March 2008
Number 7

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

Important Changes for 2008:

March 1st, 2008

Transition of Medical Review Functions from PSCs to DME MACs

May 1st, 2008

Transition of EDI Functions from DME MACs to the CEDI Contractor

Be sure to read the articles in this Bulletin and stay tuned via our ListServe and Web site for additional details and updates.

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

NHIC, Corp.

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GEN General	**OXY** Oxygen	**VIS** Vision
MOB Mobility/Support Surfaces	**PEN** Parenteral/Enteral Nutrition	

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Billing/Finance

Annual Update of Healthcare Common Procedure Codes System (HCPCS) Codes Used for Home Health Consolidated Billing Enforcement (MM5829)

MLN Matters Number: MM5829
Related CR Release Date: December 14, 2007
Related CR Transmittal #: R1391CP
Related Change Request (CR) #: 5829
Effective Date: January 1, 2008
Implementation Date: January 7, 2008

Provider Types Affected
Physicians, suppliers, and providers who bill Medicare contractors (Fiscal Intermediaries (FIs), carriers, regional home health intermediaries (RHHIs), and DME Medicare Administrative Contractors (DME MACs) and Part A/B Medicare Administrative Contractors (A/B MACs)) for medical supply or therapy services.

What Providers Need to Know
The Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of Healthcare Common Procedure Codes System (HCPCS) codes subject to the consolidated billing provision of the Home Health Prospective Payment System (HH PPS). This article provides the annual HH consolidated billing update effective January 1, 2008. Affected providers may note the changes in the table listed within this article or consult the instruction issued to the Medicare contractors as listed in the *Additional Information* section of this article.

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

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

Medicare has issued a Recurring Update Notification, which provides the annual HH consolidated billing updates for non-routine supplies and therapies effective January 1, 2008. These lists are updated annually, effective each January 1, to reflect the annual changes to the HCPCS code set. The lists may also be updated as frequently as quarterly if required by the creation of temporary HCPCS codes during the year.

CR5829 provides the annual HH consolidated billing update effective January 1, 2008. The following tables describe the HCPCS codes and the specific changes to each that this notification is implementing for claims with dates of service on or after January 1, 2008.

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Annual Update of Healthcare Common Procedure Codes System (HCPCS) Codes Used for Home Health Consolidated Billing Enforcement (MM5829) (Continued)

Table 1: Non Routine Supplies

Code	Description	Action
A5083	CONTINENT DEVICE, STOMA ABSORPTIVE COVER FOR CONTINENT STOMA	Add
A5105	URINARY SUSPENSORY WITH LEG BAG WITH OR WITHOUT TUBE, EACH	Redefine
A6200	COMPOSITE DRESSING, PAD SIZE 16 SQ. IN. OR LESS, WITHOUT ADHESIVE BORDER, EACH DRESSING	Delete
A6201	COMPOSITE DRESSING, PAD SIZE MORE THAN 16 SQ. IN. BUT LESS THAN OR EQUAL TO 48 SQ. IN., WITHOUT ADHESIVE BORDER, EACH DRESSING	Delete
A6202	COMPOSITE DRESSING, PAD SIZE MORE THAN 48 SQ. IN., WITHOUT ADHESIVE BORDER, EACH DRESSING	Delete
A6413	ADHESIVE BANDAGE, FIRST-AID TYPE, ANY SIZE, EACH	Add

Table 2: Therapies

Code	Description	Action	Replacement Code or Code being Replaced
96125	STANDARDIZED COGNITIVE PERFORMANCE TESTING PER HOUR	Add	96125

Additional Information

For details regarding this CR, please see the official instruction issued to your Medicare FI, carrier, A/B MAC, RHHI, or DME MAC. This may be viewed at **http://www.cms.hhs.gov/Transmittals/downloads/R1391CP.pdf** on the CMS website.

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

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

To review the Medicare manual instructions discussed in this article see the *Medicare Claims Processing Manual*, Chapter 10, Section 20.1 at **http://www.cms.hhs.gov/manuals/downloads/clm104c10.pdf** on the CMS website.

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Crossover of Assignment of Benefits Indicator (CLM08) From Paper Claim Input (MM5780)

MLN Matters Number: MM5780
Related CR Release Date: November 2, 2007
Related CR Transmittal #: R1369CP
Related Change Request (CR) #: 5780
Effective Date: April 1, 2008
Implementation Date: April 7, 2008

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

Provider Action Needed
Impact to You
This article is based on Change Request (CR) 5780 which makes system changes to the manner in which the Medicare sets the CLM08 value in the Coordination of Benefits (COB) flat file for transmission of claims to COB partners.

What You Need to Know
CR 5780 will result in changes to Medicare systems to appropriately set the correct indicator in CLM08 based on the presence of or lack of a patient signature in box/item 13 of the Form CMS-1500.

What You Need to Do
See the Background and Additional Information Sections of this article for further details regarding these changes and be sure billing personnel complete box/item 13 of the Form CMS-1500 in accordance with the revised instructions.

Background
The basic claims form prescribed by the Centers for Medicare & Medicaid Services (CMS) for the Medicare program is the Form CMS-1500. It answers the needs of many health insurers, and it is only accepted from physicians and suppliers that are excluded from the mandatory electronic claims submission requirements set forth in the Administrative Simplification Compliance Act, Public Law 107-105 (ASCA) and the implementing regulation at 42 CFR 424.32 (**http://www.access.gpo.gov/nara/cfr/waisidx_02/42cfr424_02.html**).

Coordination of Benefits (COB) trading partners requested that CMS change the current process of automatically setting a "Y" value in the CLM08 segment of the 837 Professional Coordination of Benefits (COB) claim crossover file. Trading partners may use the CLM08 value to determine where the claim reimbursement is to go and have, in some cases, reimbursed the provider instead of the beneficiary.

Note: *CLM08 is the assignment of benefits indicator, and a "Y" value indicates insured or authorized person authorizes benefits to be assigned to the provider; an "N" value indicates benefits have not been assigned to the provider.*

CR 5780 initiates system changes to appropriately set the correct indicator in CLM08 based on the presence of or lack of a signature in box/item 13 of the Form CMS-1500. In addition, CR5780 revises the Form CMS-1500 claim completion instructions in order to inform providers regarding how the presence or lack of a signature in box 13 will affect downstream patient assignment of benefits. Specifically, the *Medicare Claims Processing Manual* (Chapter 26, Section 10.3 - Items 11a-13 - Patient and Insured Information) is revised ***(changes are bolded and italicized)*** as follows:

> ***"Item 13 - The patient's signature or the statement "signature on file" in this item authorizes payment of medical benefits to the physician or supplier. The patient or his/her authorized representative signs this item or the signature must be on file separately with the provider as an authorization.***
>
> ***The presence of or lack of a signature or "signature on file" in this field will be indicated as such to any downstream Coordination of Benefits trading partners (supplemental insurers) with whom we have a payer-to-payer coordination of benefits relationship. Medicare has no control over how supplemental claims are processed, so it is important that providers accurately address this field as it may or may not affect supplemental payments to providers and/or their patients.***
>
> ***In addition,*** the signature in this item authorizes payment of mandated Medigap benefits to the participating physician or supplier if required Medigap information is included in item 9 and its subdivisions. The patient or his/her authorized representative signs this item or the signature must be on file as a separate Medigap authorization. The Medigap assignment on file in the participating provider of service/supplier's office must be insurer specific. It may state that the authorization applies to all occasions of service until it is revoked."

Note: *This can be "Signature on File" signature and/or a computer generated signature.*

The business requirements in CR 5780 do not affect inbound claims or current Medicare claims processing guidelines. They specifically address COB claims only which are sent to trading partners.

Additional Information
The official instruction, CR5680, issued to your carrier, DME MAC, and A/B MAC regarding this change may be viewed at **http://www.cms.hhs.gov/Transmittals/downloads/R1369CP.pdf** on the CMS website.

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.

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Durable Medical Equipment Medicare Administrative Contractors (DME MACs) - Discontinuance/Cancellation of the Use of a "WL" Modifier on Claims for the DeWall Posture Protector Orthotic Body Jacket HCPCS Code (L0430) (MM5758)

MLN Matters Number: MM5758
Related CR Release Date: October 15, 2007
Related CR Transmittal #: R295OTN
Related Change Request (CR) #: 5758
Effective Date: July 16, 2007
Implementation Date: November 16, 2007

Provider Types Affected
All suppliers who submit claims to durable medical equipment Medicare Administrative Contractors (DME MACs) for the DeWall Posture Protector Orthotic Body Jacket.

What Providers Need to Know
This article is based on Change Request (CR) 5758, which states that DME/MACs shall accept claims billed with Healthcare Common Procedure Coding System (HCPCS) Code L0430 with no modifier requirements for the DeWall Posture Protector Orthotic Body Jacket. See *"Key Points"* for specific details.

Background
On November 2, 2004, the Centers for Medicare & Medicaid Services (CMS) entered into a settlement agreement ("Stipulation for Compromised Settlement") resolving the DeWall court case. The United States District Court for the District of Nebraska approved of the settlement and dismissed the DeWall case by Order dated November 3, 2004, (Filing 121). The settlement agreement stipulates that "code L0430 be reinstated for a period of five years from the date of reinstatement, with no modifiers, as a HCPCS L code, with a descriptor that indicates that it describes only the Dewall Posture Protector."

On January 1, 2005, CMS reinstated code L0430 for the DeWall Posture Protector only, for a five-year period ending on December 31, 2009. By agreement of the parties, the **five-year duration of the settlement agreement ending December 31, 2009, will be extended to August 1, 2012.**

On July 16, 2007, CMS issued further instructions to the DME MACs to reiterate the terms of this court order and ensure compliance with the stipulation to **accept and process claims using the L0430 code, when the item furnished is a DeWall Posture Protector, without requiring any modifiers.**

Key Points
In accordance with CR5758, DME MACs shall:

- Accept and process claims for the DeWall Posture Protector Spinal Orthosis, submitted using HCPCS code L0430, when the item furnished is a DeWall Posture Protector, without requiring any modifiers, including the "KX" or "WL" modifiers;
- Apply all other current applicable Medicare edits to such claims; and
- Upon implementation of CR5758, retire all use of the "WL" modifier.

Additional Information
To see the official instruction (CR5758) issued to your Medicare DME MAC visit **http://www.cms.hhs.gov/Transmittals/downloads/R295OTN.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.

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Important changes for 2008: March 1st - Medical Review functions transition; May 1st - EDI functions transition. Be sure to read the articles in this bulletin and stay tuned via our ListServe and Web site for additional details and updates.

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Fee Schedule Update for 2008 for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (MM5803)

MLN Matters Number: MM5803
Related CR Release Date: December 7, 2007
Related CR Transmittal #: R1388CP
Related Change Request (CR) #: 5803
Effective Date: January 1, 2008
Implementation Date: January 7, 2008

Provider Types Affected
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 Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) provided to Medicare beneficiaries.

Provider Action Needed
This article is based on Change Request (CR) 5803, which provides the annual update to the 2008 DMEPOS fee schedules in order to implement fee schedule amounts for new codes and to revise any fee schedule amounts for existing codes that were calculated in error. Be sure your billing staff are aware of these changes.

Background
This recurring update notification, CR5803, provides specific instructions regarding the 2008 annual update for the DMEPOS fee schedule. Payment on a fee schedule basis is required for durable medical equipment (DME), prosthetic devices, orthotics, prosthetics, and surgical dressings by §1834(a), (h), and (i) of the Social Security Act. Payment on a fee schedule basis is required for parenteral and enteral nutrition (PEN) by regulations contained at 42 CFR 414.102.

The update process for the DMEPOS fee schedule is located in the *Medicare Claims Processing Manual* (Publication 100-04), Chapter 23, Section 60; **http://www.cms.hhs.gov/manuals/downloads/clm104c23.pdf)** on the Centers for Medicare & Medicaid Services (CMS) website. Other information on the fee schedule, including access to the DMEPOS fee schedules is at **http://www.cms.hhs.gov/DMEPOSFeeSched/01_overview.asp** on the CMS website.

Key Points

- The following codes are being **deleted** from the HCPCS effective January 1, 2008, and are therefore being removed from the DMEPOS and PEN fee schedule files:

B4086	L3800	L3850	L3926	L3946
E2618	L3805	L3855	L3928	L3948
K0553	L3810	L3860	L3930	L3950
K0554	L3815	L3907	L3932	L3952
K0555	L3820	L3910	L3934	L3954
L0960	L3825	L3916	L3936	L3985
L1855	L3830	L3918	L3938	L3986
L1858	L3835	L3820	L3940	
L1870	L3840	L3922	L3942	
L1880	L3845	L3924	L3944	

- The payment category for code K0730 is revised to move the controlled dose inhalation drug delivery system from the DME payment category for capped rental items to the DME payment category for inexpensive and routinely purchased items, effective January 1, 2008. The total payment for inexpensive and/or routinely purchased items may not exceed the fee schedule amount for purchase of the equipment. In the case of controlled dose inhalation drug delivery systems furnished on a purchase basis on or after January 1, 2008, the allowed payment amount will be reduced by the total rental payments previously made for the item.
- The fee schedule amounts established for HCPCS codes K0553, K0554 and K0555 will directly crosswalk to new HCPCS codes A7027, A7028 and A7029, respectively.
- As of the July 2007 HCPCS Quarterly Update, the following composite dressing HCPCS codes are non-covered by Medicare, effective July 1, 2007: A6200, A6201 and A6202. To reflect this change, the fee schedule amounts for codes A6200, A6201 and A6202 will be removed from the fee schedule file as part of this update. Medicare Contractors will deny claims for A6200, A6201 and A6202 with dates of service July 1, 2007 through December 31, 2007.
- CMS will establish fee schedule amounts for the following HCPCS codes : B4087, B4088, E2312, E2312KC, E2373, E2313, L1846, L3808, L3923, L3764, L3763, L3925, L3929, and L3931. These fee schedule amounts will be added to the fee schedule file on January 1, 2008, and are effective for claims with dates of service on or after January 1, 2008. The existing fee schedule amounts for HCPCS code E2373 will become the full replacement E2373 KC fees, effective January 1, 2008.
- Suppliers are to submit the KC modifier when billing for the full replacement of HCPCS power wheelchair interface codes E2373 and E2312.

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Fee Schedule Update for 2008 for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (MM5803) (Continued)

- Note that HCPCS codes E0328 and E0329 are rarely appropriate for Medicare billings, payment for pediatric beds represented by these codes will be based on individual Medicare contractor consideration.
- As part of this update, CMS is implementing the 2008 national monthly payment rates for stationary oxygen equipment, (HCPCS codes E0424, E0439, E1390 and E1391), effective for claims with dates of service on or after January 1, 2008. CMS is revising the fee schedule file to include the new 2008 monthly payment rate of $199.28 for stationary oxygen equipment. As required by statute, these payment rates are adjusted annually to assure budget neutrality on the addition of the new oxygen generating portable equipment class. Accordingly, a reduction to the national monthly payment amount for stationary oxygen equipment for 2008 that is necessary to offset payments under the new class will be slightly lower ($0.56) (from $199.84 to $199.28) than previously announced.
- As a result of the above adjustments, CMS is also revising the fee schedule amounts for HCPCS codes E1405 and E1406 as part of this update. Since 1989, the fees for codes E1405 and E1406 have been established based on a combination of the Medicare payment amounts for stationary oxygen equipment and nebulizer codes E0585 and E0570, respectively.
- The following are the new HCPCS codes, effective January 1, 2008:

A4252	A9276	E0329	L3925	L7614
A5083	A9277	E0856	L3927	L7621
A6413	A9278	E2227	L3929	L7622
A7027	A9283	E2228	L3931	V2787
A7028	B4087	E2312	L7611	
A7029	B4088	E2313	L7612	
A9274	E0328	E2397	L7613	

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 (CR5803) issued to your Medicare A/B MAC, FI, DMERC, DME/MAC, RHHI or carrier by going to **http://www.cms.hhs.gov/Transmittals/downloads/R1388CP.pdf** on the CMS website.

