cost by the hospital's overall cost to charge ratio.

On or after June 19, 2007, revised January 2007 and April 2007 ASP payment files and the July 2007 ASP file will be available for retrieval from the CMS ASP webpage. The payment limits included in the revised ASP and NOC payment files supersede the payment limits for these codes in any publication published prior to this document. The CMS ASP webpage is located at **http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/** on the CMS website. 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
July 2007	July 1, 2007 through September 30, 2007
January 2007	January 1, 2007 through March 31, 2007
April 2007	April 1, 2007 through June 30, 2007

NOTE: The absence or presence of a 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.

Drugs Furnished During Filling or Refilling an Implantable Pump or Reservoir

Physicians (or a practitioner described in the Social Security Act (Section 1842(b) (18) (C); **http://www.ssa.gov/OP_Home/ssact/title18/1842.htm** may be paid for filling or refilling an implantable pump or reservoir when it is medically necessary for the physician (or other practitioner) to perform the service. Medicare contractors must find the use of the implantable pump or reservoir medically reasonable and necessary in order to allow payment for the professional service to fill or refill the implantable pump or reservoir and to allow payment for drugs furnished incident to the professional service.

If a physician (or other practitioner) is prescribing medication for a patient with an implantable pump, a nurse may refill the pump if the medication administered is accepted as a safe and effective treatment of the patient's illness or injury; there is a medical reason that the medication cannot be taken orally; and the skills of the nurse are needed to infuse the medication safely and effectively. Payment for drugs furnished incident to the filling or refilling of an implantable pump or reservoir is determined under the ASP methodology as described above. Note that pricing for compounded drugs is done by your local Medicare contractor.

Additional Information

The official instruction (CR5646) issued to your Medicare carrier, FI, A/B MAC, DME MAC, DMERC, or RHHI is available at **http://www.cms.hhs.gov/Transmittals/downloads/R1270CP.pdf** on the CMS web site.

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

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

July, 2007 Quarterly Update to the HCPCS Codes for Albuterol, Levalbuterol, and Reclast® (MM5645)

MLN Matters Number: MM5645
Related CR Release Date: June 1, 2007
Related CR Transmittal #: R1260CP

Related Change Request (CR) #: 5645
Effective Date: July 1, 2007
Implementation Date: July 2, 2007

Provider Types Affected
Physicians, providers, and suppliers who bill Medicare contractors (carriers, fiscal intermediaries (FI)(including Regional Home Health Intermediaries (RHHI)), Medicare Administrative Contractors (A/B MAC) and Durable Medical Equipment Medicare Administrative Contractors (DME MAC)) for providing Albuterol, Levalbuterol, Reclast®, and Zometa® to Medicare beneficiaries.

What Providers Need to Know
CR 5645, from which this article is taken, implements the July 2007 quarterly update to the HCPCS Codes for Albuterol, Levalbuterol, and Reclast®.

Effective for dates of service on or after July 1, 2007, the following HCPCS codes are no longer payable by Medicare: J7611, J7612, J7613, and J7614; and the following are payable by Medicare: Q4093, Q4094, and Q4095. Code J3487 continues in use for Zometa®.

You should make sure that your billing staffs are aware of these HCPCS code changes.

Background
CR 5645, from which this article is taken, implements the July, 2007 quarterly update to the HCPCS Codes for Albuterol, Levalbuterol, and Reclast®.

Effective July 1, 2007, the Health Care Procedure Code System (HCPCS) codes in **table 1** will no longer be payable for Medicare.

Table 1
HCPCS Codes Not Payable for Dates of Service on or after July 1, 2007

HCPCS Code	Short Description	Long Description
J7611	Albuterol non-comp con	Albuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, concentrated form, 1 mg
J7612	Levalbuterol non-comp con	Levalbuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, concentrated form, 0.5 mg
J7613	Albuterol non-comp unit	Albuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose, 1 mg
J7614	Levalbuterol non-comp unit	Levalbuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose, 0.5 mg

In place of the Table 1 codes, the HCPCS codes displayed in **Table 2** will be payable, effective July 1, 2007.

Table 2
HCPCS Codes Payable for Services on or After July 1, 2007

HCPCS Code	Short Description	Long Description
Q4093	Albuterol inh non-comp con	Albuterol, all formulations including separated isomers, inhalation solution, FDA-approved final product, non-compounded, administered through DME, concentrated form, per 1 mg (Albuterol) or per 0.5 mg (Levalbuterol)
Q4094	Albuterol inh non-comp u d	Albuterol, all formulations including separated isomers, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose, per 1 mg (Albuterol) or per 0.5 mg (Levalbuterol)

In addition, a new code, Q4095 (in **Table 3**) will be effective July 1, 2007, for Reclast®.

Table 3
HCPCS Q4095 Payable for Services on or after July 1, 2007

HCPCS Code	Short Description	Long Description
Q4095	Reclast injection	Injection, zoledronic acid (Reclast), 1 mg

July, 2007 Quarterly Update to the HCPCS Codes for Albuterol, Levalbuterol, and Reclast® (MM5645) (Continued)

Also, please note the following:

- Currently, Reclast® 5 mg/100 ml bottle (NDC 0078-0435-61) is the only product that should be billed using code Q4095. If other products under the FDA's approval for Reclast® become available, code Q4095 would be used to bill for such products.
- HCPCS code J3487 (short description: Zoledronic acid; long description: Injection, zoledronic acid, 1 mg) is used to bill for products under the FDA's approval for Zometa® or such therapeutically equivalent products that may become available as identified in the FDA's Orange Book.
- Payment limits for the new Q codes will be included in the July 2007 quarterly Average Sales Price payment file, when those files are posted at **http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/01a_2007aspfiles.asp#TopOfPage**.
- Payment information for the new Q codes under the Hospital Outpatient Prospective Payment System (OPPS) can be found in the July 2007 update of OPPS Addendum A and Addendum B when those addendums are added to the hospital outpatient website at: **http://www.cms.hhs.gov/HospitalOutpatientPPS/AU/list.asp#TopOfPage**/.

Additional Information

You can find the official instruction, CR 5645, issued to your carrier, FI (including RHHI), A/B MAC or DME MAC by visiting **http://www.cms.hhs.gov/Transmittals/downloads/R1260CP.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**.

July Quarterly Update for 2007 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule (MM5641)

MLN Matters Number: MM5641 - Revised
Related CR Release Date: June 8, 2007

Related CR Transmittal #: R1263CP

Related Change Request (CR) #: 5641
Effective Date: January 1, 2007 for implementation of fee schedule amounts for codes in effect on January 1, 2007; July 1, 2007 for all other changes
Implementation Date: July 2, 2007

Note: This article was revised on June 19, 2007, to clarify that the modifier that should not be used with HCPCS codes E0691, E0692, E0693, and E0694 for dates of service on or after January 1, 2005, is the KF modifier. All other information remains the same.

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 5641, which provides the July 2007quarterly update to the DMEPOS fee schedules in order to implement fee schedule amounts for new codes and to revise any fee schedule amounts for existing codes that were calculated in error or that may no longer be paid under the fee schedule. Be sure billing staff are aware of these changes.

Background

The quarterly updates process for the DMEPOS fee schedule is located in the *Medicare Claims Processing Manual* (Publication 100-04), Chapter 23, Section 60; **http://www.cms.hhs.gov/manuals/downloads/clm104c23.pdf** on the CMS website.

CR 5641 provides specific instructions regarding the July quarterly update for the 2007 DMEPOS fee schedule. Payment on a fee schedule basis is required for durable medical equipment (DME), prosthetic devices, orthotics, prosthetics, and surgical dressings by the Social Security Act (Sections 1834(a), (h), and (i)). Payment on a fee schedule basis is required for parenteral and enteral nutrition (PEN) by regulations contained in Title 42 of the Code of Federal Regulations (42 CFR 414.102).

July Quarterly Update for 2007 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule (MM5641) (Continued)

Key Points

The following are key changes in the July 2007 quarterly update of the DMEPOS fee schedule including the Healthcare Common Procedure Coding System (HCPCS) codes:

- **HCPCS code E0762** (Transcutaneous electrical joint stimulation device system, includes all accessories) is:
  - **Added** to the fee schedule on **July 1, 2007, and**
  - **Effective** for claims submitted with dates of service on or after **January 1, 2007**.
- HCPCS codes added July 1, 2007 with dates of service on or after July 1, 2007 are:
  - **K0553** Combination Oral/Nasal Mask, Used With Continuous Positive Airway Pressure Device, Each
  - **K0554** Oral Cushion For Combination Oral/Nasal Mask, Replacement Only, Each
  - **K0555** Nasal Pillows For Combination Oral/Nasal Mask, Replacement Only, Pair
- Suppliers must use the **"KL" modifier** on claims for all diabetic supplies that are **delivered via mail** with dates of service on or after **July 1, 2007**, with the following codes: A4233, A4234, A4235, A4236, A4253, A4256, A4258 and A4259. The KL modifier must be used with diabetic supplies that are ordered remotely (i.e., by phone, email, internet, or mail) and delivered to the beneficiary's residence by common carriers (e.g., U.S. postal service, Federal Express, United Parcel Service) and not with items obtained by beneficiaries from local supplier storefronts.
- Fee schedule amounts for HCPCS code E2374 (Power Wheelchair Accessory, Hand or Chin Control Interface, Standard Remote Joystick (Not Including Controller), Proportional, Including all Related Electronics and Fixed Mounting Hardware, Replacement Only) are being revised to correct errors in the fee schedule calculation. Medicare contractors will adjust previously processed claims with dates of service on or after January 1, 2007, if resubmitted as adjustments.
- If suppliers re-submit previously processed claims for code K0864 in Puerto Rico with dates of service from November 15, 2006 through March 31, 2007, the DME MACs and DMERCs will adjust the claims for payment.

Also, after consulting with the Food and Drug Administration, the Centers for Medicare & Medicaid Services (CMS) determined that **ultraviolet light therapy** systems are classified as **class II devices** and are not class III devices. Thus, suppliers **should not submit the class III "KF" modifier with claims for HCPCS codes E0691, E0692, E0693 and E0694 with dates of service on or after January 1, 2005.** CMS is removing HCPCS codes E0691, E0692, E0693, and E0694, billed with the KF modifier, from the fee schedule, effective July 1, 2007 and as of that date, Medicare contractors will reject claims for HCPCS codes E0691, E0692, E0693, and E0694, which contain the KF modifier and a date of service on or after January 1, 2005. Medicare contractors will adjust previously processed claims for E0691, E0692, E0693 and E0694 with dates of service on or after January 1, 2007, if suppliers resubmit the claims as adjustments.

The HCPCS Quarterly Update public use file, containing the long and short descriptors for all new codes, is available for downloading at **http://www.cms.hhs.gov/HCPCSReleaseCodeSets/02_HCPCS_Quarterly_Update.asp**.

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 (CR5641) issued to your Medicare A/B MAC, FI, DMERC, DME MAC, RHHI or carrier. That instruction may be viewed by going to **http://www.cms.hhs.gov/Transmittals/downloads/R1263CP.pdf** on the CMS website.

Please be sure that you have the most updated version of the IVR Guide and IVR Call Flow in your office, both can be found at

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

New Deadline for Required Submission of the Form CMS-1500 (08-05) (MM5616)

MLN Matters Number: MM5616
Related CR Release Date: May 25, 2007
Related CR Transmittal #: R1247CP
Related Change Request (CR) #: 5616
Effective Date: July 1, 2007
Implementation Date: July 2, 2007

Provider Types Affected
Physicians and suppliers who qualify for an exemption from the mandatory electronic claims submission requirements, and who submit Medicare claims to carriers, Medicare Administrative Contractors (MACs), and durable Medical Equipment Medicare Administrative Contractors (DME MACs) using the paper claim Form CMS-1500.

Provider Action Needed
CR 5616, from which this article is taken announces that, beginning July 2, 2007, you must use the Form CMS-1500, version (08-05) for paper claims submission to Medicare. Claims received on or after July 2, 2007 using Form CMS-1500, version (12-90) will be rejected.

Make sure that your billing staffs use Form CMS-1500 (08-05) for your claims, beginning July 2, 2007.

Background
The Form CMS-1500 is the paper claim form that physicians and suppliers, who qualify for an exemption from the mandatory electronic claims submission requirements (as set forth in the Administrative Simplification Compliance Act, Public Law 107-105 (ASCA) and the implementing regulation at 42 CFR 424.32), use to submit claims.

CR 5568, released March 19, 2007, instructed Medicare contractors to continue to accept the earlier (12-90) version of Form CMS-1500 (tentatively until June 1, 2007), because of reports that some vendors had printed the newer (08-05) version of the form incorrectly. After analysis, however, the problem does not appear to be as widespread as previously suspected.

Therefore, CR 5616, from which this article is taken, announces, based on the information at hand, that beginning July 2, 2007, you will need to submit claims using the Form CMS-1500 (08-05).

Note: CR5616 addresses submission of the revised Form CMS-1500 paper claim form only, and has no bearing on the implementation of the National Provider Identifier (NPI), nor does CR5616 mandate the submission of the NPI by July 1, 2007.

Additional Information
You can find more information about the official instruction issued to your Medicare contractor on this issue (CR5616) at **http://www.cms.hhs.gov/Transmittals/downloads/R1247CP.pdf** on the CMS website.

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

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

MLN Matters Number: MM5571 - Revised
Related CR Release Date: April 13, 2007
Related CR Transmittal #: R198PI
Related Change Request (CR) #: 5571
Effective Date: October 1, 2006
Implementation Date: July 2, 2007

Note: This article was revised on May 8, 2007, to show that the effective dates refer to the dates the claims/forms are processed, as opposed to date of service. All other information remains the same.

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

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

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

What You Need to Know

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

What You Need to Do

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

Background

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

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

Recap of MM4296 Information

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

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

Claims Accepted During Transition Period

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

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

Newly Revised CMNs Accepted During Transition Period

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

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

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

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

New DIFs Accepted During Transition Period

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

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

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

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

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

CMNs Eliminated

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

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

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

Additional Information

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

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

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

Quarterly Update to Medically Unlikely Edits (MUEs), Version 1.2, Effective July 1, 2007 (MM5603)

MLN Matters Number: MM5603 - Revised
Related CR Release Date: June 12, 2007
Related CR Transmittal #: R1265CP
Related Change Request (CR) #: 5603
Effective Date: July 1, 2007
Implementation Date: July 2, 2007

Note: This article was revised on June 12, 2007, to reflect the changes made to CR5603 on that date. The CR release date, transmittal number and Web address for accessing CR5603 were changed. All other information remains the same.

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

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. Key points of CR5603 are as follows:

- CR5603 announces the upcoming release of the next version of the MUEs, which is version 1.2.
- 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.
- CR5603 states that Medicare carriers and A/B MACs will deny the entire claim line from providers with units of service that exceed MUE criteria and pay the other services on the claims, where the claims are processed by either Medicare's DME system (VMS) or carriers system (MCS).
- FIs and A/B MACs will RTP claims from institutional providers with units of service that exceed MUE criteria and which are processed by Medicare's fiscal intermediary shared system (FISS).

With regard to MUEs, providers are reminded of the following:

- An appeal process will not be allowed for RTP'ed claims as a result of an MUE. Instead, providers should determine why the claim was returned, correct the error, and resubmit the corrected claim.
- Providers may appeal MUE criteria by forwarding a request the carrier or A/B MAC who, if they agree, will forward the appeal to the National Correct Coding Contractor.
- Excess **charges due to units of service greater than the MUE may not be billed to the beneficiary (this is a "provider liability"),** and this provision can neither be waived nor subject to an Advanced Beneficiary Notice (ABN).

Additional Information
To see the official instruction (CR5603) issued to your Medicare carrier, FI, A/B MAC, DME MAC, DMERC, or RHHI. That instruction may be viewed by going to **http://www.cms.hhs.gov/Transmittals/downloads/R1265CP.pdf** on the CMS website.

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

Reimbursement for Vaccines and Vaccine Administration Under Medicare Part D (SE0727)

MLN Matters Number: SE0727
Related CR Release Date: N/A
Related CR Transmittal #: N/A
Related Change Request (CR) #: N/A
Effective Date: N/A
Implementation Date: N/A

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

Provider Action Needed
This Special Edition *MLN Matters* article describes the Centers for Medicare & Medicaid Services (CMS) policy regarding provider reimbursement for Part D vaccines and vaccine administration in 2007 and 2008 under the Medicare Prescription Drug Benefit (Part D). In addition, the article outlines various approaches that Part D plans may implement to ensure beneficiaries have adequate access to Part D vaccines.

Reimbursement for Vaccines and Vaccine Administration Under Medicare Part D (SE0727) (Continued)

Background
With the advent of the Medicare Part D program, there is now broader reimbursement available to providers for vaccines administered to Medicare beneficiaries. Some vaccines are covered under Medicare Part B and others under Part D. The Part B program covers most of the vaccines indicated for the Medicare population, with the immunizer administering the vaccine and billing the Part B contractor (Medicare carrier or Part A/B Medicare Administrative Contractor or A/B MAC) for both the vaccine and its associated administration. The Part D program generally covers those vaccines not available under Part B; however, unlike Part B, the immunizer may or may not be able to directly bill the Part D Sponsor for the vaccine and its administration, but instead may need to work with the beneficiary and his/her Part D plan to facilitate reimbursement. The first step is for the provider to understand which vaccines are available under the two different programs so he/she can assist the beneficiary in obtaining the vaccines needed to maintain and improve his/her health.

Coverage of Vaccines Under the Part B Program

- Medicare Part B currently covers the following immunizations:
- Pneumococcal pneumonia vaccine;
- Influenza virus vaccine;
- Hepatitis B vaccine for individuals at high or intermediate risk; and
- Other vaccines (e.g. tetanus toxoid) when directly related to the treatment of an injury or direct exposure to a disease or condition.

