DME MAC Jurisdiction A Resource

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

Table of Contents

June 2008
Number 8

Billing/Finance

Electronic Data Interchange

General Information

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

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

Table of Contents

Medical Review

National Provider Identifier

Table of Contents

Outreach & Education

Legend

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

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

Additional Clarification to Chapter 17, Section 40, Regarding Processing of Drug Claims with the JW Modifier (MM5923) DRU

MLN Matters Number: MM5923
Related CR Release Date: March 14, 2008
Related CR Transmittal #: R1478CP
Related Change Request (CR) #: 5923
Effective Date: January 1, 2008
Implementation Date: April 14, 2008

Provider Types Affected
Physicians, providers and suppliers billing Medicare Contractors (Medicare Administrative Contractors (A/B MACs), fiscal intermediaries (FIs), carriers and/or Durable Medical Equipment Medicare Administrative Contractors (DME MACs)) for drugs or biologicals provided to Medicare beneficiaries.

Impact on Providers
When processing all drugs **except those provided under the Competitive Acquisition Program (CAP)** for Part B drugs and biologicals, Medicare contractors may require the use of the modifier JW to identify unused drug or biologicals from single use vials or single use packages that are appropriately discarded. **This modifier will provide payment for the discarded drug or biological.**

Background
The Centers for Medicare & Medicaid Services (CMS) issued this CR 5923 to notify providers of the *Medicare Claims Processing Manual* update that clarifies the use of the JW modifier when processing all drugs except CAP drugs.

Additional Information
To see the official instruction (CR5923) issued to your Medicare Carrier, DME/MAC, FI and/or A/B MAC, visit **http://www.cms.hhs.gov/Transmittals/downloads/R1478CP.pdf** o the CMS website.

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

Adjudicating Claims for Immunosuppressive Drugs When Medicare Did Not Pay for the Original Transplant (MM5916) DRU

MLN Matters Number: MM5916
Related CR Release Date: February 15, 2008
Related CR Transmittal #: R1448CP
Related Change Request (CR) #: 5916
Effective Date: July 1, 2008
Implementation Date: July 7, 2008

Provider Types Affected
Suppliers who bill Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for immunosuppressive drugs.

What You Need to Know
CR 5916, from which this article is taken, implements an automated process for adjudicating claims for immunosuppressive drugs when the beneficiary was enrolled in Medicare Part A at the time of their transplant, even though Medicare did not pay for the transplant.

Make sure that your billing staffs are aware that you must be able to document the date of the patient's transplant, and must include the "KX" Modifier on the claim to attest that you have documentation on file that proves that the beneficiary had the transplant for which the immunosuppressive drug was prescribed while the beneficiary was enrolled in Medicare Part A.

Background
Medicare covers a beneficiary's immunosuppressive drugs following an organ transplant, provided that the beneficiary receiving the drug was enrolled in Medicare Part A at the time of the organ transplant procedure. Moreover, Medicare will pay for medically necessary immunosuppressive drugs for such a beneficiary whether or not Medicare paid for the transplant itself.

Prior to April of 2006, the Durable Medical Equipment (DME) Regional Carriers (DMERCs) received information about the date of a beneficiary's transplant through a DMERC Information Form (DIF), which included a field in which the supplier could enter a transplant date. However, on February 17, 2006, the Centers for Medicare & Medicaid Services (CMS) issued Transmittal 867, Change Request (CR) 4241, which: 1) eliminated the DIF; and 2) implemented an edit at the Medicare's Common Working File (CWF) system to search the Medicare's Master Beneficiary Record (MBR) for a transplant upon receipt of a claim for an immunosuppressive drug. If the CWF system does not find evidence of a transplant in the MBR, the claim line for immunosuppressive drug is rejected.

Because CWF does not have a transplant record for a beneficiary if Medicare did not actually pay for the procedure, the DME Medicare Administrative Contractors (DME MACs) have been inappropriately denying claims even when such beneficiaries were enrolled in Medicare Part A at the time of their transplant.

To resolve this issue, CR 5916, from which this article is taken, implements an automated process for adjudicating claims for immunosuppressive drugs when the beneficiary was enrolled in Medicare Part A at the time of their transplant, but Medicare did not pay for the transplant.

Specifically, CR 5916 requires that:

- For claims filed on and after July 1, 2008, suppliers who furnish an immunosuppressive drug to a Medicare beneficiary (in association with a previous organ transplant): 1) Secure from the prescriber the date of the organ transplant, 2) Retain documentation of the transplant date in its files, and 3) Annotate the Medicare claim for the drug with the "KX" modifier to signify both that the supplier retains the documentation of the beneficiary's transplant date and that the transplant date precedes the Date of Service (DOS) for furnishing the drug.

- For claims received on and after July 1, 2008, DME MACs will accept claims for immunosuppressive drugs without a KX modifier but will deny such claims if the MBR shows that Medicare has made payment for an organ transplant on a date that precedes the date of service (DOS) of the immunosuppressive drug claim.

Suppliers should note that the use of the KX modifier, in the context of a claim submitted to Medicare in order to receive payment for an immunosuppressive drug, signifies that the supplier attests that it has on file documentation that the beneficiary has undergone an organ transplant on a particular date while enrolled in Medicare Part A and that the immunosuppressive drug has been prescribed associated with that transplant.

A supplier who has not determined (or does not have documentation on file to support a determination) that the beneficiary either did not receive an organ transplant, or was not enrolled in Medicare Part A as of the date of the transplant; may not: 1) Bill Medicare for furnishing an immunosuppressive drug, 2) bill or collect any amount from the beneficiary for such a drug, or 3) issue an Advance Beneficiary Notice (ABN) to the beneficiary.

Additional Information
The official instruction, CR 5916, issued to your DME MAC is available at **http://www.cms.hhs.gov/Transmittals/downloads/R1448CP.pdf** on the CMS website. The revised *Medicare Claims Processing Manual*, Chapter 17 (Drugs and Biologicals), Section 80.3 (Billing for Immunosuppressive Drugs) is an attachment to that CR.

If you have any questions, please contact your 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.

April 2008 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files (MM5982) DRU

MLN Matters Number: MM5982
Related CR Release Date: March 26, 2008
Related CR Transmittal #: R1484CP
Related Change Request (CR) #: 5982
Effective Date: April 1, 2008
Implementation Date: April 7, 2008

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

What You Need to Know
CR 5982, from which this article is taken, instructs Medicare contractors to download and implement the April 2008 Average Sales Price (ASP) drug pricing file for Medicare Part B drugs; and if released by CMS, also the revised January 2008, January 2007, April 2007, July 2007, October 2007, and October 2006 files.

Background
Section 303(c) of the Medicare Modernization Act of 2003 revised the payment methodology for Part B covered drugs and biologicals that are not paid on a cost or prospective payment basis. Beginning January 1, 2005, the vast majority of 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 has been performed by the local contractor.

Additionally, beginning in 2006, all end-stage renal disease (ESRD) drugs (that both independent and hospital-based ESRD facilities furnish), as well as specified covered outpatient drugs, and drugs and biologicals with pass-through status under the Outpatient Prospective Payment System (OPPS), are paid based on the ASP methodology.

The ASP methodology is based on quarterly data that drug manufacturers submit to the Centers for Medicare & Medicaid Services (CMS), which CMS then provides (quarterly) to Medicare contractors (carriers, DME MACs, FIs, A/B MACs, and/or RHHIs) through the ASP drug pricing files for Medicare Part B drugs.

As announced in late 2006, CMS has been working further to ensure that accurate and separate payment is made for single source drugs and biologicals as required by Section 1847A of the Social Security Act. As part of the effort to ensure compliance with this requirement, CMS has also reviewed how the terms "single source drug," "multiple source drug," and "biological product" have been operationalized in the context of payment under section 1847A.

For the purpose of identifying "single source drugs" and "biological products" subject to payment under section 1847A, CMS (and its contractors) will generally utilize a multi-step process that will consider:

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

The payment limit for the following will be based on the pricing information for products marketed or sold under the applicable FDA approval:

- A biological product (as evidenced by a new FDA Biologic License Application or other relevant FDA approval), first sold in the United States after October 1, 2003; or
- A single source drug (a drug for which there are **not** 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.

As appropriate, a unique HCPCS code will be assigned to facilitate separate payment. Separate payment may be operationalized through use of "not otherwise classified, (NOC)" HCPCS codes.

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 of the ASP. Further, beginning January 1, 2006, payment allowance limits are paid based on 106 percent 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.

Beginning January 1, 2008, under the OPPS, payment allowance limits for specified covered outpatient drugs are paid based on 105 percent of the ASP. Drugs and biologicals with pass-through status under the OPPS continue to have a payment allowance limit of 106 percent of the ASP. CMS will update the payment allowance limits quarterly.

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 of the average wholesale price (AWP) as reflected in the published compendia. The payment allowance limits are 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 Ambulatory Payment Class (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 of the AWP reflected in the published compendia as of October 1, 2003, unless the drug is compounded or the drug is furnished incident to a professional service. **The payment allowance limits will not be updated in 2008.** The payment allowance limits for infusion drugs furnished through a covered item of durable medical equipment that were not listed in the published compendia as of October 1, 2003, (i.e., new drugs) are 95 percent of the first published AWP unless the drug is compounded or the drug is furnished incident to a professional service.

- The payment allowance limits for influenza, Pneumococcal and Hepatitis B vaccines are 95 percent of the AWP as reflected in the published compendia except where the vaccine is furnished in a hospital outpatient department. Where the vaccine is administered in the hospital outpatient department, the vaccine 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 NOC Pricing File, other than new drugs and biologicals that are produced or distributed under a new drug application (or other application) approved by the FDA, are based on the published wholesale acquisition cost (WAC) or invoice pricing, except under OPPS where the payment allowance limit is 95 percent of the published AWP. In determining the payment limit based on WAC, the contractors follow the methodology specified in Pub. 100-04, Chapter 17, Drugs and Biologicals, for calculating the AWP but substitute WAC for 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. **For 2008, the blood clotting furnishing factor of $0.158 per I.U. is added to the payment amount for the blood clotting factor when the blood clotting factor is not included on the ASP file.**

- The payment allowance limits for new drugs and biologicals that are produced or distributed under a new drug application (or other new application) approved by the FDA and that are not included in the ASP Medicare Part B Drug Pricing File or 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 and biologicals that were first sold on or after January 1, 2005.

- The payment allowance limits for radiopharmaceuticals are not subject to the ASP payment methodology. Medicare contractors determine payment limits for radiopharmaceuticals based on the methodology in place as of 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 March 18, 2008, the April 2008 ASP file will be available for download along with revisions to prior ASP payment files, if CMS determines that revisions to these prior files are necessary. On or after March 18, 2008, the April 2008 ASP NOC files will be available for retrieval from the CMS ASP webpage along with revisions to prior ASP NOC files, if CMS determines that revisions to these prior files are necessary. The payment limits included in revised ASP and NOC payment files supersede the payment limits for these codes in any publication published prior to this document.

The payment files will be applied to claims processed or reprocessed on or after the implementation date of CR5982 for the dates of service noted in the following table:

Payment Allowance Limit Revision Date	Applicable Dates of Service
April 2008 ASP and ASP NOC files	April 1, 2008, through June 30, 2008
January 2008 ASP and ASP NOC files	January 1, 2008, through March 31, 2008
October 2007 ASP and ASP NOC files	October 1, 2007, through December 31, 2007
July 2007 ASP and ASP NOC files	July 1, 2007, through September 30, 2007
April 2007 ASP and ASP NOC files	April 1, 2007, through June 30, 2007
January 2007 ASP and ASP NOC files	January 1, 2007, through March 31, 2007
October 2006 ASP and ASP NOC files	October 1, 2006, through December 31, 2006

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 makes these determinations.*

Drugs Furnished During Filling or Refilling an Implantable Pump or Reservoir
Physicians may be paid for filling or refilling an implantable pump or reservoir when it is medically necessary for the physician (or other practitioner) to perform the service. Medicare contractors must find the use of the implantable pump or reservoir medically reasonable and necessary in order to allow payment for the professional service to fill or refill the implantable pump or reservoir and to allow payment for drugs furnished incident to the professional service.

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

Additional Information
To see the official instruction (CR5982) issued to your Medicare contractor visit **http://www.cms.hhs.gov/Transmittals/downloads/R1484CP.pdf** on the CMS website.

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

Claim Status Category Code and Claim Status Code Update (MM5947) GEN

MLN Matters Number: MM5947
Related CR Release Date: February 29, 2008
Related CR Transmittal #: R1468CP
Related Change Request (CR) #: 5947
Effective Date: April 1, 2008
Implementation Date: April 7, 2008

Provider Types Affected
Physicians, providers, and suppliers who submit Health Care Claim Status Transactions to Medicare contractors (carriers, Medicare Administrative Contractors (A/B MACs), Durable Medical Equipment Medicare Administrative Contractors (DME MACs), fiscal intermediaries (FIs), and Regional Home Health Intermediaries (RHHIs)).

Provider Action Needed
Impact to You
This article is based on Change Request (CR) 5947 which indicates there have been updates to the Claim Status Category Codes and Claim Status Codes.

What You Need to Know
All code changes approved during the October 2007 meeting of the national Code Maintenance Committee have been posted at **http://www.wpc-edi.com/content/view/180/223/** and will become effective April 1, 2008.

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

Background
The Health Insurance Portability and Accountability Act (HIPPA) requires all health care benefit payers, including Medicare, to use only Claim Status Category Codes and Claim Status Codes approved by the national Code Maintenance Committee. These codes are used in the X12 276/277 Health Care Claim Status Request and Response format to explain the status of submitted claim(s).

The decisions about additions, modifications, and retirement of existing Claim Status Category and Claim Status codes made at the October 2007 meeting of the national Code Maintenance Committee were posted at **http://www.wpc-edi.com/content/view/180/223/** on November 5, 2007. These updates are effective April 1, 2008 and are to be used in editing of all X12 276 transactions processed by Medicare contractors on or after April 7, 2008.

Additional Information
To see the official instruction (CR5947) issued to your Medicare FI, carrier, DME MAC, or A/B MAC, refer to **http://www.cms.hhs.gov/Transmittals/downloads/R1468CP.pdf** on the CMS website.

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

CR 5550 Clarification - Signature Requirements (MM5971) GEN

MLN Matters Number: MM5971
Related CR Release Date: March 28, 2008
Related CR Transmittal #: R248PI
Related Change Request (CR) #: 5971
Effective Date: September 3, 2007
Implementation Date: April 28, 2008

Provider Types Affected
Physicians and other providers who bill Medicare Contractors (Carriers, Fiscal Intermediaries, Regional Home Health Intermediaries, Part A/B Medicare Administrative Contractors, including Durable Medical Equipment Medicare Administrative Contractors) for care provided to Medicare beneficiaries in hospice.

What You Need to Know
CR 5971, from which this article is taken, clarifies the instructions on signature requirements for the certification of terminal illness for hospice. It provides that Medicare contractors will accept a facsimile of an original written or electronic signature in documenting the certification of terminal illness for hospice.

Make sure that your billing staffs are aware that, to document the certification of terminal illness for hospice, a facsimile of an original written or electronic signature is acceptable.

Background
CR 5971, from which this article is taken, clarifies the instructions in *Medicare Program Integrity Manual* Chapter 3 (Verifying Potential Errors and Taking Corrective Actions), Subsection 3.4.1.1B (Signature Requirements) that address the signature requirements for the certification of terminal illness for hospice, that were provided in CR 5550 (*Various Medical Review Clarifications*).

Subsection 3.4.1.1B of the manual notes that Medicare contractors require a legible identifier for services provided/ordered. It further requires that when this documentation is for medical review purposes, the only acceptable method of documenting the provider signature is by written or an electronic signature. Stamp signatures are not acceptable to sign an order or other medical record documentation for medical review purposes.

CR 5971 provides that there is an exception to this requirement.

It announces that a facsimile of an original written or electronic signature is acceptable for the certification of terminal illness for hospice. Please be sure to note however, that while a signature facsimile is acceptable in this instance; it and **hard copies of a physician's electronic signature** must be present in the patient's medical record.

Additional Information
You can find more information about the signature requirements for the certification of terminal illness for hospice by going to CR 5971, located at **http://www.cms.hhs.gov/Transmittals/downloads/R248PI.pdf** on the CMS website. You will find updated *Medicare Program Integrity Manual* Chapter 3 (Verifying Potential Errors and Taking Corrective Actions), Subsection 3.4.1.1B (Signature Requirements) as an attachment to this CR.

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.

Fee Schedule Updates GEN

The 2008 fee schedules and subsequent updates are available via the "Fee Schedules" section of the Jurisdiction A Durable Medical Equipment Medicare Administrative Contractor (DME MAC A) Web site, **http://www.medicarenhic.com/dme/dmfees.shtml**. The following notices have been posted:

- There are no April Updates to the 2008 Jurisdiction A DME MAC Fee Schedule
- April 2008 Quarterly Average Sales Price Medicare Part B Drug Pricing File
- 2nd Quarter 2008 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.

Medicare Shared Systems Modifications Necessary to Accept and Crossover to Medicaid National Drug Codes (NDC) and Corresponding Quantities Submitted on CMS-1500 Paper Claims (MM5835) DRU

MLN Matters Number: MM5835
Related CR Release Date: December 21, 2007
Related CR Transmittal #: R1401CP
Related Change Request (CR) #: 5835
Effective Date: April 7, 2008
Implementation Date: April 7, 2008

Provider Types Affected
All physicians, providers, and suppliers who submit paper claims using Form CMS-1500 to Medicare contractors (carriers, Medicare Administrative Contractors (A/B MACs), and durable medical equipment Medicare Administrative Contractors (DME/MACs)) for certain physician administered drugs provided to Medicare beneficiaries

Provider Action Needed
Impact to You
The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 5835 that notifies physicians and suppliers who use Claim Form CMS-1500 (those providers who qualify for a waiver from the Administrative Simplification Compliance Act (ASCA)) that changes are being made to Medicare systems to conform with instructions for submitting NDC drug code and quantity information on Form CMS-1500.

What You Need to Know
This article only applies to those providers eligible to submit paper claims and who do so for patients who are dually eligible for Medicaid and Medicare. Such claims need to include NDCs and corresponding quantity amounts for physician-administered drugs. The Key Points section of this CR outlines the changes required in the Form CMS-1500.

What You Need to Do
Make certain your office staffs are aware of these changes in the content requirements of your paper claims.

Background
The Deficit Reduction Act (DRA) of 2005 required State Medicaid agencies to provide for the collection of National Drug Codes (NDC) on all claims for certain physician-administered drugs for the purpose of billing manufacturers for Medicaid drug rebates. Prior to the DRA, physicians' offices, outpatient hospital departments and clinics generally used Healthcare Common Procedure Coding System (HCPCS) codes to bill Medicaid for drugs dispensed to Medicaid patients. However, because State Medicaid agencies are required to invoice manufacturers for rebates using NDCs for drugs for which the States have made payments, often States were not able to fulfill the rebate requirements for physician-administered drugs. The requirements for the collection of NDCs became effective beginning January 1, 2007. In addition, beginning January 1, 2008, in order for Federal financial participation (FFP) to be available for these drugs, State Medicaid agencies must be in compliance with the requirements. These requirements were implemented in a final rule published on July 17, 2007.

Also, the quantity field of the CMS-1500 paper claim should be captured on all crossover claims for Medicaid billing, as provided for by the National Uniform Claims Committee (NUCC). Information regarding the quantities of physician-administered drugs billed to Medicaid is also necessary for States to bill manufacturers for Medicaid drug rebates.

Key Points
When required to submit NDC drug number and quantity information for Medicaid rebates on the CMS-1500 paper claim be aware of the following:

- Submit the NDC code in the red shaded portion of the detail line item in positions 01 through position 13.
- The NDC is to be preceded with the qualifier N4 and followed immediately by the 11digit NDC code (e.g. N499999999999).
- Report the NDC quantity in positions 17 through 24 of the same red shaded portion. The quantity is to be preceded by the appropriate qualifier: UN (units), F2 (international units), GR (gram) or ML (milliliter). There are six positions available for quantity. If the quantity is less than six positions, the entry should be left justified with spaces filling the remaining positions.

Additional Information
To see the official instruction (CR5835) issued to your Medicare Carrier, DME/MAC, or A/B MAC refer to **http://www.cms.hhs.gov/Transmittals/downloads/R1401CP.pdf** on the CMS website.