Fee Schedule Updates

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:

New:

- 2008 Jurisdiction A DME MAC Fee Schedule
- January 2008 Quarterly Average Sales Price Medicare Part B Drug Pricing File
- 1st 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.

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January 2008 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files (MM5852)

MLN Matters Number: MM5852
Related CR Release Date: January 8, 2008
Related CR Transmittal #: R1406CP
Related Change Request (CR) #: 5852
Effective Date: January 1, 2008
Implementation Date: January 7, 2008

Provider Types Affected
Physicians, providers, and suppliers submitting claims to Medicare contractors (Carriers, Durable Medical Equipment Medicare Administrative Contractors (DME MACs), 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.

What You Need to Know
CR 5852, from which this article is taken, instructs Medicare contractors to download and implement the January 2008 Average Sales Price (ASP) drug pricing file for Medicare Part B drugs; and if released by CMS, also the revised January 2007, April 2007, July 2007, October 2007, April 2006, July 2006, 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:

1. The FDA approval,
2. Therapeutic equivalents as determined by the FDA, and
3. 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
In general, 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% of the ASP. Beginning January 1, 2006, payment allowance limits are paid based on the ASP methodology 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.

Summary of Exceptions to this General Rule
1. Except for blood clotting factors, the payment allowance limits for **blood and blood products** (that are not paid on a prospective payment basis) are determined in the same manner they were determined on October 1, 2003. Specifically, the payment allowance limits for blood and blood products are 95% of the average wholesale price (AWP) as reflected in the published compendia; and will be updated on a quarterly basis. Blood and blood products furnished in the hospital outpatient department are paid under OPPS at the amount specified for the APC to which the product is assigned.

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January 2008 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files (MM5852) (Continued)

Note: 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 a new blood clotting factor when a new blood clotting factor is not included on the ASP file. For 2008, a separate fee of $0.158 per I.U. of blood clotting factor furnished is payable when separate payment for the blood clotting factor is made. The furnishing fee will be included in the payment amounts on the quarterly ASP pricing files.*

2. Payment allowance limits for **infusion drugs furnished through a covered item of durable medical equipment (DME)** on or after January 1, 2005, will continue to be 95% of the AWP reflected in the published compendia as of October 1, 2003, unless the drug is compounded or incident to a professional service. **The payment allowance limits will not be updated in 2008.**

Similarly, payment allowance limits for **infusion drugs furnished through a covered item of DME** that were not listed in the published compendia as of October 1, 2003, (i.e., new drugs) are 95 percent (95%) of the first published AWP unless the drug is compounded or furnished incident to a professional service.

3. The payment allowance limits for **influenza, Pneumococcal and Hepatitis B vaccines** are 95% of the AWP as reflected in the published compendia except, when administered in a hospital outpatient department, the vaccines are paid at reasonable cost.

4. Except for new drugs and biologicals that are produced, or distributed, under a new drug application (or other application) approved by the Food and Drug Administration (FDA), the payment allowance limits for **drugs and biologicals that are not included in the ASP Medicare Part B Drug Pricing File** or Not Otherwise Classified (NOC) Pricing File, are based on the published wholesale acquisition cost (WAC) or invoice pricing (except under OPPS in which the payment allowance limit is 95% of the published AWP).

In determining the payment limit based on WAC, contractors will follow the methodology specified in the *Medicare Claims Processing Manual*, Chapter 17, Drugs and Biologicals, for calculating the AWP but will substitute WAC for AWP. The payment limit is 100% of the lesser of the lowest-priced brand or median generic WAC.

5. The payment allowance limits for **new drugs and biologicals** that were first sold on or after January 1, 2005; and are: 1) Produced or distributed under a new drug application (or other new application) approved by the Food and Drug Administration, and 2) Not included in the ASP Medicare Part B Drug Pricing File or Not Otherwise Classified (NOC) Pricing File; are based on 106% of the WAC (or invoice pricing if the WAC is not published) except under OPPS in which the payment allowance limit is 95% of the published AWP.

6. The payment allowance limits for **radiopharmaceuticals** are not subject to the ASP payment methodology. Contractors should 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.

7. The payment methodology for **drugs furnished incident to the filling or refilling of an implantable pump or reservoir** is determined under the ASP methodology (as described above) unless the drug furnished incident to the filling or refilling of an implantable pump or reservoir is a compounded drug, then pricing is performed by the local contractor.

Physicians (or a practitioner described in Section 1842(b) (18) (C)) may be paid for filling or refilling an implantable pump or reservoir when it is medically necessary that they perform the service. Contractors must find the use of the implantable pump or reservoir medically reasonable and necessary in order to allow payment for the professional service to fill or refill the implantable pump or reservoir and to allow payment for drugs furnished incident to the professional service.

If a physician (or other practitioner) is prescribing medication for a patient with an implantable pump, a nurse may refill the pump if the medication administered is:

- Accepted as a safe and effective treatment of the patient's illness or injury;
- There is a medical reason that the medication cannot be taken orally; and
- The skills of the nurse are needed to infuse the medication safely and effectively.

On or after December 18, 2007, the January 2008 ASP file and ASP NOC files will be available for retrieval from the CMS ASP webpage. If CMS determines that revisions to the January 2007, April 2007, July 2007, October 2007, April 2006, July 2006 and October 2006 ASP payment files are necessary, the revised files will also be available for retrieval from the CMS webpage on or after December 18, 2007. The revised payment files will be applied to claims processed or reprocessed on or after this CR's (5852) effective date.

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January 2008 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files (MM5852) (Continued)

Table 1 below displays the payment allowance limit revision dates, and the applicable dates of service.

Table 1

Payment Allowance Limit Revision Date	Applicable Dates of Service
January 2008	January 1, 2008 through March 31, 2008
Revised January 2007*	January 1, 2007 through March 31, 2007
Revised April 2007*	April 1, 2007 through June 30, 2007;
Revised July 2007*	July 1, 2007, through September 30, 2007
Revised October 2007*	October 1, 2007 through December 31, 2007
Revised April 2006*	April 1, 2006 through June 30, 2006;
Revised July 2006*	July 1, 2006, through September 30, 2006
Revised October 2006*	October 1, 2006, through December 31, 2006

*If made available by CMS

Note: *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.*

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

Contractors (at their discretion) may contact CMS to obtain payment limits for drugs and biologicals not included in the quarterly ASP or NOC files, or that CMS has not otherwise made available on its website. If the payment limit is available from CMS, contractors will substitute CMS-provided payment limits for pricing based on WAC or invoice pricing.

Contractors will not search for, and adjust, a claim that has already been processed unless you bring it to their attention.

Implementation
The implementation date is January 7, 2008.

Additional Information
For complete details, please see the official instruction (CR 5852) issued to your carriers, DME MACs, FIs, A/B MACs, and/or RHHIs regarding this change, by visiting **http://www.cms.hhs.gov/Transmittals/downloads/R1406CP.pdf** on the CMS website.

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

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Nebulized Beta Adrenergic Agonist Therapy for Lung Diseases (MM5820)

MLN Matters Number: MM5820
Related CR Release Date: December 21, 2007
Related CR Transmittal #: R79NCD
Related Change Request (CR) #: 5820
Effective Date: September 10, 2007
Implementation Date: January 22, 2008

Provider Types Affected
Providers and suppliers who bill Medicare contractors (fiscal intermediaries (FI), regional home health intermediaries (RHHI), carriers, Medicare Administrative Contractors (A/B MAC), and Durable Medical Equipment Contractors (DME MAC) for nebulized beta adrenergic agonist therapy services for lung diseases.

What You Need to Know
CR 5820, from which this article is taken, provides that (effective September 10, 2007) no National Coverage Determination (NCD) for nebulized beta adrenergic agonist therapy for lung diseases is appropriate. Therefore, you should make sure that your billing staffs are aware that local contractors will continue to make Section 1862(a)(1)(A) reasonable and necessary decisions through a local coverage determination process or case-by-case adjudication.

Note: *No changes to process or policy are being made with CR5820.*

Background
Lung diseases such as chronic obstructive pulmonary disease (COPD) and asthma are characterized by airflow limitation that may be partially or completely reversible. Pharmacologic treatment with bronchodilators (intended to improve the movement of air into and from the lungs by relaxing and dilating the bronchial passageways) is used to prevent and/or control daily symptoms that may cause disability for persons with these diseases.

Beta adrenergic agonists (which can be administered via nebulizer, metered dose inhaler, orally, or dry powdered inhaler) are a commonly prescribed class of bronchodilator drug. For example, nebulized beta adrenergic agonist with racemic albuterol has been used for many years, and more recently, levalbuterol, the (R) enantiomer of racemic albuterol, has been used in some patient populations.

Because of concerns regarding the appropriate use of nebulized beta adrenergic agonist therapy for lung disease, the Centers for Medicare & Medicaid Services (CMS) internally generated a formal request for a national coverage determination (NCD) to determine when treatment with a nebulized beta adrenergic agonist is reasonable and necessary for Medicare beneficiaries with COPD.

The examination of the published medical evidence did not provide sufficient information that would enable CMS to define, at this time, specific populations of patients who would benefit from a particular treatment with particular medications. Moreover, because an NCD is defined, in part, as including "whether or not a particular item or service is covered nationally" under title XVIII, sections 1862(l), 1869(f)(1)(B); CMS does not believe a national policy is possible or prudent at this time.

Therefore, effective with dates of service on and after September 10, 2007, Medicare contractors will continue to make 1862(a)(1)(A) reasonable and necessary decisions and process claims for nebulized beta adrenergic agonist therapy for lung disease through their local coverage determination process or case-by-case adjudication.

Note: *No changes to process or policy are being made with CR5820.*

Additional Information
You can find the official instruction, CR 5820, issued to your FI, RHHI, Carrier, A/B MAC, or DME MAC by visiting **http://www.cms.hhs.gov/Transmittals/downloads/R79NCD.pdf** on the CMS website. You will find the *Medicare National Coverage Determinations Manual*, Chapter 1, Part 4 (Sections 200 - 310.1) Coverage Determinations, Section 200.2 - Nebulized Beta Adrenergic Agonist Therapy for Lung Diseases - (Effective September 10, 2007) as an attachment to that 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.

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Effective 3/01/08, Medical Policies are now housed on the DME MAC A Web site

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Outpatient Therapy Caps With Exceptions Start January 1, 2008 (MM5871)

MLN Matters Number: MM5871 - Revised
Related CR Release Date: January 10, 2008
Related CR Transmittal #: R1414CP
Related Change Request (CR) #: 5871
Effective Date: January 1, 2008
Implementation Date: January 25, 2008

Note: *This article was revised on January 18, 2008, to reflect changes to CR5871, which CMS revised on January 17. The CR release date, transmittal number, implementation date, and Web address for accessing CR5871 were changed. All other information remains the same.*

Provider Types Affected
Therapists and other providers who bill Medicare contractors (carriers, fiscal intermediaries (FIs), or Medicare Administrative Contractors (A/B MAC)) for therapy services for Medicare beneficiaries.

Provider Action Needed
CR 5871, from which this article is taken announces the dollar amount of outpatient therapy caps for 2008, and clarifies the *Medicare Claims Processing Manual* regarding exceptions to outpatient therapy services.

On January 1, 2008, the financial limits on outpatient therapy services will be $1,810 for combined physical therapy and speech-language pathology services; and $1,810 for occupational therapy services.

You should make sure that your billing staffs are aware of these new outpatient therapy caps. You might also want to refer to the updated *Medicare Claims Processing Manual*, Chapter 5 (Part B Outpatient Rehabilitation and CORF/OPT Services), Section 10.2 (The Financial Limitation), for the complete documentation of the outpatient therapy services exceptions clarifications (which are summarized below). The complete revised manual sections are attached to CR5871, which is available at **http://www.cms.hhs.gov/Transmittals/downloads/R1414CP.pdf** on the Centers for Medicare & Medicaid Services (CMS) website.

Background
The Balanced Budget Act of 1997 enacted financial limitations on outpatient physical therapy, occupational therapy, and speech-language pathology services in all settings except outpatient hospital services. The 2006 Deficit Reduction Act enacted exceptions to the limits, and the Medicare, Medicaid, and SCHIP Extension Act of 2007 extended the cap exceptions process through June 30, 2008. The dollar amount of the cap is updated annually in accordance with the Medicare Economic Index.

CR 5871, from which this article is taken announces the dollar amount of outpatient therapy caps for 2008. Effective January 1, 2008, the financial limits on outpatient therapy services will be $1,810 for combined physical therapy and speech-language pathology services; and $1,810 for occupational therapy services. Exceptions are allowed for medically necessary outpatient therapy services.

The financial limits on outpatient therapy services over the last three years are displayed in Table 1.

Table 1
Financial Limits on Outpatient Therapy Services*

Year	Physical Therapy and Speech Language Pathology Combined	Occupational Therapy
2008	$1,810	$1,810
2007	$1,780	$1,780
2006	$1,740	$1,740

Note: *Medicare pays up to 80% of the limits after the deductible has been met.*

The Medicare Summary Notice (MSN) message 38.18 has been updated to read:
"ALERT: Coverage by Medicare is limited to $1,780 in 2007 and $1,810 in 2008 for outpatient physical therapy and speech-language pathology combined. Occupational therapy services have the same limits. Medicare pays up to 80 percent of the limits after the deductible has been met. Exceptions to these limits apply to therapy billed by hospital outpatient departments and may also apply to medically necessary services."

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Outpatient Therapy Caps With Exceptions Start January 1, 2008 (MM5871) (Continued)

CR 5871 also clarifies the *Medicare Claims Processing Manual*, Chapter 5 (Part B Outpatient Rehabilitation and CORF/OPT Services), Section 10.2 (The Financial Limitation), regarding exceptions to outpatient therapy services (except when billed by outpatient hospitals). A summary of the major manual clarifications follows:

1. Section 10.2, Subsection B. Moratoria and Exceptions for Therapy Claims
   Future exceptions language added as follows:
   The cap exception for therapy services billed by outpatient hospitals was part of the original legislation (Balanced Budget Act of 1997), and applies as long as caps are in effect. Exceptions to caps based on the medical necessity of the service are in effect only when Congress legislates the exceptions, as they did for 2007 and as they again extended through June 30, 2008, as part of the Medicare, Medicaid, and SCHIP Extension Act of 2007.
2. Section 10.2, Subsection C-1 Exceptions to Therapy Caps - General
   When the exceptions process (as directed by legislation) is in effect the policies in this section apply. Further, with the exception of the use of the KX modifier, the guidance in this section applies to all therapy services addressed by this section.

   The beneficiary may qualify for use of the cap exceptions at any time during the episode when documented medically necessary services exceed caps. All covered and medically necessary services qualify for exceptions to caps.
3. Section 10.2, Subsection C-2 Automatic Process Exceptions
   Beginning January 1, 2007, all exceptions are processed automatically. You should be aware that the term "automatic process exceptions" indicates that the claims processing for the exception is automatic, and not that the exception, itself, is automatic.