If a vaccine is covered under Part B, it will continue to be covered under Part B regardless of the changes to Part D vaccine administration reimbursement in 2007 and 2008 discussed later in this article.

Coverage of Vaccines under the Part D Program
The Part D program will generally cover those vaccines not available for reimbursement under Medicare Parts A or B when administration is reasonable and necessary for the prevention of illness.

Part D plans identify covered drugs and vaccines through the use of formularies. However, a new preventative vaccine may not be specifically listed on the Part D plan's formulary. This does not mean the vaccine is not available for reimbursement. The provider can contact the Part D plan about coverage and any supporting information that might be necessary to facilitate vaccine coverage for the beneficiary (Part D plan contact information is located at the end of this article).

To facilitate greater access to Part D vaccines, CMS has directed that starting in 2008 all Part D plans' formularies must contain all commercially available vaccines (unless excluded due to available reimbursement under Part B, e.g., influenza or pneumococcal vaccines as discussed above).

Example of identifying vaccines covered under Part B or Part D
Hepatitis B vaccine provides a useful illustration of how a provider could approach vaccine reimbursement under Medicare Part B or D. **Part B covers Hepatitis B vaccine for intermediate and high risk patients.** A beneficiary meeting the intermediate or high risk coverage criteria could obtain the Hepatitis B vaccination series from their physician and the physician would submit a claim to the Medicare Part B contractor. For the beneficiary who did not satisfy the appropriate Part B risk criteria, he or she could still obtain the Hepatitis B vaccine from their physician; however, any potential reimbursement would be available from the beneficiary's Part D plan instead of the Part B contractor. Facilitation of Part D vaccine reimbursement is discussed later in this article.

Coverage of Vaccine Administration Under the Part B Program
The Tax Relief and Health Care Act (TRHCA), effective January 1, 2007, provided for reimbursement of vaccine administration associated with Part D vaccines. Pharmacies and physicians can use a newly instituted G code (G0377) to bill Part D vaccine administration to local Medicare Part B contractors. Normal Part B beneficiary deductible and coinsurance requirements apply and **reimbursement for this code is only effective for calendar year 2007.**

Payment for the actual Part D covered vaccine is the responsibility of the beneficiary's Part D plan. In other words, in 2007 Medicare Part B will not pay for the Part D vaccine (i.e. low risk Hepatitis B vaccine), just the Part D vaccine administration.

For additional information on Part B reimbursement of Part D vaccine administration in 2007 see the *MLN Matters* articles MM5443 and MM5459, published in December, 2006:

- MM5443 is available at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5443.pdf** and
- MM5459 is available at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5459.pdf.**

Reimbursement for Vaccines and Vaccine Administration Under Medicare Part D (SE0727) (Continued)

Coverage of Vaccine Administration Under the Part D Program

TRHCA modified the definition of a Part D drug to include "for [Part D] vaccines administered on or after January 1, 2008, **its administration**." Consequently, beginning on January 1, 2008, the Part D program will cover vaccine administration costs associated with Part D vaccines. **Thus, the coverage available in 2007 under Part B will cease and reimbursement will be available solely under Part D.** CMS interprets this new statutory requirement to mean that the Part D vaccine administration costs are a component of the negotiated price for a Part D-covered vaccine. In other words, the negotiated price for a Part D vaccine will be comprised of the vaccine ingredient cost, a dispensing fee (if applicable), sales tax (if applicable) and a vaccine administration fee. This interpretation recognizes the intrinsic linkage that exists between the vaccine and its corresponding administration, since a beneficiary would never purchase a vaccine without the expectation that it would be administered.

In general, CMS believes that Part D vaccines, including the associated administration costs, should be billed on one claim for both in- and out-of-network situations. For example, if an in-network pharmacy dispenses and administers the vaccine in accordance with State law, the pharmacy would process a single claim to the Part D sponsor and collect from the enrollee any applicable cost-sharing on the vaccine and its administration. Alternatively, if a vaccine is administered out-of-network in a physician's office, the physician would administer the vaccine and then bill the beneficiary for the entire charge, including both components. The beneficiary would, in turn, submit a paper claim to the Part D sponsor for reimbursement of plan allowable costs for both the vaccine cost and the administration fee.

Cost-Sharing Considerations

In general, a Part D plan should not charge separate copays for the vaccine and its administration since CMS views the vaccine and its administration as intrinsically linked. If a Part D plan charges coinsurance, it should be applied relative to the entire price of both components. Low income subsidy eligible individuals with copays set by statue (see section 1860D-14(a)(1)(D) of the Social Security Act) will always pay only one copay for a vaccine and all related charges. Thus, for example, a low income subsidy eligible individual entitled to $1.05/$3.10 copays in 2008 would pay only $3.10 for both the vaccine and its administration (and any applicable dispensing fee) even if the components are billed separately.

Elements of Vaccine Administration

CMS expects that Part D plans will take into consideration the elements reflected in existing 2007 Part B vaccine administration fees when establishing their own vaccine administration fees for 2008. Part D plans will have the discretion to implement either a single vaccine administration fee for all vaccines or multiple administration fees based on type of vaccine, variance in provider type, and product administration complexity. Providers should contact Part D plans regarding specific vaccine administration fees for 2008. (Part D plan contact information is listed at the end of this article.)

Part D Reimbursement for Vaccines in Provider Settings

As stated earlier, Part D plans are required to provide access to vaccines not covered under Parts A or B. During initial Part D rulemaking, CMS described use of standard out-of-network requirements to ensure adequate access to the small number of vaccines covered under Part D that are administered in a physician's office. CMS' approach was based on the fact that most vaccines of interest for the Medicare Population (influenza, pneumococcal, and hepatitis B for intermediate and high risk patients) were covered and remain covered under Part B. For those that are not covered under Part B, the beneficiary would pay the physician and then submit a paper claim to his or her Part D plan for reimbursement up to the plan's allowable charge. In the absence of communication with the plan prior to vaccine administration, the amount the physician charges may be different from the plan's allowable charge, and a differential may remain that the beneficiary will be responsible for paying.

As newer vaccines have entered the market with indications for use in the Medicare population, Part D vaccine in-network access has become more imperative. Requiring the beneficiary to pay the physician's full charge for a vaccine out of pocket first and be reimbursed by the plan later is not an optimal solution, and CMS has urged Part D plans to implement cost-effective, real-time billing options at the time of administration. CMS issued guidance to Part D plans to investigate alternative approaches to improve access to vaccines under the Drug Benefit without requiring up-front beneficiary payment and to ensure adequate access to Part D vaccines.

CMS outlined the following options to Part D plans for their consideration. Physicians should expect to see various models develop and should be aware of both their potential existence and use by Medicare beneficiaries.

Reimbursement for Vaccines and Vaccine Administration Under Medicare Part D (SE0727) (Continued)

Options to Ensure Adequate Access under Part D to Covered Vaccines

In-Network Distribution Approaches

- **In-Network Access to Retail Pharmacies:** Enrollees could obtain a prescription from the physician and bring it to their local network retail pharmacy for filling. In some states, it will already be possible for the vaccine to be administered by the pharmacist. Forty-six states currently allow pharmacists to provide some type of vaccinations. When it is safe to dispense and administer these vaccines in the pharmacy, plans will be exploring utilization of their network pharmacists as a provider of adult Medicare Part D vaccines.
- **In-Network Pharmacy Distribution:** A Part D plan's local pharmacy or specialty pharmacy could provide vaccines directly to physician offices. Under this scenario, the physician could call in a prescription, or the beneficiary could deliver or mail a prescription for the vaccine to the pharmacy. The pharmacy would fill the prescription for the vaccine, ship or deliver to the physician's office, and bill the Part D plan for the vaccine. (This model resembles the competitive acquisition program (CAP) for Medicare Part B drugs in that the drug is shipped to the physician, but the physician never purchases or gets reimbursed for the drug.)

Out-of-Network Approaches: Facilitated Out-of-Network Access Approaches

- **Web-Assisted Out-of-Network Billing:** Under this approach, physicians would electronically submit beneficiary out-of-network claims to Part D plans for vaccines dispensed and administered in the physician's office through a web-assisted portal (vendor). This approach would allow the beneficiary to pay out of pocket only the appropriate deductible and copay or cost sharing directly to the physician, thus avoiding any up-front payment and repayment for the full cost of the vaccine. The physician would assume responsibility for submitting the claim on behalf of the beneficiary and would agree to accept Part D plan payment as payment in full.
- **Model Vaccine Notice for Physicians (Paper Claim Enhancement):** Part D plans would provide all enrollees with a vaccine-specific notice that the enrollees could bring to their physicians. This notice would provide information necessary for a physician to contact the enrollee's Part D plan to receive authorization of coverage for a particular vaccine, reimbursement rates, enrollee cost-sharing to be collected by the physician, and instructions on how to submit the out-of-network claim on the beneficiary's behalf.

It is important to emphasize for either out-of-network approach, the physician does not become a network provider, but is assisting the beneficiary in the submission of his or her out-of-network claim.

CMS is working with Part D Sponsors to facilitate these various approaches. CMS encourages additional exploration of other possible means to coordinate the billing of vaccines in the real-time environment of the Part D benefit. CMS expects significant development in this area over the next year.

Frequently Asked Questions

If I need to immunize a beneficiary with a Part D vaccine, what do I need to do?

The beneficiary or physician can call the Part D Plan to discuss what the cost sharing and allowable charges would be for the vaccine as part of the Part D plan's out-of-network access or inquire as to the availability of any alternative vaccine access options. Plan contact information is available at the following website: **http://www.medicare.gov/MPDPF/Public/Include/DataSection/Questions/MPDPFIntro.asp** and then follow the directions on the section Learn More About Plans in Your Area. You may also obtain plan contact information by calling 1-800-MEDICARE.

Do I need to provide Advanced Beneficiary Notice (ABN)?

No. Unlike traditional Medicare, Part D does not require ABNs.

Can I charge an administration fee?

Yes. Administration fees for vaccines could be handled in the following manner:

- Before January 1, 2008: When a physician administers a Part D vaccine, the physician should use HCPCS code G0377 (linked to CPT code 90471) to bill the Part B local carrier for the administration fee of the vaccine.
- January 1, 2008 and after: Part D vaccines, including the associated administration costs could be billed on one claim to the beneficiary or to the Part D plan, as stated in the preceding examples.

Is the Herpes zoster vaccine (Trade name Zostavax) covered under Medicare Part B or D?

Since the Herpes zoster vaccine is a preventive vaccine, it will be available for reimbursement under Part D. Beneficiaries and providers should contact the Part D plans for more information about costs and reimbursement for this and other preventive vaccines.

Additional Information

More information about Part D for physicians' is available on the CMS prescription drug webpage for physicians, which is at **http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/04_Formulary.asp#TopOfPage**

Fee Schedule Updates

The 2006 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:

- July Updates to the 2007 Jurisdiction A DME MAC Fee Schedule
- July 2007 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing File
- 3rd Quarter 2007 Update: Oral Anticancer Drug Fees

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

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

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)

Medicare Remit Easy Print (MREP) - Version 2.2 is Now Available for Download! (CMS Message 2007-07-13)

Medicare Fee-for-Service Professional Providers and Suppliers:
You can access the latest version of MREP at
http://www.cms.hhs.gov/AccesstoDataApplication/02_MedicareRemitEasyPrint.asp on the CMS website.

What's New
National Provider Identifier (NPI) Changes

- Updates have been made to the MREP software to allow for the Stage 3 NPI changes that impact the 835v4010A1 transactions. The remittance advices that are generated (preview and print) from the Entire Remittance option and Claim Detail tab are being updated to accommodate the changes.
- The NPI value is being removed the from the drop-down box on the Search tab. The Rendering Provider Number can be used to search for claim information whether the "rendering provider number" is a legacy number or an NPI value.

Enhancements

- Updates have been made to the Search Tab within the MREP software to allow a user to search claim information for a National Drug Code (NDC).
- The heading "Procedure Code" is being changed to "Product/Service ID" on the Search Tab and Search Result Listing print/preview to accommodate those claim lines that have a National Drug Code (NDC).
- The heading "Proc/Mod" is being changed to "Prod/Serv ID" on the various claim line level reports to accommodate those claim lines that have an National Drug Code (NDC). The reports that are affected are Adjusted Service Lines, Deductible Lines, Coinsurance Lines, Deductible/Coinsurance Lines, and Denied Service Lines.

Remember, you can save time and money by taking advantage of **FREE** MREP software available to view and print the Health Insurance Portability and Accountability Act (HIPAA) compliant 835!

Note: *Since changes were made to the MREP software, the updated Claim Adjustment Reason Codes and Remittance Advice Remark Codes file is included with version 2.2 of the MREP software. However, the separate codes.ini file is provided when the MREP software is distributed.*

New Healthcare Provider Taxonomy Code List Effective April 2007

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

Although updates may be posted on the WPC Web page three months prior to the effective date, changes are not effective until April 1, 2007. In addition, newly approved codes are not approved for use prior to the effective date and terminated codes may not be used after the specific date. To avoid delays in the processing of your claims, please ensure you are using only the latest HPTC set list.

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

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

Appeals Transition - BIPA Section 521 Appeals (MM5460)

MLN Matters Number: MM5460
Related CR Release Date: June 29, 2007
Related CR Transmittal #: R1274CP
Related Change Request (CR) #: 5460
Effective Date: July 1, 2007
Implementation Date: October 1, 2007

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

Provider Action Needed
This article is based on Change Request (CR) 5460, which notifies Medicare contractors about their need to comply with changes to provisions in Chapter 29 of the *Medicare Claims Processing Manual* (Publication 100-04) that address the appointment of representatives, fraud and abuse, guidelines for writing appeals correspondence, and the disclosure of information.

Background
The Medicare claims appeals process was amended by the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (BIPA) and the Medicare Prescription Drug Improvement and Modernization Act (MMA). The Social Security Act (Section 1869(c)), as amended by BIPA and MMA, requires changes to the Code of Federal Regulations (CFR; Title 42) regarding:

- Appointment of representatives,
- Fraud and abuse,
- Guidelines for writing appeals correspondence, and
- The disclosure of information.

Therefore, the Centers for Medicare & Medicaid Services (CMS) is revising provisions in Chapter 29 of the *Medicare Claims Processing Manual* that address these changes.

The purpose of CR5460 is to notify Medicare contractors about their need to comply with these revised *Medicare Claims Processing Manual* provisions, which are included as an attachment to CR5460.

Some of the key changes to the manual direct Medicare contractors to:

- Follow the procedures that define who may be a representative and how a representative is appointed (via the CMS-1696 Appointment of Representative (AOR) form);
  - Do not accept an appointment if the contractor has evidence that the appointment should not be honored;
  - Send notice only to the representative when the contractor takes action or issues a redetermination [if there is an appointed representative];
  - Provide assistance in completing the CMS-1696 form, as needed; and
  - Do not release beneficiary-specific information to a representative before the beneficiary or appellant and the prospective representative have completed and signed the CMS-1696 or other conforming written instrument.

Please note that the **AOR** applies to all services, claims and appeals submitted on behalf of the beneficiary for the duration of the AOR.

- Follow the procedures that describe the process a beneficiary must use to assign their appeal rights to a provider (via the CMS-20031) Transfer of Appeal Rights form):
  - For each new appeal request, a form needs to be submitted, this form is valid for all levels of the appeal process including judicial review, even in the event of the death of the beneficiary;
  - If a provider furnishes the service, he/she would be a party to the initial determinations, only providers or suppliers who are not a party may accept assignment of appeal rights from a beneficiary. That is assignment of appeal rights applies only to providers and suppliers who are never a party to an appeal because they do not participate in Medicare and have not taken the claim on assignment; and
  - The provider or supplier who accepts the appeal rights to collect payment from the beneficiary for the item or service that is the subject of the appeal. The provider or supplier may collect any applicable deductible or coinsurance. The provider or supplier agrees to this waiver by completing and signing Section II of the Transfer of Appeal Rights form.
- Provide redetermination letters that are understandable to beneficiaries.

Please note that an **Assignment of Appeal Rights** is valid for the duration of an appeal unless it is revoked by the beneficiary.

Additional Information
The official instruction, CR5460, issued to your Medicare contractor regarding this change may be viewed at **http://www.cms.hhs.gov/Transmittals/downloads/R1274CP.pdf** on the CMS website. The revised portions of the *Medicare Claims Processing Manual* are attached to that CR.

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

Department of Health and Human Services (HHS) Fights Durable Medical Equipment Fraud (CMS Message 2007-07-03)

HHS Fights Durable Medical Equipment Fraud
Demonstration Project Targets Fraudulent Business Practices in South Florida and Southern California

HHS Secretary Mike Leavitt announced a two-year effort designed to further protect Medicare beneficiaries from fraudulent suppliers of durable medical equipment, prosthetics and orthotics supplies (DMEPOS). The initiative is focused on preventing deceptive companies from operating in South Florida and Southern California.

The new initiative will have immediate effect in two regions of the country where there is a high concentration of suppliers, South Florida and Southern California. Based on the results of the project, it could be expanded nationwide.

Miami and Los Angeles have been identified as high-risk areas when it comes to fraudulent billing by DMEPOS suppliers. HHS, working with the Department of Justice (DOJ), formed a Medicare Fraud Strike Force to combat fraud through the use of real-time analysis of Medicare billing data. In just three months, 56 individuals have been charged in the Southern District of Florida with fraudulently billing Medicare for more than $258 million. The strike force is made up of federal, state and local investigators.