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

New "K" Code for Replacement Interface Material (MM5900) GEN

MLN Matters Number: MM5900
Related CR Release Date: February 7, 2008
Related CR Transmittal #: R1441CP
Related Change Request (CR) #: 5900
Effective Date: April 1, 2008
Implementation Date: April 7, 2008

Provider Types Affected
Suppliers who bill Durable Medical Equipment Medicare Administrative Contractors (DME MAC) for orthosis services for Medicare beneficiaries

What You Need to Know
CR 5900, from which this article is taken, announces that (effective April 1, 2008) a new "K" code (K0672 - Addition to lower extremity orthosis, removable soft interface, all components, replacement only, each) will be established for replacement interface material. You should make sure that your billing staffs are aware of this new "K" code.

Additional Information
You can find more information about K0672 (new "K" code for interface material) by going to CR 5900, located at **http://www.cms.hhs.gov/Transmittals/downloads/R1441CP.pdf** on the Centers for Medicare & Medicaid Services (CMS) website.

If you have any questions, please contact your 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.

New HCPCS Codes for the April 2008 Update (MM5981) DRU

MLN Matters Number: MM5981
Related CR Release Date: April 18, 2008
Related CR Transmittal #: R1492CP
Related Change Request (CR) #: 5981
Effective Date: April 1, 2008
Implementation Date: April 7, 2008

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) 5981, which instructs Medicare Contractors to implement Healthcare Common Procedure Coding System (HCPCS) code changes effective April 1, 2008. Make sure that your billing staffs are aware of these changes.

Background
The Centers for Medicare & Medicaid Services (CMS) updates the Healthcare Common Procedure Coding System (HCPCS) code set on a quarterly basis.

Effective for claims with dates of service on or after April 1, 2008, the following HCPCS codes will no longer be payable for Medicare:

HCPCS Code	Short Description	Long Description
J7602	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)
J7603	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)
J1751	Iron dextran 165 injection	INJECTION, IRON DEXTRAN 165, 50 MG
J1752	Iron dextran 267 injection	INJECTION, IRON DEXTRAN 267, 50 MG

Effective for claims with dates of service on or after April 1, 2008, the following HCPCS codes will be payable for Medicare:

HCPCS Code	Short Description	Long Description

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, 1MG
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, ADMINISTEREDTHROUGH DME, UNIT DOSE, 1MG
J7614	Levalbuterol non-comp unit	LEVALBUTEROL, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, UNIT DOSE, 0.5 MG
Q4096	VWF complex, NOS	INJECTION, VON WILLEBRAND FACTOR COMPLEX, HUMAN, RISTOCETIN COFACTOR (NOT OTHERWISE SPECIFIED), PER I.U. VWF:RCO
Q4097	Inj IVIG Privigen 500 mg	INJECTION, IMMUNE GLOBULIN (PRIVIGEN), INTRAVENOUS, NON-LYOPHILIZED (E.G., LIQUID), 500 MG
Q4098	Inj iron dextran	INJECTION, IRON DEXTRAN, 50MG
Q4099	Formorterol fumarate, inh	FORMORETOL FUMARATE, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, UNIT DOSE FORM, 20 MICROGRAMS

Currently, Alphanate® is the only product that should be billed using code Q4096. J7190 should continue to be billed when Alphanate® is furnished for purposes of administering Factor VIII. The blood clotting furnishing fee is payable when payment is allowed for Q4096. When a payment allowance limit for Q4096 is included on the quarterly Part B drug pricing files, the payment allowance limit will include payment for the blood clotting furnishing fee.

Effective for dates of service on or after April 1, 2008, the requirements under CR 5713 (See the *MLN Matters* article for CR5713, which is at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5713.pdf** on the CMS website) are being updated by CR 5981 to apply to claims that bill Intravenous Immunoglobulins (IVIG) using Q4097 as follows:

- Effective for dates of service on or after April 1, 2008, Medicare Contractors will:
  - Only pay a claim for preadministration-related services (G0332) associated with IVIG administration if G0332, the drug (IVIG, HCPCS codes: J1566, J1568, J1569, J1561, J1572 and/or Q4097), and the drug administration service are all billed on the same claim for the same date of service;
  - Return institutional claims for G0332 to the provider if J1566, J1568, J1569, J1561, J1572 and/or Q4097 and a drug administration service are not also billed for the same date of service on the same claim;
  - Reject professional claims as unprocessable for G0332 if J1566, J1568, J1569, J1561, J1572 and/or Q4097 and a drug administration service are not billed for the same date of service on the same claim; and
  - Use the appropriate reason/remark messages such as: M67 "Missing other procedure codes" and/or 16 "Claim/service lacks information" which are needed for adjudication when claims are returned/rejected.

Additional Information

The official instruction, CR 5981, issued to your carrier, FI, RHHI, A/B MAC, and DME MAC regarding these changes may be viewed at **http://www.cms.hhs.gov/transmittals/downloads/R1492CP.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** on the CMS website.

New Healthcare Common Procedure Coding System (HCPCS) Modifiers when Billing for Patient Care in Clinical Research Studies (MM5805) GEN

MLN Matters Number: MM5805
Related CR Release Date: January 18, 2008
Related CR Transmittal #: R1418CP
Related Change Request (CR) #: 5805
Effective Date: January 1, 2008
Implementation Date: No later than April 7, 2008

Provider Types Affected
Physicians, providers, and suppliers who bill Medicare contractors (carriers, fiscal intermediaries (FIs), including Regional Home Health Intermediaries (RHHIs), Medicare Administrative Contractors (A/B MACs) and Durable Medical Equipment Medicare Administrative Contractors (DME MACs)) for services provided to Medicare beneficiaries in clinical research studies.

What Providers Need to Know
This article is based on Change Request (CR) 5805. The Centers for Medicare & Medicaid Services (CMS) is discontinuing the QA (FDA Investigational Device Exemption), QR (Item or Service Provided in a Medicare Specified Study), and QV (Item or Service Provided as Routine Care in a Medicare Qualifying Clinical Trial) HCPCS modifiers as of December 31, 2007, and creating two new modifiers that will be used solely to differentiate between routine and investigational clinical services.

These new modifiers will be included in the 2008 Annual HCPCS Update and are effective for dates of service on and after January 1, 2008:

Q0 - Investigational clinical service provided in a clinical research study that is in an approved clinical research study. Q0 replaces QA and QR.

Q1 - Routine clinical service provided in a clinical research study that is in an approved clinical research study. Q1 replaces QV.

Use these two new modifiers as follows:

Investigational clinical services are defined as those items and services that are being investigated as an objective within the study. Investigational clinical services may include items or services that are approved, unapproved, or otherwise covered (or not covered) under Medicare.

Routine clinical services are defined as those items and services that are covered for Medicare beneficiaries outside of the clinical research study; are used for the direct patient management within the study; and, do not meet the definition of investigational clinical services. Routine clinical services may include items or services required solely for the provision of the investigational clinical services (e.g., administration of a chemotherapeutic agent), clinically appropriate monitoring, whether or not required by the investigational clinical service (e.g., blood tests to measure tumor markers), and items or services required for the prevention, diagnosis, or treatment of research related adverse events (e.g., blood levels of various parameters to measure kidney function).

Medicare contractors will not search their files to adjust affected claims processed prior to implementation of this change, but they will adjust such claims that you bring to their attention.

Note: *If a Category A or B investigational device is used on the clinical trial, providers should continue to include the Investigational Device Exemption (IDE) in item 23 of the CMS-1500 claim form or the electronic equivalent. Also, your Medicare contractor will validate the IDE# number when it appears on the claim with the Q0 modifier and if the IDE# does not meet validation criteria, the claim will be returned as unprocessable.*

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.

You may see the official instruction (CR5805) issued to your Medicare A/B MAC, FI, DMERC, DME/MAC, RHHI or carrier by going to **http://www.cms.hhs.gov/Transmittals/downloads/R1418CP.pdf** on the CMS website.

Remittance Advice Remark Code (RARC) and Claim Adjustment Reason Code (CARC) Update (MM5942) GEN

MLN Matters Number: MM5942
Related CR Release Date: March7, 2008
Related CR Transmittal #: R1475CP
Related Change Request (CR) #: 5942
Effective Date: April 1, 2008
Implementation Date: April 7, 2008

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 Medicare Administrative Contractors (DME MACs)) for services

Provider Action Needed
CR 5942, from which this article is taken, announces the latest update of Remittance Advice Remark Codes (RARCs) and Claim Adjustment Reason Codes (CARCs), effective April 1, 2008. Be sure billing staff are aware of these changes.

Background
Two code sets-the reason and remark code sets-must be used to report payment adjustments in remittance advice transactions. The reason codes are also used in some coordination-of-benefits (COB) transactions. The RARC list is maintained by the Centers for Medicare & Medicaid Service (CMS), and used by all payers; and additions, deactivations, and modifications to it may be initiated by any health care organization. The CARC list is maintained by a national Code Maintenance committee that meets when X12 meets for their trimester meetings to make decisions about additions, modifications, and retirement of existing reason codes.

Both code lists are updated three times a year, and are posted at **http://www.wpc-edi.com/Codes** on the Internet. The lists at the end of this article summarize the latest changes to these lists, as announced in CR 5942.

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

Additional Information
To see the official instruction (CR5942) issued to your Medicare Carrier, RHHI, DME/MAC, FI and/or A/B MAC refer to **http://www.cms.hhs.gov/Transmittals/downloads/R1475CP.pdf** on the CMS website.

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

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

Remittance Advice Remark Code Changes

New Codes

Code	Current Narrative	Medicare Initiated
N430	Procedure code is inconsistent with the units billed. Start: 11/5/2007 Note: (New Code 11/5/07)	YES
N431	Service is not covered with this procedure. Start: 11/5/2007 Note: (New Code 11/5/07)	YES
N432	Adjustment based on a Recovery Audit. Start: 11/5/2007 Note: (New Code 11/5/07)	YES

Modified Codes

Code	Current Modified Narrative	Last Modification Date
M25	The information furnished does not substantiate the need for this level of service. If you believe the service should have been fully covered as billed, or if you did not know and could not reasonably have been expected to know that we would not pay for this level of service, or if you notified the patient in writing in advance that we would not pay for this level of service and he/she agreed in writing to pay, ask us to review your claim within 120 days of the date of this notice. If you do not request a appeal, we will, upon application from the patient, reimburse him/her for the amount you have collected from him/her in excess of any deductible and coinsurance amounts. We will recover the reimbursement from you as an overpayment.	11/5/2007
M26	The information furnished does not substantiate the need for this level of service. If you have collected any amount from the patient for this level of service /any amount that exceeds the limiting charge for the less extensive service, the law requires you to refund that amount to the patient within 30 days of receiving this notice. The requirements for refund are in 1824(I) of the Social Security Act and 42CFR411.408. The section specifies that physicians who knowingly and willfully fail to make appropriate refunds may be subject to civil monetary penalties and/or exclusion from the program. If you have any questions about this notice, please contact this office.	11/5/2007
M75	Multiple automated multichannel tests performed on the same day combined for payment.	11/5/2007
M112	Reimbursement for this item is based on the single payment amount required under the DMEPOS Competitive Bidding Program for the area where the patient resides.	11/5/2007
M113	Our records indicate that this patient began using this item/service prior to the current contract period for the DMEPOS Competitive Bidding Program.	11/5/2007
M114	This service was processed in accordance with rules and guidelines under the DMEPOS Competitive Bidding Program or a Demonstration Project. For more information regarding these projects, contact your local contractor.	11/5/2007
M115	This item is denied when provided to this patient by a non-contract or non-demonstration supplier.	11/5/2007
N70	Consolidated billing and payment applies.	11/5/2007
N367	Alert: The claim information has been forwarded to a Consumer Account Fund processor for review.	11/5/2007
N377	Payment based on a processed replacement claim.	11/5/2007
N385	Notification of admission was not timely according to published plan procedures.	11/5/2007

Deactivated Codes

Code	Current Narrative	Modification Date
MA119	Provider level adjustment for late claim filing applies to this claim. Start: 1/1/1997 | Stop: 5/1/2008 | Last Modified: 11/5/2007 Note: (Deactivated eff. 5/1/08) Consider using Reason Code B4.)	Deactivated eff. 5/1/08

Claim Adjustment Reason Codes

New Codes

Code	Current Narrative	Implementation Date
212	Administrative surcharges are not covered Start: 11/05/2007	11/05/2007

Modified Codes

Code	Modified Narrative	Implementation Date
121	Indemnification adjustment - compensation for outstanding member responsibility. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
192	Non standard adjustment code from paper remittance. Note: This code is to be used by providers/payers providing Coordination of Benefits information to another payer in the 837 transaction only. This code is only used when the non-standard code cannot be reasonably mapped to an existing Claims Adjustment Reason Code, specifically Deductible, Coinsurance and Co-payment. Start: 10/31/2005 | Last Modified: 09/30/2007	4/1/2008
206	National Provider Identifier - missing. Start: 07/09/2007 | Last Modified: 09/30/2007	4/1/2008
207	National Provider identifier - Invalid format Start: 07/09/2007 | Stop: 05/23/2008 | Last Modified: 09/30/2007	4/1/2008
208	National Provider Identifier - Not matched. Start: 07/09/2007 | Last Modified: 09/30/2007	4/1/2008
15	The authorization number is missing, invalid, or does not apply to the billed services or provider. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
17	Requested information was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.) Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
19	This is a work-related injury/illness and thus the liability of the Worker's Compensation Carrier. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
20	This injury/illness is covered by the liability carrier. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
21	This injury/illness is the liability of the no-fault carrier. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
22	This care may be covered by another payer per coordination of benefits. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
23	The impact of prior payer(s) adjudication including payments and/or adjustments. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
24	Charges are covered under a capitation agreement/managed care plan. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
31	Patient cannot be identified as our insured. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
33	Insured has no dependent coverage. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
34	Insured has no coverage for newborns. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
55	Procedure/treatment is deemed experimental/investigational by the payer. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
56	Procedure/treatment has not been deemed 'proven to be effective' by the payer. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
58	Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
59	Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
61	Penalty for failure to obtain second surgical opinion. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008

Code	Modified Narrative	Implementation Date
95	Plan procedures not followed. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
107	The related or qualifying claim/service was not identified on this claim. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
108	Rent/purchase guidelines were not met. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
112	Service not furnished directly to the patient and/or not documented. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
115	Procedure postponed, canceled, or delayed. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
116	The advance indemnification notice signed by the patient did not comply with requirements. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
117	Transportation is only covered to the closest facility that can provide the necessary care. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
118	ESRD network support adjustment. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.) Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
129	Prior processing information appears incorrect. Start: 02/28/1997 | Last Modified: 09/30/2007	4/1/2008
135	Interim bills cannot be processed. Start: 10/31/1998 | Last Modified: 09/30/2007	4/1/2008
136	Failure to follow prior payer's coverage rules. (Use Group Code OA). Start: 10/31/1998 | Last Modified: 09/30/2007	4/1/2008
137	Regulatory Surcharges, Assessments, Allowances or Health Related Taxes. Start: 02/28/1999 | Last Modified: 09/30/2007	4/1/2008
138	Appeal procedures not followed or time limits not met. Start: 06/30/1999 | Last Modified: 09/30/2007	4/1/2008
141	Claim spans eligible and ineligible periods of coverage. Start: 06/30/1999 | Last Modified: 09/30/2007	4/1/2008
142	Monthly Medicaid patient liability amount. Start: 06/30/2000 | Last Modified: 09/30/2007	4/1/2008
146	Diagnosis was invalid for the date(s) of service reported. Start: 06/30/2002 | Last Modified: 09/30/2007	4/1/2008
148	Information from another provider was not provided or was insufficient/incomplete. Start: 06/30/2002 | Last Modified: 09/30/2007	4/1/2008
150	Payer deems the information submitted does not support this level of service. Start: 10/31/2002 | Last Modified: 09/30/2007	4/1/2008
151	Payer deems the information submitted does not support this many services. Start: 10/31/2002 | Last Modified: 09/30/2007	4/1/2008
152	Payer deems the information submitted does not support this length of service. Start: 10/31/2002 | Last Modified: 09/30/2007	4/1/2008
153	Payer deems the information submitted does not support this dosage. Start: 10/31/2002 | Last Modified: 09/30/2007	4/1/2008
154	Payer deems the information submitted does not support this day's supply. Start: 10/31/2002 | Last Modified: 09/30/2007	4/1/2008

Code	Modified Narrative	Implementation Date
155	Patient refused the service/procedure. Start: 06/30/2003 | Last Modified: 09/30/2007	4/1/2008
157	Service/procedure was provided as a result of an act of war. Start: 09/30/2003 | Last Modified: 09/30/2007	4/1/2008
158	Service/procedure was provided outside of the United States. Start: 09/30/2003 | Last Modified: 09/30/2007	4/1/2008
159	Service/procedure was provided as a result of terrorism. Start: 09/30/2003 | Last Modified: 09/30/2007	4/1/2008
160	Injury/illness was the result of an activity that is a benefit exclusion. Start: 09/30/2003 | Last Modified: 09/30/2007	4/1/2008
163	Attachment referenced on the claim was not received. Start: 06/30/2004 | Last Modified: 09/30/2007	4/1/2008
164	Attachment referenced on the claim was not received in a timely fashion. Start: 06/30/2004 | Last Modified: 09/30/2007	4/1/2008
165	Referral absent or exceeded. Start: 10/31/2004 | Last Modified: 09/30/2007	4/1/2008
168	Service(s) have been considered under the patient's medical plan. Benefits are not available under this dental plan. Start: 06/30/2005 | Last Modified: 09/30/2007	4/1/2008
169	Alternate benefit has been provided. Start: 06/30/2005 | Last Modified: 09/30/2007	4/1/2008
173	Service was not prescribed by a physician. Start: 06/30/2005 | Last Modified: 09/30/2007	4/1/2008
174	Service was not prescribed prior to delivery. Start: 06/30/2005 | Last Modified: 09/30/2007	4/1/2008
175	Prescription is incomplete. Start: 06/30/2005 | Last Modified: 09/30/2007	4/1/2008
176	Prescription is not current. Start: 06/30/2005 | Last Modified: 09/30/2007	4/1/2008
177	Patient has not met the required eligibility requirements. Start: 06/30/2005 | Last Modified: 09/30/2007	4/1/2008
178	Patient has not met the required spend down requirements. Start: 06/30/2005 | Last Modified: 09/30/2007	4/1/2008
179	Patient has not met the required waiting requirements. Start: 06/30/2005 | Last Modified: 09/30/2007	4/1/2008
180	Patient has not met the required residency requirements. Start: 06/30/2005 | Last Modified: 09/30/2007	4/1/2008
181	Procedure code was invalid on the date of service. Start: 06/30/2005 | Last Modified: 09/30/2007	4/1/2008
182	Procedure modifier was invalid on the date of service. Start: 06/30/2005 | Last Modified: 09/30/2007	4/1/2008
186	Level of care change adjustment. Start: 06/30/2005 | Last Modified: 09/30/2007	4/1/2008
191	Not a work related injury/illness and thus not the liability of the workers' compensation carrier. Start: 10/31/2005 | Last Modified: 09/30/2007	4/1/2008
194	Anesthesia performed by the operating physician, the assistant surgeon or the attending physician. Start: 02/28/2006 | Last Modified: 09/30/2007	4/1/2008
195	Refund issued to an erroneous priority payer for this claim/service. Start: 02/28/2006 | Last Modified: 09/30/2007	4/1/2008
197	Precertification/authorization/notification absent. Start: 10/31/2006 | Last Modified: 09/30/2007	4/1/2008

Code	Modified Narrative	Implementation Date
198	Precertification/authorization exceeded. Start: 10/31/2006 | Last Modified: 09/30/2007	4/1/2008
202	Precertification/authorization exceeded. Start: 10/31/2006 | Last Modified: 09/30/2007	4/1/2008
203	Discontinued or reduced service. Start: 02/28/2007 | Last Modified: 09/30/2007	4/1/2008
A8	Ungroupable DRG. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
B5	Coverage/program guidelines were not met or were exceeded. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
B8	Alternative services were available, and should have been utilized. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
B9	Patient is enrolled in a Hospice. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
B14	Only one visit or consultation per physician per day is covered. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
B16	'New Patient' qualifications were not met. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
B18	This procedure code and modifier were invalid on the date of service. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
B20	Procedure/service was partially or fully furnished by another provider. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
B23	Procedure billed is not authorized per your Clinical Laboratory Improvement Amendment (CLIA) proficiency test. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008

Deactivated Codes

Code	Current Narrative	Implementation Date
25	Payment denied. Your Stop loss deductible has not been met. Start: 01/01/1995 | Stop: 04/01/2008	4/1/2008
126	Deductible -- Major Medical Start: 02/28/1997 | Stop: 04/01/2008 | Last Modified: 09/30/2007 Notes: Use Group Code PR and code 1.	4/1/2008
127	Coinsurance -- Major Medical Start: 02/28/1997 | Stop: 04/01/2008 | Last Modified: 09/30/2007 Notes: Use Group Code PR and code 2.	4/1/2008
145	Premium payment withholding Start: 06/30/2002 | Stop: 04/01/2008 | Last Modified: 09/30/2007 Notes: Use Group Code CO and code 45.	4/1/2008
A4	Medicare Claim PPS Capital Day Outlier Amount. Start: 01/01/1995 | Stop: 04/01/2008 | Last Modified: 09/30/2007	4/1/2008

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.