   In making a decision about whether to utilize the automatic process for exception, clinicians should consider, (among other considerations) whether services are appropriate to the patient's condition including the diagnosis, complexities and severity You should be aware that the list of the ICD-9 codes (for conditions and complexities that might qualify a beneficiary for exception to caps) that is found in the table in subsection 10.2 C-3 is only a guideline; and neither assures that services on the list will be excepted, nor limits the provision of covered and medically necessary services for conditions that are not on the list.

   Not all patients who have a condition or complexity on the ICD-9 code list are "automatically" excepted from therapy caps. You should see the *Medicare Benefit Policy Manual*, Chapter 15 (Covered Medical and Other Health Services), Section 230.3 (Practice of Speech-Language Pathology) for documenting the patient's condition and complexities. Note that Medicare contractors may scrutinize claims from providers whose services exceed caps more frequently than is typical. Further guidance on billing therapy services are found in the Local Coverage Determinations of some contractors.
4. Subsection C-3. ICD-9 Codes That are Likely to Qualify for the Automatic Process Therapy Cap Exception Based Upon Clinical Condition or Complexity
   Some Medicare contractors' Local Coverage Determinations do not allow the use of some of the codes on the list in this Subsection to be in the primary diagnosis position on a claim. If your contractor has determined that these codes do not characterize patients who require medically necessary services, you may not use these codes. Rather, to describe the patient's condition, you must use a billable diagnosis code that your contractor allows.

   Medicare will apply therapy caps to services based on the medical necessity of the service for the patient's condition, not on the condition itself. If a service would be payable before the cap is reached and is still medically necessary after the cap is reached, that service is excepted.

   You may use the automatic process for exception for medically necessary services when the patient has a billable condition that is not on the list in this subsection. The diagnosis on this list may be put in a secondary position on the claim and/or in the medical records, as your contractor directs.

Additional Information

You can find more information about the outpatient therapy caps for 2008, and the *Medicare Claims Processing Manual* clarifications regarding exceptions to outpatient therapy services by going to CR 5871, located at **http://www.cms.hhs.gov/Transmittals/downloads/R1414CP.pdf** on the CMS website. The updated *Medicare Claims Processing Manual*, Chapter 5 (Part B Outpatient Rehabilitation and CORF/OPT Services), Section 10.2 (The Financial Limitation) is an attachment to that CR.

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

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

MLN Matters Number: MM5740 - Revised
Related CR Release Date: September 28, 2007
Related CR Transmittal #: R1344CP
Related Change Request (CR) #: 5740
Effective Date: January 1, 2008
Implementation Date: January 7, 2008

Note: *This article was revised on November 7, 2007 to change the title to the chart showing the payment limits. That chart should have read "2008" and not "2007". All other information is unchanged.*

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

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

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

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

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

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

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

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

Dialysis Supplies Billed With AX Modifier

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

Dialysis Supplies Billed Without AX Modifier

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

Dialysis Equipment Billed With AX Modifier

E0210NU	E1632	E1637	E1639

Dialysis Equipment Billed Without AX Modifier

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

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

Additional Information

Detailed instructions for Calculating:

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

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

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

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

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

2008 Payment Limits for Splints and Casts

Code	Payment Limit	Code	Payment Limit
A4565	$7.38	Q4025	$32.45
Q4001	$42.01	Q4026	$101.30
Q4002	$158.81	Q4027	$16.23
Q4003	$30.18	Q4028	$50.66
Q4004	$104.49	Q4029	$24.81
Q4005	$11.12	Q4030	$65.31
Q4006	$25.08	Q4031	$12.41
Q4007	$5.58	Q4032	$32.65
Q4008	$12.54	Q4033	$23.14
Q4009	$7.43	Q4034	$57.56
Q4010	$16.72	Q4035	$11.57
Q4011	$3.71	Q4036	$28.79
Q4012	$8.36	Q4037	$14.12
Q4013	$13.52	Q4038	$35.37
Q4014	$22.81	Q4039	$7.08
Q4015	$6.76	Q4040	$17.68
Q4016	$11.40	Q4041	$17.16
Q4017	$7.82	Q4042	$29.30
Q4018	$12.47	Q4043	$8.59
Q4019	$3.91	Q4044	$14.66
Q4020	$6.24	Q4045	$9.96
Q4021	$5.78	Q4046	$16.03
Q4022	$10.44	Q4047	$4.97
Q4023	$2.91	Q4048	$8.02
Q4024	$5.22	Q4049	$1.82

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

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Reminder - Responding to Automated Development System (ADS) Letters

Claims received by Medicare may sometimes lack information necessary to properly adjudicate the claim. If more information is needed to process a claim Medicare may, in some circumstances, request this information from providers/suppliers or the beneficiary using the Automated Development System (ADS) instead of rejecting or denying the claim. The ADS letter may ask a question(s) or may request the patient's medical records or documentation notes.

If you should receive an ADS letter, you must be sure to submit your ADS Letter responses to:

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

Addressing these responses to the correct P.O. Box ensures the timely processing of your claim. Responses received in this P.O. Box are batched right away and forwarded to the claims area. The claims associated with these responses are then processed accordingly with the information received.

Responses sent to a claim address or any other correspondence P.O. Box number may cause a delay in the processing of your claim.

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)

MLN Matters Number: MM5699
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

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.

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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) (Continued)

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.
   - 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 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-position alpha-numeric element), and the most recent numeric test result (a 3-position numeric element, decimal implied [xx.x]). Results exceeding 3-position 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.
   - 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.

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TMP-EDO-0035 Ver. 1

Update to Medicare Deductible, Coinsurance and Premium Rates for 2008 (MM5830)

MLN Matters Number: MM5830
Related CR Release Date: December 14, 2007
Related CR Transmittal #: R49GI
Related Change Request (CR) #: 5830
Effective Date: January 1, 2008
Implementation Date: January 7, 2008

Provider Types Affected
Providers who bill Medicare contractors (fiscal intermediaries (FI), regional home health intermediaries (RHHI), Medicare Administrative Contractors (A/B MAC), durable medical equipment Medicare Administrative Contractors (DME MAC) and carriers) for care rendered to Medicare beneficiaries.

What You Need to Know
CR5830, from which this article is taken, instructs Medicare contractors to update the claims processing system with new Medicare rates for deductible, coinsurance and premium payment amounts for CY 2008, as published in the Federal Register, CMS-8033-N, on October 2, 2007.

Background
The details of CR5830 follow:

2008 Part A - Hospital Insurance (HI)
Beneficiaries who use covered Part A services may be subject to deductible and coinsurance requirements.

Hospital

- A beneficiary is responsible for an inpatient hospital deductible amount, which is deducted from the amount that the Medicare program pays the hospital for inpatient hospital services it furnishes in an illness episode.
- When a beneficiary receives such services for more than 60 days during an illness encounter, he or she is responsible for a coinsurance amount that is equal to one-fourth of the inpatient hospital deductible per-day for the 61st-90th day spent in the hospital.

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

Skilled Nursing Facility

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

These details are summarized in table 1A, below.

Table 1A

2008 Part A - Hospital Insurance (HI)			
Deductible	$1,024.00		
Coinsurance	**Hospital**		**Skilled Nursing Facility**
	Days 61-90	**Days 91-150 (Lifetime Reserve Days)**	**Days 21-100**
	$256.00	$512.00	$128.00

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

Since 1994, voluntary enrollees may qualify for a reduced Part A premium if they have 30-39 quarters of covered employment. When voluntary enrollment takes place more than 12 months after a person's initial enrollment period, a 2-year 10% penalty is assessed for every year they had the opportunity to (but failed to) enroll in Part A.

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Update to Medicare Deductible, Coinsurance and Premium Rates for 2008 (MM5830) (Continued)

Details of this coverage are summarized in table 1B, below.

Table 1B

Voluntary Enrollees Part A Premium Schedule	
Base Premium (BP)	$423.00 per month
Base Premium with 10% Surcharge	$465.30 per month
Base premium with 45% Reduction	$233.00 per month (for those who have 30-39 quarters of coverage)
Base premium with 45% Reduction and 10% surcharge	$256.30 per month

2008 Part B - Supplementary Medical Insurance (SMI)

Under Part B, the Supplementary Medical Insurance (SMI) program, all enrollees are subject to a monthly premium. In addition, most SMI services are subject to an annual deductible and coinsurance (percent of costs that the enrollee must pay), which are set by statute. Further, when Part B enrollment takes place more than 12 months after a person's initial enrollment period, there is a permanent 10% increase in the premium for each year the beneficiary had the opportunity to (but failed to) enroll.

For 2008, the standard premium for SMI services is $96.40 a month; the deductible is $135.00 a year; and the coinsurance is 20%.

You should be aware that the Part B premium is influenced by the beneficiary's income. This influence is summarized in Table 2.

Table 2

Income Parameters for Determining Part B Premium			
Premium per month	**Individual Income***	**Joint Income (Married)^**	**Married but file Separate#**
$96.40	$82,000.00 or less	$164,000.00 or less	$82,000.00 or less
$122.20	$82,000.01 - $102,000.00	$164,000.01 - $204,000.00	
$160.90	$102,000.01 - $153,000.00	$204,000.01 - $306,000.00	
$199.70	$153,000.01 - $205,000.00	$306,000.01 - $410,000.00	$82,000.01 - $123,000.00
$238.40	$205,000.01 or more	$410,000.01 or more	$123,000.01 or more

***Individual Income** = Beneficiaries who file an individual tax return (including those who are single, head of household, qualifying widow(er) with dependent child, or married filing separately who lived apart from their spouse for the entire taxable year)

^Joint Income = Beneficiaries who are married and lived with their spouse at any time during the taxable year, and also file a joint tax return.

#Married but File Separate = Beneficiaries who are married and lived with their spouse at any time during the taxable year, but file a separate tax return from their spouse

Additional Information

You can find the official instruction, CR 5830, issued to your Medicare contractor by visiting **http://www.cms.hhs.gov/Transmittals/downloads/R49GI.pdf** on the CMS website.

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

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Update to Place of Service (POS) Code Set: New Code for Temporary Lodging (MM5777)

MLN Matters Number: MM5777
Related CR Release Date: November 2, 2007
Related CR Transmittal #: R1366CP
Related Change Request (CR) #: 5777
Effective Date: April 1, 2008
Implementation Date: April 7, 2008

Provider Types Affected
Providers, physicians, and suppliers who submit claims to Medicare carriers, Medicare Administrative Contractors (A/B MAC), or Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for services rendered to Medicare beneficiaries living in temporary lodging settings.

What You Need to Know
CR 5777, from which this article is taken updates the current Centers for Medicare & Medicaid Services (CMS) place of service (POS) code set to add a new code, "16," for temporary lodging and implements the systems and local-contractor-level changes needed for Medicare to adjudicate claims with the new code.

You should make sure that your billing staffs are aware of this new POS code and also aware that (effective for claims initiated as of April 1, 2008) carriers, A/B MACs, and DME MACs will pay for covered services that are payable in the temporary lodging setting (POS code 16) at the non-facility rate.

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the effective date for nonmedical data code sets, of which the POS code set is one, is the code set in effect the date the transaction is initiated. It is not the date of service. Therefore, you may begin using this code, if appropriate, on claims initiated on or after April 1, 2008, regardless of date of service.

Background
Medicare, as a Health Insurance Portability and Accountability Act of 1996 (HIPAA) covered entity, must comply (by regulation) with the statute's standards and their implementation guides. The implementation guide currently adopted for the ASC X12N 837 standard requires that each electronic claim transaction include a Place of Service (POS) code from the CMS POS code set.

One requirement of this standard's implementation guide is that each professional claim contain a valid POS code from the POS code set maintained by CMS. Under HIPAA, as a payer, Medicare complies with this requirement by itself requiring a valid POS code on each 837 professional claim it receives. Similarly, when processing professional claims, Medicare must recognize as valid all valid codes from the POS code set. In addition, although not required by HIPAA, Medicare also requires a valid POS code on professional claims submitted on paper (the CMS 1500 form).

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

Effective for claims initiated on or after April 1, 2008, CMS is adding to the POS code set a new code for temporary lodging, "16," and Medicare is preparing its systems to accept and adjudicate professional claims with this code when it is in effect. Under HIPAA, the effective date for nonmedical data code sets, of which the POS code set is one, is the code set in effect the date the transaction is initiated. It is not date of service.

Additional Information
You can find the official instruction, CR5777, issued to your carrier, A/B MAC, or DME MAC by visiting **http://www.cms.hhs.gov/Transmittals/downloads/R1366CP.pdf** on the CMS website.

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

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Durable Medical Equipment Common Electronic Data Interchange Front End

National Government Services, Inc. has been awarded the Durable Medical Equipment (DME) Common Electronic Data Interchange (CEDI) front end contract by the Centers for Medicare & Medicaid Services (CMS). With this contract, CEDI will provide a single front end solution for the submission and retrieval of electronic transactions.

With this change, DME MAC Trading Partners (Electronic Submitters) will send all electronic claims (X12 837 and NCPDP) and 276 Claim Status Inquiry transactions to CEDI. CEDI will return all electronic front end reports directly to the submitter.

CEDI will also receive the X12N 835 Electronic Remittance Advice (ERA) and 277 Claims Status Response transactions from the DME MACs and deliver them to the Trading Partner's (Electronic Submitters) CEDI mailbox.

CEDI will be working with DME suppliers, clearinghouses, billing services and vendors to minimize any disruption to the current EDI processes. Listed below are some key dates and important information to facilitate the transition to the CEDI system.

Key Dates

February 1, 2008
The CEDI system will be in production for suppliers, billing services, clearinghouses and vendors to begin testing. NOTE: Trading Partners (Electronic Submitters) can move fully into production with CEDI before their final cutover date.

March 31, 2008
Jurisdiction A and Jurisdiction D will no longer process new requests for submitter IDs or changes to an existing ID. All new setups and changes will be done by the CEDI Enrollment Team. Details on how to get setup with the CEDI Enrollment Team will be available soon.

April 30, 2008
Jurisdiction B and Jurisdiction C will no longer process new requests for submitter IDs or changes to an existing ID. All new setups and changes will be done by the CEDI Enrollment Team. Details on how to get setup with the CEDI Enrollment Team will be available soon.

April 30, 2008
Last day for Jurisdiction A and Jurisdiction D to process EDI transactions.

May 1, 2008
All Jurisdiction A and Jurisdiction D EDI transactions will be processed by CEDI.

May 31, 2008
Last day for Jurisdiction B and Jurisdiction C to process EDI transactions.

June 1, 2008
All Jurisdiction B and Jurisdiction C EDI transactions will be processed by CEDI.

There will be a Web site dedicated to CEDI as a resource for all CEDI documentation and communication. Each DME MAC will offer a link to the CEDI Web site. In addition to the CEDI Web site, CEDI outreach materials will be distributed through each of the DME MAC Jurisdictions.

The CEDI Help Desk will provide support for Trading Partners (Electronic Submitters), vendors, clearinghouses, and billing services to resolve issues and answer questions about connectivity, receipt of files, and electronic formats. The CEDI Help Desk number will be 866-311-9184 and will be operational beginning February 1, 2008 from 9:00 AM - 9:00 PM (ET). National Government Services CEDI is putting the final touches on the CEDI email address and Web site and we will notify you of these shortly.

More detailed and additional information will be provided regarding the transition to the CEDI system throughout the implementation period.

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For ADMC Requests be sure to use the ADMC Request cover sheet at
http://www.medicarenhic.com/dme/dme_forms.shtml

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Medicare Remit Easy Print (MREP) - Version 2.3 is Now Available for Download (CMS Message 2007-10-17)

You can access the latest version of MREP at
http://www.cms.hhs.gov/AccesstoDataApplication/02_MedicareRemitEasyPrint.asp on the CMS website.