For more information, you can view the HHS Press Release at **http://www.hhs.gov/news/press/2007pres/07/pr20070702a.html** and the HHS Fact Sheet at **http://www.hhs.gov/news/facts/medicarefraud/index.html**

Foot Care Coverage Guidelines (SE0707)

MLN Matters Number: SE0707
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
This article is for informational purposes only for providers billing Medicare for foot care services. It is an overview of existing policy and no change in policy is being conveyed.

Medicare Podiatry Services
The scope of the practice for Podiatry is defined by state law and the individual state laws should be consulted in determining a specific podiatrist's (or doctor of podiatric medicine) scope of practice.

This article covers routine care of the foot as well as care related to underlying systemic conditions such as metabolic, neurologic or peripheral vascular disease, or injury, ulcers, wounds, and infections.

Medicare Covered Foot Care Services
According to the *Medicare Benefit Policy Manual* (MBPM), Chapter 15, Section 290, Medicare covered foot care services only include medically necessary and reasonable foot care. Any other foot care services that are offered would be considered routine care.

Please note that the treatment of **warts** (including plantar warts) on the foot is covered to the same extent as services provided for the treatment of warts located elsewhere on the body.

Foot Care Coverage Guidelines (SE0707) (Continued)

Exclusions from Coverage

Certain foot care related services are not generally covered by Medicare, (though there are some exceptions where certain services will be covered). In general, the following services, whether performed by a podiatrist, osteopath or doctor of medicine, and without regard to the difficulty or complexity of the procedure, **are not covered by Medicare:**

Podiatry Service Excluded	Exception To Exclusions (Covered by Medicare)
Routine Foot Care	The presence of a systemic condition - such as metabolic, neurologic, or peripheral vascular disease may require scrupulous foot care by a professional that in the absence of such condition(s) would be considered routine. Mycotic nails - In the absence of a systemic condition, treatment of mycotic nails may be covered when the physician attending the patient's mycotic condition documents that: • There is clinical evidence of mycosis of the toenail, and • The patient has marked limitation of ambulation, [for ambulatory patients] pain, or secondary infection resulting from the thickening and dystrophy of the infected toenail plate. Routine procedures are covered only if the patient is under the active care of a doctor of medicine or osteopathy who documents the condition for the following: • Diabetes mellitus • Chronic thrombophlebitis • Peripheral neuropathies involving feet associated with: • Malnutrition and vitamin deficiency such as malnutrition (general, pellagra), alcoholism, malabsorption (celiac disease, tropical sprue), and pernicious anemia • Carcinoma • Diabetes mellitus • Drugs and toxins • Multiple sclerosis • Uremia (chronic renal disease). Although not intended as a comprehensive list, Chapter 15, Section 290 of the Medicare Benefit Policy Manual (Pub 100-2) lists some of the most commonly underlying conditions that might justify coverage for routine foot care.
Flat Foot	None
Subluxation of the Foot	Medical or surgical treatment of subluxation of the ankle joint (talo-crural joint). Reasonable and necessary medical or surgical services, diagnosis, or treatment for medical conditions that have resulted from or are associated with partial displacement of structures.
Supportive Devices for Feet	Orthotic shoes that are an integral part of a leg brace (the expense is included as part of the cost of the brace) Therapeutic shoes for diabetic beneficiaries
Therapeutic Shoes for Individuals with Diabetes	A narrow exception permits coverage of special shoes and inserts for certain patients with diabetes. (MBPM, chapter 15, section 140)

Presumption of Coverage for Routine Services

When evaluating whether the routine services can be reimbursed, a presumption of coverage may be made where the evidence available discloses certain physical and/or clinical findings consistent with the diagnosis and indicative of severe peripheral involvement. For the purposes of applying this presumption, please refer to the *Medicare Benefit Policy Manual* (MBPM), Chapter 15, Section 140.

Foot Care Coverage Guidelines (SE0707) (Continued)

When the routine services are **rendered by a podiatrist**, your Medicare carrier may deem the active care requirement met if the claim or other evidence available discloses that the patient has seen an M.D. or D.O. for treatment and/or evaluation of the complicating disease process during the six-month period prior to the rendition of the routine-type services.

The carrier may also accept the podiatrist's statement that the diagnosing and treating M.D. or D.O. also concurs with the podiatrist's findings as to the severity of the peripheral involvement indicated.

Foot Care for Patients with Chronic Disease

Loss of Protective Sensation (LOPS)

Effective for services furnished on or after July 1, 2002, Medicare covers an evaluation (examination and treatment) of the feet no more often than every six months for individuals with a documented diagnosis of diabetic sensory neuropathy and LOPS, as long as the beneficiary has not seen a foot care specialist for some other reason in the interim.

The diagnosis of diabetic sensory neuropathy with LOPS should be established and documented prior to coverage of foot care. Other causes of peripheral neuropathy should be considered and investigated by the primary care physician prior to initiating or referring for foot care for persons with LOPS.

Please refer to the *National Coverage Determination Manual*, Section 70.2.1, for additional information.

Treatments for Wound Care

Electrostimulation for Wounds (Claims submitted on or after 7/6/2004)

The Centers for Medicare & Medicaid Services (CMS) will allow for coverage for the use of electrical and electromagnetic stimulation for chronic Stage III and Stage IV pressure ulcers, arterial ulcers, diabetic ulcers, and venous stasis ulcers. All other uses of electrical and electromagnetic stimulation for the treatment of wounds are noncovered. Chronic ulcers are defined as ulcers that have not healed within 30 days of occurrence.

Please refer to the National Coverage Decision: NCA for Electrostimulation for Wounds (CAG-00068R) for additional information. National Coverage Decisions are available at **http://www.cms.hhs.gov/mcd/viewdecisionmemo.asp?id=28** on the CMS website.

Hyperbaric Oxygen (HBO) Therapy for Hypoxic Wounds and Diabetic Wounds of the Lower Extremities (CAG-00060N)

For claims submitted on or after April 1, 2000, HBO therapy in the treatment of diabetic wounds of the lower extremities will be covered in patients who meet each of the following three criteria. Patient has:

- Type I or Type II Diabetes and has a lower extremity wound that is due to diabetes;
- A wound classified as Wagner grade III or higher; and has
- Failed an adequate course of standard wound therapy (defined below).

The use of HBO therapy will be covered as adjunctive therapy **only after there are no measurable signs of healing for at least 30-days of treatment with standard wound therapy** and must be used in addition to standard wound care.

Failure to respond to standard wound care occurs when there are no measurable signs of healing for at least 30 consecutive days. Wounds must be evaluated at least every 30 days during administration of HBO therapy. Continued treatment with HBO therapy is not covered if measurable signs of healing have not been demonstrated within any 30-day period of treatment.

For more information about HBO therapy for diabetic wounds of the lower extremities, please refer to the National Coverage Determination (CAG-00060N). That document is available at **http://www.cms.hhs.gov/mcd/viewdecisionmemo.asp?id=37** on the CMS website.

Additional Billing Guidelines

Claims Involving Complicating Conditions

- When submitting claims for services furnished to Medicare beneficiaries who have complicating conditions, **the name of the M.D. or D.O. who diagnosed the complicating condition must be submitted with the claim**, along with the **approximate date** that the beneficiary was last seen by the indicated physician.
- Document carefully any convincing evidence showing that non-professional performance of a service would have been hazardous for the beneficiary because of an underlying systemic disease. Stating that the beneficiary has a complicating condition such as diabetes does not of itself indicate the severity of the condition.
- Exceptional situations include initial diagnostic services performed in connection with a specific symptom or complaint if it seems likely that its treatment would be covered even though the resulting diagnosis may be one requiring only noncovered care.
- The exclusion of foot care is **determined by the nature of the service** and not according to who provides the service. When an itemized bill shows both covered services and noncovered services that are not integrally related to the covered service, the portion of the charges that are attributable to the noncovered services should be denied.
- Sometimes payment is made for incidental noncovered services that are performed as a necessary and integral part of, and secondary to, a covered procedure. For example, if toenails must be trimmed in order to apply a cast to a fractured foot, then the charge for the trimming of nails would be covered.

Foot Care Coverage Guidelines (SE0707) (Continued)

- However, a separately itemized charge for this excluded service would not be allowed. Please refer to your Medicare contractor for questions about coverage that is "incident to" a covered procedure.
- Information about coverage **Incident to Physician's Professional Services** can also be found in the *Medicare Benefit Policy Manual*, Chapter 15, Covered Medical and Other Health Services, Section 60 - Services and Supplies.

Therapeutic Shoes for Individuals with Diabetes (MBPM, Chapter 15, Section 140)

- Coverage of depth or custom-molded therapeutic shoes and inserts for individuals with diabetes is available as of May 1, 1993.
- These diabetic shoes are covered if the requirements specified in the *Medicare Benefits Policy Manual*, Chapter 15, Section 140, regarding certification and prescription are met.
- This benefit provides for a pair of diabetic shoes each equipped so that the affected limb, as well as the remaining limb, is protected, for both feet, even if only one foot suffers from diabetic foot disease.
- Claims for therapeutic shoes for diabetics are processed by the durable medical equipment regional carriers (DMERCs). Therapeutic shoes for diabetics are not DME and are not considered DME nor orthotics, but a separate category of coverage under Medicare Part B.

Related Links

Medicare Manuals

The *Medicare Benefit Policy Manual*, Publication 100-2, Chapter 15 can be found at **http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf** on the CMS website.

The *Medicare Program Integrity Manual* can be found at **http://www.cms.hhs.gov/manuals/downloads/pim83c05.pdf** on the CMS website.

The *Medicare Carrier Manual* can be found at **http://www.cms.hhs.gov/Manuals/PBM/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS021921** on the CMS website.

The *National Coverage Determination Manual* can be found at **http://www.cms.hhs.gov/Manuals/IOM/itemdetail.asp?filterType=keyword&filterValue=national&filterByDID=0&sortByDID=1&sortOrder=ascending&itemID=CMS014961** on the CMS website.

Local Coverage Decisions

The Medicare Coverage Database provides access to local coverage decision articles published for Medicare contractors. These articles can be found at **http://www.cms.hhs.gov/mcd/index_local_alpha.asp?from=alphaarticle&letter=P** on the CMS website.

Related Change Requests and MLN Matters Articles

Program Memorandum Transmittal AB-02-096, Change Request 2269, "Coverage and Billing of the Diagnosis and Treatment of Peripheral Neuropathy with Loss of Protective Sensation in People with Diabetes" can be found at **http://www.cms.hhs.gov/Transmittals/downloads/AB02096.pdf** on the CMS website.

Program Memorandum Transmittal AB-02-105, Change request 2272, "Medical Review of Medicare Payments for Nail Debridement Services," can be found at **http://www.cms.hhs.gov/Transmittals/Downloads/AB02105.pdf** on the CMS website.

MLN Matters article, MM3430, "Reasonable charge update for 2005 splints, casts, dialysis supplies, dialysis equipment, therapeutic shoes and certain intraocular lenses" can be found at **http://www.cms.hhs.gov/MedlearnMattersArticles/downloads/mm3430.pdf** on the CMS website.

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

Medicare Contractor Annual Update of the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) (MM5643)

MLN Matters Number: MM5643
Related CR Release Date: June 15, 2007
Related CR Transmittal #: R1269CP

Related Change Request (CR) #: 5643
Effective Date: October 1, 2007
Implementation Date: October 1, 2007

Provider Types Affected
Physicians, suppliers, and providers billing Medicare contractors (carriers, Medicare administrative Contractors (A/B MACs), durable medical equipment administrative contractors (DMACs), and fiscal intermediaries (FIs) including regional home health intermediaries (RHHIs))

What Providers Need to Know
CR 5643, from which this article is taken, reminds the Medicare contractors and providers that the annual ICD-9-CM update will be effective for dates of service on and after October 1, 2007 (for institutional providers, effective for discharges on or after October 1, 2007).

You can see the new, revised, and discontinued ICD-9-CM diagnosis codes on the CMS website at **http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/07_summarytables.asp#TopOfPage**, or at the National Center for Health Statistics (NCHS) website at **http://www.cdc.gov/nchs/icd9.htm** in June of each year.

Background
ICD-9- CM codes, became mandatory as follows:

- In 1979 for use in reporting provider services on Form CMS-1450;
- On April 1, 1989, for use by all physician services submitted on Form CMS-1500; and
- On October 1, 2003 for all paper and electronic claims billed to Medicare carriers with the exception of ambulance claims (specialty type 59);

The ICD-9-CM codes are updated annually as stated in the *Medicare Claims Processing Manual*, Chapter 23 (Fee Schedule Administration and Coding Requirements), Section 10.2 (Relationship of ICD-9-CM Codes and Date of Service).

CMS issued CR 5643 as a reminder that the annual ICD-9-CM coding update will be effective for dates of service on or after October 1, 2007 (for institutional providers, effective for discharges on or after October 1, 2007).

You should remember that an ICD-9-CM code is required for all professional claims (including those from physicians, non-physician practitioners, independent clinical diagnostic laboratories, occupational and physical therapists, independent diagnostic testing facilities, audiologist, ambulatory surgical centers (ASCs)), and for all institutional claims; but is not required for ambulance supplier claims.

Additional Information
You can find the official instruction, CR5643, issued to your Medicare contractor by visiting **http://www.cms.hhs.gov/Transmittals/downloads/R1269CP.pdf** on the CMS website. As mentioned, you can find the new, revised, and discontinued ICD-9-CM diagnosis codes on the CMS website at **http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/07_summarytables.asp#TopOfPage**, or at the National Center for Health Statistics (NCHS) Web site at **http://www.cdc.gov/nchs/icd9.htm**, in June of each year. The annual ICD-9-CM code changes are also included in a CD-ROM, which you can purchase for $25.00 from the Government Printing Office (GPO), stock number 017-022-01573-1.

To learn more about ICD-9-CM codes, you might want to read *Medicare Claims Processing Manual*, Chapter 23 (Fee Schedule Administration and Coding Requirements), Section 10.2 (Relationship of ICD-9-CM Codes and Date of Service); or look at the information provided at **http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/01_overview.asp#TopOfPage** on the CMS website.

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

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

Notifying Affected Parties Regarding Changes to the Mandatory Medigap ("Claim-Based") Crossover Process (MM5662)

MLN Matters Number: MM5662 - Revised
Related CR Release Date: June 15, 2007
Related CR Transmittal #: R283OTN

Related Change Request (CR) #: 5662
Effective Date: June 15, 2007
Implementation Date: July 16, 2007

Note: This article was revised on June 26, 2007, to reflect a corrected Web address on page 3 as noted when CR5662 was re-issued on June 26. All other information remains the same.

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

What Providers Need to Know
CR 5662, from which this article is taken, outlines the processes that Part B carriers, Medicare Administrative Contractors (MACs) responsible for Part B claims processing, and Durable Medical Equipment Medicare Administrative Contractors (DMACs) shall follow in notifying affected parties that the mandatory Medigap (claim-based) crossover process is being transitioned to the Coordination of Benefits Contractor (COBC) effective October 1, 2007

Background
The Centers for Medicare & Medicaid Services (CMS) has decided that, effective October 1, 2007, all mandatory Medigap ("claim-based") crossovers will now be accomplished through its Coordination of Benefits Contractor (COBC). Further, CMS has decided that, in accordance with Public Law 104-191 and 45 *Code of Federal Regulations* (CFR) 160, it will **only** - transmit claims to Medigap claim-based crossover recipients in the Health Insurance Portability and Accountability Act (HIPAA) American National Standards Institute (ANSI) X12-N 837 professional (version 4010A1) coordination of benefits (COB) claim format or in the National Council for Prescription Drug Programs (NCPDP) version 5.1 batch standard 1.1 format. (**NOTE:** The systematic requirements relating to this transition were communicated via change request (CR) 5601, as reflected in *MLN Matters* article MM5601 at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5601.pdf** on the CMS website.)

Starting with June 2007, CMS' COBC will gradually begin to assign new Medigap claim-based COBA identifiers (range 55000 to 59999) to Medigap insurers that have not voluntarily moved to the COBA eligibility file-based crossover process. CMS anticipates that the COBC will complete the execution of crossover agreements with Medigap claim-based insurers and assign new COBA Medigap claim-based identifiers to these entities by August 31, 2007. As the COBC assigns a new COBA Medigap claim-based ID to a Medigap claim-based crossover recipient, CMS will alert all Part B contractors, including MACs, and DMACs via e-mail of this action on a weekly basis. The CMS alert will include the following information: affected entity's name; the entity's multiple formerly contractor-assigned Other Carrier Name and Address (OCNA) or N-key identifiers; and its newly assigned COBA Medigap claim-based ID. Upon receipt of the CMS alert, the affected contractors shall manually add the newly assigned COBA Medigap claim-based ID to their existing insurer screens or tables to replace the formerly assigned OCNA or N-key identifier. Contractors shall also maintain a link to the COB website (**http://www.cms.hhs.gov/COBAgreement**) for purposes of receiving updates to the COBA Medigap claim-based ID listing.

The affected contractors shall post CMS' Medigap claim-based crossover transition announcement in its entirety on their websites that are accessed by the public and insurers. These contractors shall also mail the CMS announcement on a one-time basis to their electronic Medigap claim-based crossover recipients and shall also notify their paper claim recipients through information included with their next scheduled claim mailings.