Attention All DME MAC Electronic Submitters and Vendors GEN

Electronic Trading Partners in Jurisdictions A were to be transitioned to CEDI before May 1, 2008.

Jurisdiction A EDI Front End and Help Desk Support
On **April 30, 2008**, the Jurisdiction A EDI front end was taken down at 5:00 p.m. EST to remove the ability for trading partners/submitters to send claims and download front end edit reports and/or electronic remittance files.

CEDI received all Front End Edit Reports and electronic remittance advice (ERA) files produced by the DME MAC Jurisdictions regardless of whether the claims were submitted to a DME MAC or to CEDI. After **April 30, 2008**, Jurisdiction A trading partners/submitters will need to retrieve their ERA and front end reports from CEDI. CEDI maintains 45 days of reports and ERAs under each CEDI login for retrieval by the trading partners/submitters.

Starting on **April 30, 2008**, the Jurisdiction A Help Desk is no longer available to assist trading partners/submitters with EDI related questions or issues. The Jurisdiction A Help Desk will only provide support as listed in the section below, "*DME MAC Support*".

Questions regarding CEDI should be referred to the CEDI Help Desk via email at **NGS.CEDIHelpdesk@wellpoint.com** and by telephone at **866-311-9184**. The CEDI Help Desk is available from 9:00 a.m. - 9:00 p.m. EST Monday through Friday.

DME MAC Support
The DME MAC Jurisdictions will continue to provide support for the following services after EDI functions have transitioned to CEDI.

1. Claim Status Inquiry (CSI), VPIQ and/or PINQ
   - Enrollment or setup status
   - Logon or User ID
   - Password resets
   - Education
2. Electronic Funds Transfer (EFT)
   - Setup Status
   - Questions regarding payments or banking information
3. Status of claims in the Jurisdiction A DME MAC processing system
4. Questions regarding the adjudication of claims
5. Questions regarding the **content** of an Electronic Remittance Advice
   - Amount paid on a claim
   - Deductible or co-pays applied
   - Denied claims

PC-Ace Pro32 Software Users
All PC-Ace Pro32 users must complete the following instructions to communicate with CEDI.

1. Visit the CEDI Web site at **http://www.ngscedi.com**. Select "Telecommunications" and download the Asynchronous Communication Manual.
2. Contact the CEDI Help Desk at **NGS.CEDIHelpdesk@wellpoint.com** to obtain the CEDI phone number and your password. Be sure to provide your Trading Partner/Submitter ID and your company name.
3. Follow the instructions in the Asynchronous Communication Manual to change the dial-in phone number to the CEDI phone number obtained from the CEDI Help Desk.
4. Follow the instructions in the Asynchronous Communication Manual to dial, login, connect and begin sending and receiving files with CEDI.

5. The January 2008 version of PC-Ace Pro32 is the most current version. There was not an upgrade release for April 2008. CEDI will provide the July 2008 upgrade on the CEDI Web site.

Express Plus Software Users
All Express Plus users must download the upgrade (Version 4.3.8) and follow the instructions below to communicate with CEDI. To download and begin using the new Version 4.3.8 of Express Plus, you need to:

1. Access the CEDI Web site at: **http://www.ngscedi.com**

2. Select "Software Downloads"

3. On the "Software Downloads" page, print ALL of the following documents:
   - Express Plus Upgrade Instructions - These instructions will guide you through the process of running the Express Plus upgrade program.
   - Express Plus CEDI Script - These instructions will guide you through the procedures to create the communications' scripts to connect to and send/receive files with CEDI.
   - Express Plus CEDI Connection and Login - These instructions will assist you in logging into CEDI and sending/receiving files with CEDI.

4. Follow the instruction documents listed in the order above.

5. You may also download the updated DME Express Plus User Manual from the "Software Downloads" page.

CEDI Claims Submission Cutoff Times
CEDI will accept claims submissions 24 hours a day, Monday through Sunday (See the *CEDI Maintenance Window* section below).

CEDI delivers claims and 276 Claim Status Request files to the DME MACs at 4:00 p.m. EST Monday through Friday. Files received before 3:00 p.m. EST will be delivered that day to the DME MACs for processing and you will receive your DME MAC Front End Edit Report and/or 277 Claim Status Response file the following business day.

Claims and 276 Claim Status Request files received between 3:00 p.m. and 3:30 p.m. EST **may be** delivered on the next business day and you will receive your DME MAC Front End Edit Report two business days following submission of your claim file.

Claims and 276 Claim Status Request files received after 4:00 p.m. EST will be delivered on the next business day and you will receive your DME MAC Front End Edit Report and/or 277 Claim Status Response file two business days following submission of your file.

CEDI Maintenance Window
CEDI performs routine maintenance on Sundays between 12:00 a.m. - 12:00 p.m. EST. During this time, CEDI will accept electronic files but will not produce Level 1 and Gen Response reports. Beginning no later than Monday at 12:00 a.m. EST, CEDI will resume processing files received on Sundays and will begin to return Level 1 and Gen Response reports.

CEDI Listserv
To stay informed of all CEDI updates, visit the CEDI Web site at **http://www.ngscedi.com** and sign up for the CEDI Listserv by selecting the Listserv Registration Link. You will then be prompted to submit your email address and name to subscribe. This listserv is for all entities participating with CEDI whether you are a third-party billing agency or a supplier performing your own EDI transmissions.

COBA List on CMS Web Site (CR 5837) GEN

Effective February 1, 2008 the COBA list will no longer be available for download from the NHIC, Corp DME website. Complete and up to date information will be available in the Coordination of Benefits Contractor (COBC) Medigap list on the CMS website at **http://www.cms.hhs.gov/COBAgreement/Downloads/Medigap%20Claim-based%20COBA%20IDs%20for%20Billing%20Purpose.pdf**

Reminder: Medicare DME MAC EDI (electronic) billers **and** providers who submit CMS-1500 paper claim forms must use the new 5-digit COBA numbers on incoming crossover claims.

For more information:
Please view this special *MLN Matters* article on COBA / Medigap billing at:
http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0743.pdf

Coordination of Benefits (COB) Overview on the CMS Web site at:
http://www.cms.hhs.gov/cobagreement/

Updated Healthcare Provider Taxonomy Code (HPTC) List Codes Effective April 1, 2008 (CR5951) GEN

A list of Healthcare Provider Taxonomy Codes (HPTCs), effective April 1, 2008, is available on the Washington Publishing Company (WPC) web site at: **http://www.wpc-edi.com/codes/taxonomy**

Use of the taxonomy code is not required on Medicare DME MAC Jurisdiction A claims. However, **if used, the code must be the correct code.** To avoid delays in the processing of your claims, please ensure you are using only the latest HPTC code list. New code values may not be used prior to the effective date and prior code may not be used after the new code effective date. Although updates may be posted on the WPC Web page up to 3 months prior to the effective date, changes are not effective until the date noted.

If you have any questions regarding the new HPTC list please contact CEDI at **866-311-9184** or **ngs.CEDIHelpdesk@wellpoint.com**

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

Announcing the Release of the Revised CMS-855 Medicare Enrollment Applications (SE0810) GEN

MLN Matters Number: SE0810
Related CR Release Date: N/A
Related CR Transmittal #: N/A

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

Provider Types Affected
All Medicare physicians, providers, and suppliers

Background
The Centers for Medicare & Medicaid Services (CMS) issued revised CMS-855 Medicare enrollment applications in March 2008. With the exception of providers enrolling as a specialty hospital on the CMS-855A, Medicare contractors will continue to accept the 2006 version of the Medicare enrollment application through June 2008. **Providers and suppliers should begin to use the new Medicare enrollment applications immediately.** Initially, these applications will be available only from the CMS provider enrollment web site. The link for that CMS web site is listed in the *Additional Information* section of this article.

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

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

Application-Specific Changes for Physicians and Non-Physician Practitioners (CMS-855I)
- Removed the requirement in Section 17 that providers attached their National Provider Identifier notification that is received from the National Plan and Provider Enumeration System.

Application-Specific Changes for Clinics/Group Practices and Certain Other Suppliers (CMS-855B)
- Removed the supplier type "Voluntary Health/Charitable Agency" from Section 2A.
- Clarified reporting timeframes throughout the CMS-855B.
- Added additional information about the National Provider Identifier (NPI)-legacy association and expanded the number of NPI – legacy combinations that a provider may enter in Section 4A from one to five.
- Removed the requirement in Section 17 that providers attach their National Provider Identifier notification that is received from the National Plan and Provider Enumeration System.
- Required that an Independent Diagnostic Testing Facility (IDTF) submit copies of its comprehensive liability insurance policy in Section 17.
- Added a list of the new IDTF standards found in 42 CFR 410.33(g) on a separate page in Attachment 2.
- Added instructions that explain the IDTF liability insurance requirements in 42 CFR 410.33(g)(6) to Attachment 2.

Application-Specific Changes for Institutional Providers (CMS-855A)
- Revised Section 2A2 to include a specific box that specialty hospitals must check when completing the application. Instructions explaining the definition of a "specialty hospital" were also added to the form.
- Clarified the term "primary practice location" in the instructions in Section 4. (The clarification did not change any data elements on the form.)
- Added additional information about the National Provider Identifier (NPI)-legacy association and expanded the number of NPI – legacy combinations that a provider may enter in Section 4A from one to five.
- Removed the data element "Medicare Year-End Cost Report Date" from Section 2.
- Removed the requirement in Section 17 that providers attach their National Provider Identifier notification that is received from the National Plan and Provider Enumeration System

Application-Specific Changes for DMEPOS Suppliers (CMS-855S)
- Added supplier standards 22 – 25 to the list of DMEPOS supplier standards found on page 31.

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

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

Change in the Amount in Controversy Requirement for Administrative Law Judge Hearings and Federal District Court Appeals (MM5897) GEN

MLN Matters Number: MM5897
Related CR Release Date: February 5, 2008
Related CR Transmittal #: R1437CP
Related Change Request (CR) #: 5897
Effective Date: January 1, 2008
Implementation Date: May 5, 2008

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

Impact on Providers
This article is based on Change Request (CR) 5987 which notifies Medicare contractors of an increase in the Amount in Controversy (AIC) required to sustain Administrative Law Judge (ALJ) and Federal District Court appeal rights beginning January 1, 2008. **The amount remaining in controversy requirement for ALJ hearing requests made before January 1, 2008 is $110. The amount remaining in controversy requirement for requests made on or after January 1, 2008 is $120. For Federal District Court review, the amount remaining in controversy goes from $1,130 for requests prior to January 1, 2008 to $1,180for requests on or after that date.**

Background
The Medicare claims appeal process was amended by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA). In addition, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 provides for annual reevaluation (beginning in 2005) of the dollar amount in controversy required for an Administrative Lay Judge (ALJ) hearing and Federal District Court review.

Change Request (CR) 5897 revises the *Medicare Claims Processing Manual* (Publication 100-4, Chapter 29, Section 330.1 and Section 345.1) to update the Amount In Controversy (AIC) required for an ALJ hearing or Federal District Court review. As of January 1, 2008, the amount remaining in controversy must be at least $120 for an ALJ hearing or at least $1,180 for a Federal District Court review requested on or after January 1, 2008.

Additional Information
The official instruction, CR5987, issued to your carrier, FI, RHHI, A/B MAC, and DME MAC regarding this change may be viewed at **http://www.cms.hhs.gov/Transmittals/downloads/R1437CP.pdf** on the Centers for Medicare & Medicaid Services (CMS) website.

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

Clarification Regarding the Coordination of Benefits Agreement (COBA) Medigap Claim-based Crossover Process (MM5837) GEN

MLN Matters Number: MM5837 - Revised
Related CR Release Date: January 25, 2008
Related CR Transmittal #: R1420CP and R135FM
Related Change Request (CR) #: 5837
Effective Date: October 1, 2007
Implementation Date: February 1, 2008

Note: *This article was revised on January 30, 2008, to show the correct implementation date (see above), which is February 1, 2008. All other information remains the same.*

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

Provider Action Needed
Impact to You
This article is based on Change Request (CR) 5837 which clarifies instructions regarding the Coordination of Benefits Agreement (COBA) Medigap claim-based crossover process.

What You Need to Know
CR 5837 provides formal confirmation of a recent Centers for Medicare & Medicaid Services (CMS) decision to **not require** Medicare Part B contractors (including Durable Medical Equipment Medicare Administrative Contractors (DME MACs) to update their internal insurer tables or files with each Medigap insurer's newly assigned Coordination of Benefits Agreement (COBA) Medigap claim-based ID, as was previously prescribed in CR 5662. In addition, CR 5837 conveys clarifying provider billing requirements in relation to Medigap claim-based crossovers.

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

Background
Effective October 1, 2007, the CMS transferred responsibility for the mandatory Medigap crossover process (also known as the "Medicare claim-based crossover process") to its Coordination of Benefits Contractor. With this change, Part B contractors, including A/B MACs and DME MACs:

- No longer maintain crossover relationships with Medigap insurers, and
- No longer bill such entities for crossover claims effective with the last claims file that they transmit to these entities no later than October 31, 2007.

In a directive issued on September 18, 2007, CMS communicated to Medicare Part B contractors (carriers, DME MACs, and A/B MACs) its decision that they are not required to update their internal insurer files or tables with the Coordination of Benefits Contractor (COBC)-assigned COBA Medigap claim-based identifiers (IDs). This is because, as discussed in Change Request (CR) 5601, the contractors' front-end system now simply verifies that a Medigap claim-based crossover identifier on an incoming claim is syntactically correct (5 digits, beginning with a "5"). CMS' Common Working File (CWF) system is now tasked with validation of the actual ID submitted on incoming claims.

The September 18, 2007, directive represented a departure from previous guidance communicated in CR5662 (see *MLN Matters* article, MM5662, at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5662.pdf** on the CMS website), in which CMS provided for transitional updating of the contractors' internal insurer files/tables prior to October 1, 2007, once the COBC had:

- Assigned COBA Medigap claim-based IDs to the various Medigap insurers, and
- Deemed Medigap insurers "production-ready."

CMS also required Medicare contractors to post language on their provider websites stipulating that:

- Providers are not to begin including the new COBA Medigap claim-based IDs on incoming Part B claims or claims for durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) before October 1, 2007.

CR 5837 instructs Part B contractors (including A/B MACs and DME MACs) that they **are not required to update their internal insurer files/tables** following a Medigap insurer's readiness to move into production with the COBC. This requirement formerly applied to situations where CMS expected that contractors update their internal insurer files/tables prior to October 1, 2007, in accordance with CR 5662 (Transmittal 283). These Part B contractors may retain their older Other Carrier Name and Address (OCNA) or N-key identifiers within their internal insurer files/tables for purposes of avoiding system issues or for the printing of post-hoc beneficiary-requested Medicare Summary Notices (MSNs). However, in accordance with CR 5601, at **http://www.cms.hhs.gov/transmittals/downloads/R1242CP.pdf** on the CMS website, contractors will have disabled the logic that they formerly used to tag claims for crossover to Medigap insurers effective prior to claims they received for processing on October 1, 2007.

Effective with CR 5837, all Part B contractors (including A/B MACs and DME MACs) will discontinue publication of their routine Medigap newsletters. These contractors may, however, at their discretion, publish one last edition of this newsletter if desired to include the provider education language that follows:

In accordance with the language modification to MSN message 35.3

"A copy of this notice will not be forwarded to your Medigap insurer because the information submitted on the claim was incomplete or invalid. Please submit a copy of this notice to your Medigap insurer."—which contractors made as part of Transmittal 1242, CR 5601, all Part B contractors, including A/B MACs, and DME MACs shall make available a Spanish translation of the modified MSN message, which shall read as follows: "No se enviará copia de esta notificación a su asegurador de Medigap debido a que la información estaba incompleta o era inválida. Favor de someter una copia de esta notificación a su asegurador Medigap."

All Part B contractors (including A/B MACs, and DME MACs) are to inform their associated billing providers that are exempted from billing their claims electronically under the Administrative Simplification Compliance Act (ASCA) that they should only be entering the newly assigned 5-byte COBA Medigap claim-based ID (range 55000 to 59999) with item 9-D of the CMS-1500 claim form for purposes of triggering a crossing over of the claim to a Medigap insurer.

All Part B contractors (including A/B MACs, and DME MACs) are also to provide a link on their provider Web sites (preferably under "Hot Topics") to the recently published special edition *MLN* article (SE0743 at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0743.pdf** on the CMS website) that clarifies for providers the differences between:

- Medigap crossover that is accomplished via the automatic, eligibility file-based crossover process, and
- The Medigap claim-based crossover process, which is triggered by information that they include on incoming claim.

Providers should note that the listing at **http://www.cms.hhs.gov/COBAgreement/Downloads/Medigap%20Claim-based%20COBA%20IDs%20for%20Billing%20Purpose.pdf** on the CMS COB website is:

- Complete and up-to-date, and
- The only source for the identifiers to be included on incoming claims for purposes of triggering crossovers to those Medigap insurers that **do not** participate fully in the automatic crossover process.

Additional Information

The official instruction, CR 5837, was issued in two transmittals issued to your Medicare carrier, DME MAC, or A/B MAC. Those transmittals may be viewed at **http://www.cms.hhs.gov/Transmittals/downloads/R1420CP.pdf** and **http://www.cms.hhs.gov/Transmittals/downloads/R135FM.pdf** on the CMS website. These transmittals make revisions to the Medicare Claims Processing and Medicare Financial Management Manuals, respectively

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

CMS News Flash GEN

Additional election period for the Competitive Acquisition Program (CAP)
An additional election period for the Competitive Acquisition Program (CAP) for Medicare Part B drugs will start on January 15 and run through February 15, 2008, to give physicians a chance to take advantage of new changes to the program that began on January 1, 2008. The CAP is a voluntary program that provides an alternative to ASP for physicians to obtain certain Part B drugs. More information about the CAP is available at **http://www.cms.hhs.gov/CompetitiveAcquisforBios/01_overview.asp** on the CMS website.

It's Not Too Late to Get the Flu Shot
We are in the midst of flu season and a flu vaccine is still the best way to prevent infection and the complications associated with the flu. But re-vaccination is necessary each year because flu viruses change each year. Please encourage your Medicare patients who haven't already done so to get their annual flu shot. And don't forget to immunize yourself and your staff. Protect yourself, your patients, and your family and friends. Get Your Flu Shot - Not the Flu! Remember - Influenza vaccination is a covered Part B benefit. Note that influenza vaccine is NOT a Part D covered drug. Health care professionals and their staff can learn more about Medicare's coverage of adult immunizations and related provider education resources, by reviewing Special Edition *MLN Matters* article SE0748 at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0748.pdf** on the CMS website.

Medicare Remit Easy Print (MREP) Software
Medicare Remit Easy Print (MREP) software allows professional providers and suppliers to view and print the Health Insurance Portability and Accountability Act (HIPAA) compliant 835. This software, which is available for free can be used to access and print RA information, including special reports, from the HIPAA 835. Please go to your Carrier or DME MACs website to download the MREP software. To find your carrier or DME MACs web address, see **http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip** on the CMS website.

The Quarterly Journal Ad
A New *MLN* Feature - the Quarterly Journal Ad - Each calendar quarter, the *Medicare Learning Network* will create a journal advertisement based on an initiative or new product of particular importance during that time frame. National, state and local associations are encouraged to use this journal ad in their publications and/or newsletters and websites, as appropriate. This quarter's journal ad features a basic message about the *Medicare Learning Network* and where to go on the CMS Website to get more information. The ad is designed to fit the requirements for most journals' print specifications. The files for this quarter's ad, as well as future ads, can be found at **http://www.cms.hhs.gov/MLNGenInfo/downloads/MLNQuarterly_Journal.zip** on the CMS Website.