What's New

Corrected Issues

- A change was made so that the third line of header information (Check/EFT #, Date, page #, and the word 'Notice') displays on all subsequent pages of a multiple page MREP Remittance Advice.
- A change was made to display the appropriate sub-heading when generating a print preview or printing from the Claims List tab. When you perform a print preview or print from the Claims List tab, the subheading contains "Claim List" inside the square brackets.

Informational

- Since changes are being made to the MREP software, the updated Claim Adjustment Reason Codes / Remittance Advice Remarks Codes file is included with version 2.3 of the MREP software. However, the separate Codes.ini file is provided when the MREP software is distributed.

VMS Modifications to Implement the Common Electronic Data Interchange (CEDI) System (MM5755)

MLN Matters Number: MM5755
Related CR Release Date: December 21, 2007
Related CR Transmittal #: R1402CP
Related Change Request (CR) #: 5755
Effective Date: April 1, 2008
Implementation Date: April 7, 2008

Provider Types Affected

Suppliers submitting claims to Medicare contractors (DME Medicare Administrative Contractors (DME MACs)) for services provided to Medicare beneficiaries.

Provider Action Needed

Change Request (CR) 5755 prescribes the requirements for the system changes necessary to prepare for the implementation of the DME MAC CEDI front end. CR5755 does not affect Fiscal intermediaries (FIs), carriers, Regional Home Health Intermediaries (RHHIs), the Fiscal Intermediary Standard System (FISS), or the Multi-Carrier System (MCS). **This article is informational only for suppliers and suppliers need not make any changes to their claim submission processes.**

Background

Currently, front- end electronic data interchange (EDI) processing for Durable Medical Equipment (DME) claims occurs in 4 separate systems. Two of these systems are operated by DME Medicare Administrative Contractor (MACs), and two are operated by data center services contractors under direct contract with the Centers for Medicare & Medicaid Services (CMS).

The front-end EDI systems perform edits on incoming Medicare DME claims, and then it forwards the output data (from transactions that pass edits) to the core of the ViPS Medicare Shared System (VMS) claims processing environment. ViPS maintains the claim processing system used by your Durable Medical Equipment Medicare Administrative Contractor (DME MAC).

Each of the 4 systems used for DME front end transaction processing has been developed as a proprietary system, and logic specific to Medicare requirements was added to accommodate the Medicare claims transactions. Since each system is owned and developed by separate entities, variations exist in how individual front end systems process claims and in the results they produce. This can creates confusion for suppliers and beneficiaries.

Therefore, CMS requested a system analysis from ViPS regarding the system changes that would be required in order to remove or disable certain functionality of the current EDI front end systems. Removing or disabling certain functionality of the EDI front end systems would be in preparation for the implementation of the Common Electronic Data Interchange (CEDI) System, a common EDI front end at the DME MACs.

As a result of that analysis, CR5755 provides the requirements for the system changes necessary to prepare for the implementation of the DME MAC CEDI front end.

Note: *CR5755 does not affect claims submitted to Medicare Fiscal intermediaries (FIs), carriers, Regional Home Health Intermediaries (RHHIs), or Part A/B MACs.*

Additional Information

The official instruction, CR5755, issued to your DME MAC regarding this change may be viewed at
http://www.cms.hhs.gov/Transmittals/downloads/R1402CP.pdf on the CMS web site.

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

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2007 - 2008 Influenza (Flu) Season Resources for Health Care Professionals (SE0748)

MLN Matters Number: SE0748
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 fee-for-service (FFS) physicians, non-physician practitioners, providers, suppliers, and other health care professionals who bill Medicare for flu vaccines and vaccine administration provided to Medicare beneficiaries.

Provider Action Needed
- Keep this Special Edition *MLN Matters* article and refer to it throughout the 2007 - 2008 flu season.
- Talk with your patients about their risk of contracting the flu virus and complications arising from the virus and encourage them to get the flu shot. (Medicare provides coverage of the flu vaccine and its administration without any out-of-pocket costs to the Medicare beneficiaries, (i.e., no deductible or copayment/coinsurance.)
- Stay abreast of the latest flu information and inform your patients.
  - Order appropriate provider resources for yourself and your staff.
  - Have appropriate literature on hand about seasonal flu that can be handed out to your patients during the flu season.
- Don't forget to immunize yourself and your staff - **Get the Flu Shot - Not the Flu!**

Introduction
Historically the flu vaccine has been an under-utilized benefit by Medicare beneficiaries. Yet, of the nearly 36,000 people who, on average, die every year in the United States from seasonal flu and complications arising from the flu, the majority of deaths occur in persons 65 years of age and older. People with chronic medical conditions such as diabetes and heart disease are considered to be at high risk for serious complications from the flu, as are people in nursing homes and other long-term care facilities. Complications of flu can include bacterial pneumonia, ear infections, sinus infections, dehydration, and worsening of chronic medical conditions, such as congestive heart failure, asthma, or diabetes.

Prevention is Key to Public Health!
- While flu season can begin as early as October and last as late as May the optimal time to get a flu vaccine is in October or November. However, protection can still be obtained if the flu vaccine is given in December or later. The flu vaccine continues to be the most effective method for preventing flu virus infection and its potentially severe complications. You can help your Medicare patients reduce their risk for contracting seasonal flu and serious complications by recommending that they take advantage of the annual flu shot covered by Medicare.
- Medicare Part B reimburses health care professionals who accept the Medicare-approved payment amount for the flu vaccine and its administration. There is no beneficiary coinsurance or copayment and beneficiaries do not have to meet their deductible to receive the flu shot.
- Health care providers and their staff are also at risk for contracting the flu, so do not forget to immunize yourself and your staff. Protect yourself, your patients, your staff, and your family and friends. **Get Your Flu Shot - Not the Flu!**

Helping You Stay Informed
- CMS has developed a variety of educational resources to help promote increased awareness and utilization of the flu vaccine among beneficiaries, providers, and their staff and to ensure that Medicare FFS health care professionals have the information they need to bill Medicare correctly for the flu vaccines and their administration.

The following educational products have been developed by CMS to be used by Medicare FFS health care professionals and are not intended for distribution to Medicare beneficiaries.

Products
1. ***MLN Matters Articles***
   - **MM5744:** Payment Allowances for the Influenza Virus Vaccine and the Pneumococcal Vaccine When Payment is Based on 95 Percent of the Average Wholesale Price (AWP) located at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5744.pdf** on the CMS website.
   - **MM5511:** Update to *Medicare Claims Processing Manual* (Publication 100-04), Chapter 18, Section 10 For Part B Influenza Billing located at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5511.pdf** on the CMS website.
   - **MM4240:** Guidelines for Payment of Vaccine (Pneumococcal Pneumonia Virus, Influenza Virus, and Hepatitis B Virus) Administration located at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4240.pdf** on the CMS website.
   - **MM5037:** Reporting of Diagnosis Code V06.6 on Influenza Virus and/or Pneumococcal Pneumonia Virus (PPV) Vaccine Claims and Acceptance of Current Procedural Terminology (CPT) Code 90660 for the Reporting of the Influenza Virus Vaccine located at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5037.pdf** on the CMS website.

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2007 - 2008 Influenza (Flu) Season Resources for Health Care Professionals (SE0748) (Continued)

2. *MLN* Influenza Related Products for Health Care Professionals

- **Quick Reference Information: Medicare Immunization Billing -** This two-sided laminated chart provides Medicare FFS physicians, providers, suppliers, and other health care professionals with quick information to assist with filing claims for the influenza, pneumococcal, and hepatitis B vaccines and their administration. Available in print and as a downloadable PDF file at **http://www.cms.hhs.gov/MLNProducts/downloads/qr_immun_bill.pdf** on the CMS website.
- **The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals, Second Edition** - This updated comprehensive guide to Medicare-covered preventive services and screenings provides Medicare FFS physicians, providers, suppliers, and other health care professionals information on coverage, coding, billing, and reimbursement guidelines of preventive services and screenings covered by Medicare. The guide includes a chapter on influenza, pneumococcal, and hepatitis B vaccines and their administration. Also includes suggestions for planning a flu clinic and information for mass immunizers and roster billers. Available as a downloadable PDF file. Updated August 2007 at **http://www.cms.hhs.gov/MLNProducts/downloads/mps_guide_web-061305.pdf** on the CMS website.
- **Medicare Preventive Services Adult Immunizations Brochure** - This two-sided tri-fold brochure provides health care professionals with an overview of Medicare's coverage of influenza, pneumococcal, and hepatitis B vaccines and their administration. Updated August 2007. Available in print and as a downloadable PDF file at **http://www.cms.hhs.gov/MLNProducts/downloads/Adult_Immunization.pdf** on the CMS website.
- **Medicare Preventive Services Series: Part 1 Adult Immunizations Web-based Training (WBT) Course** - This WBT course contains four modules that include information about Medicare's coverage of influenza, pneumococcal, and hepatitis B vaccines. Module Four includes lessons on mass immunizers, roster billing, and centralized billing. This course was updated September 2007 and has been approved for .1 IACET* CEU for successful completion. This course can be accessed through the *MLN* Product Ordering web page located at **http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5** on the CMS website.
- **An Overview of Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals video program** - This educational video program provides health care professionals with an overview of Medicare-covered preventive services. The program includes a segment on Medicare's coverage of influenza, pneumococcal, and hepatitis B vaccines. Included in the segment are strategies that providers may use to increase the use of these vaccines in their practices and tips for setting up a flu clinic. This educational video has been approved for .1 IACET* CEU for successful completion. This video program can be ordered through the *MLN* Product Ordering web page located at **http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5** on the CMS website.
- **Quick Reference Information: Medicare Preventive Services** - This two-sided laminated chart gives Medicare FFS physicians, providers, suppliers, and other health care professionals a quick reference to Medicare's preventive services and screenings, identifying coding requirements, eligibility, frequency parameters, and copayment/coinsurance and deductible information for each benefit. This chart includes influenza, pneumococcal, and hepatitis B. Available in print or as a downloadable PDF file at **http://www.cms.hhs.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf** on the CMS website.
- **Medicare Preventive Services Bookmark** - This bookmark lists the preventive services and screenings covered by Medicare (including influenza) and serves as a handy reminder to health care professionals about the many preventive benefits covered by Medicare. Appropriate for use as a give away at conferences and other provider related gatherings. Available in print or as a downloadable PDF file at **http://www.cms.hhs.gov/MLNProducts/downloads/medprevsrvcesbkmrk.pdf** on the CMS website.

***MLN* Preventive Services Educational Products Web Page -** This *Medicare Learning Network (MLN)* web page provides descriptions of all *MLN* preventive services related educational products and resources designed specifically for use by Medicare FFS providers. PDF files provide product ordering information and links to all downloadable products, including those related to the influenza vaccine and its administration. This web page is updated as new product information becomes available. Bookmark this page **(http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp#TopOfPage)** for easy access.

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2007 - 2008 Influenza (Flu) Season Resources for Health Care Professionals (SE0748) (Continued)

3. Other CMS Resources

- **CMS Adult Immunizations Web Page** located at **http://www.cms.hhs.gov/AdultImmunizations/** on the CMS website.
- **CMS Frequently Asked Questions** located at **http://questions.cms.hhs.gov/cgi-bin/cmshhs.cfg/php/enduser/std_alp.php?p_sid=I3ALEDhi** on the CMS website.
- ***Medicare Benefit Policy Manual* - Chapter 15, Section 50.4.4.2 - Immunizations** located at **http://www.cms.hhs.gov/manuals/downloads/bp102c15.pdf** on the CMS website.
- ***Medicare Claims Processing Manual* - Chapter 18, Preventive and Screening Services** located at **http://www.cms.hhs.gov/manuals/downloads/clm104c18.pdf** on the CMS website.

4. Other Resources

The following non-CMS resources are just a few of the many available in which clinicians may find useful information and tools to help increase flu vaccine awareness and utilization during the 2007 - 2008 flu season:

- **Advisory Committee on Immunization Practices** located at **http://www.cdc.gov/vaccines/recs/acip/default.htm** on the Internet.
- **American Lung Association's Influenza (Flu) Center** located at **http://www.lungusa.org** on the Internet. - This site provides a flu clinic locator at **http://www.flucliniclocator.org** on the Internet. Individuals can enter their zip code to find a flu clinic in their area. Providers can also obtain information on how to add their flu clinic to this site.
- **Centers for Disease Control and Prevention - http://www.cdc.gov/flu**
- **Immunization Action Coalition - http://www.immunize.org**
- **Immunization: Promoting Prevention for a Healthier Life - http://www.nfid.org/pdf/publications/naiaw06.pdf**
- **Medicare Quality Improvement Community - http://www.medqic.org**
- **National Alliance for Hispanic Health - http://www.hispanichealth.org/**
- **The National Center for Immunization and Respiratory Diseases (NCIRD)** (established spring 2007) replaces the name National Immunization Program (NIP) - **http://www.cdc.gov/vaccines/about/**
- **National Foundation For Infectious Diseases - http://www.nfid.org/influenza**
- **National Network for Immunization Information - http:/www.immunizationinfo.org**
- **National Vaccine Program - http://www.hhs.gov/nvpo**
- **Office of Disease Prevention and Promotion - http://odphp.osophs.dhhs.gov**
- **Partnership for Prevention - http://www.prevent.org**
- **World Health Organization - http://www.who.int/csr/disease/influenza/en/**

Additional Information

For information to share with your Medicare patients, please visit, **http://www.medicare.gov** on the Web.

Note: *The Centers for Medicare & Medicaid Services (CMS) has been reviewed and approved as an Authorized provider by the International Association for Continuing Education and Training (IACET), 8405 Greensboro Drive, Suite 800, McLean, VA 22102. The authors of the video program and web-based training course have no conflicts of interest to disclose. The video program and web-based training course were developed without any commercial support.*

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

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An Overview of Medicare Covered Diabetes Supplies and Services (SE0738)

MLN Matters Number: SE0738 - Revised
Related CR Release Date: N/A
Related CR Transmittal #: N/A
Related Change Request (CR) #: N/A
Effective Date: N/A
Implementation Date: N/A

Note: *This article was revised on December 12, 2007, to remove a bullet point on page 3 which indicated an initial prescription needed to specify how many lancets and test strips were needed for a month and to remove a second bullet from the same page that stated a new prescription is needed every 12 months for lancets and test strips. Both of these requirements were eliminated from local policy.*

Provider Types Affected
Physicians, providers, suppliers, and other health care professionals who furnish or provide referrals for and/or file claims to Medicare contractors (carriers, DME Medicare Administrative Contractors (DME MACs), Fiscal Intermediaries (FIs), and/or Part A/B Medicare Administrative Contractors (A/B MACs)) for Medicare-covered diabetes benefits.

Provider Action Needed
This article is informational only and represents no Medicare policy changes.

Background
Diabetes is the sixth leading cause of death in the United States, and approximately 20 million Americans have diabetes with an estimated 20.9 percent of the senior population age 60 and older being affected. Millions of people have diabetes and do not know it. Left undiagnosed, diabetes can lead to severe complications such as heart disease, stroke, blindness, kidney failure, leg and foot amputations, and death related to pneumonia and flu. Scientific evidence now shows that early detection and treatment of diabetes with diet, physical activity, and new medicines can prevent or delay much of the illness and complications associated with diabetes.

This special edition article presents an overview of the diabetes services and supplies covered by Medicare (Part B and Part D) to assist physicians, providers, suppliers, and other health care professionals who provide diabetic supplies and services to Medicare beneficiaries.