Notifying Affected Parties Regarding Changes to the Mandatory Medigap ("Claim-Based") Crossover Process (MM5662) (Continued)

Providers should note the following: Effective October 1, 2007, the COBC will assume responsibility for the Medigap claim-based crossover, which is driven by information that participating providers enter on the incoming claim. The primary change for providers resulting from this transition will be that they will need to include a new Medigap identifier, even in advance of October 1, 2007, on their incoming Medicare claims to trigger crossovers to Medigap insurers. During June through August 2007, CMS will assign each Medigap insurer that does not provide an eligibility file to the COBC to identify all of its covered policy or certificate holders for crossover purposes a new 5-digit COBA Medigap claim-based identifier (ID). Providers may reference a weekly updated listing of the newly assigned COBA Medigap claim-based IDs for Medicare billing purposes at the following website: **http://www.cms.hhs.gov/COBAgreement/Downloads/Medigap Claim-based COBA IDs for Billing Purpose.pdf.** Once the COBC has assigned a new COBA Medigap claim-based ID to a Medigap insurer, participating providers that wish to trigger crossovers to Medigap insurers will be required to include that new identifier, as found on the CMS COB website, on their incoming Medicare claims. Failure to do so will result in their claims not being successfully crossed over to the Medigap insurer. If the older contractor-assigned number is included on the claim, Medicare will include the standard MA19 message-'Information was not sent to the Medigap insurer due to incorrect/invalid information you submitted concerning the insurer. Please verify your information and submit your secondary claim directly to that insurer.'-on the provider's electronic remittance advice (ERA) or other production remittance advice for the associated claim(s). Participating providers that are permitted under Administrative Simplification Compliance Act (ASCA) to bill Medicare on paper should include the newly assigned 5-digit COBA Medigap claim-based ID within block 9-D of the CMS-1500 claim form. Providers that are required to bill Medicare electronically using the Health Insurance Portability and Accountability Act (HIPAA) American National Standards Institute (ANSI) X12-N 837 professional claim shall include the newly assigned 5-byte only COBA Medigap claim-based ID (range=55000 to 59999) left-justified in field NM109 of the NM1 segment within the 2330B loop and followed by spaces. **(See important note that follows regarding the submission of claims to DMACs.)**

Retail pharmacies that bill National Council for Prescription Drug Programs (NCPDP) batch claims to Medicare shall include the newly assigned Medigap identifier left-justified within field 301-C1 of the T04 segment of their incoming NCPDP claims and followed by spaces. **IMPORTANT:** For all of the claim submission situations discussed above, suppliers (including retail pharmacies) that bill DMACs must include an accompanying 4-byte "Z001" identifier with the newly assigned COBA Medigap claim-based crossover ID (for example, 55000Z001) when seeking to trigger Medigap claim-based crossovers during the interim transitional period, which runs from June through September 30, 2007.

Providers should notify their clearinghouses and billing vendors of the impending changes to the existing Medigap claim-based crossover process as soon as possible.

Additional Information

You can find the official instruction, CR5662, issued to your carrier, MAC, or DMAC by visiting **http://www.cms.hhs.gov/Transmittals/downloads/R283OTN.pdf** on the CMS website.

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

Excerpt from "Notifying Affected Parties Regarding Changes to the Mandatory Medigap ("Claim-Based") Crossover Process" (CR5662)

B. Policy: The Centers for Medicare & Medicaid Services (CMS) has decided that, effective October 1, 2007, all mandatory Medigap ("claim-based") crossovers will now be accomplished through its Coordination of Benefits Contractor (COBC). Further, CMS has decided that, in accordance with Public Law 104-191 and 45 *Code of Federal Regulations* (CFR) 160, it will **only** cross claims over to claim-based Medigap recipients in the Health Insurance Portability and Accountability Act (HIPAA) American National Standards Institute (ANSI) X12-N 837 professional (version 4010A1) coordination of benefits (COB) claim format or in the National Council for Prescription Drug Programs (NCPDP) version 5.1 batch standard 1.1 format. (**Note:** *The systematic requirements relating to this transition were communicated via Transmittal 1242, change request (CR) 5601.*)

Excerpt from "Notifying Affected Parties Regarding Changes to the Mandatory Medigap ("Claim-Based") Crossover Process" (CR5662) (Continued)

Starting with June 2007, CMS' COBC will gradually begin to assign new Medigap claim-based COBA identifiers (range 55000 to 59999) to Medigap insurers that have not voluntarily moved to the COBA eligibility file-based crossover process following their execution of a national crossover agreement. CMS anticipates that the COBC will complete this process by August 31, 2007. As the COBC assigns a new COBA Medigap claim-based ID to a Medigap claim-based crossover recipient, CMS will alert all Part B contractors, including MACs, and DMACs via e-mail of this action on a weekly basis. The CMS alert will include the following information: affected entity's name; the entity's multiple formerly assigned Other Carrier Name and Address (OCNA) or N-key identifiers; and its newly assigned COBA Medigap claim-based ID. Upon receipt of the CMS alert, the affected contractors shall manually add the newly assigned COBA Medigap claim-based ID to their existing insurer screens or tables to replace the formerly assigned OCNA or N-key identifier. Contractors shall also maintain a link to the (**http://www.cms.hhs.gov/COBAgreement**) for purposes of receiving updates to the COBA Medigap claim-based ID listing. During the interim period (June through September 2007), contractors are not expected to add COBA Medigap COBA IDs to their internal insurer screens/tables for Medigap insurers for which they previously did not establish an OCNA or N-key identifier. As appropriate, the CMS will issue a future instruction that addresses the contractors' requirement to add the balance of the COBA Medigap claim-based IDs, with accompanying insurer names, to their internal insurer screens/tables, with this action being accomplished following the implementation of the new COBA Medigap claim-based crossover process on October 1, 2007.

The affected contractors shall post CMS' Medigap claim-based crossover transition announcement in its entirety on their websites that are accessed by the public and insurers. These contractors shall also mail the CMS announcement on a one-time basis to their electronic Medigap claim-based crossover recipients. Those contractors that send paper claims, known as "Notices of Medigap Claims Information" (NOMCIs), to their Medigap insurers shall, at the next scheduled claims delivery date, include with those claims a separate notification (an envelope stuffer would be acceptable) that includes the following informational blurb: **"Notice:** *Please see the following website to learn about changes that you will be required to make to ensure your continued receipt of Medicare crossover claims:* **http://www.medicarenhic.com/dme/**."

Part B contractors, including MACs, and DMACs shall inform their providers and suppliers of the changes to the Medigap claim-based crossover process via their next regularly scheduled provider bulletins. The affected contractors shall include the following language within their next regularly scheduled provider bulletin: "CMS' Coordination of Benefits Contractor (COBC) will assume responsibility for the Medigap claim-based crossover, which is driven by information that participating providers enter on the incoming claim, effective October 1, 2007. During June through August 2007, CMS will assign each Medigap insurer that does not provide an eligibility file to the COBC to identify all of its covered policy or certificate holders for crossover purposes a new 5-digit Medigap identifier (ID). Providers may reference a weekly updated listing of the newly assigned COBA Medigap claim-based IDs on CMS' Coordination of Benefits website at: **http://www.cms.hhs.gov/COBAgreement/Downloads/Medigap Claim-based COBA IDs for Billing Purpose.pdf.** Once the COBC has assigned a new COBA Medigap claim-based ID to a Medigap insurer, participating providers that wish to trigger crossovers to Medigap insurers will be required to include that new identifier, as found on the CMS COB website, on their incoming Medicare claims. Failure to do so will result in their claims not being successfully crossed over to the Medigap insurer. If the older contractor-assigned number is included on the claim, Medicare will include the standard MA19 message - 'Information was not sent to the Medigap insurer due to incorrect / invalid information you submitted concerning the insurer. Please verify your information and submit your secondary claim directly to that insurer.' - on the provider's electronic remittance advice (ERA) or other production remittance advice for the associated claim(s). Participating providers that are permitted under Administrative Simplification Compliance Act (ASCA) to bill Medicare on paper should include the newly assigned 5-digit COBA Medigap claim-based ID within block 9-D of the CMS-1500 claim form. Providers that are required to bill Medicare electronically using the Health Insurance Portability and Accountability Act (HIPAA) American National Standards Institute (ANSI) X12-N 837 professional claim shall include the newly assigned 5-byte only COBA Medigap claim-based ID (range=55000 to 59999) left-justified in field NM109 of the NM1 segment within the 2330B loop and followed by spaces. (**See important note that follows regarding the submission of claims to Durable Medical Equipment Medicare Administrative Contractors [DMACs].**) Retail pharmacies that bill National Council for Prescription Drug Programs (NCPDP) batch claims to Medicare shall include the newly assigned Medigap identifier left-justified within field 301-C1 of the T04 segment of their incoming NCPDP claims and followed by spaces. **IMPORTANT:** For all of the claim submission situations discussed above, suppliers (including retail pharmacies) that bill DMACs must include an accompanying 4-byte "Z001" identifier with the newly assigned COBA Medigap claim-based crossover ID (for example, 55000Z001) when seeking to trigger Medigap claim-based crossovers during the interim transitional period, which runs from June through September 30, 2007. Providers should notify their clearinghouses and billing vendors of the impending changes to the existing Medigap claim-based crossover process as soon as possible." In addition, contractors shall include the link to the URL where they post the Medigap transitional announcement (see Attachment A) along with the foregoing language within their next regularly scheduled provider bulletin.

Notifying Affected Parties Regarding Changes to the Mandatory Medigap ("Claim-Based") Crossover Process (CR5662) Attachment A

Dear Medigap Insurer:

MEDIGAP CLAIM-BASED CROSSOVER MOVES TO A CONSOLIDATED, STANDARDIZED PROCESS.
This announcement is to inform you that, effective October 1, 2007, the Centers for Medicare & Medicaid Services (CMS) will transfer the mandatory Medicare supplemental (Medigap) insurance claim-based crossover process from its Medicare contractors to the national Coordination of Benefits Contractor (COBC). The definition of a "Medicare supplemental (Medigap) policy" is found at §1882(g)(1) of the Social Security Act, the text of which is being attached for your reference. The Medigap crossover process is mandated by §1842(h)(3)(B) of Title XVIII of the Social Security Act and is activated when 1) a participating Medicare provider includes a specific identifier on the beneficiary's claim and 2) the beneficiary assigns payment rights to that provider.

WHAT DOES THIS MEAN TO YOU?
The CMS is expecting your organization to contact the COBC during June 2007 regarding your need to sign a national Coordination of Benefits Agreement (COBA) that will enable you to continue receiving Medigap claim-based crossover claims. You may reach the COBC for this purpose by dialing 1-646-458-6740. The executed COBA will address claim transfer protocols, the frequency of the claim transfers (available options include daily, weekly, bi-weekly, or monthly), and the standard crossover fee. After your organization has signed the COBA, you will be assigned a new 5-byte COBA Medigap claim-based identifier. All participating providers will then have access to the Medigap insurer's new COBA Medigap claim-based identifier prior to October 1, 2007, and will be required to include this new identifier on your policy or certificate holders' incoming Medicare claims to successfully trigger mandatory Medigap claim-based crossovers.

With the transition of the Medigap claim-based crossover process to the COBC, Medigap insurers will enjoy the benefit of only needing to interact with one entity when they have questions or concerns. In addition, the Medigap insurers will now receive their claims and invoices from a single entity rather than individually from numerous Medicare contractors across the nation.

Effective October 1, 2007, CMS will discontinue the use of all non-standard claim formats, including National Standard Format (NSF) and paper claims. As "covered entities" under the final Health Insurance Portability and Accountability Act (HIPAA) transactions and code sets rule, Medigap insurers must be able to accept the standard HIPAA American National Standards Institute (ANSI) X12-N 837 professional coordination of benefits (COB) version 4010-A1 claim. In addition, your organization should be able to accept National Council for Prescription Drug Programs (NCPDP) version 5.1 batch standard 1.1 Part B drug claims. However, CMS is **not** mandating receipt of NCPDP batch standard claims at this time. CMS will advise your organization when acceptance of these claims is required. Therefore, effective October 1, 2007, your organization will receive Part B physician and supplier claims in the HIPAA ANSI X12-N 837 professional claim (with receipt of NCPDP batch standard claims to follow in the future). In accordance with volume 55, number 225 of the November 21, 1990, Federal Register Notice, CMS will exclude non-assigned, fully paid original and fully paid adjustment claims, fully denied original and fully denied adjustment claims, and non-monetary adjustment claims from its national COBA Medigap claim-based crossover process with your organization.

Medigap insurers will continue to receive their crossover claims from their associated Medicare contractors at their currently designated frequency and in their currently designated claims format during the interim period from June 1 to September 30, 2007. Until October 1, 2007, the only change to the current Medigap claim-based process is that the Medigap insurer will be replacing its current identifier that initiates claim-based crossover to the 5-byte COBA Medigap claim-based identifier for processing purposes. This change will occur shortly after execution of the COBA.

WHAT CAN MY ORGANIZATION DO TO BE PREPARED FOR THE OCTOBER 1, 2007, CHANGE?
Since your organization will no longer receive Medigap claim-based crossovers from CMS' Medicare contractors effective October 1, 2007, CMS strongly encourages all Medigap insurers that are currently receiving their crossovers via this methodology to act now and contact the COBC at 1-646-458-6740 to obtain more information about signing the national Coordination of Benefits Agreement (COBA). Your COBA will need to be signed during the months from June to August 2007, to allow your organization sufficient time for testing with the COBC in advance of the October 1, 2007, implementation. In addition, since Medicare will exclusively be crossing claims over to your organization in the standard HIPAA ANSI X12-N 837 professional claim format effective October 1, 2007, your organization may need to consider planning now to contract with an outside vendor that is able to accept the standard HIPAA claims format on your behalf.

Upon receipt of your COBA Medigap claim-based identifier, your organization should initiate provider and member education on the use of the new identifier. CMS recommends that, in accordance with §1882(c)(3)(C) of the Social Security Act, you consider issuing new cards to your Medigap policy and certificate holders that inform them of the new COBA Medigap claim-based ID for your organization. This will assist your policy or certificate holders with ensuring that their providers include the correct number on their incoming claims to Medicare. In addition, Medicare will be conducting extensive provider education concerning the new COBA Medigap crossover process through its Medicare contractor provider communication channels and websites.

If your organization currently provides an eligibility file to initiate COBA Medigap crossovers, you may simply add all policy or certificate holders to your COBA eligibility file and maintain your current COBA identifier. In addition, please contact your COBC EDI or CMS representative for information on discontinuing your current Medigap claim-based crossover contract(s) with the Medicare contractor(s) if applicable.

Notifying Affected Parties Regarding Changes to the Mandatory Medigap ("Claim-Based") Crossover Process (CR5662) Attachment A (Continued)

WHAT OTHER DETAILS SHOULD MY ORGANIZATION KNOW?
Effective with claims received after your COBA has been executed, your previously assigned Other Carrier Name and Address (OCNA) or N-key Medigap identifier will no longer be accepted on participating provider claims as a basis for triggering the crossing over of adjudicated claims to your organization. Also, unless your organization has executed a COBA with the COBC prior to October 1, 2007, your organization will be unprepared to test the new process with the COBC and, consequently, will be unable to receive production claim-based crossover claims following the implementation of the new process on October 1, 2007.

Starting October 1, 2007, claims will exclusively be selected for crossover to your organization through the new COBA Medigap claim-based crossover process. CMS' Medicare contractors will cease crossing claims directly to your organization. In addition, all current Medigap claim-based crossover recipients are advised that CMS' Medicare contractors will automatically terminate any existing crossover agreements with your organization no later than October 31, 2007, following your receipt of the final or residual claims that were tagged for crossover directly from the Medicare contractors prior to October 1, 2007.

If your organization has already signed a COBA with the COBC to participate in the eligibility file-based crossover process but you wish to continue receipt of claim-based crossovers for a portion of your policy or certificate holders, your organization will need to sign a new COBA (base agreement and attachment) to address your receipt of claims via the COBA Medigap claim-based crossover process.

The CMS and its COBC look forward to working with your organization to ensure a smooth transition from your current Medigap claim-based crossover process to the consolidated COBA Medigap claim-based crossover process.

ATTACHMENT A-Additional Information
Definition of a Medicare Supplemental (Medigap) Policy

In accordance with §1882 (g)(1) of Title XVIII of the Social Security Act, a Medicare supplemental policy is a health insurance policy or other health benefit plan offered by a private entity to individuals who are entitled to have payment made under this title, which provides reimbursement for expenses incurred for services and items for which payment may be made under this title but which are not reimbursable by reason of the applicability of deductibles, coinsurance amounts, or other limitations imposed pursuant to this title; but does not include a Medicare+Choice plan or any such policy or plan of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations (or combination thereof), for employees or former employees (or combination thereof) or for members or former members (or combination thereof) of the labor organizations and does not include a policy or plan of an eligible organization (as defined in section 1876(b), which is located at **http://www.ssa.gov/OP_Home/ssact/title18/1876.htm#b**), if the policy or plan provides benefits pursuant to a contract under section 1876, which is located at **http://www.ssa.gov/OP_Home/ssact/title18/1876.htm**, or an approved demonstration project described in section 603(c) of the Social Security Amendments of 1983, section 2355 of the Deficit Reduction Act of 1984, or section 9412(b) of the Omnibus Budget Reconciliation Act of 1986, or, during the period beginning on the date specified in subsection (p)(1)(C) and ending on December 31, 1995, a policy or plan of an organization if the policy or plan provides benefits pursuant to an agreement under section 1833(a)(1)(A), which is located at **http://www.ssa.gov/OP_Home/ssact/title18/1833.htm#a1A**. For purposes of this section, the term "policy" includes a certificate issued under such policy.

Pre-Bidding Activities for the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program (SE0714)

MLN Matters Number: SE0714 - Revised
Related CR Release Date: N/A
Related CR Transmittal #: N/A
Related Change Request (CR) #: N/A
Effective Date: N/A
Implementation Date: N/A

Note: This article was changed on July 9, 2007 to add a link to a related DMEPOS Competitive Bidding article SE0717 on page 3. All other information remains the same.

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

Pre-Bidding Activities for the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program (SE0714) (Continued)

Provider Action Needed
This Special Edition (SE) article, SE0714, outlines the pre-bidding activities that DME suppliers need to follow in order to participate in the Medicare DMEPOS Competitive Bidding Program.