Medicare Appeals Process Brochure
The Medicare Appeals Process: *Five Levels to Protect Providers, Physicians and Other Suppliers* brochure has been updated and is now available to order print copies or as a downloadable PDF file. To view the PDF file, go to **http://www.cms.hhs.gov/MLNProducts/downloads/MedicareAppealsProcess.pdf** or to order hard copies, please visit the *MLN* Product Ordering Page at **http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5** on the CMS website.

Single payment amounts for Round 1 of the Medicare DMEPOS Competitive Bidding Program
CMS has announced the single payment amounts for Round 1 of the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding Program. Visit the CMS website at **http://www.cms.hhs.gov/CompetitiveAcqforDMEPOS/** to view additional information. To view the Press Release, please click **http://www.cms.hhs.gov/apps/media/press_releases.asp** on the CMS website.

The NPI will be Required for all HIPAA Standard Transactions on May 23rd
As of May 23, 2008, the NPI will be required for all HIPAA standard transactions. This means: - For all primary and secondary provider fields, only the NPI will be accepted and sent on all HIPAA electronic transactions (837I, 837P, NCPDP, DDE, 276/277, 270/271 and 835), paper claims (UB-04 and CMS-1500) and SPR remittance advice; and - Reporting of Medicare legacy identifiers in any primary or secondary provider fields will result in the rejection of the transaction.

Establish Pre-Payment Auto-denial Edits in Applicable States for DMEPOS Suppliers of Oxygen and Oxygen Equipment (DME MACs only) (MM5929) GEN

MLN Matters Number: MM5929 - Revised
Related CR Release Date: April 18, 2008
Related CR Transmittal #: R1493CP
Related Change Request (CR) #: 5929
Effective Date: April 1, 2008
Implementation Date: April 7, 2008

Note: *This article was revised on April 21, 2008, to amend the last bullet point in the "Key Points" section. All other information remains the same.*

Provider Types Affected
Medicare Durable Medical Equipment Prosthetic, Orthotics & Supplies (DMEPOS) suppliers who submit claims for Medicare payment for oxygen and/or oxygen related equipment to DME Medicare Administrative Contractors (DME MACs).

Key Points

- Presently, 38 states require licensure and/or certification to provide oxygen and/or oxygen related equipment. A table listing the licensure/certification requirements, if any, is at the end of this article.
- CR 5929 clarifies that Medicare DMEPOS suppliers who submit claims for Medicare payment for oxygen and/or oxygen related equipment must notify the National Supplier Clearinghouse (NSC) via the supplier enrollment process (using the CMS 855S application) and provide a copy of their state license and/or certification to the NSC.
- DME MACs are currently processing these claims from enrolled and approved DMEPOS suppliers without regard to the specialty identified and services to be provided on the enrollment application form (CMS-855S).
- CR5929 **requires** the National Supplier Clearinghouse (NSC) to **assign an oxygen specialty code** to all suppliers who have indicated they will be providing oxygen and/or oxygen related services on their CMS 855S enrollment application.
- In addition, this instruction requires DME MACs to **edit claims to look for the oxygen specialty code**, which will assure that those suppliers specifying the provision of oxygen and/or oxygen related products on their enrollment application and supplying the license/certification are the **only entities that will receive Medicare payment for such supplies in the applicable states**. The DME MACs will establish a **claims processing pre-payment auto-denial edit** in place to deny claims in those states where oxygen and/or oxygen related equipment must be provided by a supplier with oxygen specific licensure and/or certification and where Medicare files do not reflect such license/certification.
- The effective date for the specialty code annotation in Medicare files will be the date the NSC assigns the specialty code for newly enrolled DMEPOS suppliers or the date a DMEPOS supplier initially adds the specialty to their file via a CMS 855S Change of Information submission providing all required licensure/certification is valid. The effective date of the specialty code for existing DMEPOS suppliers will be the date the DMEPOS supplier added or enrolled the specialty with the NSC, providing all required licensure/certification is valid.
- DMEPOS suppliers who are on file with the NSC prior to April 1, 2008 as providing oxygen and/or oxygen related equipment do not need to submit a CMS 855S Change of Information as a result of this instruction.
- Any future oxygen and/or oxygen equipment claims submission by a DMEPOS supplier in a state where licensure/certification is required, where the DMEPOS supplier does not have the oxygen and/or oxygen equipment specialty code on file with the NSC will result in an investigation by the NSC.

Background
In the absence of national Medicare policy regarding who may bill and be paid for oxygen and/or oxygen related equipment, the National Supplier Clearinghouse (NSC) looks to state requirements. The Center for Medicare & Medicaid Services (CMS) regulations (see 42 CFR § 424.57(c)) require all DMEPOS suppliers wishing to bill Medicare meet all supplier standards. The standard in § 424.57(c)(1) requires suppliers to operate their business and furnish Medicare-covered items in compliance with all applicable Federal and State licensure and regulatory requirements. This claims processing edit will ensure that suppliers in the (currently) 38 states are in compliance with this requirement.

Additional Information
CR5929 is the official instruction issued to your DME MAC. That instruction may be viewed by going to **http://www.cms.hhs.gov/transmittals/downloads/R1493CP.pdf** on the CMS website.

Should you have any questions regarding this issue, please contact your DME MAC on their toll-free number, which is available at **http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip** on the CMS website.

The following is the list of the (currently) 38 states that have licensure requirements for oxygen and oxygen related equipment.

State	DME Supplier License	Oxygen License	Other	Notes
AK				
AL		X		
AR	X			
AZ		X		
CA	X		X	"Drug Manufacturing License" issued by CA Department of Health; if wholesaler, permit from Board of Pharmacy is required
CO				
CT		X		
DC	X			"Certificate of Occupancy" issued by the Dept. of Consumer and Regulatory Affairs, Building and Land Regulation Administration Zoning Division, and if operating business from a principal residence, a "Home Occupation Permit" is also required, issued by the Dept. of Consumer and Regulatory Affairs, Building and Land Regulation Administration Zoning Division
DE				
FL	X	X		
GA				
HI		X		Pharmacy license - HI Dept. of Commerce and Consumer Affairs
IA		X		
ID	X			
IL	X			
IN				
KS		X	X	Distributor License required if supplying item/drug classified by FDA as a prescription device, issued by KS Board of Pharmacy
KY		X		
LA		X		
MA			X	"Controlled Substances" license, issued by MA Dept. of Public Health, Division of Food and Drugs
MD	X	X		
ME		X		
MI				
MN		X		
MO	X			
MS	X			
MT				
NC	X			
ND		X		
NE	X	X		
NH		X	X	"Home Health Care Provider" license if respiratory therapy or services provided in patient's residence, issued by NH DHHS, Division of Public Health Services
NJ				
NM				

State	DME Supplier License	Oxygen License	Other	Notes
NV	X	X	X	Must have physician or respiratory therapist on staff, with "Medical License" or respiratory therapist license, both issued by NV State Board of Medical Examiners
NY				
OH	X	X		
OK		X	X	If transfilling oxygen, company must be registered and listed with the FDA and have validated registration letter on file
OR		X		
PA	X			
PR		X		
RI		X		
SC		X		Oxygen license not needed if supplier has "SC Pharmacy Permit"
SD				
TN		X		
TX	X	X		
UT			X	"Retail Pharmacy" license required if supplying oxygen
VA	X	X		
VT				
WA				
WI		X		
WV				
WY		X		

Importance of Supplying Correct Provider Identification Information Required in Items 17, 17a, 24K, and 33 of the Form CMS-1500 (12-90), and the Electronic Equivalent (SE0529) (GEN)

Related Change Request (CR) #: N/A - Revised **MLN Matters Number: SE0529**
Related CR Release Date: N/A

This article was revised on April 21, 2008, to remove all references to the 12-90 version of the Form CMS-1500. The Form CMS-1500 (12-90) version of the claim form is discontinued. **Only the revised Form CMS-1500 (08-05) is to be used, effective on April 2, 2007.**

Providers should read *MLN Matters* article MM5060 at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/mm5060.pdf**, which states the requirements for the newer form, CMS-1500 (08-05). Providers may also want to view *MLN Matters* MM5890 (**http://www.cms.hhs.gov/MLNMattersArticles/downloads/mm5890.pdf**). MM5890 stated that effective with claims received on or after May 23, 2008, Medicare will not pay for referred or ordered services or items, unless the fields for the name and NPI of the ordering, referring and attending, operating, other, or service facility providers are completed on the claims.

Items and Special Services Having Special DME Review Considerations (MM5909) GEN

MLN Matters Number: MM5909
Related CR Release Date: February 22, 2008
Related CR Transmittal #: R242PI

Related Change Request (CR) #: 5909
Effective Date: March 1, 2008
Implementation Date: March 1, 2008

Provider Types Affected
Suppliers who submit claims to durable medical equipment Medicare Administrative Contractors (DME MACs) for DME items and services furnished to Medicare beneficiaries.

What Suppliers Need to Know
This article is informational for suppliers and is based on Change Request (CR) 5909 that alerts suppliers that the medical review (MR) function (Chapter 5 of the *Program Integrity Manual* (*PIM*) - Items and Services Having Special DME Review Considerations) that was the responsibility of the DME Program Safeguard Contractors (PSCs) is being transitioned to the DME MACs.

CR 5909 rescinds and replaces CR 5765 of the same title. This replacement also **renames the** DME PSCs to be Zone Program Integrity Contractors (ZPICS).

Additional Information
To see the official instruction (CR5909) issued to your Medicare DME MAC visit **http://www.cms.hhs.gov/Transmittals/downloads/R242PI.pdf** on the CMS website.

If you have questions, please contact your Medicare 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.

Revised ABN Form - Effective March 3, 2008 GEN

Effective **March 3, 2008**, CMS implemented use of the revised Advance Beneficiary Notice of Noncoverage (ABN) (CMS-R-131). This form replaces the General Use ABN (CMS-R-131-G). The form and notice instructions are posted on the Beneficiary Notice Initiative web page (**http://www.cms.hhs.gov/bni**).

Some key features of the new form:

- A new, official title to more clearly convey the purpose of the notice: "Advance Beneficiary Notice of Noncoverage (ABN)"
- Replaces both the existing ABN-G and ABN-L
- May also be used for voluntary notifications, in place of the Notice of Exclusion from Medicare Benefits (NEMB)
- A mandatory field for cost estimates of the items/services at issue
- A new beneficiary option, under which an individual may choose to receive an item/service, and pay for it out-of-pocket, rather than submit a claim to Medicare

CMS will allow a 6 month transition period from the date of implementation for use of the revised form and instructions. **Thus, all providers and suppliers must begin using the new ABN (CMS-R-131) no later than September 1, 2008.**

Opportunity to Participate in Third Annual Medicare Contractor Provider Satisfaction Survey (MCPSS) Ends in April (SE0804) GEN

MLN Matters Number: SE0804
Related CR Release Date: N/A
Related CR Transmittal #: N/A
Related Change Request (CR) #: N/A
Effective Date: N/A
Implementation Date: N/A

Provider Types Affected
All Medicare physicians, providers, and suppliers billing the Medicare fee-for-service (FFS) program who were selected to participate in the MCPSS for 2008.

Provider Action Needed
Those Medicare providers who were selected by the Centers for Medicare & Medicaid Services (CMS) to participate in the MCPSS are asked to please take the time to complete the survey or respond to the survey contractor, Westat, follow-up calls. The survey is designed so that it can be completed in 15 minutes and responses may be submitted via a secure website, mail, fax or over the telephone. Currently the average response rate is 32%; CMS' goal is to reach a 65% response rate. Data collection ends in April.

Background
The MCPSS offers providers the opportunity to contribute directly to CMS' understanding of contractor performance as well as aid future process improvement efforts of Medicare contractors (carriers, fiscal intermediaries, Medicare Administrative Contractors, (A/B MACs), and Durable Medical Equipment Medicare Administrative Contractors (DME MACs). Specifically, the survey is used by CMS as an additional measure to evaluate contractor performance. In fact, all Medicare Administrative Contractors (MACs) will be required to achieve performance targets on the MCPSS as part of their contract requirements by 2009.

The MCPSS is designed to gather quantifiable data on provider satisfaction levels with the key services that comprise the provider-contractor relationship. The survey focuses on seven major parts of the relationship: provider inquiries, provider outreach and education, claims processing, appeals, provider enrollment, medical review, and provider audit and reimbursement.

Respondents are asked to rate their experience working with contractors using a scale of 1 to 6 with "1" representing "not at all satisfied" and "6" representing "completely satisfied." The results of the second MCPSS showed that 85 percent of respondents rated their contractors between 4 and 6.

The 2007 MCPSS results indicate that the provider inquiry function has the greatest influence on whether providers are satisfied with their contractors. This indicated a shift from 2006, when the claims processing function was the strongest predictor of a provider's overall satisfaction.

"CMS and the Medicare contractor community are committed to high quality relationships with the provider community," CMS Acting Administrator Kerry Weems said in a recent CMS press release. "The MCPSS provides contractors with greater insight into their provider communities, and allows them to make process improvements based on provider feedback."

"The shift from claims processing to provider inquiries as the top predictor of satisfaction is a perfect example of the type of trend data the MCPSS will reveal," Weems said. "Contractors are able to factor this insight into how they prioritize their provider-focused efforts."

Additional Information
To review the complete report of the second MCPSS refer to: **http://www.cms.hhs.gov/mcpss/downloads/mcpss_report.pdf** on the CMS website. To review a summary of the 2007 MCPSS refer to **http://www.cms.hhs.gov/mlnmattersarticles/downloads/se0733.pdf** on the CMS website. CMS plans to make the survey results publicly available in July 2008. Further information about the MCPSS is available at **http://www.cms.hhs.gov/MCPSS** on the CMS website.

Pre-Bidding Activities for the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program (SE0811) GEN

MLN Matters Number: SE0811
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
Suppliers of Durable Medical Equipment (DME) that wish to participate in the upcoming Medicare DMEPOS competitive bidding program.

Provider Action Needed
In order to participate in the second round of the DMEPOS Competitive Bidding Program, suppliers will be required to register in the Centers for Medicare & Medicaid Services (CMS) security system known as the Individuals Authorized Access to CMS Computer Services (IACS). This includes suppliers that bid in the first round of competition last year and are interested in competing in the second round. Although the bidding window for the second round of competition may not be announced before the issue date of this article, CMS urges suppliers planning to bid in the 2008 bidding cycle to make sure their provider enrollment record is current. Specifically, suppliers should verify their supplier number(s) and Authorized Official(s) information associated with that supplier number(s) on file with the National Supplier Clearinghouse (NSC). The accuracy of this data is critical for successful bid registration.

Background
In this year's bid cycle, suppliers who wish to bid will need to first register in IACS, before the bidding window opens. There will be three user roles available, which are described as follows:

- Authorized Official (AO) - Each supplier's organization will be allowed one AO. The AO role can approve all other users associated with their organization who are requesting access to the bidding system. The AO will be able to input bid data, approve Form A and certify Form B in the bidding system.

- Backup Authorized Official (BAO) - Each supplier organization will be allowed to designate one or more Backup Authorized Officials (BAOs). In this role, the BAO can approve the supplier's End User registration for access to the bidding system. Like the AO, the BAO can also input bid data, approve Form A and certify Form B in the bidding system.

- End User - Each supplier organization will be allowed one or more End User(s). The End User can input bid data, but cannot approve Form A or certify Form B.

Save Time and Delay by Verifying NSC Information Prior to Registering to Bid
Only those AOs listed on the CMS-855S (Medicare Enrollment Application) as an AO can register in IACS to approve and certify as described above. As part of the CMS-855S, a supplier designates one or more AO(s). The AO is an appointed official to whom the organization has granted the legal authority to enroll it in the Medicare program and to commit the organization to fully abide by the statutes, regulations and program instructions of the Medicare program.

End Users do not need to be listed on the CMS-855S. However, the AO or BAO will need to approve an End User's request for access to the bidding system.

Take Action Now
Be sure that the data you are submitting is current and in accordance with that submitted to the NSC. In particular, this concerns the AO's name, date of birth, Social Security Number (SSN), and mailing address. If any of these data elements have changed since your last submission to the NSC, then you should PROMPTLY complete a change of information on the CMS 855-S.

CMS urges that suppliers do it now. The NSC processing time to complete a change of information on the CMS-855S is approximately 45 days and all submissions are processed in the order in which they are received.

Overview of AO IACS Registration Process
For an AO, the verification of his/her last name, date of birth, and SSN must be validated against the data maintained by NSC. The NSC received this AO data when the supplier completed their most recent CMS-855S Medicare Enrollment Application. The AO's last name is listed in Section 15 and the AO's date of birth and SSN in Section 6A of the CMS-855S. If the data does not match, the registration will be rejected.

Following successful registration, as an added measure of security, the AO's User ID and password is then mailed in a separate correspondence to the mailing address listed in Section 2A2 of the CMS-855S Medicare Enrollment Application.

The BAO goes through a similar process and an AO for the organization must approve a BAO's request for access before a User ID and password will be emailed to the BAO.

Do I need a BAO role?
The establishment of a BAO is highly recommended to avoid any disruption in the bidding process. The AO's role is instrumental to bidding, as the AO's role must be active to avoid all other users of the organization from losing access to the bidding system. If the AO leaves the organization, the BAO role can be changed to an AO role by the Competitive Bidding Implementation Contractor (CBIC).

You will want to verify that the CMS-855S Medicare Enrollment Application for your organization has two or more AOs listed.

Additional Information
For more information on the DMEPOS competitive bidding program, visit **http://www.cms.hhs.gov/CompetitiveAcqforDMEPOS/** on the CMS website.

Reporting of Hematocrit or Hemoglobin Levels on All Claims for the Administration of Erythropoiesis Stimulating Agents (ESAs), Implementation of New Modifiers for Non-ESRD ESA Indications, and Reporting of Hematocrit or Hemoglobin Levels on all Non-ESRD, Non-ESA Claims Requesting Payment for Anti-Anemia Drugs (MM5699) DRU

MLN Matters Number: MM5699 - Revised
Related CR Release Date: January 11, 2008
Related CR Transmittal #: R1412CP
Related Change Request (CR) #: 5699
Effective Date: January 1, 2008
Implementation Date: April 7, 2008

Note: *This article was revised on February 15, 2008, to add clarifying information to bullet points 1 and 3 on pages 3 and 4, respectively. All other information remains the same.*

Provider Types Affected
Physicians, providers, and suppliers who bill Medicare contractors (carriers, including durable medical equipment Medicare administrative contractors (DME MACs), fiscal intermediaries (FIs), Competitive Acquisition Plan (CAP) Designated Carriers, and A/B Medicare administrative contractors (A/B MACs)) for providing ESAs and related anti-anemia administration services to Medicare beneficiaries.

Impact on Providers
Effective for services on or after January 1, 2008, you must report the most recent hemoglobin or hematocrit levels on any claim for a Medicare patient receiving: (1) ESA administrations, or (2) Part B anti-anemia drugs other than ESAs used in the treatment of cancer that are not self-administered. In addition, non-ESRD claims for the administration of ESAs must also contain one of three new Healthcare Common Procedure Coding System (HCPCS) modifiers effective January 1, 2008. Failure to report this information will result in your claim being returned as unprocessed. (**Note that renal dialysis facilities are already reporting this information on claim types 72X, so CR5699 applies to providers billing with other types of bills.**) See the rest of this article for reporting details.

Background
Medicare Part B provides payment for certain drugs used to treat anemia caused by the cancer itself or by various anti-cancer treatments, including chemotherapy, radiation, and surgical therapy. The treatment of anemia in cancer patients commonly includes the use of drugs, specifically ESAs such as recombinant erythropoietin and darbepoetin. Emerging data and recent research has raised the possibility that ESAs administered for a number of clinical indications may be associated with significant adverse effects, including a higher risk of mortality in some populations.

Most recently, section 110 of Division B of the Tax Relief and Health Care Act (TRHCA) of 2006 directs the Secretary to amend Section 1842 of the Social Security Act by adding at the end the following new subsection: "*Each request for payment, or bill submitted, for a drug furnished to an individual for the treatment of anemia in connection with the treatment of cancer shall include (in a form and manner specified by the Secretary) information on the hemoglobin or hematocrit levels for the individual.*"

In light of the health and safety factors and the TRHCA legislation, effective January 1, 2008, the Centers for Medicare & Medicaid Services (CMS) is implementing an expanded reporting requirement for all claims billing for administrations of an ESA. Hematocrit and /or hemoglobin readings are already required for ESRD claims for administrations of an ESA. Effective with the implementation of change request (CR) 5699, all other claims for ESA administrations will also require the reporting of the most recent hematocrit or hemoglobin reading, along with one of three new HCPCS modifiers effective January 1, 2008.