Medicare Part B Covered Diabetic Supplies
Medicare covers certain supplies if a beneficiary has Medicare Part B and has diabetes. These supplies include:
- Blood glucose self-testing equipment and supplies;
- Therapeutic shoes and inserts; and
- Insulin pumps and the insulin used in the pumps

Blood Glucose Self-testing Equipment and Supplies
Blood glucose self-testing equipment and supplies are covered for all people with Medicare Part B who have diabetes. This includes those who use insulin and those who do not use insulin. These supplies include:
- Blood glucose monitors;
- Blood glucose test strips;
- Lancet devices and lancets; and
- Glucose control solutions for checking the accuracy of testing equipment and test strips.

Medicare Part B covers the same type of blood glucose testing supplies for people with diabetes whether or not they use insulin. However, the amount of supplies that are covered varies.

If the beneficiary
- **Uses insulin,** they may be able to get up to 100 test strips and lancets every month, and 1 lancet device every 6 months.
- **Does not use insulin,** they may be able to get 100 test strips and lancets every 3 months, and 1 lancet device every 6 months.

If a beneficiary's doctor documents why it is medically necessary, Medicare will cover additional test strips and lancets for the beneficiary.

Medicare will only cover a beneficiary's blood glucose self-testing equipment and supplies if they get a prescription from their doctor.

Their prescription should include the following information:
- That they have diabetes;
- What kind of blood glucose monitor they need and why they need it (i.e., if they need a special monitor because of vision problems, their doctor must explain that.);
- Whether they use insulin; and
- How often they should test their blood glucose.

A beneficiary needing blood glucose testing equipment and/or supplies:
- Can order and pick up their supplies at their pharmacy;
- Can order their supplies from a medical equipment supplier, but they will need a prescription from their doctor to place their order; and
- Must ask for refills for their supplies.

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An Overview of Medicare Covered Diabetes Supplies and Services (SE0738) (Continued)

Note: *Medicare will not pay for any supplies not asked for, or for any supplies that were sent to a beneficiary automatically from suppliers. This includes blood glucose monitors, test strips, and lancets. Also, if a beneficiary goes to a pharmacy or supplier that is not enrolled in Medicare, Medicare will not pay. The beneficiary will have to pay the entire bill for any supplies from non-enrolled pharmacies or non-enrolled suppliers.*

All Medicare-enrolled pharmacies and suppliers must submit claims for blood glucose monitor test strips. A beneficiary cannot submit a claim for blood glucose monitor test strips themselves. The beneficiary should make sure that the pharmacy or supplier accepts assignment for Medicare-covered supplies. If the pharmacy or supplier accepts assignment, Medicare will pay the pharmacy or supplier directly. Beneficiaries should only pay their coinsurance amount when they get their supply from their pharmacy or supplier for assigned claims. If a beneficiary's pharmacy or supplier **does not** accept assignment, charges may be higher, and the beneficiary may pay more. They may also have to pay the entire charge at the time of service and wait for Medicare to send them its share of the cost.

Before a beneficiary gets a supply, it is important for them to ask the supplier or pharmacy the following questions:

- Are you enrolled in Medicare?
- Do you accept assignment?

If the answer to either of these two (2) questions is "no," they should call another supplier or pharmacy in their area who answers "yes" to be sure their purchase is covered by Medicare, and to save them money.

If a beneficiary can not find a supplier or pharmacy in their area that is enrolled in Medicare and accepts assignment, they may want to order their supplies through the mail, which may also save them money.

Therapeutic Shoes and Inserts

If a beneficiary has Medicare Part B, has diabetes, and meets certain conditions (see below), Medicare will cover therapeutic shoes if they need them. The types of shoes that are covered each year include one of the following:

- One pair of depth-inlay shoes **and** three pairs of inserts; or
- One pair of custom-molded shoes (including inserts) if the beneficiary cannot wear depth-inlay shoes because of a foot deformity **and** two additional pairs of inserts.

Note: *In certain cases, Medicare may also cover shoe modifications instead of inserts.*

In order for Medicare to pay for the beneficiary's therapeutic shoes, the doctor treating their diabetes must certify that they meet **all** of the following three conditions:

- They have diabetes;
- They have at least 1 of the following conditions in one or both feet:
  - Partial or complete foot amputation;
  - Past foot ulcers;
  - Calluses that could lead to foot ulcers;
  - Nerve damage because of diabetes with signs of problems with calluses;
  - Poor circulation; or
  - Deformed foot;
- They are being treated under a comprehensive diabetes care plan and need therapeutic shoes and/or inserts because of diabetes.

Medicare also requires the following:

- A podiatrist or other qualified doctor must prescribe the shoes, and
- A doctor or other qualified individual like a pedorthist, orthotist, or prosthetist must fit and provide the shoes to the beneficiary.

Medicare helps pay for one pair of therapeutic shoes and inserts per calendar year, and the fitting of the shoes or inserts is covered in the Medicare payment for the shoes.

Insulin Pumps and the Insulin Used in the Pumps

Insulin pumps worn outside the body (external), including the insulin used with the pump, may be covered for some people with Medicare Part B who have diabetes and who meet certain conditions. If a beneficiary needs to use an insulin pump, their doctor will need to prescribe it. In the Original Medicare Plan, the beneficiary pays 20% of the Medicare-approved amount after the yearly Part B deductible. Medicare will pay 80% of the cost of the insulin pump. Medicare will also pay for the insulin that is used with the insulin pump.

Medicare Part B covers the cost of insulin pumps and the insulin used in the pumps. However, if the beneficiary injects their insulin with a needle (syringe), Medicare Part B does not cover the cost of the insulin, but the Medicare prescription drug benefit (Part D) covers the insulin and the supplies necessary to inject it. This includes syringes, needles, alcohol swabs and gauze. The Medicare Part D plan will cover the insulin and any other medications to treat diabetes at home as long as the beneficiary is on the Medicare Part D plan's formulary.

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An Overview of Medicare Covered Diabetes Supplies and Services (SE0738) (Continued)

Coverage for diabetes-related durable medical equipment (DME) is provided as a Medicare Part B benefit. The Medicare Part B deductible and coinsurance or copayment applies after the yearly Medicare part B deductible has been met. In the Original Medicare Plan, Medicare covers 80% of the Medicare-approved amount (after the beneficiary meets their annual Medicare Part B deductible of $131 in 2007), and the beneficiary pays 20% of the total payment amount (after the annual Part B deductible of $131 in 2007). This amount can be higher if the beneficiary's doctor does not accept assignment, and the beneficiary may have to pay the entire amount at the time of service. Medicare will then send the beneficiary its share of the charge.

Medicare Part D Covered Diabetic Supplies and Medications

This section provides information about Medicare prescription drug coverage (Part D) for beneficiaries with Medicare who have or are at risk for diabetes. If a beneficiary wants Medicare prescription drug coverage, they must join a Medicare drug plan. The following diabetic medications and supplies are covered under Medicare drug plans:

- Diabetes supplies;
- Insulin; and
- Anti-diabetic drugs.

Diabetes Supplies

Diabetes supplies associated with the administration of insulin may be covered for all people with Medicare Part D who have diabetes. These medical supplies include the following:

- Syringes;
- Needles;
- Alcohol swabs;
- Gauze; and
- Inhaled insulin devices.

Insulin

Injectable insulin **not** associated with the use of an insulin infusion pump is covered under Medicare Part D drug plans.

Anti-diabetic Drugs

Medicare drug plans can cover anti-diabetic drugs such as:

- Sulfonylureas (i.e. Glipizide, Glyburide);
- Biguanides (i.e. metformin);
- Thiazolidinediones (i.e. Starlix® and Prandin®); and
- Alpha glucosidase inhibitors (i.e. Precose®).

Medicare Part B Covered Diabetic Services

All of the diabetes services listed in this section are covered by Medicare Part B unless otherwise noted. For people with diabetes, Medicare covers certain services. A doctor must write an order or referral for the beneficiary to get these services. These services include the following:

- Diabetes screenings;
- Diabetes self-management training;
- Medical nutrition therapy services;
- Hemoglobin A1c tests; and
- Special eye exams.

Diabetes Screenings

Medicare pays for a beneficiary to get diabetes screening tests if they are at risk for diabetes. These tests are used to detect diabetes early, and some, but not all, of the conditions that may qualify a beneficiary as being at risk for diabetes include:

- High blood pressure;
- Dyslipidemia (history of abnormal cholesterol and triglyceride levels);
- Obesity (with certain conditions);
- Impaired blood glucose tolerance; and
- High fasting blood glucose.

Diabetes screening tests are also covered if a beneficiary answers "yes" to two or more of the following questions:

- Are you age 65 or older?
- Are you overweight?
- Do you have a family history of diabetes (parents, siblings)?
- Do you have a history of gestational diabetes (diabetes during pregnancy),or
- Did you deliver a baby weighing more than 9 pounds?

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An Overview of Medicare Covered Diabetes Supplies and Services (SE0738) (Continued)

Based on the results of these tests, a beneficiary may be eligible for up to 2 diabetes screenings every year at no cost (no coinsurance, or copayment or Part B deductible). Medicare will pay for a beneficiary to get 2 diabetes screening tests in a 12-month period, but not less than 6 months apart. After the initial diabetes screening test, the beneficiary's doctor will determine when to do the second test. Diabetes screening tests that are covered include the following:

- Fasting blood glucose tests; and
- Other tests approved by Medicare as appropriate.

Diabetes Self-management Training (DSMT)

Diabetes self-management training helps a beneficiary learn how to successfully manage their diabetes. Their doctor or qualified non-physician practitioner must prescribe this training for them for Medicare to cover it. A beneficiary can get diabetes self-management training if they met one (1) of the following conditions during the last twelve (12) months:

- They were diagnosed with diabetes;
- They changed from taking no diabetes medication to taking diabetes medication, or from oral diabetes medication to insulin;
- They have diabetes and have recently become eligible for Medicare;
- They are at risk for complications from diabetes. A doctor may consider the beneficiary at increased risk if they have any of the following:
  - They had problems controlling their blood glucose, have been treated in an emergency room or have stayed overnight in a hospital because of their diabetes,
  - They have been diagnosed with eye disease related to diabetes,
  - They had a lack of feeling in their feet or some other foot problems like ulcers, deformities, or have had an amputation, or
  - Been diagnosed with kidney disease related to diabetes.

A beneficiary must get this training from an accredited diabetes self-management education program as part of a plan of care prepared by their doctor or qualified non-physician practitioner. These programs are accredited by the American Diabetes Association or the Indian Health Service. Classes are taught by health care providers who have special training in diabetes education.

A beneficiary is covered by Medicare to get a total of 10 hours of initial training within a continuous 12-month period. One of the hours can be given on a one-on-one basis. The other 9 hours must be training in a group class. The initial training must be completed no more than 12 months from the time the beneficiary starts the training.

A doctor or qualified non-physician practitioner may prescribe 10 hours of individual training if the beneficiary is blind or deaf, has language limitations, or no group classes have been available within 2 months of the doctor's order. To be eligible for 2 more hours of follow-up training each year after the year the beneficiary received initial training, they must get another written order from their doctor. The 2 hours of follow-up training can be with a group or they may have one-on-one sessions. A doctor or qualified non-physician practitioner must prescribe the follow-up training each year for Medicare to cover it.

Beneficiaries learn how to successfully manage their diabetes in DSMT classes, and the training includes information on self-care and making lifestyle changes. The first session consists of an individual assessment to help the instructors better understand the beneficiary's needs. Classroom training includes topics such as the following:

- General information about diabetes, and the benefits and risks of blood glucose control;
- Nutrition and how to manage ones diet;
- Options to manage and improve blood glucose control;
- Exercise and why it is important to ones health;
- How to take ones medications properly;
- Blood glucose testing and how to use the information to improve ones diabetes control;
- How to prevent, recognize, and treat acute and chronic complications from ones diabetes;
- Foot, skin, and dental care;
- How diet, exercise, and medication affect blood glucose;
- How to adjust emotionally to having diabetes;
- Family involvement and support; and
- The use of the health care system and community resources.

Note: *If a patient lives in a rural area, they may be able to get DSMT in a Federally Qualified Health Center (FQHC). For more information about FQHCs, visit* **http://www.cms.hhs.gov/center/fqhc.asp** *on the CMS website. FQHCs are special health centers, usually located in urban or rural areas, and they can give routine health care at a lower cost. Some FQHCs are Community Health Centers, Tribal FQHC Clinics, Certified Rural Health Clinics, Migrant Health Centers, and Health Care for the Homeless Programs.*

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An Overview of Medicare Covered Diabetes Supplies and Services (SE0738) (Continued)

Medical Nutrition Therapy (MNT) Services
In addition to DSMT, medical nutrition therapy services are also covered for beneficiaries with diabetes or renal disease. To be eligible for this service, a beneficiary's fasting blood glucose has to meet certain criteria. Also, their doctor must prescribe these services for them. These services can be given by a registered dietitian or certain nutrition professionals. MNT services covered by Medicare include the following:

- An initial nutrition and lifestyle assessment;
- Nutrition counseling (what foods to eat and how to follow an individualized diabetic meal plan);
- How to manage lifestyle factors that affect diabetics; and
- Follow-up visits to check on progress in managing diet.

Medicare covers 3 hours of one-on-one medical nutrition therapy services the first year the service is provided, and 2 hours each year after that. Additional MNT hours of service may be obtained if the beneficiary's doctor determines there is a change in their diagnosis, medical condition, or treatment regimen related to diabetes or renal disease and orders additional MNT hours during that episode of care.

Foot Exams and Treatment
If a beneficiary has diabetes-related nerve damage in either of their feet, Medicare will cover 1 foot exam every 6 months by a podiatrist or other foot care specialist, unless they have seen a foot care specialist for some other foot problem during the past 6 months. Medicare may cover more frequent visits to a foot care specialist if a beneficiary has had a non-traumatic (not because of an injury) amputation of all or part of their foot or their feet have changed in appearance which may indicate they have serious foot disease.

Hemoglobin A1c Tests
A hemoglobin A1c test is a lab test ordered by the beneficiary's doctor. It measures how well a beneficiary's blood glucose has been controlled over the past 3 months. Anyone with diabetes is covered for this test if it is ordered by their doctor. Medicare may cover this test when a beneficiary's doctor orders it.

Glaucoma Tests
Medicare will pay for a beneficiary to have their eyes checked for glaucoma once every 12 months. This test must be done or supervised by an eye doctor who is legally allowed to give this service in their state.

Special Eye Exam
People with Medicare who have diabetes can get special eye exams to check for eye disease (called a dilated eye exam). These exams must be done by an eye doctor who is legally allowed to provide this service in their state. The dilated eye exam is recommended once a year and must be performed by an eye doctor who is legally allowed to provide this service in the beneficiary's state.

Supplies and Services Not Covered by Medicare
The Original Medicare Plan and Medicare drug plans (Part D) don't cover everything. Diabetes supplies and services not covered by Medicare include:

- Eye exams for glasses (eye refraction);
- Orthopedic shoes;
- Routine or yearly physical exams (Medicare will cover a one-time initial preventive physical exam (the "Welcome to Medicare" physical exam) within the first 6 months of the beneficiary enrolling in Part B-coinsurance and Part B deductible applies.); and
- Weight loss programs.