Background
Providers and suppliers that furnish certain DMEPOS to Medicare beneficiaries under Medicare Part B will have an opportunity to participate in a competitive acquisition program (the "Medicare DMEPOS Competitive Bidding Program"). This program will improve the accuracy of Medicare's payments for certain DMEPOS, reduce beneficiary out-of-pocket expenses, and save the Medicare program money while ensuring beneficiary access to quality DMEPOS items and services.

To assist with the DMEPOS Competitive Bidding Program, CMS awarded a contract to Palmetto GBA to serve as the Competitive Bidding Implementation Contractor (CBIC) for program implementation and monitoring.

As the DMEPOS Competitive Bidding Program progresses, suppliers may want to view the final rule governing the program, which is available at **http://www.cms.hhs.gov/quarterlyproviderupdates/downloads/cms1270f.pdf** on the CMS Web site. In addition, you may want to visit **http://www.cms.hhs.gov/competitiveacqfordmepos** for more complete information on the program and the process whereby suppliers can bid and participate.

There are other *MLN Matters* articles on the program. These articles are discussed briefly in the "Additional Information" section of this article.

Basic Instructions
All suppliers submitting a bid must:

- Be in good standing and have an active National Supplier Clearinghouse number (NSC#);
- Meet any local or State licensure requirements, if any, for the item being bid;
- Be accredited or be pending accreditation. CMS cannot accept a bid from any supplier that is not accredited or that has not applied for accreditation. The accreditation deadline for the first round of competitive bidding is August 31, 2007. Suppliers should apply for accreditation immediately to allow adequate time to process their applications. (For a listing of CMS-approved accrediting organizations, please visit **http://www.cms.hhs.gov/CompetitiveAcqforDMEPOS/downloads/DMEPOS_Accreditation_Organizations.pdf** on the CMS Web site. *MLN Matters* article SE0713 provides additional information on accreditation and is located at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0713.pdf**; and
- Complete initial registration in the internet application (Individuals Authorized Access CMS computer Services, IACS) to get a USER ID and password. Suppliers need to complete this initial registration process early to avoid delays in being able to submit bids. The initial registration process requires the **authorized official**, as identified in Section 15 of the CMS 855S, to complete the information required in the internet application. The authorized official's information must match the information on file at the National Supplier Clearinghouse. To complete this initial registration and obtain a USER ID and password, please go to **https://applications.cms.hhs.gov**.

All suppliers submitting a bid should:

- Review *MLN Matters* article SE0717, Initial Supplier Registration for Competitive Bidding Program is Now Open, which provides important information about the registration process. SE0717 can be viewed at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0717.pdf** on the CMS website;
- Review the information in the Bid Application Tool Kit to facilitate a better understanding of the bidding process and rules. This information is located on the CBIC Web site at **http://www.dmecompetitivebid.com/cbic/cbic.nsf/(subpages)/CBICSuppliersBid%20Application%20Tool%20Kit**;
- View the educational webcast to learn more about the Medicare DMEPOS Competitive Bidding Program and detailed information on the bid application process. This information is located on the CBIC Web site at **http://www.dmecompetitivebid.com/cbic/cbic.nsf/(subpages)/CBICSuppliersEducational%20Tools**; and
- CMS encourages you to register to receive updates on the Competitive Bidding Program. You may do so by going to **http://www.cms.hhs.gov/apps/mailinglists/** on the Web.

Additional Information
The CMS complete listing of all DME resources is available at **http://www.cms.hhs.gov/center/dme.asp** on the CMS Web site. A background review of the rationale for this program is at **http://www.cms.hhs.gov/CompetitiveAcqforDMEPOS/downloads/DME_sum.pdf** on the CMS Web site.

MLN Matters article SE0713, *Accreditation Information for Suppliers of Durable Medical Equipment, Orthotics, Prosthetics, and Supplies (DMEPOS),* **relates to** this article and provides an overview of the Medicare Modernization Act legislation and how it impacts this competitive bidding program. It also outlines the quality standards for suppliers, describes the status of accreditation, and provides the web addresses of the ten accrediting organizations. SE0713 can be viewed at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0713.pdf** on the CMS website.

Pre-Bidding Activities for the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program (SE0714) (Continued)

Another article, MM5574, provides more overview information regarding the DMEPOS Competitive Bidding Program and that article is at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5574.pdf** on the CMS site.

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

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

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

This article was revised on May 7, 2007, to add this statement that Medicare FFS has announced a contingency plan regarding the May 23, 2007 implementation of the NPI. For some period after May 23, 2007, Medicare FFS will allow continued use of legacy numbers on transactions; accept transactions with only NPIs; and accept transactions with both legacy numbers and NPIs. For details of this contingency plan, see the *MLN Matters* article, MM5595, at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5595.pdf** on the CMS website. Also, on June 28, 2007, the article was revised to delete one sentence that should not have been in the article.

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

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

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

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

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

Key Points of CR5508
If an individual provider dies before obtaining an NPI, the following apply:

- If a provider dies before obtaining an NPI and claims for that provider are received by a Medicare contractor after May 23, 2007, and Medicare (the Medicare contractor, the Medicare Online Survey and Certification Reporting System (OSCAR), of the National Supplier Clearinghouse (NSC)) has not been notified of the death, the claims will reject when received by Medicare due to the absence of the provider's NPI.
- At that point, the claim submitter would be expected to contact the Medicare contractor to which the claims were submitted to discuss payment of the claims and report the provider's death. Toll free number of the Medicare contractors are available at **http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip** on the CMS website.

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

- The State in which a provider furnishes care will continue to be responsible for notification of Medicare of the death of a provider following existing procedures. Since some States send such notifications on a quarterly basis, CMS is implementing the following procedures to enable affected claims to be paid more promptly:
  - Because Medicare will reject an electronic claim received without an NPI after May 23, 2007, in cases where the provider died prior to obtaining an NPI, the provider's representative will need to submit the claim on paper.
  - A representative of the estate should then contact the claims processing contractor, who will notify the provider that they must submit the claims on paper and that they must annotate the claim to state that the provider is deceased in Item 19.

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

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

Revised HCPCS Codes Relating to Immune Globulin (MM5635)

MLN Matters Number: MM5635 - Revised
Related CR Release Date: June 1, 2007
Related CR Transmittal #: R1261CP
Related Change Request (CR) #: 5635
Effective Date: July 1, 2007
Implementation Date: July 2, 2007

Note: This article was corrected on June 20, 2007, to show the correct HCPCS code for Flebogamma Injection in Table 1 of page 2 is Q4091. All other information remains the same.

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

What You Need to Know
CR 5635, from which this article is taken, implements HCPCS coding changes for Immune Globulin. **On and after July 1, 2007**:

- **HCPCS code J1567** (injection, immune globulin, intravenous, non-lyophilized (e.g. liquid), 500 mg)) **will no longer be payable by Medicare.**
- **In its place, the following HCPCS codes are payable: Q4087 (Octagam Injection), Q4088 (Gammagard Liquid Injection), Q4091 (Flebogamma Injection), and Q4092 (Gamunex Injection);**
- **In addition, for services on or after July 1, 2007, two new codes are payable:**
  - **Q4089 (Rhophylac injection).** *Note that currently, Rhophylac® is the only product that should be billed using code Q4089. If other products under the Food and Drug Administration's (FDA) approval for Rhophylac® become available, code Q4089 would be used to bill for such products.*
  - **Q4090 (HepaGam B injection).** *Note that currently, HepaGam B™, when given intramuscularly, is the only product that should be billed using code Q4090. If other products under the FDA's approval for HepaGam B™ IM become available, code Q4090 would be used to bill for such products. HepaGam B™ when given intravenously should be billed using an appropriate Not Otherwise Classified code in the absence of a specific HCPCS code.*
- For institutional claims, revenue code 0636 should be used for billing codes Q4087, Q4088, Q4089, Q4090, Q4091, and Q4092.
- As described in CR 5428, Medicare contractors will pay for pre-administration-related services (G0332) associated with intravenous Immune Globulin administration when Q4087, Q4088, Q4091, or Q4092 is billed in lieu of J1567.

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

Revised HCPCS Codes Relating to Immune Globulin (MM5635) (Continued)

Background
CR 5635, from which this article is taken, implements HCPCS Coding Changes for Immune Globulin, Effective for services on or after July 1, 2007. See Table 1, below, for details.

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

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

* Currently, Rhophylac® is the only product that should be billed using code Q4089. If other products under the FDA approval for Rhophylac® become available, code Q4089 would be used to bill for such products.

^ Currently, HepaGam B™, when given intramuscularly, is the only product that should be billed using code Q4090. If other products under the FDA's approval for HepaGam B™ IM become available, code Q4090 would be used to bill for such products. HepaGam B™ when given intravenously should be billed using an appropriate Not Otherwise Classified code in the absence of a specific HCPCS code.

Additional Information
You can find the official instruction issued to your Medicare contractor about the revised HCPCS codes relating to Immune Globulin by going to CR5635, located at **http://www.cms.hhs.gov/Transmittals/downloads/R1261CP.pdf** on the CMS website.

Payment limits for the new Q codes will be included in the July 2007 quarterly Average Sales Price payment file, which will be posted at **http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/01a_2007aspfiles.asp#TopOfPage**.

In addition, more information regarding the Outpatient Prospective Payment System (OPPS) and the new Q codes in the July update of OPPS Addendum A and Addendum B on the hospital outpatient website at **http://www.cms.hhs.gov/HospitalOutpatientPPS/AU/list.asp#TopOfPage**.

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

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

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

MLN Matters Number: MM5597
Related CR Release Date: June 29, 2007
Related CR Transmittal #: R19COM

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

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

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

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

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

Overlapping Claims-New Rules

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

Information Available on the IVR

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

Information Available on the Remittance Advice (RA)

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

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

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

Authentication of Beneficiary Elements - additions to current rules.
CR5597 contains, within its attachments, a detailed table showing the data elements that are released in response to provider inquiries for beneficiary information. A key new provision allows Medicare contractors to release abdominal aortic aneurysm screening information to providers. CR5597 is available at **http://www.cms.hhs.gov/Transmittals/downloads/R19COM.pdf** on the CMS website.

Additional Key Points of CR5597
- Medicare's CSRs have the discretion to end a provider telephone inquiry if the caller places them on hold for two minutes or longer. Where possible, the CSR will give prior notice that a disconnection may occur.
- If a provider requests a copy of the Report of Contact made during a telephone response to a written inquiry, Medicare contractors will send you a letter detailing the discussion. This letter may be sent to you by e-mail or fax, if you request, unless the details include specific beneficiary or claim related information.
- When your Medicare contractor schedules a training event for which there is a charge for attendance and you register and pay, but are unable to attend, you may be entitled to a refund of some or all of your payment. But, to receive such a refund, **you must notify the contractor before the event.**

Additional Information
For complete details regarding this Change Request (CR) please see the official instruction (CR5597) issued to your Medicare carrier, FI, A/B MAC, DME MAC, or RHHI. That instruction may be viewed by going to **http://www.cms.hhs.gov/Transmittals/downloads/R19COM.pdf** on the CMS website.

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

Revisions to the Medicare Claims Processing Manual, Chapter 17, Sections 40 and 100, Regarding Discarded Drugs and Biologicals and Submission of Claims With the Modifier JW, "Drug Amount Discarded/Not Administered to Any Patient" (MM5520)

MLN Matters Number: MM5520
Related CR Release Date: May 25, 2007
Related CR Transmittal #: R1248CP
Related Change Request (CR) #: 5520
Effective Date: July 1, 2007
Implementation Date: July 2, 2007

Provider Types Affected
Physicians, hospitals, other providers, and suppliers who bill Medicare contractors (carriers, fiscal intermediaries (FI), regional home health intermediaries (RHHI), Part A/B Medicare Administrative Contractors (MACs), Durable Medical Equipment Medicare Administrative Contractors (DME MACs)) for administering or supplying drugs and biologicals.

What You Need to Know
CR 5520, from which this article is taken, revises the *Medicare Claims Processing Manual*, Chapter 17, Sections 40 and 100.2.9 to include language that references payment for administering (and discarding) both single use vials and single use packages. Specifically, the change is to clarify that Medicare will cover the amount of a single use vial or single use package of a drug or biological that was discarded along with the amount of that single use vial/package that was administered to the Medicare patient.

Revisions to the Medicare Claims Processing Manual, Chapter 17, Sections 40 and 100, Regarding Discarded Drugs and Biologicals and Submission of Claims With the Modifier JW, "Drug Amount Discarded/Not Administered to Any Patient" (MM5520) (Continued)

Background
CR 5520, from which this article is taken revises the *Medicare Claims Processing Manual,* Chapter 17 (Drugs and Biologicals), Sections 40 (Discarded Drugs and Biologicals) and 100.2.9 (Discarded Drugs and Biologicals) to ensure the proper billing of discarded drugs and biologicals in both single use vials and single use packages.

These revisions are summarized as follows:

- The Centers for Medicare and Medicaid Services (CMS) encourages physicians, hospitals and other providers to schedule patients in such a way that they can use drugs or biologicals most efficiently, in a clinically appropriate manner.
- Section 40 of Chapter 17 is amended to address single use vials/packages of drugs and boilogicals. If after administering a dose/quantity of the drug or biological to a Medicare patient, a physician, hospital or other provider must discard the remainder of a single use vial or other single use package, the program provides payment for the amount of drug or biological administered and the amount discarded, up to the total amount of the drug or biological as indicated on the vial or package label.
- Section 100.2.9 is amended to show that CMS will reimburse physicians, providers and suppliers for the amount of a drug or biological administered (and for the amount discarded) when:
  - The participating competitive acquisition program (CAP) physician has made a good faith effort to minimize the unused portion of the CAP drug or biological in scheduling patients and in ordering, accepting, storing, and using the drug or biological;
  - In its process of supplying the drug or biological to the participating CAP physician, the approved CAP vendor has made a good faith effort to minimize the unused portion of the drug or biological.

Note: Multi-use vials are not subject to payment for discarded amounts of drug or biological.

Additional Information
You can view CR 5520, the official instruction issued to your Medicare contractor, by visiting **http://www.cms.hhs.gov/Transmittals/downloads/R1248CP.pdf** on the CMS website. You will find the revised *Medicare Claims Processing Manual*, Chapter 17 (Drugs and Biologicals), Sections 40 (Discarded Drugs and Biologicals) and 100.2.9 (Discarded Drugs and Biologicals) as an attachment to that CR. If you have any questions, please contact your FI, RHHI, carrier, A/B MAC, or DME MAC at their toll-free number, which may be found at **http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip**.

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

MLN Matters Number: MM5601
Related CR Release Date: May 18, 2007
Related CR Transmittal #: R1242CP
Related Change Request (CR) #: 5601
Effective Date: October 1, 2007
Implementation Date: October 1, 2007

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

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

Provider Action Needed

Impact to You

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

What You Need to Know

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

What You Need to Do

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

Background

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

Key Points of CR5601

- Be aware that during the transition period from June through September 2007 the COBC will assign new 5-byte claim-based Coordination of Benefits Agreement (COBA) IDs to the Medigap insurers on a graduated basis throughout the three month period prior to the actual transition. Until CMS' COBC assigns a new 5-digit COBA Medigap claim-based ID to a Medigap insurer, Medicare will continue to accept the older contractor-assigned OCNA or N-key identifiers for purposes of initiating Medigap claim-based crossovers. During June through September 2007, the affected contractors will also continue to cross claims over as normal to their Medigap claim-based crossover recipients. CMS will be regularly apprising the affected Medicare contractors when -the COBC has assigned new COBA Medigap claim-based IDs to the Medigap insurers and will post this information on its COB website so that contractors **may direct providers to that link for purposes of obtaining regular updates.**
- Effective with claims filed to Medicare on October 1, 2007:
  - All participating providers that have been granted a billing exception under the Administrative Simplification Compliance Act (ASCA) should enter CMS' newly assigned COBA Medigap claim-based identifier (ID) within block 9-D of the incoming CMS-1500 claim for purposes of triggering Medigap claim-based crossovers.
  - All other participating providers shall enter the newly assigned COBA Medigap claim-based ID, left-justified and followed by spaces, within the NM109 portion of the 2330B loop of the incoming HIPAA ANSI X12-N 837 professional claim **and** within field 301-C1 of the T04 segment on incoming National Council for Prescription Drug Programs (NCPDP) claims for purposes of triggering Medigap claim-based crossovers.
- Providers will need to make certain that claims are submitted with the appropriate identifier that begins with a "5" and contains "5" numeric digits.
- Be mindful that claims for Medigap claim-based crossovers shall feature a syntactic editing of the incoming COBA claim-based Medigap ID to ensure that the identifier begins with a "5" and contains 5 numeric digits. If your claim does not follow the appropriate format, Medicare will continue to adjudicate your claim as normal but will notify you via the Electronic Remittance Advice (ERA) and the beneficiary via the Medicare Summary Notice (MSN) that the information reported was insufficient to cause the claim to be crossed over.