In addition, CR 5699 requires the reporting of the most recent hematocrit or hemoglobin readings on all claims for the administration of Part B anti-anemia drugs OTHER THAN ESAs used in the treatment of cancer that are not self-administered.

What you Need to Know

CR 5699, from which this article is taken, instructs all providers and suppliers that:

1. Effective January 1, 2008, all claims billing for the administration of an ESA with HCPCS codes J0881, J0882, J0885, J0886 and Q4081 must report the most recent hematocrit or hemoglobin reading available when the billed ESA dose was administered. Facilities should bill at a frequency that allows for the reporting of the most recent hematocrit or hemoglobin reading prior to the start of the billing period that is applicable to the administrations billed on the claim. For new patients this would be the most recent reading prior to the onset of treatment. Note that a provider may have to submit more than one claim for the month if there were multiple readings that were applicable to the administrations given during the month. Claims submitted prior to the publication of change request 5699 that were not completed per the instructions in change request 5699 should be re-submitted.

- For institutional claims, the hemoglobin reading is reported with a value code 48 and a hematocrit reading is reported with the value code 49. Such claims for ESAs not reporting a value code 48 or 49 will be returned to the provider.

- Effective for services on or after January 1, 2008, for professional paper claims, test results are reported in item 19 of the Form CMS-1500 claim form. For professional electronic claims (837P) billed to carriers or A/B MACs, providers report the hemoglobin or hematocrit readings in Loop 2400 MEA segment. The specifics are MEA01=TR (for test results), MEA02=R1 (for hemoglobin) or R2 (for hematocrit), and MEA03=the test results. The test results should be entered as follows: TR= test results, R1=hemoglobin or R2=hematocrit (a 2-byte alpha-numeric element), and the most recent numeric test result (a 3-byte numeric element, decimal implied [xx.x]). Results exceeding 3-byte numeric elements (10.50) are reported as 10.5.

  Examples: *If the most recent hemoglobin test results are 10.50, providers should enter: TR/R1/10.5, or, if the most recent hematocrit results are 32.3, providers would enter: TR/R2/32.3.*

- Effective for dates of service on and after January 1, 2008, contractors will return to provider paper and electronic professional claims, or return as unprocessable paper and electronic institutional claims for ESAs when the most recent hemoglobin or hematocrit test results are not reported.

- When Medicare returns a claim as unprocessable for ESAs with HCPCS codes J0881, J0882, J0885, J0886, or Q4081 for failure to report the most recent hemoglobin or hematocrit test results, it will include Claim Adjustment Reason Code 16 (Claim/service lacks information which is needed for adjudication.) and Remittance Advice Code MA130 (Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with complete/correct information.)

2. Effective January 1, 2008, all non-ESRD ESA claims billing HCPCS J0881 and J0885 must begin reporting one (**and only one**) of the following three modifiers on the same line as the ESA HCPCS:
   - EA: ESA, anemia, chemo-induced;
   - EB: ESA, anemia, radio-induced; or
   - EC: ESA, anemia, non-chemo/radio

- Non-ESRD ESA institutional claims that do not report one of the above three modifiers along with HCPCS J0881 or J0885 will be returned to the provider.

- Non-ESRD ESA professional claims that are billed without one of the three required modifiers as line items along with HCPCS J0881 or J0885 will be returned as unprocessable with reason code 4 and remark code MA130. If more than one modifier is reported, the claim will be returned with reason code 125 and remark code N63.

3. Effective January 1, 2008, all non-ESRD, non-ESA claims billing for the administration of Part B anti-anemia drugs used in the treatment of cancer that are not self-administered must report the most recent hematocrit or hemoglobin reading. Facilities should bill at a frequency that allows for the reporting of the most recent hematocrit or hemoglobin reading prior to the start of the billing period that is applicable to the administrations billed on the claim. For new patients this would be the most recent reading prior to the onset of treatment. Note that a provider may have to submit more than one claim for the month if there were multiple readings that were applicable to the administrations given during the month.

- Institutional claims that do not report the most recent hematocrit or hemoglobin reading will be returned to the provider.

- Professional claims that do not report the most recent hematocrit or hemoglobin reading will be returned as unprocessable using Reason Code 16, and Remarks Codes MA130 and N395

- Your Medicare contractor will not search for claims with dates of service on or after January 1, 2008, processed prior to implementation of this CR, but will adjust such claims when you bring them to the attention of your contractor.

Additional Information
For complete details regarding this CR please see the official instruction (CR5699) issued to your Medicare carrier, FI, DME MAC, CAP Designated Carrier, and A/B MAC. That instruction may be viewed by going to **http://www.cms.hhs.gov/Transmittals/downloads/R1412CP.pdf** on the CMS website.

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

Support Income Tax Reporting (MM5816) GEN

MLN Matters Number: MM5816
Related CR Release Date: January 25, 2008
Related CR Transmittal #: R311OTN
Related Change Request (CR) #: 5816
Effective Date: January 1, 2007 (date of payment)
Implementation Date: January 30, 2008

Provider Types Affected
Suppliers submitting claims to Durable Medical Equipment Medicare Administrative Contractors (DME MACs).

Provider Action Needed
This article is based on Change Request (CR) 5816, which notifies all DME MACs of the requirements to issue Internal Revenue Service (IRS) Form 1099-MISC to every supplier paid under contract and/or any other forms required for income tax and reporting purposes. Thus, your DME MAC will issue appropriate 1099 forms to you, when you receive $600 or more in Medicare payments in a calendar year, beginning with January 1, 2007.

Background
The reporting requirements of the Internal Revenue Code (Section 6041A) state that any service-recipient engaged in a trade or business that pays in the course of such trade or business during any calendar year remuneration for such services in the aggregate of $600 or more must file an information return with the Internal Revenue Service (IRS). Internal Revenue Code section 6041A(d)(3) provides that payments made for services performed by a corporation are subject to information reporting requirements when the remuneration has been paid to the corporation by a Federal executive agency. The $600 or more paid by a Federal executive agency to a corporation is subject to information reporting requirements per section 6041A(d)(3) of the Internal Revenue Code.

Further, the IRS has determined that payments to Durable Medical Equipment companies paid from Medicare trust fund monies are subject to Form 1099 MISC reporting requirements. IRS has also ruled that payments to persons providing health care services, including proprietary hospitals, physicians and dentists, often include charges for injections, drugs, dentures, and similar items. In such cases, the entire payment is subject to information reporting.

IRS instructions for completing form 1099-MISC states in part that Form 1099-MISC (Miscellaneous Income) should be filed for each person to whom one has paid during the year:

- At least $600 in rents, services (including parts and materials), prizes and awards, other income payments, medical and health care payments.

For more information, visit **http://www.irs.gov/pub/irs-pdf/f1099msc.pdf** and **http://www.irs.gov/pub/irs-pdf/i1099msc.pdf** on the Internet.

Note that "services" as defined by Medicare means "medical care or services and items, such as medical diagnosis and treatment, drugs and biologicals, supplies, appliances, and equipment, medical social services, and use of hospital, Critical Access Hospital (CAH), or Skilled Nursing Facility (SNF)."

In summary, CR5816 instructs that DME MACs should:

- Issue to every supplier paid under contract a 1099 and/or any other forms required for income tax and reporting purpose;
- Comply with Form 1099 rules, regulations, procedures and instructions as published at **http://www.irs.gov/**; and
- Report all payments made to suppliers during the previous year.

Additional Information

The official instruction, CR 5816, issued to your DME MAC regarding this change may be viewed at **http://www.cms.hhs.gov/Transmittals/downloads/R311OTN.pdf** on the CMS website.

If you have any questions, please contact your 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.

Updating Supplier Records GEN

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

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

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

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

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

Use of an 8-Digit Registry Number on Clinical Trail Claims (MM5790) GEN

MLN Matters Number: MM5790
Related CR Release Date: January 18, 2008
Related CR Transmittal #: R310OTN

Related Change Request (CR) #: 5790
Effective Date: April 1, 2008
Implementation Date: April 7, 2008

Provider Types Affected
Physicians, providers, and suppliers who bill Medicare contractors (carriers, fiscal intermediaries (FIs), Medicare Administrative Contractors (A/B MACs) and Durable Medical Equipment Medicare Administrative Contractors (DME MACs)) for services provided to Medicare beneficiaries in clinical research studies.

Provider Action Needed
This article is based on Change Request (CR) 5790 that notifies providers and suppliers that Medicare claims forms will be modified to accommodate the 8-digit clinical trail number for claims that Medicare receives on or after April 1, 2008. Reporting this number is voluntary and claims submitted without the clinical trial number will be paid the same as claims containing a number. While reporting is voluntary, the number will assist the Centers for Medicare & Medicaid Services (CMS) in informing beneficiaries about the availability of clinical trials and to use claims information to inform coverage decisions. Be sure your billing staff is aware of this rule.

Background
The purpose of CR5790 is to instruct providers and suppliers on new, voluntary reporting for placing a clinical trial number on claims for items and services provided in clinical trials that are qualified for coverage as specified in the *Medicare National Coverage Determination Manual*, Publication 100-03, section 310.1. That publication is available at **http://www.cms.hhs.gov/Manuals/IOM/list.asp** on the CMS website. The clinical trial number that the CMS is requesting to be voluntarily reported is the number assigned by the National Library of Medicine (NLM) Clinical Trials Data Bank when a new study is registered by a sponsor or investigator. Information regarding NLM clinical trials is available at **http://clinicaltrials.gov/** on the Internet.

CMS will use this number to identify all items and services provided to beneficiaries during their participation in a clinical trial. Furthermore, this identifier will permit CMS to meet the recommendations of the 2000 Institute of Medicine report that led to the Executive Memorandum to increase participation of Medicare beneficiaries in clinical trials and the development and implementation of the CMS clinical trials policy.

Recommendations from The White House Executive Memorandum included:
- Tracking Medicare payments;
- Ensuring that the information gained from the research is used to inform coverage decisions;
- Making certain that the research focuses on issues of importance to the Medicare population; and,
- Enabling CMS to better inform Medicare beneficiaries about the clinical studies available for their participation.

Key Points
- Claims submitted without the clinical trial number will be paid the same as claims containing a number.
- Institutional clinical trial claims are identified through the presence of all of the following elements:
  - Value Code D4 and corresponding 8-digit clinical trial number (when present on the claim);
  - ICD-9 diagnosis code V70.7;
  - Condition Code 30; and
  - HCPCS modifier Q1: outpatient claims only. (See MM5805 related to CR5805 for more information regarding modifier Q1.)
- Practitioner/DME clinical trail claims are identified through the presence of all of the following elements:
  - ICD-9 diagnosis code V70.7;
  - HCPCS modifier Q1; and
  - 8-digit clinical trial number (when present on the claim).
- On institutional claims, the 8-digit numeric clinical trial number should be placed in the value amount of value code D4 on the paper claim UB-40 (Form Locators 39-41) or in Loop 2300, HI - Value Information segment, qualifier BE on the 837I.
- On professional claims, the clinical trial registry number should be preceded by the two alpha characters of "CT" and placed in Field 19 of the paper Form CMS-1500 or it should be entered WITHOUT the "CT" prefix in the electronic 837P in Loop 2300 REF02(REF01=P4).

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

You may see the official instruction (CR5790) issued to your Medicare A/B MAC, FI, DME/MAC, or carrier by going to **http://www.cms.hhs.gov/Transmittals/downloads/R310OTN.pdf** on the CMS website.

You may see the article related to the Q1 modifier, MM5805, at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5805.pdf** on the CMS website.

Overview of New Medicare Competitive Bidding Program for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) - The first in a series of articles on the implementation of this program. (SE0805) GEN

MLN Matters Number: SE0805
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
Any Medicare Fee-for-Service (FFS) provider that may be in a position of ordering, referring, or supplying DMEPOS to a Medicare beneficiary may be affected by this program. This includes DMEPOS suppliers, physicians (including podiatric physicians), other treating practitioners (nurse practitioners, physician assistants, and clinical nurse specialists), physical and occupational therapists, and institutional providers (especially skilled nursing facilities and their social workers or care coordinators, hospitals and their discharge planners, home health agencies and pharmacists).

Note that those who refer or order DMEPOS for Medicare beneficiaries are being described as "referral agents" throughout this series.

Provider Action Needed
Impact to You
Effective July 1, 2008, Medicare will begin implementation of a new program for purchasing DMEPOS for Medicare patients. For Medicare beneficiaries whose permanent residence is in 1 of the 10 metropolitan statistical areas (MSAs) affected by the first phase of this program, only contract suppliers, in most instances, will be eligible to provide competitive bid items and receive payment from Medicare. While new payment rules may not impact referral agents directly, they may impact your patients. Therefore, the Centers for Medicare & Medicaid Services (CMS) is providing this information to make you aware of the program so you can discuss it with your patients when necessary.

What You Need to Know
This program, initially, will affect patients obtaining DMEPOS in 10 Competitive Bidding Areas (CBAs) that align with the 10 MSAs affected by the first phase of this program and will include 10 product categories of DMEPOS. These areas and product categories will be identified later in this article. In general, if your patients reside in one of the CBAs, they must use a Medicare contract supplier for competitive bid items, unless they are willing to be responsible for full payment of these items. This means that some of your patients may have to change from a noncontract supplier to a contract supplier. Also, certain suppliers that rent DMEPOS that were not awarded contracts may be "grandfathered" under this program and may be able to continue to supply certain DMEPOS items/services should the beneficiary choose to continue to receive these items from a grandfathered supplier.

What You Need to Do
It is important that all affected providers know this information. This program determines how much Medicare will pay for competitive bidding items and which suppliers are eligible to receive Medicare payments for these items. Be aware that the new program impacts payment amounts for certain DMEPOS items received by beneficiaries residing in one of the CBAs no matter where in the country they obtain their DMEPOS.

Be prepared for this program if you treat Medicare patients in one of the 10 areas affected by the first phase of this program, which are listed later in this article. Note that the program will expand to 70 additional MSAs in 2009.

Background
Currently, Medicare payment for most DMEPOS is based on fee schedules. Recent amendments to the Social Security Act (the Act), however, will alter the process for determining payment amounts for certain DMEPOS items. Specifically, Section 1847 of the Act mandates that competitive bidding payment amounts replace the current DMEPOS fee schedule payment amounts for selected items in selected areas. The intent is to improve the effectiveness of the Medicare methodology for setting DMEPOS payment amounts, which will reduce beneficiary out-of-pocket expenses and save the Medicare program money while ensuring beneficiary access to quality items and services. The new method brings the payment amount for these items in line with that of a competitive market and reduces your patients' out-of-pocket expenses. The program also ensures the availability of a sufficient number of accredited suppliers for access to quality items and services. For more information on accreditation of DME suppliers, visit **http://www.cms.hhs.gov/CompetitiveAcqforDMEPOS/04_New_Quality_Standards.asp** on the CMS website.

The law also provides for phasing in competitive bidding beginning in 10 of the largest MSAs. The program will be expanded into 70 additional MSAs in 2009 and the program will be expanded into additional areas after 2009. Areas that may be exempt from competitive acquisition of DMEPOS include rural areas and areas with low population density that are not competitive, unless there is a significant national market through mail order for a particular item or service. An area is chosen for the Competitive Bidding Program based on several variables, including the size of its Medicare population and the amount of money spent on medical equipment and supplies in those areas.

Definitions
The following definitions are provided to explain several terms and their usage in this series of articles:

- *Contract Supplier* - An entity that is awarded a contract by CMS to furnish items under a competitive bidding program.
- *Noncontract Supplier* - A supplier that is not awarded a contract by CMS to furnish items included in a competitive bidding program.
- *Referral Agents* - This term applies to the range of physicians, practitioners or providers who prescribe DMEPOS (in essence, "order" or "refer") for their patients.
- *Grandfathered Supplier* - A noncontract supplier that chooses to continue to furnish grandfathered items to a beneficiary in a CBA.
- *Grandfathered Item* - Any one of the items (as described in CFR §414.220, 222, 226, and 229) for which payment is made on a rental basis prior to the implementation of a competitive bidding program and for which payment is made after implementation of a competitive bidding program to a grandfathered supplier that continues to furnish the items in accordance with §414.408(j).
- *Single payment amount* means the allowed payment for an item furnished under a competitive bidding program.

For more information on single payment amounts, visit **http://dmecompetitivebid.com/SPA** on the Internet.

Initial Competitive Bidding Areas (CBAs)
Effective July 1, 2008, the competitive bidding program will be implemented in the following CBAs within these10 MSAs:

- Charlotte-Gastonia-Concord, North Carolina and South Carolina;
- Cincinnati-Middletown, Ohio, Kentucky, and Indiana;
- Cleveland-Elyria-Mentor, Ohio;
- Dallas-Fort Worth-Arlington, Texas;
- Kansas City, Missouri and Kansas;
- Miami-Fort Lauderdale-Miami Beach, Florida;
- Orlando-Kissimmee, Florida;
- Pittsburgh, Pennsylvania;
- Riverside-San Bernardino-Ontario, California;
- San Juan-Caguas-Guaynabo, Puerto Rico.

Product Categories
Effective July 1, 2008, the competitive bidding program will be implemented for the following product categories:

- Oxygen supplies and equipment;
- Standard power wheelchairs, scooters, and related accessories;
- Complex rehabilitative power wheelchairs and related accessories;
- Mail-order diabetic supplies;
- Enteral nutrients, equipment, and supplies;
- Continuous positive airway pressure (CPAP), respiratory assist devices (RADs), and related supplies and accessories;
- Hospital beds and related accessories;
- Negative pressure wound therapy (NPWT) pumps and related supplies and accessories;
- Walkers and related accessories;
- Support surfaces (Group 2 mattresses and overlays (**Miami MSAs only**)).

Traveling Beneficiaries
As previously mentioned, any beneficiary obtaining competitive bidding items in one of the CBAs is affected by the rules of the Medicare DMEPOS Competitive Bidding Program. Beneficiaries who reside in a CBA and travels outside their CBAs may obtain competitive bid items and the supplier will be paid the single payment amount under the program.

In addition, beneficiaries who do not reside in CBAs and who travel to CBAs are also affected. If they require competitive bid items, they must obtain competitive bid items from a contract supplier for that CBA. In such instances, Medicare will pay that contract supplier the DMEPOS fee schedule amount.

The following table details how DMEPOS supplies may be acquired, given different scenarios:

If a beneficiary permanently lives in…	**And travels to…**	**Type of supplier a beneficiary may go to…**
A competitive bidding area	A competitive bidding area	A beneficiary must get competitively bid items from a contract supplier located in the competitive bidding area to which he/she traveled.
A competitive bidding area	An area **NOT** covered by the competitive bidding program	A beneficiary may get items from any Medicare-enrolled DME supplier, and the supplier will be paid by Medicare as if it were in the beneficiary's competitive bidding area.
An area **NOT** covered by the competitive bidding program	A competitive bidding area	A beneficiary must get the competitively bid item from a contract supplier in the competitive bidding area. If the beneficiary does not use a contract supplier, the noncontract supplier must ask him/her to sign an Advance Beneficiary Notice. Medicare will not pay for competitively bid items furnished by noncontract suppliers.
An area **NOT** covered by the competitive bidding program	An area **NOT** covered by the competitive bidding program	A beneficiary may get items from any Medicare-enrolled DMEPOS supplier.

CMS is conducting extensive outreach to Medicare beneficiaries who reside in the CBAs and will be offering to help them identify contract suppliers.

If DMEPOS suppliers or referral agents are unsure whether a beneficiary resides in a CBA and is affected by this program effective July 1, they can make that determination by comparing the ZIP code of the patient's residence to the list of ZIP codes for the CBAs, which is available at **http://dmecompetitivebid.com/Palmetto/Cbic.nsf/docsCat/DMEPOS%20Competitive%20Bidding%20Areas%20Zip%20Codes?opendocument** on the Internet.

Payment
Payment for contract DMEPOS items will be the single payment amounts that were announced by CMS on March 20, 2008 (versus the current fee schedule determination of payment) for:

- Contract Suppliers, and

- Noncontract Suppliers that provide item to traveling beneficiaries.

Additional Information
DMEPOS suppliers should note that previous articles have explained the program in more detail as it relates to DMEPOS suppliers. *MLN Matters* article SE0714, "*Pre-Bidding Activities for the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program*," is available at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0714.pdf** on the CMS website. Also, *MLN Matters* article MM5574, "*Program Instructions Designating the Competitive Bidding Areas and Product Categories Included in the CY 2007 DMEPOS Competitive Bid Program*," is available at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5574.pdf** on the CMS website.

In addition, all providers may find more detailed information at **http://www.dmecompetitivebid.com** on the Internet and at **http://www.cms.hhs.gov/CompetitiveAcqforDMEPOS/** on the CMS website.