Additional Information

- The Centers for Medicare & Medicaid Services (CMS) has developed a variety of educational resources for use by health care professionals and their staff as part of a broad outreach campaign to promote awareness and increase utilization of preventive services covered by Medicare. For more information about coverage, coding, billing, and reimbursement of Medicare-covered preventive services and screenings, visit **http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp#TopOfPage** on the CMS website.
- ***Medicare Learning Network*** - The *Medicare Learning Network (MLN)* is the brand name for official CMS educational products and information for Medicare fee-for-service providers. For additional information visit the Medicare Learning Network's web page at **http://www.cms.hhs.gov/MLNGenInfo** on the CMS website.
- **Patient Resources** - For literature to share with Medicare patients, please visit **http://www.medicare.gov** on the Internet.
- **The National Diabetes Education Program -** NDEP (**http://ndep.nih.gov/**) provides a wealth of resources for health care professionals, educators, business professionals, and patients about diabetes, its complications, and self-management.

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

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Application of Administrative Simplification Compliance Act (ASCA) Enforcement Review Decisions Made by Other Medicare Contractors to the Same Providers When Selected for ASCA Review by the Railroad Medicare Carrier, Elimination of References to Claim Status and COB Medicare HIPAA Contingency Plans and Changes to Reflect Transfer of Responsibility for Medigap Claims to the COBC Contractor (MM5606)

MLN Matters Number: MM5606
Related CR Release Date: October 15, 2007
Related CR Transmittal #: R1583CP

Related Change Request (CR) #: 5606
Effective Date: January 1, 2008
Implementation Date: January 7, 2008

Provider Types Affected

Physicians, providers, and suppliers submitting claims to the Railroad Medicare carrier, and other Medicare carriers, Part A/B Medicare Administrative Contractors (A/B MACs), and/or DME Medicare Administrative Contractors (DME MACs) for services provided to both Railroad and non-Railroad Medicare beneficiaries.

Provider Action Needed

Impact to You

This article is based on Change Request (CR) 5606, which implements a process to enable the application of the Administrative Simplification Compliance Act (ASCA) enforcement review decisions made by non-Railroad (non-RR) Medicare Contractors to the same providers when they bill the Railroad (RR) Medicare Carrier (RMC).

What You Need to Know

Due to distribution of RR retirees, many providers submit fewer than 10 claims a month to the RR Medicare Carrier (RMC), and these providers have been allowed to continue to submit paper claims to the RMC. The same providers may also treat non-RR Medicare beneficiaries and submit more than 10 claims a month to other Medicare contractors. ASCA electronic claim filing exceptions apply to Medicare overall, and do not differentiate based on contractors or between RR and non-RR contractors. By adding ASCA enforcement review decision information to the file sent from non-RR Medicare contractors to the RMC to share provider data, the RMC can apply decisions that providers are ineligible to submit paper claims to those same providers when they bill the RMC.

What You Need to Do

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

Background

The Administrative Simplification Compliance Act (ASCA) requires that providers submit claims to Medicare electronically to be considered for payment, with a limited number of exceptions including an exception that allows providers that submit fewer than 120 claims per year (no more than 10 claims per month or 30 claims per quarter) to Medicare to continue to submit paper claims. See the *Medicare Claims Processing Manual*, Chapter 24, Sections 90-90.6 at **http://www.cms.hhs.gov/manuals/downloads/clm104c24.pdf.**

Due to the dispersion of railroad (RR) retirees in the United States, however, few physicians/practitioners/suppliers treat a large number of RR Medicare beneficiaries. As result, many of these providers submit fewer than 10 claims a month to the RR Medicare Carrier (RMC), and they have been allowed to continue to submit paper claims to the RMC. In addition, the same providers generally treat non-RR Medicare beneficiaries and submit more than 10 claims a month to other Medicare contractors.

However, ASCA electronic claim filing exceptions apply to Medicare overall, and do not differentiate based on contractors or between RR and non-RR contractors. Providers that submit paper claims to multiple Medicare contractors, including both RR and non-RR Medicare contractors, are subject to ASCA Enforcement Review by each of those contractors.

If a non-RR Medicare contractor 1) determines that a provider does not meet criteria which would permit that provider to continue to submit Medicare claims on paper and 2) notifies the provider that all paper claims submitted on or after a specific date will be denied, then that same decision is to be applied to that provider if submitting paper claims to the RMC even if that provider would not normally submit 10 or more paper claims to the RMC monthly.

If a provider reports that another Medicare contractor has reversed a decision that the provider is ineligible to submit paper claims, the RMC will ask that provider to submit a copy of the reversal letter from that contractor and to hold all new paper claims until such time as the RMC reviews the reversal letter and can advise the provider by letter that they can submit the paper claims.

Effective with the implementation date of CR5606, the Medicare Claims System (MCS) maintainer that prepares the provider files for transfer to the RMC will add ASCA Enforcement Review information when that information is in the non-RR provider files used to prepare the report for the RMC. Once added to the file, information concerning ASCA Enforcement decisions made by the non-RR Medicare contractors (such as providers are ineligible to submit paper claims) will be accessible to the RMC so the same decisions can be applied to the same providers when they bill the RMC.

CR5606 also updates the *Medicare Claims Processing Manual* to eliminate references to Claims Status and Coordination of Benefits ((COB) Medicare HIPAA Contingency Plans and changes to reflect transfer of responsibility for Medigap claims to the COB contractor.

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Application of Administrative Simplification Compliance Act (ASCA) Enforcement Review Decisions Made by Other Medicare Contractors to the Same Providers When Selected for ASCA Review by the Railroad Medicare Carrier, Elimination of References to Claim Status and COB Medicare HIPAA Contingency Plans and Changes to Reflect Transfer of Responsibility for Medigap Claims to the COBC Contractor (MM5606) (Continued)

Additional Information
The official instruction, CR5606, issued to your Medicare carrier, A/B MAC, or DME MAC regarding this change may be viewed at **http://www.cms.hhs.gov/Transmittals/downloads/R1353CP.pdf** on the CMS website.

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

Centers for Medicare & Medicaid Services (CMS) Seeks Provider Input on Satisfaction with Medicare Fee-for-Service Contractor Services (SE0750)

MLN Matters Number: SE0750
Related CR Release Date: N/A
Related CR Transmittal #: N/A
Related Change Request (CR) #: N/A
Effective Date: January 1, 2008
Implementation Date: January 7, 2008

Provider Types Affected
Sample of 35,000 Medicare providers served by Medicare Fee-for-Service (FFS) Contractors, including Medicare Administrative Contractors (A/B MACs), carriers, fiscal intermediaries (FIs), durable medical equipment Medicare Administrative Contractors (DME/MACs) and regional home health intermediaries (RHHIs)

Provider Action Needed
Impact to You
CMS offers providers the opportunity to voice your opinions about the services you receive from your FFS contractors. CMS announced it has begun its third annual provider satisfaction survey of Medicare FFS contractors who process and pay more than $280 billion in Medicare claims each year. The Medicare Contractor Provider Satisfaction Survey (MCPSS) is designed to gather quantifiable data on provider satisfaction with the performance of FFS contractors as well as aid future process improvement efforts at the contractor level. The survey is used by CMS as an additional measure to evaluate contractor performance. In fact, all MACs will be required to achieve performance targets on the MCPSS as part of their contract requirements by 2009.

What You Need to Know
CMS is sending the 2008 survey to about 35,000 randomly selected providers, including physicians and other health care practitioners, suppliers and institutional facilities that serve Medicare beneficiaries across the country. Those providers selected to participate in the survey will be notified by December 2007. The survey is designed so that it can be completed in about 15 minutes. Providers can submit their responses via a secure website, mail, fax, or over the telephone. CMS is urging all Medicare providers selected to participate in the survey by completing and returning their surveys upon receipt.

What You Need to Do
Be alert for a notification via e-mail, phone or mail by the survey contractor, Westat. If you are selected to participate in the survey, please take the time to complete and submit your survey responses upon receipt.

Background
The 2008 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.

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Centers for Medicare & Medicaid Services (CMS) Seeks Provider Input on Satisfaction with Medicare Fee-for-Service Contractor Services (SE0750) (Continued)

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 — which are available to health care providers and contractors on at **http://www.cms.hhs.gov/MCPSS** on the CMS website. Last year's findings showed that 85 percent of respondents rated their contractors between 4 and 6.

Further, 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.

Additional Information
CMS plans to make the survey results publicly available in July 2008. For questions or additional information about the MCPSS please visit: **http://www.cms.hhs.gov/MCPSS** on the CMS website.

CMS News Flash

The 2nd Edition of *The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals* is now available in downloadable format from the Centers for Medicare & Medicaid Services, *Medicare Learning Network (MLN)*. This comprehensive guide provides fee-for-services health care providers and suppliers with coverage, coding, billing and reimbursement information for preventive services and screenings covered by Medicare. This guide gives clinicians and their staff the information they need to help them in recommending Medicare-covered preventive services and screenings that are right for their Medicare patients and provides information needed to effectively bill Medicare for services furnished. To view online, go to **http://www.cms.hhs.gov/MLNProducts/downloads/mps_guide_web-061305.pdf** on the CMS website.

Medicare Remit Easy Print (MREP) - Still using Standard Paper Remittance Advices (SPRs)? Did you know that with the new MREP software that is available to you (for free!), you can view and print as many or as few claims as needed? With the MREP software, you can navigate and view an Electronic Remittance Advice (ERA) using your personal computer. This is especially helpful when you need to print only one claim from the Remittance Advice (RA) when forwarding a claim to a secondary payer. CMS developed the MREP software to enable you to read and print the HIPAA-compliant ERA, also known as Transaction 835 or "the 835". Contact your carrier, A/B MAC or DME MAC to find out more about MREP and/or for information on how to receive HIPAA compliant ERAs.

Flu Season is upon us! Begin now to take advantage of each office visit as an opportunity to talk with your patients about the flu virus and their risks for complications associated with the flu. Encourage them to get their flu shot. It's their best defense against combating the flu this season. (Medicare provides coverage of the flu vaccine without any out-of-pocket costs to the Medicare patient. No deductible or copayment/coinsurance applies.) And don't forget, health care professionals need to protect themselves also. 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. For information about Medicare's coverage of flu vaccine and its administration as well as related educational resources for health care professions, please go to
http://www.cms.hhs.gov/MLNProducts/Downloads/flu_products.pdf on the CMS website.

It's seasonal flu time again! If you have Medicare patients who haven't yet received their flu shot, you can help them reduce their risk of contracting the seasonal flu and potential complications by recommending an annual influenza and a one-time pneumococcal vaccination. Medicare provides coverage for flu and pneumococcal vaccines and their administration. - And don't forget to immunize yourself and your staff. Protect yourself, your patients, and your family and friends. Get Your Flu Shot - Not the Flu! Remember - Influenza vaccination is a covered Part B benefit but the 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
http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0748.pdf on the CMS website.

Understanding the Remittance Advice: A Guide for Medicare Providers, Physicians, Suppliers, and Billers serves as a resource on how to read and understand a Remittance Advice (RA). Inside the guide, you will find useful information on topics such as the types of RAs, the purpose of the RA, and the types of codes that appear on the RA. The RA Guide is available as a downloadable document from the *Medicare Learning Network* Publications web page. To download and view, please go to **http://www.cms.hhs.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf** on the CMS website.

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CMS News Flash (Continued)

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.

Test Your Medicare Claims Now! After you have submitted claims containing both National Provider Identifiers (NPIs) and legacy identifiers and those claims have been paid, Medicare urges you to send a small batch of claims now with only the NPI in the primary provider fields. If the results are positive, begin increasing the number of claims in the batch. (Reminder: For institutional claims, the primary provider fields are the Billing and Pay-to Provider fields. For professional claims, the primary provider fields are the Billing, Pay-to, and Rendering Provider fields. If the Pay-to Provider is the same as the Billing Provider, the Pay-to Provider does not need to be identified.)

Effective January 1, 2008, National Provider Identifiers (NPIs) will be required to identify the primary providers (the Billing and Pay-to Providers) in Medicare electronic and paper institutional claims (i.e. 837I and UB-04 claims). You may continue to use the legacy identifier in these fields as long as you also use the NPI in these fields. This means that 837I and UB-04 claims with ONLY legacy identifiers in the Billing and Pay-to Provider fields will be rejected starting on January 1, 2008. (Pay-to Provider is identified only if it is different from the Billing Provider.) You may continue to use only legacy identifiers for the secondary provider fields in the 837I and UB-04 claims until May 23, 2008, if you choose.

Effective March 1, 2008, Medicare fee-for-service 837P and CMS-1500 claims must include an NPI in the primary fields on the claim (i.e., the billing, pay-to, and rendering fields). You may continue to submit NPI/legacy pairs in these fields or submit only your NPI on the claim. You may not submit claims containing only a legacy identifier in the primary fields. Failure to submit an NPI in the primary fields will result in your claim being rejected or returned as unprocessable beginning March 1, 2008. Until further notice, you may continue to include legacy identifiers only for the secondary fields.

Handling Personally Identifiable Information (PII) on the Medicare Summary Notice (MSN) (MM5770)

MLN Matters Number: MM5770
Related CR Release Date: December 19, 2007
Related CR Transmittal #: R1399CP
Related Change Request (CR) #: 5770
Effective Date: January 7, 2008
Implementation Date: January 7, 2008

Provider Types Affected
Physicians, providers, and suppliers who submit claims to Medicare Carriers, Fiscal Intermediaries, (FIs), Medicare Administrative Contractors (A/B MACs), and Durable Medical Equipment Medicare Administrative Contractors (DME MACs)

What You Need to Know
When the Health Insurance Claim Number (HICN) and name of the beneficiary do not match on the submitted claim, Medicare carriers, intermediaries, and A/B MACs will return the claim to the provider as unprocessable. When non-institutional providers submit claims to Medicare carriers or A/B MACs that do not result in a match on name and HICN, the claim is returned with reason code 140 (Patient/Insured health identification number and name do not match).

In addition, effective January 7, 2008, on ALL MSNs, the first 5 digits of the HICN will be replaced with "XXX-XX" to avoid displaying the Medicare beneficiary's personally identifiable information (PII). This applies to pay, no-pay, and duplicate copies of the MSN.

Background
This article is based on CR5770, which describes new procedures resulting from the Centers for Medicare & Medicaid Services (CMS) implementation of the Privacy Act and the Health Insurance Portability and Accountability Act (HIPAA). CR 5770 ensures that (1) MSNs are not issued when the HICN and name do not match, and (2) beneficiaries' PII is protected on the MSN.

Additional Information
You may see the official instruction, CR5770, issued to your Medicare Carrier, FI, A/B MAC or DME MAC at **http://www.cms.hhs.gov/Transmittals/downloads/R1399CP.pdf** on the CMS website.

If you have questions, please contact your Medicare 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.

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Individuals Authorized Access to CMS Computer Services - Provider Community (IACS-PC): THE FIRST IN A SERIES OF ARTICLES (SE0747)

MLN Matters Number: SE0747 **Related Change Request (CR) #: N/A**
Related CR Release Date: N/A **Effective Date: N/A**
Related CR Transmittal #: N/A **Implementation Date: N/A**

These articles will help providers to register for future access to CMS online computer services. This article contains:

- 10 questions and answers to get you started and
- Overview of the registration process for IACS-PC defined provider organization users.

Provider Types Affected
Physicians, providers, and suppliers who submit fee-for-service claims to Medicare contractors (carriers, fiscal intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), and Medicare Administrative Contractors (A/B MACs)).

Special Note: *Durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers should not register for IACS -PC at this time. DMEPOS suppliers may want to review question # 10 below.*

What Providers Need to Know
In the near future, the Centers for Medicare & Medicaid Services (CMS) will be announcing new online enterprise applications that will allow Medicare fee-for-service providers to access, update, and submit information over the Internet. Details of these provider applications will be announced as they become available.