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

- Your Medicare contractor's screening process will also -continue to verify that you participate with Medicare and that the beneficiary has assigned benefits to you as the provider.
- If the claim submitted to the Medicare contractor indicates that (1) the claim contained an invalid claim-based Medigap crossover ID, **the Medicare contractor** will send the following standard message to you, the provider.
  - "Information was **not** sent to the Medigap insurer due to incorrect/invalid information you submitted concerning the insurer. **Please verify your information and submit your secondary claim directly to that insurer.**"
- In addition, in these cases, if CMS' Common Working File (CWF) system determines that the beneficiary was identified for crossover on a Medigap insurer's eligibility file, the CWF system will suppress crossover to the Medigap insurer whose information was entered on the incoming claim.
- Also, the Medicare contractor will include the following message on the beneficiary's MSN in association with the claim: (MSN #35.3):
  - "A copy of this notice will not be forwarded to your Medigap insurer because the Medigap information submitted on the claim was incomplete or invalid. Please submit a copy of this notice to your Medigap insurer."
- **REMEMBER:** As CMS's COBC assigns new 5-digit COBA Medigap claim-based identifiers to Medigap insurers, participating providers will be expected to include the new 5 digit identifier on incoming crossover claims for purposes of triggering claim-based Medigap crossovers. Additionally, effective with **October 1, 2007, Medigap claim-based crossovers will occur exclusively through the COBC in the HIPAA ANSI X12-N 837 professional claim format (version 4010A1 or more current standard) and NCPDP claim format.**

Additional Information
For complete details regarding this Change Request (CR) please see the official instruction (CR5601) issued to your Medicare carrier, A/B MAC, DME MAC, or DMERC. That instruction may be viewed by going to **http://www.cms.hhs.gov/Transmittals/downloads/R1242CP.pdf** on the CMS website.

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

Update of Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) and Enhancement of Medicare Remit Easy Print (MREP) (MM5634)

MLN Matters Number: MM5634
Related CR Release Date: June 15, 2007
Related CR Transmittal #: R1267CP
Related Change Request (CR) #: 5634
Effective Date: July 1, 2007
Implementation Date: July 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
This article is based on Change Request (CR) 5634 which instructs Medicare contractors that a Remittance Advice Remark Code (RARC) must be used with Claim Adjustment Reason Codes (CARCs) 16, 17, 96, 125, and A1. CR5634 also instructs that updated Medicare Remit Easy Print (MREP) software will be provided which incorporates enhancements approved by the Centers for Medicare & Medicaid Services (CMS) and the currently valid Claim Adjustment Reason and and Remittance Advice Remark Codes.

Background
The Health Insurance Portability and Accountability Act (HIPAA) of 1996 instructs health plans to be able to conduct standard electronic transactions (submission of claims, claims inquiries, electronic remittance advice, etc.) adopted under HIPAA using valid standard codes. The American National Standards Institute (ANSI) Accredited Standards Committee (ASC) X12 transactions are part of the Transactions and Code Sets Rule selected by HIPAA, and the ANSI X12 subcommittee 'N' covers standards in the insurance industry, including health insurance (hence these are X12N standards). The ANSI ASC X12N transaction number 835 (ANSI ASC X12N-835) is the ANSI standard electronic remittance advice (ERA) transaction that provides payment information on a submitted claim.

Update of Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) and Enhancement of Medicare Remit Easy Print (MREP) (MM5634) (Continued)

Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) Update

As a reminder, Medicare policy states that:

- Claim Adjustment Reason Codes (CARCs) are required in the remittance advice and coordination of benefits transactions, and
- Remittance Advice Remark Codes (RARCs) are **required in the remittance advice for both paper and electronic formats.**

When the payment differs from the amount being billed, Payers communicate the reason for any adjustment using:

- **Group Codes** (which identify who is financially responsible for the amount that the payer is not reimbursing),
- **CARCs** (which provide an explanation why an amount is being adjusted), and
- **RARCs** (which provide a supplemental explanation about the adjustment) Any RARC that has the word "Alert" is an informational remark code that does not provide any supplemental explanation for a specific adjustment but provides general information related to adjudication.

The following table includes Group Codes currently being used by CMS:

Group Code	Definition
CO	Contractual Obligation (Provider is financially responsible)
PR	Patient responsibility (Provider can collect the amount from patient)
OA	Other Adjustment (Generally used to report bundling/unbundling situation, predetermination of benefits, and secondary payments)
CR	Correction (Used with reversal and correction)

The ANSI ASC X12N-835 Implementation Guide (version 004010A1) requires CARCs (if needed) but does not require use of RARCs. A HIPAA compliant version of the Implementation Guide for transaction 835 (Health Care Claim Payment & Remittance Advice) is available at: **http://www.wpc-edi.com/HIPAA**.

The code committee that maintains the CARC code set recently modified five CARCs (16, 17, 96, 125, and A1). These CARCs were selected for modification because they were very generic, and they were used most frequently. Of these 5 CARCs, the following 4 now require the use of at least one appropriate RARC, and they are **effective April 1, 2007**:

CARC	Definition
16	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.)
17	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.)
96	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.)
125	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.)

The remaining 1 CARC (which follows) also requires at least one RARC, but it is **effective June 1, 2007**.

CARC	Definition
A1	Claim denied charges

Update of Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) and Enhancement of Medicare Remit Easy Print (MREP) (MM5634) (Continued)

CMS instructed your Medicare contractor(s) to analyze their current use of RARCs with CARCs 16, 17, 96, and 125, and determine if any existing RARCs (that are not currently being used) may be appropriate to explain an adjustment. Your Medicare contractor(s) may start using any of the currently existing RARCs with CARCs 16, 17, 96, 125, and A1.

Note: The most current list of RARCs can be found at: **http://www.wpc-edi.com/codes**.

In addition, the committee that maintains reason codes approved the following CARC effective February 28, 2007:

CARC	Definition
204	**This service/equipment/drug is not covered under the patient's current benefit plan**

Your Medicare contractor(s) may use CARC 204 instead of CARC 96 and an appropriate remark code, e.g., N130.

RARC	Definition
N130	**Consult plan benefit documents for information about restrictions for this service**

RARC N130 will be used with CARC 96 as a default combination to be reported on all DME claims if:

- No code has been assigned by your Medicare contractor, and
- The service is not covered by Medicare.

Medicare Remit Easy Print (MREP) Enhancement

CMS developed Medicare Remit Easy Print (MREP) software that gives providers a tool to read and print an electronic remittance advice (RA) in a human readable format. Providers who use the MREP software have the ability to print paper documentation that can be used to reconcile accounts receivable, as well as create document(s) that can be included with claims submissions to secondary/tertiary payers for Coordination of Benefits. Information regarding MREP and instructions on obtaining MREP are available through your Medicare contractor.

In a continuing effort to improve MREP, CMS established a process to receive suggestions to enhance the functionality and effectiveness of MREP from providers, contractors, and CMS staff. The next updated version of MREP that incorporates improvements approved by CMS will be available in July 2007. Note that the timeline for the annual MREP enhancement update has changed from October to July.

Additional Information

The official instruction, CR5634, issued to your carrier, FI, RHHI, A/B MAC, or DME MAC regarding this change may be viewed at **http://www.cms.hhs.gov/Transmittals/downloads/R1267CP.pdf** on the CMS web site.

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

CMS News Flash

- **National Provider Identifier (NPI) News**
  Medicare is now asking that submitters send a small number of claims using only the NPI. If no claims are rejected, the submitter can gradually increase the volume. Additional information can be found at the CMS NPI website at **http://www.cms.hhs.gov/NationalProvIdentStand/**.
- The Centers for Medicare & Medicaid Services has announced the proposed rule that would establish new policies and payment rates for physicians and other providers who are paid under the Medicare physician fee schedule. Included in the proposed rule is important information directly related to 2008 PQRI. To view or download the proposed rule, visit, **http://www.cms.hhs.gov/center/physician.asp**, click on CMS-1385-P, then go to page 402 of the document.

CMS News Flash (Continued)

- **PQRI Tool Kit Available**
  The Centers for Medicare & Medicaid Services (CMS) is pleased to announce that the 2007 Physician Quality Reporting Initiative (PQRI) Tool Kit is now available. To access the Tool Kit, visit the PQRI web page at **http://www.cms.hhs.gov/PQRI** on the CMS website, then go to the PQRI Tool Kit section. To access all of the other resources you need to assist in successful reporting, go to the Educational Resources section of the previously mentioned website.

- **Physician Quality Reporting Initiative (PQRI) Measures and Specifications**
  The Centers for Medicare & Medicaid Services (CMS) is pleased to announce that the 2007 Physician Quality Reporting Initiative (PQRI) Quality Measures and Specifications are now available. To access both the measures and measure specifications documents, visit the PQRI web page at **http://www.cms.hhs.gov/PQRI** on the CMS website. Once there, go to the Measures/Codes section of the page and scroll down to the Downloads section. Please note that many of the quality codes are new and will be rejected by Medicare claims processing systems prior to the July 1, 2007 HCPCS update.

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

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

- If you treat a Medicare Advantage enrolled beneficiary and you have questions about their Medicare Advantage Plan, you may wish to contact that plan. A plan directory and MA claims processing contact directory are available at **http://www.cms.hhs.gov/MCRAdvPartDEnrolData/** on the CMS website. CMS updates this site on a monthly basis.

- **Medicare Fee-For-Service (FFS) Contingency Plan Announced!**
  Effective May 23, 2007, Medicare FFS is establishing a contingency plan for implementing the National Provider Identifier (NPI). In this plan, as soon as Medicare considers the number of claims submitted with an NPI for primary providers (Billing, pay-to and rendering providers) is sufficient, Medicare (after advance notification to providers) will begin rejecting claims without an NPI for primary providers, perhaps as early as July 1, 2007. For more information on this contingency plan, please visit the NPI dedicated website at **http://www.cms.hhs.gov/nationalprovidentstand/**.

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

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

- Revised errata sheets and downloadable versions (April 2007) of the Medicare Physician Guide: A Resource for Residents, Practicing Physicians, and Other Health Care Professionals and the Facilitator's Guide - Companion to Medicare Physician Guide: A Resource for Residents, Practicing Physicians, and Other Health Care Professionals have been posted on the CMS Medicare Learning Network. To access these publications, visit **http://www.cms.hhs.gov/MLNProducts/MPUB/list.asp**.

CMS News Flash (Continued)

- The Medicare Durable Medical Equipment Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program Final Regulation is now available. CMS has also announced the first 10 metropolitan areas in which competition will occur as well as the first items to be competitively bid. Visit the CMS Website at **http://www.cms.hhs.gov/competitiveacqfordmepos**/ to view the rule and get more information.
- The Centers for Medicare & Medicaid Services (CMS) is now soliciting bids for the first round of the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding Program. All bids are due by 9:00 p.m. prevailing Eastern Time on July 13, 2007. The contract period for mail order diabetic supplies is April 1, 2008 - December 31, 2009. The contract period for all other first round product categories is April 1, 2008 - March 31, 2011. Suppliers must be accredited or have pending accreditation to submit a bid and will need to be accredited to be awarded a contract. The accreditation deadline for the first round of competitive bidding is August 31, 2007. Suppliers should apply for accreditation immediately to allow adequate time to process their applications. Suppliers interested in bidding must first register and receive a User ID and Password before they can access the internet-based bid submission system. Suppliers should register immediately to avoid a delay in being able to submit bids. The registration deadline is June 30, 2007. For more information on the program as well as bidding and accreditation information, please visit **http://www.dmecompetitivebid.com** or **http://www.cms.hhs.gov/CompetitiveAcqforDMEPOS**.

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**

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

MLN Matters Number: MM5584
Related CR Release Date: May 31, 2007
Related CR Transmittal #: R207PI

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

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

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

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

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

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

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

Important Note: Effective May 23, 2007, Medicare FFS is establishing a contingency plan for implementing the National Provider Identifier (NPI). In this plan, as soon as Medicare considers the number of claims submitted with an NPI for primary providers (Billing, pay-to and rendering providers) is sufficient, Medicare (after advance notification to providers) will begin rejecting claims without an NPI for primary providers, perhaps as early as July 1, 2007. For more information on this contingency plan, please visit the NPI dedicated website at **http://www.cms.hhs.gov/NationalProvIdentStand**/. This contingency plan does not affect CMS plans to discontinue assigning UPINs on June 29, 2007 or to disable the UPIN "look-up" functionality as of September 30, 2007.

The CMS will discontinue assigning on June 29, 2007, but CMS will maintain its UPIN public "look-up" functionality and Registry website (**http://www.upinregistry.com**/) through September 30, 2007.

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

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

The official instruction, CR5584, issued to your carrier, intermediary, RHHI, A/B MAC and DME MAC regarding this change may be viewed at **http://www.cms.hhs.gov/Transmittals/downloads/R207PI.pdf** on the CMS website.

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

Important Information for Providers/Suppliers Regarding National Plan and Provider Enumeration System (NPPES) Errors, Using the NPI on Medicare Claims and 835 Remittance Advice Changes (SE0725)

MLN Matters Number: SE0725
Related CR Release Date: N/A
Related CR Transmittal #: N/A
Related Change Request (CR) #: N/A
Effective Date: N/A
Implementation Date: N/A

Provider Types Affected
Physicians, providers, and suppliers who submit claims to Medicare fee-for-service contractors (Carriers, Fiscal Intermediaries (FIs), including Regional Home Health Intermediaries (RHHIs), Part A/B Medicare Administrative Contractors (A/B MACs), and Durable Medical Equipment Medicare Administrative Contractors (DME MACs))

Provider Action Needed
Impact to You
Certain information you enter into the National Plan and Provider Enumeration System (NPPES) in order to obtain and maintain your National Provider Identifier (NPI) is used by Medicare in processing claims.

What You Need to Know
If the information you entered in NPPES is not correct, your claims may reject. It is important to verify that information was entered correctly. Other guidance in this article will also help assure your claims are processed timely and correctly.

What You Need to Do
The Centers for Medicare & Medicaid Services (CMS) recommends that physicians, providers, and suppliers validate their NPPES data and be sure their staff are aware of the key elements that need to be correct as explained in this article. Also, you may want to be sure your staff are aware of the important billing tips in this article.

Background
As Medicare begins to implement the NPI into its systems, several enumeration and billing errors have been identified that may result in claim rejections.

Common Enumeration Errors in NPPES
Below are some of the more frequent errors providers have been making when applying for NPIs:

- **Errors in Employer Identification Number (EIN):** As a reminder, providers that are organizations are required to report the EIN when they apply for an NPI (on-line, paper, and electronic file interchange (EFI)). That EIN may also be the Taxpayer Identification Number (TIN). With the revised NPI Application/Update Form (CMS-10114) (to be used beginning July 10, 2007, for on-line, paper, and EFI), organizations that are subparts will be required to report the legal business name (LBN) of their "parent" and the "parent's" TIN. The applicant will continue to be required to report its EIN. **If the EIN error is on the Medicare provider enrollment record, the provider should submit a CMS-855 to the Medicare contractor to correct it.**
- **Invalid or incomplete data within the 'Other Provider Identifiers' section of the NPPES online application, such as:**
  - The absence of the Medicare legacy number,
  - Not having the *'Type'* listed as Medicare for a Medicare provider number, and/or
  - Reporting Medicare provider numbers that do not belong to the provider applying for the NPI and, therefore, should not be linked to the assigned NPI.
- **Reporting an Incomplete Identifier:** Medicare providers/suppliers need to ensure that, if reporting their Medicare legacy identifiers to NPPES, they report the full identifier. This means that suffixes to the OSCAR/Certification Numbers are to be reported. If the full identifier is not reported, it will be impossible for Medicare to establish the linkage from the NPI to that particular Medicare legacy identifier when using NPPES data and the NPI crosswalk.

Important Information for Providers/Suppliers Regarding National Plan and Provider Enumeration System (NPPES) Errors, Using the NPI on Medicare Claims and 835 Remittance Advice Changes (SE0725) (Continued)

- **Having More than the Allowable Number of Legacy Numbers:** At the present time, the NPPES can capture a grand total of 20 "Other Provider Identification Numbers." While this adequately accommodates the majority of providers/suppliers, it does not accommodate all of them. NPPES will be expanded to capture more than 20 "Other Provider Identification Numbers" at a future date. Medicare providers/suppliers who have more than 20 Medicare legacy identifiers that need to be linked directly to the NPI to be assigned should contact their Medicare fee-for-service contractors to determine how best to inform those contractors of all of the Medicare legacy identifiers.
- **Listing Legacy Numbers that Do Not Belong to the Applicant:** The provider/supplier should make sure that any Medicare legacy identifier(s) (OSCAR/Certification Number, Provider Identification Number (PIN), Unique Physician Identification Number (UPIN), and National Supplier Clearinghouse (NSC) Number) entered in that field in NPPES are those that will need to be linked directly to the NPI to be assigned. That is, do not list in the "Other Provider Identification Numbers" section identifiers that belong to providers other than the one that is applying for the NPI. Specific examples follow in the "Do's and Don'ts" section below.

Dos and Don'ts When Reporting "Other Provider Identification Numbers" in NPPES

- **For a Medicare physician or other practitioner applying for an NPI:** DO include your UPIN (if one was assigned) and your PIN when applying for an NPI. DO NOT include the PIN of your group practice or clinic if you are affiliated with a group practice or clinic.
- **For a Medicare group practice or clinic applying for an NPI:** DO include your PIN. DO NOT include the PINs or UPINs of any of the members of the group practice or clinic.
- **For a Medicare pharmacy that is enrolled as both a pharmacy and a DME supplier that is applying for an NPI as a pharmacy/DME supplier:** DO include both NSC Numbers (pharmacy and DME supplier).
- **For a Medicare pharmacy that is enrolled as both a pharmacy and a DME supplier that is applying for an NPI as a pharmacy:** DO include the NSC number assigned to the pharmacy, but DO NOT include the NSC number assigned to the DME supplier.
- **For a Medicare pharmacy that is applying for an NPI as a DME supplier:** DO include the NSC Number assigned to the DME supplier. DO NOT include the NSC Number assigned to the pharmacy.
- **For a Medicare hospital swing bed unit that is applying for an NPI as a swing bed unit:** DO include the OSCAR/Certification Number assigned to the swing bed unit. DO NOT include the OSCAR/Certification Number assigned to the hospital.
- **For a Medicare hospital that is applying for an NPI but does not want swing bed units or rehabilitation units (if they have these units) to have their own NPIs:** DO include the OSCAR/Certification number assigned to the hospital and the OSCAR/Certification Numbers assigned to both the swing bed unit and the rehabilitation unit.