As this is the first in a series of *MLN Matters* articles on this issue, further articles will be released in the very near future.

Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program: Grandfathering, Repair and Replacement, Mail Order Diabetic Supplies and Advanced Beneficiary Notices (ABNs) - The second in a series of articles on the new DMEPOS competitive bidding program. (SE0806) GEN

MLN Matters Number: SE0806
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
Any Medicare Fee-for-Service (FFS) provider supplying DMEPOS to a Medicare beneficiary. This article also contains information of interest to those who order DMEPOS and to referral agents as defined in *MLN Matters* article SE0805.

Provider Action Needed
The first article (SE0805) in this series on the DMEPOS Competitive Bidding Program being instituted by the Centers for Medicare & Medicaid Services (CMS) presented an overview of how the program may affect your patients. There are also some key provisions of the program about which your patients may raise questions. While the competitive bidding program only affects ten areas of the country as of July 1, 2008, it will expand to 70 additional geographic areas in 2009. Thus, it is important for you to be familiar with this program.

Background
MLN Matters article SE0805, entitled "*Overview of New Medicare Competitive Bidding Program for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)*," which is available at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0805.pdf** on the CMS website, summarizes information on competitive bidding that may impact your patients. Article SE0805 contains the list of competitive bidding areas for the first phase of competitive bidding as well as a list of the DMEPOS product categories that are included in the program's initial implementation.

In using this series of DMEPOS articles, it is important to remember that in most instances, beneficiaries maintaining a permanent residence in one of the Competitive Bidding Areas (CBAs) must obtain competitive bidding items from a contract supplier. There are also program requirements that apply to beneficiaries who reside in CBAs but travel outside of those CBAs and to beneficiaries who do not live in CBAs but travel to them.

Grandfathered Suppliers
The Medicare DMEPOS Competitive Bidding Program requires Medicare beneficiaries to obtain competitive bidding items from a contract supplier, unless an exception applies. Therefore, in some instances, your patient may be required to change from a non-contract

supplier to a contract supplier. However, the program does allow for certain suppliers to be "grandfathered." Grandfathered suppliers are allowed to continue to provide certain rented DME items and services even though they are not contract suppliers.

Grandfathering only applies when the patient is renting DME or oxygen equipment at the time the competitive bidding program becomes effective and the rental period for the item began before the start of the competitive bidding program.

Beneficiaries who are receiving oxygen, oxygen equipment or rented DME at the time the competitive bidding program becomes effective may elect to continue to receive these items from a non-contract supplier, if the supplier is willing to continue furnishing these items. If a non-contract supplier chooses not to be "grandfathered" or if a beneficiary wants to change to a contract supplier, the non-contract supplier must pick up the rental equipment and oxygen equipment. Unless a beneficiary relocates outside of the CBA and the supplier service area, the supplier cannot discontinue services by picking up a medically necessary item prior to the end of a rental month for which the supplier was eligible to receive a rental payment, even if the last day of a rental month is after the start date of the program. If the date of the beginning of a monthly rental period is prior to the start of the competitive bidding program, the supplier must submit a claim for that month. Note that the grandfathering provision also applies to Medicare beneficiaries who transition from a Medicare Advantage Plan to the Fee-for-Service program.

If the beneficiary stays with a "grandfathered" supplier, he or she may elect to change to a contract supplier at any time, and the contract supplier would be required to accept the beneficiary as a customer. For more details on the grandfathering provision, visit **http://www.dmecompetitivebid.com** on the CMS website.

Repair and Replacement of Beneficiary-Owned Items

Repair ONLY

A beneficiary who owns a competitively bid item that needs to be repaired may have the repairs performed by either a contract supplier or by a non-contract supplier. In these cases, Medicare pays for reasonable and necessary labor not otherwise covered under a manufacturer's or supplier's warranty.

Repair and Replacement

If a part needs to be replaced in order to make the beneficiary-owned equipment serviceable, and the replacement part is also a competitively bid item for the CBA in which the beneficiary maintains a permanent residence, the part may be obtained from either a contract supplier or a non-contract supplier. In either case, Medicare pays the single payment amount provided under the Competitive Bidding Program for the replacement part.

Replacement ONLY

Beneficiaries maintaining permanent residences in a CBA are required to obtain replacement of all items subject to competitive bidding from a contract supplier. This includes replacement of base equipment and replacement of parts or accessories for base equipment that are being replaced for reasons other than servicing of the base equipment.

Beneficiaries who are not permanent residents of a CBA but require a replacement of a competitively bid item while visiting a CBA, must obtain the replacement item from a contract supplier. The supplier will be paid the fee schedule amount for the state where the beneficiary is a permanent resident.

Mail Order Diabetic Supplies under the Program

Medicare beneficiaries who permanently reside in a CBA may purchase their diabetic testing supplies from:

- A mail order contract supplier for the area in which the beneficiary maintains a permanent residence; or
- A non-contract supplier in cases where the supplies are not furnished on a mail order basis.

The mail order contract period covers diabetic testing supplies furnished from **July 1, 2008 through March 31, 2010**. The term "mail order" refers to items 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 does not include items obtained by beneficiaries from local supplier storefronts.

Mail order contract suppliers will be reimbursed at the single payment amount for the CBA where the beneficiary maintains a permanent residence.

For diabetic supplies that are not furnished through mail order, suppliers will be paid the fee schedule amount.

Medicare payment will not be made to non-contract suppliers that furnish mail order diabetic testing supplies to Medicare beneficiaries residing in a CBA. A special modifier, KL, will be used on each claim to indicate that the item was furnished on a mail order basis.

Note: *Suppliers that furnish diabetic testing supplies on a mail order basis and do not attach the mail order modifier could be subject to significant penalties under the False Claims Act.*

Both the Medicare program and beneficiaries will save money each time a mail order contract supplier is used; **however, it is solely up to the beneficiaries to decide whether or not they wish to obtain their diabetic testing supplies on a mail order basis.**

All mail order contract suppliers are required to report the manufacturer or make and model number of products they furnish and must update this list on a quarterly basis. This information will be made available to the public once the contract suppliers have been announced and will be updated on a routine basis. Contract suppliers will be required to make available the same range of products to Medicare beneficiaries that they make available to non-Medicare customers.

Advance Beneficiary Notice (ABN) Information

In general, if a non-contract supplier in a CBA furnishes a competitively bid item to any Medicare beneficiary regardless of whether that beneficiary maintains a permanent residence in the CBA or another area, and no applicable exceptions apply, Medicare will not make payment. In addition, the beneficiary is not liable for payment unless the non-contract supplier in a CBA obtains an ABN signed by the beneficiary.

A signed ABN indicates that the beneficiary was informed in writing prior to receiving the item that there would be no Medicare coverage due to the supplier's contract status, and that the beneficiary understands that he/she will be liable for all costs that the non-contract supplier may charge the beneficiary for the item.

If a non-contract supplier furnishes a competitively bid item to a beneficiary and the beneficiary signs an ABN, the supplier must use the "GA" modifier on their claim. If the "GA" modifier is not present on the claim, the supplier may not hold the beneficiary liable for the cost of the item.

Additional Information

CMS contracted with the Competitive Bidding Implementation Contractor (CBIC) to administer the DMEPOS Competitive Bidding Program. Downloadable **Patient Education Fact Sheets** can be found at:
http://www.dmecompetitivebid.com/palmetto/CBIC.nsf/docsCat/CBIC~Referral%20Providers~Patient%20Education%20Fact%20Sheets?open&cat=CBIC~Referral%20Providers~Patient%20Education%20Fact%20Sheets .

If you have concerns, questions, or complaints about the quality of an item or the service that a patient received from a contract supplier, please call the Competitive Bidding Program helpline at 1-877-577-5331.

For more information about the Competitive Bidding Program, call 1-877-577-5331. TTY users call 1-877-486-2048. Stay tuned for additional articles in this series. You can also visit **http://www.cms.hhs.gov/CompetitiveAcqforDMEPOS/** on the CMS website or **http://www.dmecompetitivebid.com/** on the Internet for more details.

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

Important Exceptions and Special Circumstances that Occur under the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program - The third in a series of articles on the new DMEPOS competitive bidding program. (SE0807) GEN

MLN Matters Number: SE0807
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
The following providers may be affected by this program:

- Physicians and other treating practitioners who are Medicare enrolled DMEPOS suppliers;
- Physicians and others who order or refer DMEPOS items or services for their patients;
- Skilled nursing facilities (SNFs) and nursing facilities (NFs); and
- Physical therapists and occupational therapists in private practice who are Medicare enrolled DMEPOS suppliers.

Many Medicare Fee-for-Service (FFS) providers may be in a position of ordering, referring, or supplying DMEPOS to a Medicare beneficiary. This includes physicians (including podiatric physicians), other treating practitioners (nurse practitioners, physician assistants, and clinical nurse specialists), physical and occupational therapists, and institutional providers (especially skilled nursing facilities and their social workers or care coordinators, hospitals and their discharge planners, home health agencies and pharmacists).

Provider Action Needed
Understand these special program rules that may affect you. This article is especially important if you are a Medicare enrolled DMEPOS supplier of items governed by the new program, even if you are not located in a competitive bidding area (CBA). It is important to understand that the program affects any beneficiaries who permanently reside in or travel to CBAs. Some program requirements apply to beneficiaries who reside in CBAs even if these beneficiaries travel outside their CBAs. Thus, it is important for you to be familiar with this program.

While the first phase of the competitive bidding program only affects ten CBAs in the country as of July 1, 2008, the second phase will expand to 70 additional geographic areas in 2009. See *MLN* article SE0805 for information about CBAs and items governed by this new program and for information about how the program applies to traveling beneficiaries.

Background
MLN Matters article SE0805 that is entitled, "*Overview of New Medicare Competitive Bidding Program for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)*," which is available at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0805.pdf** on the CMS website, summarizes information on competitive bidding that may impact your patients. Article SE0805 contains the list of competitive bidding areas for the first phase of competitive bidding as well as a list of the DMEPOS product categories that are included in the program's initial implementation.

MLN Matters article SE0806 that is entitled, "*Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program: Grandfathering, Repair and Replacement, Mail Order Diabetic Supplies and Advanced Beneficiary Notices (ABNs)*," which is available at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0806.pdf** on the CMS website, provides an overview of the rules regarding grandfathered suppliers, repair and replacement of beneficiary-owned equipment, mail order diabetic supplies under the program, and ABNs.

In this, the third in a series of articles on the new DMEPOS competitive bidding program, we provide information on some special circumstances and exceptions of particular interest to physicians and other treating practitioners, SNFs and NFs , and physical and occupational therapists in independent practice.

Note: *It is important to note that the Competitive Bidding Program does not affect your patients' choice of physician or treating practitioner.*

In using this series of DMEPOS articles, remember that in most instances, beneficiaries maintaining a permanent residence in one of the Competitive Bidding Areas (CBAs) must obtain competitive bidding items from a contract supplier. There are also program requirements that apply to beneficiaries who reside in CBAs but travel outside of those CBAs and to beneficiaries who do not live in CBAs but travel to them.

Physicians and Other Treating Practitioners Who are Enrolled Medicare DMEPOS Suppliers
Medicare physicians and treating practitioners who have also enrolled as Medicare DMEPOS suppliers via the 855S enrollment form have the option to furnish certain types of competitively bid items to their own patients without submitting a bid or being awarded a competitive bid contract, provided the following requirements are met:

- For the first phase of the program being implemented July 1 2008, the item furnished must be a walker. In the future, the items will be limited to crutches, canes, walkers, folding manual wheelchairs, blood glucose monitors, and infusion pumps that are DME;

- The items must be furnished by the physician or treating practitioner DMEPOS supplier **to his or her own patients as part of his or her professional service; and**

- The items must be billed to a DME MAC using the DMEPOS billing number that is assigned to the physician, the treating practitioner (if possible), or a group practice to which the physician or treating practitioner has reassigned the right to receive Medicare payment.

Where the furnished item is a bid item and the beneficiary resides in a CBA, the physician or treating practitioner will be paid the single payment amount established by this program for the item. This exception does not affect the applicability of the physician self-referral (Stark law) provisions in section 1877 of the Act. All provisions of the physician self-referral law remain fully in effect.

Physicians and Other Treating Practitioners Who Prescribe Specific Brand or Mode of Delivery to Avoid an Adverse Medical Outcome
A physician (including a podiatric physician) or treating practitioner may prescribe, in writing, a particular brand of DMEPOS bid item or mode of delivery for an item if he or she determines that the particular brand or mode of delivery would avoid an adverse medical outcome for the beneficiary. The physician or treating practitioner must document in the beneficiary's medical record the reason why the specific brand or mode of delivery is necessary to avoid an adverse medical outcome.

In these cases, the contract supplier under the Competitive Bidding Program must:

- Furnish the particular brand or mode of delivery as prescribed by the physician or treating practitioner;

- Consult with the physician or treating practitioner to find another appropriate brand of item or mode of delivery for the beneficiary and obtain a revised written prescription from the physician or treating practitioner; or

- Assist the beneficiary in locating a contract supplier that can furnish the particular brand of item or mode of delivery prescribed by the physician or treating practitioner.

Any change in the prescription requires a revised written prescription. A contract supplier is prohibited from submitting a claim to Medicare if it furnishes an item different from that specified in the written prescription received from the beneficiary's physician or treating practitioner.

Skilled Nursing Facilities (SNFs) and Nursing Facilities (NFs) Specialty Suppliers
The DMEPOS Competitive Bidding Program applies to SNFs and NFs to the extent that their residents receive competitively bid items under Medicare Part B. Unlike most suppliers, SNFs and NFs have the option to bid for, and be awarded, contracts to be "specialty suppliers" that **only furnish competitively bid items to their own residents**. SNFs and NFs that become specialty suppliers may not furnish competitively bid items and services to Medicare beneficiaries outside their facilities for purposes of Medicare payment. SNFs and NFs can also become regular contract suppliers that furnish competitively bid items to beneficiaries throughout a CBA.

If a SNF or NF is not a contract supplier (either a specialty contract supplier or a regular contract supplier), it must use a contract supplier for its CBA to furnish competitively bid items to its residents.

Physical Therapists and Occupational Therapists in Private Practice Who are Enrolled Medicare DMEPOS Suppliers
Physical therapists and occupational therapists in private practice who are enrolled DMEPOS suppliers may eventually have the option to furnish certain types of competitively bid items to their own patients and be paid the single payment amount for such items without being contract suppliers, provided the following requirements are met:

- The items are limited to off-the-shelf (OTS) orthotics; and

- The items must be furnished only to their own patients as part of the physical or occupational therapy service.

Note: *OTS orthotics are not included in the first phase of competitive bidding, this exception is not relevant in the first phase of the DMEPOS Competitive Bidding program beginning July1, 2008.*

Additional Information
If you have concerns, questions, or complaints about the quality of an item or the service that a patient received from a contract supplier please call the Competitive Bidding Program helpline at 1-877-577-5331.

For more information about the Competitive Bidding Program, call 1-877-577-5331. TTY users call 1-877-486-2048. Stay tuned for additional articles in this series. You can also visit **http://dmecompetitivebid.com/palmetto/cbic.nsf/DocsCat/Home** on the Internet and at **http://www.cms.hhs.gov/CompetitiveAcqforDMEPOS/** on the CMS website for more details.

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

DME MAC Jurisdiction A Local Coverage Determinations GEN

The LCDs can be found on the DME MAC A Web site at: **http://www.medicarenhic.com/dme/medical_review/mr_index.shtml**

LCDs can also be found on the CMS Web site within the Medicare Coverage Database (MCD), which is accessible by going to: **http://www.cms.hhs.gov/mcd/overview.asp**

LCD and Policy Article Revisions - Summary for March 2008 GEN

Outlined below is a summary of the principal changes to the DME Local Coverage Determinations (LCDs) and Policy Articles (PAs) that have been revised for the March 2008 Publication. Please review the entire LCD and each related Policy Article for complete information.

AFO/KAFO

LCD
Revision Effective Date: 01/01/2008
HCPCS CODES AND MODIFIERS:
Added: A9283

Policy Article
Revision Effective Date: 01/01/2008
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: Noncoverage statement regarding A9283.
CODING GUIDELINES:
Added: Definition of A9283

Cervical Traction Devices

LCD
Revision Effective Date: 01/01/2008
INDICATIONS AND LIMITATIONS OF COVERAGE
Added: Coverage statement regarding E0856.
HCPCS CODES AND MODIFIERS:
Added: E0856

Continuous Positive Airway Pressure System (CPAP)

LCD
Revision Effective Date: 01/01/2008
INDICATIONS AND LIMITATIONS OF COVERAGE:
Added: Usual maximum quantity parameters for new codes A7027, A7028, A7029
HCPCS CODES:
Added: A7027, A7028, A7029
Removed: K0553, K0554, K0555

Policy Article
Revision Effective Date: 01/01/2008
CODING GUIDELINES:
Substituted: New code A7027

Enteral Nutrition

LCD
Revision Effective Date: 01/01/2008
INDICATIONS AND LIMITATIONS OF COVERAGE:
Added B4087, B4088 to utilization statement
Deleted B4086 from utilization statement
HCPCS CODES AND MODIFIERS:
Added B4087, B4088
Deleted B4086
Revised narrative for B4034

External Infusion Pumps

LCD

Revision Effective Date: 01/01/2008

INDICATIONS AND LIMITATIONS OF COVERAGE:

Removed statements about coverage of supplies used with insulin pumps from general coverage section.

Moved statement about appropriate pump for use with epoprostinol/treprostinil from general coverage section to epoprostenol/treprostinil section.

Moved statement about back-up pumps to Policy Article.

Added statements about the appropriate pump for use with subcutaneous immunoglobulin, insulin pumps, and pump for use with epoprostinol/treprostinil based upon the coding guidelines.

HCPCS CODES:

Added: A9274

Revised J1562

DOCUMENTATION REQUIREMENTS:

Removed ICD-9 requirement for insulin pump claims from paragraph describing general pump criteria.

Policy Article

Revision effective date: 01/01/2008

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Added A9274 to statement about disposable infusion systems.

Added a statement about backup equipment.

CODING GUIDELINES:

Modified the definition of disposable infusion systems to include A9274.

Corrected subcutaneous immuneglobulin pump code to E0779 in paragraph that addresses K0552.

Glucose Monitors

LCD

Revision Effective Date: 01/01/2008

HCPCS CODES:

Added: A9276-A9278

Policy Article

Revision Effective Date: 01/01/2008

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Added: Codes for continuous glucose monitors.

Hospital Beds

LCD

Revision Effective Date: 01/01/2008

INDICATIONS AND LIMITATIONS OF COVERAGE:

Added E0328 and E0329

HCPCS CODES AND MODIFIERS:

Added E0328 and E0329

Policy Article

Revision Effective Date: 01/01/2008

CODING GUIDELINES:

Added E0328 and E0329

Intravenous Immunoglobulin

New LCD and Policy Article.

Knee Orthoses

New LCD and Policy Article.

Oral Anticancer Drugs

LCD

Revision Effective Date: 04/01/2008
HCPCS CODES AND MODIFIERS:
Added Topotecan.

Policy Article

Revision Effective Date: 04/01/2008
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Expanded range of payable codes. Added V58.11
ICD-9 CODES THAT ARE COVERED
Removed V58.0-V58.10, V58.12.
Added section for Topotecan.
Added 162.2-162.9 for Topotecan

Orthopedic Footwear

LCD

Revision Effective Date: 01/01/2008
HCPCS CODES:
Added: A9283

Policy Article

Revision Effective Date: 01/01/2008
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: Noncoverage of A9283
CODING GUIDELINES:
Added: Definition of A9283

Ostomy Supplies

LCD

Revision Effective Date: 01/01/2008
INDICATIONS AND LIMITATIONS OF COVERAGE:
Added: Usual maximum quantity for A5083
HCPCS CODES AND MODIFIERS:
Added: A5083

Policy Article

Revision Effective Date: 01/01/2008
Removed DMERC references

Oxygen

LCD

Revision Effective Date: 01/01/2008
CMS NATIONAL COVERAGE POLICY:
Added: NCD 240.2.1
HCPCS CODES AND MODIFIERS:
Deleted: QR modifier
DOCUMENTATION REQUIREMENTS:
Deleted: Instructions for use of QR modifier

Patient Lifts

LCD

Revision Effective Date: 01/01/2008
INDICATIONS AND LIMITATIONS OF COVERAGE:
Added E1035
HCPCS CODES AND MODIFIERS:
Added E1035
Revised E0630
DOCUMENTATION REQUIREMENTS:
Added KX modifier instructions.
Added Upgrade instructions

Policy Article

Revision Effective Date: 01/01/2008
CODING GUIDELINES:
Added E1035.