Provider Action Needed
Even though these new internet applications are not yet available, CMS recommends that providers take the time now to set up their online account so they can access these applications as soon as they are available. The first step is for the provider or appropriate staff to register for access through a new CMS security system known as the Individuals Authorized Access to CMS Computer Services - Provider Community (IACS-PC). See the following section for key questions and answers about the registration process.

10 Questions and Answers to Get You Started

1. What is IACS-PC?
IACS-PC is a security system CMS uses to control issuance of electronic identities and access to new CMS provider web-based applications. Through IACS-PC, provider organizations, as defined by IACS-PC (See question # 7 below), and their staff, as well as individual practitioners, will be able to access new CMS applications. Provider organizations will also be able to manage users who they authorize to conduct transactions on their behalf, which may include staff and contractors.

Note: *This release of IACS-PC will not impact access to FI/Carrier/MAC internet applications or the DME Competitive Bidding System (DBidS) application. New enterprise CMS systems will not offer the internet services FIs/Carriers/MACs are providing in the near future.*

2. Who can use this system?
Medicare providers and their designated representatives (e.g. clearinghouses, credentialing departments) may request access to CMS enterprise applications. At this time, the soon-to-be-announced online applications under IACS-PC do not include services to DMEPOS suppliers. (See question # 10 below.)

3. Why register NOW?
Since the new applications have not been announced at the time of this notice, it may be hard to decide if you should register to use the system. However, because IACS-PC registration must precede use, we recommend that individual practitioners and provider organizations (with the exception of DMEPOS suppliers) register now. Even if the IACS-PC registration process goes well and all documentation is in order, it can still take several weeks to finalize registration. Since the system is new, registering now gives you a "cushion" so that if there are delays in processing your registration, you will have the registration process complete in time to request access to the various CMS provider related computer services as soon as they are available early next year.

4. If I register now, how long is my password valid?
Passwords expire in 60 days. After that point, when you log into IACS-PC, you will be prompted to create a new password to re-activate your account. Therefore, we recommend that once registered, you sign on periodically to IACS-PC to keep your current password active.

5. How do I register as an IACS-PC user?
IACS-PC uses a self-registration process. The self-registration process that you will follow will depend on the type of IACS-PC user you are. There are two categories of user types: individual practitioners and provider organizations. There are step-by-step registration instructions to help you through this process.

Note: *The CMS website contains links to IACS user guides for other communities of users. Only use instruction links for the IACS-PC community as directed by CMS.*

The External User Services (EUS) Help Desk will support this process for IACS-PC. It may be reached by email at **EUSSupport@cgi.com** or by phone on 1-866-484-8049 or TTY/TDD on 1-866-523-4759.

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Individuals Authorized Access to CMS Computer Services - Provider Community (IACS-PC): THE FIRST IN A SERIES OF ARTICLES (SE0747) (Continued)

6. When would I register as an individual practitioner?

An individual practitioner is defined by IACS-PC as a physician or non- physician practitioner. This is intended for practitioners who will be conducting transactions with online applications personally and have **no staff** who will be accessing the applications.

More details can be found in the Individual Practitioner Registration - *Quick Reference Guide*, which can be found on the CMS website at: **http://www.cms.hhs.gov/MMAHelp/downloads/IACS_Individual_Practitioner_Registration_QRG_111607.pdf**

7. When would I register as an IACS-PC provider organization?

The term "organization", as defined by IACS-PC, should not be confused with the term organization as it applies to provider enrollment or the NPI. For IACS-PC registration purposes, "organization" includes providers and suppliers such as hospitals, home health agencies, skilled nursing facilities, independent diagnostic testing facilities, ambulance companies, ambulatory surgical centers and physician group practices.

It also includes individual physicians and non- physician practitioners who want to delegate staff to conduct transactions on their behalf. In this case, for IACS-PC registration purposes, registration must be as an organization.

IACS-PC provider organizations require Security Officials (see question # 9 below) that establish the provider organization in IACS-PC. All users will then be grouped together within IACS-PC under the provider organization Security Official.

8. What should I have in hand before I register?

For an individual practitioner (who will be conducting transactions with online applications personally and have no additional staff that will be accessing the applications) they will need to know their:

- Social Security Number and
- Correspondence Information.

For an IACS-PC provider organization, the Security Official (SO) of that organization will be the first person to register within IACS and create their organization. The SO should have the following organizational information available before they sign on to register:

- Taxpayer Identification Number (TIN);
- Legal Business Name;
- Corporate Address; and
- Internal Revenue Service (IRS) Issued CP-575 hard copy form.

9. How do I register my IACS-PC provider organization?

IACS-PC is based on a delegated authority model. Each organization must designate an SO who will register the organization via IACS-PC and then be accountable for users in the organization. Using information supplied via the IACS-PC registration as well as a mailed-in copy of the organization's CP-575 form, CMS will verify the SO's role in the organization, the TIN and the Legal Business Name of the organization. This can take several weeks. Once approved, the SO then has the ability to approve other registrants under the provider organization. For more detail, please read the Overview section, which follows question #10.

Once you understand IACS-PC user roles, and have designated an SO, the SO should register using the instructions in the Security Official Registration - Quick Reference Guide, which is available on the CMS website at:
http://www.cms.hhs.gov/MMAHelp/downloads/IACS_Security_Official_Registration_QRG_111607.pdf

The next *MLN article* in this series of articles will provide instructions for additional users to register in IACS-PC.

10. Why are you excluding DMEPOS suppliers from IACS-PC?

DMEPOS suppliers should not register in IACS-PC at this time because we do not expect any new online services will be available to them in 2008. DMEPOS suppliers interested in the second round of DMEPOS competitive bidding should follow CMS DMEPOS Competitive Bid instructions which will be released closer to the 2008 bid window.

OVERVIEW: Registering in IACS-PC as a Provider Organization or a Provider Organization User

For IACS-PC registration purposes, "organization" includes providers and suppliers such as hospitals, home health agencies, skilled nursing facilities, independent diagnostic testing facilities, ambulance companies, ambulatory surgical centers, and physician group practices. It also includes individual physicians and non- physician practitioners who want to delegate employees to conduct transactions on their behalf.

I. The Registration Process

IACS-PC is based on a delegated authority model. Each user self-registers and is approved as shown below. The system is designed for flexibility to meet provider needs while assuring security of computer systems and privileged information. At this time, a provider organization must have at least 2 users, one of whom will be able to access IACS-PC applications.

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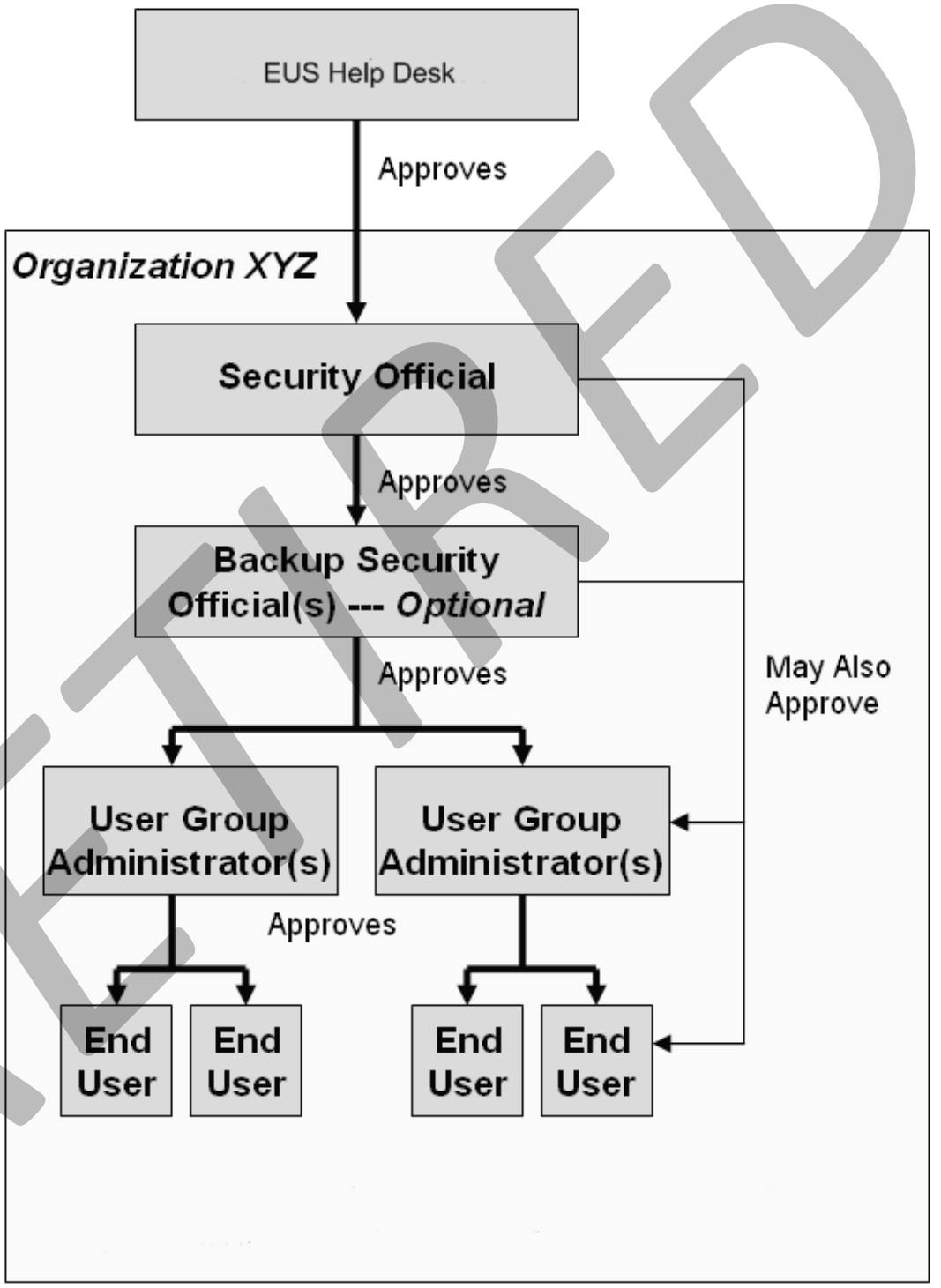
Individuals Authorized Access to CMS Computer Services - Provider Community (IACS-PC): THE FIRST IN A SERIES OF ARTICLES (SE0747) (Continued)

IACS-PC Community: Delegated Authority Model



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The "delegated authority model" previously described is below. The EUS Help Desk will be responsible for approving the organization's Security Official. Then the Security Official may approve the Backup Security Official(s) etc.

II. REGISTRATION ROLES

1. The first person to register must be the Security Official.
The Security Official is the person who registers their organization in IACS-PC and updates the organization profile information in IACS-PC. There can be only one Security Official for an organization. The Security Official is trusted to approve the access request of Backup Security Official(s) and can approve the access requests of User Group Administrators and End Users. The Security Official will be approved by CMS through its EUS Help Desk. The Security Official is held accountable by CMS for the behavior of those they approve including the End Users for the organization

The Security Official Registration - Quick Reference Guide may be found on the CMS website at:
http://www.cms.hhs.gov/MMAHelp/downloads/IACS_Security_Official_Registration_QRG_111607.pdf

Note: Additional employee and contractor users cannot be approved until the security official has been approved by the EUS Help Desk

2. An organization may choose to have one or more **Backup Security Officials.** (Optional)
This is an optional role. You need not have a Backup Security Official. The Backup Security Official is approved by the Security Official. A Backup Security Official performs the same functions as a Security Official in an organization, with the exception of approving other Backup Security Officials. There can be one or more Backup Security Officials in an organization. The Backup Security Official can approve the access requests of User Group Administrators and End Users and may aid the Security Official with the administration of User Groups and User Group Administrators' accounts.

3. The next registrant must be a **User Group Administrator (UGA).**
The UGA is approved by the Security Official or Backup Security Official. The UGA is trusted to approve the access requests of End Users for that User Group.

Organizations with 2-9 IACS-PC users must, at a minimum, have a Security Official and one or more UGAs. If there will be only one user in a group, that user must register as a UGA.

A UGA registers the User Group within an organization in IACS-PC and updates the User Group profile information in IACS-PC. There can be multiple UGAs for the same User Group within an organization.

4. Organizations with 10 or more IACS-PC users must also have **End Users.**
An End User is a staff member who is trusted to perform Medicare business and conduct transactions for the provider organization. An End User is part of a User Group within the provider organization. An End User may be an employee of a provider/supplier/practitioner or a contractor working on the behalf of one of these entities. An End User may belong to multiple groups in one or more organizations. The End User is approved by the UGA.

Note: *End User requests cannot be approved until after the User Group Administrator has been approved*

III. SURROGATE USER GROUPS

This applies to provider organizations that want to delegate online work to individuals or a company outside of the provider organization. Under this scenario, those working on behalf of the provider organization register as a **Surrogate User Group**. Examples include clearinghouses, credentialing departments, independent contractors. A Surrogate User Group has a direct contractual business relationship with the Medicare provider/supplier, but not with CMS. A Surrogate User Group may be associated with multiple provider organizations.

1. The first contractor employee to register in a **Surrogate User Group** must be the UGA.
If there will be only one user in a Surrogate Group, that user must register as a UGA. The UGA for the Surrogate User Group will register the Surrogate User Group and update the User Group profile information in IACS-PC. There can be multiple UGAs within the same Surrogate User Group. The UGA is trusted to approve the access requests of End Users for their user group.

The UGA of the Surrogate User Group must be approved by the Security Official or Backup Security Official in the provider organization on whose behalf it performs work. Once approved, the UGA of a Surrogate Group may request to associate with other provider organizations for which it performs work without registering again.

2. A contractor employee may also register as an **End User.**
An End User is approved to perform Medicare business for a surrogate or provider User Group by their UGA. An End User may belong to multiple groups in one or more organizations.

ADDITIONAL HELP

The EUS Help Desk will support this process for IACS-PC. It may be reached by email at **EUSSupport@cgi.com** or by phone on 1-866-484-8049 or TTY/TDD on 1-866-523-4759.

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Items and Special Services Having Special DME Review Considerations (MM5765)

MLN Matters Number: MM5765
Related CR Release Date: November 2, 2007
Related CR Transmittal #: R236PI
Related Change Request (CR) #: 5765
Effective Date: April 1, 2008
Implementation Date: April 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 Providers Need to Know
This article is informational for suppliers and is based on Change Request (CR) 5765 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 Medicare Affiliated Contractors (MACs).

Background
As a result of the MAC transition and effective April 1, 2008, the DME PSCs will be renamed Zone Program Integrity Contractors (ZPICs). This change of terminology from PSCs to ZPICs is noted in the PIM Chapter 5 revision. The *PIM* revision is attached to this CR5765 and the address is listed in the *Additional Information* section of this article.

Key Points
- DME/MACs will perform MR duties;
- DME/MACs will, at their discretion, recommend that the Centers for Medicare & Medicaid Services (CMS) initiate a potential Civil Monetary Penalty (CMP) case against the supplier; and
- DME/MACs will develop safeguards to investigate multiple claims for rental of the same or similar equipment from the same supplier within the same rental period.

Additional Information
To see the official instruction (CR5765) issued to your Medicare DME/MAC visit **http://www.cms.hhs.gov/Transmittals/downloads/R226PI.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.

Key Medicare News for 2008 for Physicians and Other Health Care Professionals (SE0730)

MLN Matters Number: SE0730
Related CR Release Date: N/A
Related CR Transmittal #: N/A
Related Change Request (CR) #: N/A
Effective Date: N/A
Implementation Date: N/A

Provider Types Affected
Physicians and health care professionals and their staff who bill Medicare carriers and/or Medicare Administrative Contractors (MACs).