If Medicare providers/suppliers determine that they should make changes to their NPPES records, they may do so by going to NPPES at **https://nppes.cms.hhs.gov**/ at any time and updating their information. Or, if they prefer, they may send updates on the paper NPI Application/Update Form (CMS-10114). Forms may be requested by calling the NPI Enumerator at their toll-free number, which is 1-800-465-3203, TTY 1-800-692-2326. The revised CMS-10114 is to be used beginning July 10, 2007. These forms can be obtained from the Enumerator, as outlined above, or you may download the form from the CMS Forms page at **http://www.cms.hhs.gov/cmsforms** on the Web.

CMS recommends that Medicare providers/suppliers make a copy of their NPPES information by doing a "print screen" of their NPPES record or make a photocopy of the completed paper NPI Application/Update form and keep it on hand for reference if they encounter problems.

Common Error in Reporting Change of Ownership to Medicare

Delays in reporting Change of Ownership: Whenever there is a change of ownership, the provider is responsible for reporting that change to the appropriate Medicare contractor within 30 days. Providers are supposed to report that change on the CMS-855.

How to Use Your NPI When Billing Medicare Part A (Institutional) Claims to a Fiscal Intermediary (FI) or A/B MAC

For providers who submit electronic Part A institutional claims to Medicare FIs or A/B MACs, a high volume of claims have been received where the NPI/legacy identifier combinations cannot be validated by the Medicare NPI crosswalk.

Failure to properly submit the NPI in the correct loops may cause the claim to reject. Organization providers should utilize their NPI in the 2010AA or 2010AB loop. The attending, operating or other physicians should be identified in the 2310A, B and C loops respectively. If 2420A loop is used, the Attending Physician NPI must be submitted.

Important Information for Providers/Suppliers Regarding National Plan and Provider Enumeration System (NPPES) Errors, Using the NPI on Medicare Claims and 835 Remittance Advice Changes (SE0725) (Continued)

Below is a guide to use when submitting primary NPIs:

Name/Loop	Legacy Information	NPI Information
Billing Provider 2010AA Loop	**OSCAR**	**Provider NPI**
Pay to Provider 2010AB Loop	**OSCAR**	**Provider NPI**
Attending Physician 2310A Loop	**PIN, UPIN**	**Physician NPI**
Operating Physician 2310B Loop	**PIN, UPIN**	**Physician NPI**
Other Physician 2310C	**PIN, UPIN**	**Physician NPI**
Attending Physician 2420A	**PIN, UPIN**	**Physician NPI**

Some Medicare FIs and A/B MACs have developed front-end reason codes that will return claims to the providers when the NPI and Legacy combination submitted does not match the NPI crosswalk.

If a reject or RTP (Return to Provider) is received, **providers are encouraged to verify that their NPI/Legacy combination is valid in NPPES first at https://nppes.cms.hhs.gov/**

The following is a listing of Front-end Processing Reason Codes:

Code	Description
32000	This claim has been rejected because the intermediary has no record of the Medicare provider number submitted.
32102	The claim contains an NPI but the first digit of the NPI is not equl to “1”, “2”, “3”. “4” or the 10th digit of the NPI does not follow the check digit validation routine. Please verify billing and, if appropriate, correct. **Online providers - press PF9 to store the claim. **Other providers - return to the intermediary
32103	NPI/OSCAR pair on the claim is not present in the Medicare NPI Crosswalk File. This edit applies to the NPI associated with the OSCAR number. Please verify provider billing number and, if appropriate, please correct either NPPES or your CMS-855 information. Please verify all of your information in NPPES. You should validate that the NPI/OSCAR pair you are using on the claim reflects the OSCAR number that you reported to NPPES. You may view/correct your NPPES information by going to **https://nppes.cms.hhs.gov** If your NPPES information is correct, and you have included all Medicare legacy identifiers (OSCARS) in NPPES, but you are still experiencing problems with your claims that contain a valid NPI, you may need to submit a Medicare enrollment application (i.e. - the CMS 855). Please contact your contractor prior to submitting a CMS-855 form.
32104	The NPI and the legacy (OSCAR) number are present on the claim and the NPI is present in the Crosswalk File, but the associated legacy (OSCAR) number in the Crosswalk file does not match the legacy (OSCAR) number on the claim. Please verify billing number and, if appropriate, correct. ***Online providers - Press PF9 to store the claim. ***Other Providers - Return to the intermediary.
32105	The NPI is present in the Crosswalk File but the NPI corresponds to more than one legacy (OSCAR) number. Enter the OSCAR number associated with the NPI submitted. Please verify billing number and, if appropriate, correct. ***Online providers - Press PF9 to store the claim. ***Other providers - Return to the intermediary.

Important Information for Providers/Suppliers Regarding National Plan and Provider Enumeration System (NPPES) Errors, Using the NPI on Medicare Claims and 835 Remittance Advice Changes (SE0725) (Continued)

Code	Description
32107	The NPI for the attending physician on the claim is not present in the Crosswalk File. Please verify billing number and, if appropriate, correct. ***Online providers - Press PF9 to store the claim. ***Other providers - Return to the intermediary.
32108	The attending physician's NPI and UPIN are present on the claim and the attending physician's NPI is present in the Crosswalk File, but the attending physician's UPIN in the Crosswalk File does not match the attending physician's UPIN on the claim. Please verify the UPIN and, if appropriate, correct. ***Online providers - Press PF9 to store the claim. ***Other providers - Return to the intermediary.
32109	The operating physician's NPI on the claim is not present in the Crosswalk File. Please verify billing number and, if appropriate, correct. ***Online providers - Press PF9 to store the claim. ***Other providers - Return to the intermediary.
32110	The operating physician's NPI and UPIN are present on the claim and the operating physician's NPI is present in the Crosswalk File, but the operating physician's UPIN in the Crosswalk File does not match the operating physician's UPIN on the claim. Please verify the UPIN and, if appropriate, correct. ***Online providers - Press PF9 to store the claim. ***Other providers - Return to the intermediary.
32111	The other physician NPI on the claim is not present in the Crosswalk File. Please verify the billing number and, if appropriate, correct. ***Online providers - Press PF9 to store the claim. ***Other providers - Return to the intermediary.
32112	The other physician's NPI and UPIN are present on the claim and the other physician's NPI is present in the Crosswalk File, but the other physician's UPIN in the Crosswalk File does not match the other physician's UPIN on the claim. Please verify the UPIN and, if appropriate, correct. ***Online providers - Press PF9 to store the claim. ***Other providers - Return to the intermediary.
32113	The taxonomy code entered is invalid. Or, a taxonomy code is required when the NPI is present in the Crosswalk File and the NPI corresponds to more than one legacy (OSCAR) number. Please verify the billing number and, if appropriate, correct. ***Online providers - Press PF9 to store the claim. ***Other providers - Return to the intermediary.

If your FI or A/B MAC is using the MEDATRAN claims translator, below is a list of EDI Inbound Reject codes you may receive:

Edit Number	Loop	Edit Description
99	2010AA	The NPI/Legacy combination does not match the NPI crosswalk.
99	2010AB	The NPI/Legacy combination does not match the NPI crosswalk.
99	2310A,B,C	The NPI/Legacy combination does not match the NPI crosswalk.
99	2420A	The NPI/Legacy combination does not match the NPI crosswalk.

Important Information for Providers/Suppliers Regarding National Plan and Provider Enumeration System (NPPES) Errors, Using the NPI on Medicare Claims and 835 Remittance Advice Changes (SE0725) (Continued)

How to Use Your NPI When Billing Medicare Part B (Professional) Claims to Carriers and A/B MACs

For providers who submit electronic professional claims to Medicare Part B carriers and A/B MACs, CMS test data indicates that a high volume of claims have been received where the NPI/legacy identifier combinations cannot be validated by the Medicare NPI crosswalk.

Even if you have validated your NPPES data, failure to properly submit the NPI in the correct loops may cause the claim to reject. Group providers should utilize the GROUP NPI in the 2010AA or 2010AB loop. The INDIVIDUAL or MEMBER OF GROUP NPI should only be submitted in the 2310B or 2420A loops.

Below is a guide to use when submitting primary NPIs:

Name/Loop	Legacy Information	NPI Information
Billing Provider 2010AA Loop	Group PIN Individual PIN	Group NPI Individual NPI
Pay to Provider 2010AB Loop (this should only be submitted if different from Billing Provider)	Group PIN Individual PIN	Group NPI Individual NPI
Rendering Provider 2310B Loop (this should only be submitted if a group practice)	Individual / Member of Group PIN	Individual / Member of Group NPI
Rendering Provider 2420A Loop (this should only be submitted if a group practice)	Individual / Member of Group PIN	Individual / Member of Group NPI

Some carriers and A/B MACs will return the informational messages or edits below when the NPI and legacy identifier combination submitted does not match the NPI crosswalk. As of the date of this article, claims with NPI/legacy identifiers are not rejecting because Part B contractors (except CIGNA Tennessee and Idaho), have "crosswalk bypass" logic in their system that will allow invalid pairs to process on the legacy number. The informational edits you are receiving are a warning that your claims will reject when the logic is removed. Providers are encouraged to verify that the NPI/legacy identifier combination is valid on NPPES at **https://nppes.cms.hhs.gov** prior to submission of Medicare claims.

Following is a listing of the edits you may receive when billing Professional Part B claims:

Edit Number	Loop	Edit Description
M340	2010AA	The NPI/Legacy combination does not match the NPI crosswalk.
M341	2010AB	The NPI/Legacy combination does not match the NPI crosswalk.
M343	2310B	The NPI/Legacy combination does not match the NPI crosswalk.
M347	2420A	The NPI/Legacy combination does not match the NPI crosswalk.

Important Reminders Regarding 835 Remittance Advice Changes Effective July 2, 2007 for DME Suppliers Submitting Claims to DME MACS Only.

DME suppliers are reminded that important changes will occur on your electronic remittance advice and your standard paper remittance actions, effective July 2, 2007. As of that date when you have submitted an NPI on your claim, your DME MAC will report on the 835 (or via the Medicare Remit Easy Print (MREP) Software) as follows:

- The billing/pay-to NPI will be reported at the Payee level (Loop 1000B in N104 with the XX qualifier in N103 of the 835),
- The TIN (EIN/SSN) will be reported in the REF segment (Loop 1000B, data field REF 02 with qualifier TJ in REF 01 of the 835) as Payee Additional ID,
- Any relevant Rendering Provider NPI will be reported at the claim level (Loop 2100, data field NM 109 with qualifier XX in NM 108 on the 835) if different from the Payee NPI, and
- Any relevant Rendering NPI(s) will be reported at the service line level (Loop 2110, data field REF 02 with qualifier HPI in REF 01 on the 835) when different from the claim level Rendering NPI.

Important Information for Providers/Suppliers Regarding National Plan and Provider Enumeration System (NPPES) Errors, Using the NPI on Medicare Claims and 835 Remittance Advice Changes (SE0725) (Continued)

When you do not report your NPI, but report your legacy National Supplier Clearinghouse (NSC) number on a claim, Medicare will continue to report legacy numbers in generating your remittance advice. Further information regarding the remittance changes may be found in CR5452, which is at **http://www.cms.hhs.gov/Transmittals/downloads/R1241CP.pdf** or in the related *MLN Matters* article, MM5452, at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5452.pdf** on the CMS website.

Important NOTE: The 835 Remittance Advice changes listed above will be effective for other providers submitting Part A Institutional claims and Part B Professional claims, at a later date. Medicare will notify submitters when a date is determined.

Additional Information
You may also want to review *MLN Matters* article SE0679, which has additional information on the overall NPI activity. This article is at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0679.pdf** on the CMS website.

Important information regarding current NPI implementation contingency plan is in article MM5595, which is available at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5595.pdf**.

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

National Provider Identifier (NPI) Required to Enroll in Electronic Data Interchange (EDI), and Update of Telecommunication and Transmission Protocols for EDI (MM5637)

MLN Matters Number: MM5637 - Revised
Related CR Release Date: July 6, 2007
Related CR Transmittal #: R1283CP
Related Change Request (CR) #: 5637
Effective Date: October 1, 2007
Implementation Date: October 1, 2007

Note: This article was revised on July 17, 2007, to reflect a new Web address in the Additional Information section for NPI information. All other information remains the same.

Provider Types Affected
Physicians and other providers who bill Medicare contractors (carriers, fiscal intermediaries (FI), including regional home health intermediaries (RHHI), Medicare Administrative Contractors (A/B MAC), or Durable Medical Equipment Medicare Administrative Contractors (DME MAC)) for services provided to Medicare Beneficiaries.

Provider Action Needed
Impact to You
If not already enrolled for use of electronic billing & other electronic data interchange (EDI) transactions, you will not be able to enroll to begin use if you have not yet obtained a National Provider Identifier (NPI).

What You Need to Know
CR 5637, from which this article is taken, announces that providers must obtain an NPI, as a condition for initial enrollment, for the use of EDI. Your Medicare contractor will not issue you an EDI access number and password until you obtain an NPI.

What You Need to Do
If you have not already obtained your NPI, you should apply now. You can apply on line by going to **https://nppes.cms.hhs.gov**/.

Background
Since May 2006, providers have been required to obtain a National Provider Identifier (NPI) prior to initial Medicare enrollment, or before updating their enrollment records, but were not required to have an NPI, as a condition for enrollment, in order to begin using electronic data interchange (EDI) transactions.

CR 5637, from which this article is taken, announces that (effective October 1, 2007) providers will need to obtain an NPI, as a condition for initial enrollment, for the use of EDI.

National Provider Identifier (NPI) Required to Enroll in Electronic Data Interchange (EDI), and Update of Telecommunication and Transmission Protocols for EDI (MM5637) (Continued)

This is being implemented to further support efforts by the Centers for Medicare & Medicaid Services (CMS) to have all providers obtain NPIs as soon as possible. Moreover, as indicated in *MLN Matters* article MM5595 (**http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5595.pdf**), Medicare is monitoring claims to determine the level of NPI reporting. This is being done to determine when it will be reasonable for Medicare to begin rejecting claims that lack an NPI for billing, pay-to or rendering providers.

CR 5637 also updates EDI connectivity information in the *Medicare Claims Processing Manual*, Section 24 (General EDI and EDI Support Requirements, Electronic Claims and Coordination of Benefits Requirements, Mandatory Electronic Filing of Medicare Claims), Sections 20 (EDI Enrollment) and 30.3 (Telecommunications and Transmission Protocols) because some of the information in the manual is obsolete due to technology changes.

In summary, these changes are:

- Medicare contractors will use V.90 56K modems for EDI transactions submitted via dial-in connections;
- Medicare contractors will offer data compression in a means that an EDI transaction sender/receiver requests, using the V.90 56 K modem, PK ZIP version 2.04x or higher, WinZIP or V.42 bis data compression;
- DME MACs will reject standard National Council for Prescription Drug Programs (NCPDP) transactions that do not use the standard NCPDP electronic envelope;
- Medicare contractors may, but are not required to, accommodate other types of data compression that an EDI submitter/receiver requests.

Additional Information
You can find more information about the requirement for an NPI in order to be able to use EDI transactions, by going to CR 5637, located at **http://www.cms.hhs.gov/Transmittals/downloads/R1283CP.pdf** on the CMS website. As an attachment to CR 5637, you will find updated *Medicare Claims Processing Manual*, Section 24 (General EDI and EDI Support Requirements, Electronic Claims and Coordination of Benefits Requirements, Mandatory Electronic Filing of Medicare Claims), Sections 20 (EDI Enrollment) and 30.3 (Telecommunications and Transmission Protocols). You can find more information about EDI on the CMS website at **http://www.cms.hhs.gov/ElectronicBillingEDITrans/**, and more information about the NPI at **http://www.cms.hhs.gov/NationalProvIdentstand/** on the CMS website.

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

Provider Authentication Requirements for Telephone and Written Inquires during the Medicare FFS National Provider Identifier (NPI) Contingency Plan (SE0721)

MLN Matters Number: SE0721
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 physicians, suppliers, and providers who call or write their Medicare Fee-for-Service (FFS) contractors (Fiscal intermediaries (FIs), Carriers, Part A/B Medicare Administrative Contractors (A/B MACs), DME Medicare Administrative contractors (DME/MACs), DME Regional Carriers (DMERCs) and/or Regional Home Health Intermediaries (RHHIs) with general inquiries.

Provider Action Needed
Impact to You
Due to the Medicare FFS NPI contingency plan, the NPI will not be a required authentication element for general provider telephone and written inquiries until the date that the Centers for Medicare & Medicaid Services (CMS) requires it to be on all claim transactions. In this contingency environment, the provider transaction access number (PTAN) is your current legacy provider identification number. Your PTAN, which may be referred to as your legacy number by some Medicare Fee-for-Service provider contact centers (PCCs), will be the required authentication element for all inquiries to Interactive Voice Response (IVR) systems, customer service representatives (CSRs), and the written inquiries units.

Provider Authentication Requirements for Telephone and Written Inquires during the Medicare FFS National Provider Identifier (NPI) Contingency Plan (SE0721) (Continued)

What You Need to Know

Medicare FFS will give sufficient notice to providers of the contingency plan end date. Until the date, you will need to provide the following:

- For Inquiries to the IVR:
  - PTAN / Legacy Number, depending upon the contractor
- For Inquiries to a CSR and Written Inquiries:
  - PTAN / Legacy Number, depending upon the contractor, and
  - Provider Name.

Remember, if you make inquiries to more than one contractor, you may hear the provider identification number referred to as either the legacy number or PTAN. On the date that the NPI is required to be on all claim transactions, the provider authentication elements required by all contractors will be both the NPI and PTAN.