Power Mobility Devices
LCD
Revision Effective Date: 04/01/2008
INDICATIONS AND LIMITATIONS OF COVERAGE:
Deleted: Requirement for ATP-certified individual to perform specialty evaluation.
Clarified: Requirement for ATS or ATP-certified individual to be involved with the evaluation of patients for rehab PWCs.

Respiratory Assist Devices
LCD
Revision Effective Date 01/01/2008
INDICATIONS AND LIMITATIONS OF COVERAGE:
Revised Least Costly Alternative statements for E0741 and E0740 to reflect changed payment category for E0741.
Removed 1999 transition criteria.
Added A7027-A7029 to usual quantities table
Removed K0553-K0555 from usual quantities table.
Added E0471 to humidifier coverage statement.
HCPCS CODES AND MODIFIERS:
Added A7027-A7029
Removed K0553-K0555
DOCUMENTATION REQUIREMENTS:
Removed 1999 transition requirements.

Policy Article
Revision Effective Date: 01/01/2008
CODING GUIDELINES:
Removed definition for K0553
Added definition of A7027

Surgical Dressings
LCD
Revision Effective Date: 01/01/2008
HCPCS CODES:
Added: A6413

Policy Article
Revision Effective Date: 01/01/2008
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: Noncoverage of A6413
Added: Policy concerning payment for surgical dressings that are covered under other benefits.
CODING GUIDELINES:
Removed: Guidelines concerning dressings that slightly exceed the upper limits of the size range for a code.
Added: Definition of A6413
Added: Instructions on coding dressings that contain silver.
Revised: Guidelines concerning coding of surgical dressings that are covered under other benefits.

Urological Supplies

LCD

Revision effective date: 04/01/2008
INDICATIONS AND LIMITATIONS OF COVERAGE:
- Revised indications for intermittent catheterization

HCPCS CODES:
- Revised A5105 (Code effective 01/01/2008)

APPENDICES:
- Removed definitions.

Policy Article

Revision Effective Date: 01/01/2008
CODING GUIDELINES:
- Revised guidelines for A5105.
- Added A4326.

Wheelchair Options and Accessories

LCD

Revision Effective Date: 01/01/2008
INDICATIONS AND LIMITATIONS OF COVERAGE:
- Added: Coverage criteria for gear reduction wheel for manual wheelchair (E2227)
- Added: Replacement guidelines for lithium-based battery (E2397)

HCPCS CODES:
- Added: E2227, E2228, E2312, E2313, E2397
- Revised: E0705, E2205, E2373

Policy Article

Revision Effective Date: 01/01/2008:
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
- Added: Statement concerning dual mode battery chargers.

CODING GUIDELINES:
- Added: Guidelines for codes E2227, E2228, E2312, E2313, E2377
- Added: Guidelines for standard proportional remote joysticks.
- Revised: Guidelines for E2373

Wheelchair Seating

LCD

Revision Effective Date: 01/01/2008
INDICATIONS AND LIMITATIONS OF COVERAGE:
- Added: Muscular dystrophy to the list of covered diagnoses for prefabricated skin protection and combination skin protection and positioning seat cushions.
- Removed: Instructions concerning solid seat support base (E2618)

HCPCS CODES AND MODIFIERS:
- Added: K0108
- Deleted: E2618

ICD-9 CODES THAT SUPPORT MEDICAL NECESSITY:
- Added: Muscular dystrophy (359.0, 359.1) to the list of covered diagnoses for prefabricated skin protection and combination skin protection and positioning seat cushions.
- Removed: E2618

Policy Article

Revision Effective Date: 01/01/2008
CODING GUIDELINES:
- Revised: Guidelines for solid seat support base.

Note: *The information contained in this article is only a summary of revisions to LCDs and Policy Articles. For complete information on any topic, you must review the policy and/or article.*

Continuous Passive Motion Machine Coding Guidelines O&P

From the SADMERC:
Continuous Passive Motion devices are used to exercise joints following injury or surgery.

E0935 - continuous passive motion exercise device for use on knee only

E0936 - continuous passive motion exercise device for use other than knee

Recent questions regarding the exact nature of these devices reveal confusion regarding the nature and functionality of these devices. These coding guidelines clarify the types of products described by the CPM codes.

The first test of any durable medical equipment is that it be durable and capable of repeated use over the expected five year useful life expectancy. Elastic, fabric, single use, or light plastic devices are not durable and do not meet the test for DME.

Secondly, the equipment must be capable of continuous passive motion of the affected limb. These characteristics mean that the device must have, inherent within itself, the ability to move the affected limb:

- in an appropriate plane of motion
- in a continuous fashion
- at the same rate of speed
- for a prescribed length of time
- with adjustable limits of range of motion
- with an identical range of motion in each cycle
- without any input from the patient by the contralateral or other limbs
- with easily accessible safety or cutoff switches

These characteristics require that the device be electrically powered, either by AC current or battery. Battery powered models must have an AC adapter for long term use. CPM machines must meet all these characteristics in order to be coded as **E0935** or **E0936**.

Intravenous Immune Globulin - New Policy DRU

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 provided a new benefit for intravenous immune globulin (IVIG) administered in the home setting effective for dates of service on or after January 1, 2004. Since this benefit was created there have been numerous HCPCS code changes for the drugs. In addition, questions about reimbursement for costs associated with administration are common.

This Local Coverage Determination (LCD) and related Policy Article (PA) summarize the statutory coverage requirements, provides HCPCS coding information and documentation requirements.

For complete information on the coverage of intravenous immune globulin, refer to the LCD and PA.

Knee Orthoses - New Policy O&P

On March 20, 2008, notice will be posted for the new Knee Orthoses LCD & Policy Article. The effective date will be July 1, 2008, for all DME MAC jurisdictions.

The comment period for this policy draft began on September 9, 2004, and ended on October 25, 2004. After a thorough review of the comments presented, this policy was finalized by the contractors.

It is recommended that suppliers become familiar with the new Knee Orthoses Policy prior to its effective date to minimize effects on their billing process.

Knee Orthoses - New Policy Summary O&P

On March 20, 2008, notice was posted for the new Knee Orthoses LCD & Policy Article. The effective date will be July 1, 2008, for all DME MAC Jurisdictions.

The comment period for this policy draft began on September 9, 2004, and ended on October 25, 2005. After a thorough review of the comments presented, this policy was finalized by the contractors.

The policy includes coding, coverage and documentation requirements for submission of claims for knee orthoses. The policy distinguishes between pre-fabricated orthoses and custom fabricated orthoses and outlines separate requirements for each category of orthoses. It is recommended that suppliers become familiar with the new Knee Orthoses Policy prior to its effective date to minimize effects on their billing process.

To view this Future Dated LCD, visit the CMS Medicare Coverage Database at **http://www.cms.hhs.gov/mcd/overview.asp**, or the NHIC DME MAC A Web site at
http://www.medicarenhic.com/dme/medical_review/mr_index.shtml

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Nebulizers - Brovana and Perforomist - Instructions for New HCPCS Codes, April 2008 SPE

New HCPCS codes have been created for Perforomist (formoterol, **Q4099**), effective April 1, 2008, and Brovana (arformoterol, **J7605**), effective January 1, 2008.

> **J7605** Arformoterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose form, 15 micrograms
>
> **Q4099** Formoterol fumarate, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose form, 20 micrograms

In August 2007, an article, *Nebulizers - Perforomist and Brovana - Coverage Criteria and Billing Instructions*, was published providing guidance on coverage and coding of these drugs. The updated article below includes instructions for each new product.

Coverage Criteria
FDA-approved inhalation solutions of formoterol (**Q4099**) or arformoterol (**J7605**) are covered when the following criteria are met:

1. It is medically necessary for the management of chronic obstructive pulmonary disease (ICD-9 diagnosis codes 491.0-492.8, 496); and,

2. The patient has a documented history of routine use of at least four doses per day of an FDA-approved albuterol or metaproterenol inhalation solution or at least three doses per day of an FDA-approved levalbuterol inhalation solution.

If the above coverage criteria are not met, formoterol and arformoterol will be denied as not medically necessary.

Formoterol and arformoterol are administered using a pneumatic compressor (**E0570**, **E0571**) and a small volume nebulizer (**A7003**, **A7004**, **A7005**).

A maximum of two vials of formoterol (20 micrograms each) or two vials of arformoterol (15 micrograms each) are covered per day.

Short-acting beta-adrenergic agonists (SABAs) may be covered as rescue/supplemental medication in addition to formoterol or arformoterol. However, when formoterol or arformoterol is used, the maximum amount of SABA inhalation solutions that will be covered is an average of one dose per day (31 doses per month).

Coding and Billing Guidelines
When submitting claims for formoterol or arformoterol, use the following codes:

- **Q4099** for Perforomist (formoterol), effective April 1, 2008
- **J7605** for Brovana (arformoterol), effective January 1, 2008

Append the **KO** modifier, when submitting claims for formoterol or arfomoterol.

A **KX** modifier must be appended to these codes, **only** when the coverage criteria stated above have been met.

When billing for Perforomist, 1 unit of service = 1 vial (20 micrograms).

When billing for Brovana, 1 unit of service = 1 vial (15 micrograms).

Also, remember that the LCD requires that an ICD-9 code, describing the condition, which necessitates nebulizer therapy, must be included on each claim for equipment, accessories, and/or drugs.

Refer to the Nebulizers LCD and Policy Article for additional information on coverage, coding, and billing of inhalation solutions.

The Nebulizers policy has been revised to incorporate this information.

Nebulizers – HCPCS Code Changes SPE

The following codes will be valid for claims with dates of service on or after April 1, 2008:

J7611 Albuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, concentrated form, 1 mg

J7612 Levalbuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, concentrated form, 0.5 mg

J7613 Albuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose, 1 mg

J7614 Levalbuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose, 0.5 mg

Q4099 Formoterol fumarate, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose form, 20 micrograms

The following codes, which became valid for claims with dates of service on or after January 1, 2008 will be discontinued. These codes will be invalid for claims with dates of service on or after April 1, 2008.

J7602 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)

J7603 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)

The new codes will be included in a future revision of the Nebulizers LCD and Policy Article.

Nebulizers - Policy Revisions SPE

Revisions of the Nebulizers Local Coverage Determination (LCD) and Policy Article (PA) have been released by the DME MACs. The major changes from the current policy are:

- HCPCS Code Changes
  - 2008 HCPCS Update
  - April changes to coding for albuterol and levalbuterol
- Coverage Changes
  - Claims for levalbuterol will be paid comparable to albuterol
  - Claims for DuoNeb will be paid comparable to individual unit dose vials of albuterol and ipratropium

HCPCS Code Changes
The 2008 HCPCS Update included new codes for non-compounded formoterol and compounded acetylcysteine, cromolyn, and pentamidine and revised narrative descriptions for non-compounded acetylcysteine, cromolyn, dornase alpha, iloprost, and pentamidine. These codes are effective for claims with dates of service on or after January 1, 2008.

The policy also includes codes J7611-J7614 for albuterol and levalbuterol which became effective on April 1, 2008. These codes replace codes J7602 and J7603 which were valid for claims with dates of service from January 1, 2008 to March 31, 2008. These codes changes were discussed in more detail in a recently published bulletin article titled Nebulizers - HCPCS Coding Changes.

Code Q4099 has been established for FDA-approved, non-compounded, unit dose formoterol fumarate inhalation solution (Perforomist). It is valid for claims with dates of service on or after April 1, 2008. One unit of service = 20 micrograms.

Coverage Changes
Because coverage changes in the Nebulizers LCD have been implemented in stages, it is helpful to provide some historical background. In March 2006, a draft revision of the Nebulizers policy was sent out for public comment. The major provisions of that draft policy were the downcoding of levalbuterol and DuoNeb and the elimination of coverage for compounded inhalation solutions. In December 2006, CMS initiated a National Coverage Analysis on beta adrenergic agonist inhalation solutions. As a result of this, the DME MACs and PSCs deferred addressing levalbuterol and DuoNeb downcoding. A revised Nebulizers policy was published in March 2007 and became effective on July 1, 2007. That revised policy eliminated coverage for compounded inhalation solutions. In September 2007, CMS published its final Decision Memo stating that it would not establish a national policy for beta agonist inhalation solutions. As a result of that determination, the DME MACs are now addressing the downcoding of levalbuterol and DuoNeb.

Effective for claims with dates of service on or after July 1, 2008, claims for non-compounded levalbuterol will be paid based on the allowance for the least costly medically appropriate alternative, non-compounded albuterol. One unit of service of code J7612 or J7614 will be paid comparable to one unit of service of code J7611 or J7613, respectively.

Claims for DuoNeb (J7620) will be paid based on the allowance for the least costly medically appropriate alternative, individual non-compounded unit dose vials of albuterol and ipratropium. One unit of service of code J7620 will be paid comparable to 2.5 units of service of code J7613 plus 0.5 units of service of code J7644 (ipratropium).

Urological Supplies – Policy Changes FAQ SPE

The March 2008 revision of the Urological Supplies LCD removed references to "Clean Intermittent Catheterization" and removed the requirement for re-use of intermittent catheters with that technique. This FAQ addresses some issues associated with the policy revision.

Q1. The policy on intermittent catheterization has been revised. The criteria for coverage of sterile kits, A4353, are slightly different from the previous criteria. The previous criteria required two infections while using "clean technique". This revision requires two infections while using sterile, single-use catheters (A4351, A4352). Are current A4353 patients that qualified under clean technique grandfathered under this new policy?

A1. Beneficiaries who were using A4353 sterile catheter kits prior to April 1, 2008 and who met the requirements for A4353 in the previous version of the Urological Supplies LCD continue to be eligible to receive sterile intermittent catheterization kits. The medical record must contain sufficient information to demonstrate that the applicable coverage criteria were met.

Q2. We are working with patients, who have a history of urinary tract infections (UTI), but are currently washing and reusing their catheters (A4351, A4352) – i.e., they are using clean technique. We are just waiting for their doctors to send the lab results along with the UTI dates. Sometimes it takes 3 to 4 weeks for the doctors to respond to our requests. Are sterile catheter kits (A4353) covered for these patients?

A2. No. If the beneficiary was not using sterile catheter kits (A4353) prior to 4/1/2008, he/she must meet the current criteria in order to be eligible for reimbursement. Beneficiaries who have been reusing intermittent catheters (A4351, A4352) with clean technique at the rate of one catheter per week are eligible to use a sterile catheter (A4351, A4352) and a packet of sterile lubricant (A4332) for each catheterization. The number of items needed must be determined by the treating physician and information in the medical record must justify the need for the number of items prescribed.

Q3. The policy contains a table describing the usual maximum number of supplies. Does this mean that every beneficiary should get 200 per month?

A3. No. The usual maximum number represents a determination of the number of items that beneficiaries with extreme utilization requirements will actually need. The typical beneficiary will require a much lower amount. The beneficiary's utilization should be determined by the treating physician based upon the patient's medical condition. There must be sufficient information in the medical record to justify the amount ordered.

A beneficiary or their caregiver must specifically request refills of urological supplies before they are dispensed. The supplier must not automatically dispense a quantity of supplies on a predetermined regular basis, even if the beneficiary has "authorized" this in advance. The supplier should check with the patient or caregiver prior to dispensing a new supply of intermittent catheters to determine that previous supplies are nearly exhausted.

Q4. In an audit, what information must be contained in the medical record to justify payment for both the type and quantity of urological supplies ordered by the treating physician?

A4. For urological supplies to be covered by Medicare, the patient's medical record must contain sufficient documentation of the patient's medical condition to substantiate the necessity for the type and quantity of items ordered and for the frequency of use

or replacement. The information should include the patient's diagnosis and other pertinent information including, but not limited to, duration of the patient's condition, clinical course (worsening or improvement), prognosis, nature and extent of functional limitations, other therapeutic interventions and results, past experience with related items, etc. Neither a physician's order nor a supplier-prepared statement nor a physician attestation by itself provides sufficient documentation of medical necessity, even though it is signed by the treating physician. There must be clinical information in the patient's medical record that supports the medical necessity for the item and substantiates the information on a supplier-prepared statement or physician attestation.

For intermittent catheterization, in addition to the general information described above, the patient's medical record must contain a statement from the physician specifying how often the patient (or caregiver) performs catheterizations.

The patient's medical record is not limited to the physician's office records. It may include hospital, nursing home, or home health agency (HHA) records, and records from other professionals including, but not limited to, nurses, physical or occupational therapists, prosthetists, and orthotists.

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.

Additional Information on Reporting a National Provider Identifier (NPI) for Ordering/Referring and Attending/Operating/Other/Service facility for Medicare Claims (MM5890) GEN

MLN Matters Number: MM5890 Revised
Related CR Release Date: January 18, 2008
Related CR Transmittal #: R235PI

Related Change Request (CR) #: 5890
Effective Date: May 23, 2008
Implementation Date: April 7, 2008

Note: *This article was revised on March 5, 2008, to remove the parenthetical phrase of "MD and DO" from the note box on page 3. All other information remains the same.*

Provider Types Affected
Physicians, providers and suppliers who bill Medicare contractors (carriers, fiscal intermediaries (FI), Medicare Administrative Contractors (A/B MAC), or Durable Medical Equipment Medicare Administrative Contractors (DME MAC)) for services or items furnished to Medicare beneficiaries.

Provider Action Needed
Impact to You
Effective with claims received on or after May 23, 2008, Medicare will not pay for referred or ordered services or items; unless the fields for the name and NPI of the ordering, referring and attending, operating, other, or service facility providers are completed on the claims.

What You Need to Know
CR 5890, from which this article is taken, provides that it is the claim/bill submitter's responsibility to obtain the ordering, referring and attending, operating, other, service facility providers, or purchased service providers NPIs for claims. Further, it requires that the provider or supplier who is furnishing the services or items, after unsuccessfully attempting to obtain the NPI from these providers; report their own name and NPI in the ordering/referring/attending/operating/other/service facility provider/purchased service provider fields of the claims.

What You Need to Do
Make sure that your billing staffs are aware of this requirement to place the "furnishing" provider or supplier's name and NPI in the appropriate fields and to use your name and NPI if those of the ordering/referring and attending/operating/other/service facility provider/purchased service providers are not obtainable.

Background
The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandate the adoption of a standard unique health identifier for each health care provider. The National Provider Identifier (NPI) final rule (45 CFR Part 162, CMS-045-F), published on January 23, 2004, established the NPI as this standard; and mandates that all entities covered under HIPAA (including health care providers) comply with the requirements of this NPI final rule.

Medicare previously required a unique physician identification number (UPIN) be reported on claims for any ordering, referring/attending, operating, other, and service facility providers (i.e., or for any provider that is not a billing, pay-to, or rendering provider). Further, in accordance with the NPI final rule; effective May 23, 2008, when reported on a claim, the identifier for such a provider must be an NPI, regardless of whether the provider is a covered entity, or participates in the Medicare program. **Therefore, Medicare will not pay for referred or ordered services, or items, unless the name and NPI number of the ordering, referring and attending, operating, other, or service facility provider are on the claim.**

Note: *Physicians and the following non physician practitioners: 1) nurse practitioners (NP); 2) clinical nurse specialist (CNS); 3) physician assistants (PA); 4) and certified nurse midwives (CNM) are the only types of providers eligible to refer/order services or items for beneficiaries.*

You should be aware that it is the claim/bill submitter's responsibility to obtain the ordering, referring and attending, operating, other, service facility providers, or purchased service providers' NPIs on the claim. If these providers do not directly furnish their NPIs to the billing provider at the time of the order, the billing provider must contact them to obtain their NPIs prior to delivery of the services or items.

If, after several unsuccessful attempts to obtain the NPI from the ordering, referring, attending, operating, other, service facility provider, or purchased service provider; CR 5890, from which this article is taken, requires that (effective May 23, 2008) the provider or supplier who is furnishing the services or items report their own name and NPI in the claim's ordering/referring/attending/operating/other/service facility provider/purchased service provider fields.

Additional Information
You can find more information about reporting an NPI for ordering, referring and attending, operating, other, service facility providers for Medicare Claims by going to CR 5890, located at **http://www.cms.hhs.gov/Transmittals/downloads/R235PI.pdf** on the Centers for Medicare & Medicaid Services (CMS) website.

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

Medicare Fee for Service Legacy Provider IDs Prohibited on Form CMS-1500 Claims after NPI Required Date (MM5858) GEN

MLN Matters Number: MM5858
Related CR Release Date: February 1, 2008
Related CR Transmittal #: R1432CP
Related Change Request (CR) #: 5858
Effective Date: Claims received on or after May 23, 2008
Implementation Date: April 7, 2008

Provider Types Affected
Physicians, providers, and suppliers submitting CMS-1500 and CMS-1450 (UB-04) claims to Medicare carriers, Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), Durable Medical Equipment Medicare Administrative Contractors (DME MACs), and/or Part A/B Medicare Administrative Contractors (A/B MACs) for services provided to Medicare beneficiaries.

Provider Action Needed
Impact to You
Effective May 23, 2008, if you report a Provider Legacy Identifier on Medicare CMS-1500 or CMS-1450 (UB-04) claims, your contractors will return them as unprocessable.

What You Need to Know
CR 5858, from which this article is taken, announces that Provider Legacy Identifiers are not to be reported on Medicare CMS-1500 or Form CMS-1450 claims received on or after May 23, 2008 (the date at which the NPI is required to be reported on claims). After that date, claims containing Legacy Identifiers will be returned as unprocessable.

What You Need to Do
Make sure that your billing staffs are aware that effective May 23, 2008, only NPIs are to be reported on Medicare CMS-1500 and CMS-1450 claims.

Background
The Health Insurance Portability and Accountability Act (HIPAA) of 1996 required issuance of a unique national provider identifier (NPI) to each physician, supplier, and other health care provider who conducts HIPAA standard electronic transactions. In accordance with this act, CMS began issuing NPIs on May 23, 2005.

Further, on April 2, 2007, the Department of Health and Human Services (DHHS) provided covered entities guidance regarding contingency planning for NPI implementation. In this guidance, as long as a health plan was compliant, meaning they could accept and send NPIs on electronic transactions, they could establish contingency plans to facilitate the compliance of their trading partners.

As a compliant health plan, on April 20, 2007 Medicare fee for service (FFS) established a contingency plan that followed this guidance. Since then, CMS has been allowing transactions adopted under HIPAA to be submitted with a variety of identifiers, including:

- NPI only;
- Medicare legacy only (PINs, UPINs, or National Supplier Clearinghouse number); and
- NPI and legacy combination.

CR 5858, from which this article is taken, announces that beginning on May 23, 2008, CMS requires the NPI to be submitted on the Form CMS-1500 and CMS-1450 paper claims; and legacy numbers will NOT be permitted on claims received on or after that date. Effective that date, Form CMS-1500 and CMS-1450 claims containing legacy identifiers will be returned as unprocessable, without appeal rights.

When returning these claims, your contractors will use an appropriate message and Remittance Advice Remark code, such as:

N257 Missing/incomplete/invalid billing provider primary identifier.

Note that contractors will not return claims in certain situations where an NPI is not required (e.g., foreign claims, deceased provider claims, and other situations as allowed by CMS in the future). Such claims will be processed with established procedures for such claims.

Additional Information
You can find more information about the prohibition of Medicare fee for service legacy provider IDs on Form CMS-1500 and CMS-1450 claims after the NPI required date by going to CR 5858, located at **http://www.cms.hhs.gov/Transmittals/downloads/R1432CP.pdf** on the CMS website. You will find updated *Medicare Claims Processing Manual* (100-04), Chapter 26 (Completing and Processing Form CMS-1500 Data Set), Section 10.4 (Items 14-33 - Provider of Service or Supplier Information) as an attachment to that CR.

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

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

MLN Matters Number: SE0555
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 rescinded on August 9, 2007, due to a number of factors affecting NPI implementation, especially the contingency plan announced in *MLN Matters* article MM5595. For the latest NPI information, you can view all NPI related *MLN Matters* articles by going to **http://www.cms.hhs.gov/NationalProvIdentStand/downloads/MMarticles_npi.pdf** on the Centers for Medicare & Medicaid Services 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

Upcoming Critical Dates for Medicare's Fee-for-Service (FFS) Implementation of the National Provider Identifier (NPI) (SE0802) GEN

MLN Matters Number: SE0802
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 primarily for physicians and providers who submit Medicare claims using the Medicare Fee-for-Service (FFS) 837P and the CMS-1500 form.

Provider Action Needed
This special edition article, SE0802, is being provided by the Centers for Medicare & Medicaid Services (CMS) in order to clear up some confusion that providers are experiencing regarding the March 1, 2008 implementation of the NPI on professional claims, and the May 23, 2008 requirement for **ONLY** the NPI on all Health Insurance Portability & Accountability Act (HIPAA) electronic transactions and their paper versions.

The following charts illustrate expected claim results for different identifiers, or combinations of identifiers, submitted in the primary provider fields on the Medicare FFS 837P and CMS-1500. Note that when the chart indicates that claims will be paid, this would only be if no other errors (non-NPI) exist.

Prior to March 1, 2008 - 837P and 1500 Claims, Primary Provider Fields

Legacy Medicare Identifier	NPI	Result
X		Claim will be paid
X	X	Claim will be paid as long as there is an NPI/legacy match on the NPI Crosswalk*
	X	Claim will be paid as long as there is an NPI/legacy match on the NPI Crosswalk*

As of March 1, 2008 - 837P and 1500 Claims, Primary Provider Fields

Legacy Medicare Identifier	NPI	Result
X		Claim will be rejected
X	X	Claim will be paid as long as there is an NPI/legacy match on the NPI Crosswalk*
	X	Claim will be paid as long as there is an NPI/legacy match on the NPI Crosswalk*

May 23, 2008 and Beyond – All Providers, All Transactions, Both Primary and Secondary Provider Fields**

Legacy Medicare Identifier	NPI	Result
X		Claim/transaction will reject
X	X	Claim/transaction will reject
	X	Claim/transaction will be paid/processed as long as there is an NPI/legacy match on the NPI Crosswalk*

* Claims will reject when there is not a match on the Medicare NPI Crosswalk. You must correct any data which may be preventing an NPI/legacy match on the NPI crosswalk. The correction might require that you file a CMS-855 Medicare Provider Enrollment form with your Medicare carrier, A/B MAC, or DME MAC a process which can take a number of months to accomplish.

** HIPAA electronic transactions (837I, 837P, 837COB, NCPDP, 276/277, 270/271, and 835), paper claims and SPR remittance advice.

TEST NPI-Only NOW
If you have been submitting claims with both an NPI and a Medicare legacy number and those claims have been paid, you need to test your ability to get paid using only your NPI (i.e., no Medicare legacy number) by submitting one or two claims today for each NPI

you've been assigned. If the Medicare NPI Crosswalk cannot match your NPI to your Medicare legacy number, the claim with an NPI-only will reject. You can and should do this test now! If the claim is processed and you are paid, continue to increase the volume of claims sent with only your NPI. If the claims reject, validate that the National Plan and Provider Enumeration System (NPPES) has the correct Medicare Legacy number. If your NPPES information is correct, contact your Medicare carrier or A/B MAC enrollment staff for advice right away.

Additional Information

As of January 1, 2008, FFS Medicare required an NPI in the primary provider fields on the 837I and UB-04 claim types. Providers billing with these claim forms must continue to include an NPI in the primary provider field until May 23rd at which time an NPI-only is required in all fields

For more information on correcting NPPES errors and how to use the NPI on Medicare claims, visit **http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0725.pdf** on the CMS website.

If you do not have an NPI, you need to obtain one as soon as possible. Providers can apply for an NPI online at **https://nppes.cms.hhs.gov** or can call the NPI enumerator to request a paper application at 1-800-465-3203.

A table of Medicare's key dates relative to the NPI is available at the CMS NPI page **http://www.cms.hhs.gov/NationalProvIdentStand/02_WhatsNew.asp** on the CMS website. More information and education on the NPI can be found through the CMS NPI page **http://www.cms.hhs.gov/NationalProvIdentStand** on the CMS website.

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)

Billing Reminder: Item 24E on CMS-1500 Claim Form or Electronic Equivalent GEN

Providers are reminded to enter the diagnosis code reference number in Item 24E **(either a 1, 2, 3 or 4)** referencing Item 21 **(the ICD-9-CM code number coded to the highest level of specificity)** on the 1500 Claim Form or Electronic Equivalent. Failure to submit either a 1, 2, 3 or 4 in Item 24E will result in a CO-16 M81 denial.

Enter only one reference number per line to indicate what diagnosis corresponds to the claim line(s).

If a CO-16 M81 denial is received, verify items 21 and 24E and resubmit the claim.

First Quarter 2008 - Top Claim Submission Errors GEN

A claim submission error (CSE) is an error made on a claim that would cause the claim to reject upon submission to the Jurisdiction A Durable Medical Equipment Medicare Administrative Contractor (DME MAC). The top ten American National Standards Institute (ANSI) Claim Submission Errors for January through March 2008, are provided in the following table.

Top Ten Claims Submission Errors	Number Received	Reason For Error
40022 - Procedure Code/Modifier Invalid	40,793	The procedure code and/or modifier used on this line is invalid.
20011 - Billing Provider Secondary ID Invalid	18,075	Secondary provider ID is invalid.
20269 - Pointer 1 Diagnosis Invalid	17,042	Diagnosis pointer is invalid in first diagnosis field.
40068 - Invalid/Unnecessary CMN Question	12,915	The question number entered is not valid for the DME MAC CMN you are sending.
40014 - Ordering Provider Information Missing	11,878	The ordering provider information is missing. This should be included with every service line.
20322 - Submitter ID Invalid	9,543	The NPI (National Provider Identifier) is not found on crosswalk.
40073 - Dates of Service Invalid with Procedure Code	8,402	The procedure code used is not valid for the dates of service used.
20143 - Ordering Provider Secondary ID Invalid	8,187	The provider number or Unique Physician Identification Number (UPIN) is invalid.
40021 - Capped Rental K Modifier Missing	7,672	Required capped rental K modifier is missing from the claim.
20110 - Procedure Code Invalid	7,304	Procedure Code is invalid or discontinued.

The following information is provided in an effort to reduce other initial claim denials. The information represents the top ten (10) return/reject denials for the first quarter of 2008. 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 January through March 2008.

Claims Submission Errors (Return/Reject Denials)	CMS 1500 Form(or electronic equivalent) Entry Requirement	Number Received
CO 16 N280 Claim/service lacks information which is needed for adjudication. Missing/incomplete/invalid pay to provider primary identifier.	**Item 33** - NPI bypass logic rejection - Invalid NPI/PTAN (National Provider Identifier/Provider Transaction Access Number) pair on the crosswalk file. **Note:** *Effective March 1, 2008, the NPI must be submitted, the PTAN may be submitted in addition to the NPI until May 22, 2008.*	32,686
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.	6,347
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." (Paper Claims Only)	4,588
CO 16 M51 Claim/service lacks information which is needed for adjudication. Missing/incomplete/invalid procedure codes(s) and/or rates.	**Item 24D** - Enter the procedures, services, or supplies using the HCPCS. When applicable show HCPCS modifiers with the HCPCS code.	3,811
CO 16 N64 Claim/service lacks information which is needed for adjudication. The "from" and "to" dates must be different.	**Item 24A** - Enter the precise eight-digit date (MMDDCCYY) for each procedure, service, or supply in Item 24A.	3,332
CO 16, CO 207 N265, N286 Claim/service lacks information which is needed for adjudication. 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.	2,628
CO 16 M51, N225, N29 Claim/service lacks information which is needed for adjudication. Missing/incomplete/invalid procedure code(s) and/or dates. Missing incomplete/invalid documentation.	**Item 24D** - Enter the procedures, services or supplies using the Healthcare Common Procedure Coding System (HCPCS). NOC (Not Otherwise Classified) codes billed and a narrative description was not entered.	1,010
CO 109 N127 This claim/service is not payable under our claims jurisdiction. We have notified your provider to send your claim for these services to the United Mine Workers of America (UMWA) for processing.	**Misdirected Claim** - This is a misdirected claim/service for a United Mine Workers of America (UMWA) beneficiary. Please submit claims there.	301
CO 16 MA114 Claim/service lacks information which is needed for adjudication. 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.	255
CO 16 M77 Claim/service lacks information which is needed for adjudication. Missing/incomplete/invalid place of service.	**Item 24B** - Invalid place of service submitted. Must indicate place of service where the equipment/supplies will be used.	221

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

Attention All Providers: Reduce Duplicate Denials GEN

The Jurisdiction A Outreach & Education Team conducted an analysis of all claims denied in the fourth quarter of 2007 (October - December) to determine the volume of unnecessary duplicate denials. Claims denied as a duplicate (CO-18) represented approximately 15% of all denied claims during this time frame.

CO-18 indicates a claim has been submitted for the same beneficiary, service and date of service as a previously adjudicated (processed) claim. The processing of unnecessary duplicate claims causes additional workload and expense for the DME MAC, the provider community and the over-all Medicare Program. To prevent this from occurring, the claim has to be given an adequate amount of time for adjudication before re-submitting the item for processing. For example, billing systems should not be set-up to automatically bill for the same beneficiary, service and date of service on a weekly or bi-weekly basis until the claim is paid or denied. Claim processing requirements for the DME MAC are to complete claims within 30 days of receipt.

Claims denied in full or individual claim lines denied with a duplicate denial (CO-18) should not be re-submitted.

Claims or claim lines should also not be re-submitted when denied with a medical necessity denial (CO-50). This too, will cause a duplicate denial. Claims denied for medical necessity must be submitted through the appeals process, with currently only one exception. The only medical necessity denial that qualifies for a re-opening involves adding a KX modifier when requested by the provider (submitter), for those items meeting the KX modifier requirements per the medical policy.

DME MAC A will continue to monitor the submission of duplicate claims to identify submitters (clearinghouses, billing services, providers, etc.) who have a negative impact on the volume of unnecessary duplicate claim denials. The Outreach & Education Team will then determine the most appropriate means of education and/or follow-up action to reduce this volume.

We ask that you do your part to assist in this mission. Be sure your billing systems are set-up appropriately and claims are submitted per Medicare Program and DME MAC instruction.

DME MAC A ListServes GEN

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 *Bulletins* 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 MAC A Web site at **http://www.medicarenhic.com/dme/**

New Interactive Voice Response Application GEN

Effective April 1, 2008, NHIC, Corp. DME MAC Jurisdiction A implemented a new Interactive Voice Response (IVR) application. With the implementation of the new IVR, callers are no longer required to use the IVR to speak with a Customer Service Representative (CSR). A new, alternate, telephone number is available for contacting a CSR directly for those inquiries that cannot be addressed by the IVR. The number to contact a CSR directly is 866-590-6731. As required by the Centers for Medicare and Medicaid Services (CMS), callers contacting a CSR with a question that can be handled by the IVR will be asked to disconnect and call the IVR number. The CSR will not be able to transfer the caller to the IVR.

Several enhancements to the functionality of the IVR were also implemented resulting in an improved user experience. In order to utilize the IVR to access information regarding claim status, beneficiary eligibility, or general Medicare information callers will be required to provide their Provider Transaction Access Number(s) (PTAN). A PTAN, which is the same as a legacy supplier number, is a unique number issued to providers/suppliers during the Medicare enrollment process.

The new IVR uses voice response natural language and text-to-speech technology, however, touch-tone capability is also still available throughout the application.

Oral Anticancer Drug Policy Clarification DRU

The Oral Anticancer Drug policy covers eight specified oral anticancer drugs and antiemetic drugs used in conjunction to prevent emesis. The antiemetic drugs are covered for the sole purposes of allowing the absorption of the covered oral anticancer drug. The following are the eight covered oral anticancer drugs found in the Local Coverage Determination policy on the NHIC Corp. DME MAC A web site:

Busulfan
Capecitabine
Cyclophosphamide
Etoposide
Melphalan
Methotrexate
Temozolomide
Topotecan (effective DOS 4/1/08)

When billing for one of the above covered oral anticancer drugs, the National Drug Code (NDC) that identifies the oral anticancer drug should be used. The current NDC list can be found on the SADMERC web site under NDC to HCPCS Crosswalk. The quantity of oral anticancer drugs that is dispensed should be limited to a 30-day supply. Prescriptions may be refillable.

Claims for covered antiemetic drugs billed with HCPCS codes J8498 or J8597 and used in conjunction with an oral anticancer drug should be billed on the same date of service as the covered oral anticancer drug to meet coverage criteria for being administered within 2 hours before the covered oral anticancer drug is administered. When billing for an antiemetic drug the following information is required per policy;

"*Claims for codes J8498 or J8597 must identify the name of the drug, the manufacturer, and the dosage strength of each tablet/suppository/etc. Only quantities of these drugs which meet the coverage criteria listed in the related Policy Article may be billed using these codes. The claim must also indicate which oral anticancer drug is being used and the prescribed frequency of administration of the anticancer drug. This information should be entered in the narrative field of an electronic claim.*"

Several suppliers are placing the NDC number with the above information when billing J8597. The NDC number converts the J8597 to a Q code which is not in the Oral Anticancer drug policy, but is in the Oral Antiemetic drug policy. This is incorrect and will result in a denial.

Quarterly Provider Update GEN

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 GEN

The 2008 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 2008 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 March of 2008 **all chapters** of the *DME MAC A Supplier Manual* were updated, and Chapter 12 "**Medical Review**" was added. 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.

Telephone Reopenings Process Improvement & Telephone Number Change GEN

NHIC, Corp. DME MAC Jurisdiction A is pleased to announce a process improvement that has made the telephone reopenings process faster and more efficient. Effective March 24, 2008, telephone reopenings are now performed "live" by a reopenings representative while the provider waits on the line. A new telephone number **(317-595-4371)** has been established for all telephone reopenings as a result of this new process.

Benefits of the new telephone reopenings process:

- **No Automated System** - Suppliers will be directly connected to a reopenings representative.

- **Faster Payments** - Claim reopenings are performed "live" by the reopening representative who answers the call. The supplier can wait on the line while the reopening is processed. In most cases, this process will allow for much faster payments on favorable reopenings.

Providers should have the following information available before contacting the telephone reopenings line:

- PTAN (NSC) Number
- Beneficiary's Medicare Number
- Beneficiary's Name
- Date of Service

- Claim Control Number

Note: The claim control number is a new requirement for reopenings and callers **must** have this number accessible to complete a reopening. The claim control number can be found next to the letters "ICN" on the remittance advice.

The fax reopening process is still available and has not been affected by this change. For additional details on the fax reopening process, refer to the fax reopening cover sheet at **http://www.medicarenhic.com/dme/forms/Fax_Reopening_Cover_Sheet.pdf**.

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

For Your Notes

For Your Notes

Customer Service Telephone

Interactive Voice Response (IVR) System: 866-419-9458
Customer Service Representatives: 866-590-6731
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: 781-741-3118

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

Overpayments

Refund Checks:
DME - Accounting (Refund Checks)
P.O. Box 9143
Hingham, MA 02043-9143

Payment Offset Fax Requests: 781-741-3916

Note: I*nclude both the demand letter or the remittance indicating the overpayment, and the Offset Request Form*

Appeals and Reopenings

Telephone Reopenings: 317-595-4371

Faxed Reopenings: 781-741-3914

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

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

Redetermination Requests Fax: 781-741-3118

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

Reconsiderations For Overnight Deliveries:
RiverTrust Solutions, Inc.
801 Pine Street
Chattanooga, TN 37402

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

Local Coverage Determinations (LCDs)

Draft LCDs Comments Mailing Address:
Paul J. Hughes, MD
Medical Director
DME MAC Jurisdiction A
75 Sgt. William Terry Dr.
Hingham, MA 02043

Draft LCDs Comments Email Address:
NHICDMEDraftLCDFeedback@EXAMHUB.exch.eds.com

LCD Reconsiderations Mailing Address:
Same as Draft LCDs Comments

LCD Reconsiderations Email Address:
NHICDMELCDRecon@examhub.exch.eds.com

LCD Reconsiderations Fax: 781-741-3991

ADMC Requests

NHIC, Corp.
Attention: ADMC
P.O. Box 9170
Hingham, MA 02043-9170

ADMC Requests Fax:

Attention: ADMC
781-741-3991

Common Electronic Data Interchange (CEDI)

Help Desk: 866-311-9184

Email Address: ngs.CEDIHelpdesk@wellpoint.com

DME MAC Jurisdiction A Resource

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

June 2008
Number 8

Publication Information

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

Visit the following websites for more information:

- NHIC, Corp.: www.medicarenhic.com/dme/
- TriCenturion: www.tricenturion.com
- CMS: www.cms.hhs.gov/

The *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 the *DME MAC Jurisdiction A Resource* or would like to make suggestions, please write to:

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

NHIC, Corp.
An EDS Company
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75 Sgt. William B. Terry Drive
Hingham, MA 02043