What You Need to Do

If you have not yet done so, **you should obtain your NPI now.** You can apply on line at **https://nppes.cms.hhs.gov**/ on the CMS website. Once CMS ends the contingency plans, your claims and inquiries will not be processed without NPIs.

Background

In order to give providers and other trading partners more time to obtain and use the NPI, Medicare FFS invoked a contingency plan that allows continued use of legacy numbers beyond the May 23, 2007, implementation for the NPI. As reported in *MLN Matters* article MM5595, for some period after May 23, 2007, Medicare FFS will:

- Allow continued use of legacy numbers on transactions;
- Accept transactions with only NPIs; and
- Accept transactions with both legacy numbers and NPIs.

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

As part of this plan, Medicare FFS is assessing health care provider submission of NPIs on claims. As soon as the number of claims submitted with an NPI for primary providers (billing, pay-to and rendering providers) is determined to be sufficient (and following appropriate notice to providers), Medicare will begin rejecting claims that do not contain an NPI for primary providers. Beginning May 23, 2007, Medicare FFS contractors will require that providers provide their PTAN as a required authentication element for all general telephone or written inquiries. In this contingency environment, the PTAN is the provider legacy number. Some contractors may continue to use the provider legacy number as the required authentication element. Other contractors will begin to refer to the legacy number as the PTAN.

Provider enrollment letters may also continue to refer to the provider legacy number. Newly enrolled or re-enrolled providers will receive either a legacy number or PTAN in their provider enrollment letters depending on which is used for authentication.

Remember: CMS may end the contingency plan once it appears that the level of claims containing NPIs is sufficient to do so. CMS encourages you to get and use your NPI now. Also, remember to ready your other processes to use the NPI as soon as possible to avoid a situation where your claims are not processed when the contingency ends.

Additional Information

The CMS complete listing of all NPI resources is available at **http://www.cms.hhs.gov/NationalProvIdentStand**/ on the CMS website.

More details regarding the CMS NPI contingency plan are in the *MLN Matters* article MM5595 at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5595.pdf** on the CMS website.

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

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

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

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

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

Special note regarding remittance advice transactions: Just as it is important to understand when and where to report NPIs in claim transactions, it is crucial that providers understand and be ready to accept the provider identifiers as reported on remittance advice transactions. This article discusses what provider identifiers Medicare will report on remittances under Stage 2 of Medicare's NPI implementation. However, the processes will change as Medicare moves to Stage 3 implementation of the NPI. A key difference is that NPIs will be returned in many remittance transactions as the payee and the TIN as the additional payee identifier rather than the current practice of reporting TIN and legacy number respectively, even though the provider may have included the legacy number and the NPI on their claim. Providers need to review, and understand the impact of, Stage 3 on remittances as discussed in the *MLN Matters* article MM5452, which is at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5452.pdf** on the CMS site.

Also, note that this article was revised on May 7, 2007, to add this statement that Medicare FFS has announced a contingency plan regarding the May 23, 2007 implementation of the NPI. For some period after May 23, 2007, Medicare FFS will allow continued use of legacy numbers on transactions; accept transactions with only NPIs; and accept transactions with both legacy numbers and NPIs. For details of this contingency plan, see the *MLN Matters* article, MM5595, at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5595.pdf** on the CMS website.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Important Note: The following scenarios will change under Stage 3 of Medicare's NPI implementation. To see the changes, see *MLN Matters* article MM5452, which is available at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5452.pdf** on the CMS website.

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

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

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

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

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

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

Implementation

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

Additional Information

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

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

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

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

MLN Matters Number: MM5452
Related CR Release Date: May 18, 2007
Related CR Transmittal #: R1241CP

Related Change Request (CR) #: 5452
Effective Date: July 2, 2007
Implementation Date for DME suppliers: July 2, 2007
Implementation Date for other providers: October 1, 2007

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Implementation

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

- For claims submitted to DMERcs and/or DME MACs, the changes will be implemented on July 1, 2007.
- For claims submitted to other Medicare contractors, the implementation will occur on October 2, 2007.

Additional Information

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

For complete details regarding this Change Request (CR) please see the official instruction (CR5452) issued to your Medicare FI, RHHI, DMERC, DME/MAC, or A/B MAC. That instruction may be viewed by going to **http://www.cms.hhs.gov/Transmittals/downloads/R1241CP.pdf** on the CMS web site. The revised sections of Chapter 22-Remittance Advice of the *Medicare Claims Processing Manual* are attached to CR5452.

Billing Repairs of Patient Owned Equipment

Repairs to beneficiary owned equipment are considered for coverage if they are necessary for proper functioning of the equipment. Medicare does cover repair, up to the cost of replacement, for medically necessary equipment owned by the beneficiary. Repairs for previously denied equipment will not be covered. A new CMN and / or physician's order is not needed for covered maintenance or for repairs.

Maintenance and repairs for items that require frequent and substantial servicing are not covered.

When billing code K0108 the following information is required:

1. If multiple miscellaneous accessories are provided, each should be billed on a separate claim line using code K0108.
2. A description of the item, and the brand name, make/model and part number (use abbreviations when needed). You can abbreviate the brand name by using just the first 5 letters if needed. Do not abbreviate the model/part number.

   Example: "TOGGLE SWITCH.MFR PRIDE MD#FRMASMB272 REPLCMNT" (46 characters) this could be further abbreviated to "RPL toggle MFR PRIDE MD FRMASMB272" (34 characters)
3. The date of purchase, the HCPCS code, and a description of the beneficiary owned equipment.

   Example: "RPRs to PT owned PRIDE JAZZY610 K0011 PWC PUR 41603" (51 characters)

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

When billing code E1340, the medical records should contain detailed descriptions of the repairs made.

The information needed on the claim is a statement that this service is for repairs to beneficiary owned equipment in addition to the date of purchase, the HCPCS code, and a description of the beneficiary owned equipment.

Example: "RPRs to PT owned PRIDE JAZZY610 K0011 PWC PUR 41603" (51 characters)
All other required supporting medical documentation should be retained in provider files.

Providers will need to utilize the NTE fields (2300 and 2400) to submit all information pertinent to claims filed. The note segment is limited to 80 characters at the claim level and each line level, so providers should not include any wording that does not relate to the items and services being billed. If claims that require additional information for adjudication are submitted with nothing documented in the NTE fields (e.g. repairs), these claims will be denied. **Note:** *Should it be necessary for the DME MAC and / or PSC to obtain additional documentation, the claim will be developed with an ADR (Additional Documentation Request).* Utilize the *"Suggested Abbreviations When Reporting Additional Documentation Notations in the ANSI and NCPDP Formats"* article, found on the DME MAC A web site at **http://www.medicarenhic.com/dme/ediabbrev.htm**, when submitting additional documentation for electronic claims. This "suggested list" of abbreviations contains the most common types of documentation and notations submitted to DME MAC A. Refer to this reference tool to avoid unnecessary denials.

Billing Reminder - Continuous Passive Motion (CPM) Device

DME MAC A has been receiving numerous calls and seeing many denials for the Continuous Passive Motion (CPM) Device and is issuing this billing reminder as clarification on the proper claim submission for this item.

The Continuous Passive Motion (CPM) device (E0935) used for the knee due to total knee replacement is eligible for coverage and reimbursement through the DME MAC. All of the following criteria must be met for coverage:

1. The device must be prescribed by a physician.
2. The patient must have undergone a total knee replacement (TKR).
3. The use of the device must commence within two days of the date of surgery.

Coverage is limited to that part of a 21-day period, beginning with the date of surgery, during which the device is used in the **patient's home**.

Documentation of the following dates must accompany the claim:

1. Date of surgery
2. Date CPM therapy began
3. Date of discharge from the hospital

Billing Reminder - Continuous Passive Motion (CPM) Device (Continued)

The dates listed above should be included in Item 19 for paper claims or submitted on an attachment. An electronic claim should include these details in the NTE 2400 (claim line) or 2300 (claim header) loop. Documentation of a valid diagnosis or narrative of a total knee replacement (TKR) is also required.

Claims submitted without the above information will be denied.

Negative Pressure Wound Therapy (NPWT) Billing Reminder

Refer to Tricenturion's Web site for the May 2007 article, **Widespread Quarterly Review Results for Negative Pressure Wound Therapy (NPWT) HCPCS E2402 - Jurisdiction A,** addressing widespread pre-pay probe results for more information.

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

- DME MAC A Supplier Manual, Chapter 9, regarding Documentation in the *Patient's Medical Record* and *Supplier Documentation* **http://www.medicarenhic.com/dme/dme_publications.shtml**
- Criteria for *Initial Coverage, Continued Coverage,* and *When Coverage Ends* which are outlined below and can also be referenced within the *Indications and Limitations of Coverage and/or Medical Necessity* section of the NPWT LCD **http://www.tricenturion.com/content/lcd_current_dyn.cfm**

To further ensure accuracy of billing claims, suppliers are reminded to read, understand and develop a working knowledge of the NPWT LCD in regard to coverage criteria and documentation requirements.

Initial Coverage Criteria:

An NPWT pump and supplies are covered when either criterion A or B is met:

A. Ulcers and Wounds in the Home Setting:

The patient has a chronic Stage III or IV pressure ulcer (see Appendices Section), neuropathic (for example, diabetic) ulcer, venous or arterial insufficiency ulcer, or a chronic (being present for at least 30 days) ulcer of mixed etiology. A complete wound therapy program described by criterion 1 and criteria 2, 3, or 4, as applicable depending on the type of wound, should have been tried or considered and ruled out prior to application of NPWT.

1. For all ulcers or wounds, the following components of a wound therapy program must include a minimum of all of the following general measures, which should either be addressed, applied, or considered and ruled out prior to application of NPWT:
   a. Documentation in the patient's medical record of evaluation, care, and wound measurements by a licensed medical professional, and
   b. Application of dressings to maintain a moist wound environment, and
   c. Debridement of necrotic tissue if present, and
   d. Evaluation of and provision for adequate nutritional status.
2. For Stage III or IV pressure ulcers:
   a. The patient has been appropriately turned and positioned, and
   b. The patient has used a group 2 or 3 support surface for pressure ulcers on the posterior trunk or pelvis (see medical policy on support surfaces), (a group 2 or 3 support surface is not required if the ulcer is not on the trunk or pelvis) and
   c. The patient's moisture and incontinence have been appropriately managed.
3. For neuropathic (for example, diabetic) ulcers:
   a. The patient has been on a comprehensive diabetic management program, and
   b. Reduction in pressure on a foot ulcer has been accomplished with appropriate modalities.
4. For venous insufficiency ulcers:
   a. Compression bandages and/or garments have been consistently applied, and
   b. Leg elevation and ambulation have been encouraged.

Negative Pressure Wound Therapy (NPWT) Billing Reminder (Continued)

B. Ulcers and Wounds Encountered in an Inpatient Setting:

1. An ulcer or wound (described under A above) is encountered in the inpatient setting and, after wound treatments described under A-1 through A-4 have been tried or considered and ruled out, NPWT is initiated because it is considered in the judgment of the treating physician, the best available treatment option.
2. The patient has complications of a surgically created wound (for example, dehiscence) or a traumatic wound (for example, pre-operative flap or graft) where there is documentation of the medical necessity for accelerated formation of granulation tissue which cannot be achieved by other available topical wound treatments (for example, other conditions of the patient that will not allow for healing times achievable with other topical wound treatments).

In either situation B-1 or B-2, NPWT will be covered when treatment continuation is ordered beyond discharge to the home setting.

If criterion A or B above is not met, the NPWT pump and supplies will be denied as not medically necessary.

Continued Coverage Criteria:

C. For wounds and ulcers described under A or B above, once placed on an NPWT pump and supplies, in order for coverage to continue a licensed medical professional must do the following:

1. On a regular basis,
   a. directly assess the wound(s) being treated with the NPWT pump, and
   b. supervise or directly perform the NPWT dressing changes, and
2. On at least a monthly basis, document changes in the ulcer's dimensions and characteristics.

If criteria C-1 and C-2 are not fulfilled, continued coverage of the NPWT pump and supplies will be denied as not medically necessary.

When Coverage Ends:

D. For wounds and ulcers described under A or B above, an NPWT pump and supplies will be denied as not medically necessary with any of the following, whichever occurs earliest:

1. Criteria C1-C2 cease to occur,
2. In the judgment of the treating physician, adequate wound healing has occurred to the degree that NPWT may be discontinued,
3. Any measurable degree of wound healing has failed to occur over the prior month. Wound healing is defined as improvement occurring in either surface area (length times width) or depth of the wound.
4. 4 months (including the time NPWT was applied in an inpatient setting prior to discharge to the home) have elapsed using an NPWT pump in the treatment of the most recent wound.
5. Once equipment or supplies are no longer being used for the patient, whether or not by the physician's order.

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

Second Quarter 2007 - Top Claim Submission Errors

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

Top Ten Claims Submission Errors	Number Received	Reason For Error
40022 - Procedure Code / Modifier Invalid	39,579	The procedure code and / or modifier used on this line is invalid.
40068 - Invalid/Unnecessary CMN Question	31,334	The question number entered is not valid for the DME MAC CMN you are sending.
20293 - Invalid NPI Number	21,073	Validate NPI number and must be exactly 10 digits. NPI Number must start with a 1, 2, 3, or 4 and must be all numeric
20269 - Pointer 1 Diagnosis Invalid	10,945	Diagnosis pointer is invalid.
20011 - Billing Provider Secondary ID Invalid	10,846	Secondary provider ID is invalid.
20143 - Ordering Provider Secondary ID Invalid	10,065	The provider number or Unique Physician Identification Number (UPIN) is invalid.
40021 - Capped Rental K Modifier Missing	8,581	Required capped rental K modifier is missing from the claim.
40073 - Dates of Service Invalid with Procedure Code	7,507	The procedure code used is not valid for the dates of service used.
40014 - Ordering Provider Information Missing	7,453	The ordering provider information is missing. This should be included with every service line.
20025 - Subscriber ID Code Invalid	7,421	The qualifier identifying the subscriber is invalid.

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

Claims Submission Errors (Return / Reject Denials)	CMS 1500 Form (or electronic equivalent) Entry Requirement	Number Received
CO 4 The procedure code is inconsistent with the modifier used or a required modifier is missing.	**Item 24D** - Enter the procedures, services or supplies using the Healthcare Common Procedure Coding System (HCPCS). When applicable, show HCPCS modifiers with the HCPCS code.	13,855
CO 16 M51 Claim service lacks information which is needed for adjudication. Missing / incomplete / invalid procedure codes(s) and / or rates.	**Item 24D** - Enter the procedures, services, or supplies using the HCPCS. When applicable show HCPCS modifiers with the HCPCS code.	4,115
CO 16 MA130 Claim service lacks information which is needed for adjudication. Your claim contains incomplete and / or invalid information, and no appeal rights are afforded because the claim is unprocessable.	**Item 11 -** If other insurance is primary to Medicare, enter the insured's policy or group number. If no insurance primary to Medicare exists, enter "NONE."	4,256
CO 16 N265, N286 Missing / incomplete / invalid ordering provider primary identifier.	**Item 17 -** Enter the name of the referring or ordering physician, if the service or item was ordered or referred by a physician.	3,855

Second Quarter 2007 - Top Claim Submission Errors (Continued)

Claims Submission Errors (Return / Reject Denials)	CMS 1500 Form (or electronic equivalent) Entry Requirement	Number Received
CO 16 N64 Claim / service lacks information which is needed for adjudication. The "from" and "to" dates must be different.	**Item 24A -** Enter the precise eight-digit date (MMDDCCYY) for each procedure, service, or supply in Item 24A.	2,999
CO 16 M76, M81 You are required to code to the highest level of specificity. Missing / incomplete / invalid diagnosis or condition.	**Item 21 -** Enter the patient's diagnosis / condition. All physician specialties must use an ICD-9-CM code number, coded to the highest level of specificity.	1,676
CO 16 M51, N225, N29 Missing / incomplete / invalid procedure code(s).	**Item 24D -** Enter the procedures, services or supplies using the Healthcare Common Procedure Coding System (HCPCS). When applicable, show HCPCS modifiers with the HCPCS code.	1,358
CO 16 MA114 Missing / incomplete / invalid information on where the services were furnished.	**Item 32 -** Enter the name, address, and ZIP code of the facility if the services were furnished in a hospital, clinic, laboratory, or facility other than the patient's home or physician's office.	357
CO 16 M77 Missing / incomplete / invalid place of service	**Item 24B -** Enter the appropriate place of service code(s). Identify the location, using a place of service code, for each item used or service performed.	206
CO 16 M119 Missing / incomplete / invalid / deactivated / withdrawn National Drug Code (NDC)	**Item 24D -** Only Oral Anti-Cancer Drugs can be submitted with a National Drug Codes for paper and ANSI claims. All other items must be billed with a HCPCS code in this field.	141

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

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)

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/lmrp_current_dyn.cfm**.

DME MAC A ListServes

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

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

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

Quarterly Provider Update

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

Supplier Manual News

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

Updates/Corrections Made:
In July of 2007 **chapter 3** of the *DME MAC A Supplier Manual* was updated. Suppliers who maintain hard copy manuals at their place of business need to discard the previously published pages and replace them with the revised ones. In order to avoid potential viewing and/or printing problems, be sure to follow the download instructions to access the revised pages.

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

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

Outreach & Education
781-741-3950

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

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

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

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

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

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

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

Written Inquiry FAX: 781-741-3530

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

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

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

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

Redetermination Requests FAX:
781-741-3118

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

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

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

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

National Supplier Clearinghouse
866-238-9652

SADMERC
877-735-1326

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

DME MAC Jurisdiction A Resource

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

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Number 5

Publication Information

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

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

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

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

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