Introduction
This Special Edition article is being provided to keep you, the Medicare physician and health care professional, informed about important Medicare initiatives and new Medicare benefits available in Calendar Year (CY) 2008.

As you once again make your decision to enroll in or terminate enrollment in the Medicare participation program, the Centers for Medicare & Medicaid Services (CMS) would like to take this opportunity to review some important news for 2008. CMS believes this information provides significant benefits to providers and their Medicare patients. It encourages providers to enroll or stay in the Medicare participation program in order to take full advantage of the upcoming changes.

Information You Need to Know
National Provider Identifier (NPI) - Get it! Share it! Use it!
Medicare carriers and A/B MACs began transitioning their systems to start rejecting claims when the NPI and legacy provider identifier pair that are reported on the claim cannot be found on the Medicare crosswalk. We urge you to pay attention to the reject reports you receive. The reject reports will help you and your staff identify problems that cause claims to reject.

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Key Medicare News for 2008 for Physicians and Other Health Care Professionals (SE0730) (Continued)

You should also ensure that your Medicare enrollment information is up to date. If you need to submit a completed CMS-855 (Medicare provider enrollment form), remember to list all of the NPIs that will be used in place of legacy identifiers. If you need to apply for an NPI or update your information in the National Plan and Provider Enumeration System (NPPES), please include ALL of your Medicare legacy numbers. (NPPES can accept only 20 Other Provider Identifiers, but is being expanded to accept more in the future.) If the information is different between your Medicare enrollment information and your NPPES record, there is a very good chance your claims will reject. NPPES data may be verified at **https://nppes.cms.hhs.gov** on the CMS website. Contact the NPI Enumerator at 1-800-465-3203 if you need assistance in viewing your NPPES record.

A recent *MLN Matters* article lists the informational edits that preceded the reject report messages and their meanings. Visit **http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0725.pdf** on the CMS website to view the article.

Some incorporated physicians and non-physician practitioners have obtained NPIs as follows: an individual (Entity Type 1) NPI for the physician or non-physician practitioner and an organization (Entity Type 2) NPI for the corporation. If you enrolled in Medicare as an individual and obtained a Medicare Provider Identification Number (PIN) as an individual, and you want to use your NPI and your PIN pair in your Medicare claims, be sure you use your individual NPI with your individual PIN. Pairing your corporation's NPI with your individual PIN will result in your claims being rejected. If you wish to bill Medicare with your corporation's NPI, then you must be sure your corporation is enrolled in Medicare so that it can be assigned a PIN. Please contact your servicing Medicare carrier for more information about this enrollment. Until your corporation has been enrolled in Medicare, you may continue to bill by using your individual NPI with your individual PIN to ensure no disruption in your claims being processed and paid. Please note that similar problems may result if you bill Medicare by using your individual NPI with your corporation's PIN (if the corporation is enrolled and has been assigned a PIN). In other words, when billing with the NPI/PIN pair, you must use compatible NPIs and PINs.

Note that after May 23, 2008, legacy identifiers will not be permitted on any inbound or outbound transactions. This includes inbound claims, crossover claims, both paper and electronic remittance advices, the 276/277 claims status inquiries/replies, NCPDP claims, and the 270/271 eligibility inquiries/replies. Also, for up-to-date information on the NPI, CMS recommends periodic visits to **http://www.cms.hhs.gov/NationalProvIdentStand/** on the CMS website.

Unique Physician Identification Numbers (UPINs)
CMS discontinued assigning unique physician identification numbers (UPINs) on June 29, 2007, but will maintain its UPIN public "look-up" functionality and Registry website **(http://www.upinregistry.com/)** through May 23, 2008.

Competitive Acquisition Program (CAP) for Part B Drugs
The Medicare Modernization Act requires CMS to implement a competitive acquisition program (CAP) for Medicare Part B drugs and biologicals that are not paid on a cost or prospective payment system (PPS) basis. This program is an alternative to the average sales price (ASP) methodology for acquiring certain Part B drugs which are administered incident to a physician's services. In it, physicians are given a choice between buying and billing these drugs under the ASP system, or selecting a Medicare-approved CAP vendor that will supply these drugs.

Participation in the CAP is voluntary, and each year Medicare physicians can elect to participate. Those who do participate will obtain drugs through CAP vendors; the vendors will bill Medicare for the administered drug and will bill the beneficiary for any applicable co-insurance or deductible.

All physicians who participated in the CAP in 2007, and wish to participate in 2008, will need to make the 2008 CAP election during the regular fall election period which will run from October 1, 2007, to November 15, 2007.

Participating physicians can sign up to receive CAP updates from the **CMS-CAP-Physicians-L** electronic mailing list at **http://www.cms.hhs.gov/apps/mailinglists/default.asp?audience=3** on the CMS CAP Information for Physicians webpage **(http://www.cms.hhs.gov/CompetitiveAcquisforBios/02_infophys.asp#TopOfPage)**.

Physician Quality Reporting Initiative (PQRI)
The Tax Relief and Health Care Act of 2006 (TRHCA) authorizes a physician quality reporting system. This program, which CMS has named the "Physician Quality Reporting Initiative" (PQRI), was implemented on July 1, 2007, and establishes a financial incentive for eligible professionals who participate in a voluntary quality-reporting program.

These eligible professionals, who successfully report a designated set of quality measures on claims for dates of service from July 1 to December 31, 2007, may earn a bonus payment (subject to a cap) of 1.5% of total allowed charges for covered Medicare physician fee schedule services during that same period.

The proposed 2008 PQRI quality measures were published in the Federal Register as a part of the 2008 Medicare Physician Fee Schedule (MPFS) Proposed Rule. The final 2008 PQRI measures will be published in the 2008 MPFS Final Rule and posted at **http://www.cms.hhs.gov/PQRI** on the CMS PQRI website.

For more information about the PQRI and to access important educational tools, go to **http://www.cms.hhs.gov/PQRI** on the CMS website.

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Key Medicare News for 2008 for Physicians and Other Health Care Professionals (SE0730) (Continued)

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

Certificates of medical necessity (CMN) provide a mechanism for suppliers of durable medical equipment and medical equipment and supplies to demonstrate that the item they provide meets the minimal criteria for Medicare coverage. Durable Medical Equipment Medicare Administrative Contractors (DME MAC) review the documentation that physicians, suppliers, and providers supply on the CMNs and DME Information Forms (DIFs), and determine if the medical necessity and applicable coverage criteria for selected DMEPOS were met.

On April 13, 2007, CMS announced the development of improved CMNs and DIFs that are consistent with current medical practices and that conform to Medicare guidelines. In this improvement process, CMS revised several CMNs, replaced three CMNs with two DIFs, and revised *Medicare Program Integrity Manual*, Chapter 5, Items and Services Having Special DME Review Considerations. Additionally, these new Office of Management and Budget (OMB) approved forms permit the use of a signature and date stamp that resulted in revision of the *Medicare Program Integrity Manual*, Chapter 3, Section 3.4.1.1, Documentation Specifications for Areas Selected for Prepayment or Post Payment Medical Review.

You can learn more about these revised forms by reading *MLN Matters* article MM5571 (based on CR 5571, the official instruction issued to the DME MAC); available at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5571.pdf.** The new forms are available at **http://www.cms.hhs.gov/CMSForms/CMSforms/list.asp#TopOfPage** on the CMS website.

Preventive Services

Medicare, which began covering preventive services in 1981 with the pneumococcal vaccination, now covers a broad range of services to prevent disease, detect disease early when it is most treatable and curable, and manage disease so that complications can be avoided.

These services include:

- The Initial Preventive Physical Examination (IPPE), also known as the "Welcome to Medicare" visit, which now includes coverage of a one-time preventive ultrasound screening for the early detection of abdominal aortic aneurysms (AAA) for at-risk beneficiaries (those with a family history of AAA or males age 65 to 75 who have smoked at least 100 cigarettes in their lifetime). It is important to note that in order to receive this AAA ultrasound screening benefit, beneficiaries must be referred by their physician or other qualified non-physician practitioner. You can learn more about the IPPE and AAA ultrasound screening by reading *MLN Matters* article SE0711, which you can find at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0711.pdf** on the CMS website. CMS has also developed a new quick reference information chart entitled *"The ABCs of Providing the Initial Preventive Physical Examination"*. This two-sided laminated chart may be used by Medicare fee-for-service physicians and qualified non-physician practitioners as a guide when providing the IPPE. The chart is currently available at **http://www.cms.hhs.gov/MLNProducts/downloads/MPS_QRI_IPPE001a.pdf** on the CMS website.
- Adult Immunization—Influenza Immunization, Pneumococcal Vaccination, Hepatitis B Vaccination;
- Colorectal Cancer Screening;
- Screening Mammography;
- Screening Pap Test and Pelvic Examination;
- Prostate Cancer Screening;
- Cardiovascular Disease Screening;
- Glaucoma Screening;
- Bone Mass Measurement;
- Diabetes Screening, and Self-Management, Medical Nutrition Therapy Services, and Supplies; and
- Smoking and Tobacco-Use Cessation Counseling.

To learn more details about these preventive benefits, see *The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals* located at **http://www.cms.hhs.gov/MLNProducts/downloads/mps_guide_web-061305.pdf** on the CMS website.

CMS has a variety of educational products and resources to help you become familiar with coverage, coding, billing, and reimbursement for all Medicare-covered preventive services, including:

- The *MLN* Preventive Services Educational Products Web Page, which provides descriptions and ordering information for all provider specific educational products related to preventive services. The web page is located at **http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp** on the CMS website.
- The CMS website (**http://www.cms.hhs.gov**) provides information for the individual preventive service covered by Medicare. At the site, select "Medicare", and scroll down to "Prevention".

For products to share with your Medicare patients, visit **http://www.medicare.gov/** on the Internet.

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Key Medicare News for 2008 for Physicians and Other Health Care Professionals (SE0730) (Continued)

Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding

Section 302(b) of the Medicare Modernization Act, requires Medicare to replace the current durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) payment methodology, for select items in select areas, with a competitive acquisition process to improve the effectiveness of its payment-setting methodology. This new program will establish payment amounts for certain durable medical equipment, enteral nutrition, and off-the-shelf orthotics by replacing the current payment amounts (under Medicare's DMEPOS fee schedule) with payment rates derived from a bidding process.

Suppliers that want to furnish competitively bid items in a competitive bidding area (CBA) will be required to submit bids to furnish those items, and the winning bids will be used to establish a single Medicare payment amount for each item. Contracts will be awarded to a sufficient number of winning bidders in each CBA to ensure access and service to high quality DMEPOS items.

CMS is phasing in this new program. Bidding for the first phase began in 2007 in CBAs within 10 of the largest Metropolitan Statistical Areas (MSAs), excluding New York, Los Angeles, and Chicago. Prices from the first phase of bidding are scheduled to go into effect in 2008. The program will be expanded into 70 additional MSAs in 2009. After 2009, CMS will expand the program to additional areas.

While this program may have no direct impact on most physicians, it might have impact on where your patients receive their DMEPOS. Some suppliers currently serving your patients may not be selected to continue Medicare participation under the new program and your patients may have to go to new suppliers. While this may happen, please be assured that Medicare will continue to meet the same patient needs for DMEPOS as it has prior to the new program. Medicare is just attempting to meet those concerns in a more cost effective manner in order to protect Medicare funding.

You can find more information about the Medicare DMEPOS competitive bidding program at **http://www.cms.hhs.gov/CompetitiveAcqforDMEPOS/** on the CMS website.

Provider Education Updates

The Medicare Learning Network

The *Medicare Learning Network (MLN)*, the brand name for official CMS provider educational products, is designed to promote national consistency in Medicare provider information developed for CMS initiatives. The *MLN* products available on the *MLN* web page provide easy access to web-based training courses, comprehensive training guides, brochures, fact sheets, CD-ROMs, videos, educational web guides, electronic listservs, and links to other important Medicare Program information. All educational products are available free of charge and can be ordered and/or downloaded from the *MLN* web page located at **http://www.cms.hhs.gov/MLNGenInfo** on the CMS website. Some of the new information for 2007 on the *MLN* web page follows.

Physician Educational Tools

- **The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals 2nd Edition:** Provides information on Medicare's preventive benefits including coverage, frequency, risk factors, billing and reimbursement. (August 2007); Available in downloadable format.
- **Medicare Guide to Rural Health Services Information for Providers, Suppliers, and Physicians:** Contains rural health services information pertaining to rural health facility types, coverage and payment policies, and rural provisions under the Medicare Prescription Drug, Improvement and Modernization Act of 2003 and the Deficit Reduction Act of 2005. The primary audience includes rural health providers, suppliers, and physicians. (February 2007) Available in hard copy, CD Rom, and downloadable formats.
- **Medicare Physician Guide: A Resource for Residents, Practicing Physicians, and Other Health Care Professionals:** Offers general information about the Medicare Program, becoming a Medicare provider or supplier, Medicare payment policies, Medicare reimbursement, evaluation and management documentation, protecting the Medicare Trust Fund, inquiries, overpayments, and appeals. (July 2007) Available in hard copy, CD Rom, and downloadable formats.
- **Companion Facilitator's Guide - To The Medicare Physician Guide: A Resource for Residents, Practicing Physicians, and Other Health Care Professionals:** Includes all the information and instructions necessary to prepare for and present a Medicare Resident, Practicing Physician, and Other Health Care Professional Training Program, including instructions for facilitators, a customization guide, two PowerPoint presentations with speaker notes, pre- and post-assessments, master assessment answer keys, and evaluation tools. (January 2007) Available in hard copy, CD Rom, and downloadable formats.
- **Physicians' Guide to Medicare Coverage of Kidney Dialysis and Kidney Transplant Services:** Explains how Medicare helps pay for kidney dialysis and kidney transplant services under the fee-for-service program. (June 2007); Available in hard copy and downloadable formats.

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Key Medicare News for 2008 for Physicians and Other Health Care Professionals (SE0730) (Continued)

Other Educational Tools

- **Medicare Learning Network Guidance Tool:** Now available in CD ROM format and can be ordered through the Medicare Learning Network, product ordering page. This playable CD will streamline your search to find the most relevant and up-to-date links or URLs for national provider educational materials. A tutorial will show you how to use the Guidance Tool to locate a new link (URL), refine your search, view, download and order educational articles, brochures, fact sheets, web-based training courses, worksheets and videos. Additionally, the *MLN* Guidance Tool will demonstrate by example how to navigate through sections of CMS' Medicare Learning Network. (January 2007) Available in CD ROM format.
- **Medicare Preventive Services Bookmark:** Lists the preventive services and screenings covered by Medicare and provides a message that encourages health care professionals to talk with their Medicare patients about these preventive services and encourage them to take advantage of these potentially life saving benefits. This product is appropriate for distribution at health care professional conferences, provider outreach and education activities, and other appropriate types of provider/supplier events. (January 2007) Available in hard copy and downloadable formats.
- **Quick Reference Information: Medicare Preventive Services:** A two-sided laminated reference chart that gives Medicare fee-for- service physicians, providers, suppliers, and other health care professionals a quick reference to Medicare's preventive services. (May 2007) Available in hard copy and downloadable formats.
- **Quick Reference Information: Medicare Immunization Billing (Flu, PPV, and HBV):** A two-sided laminated reference chart that gives Medicare fee-for-service physicians, providers, suppliers, and other health care professionals a quick reference to Medicare billing information for the influenza, Pneumococcal, and hepatitis B vaccines and their administration. (October 2006) Available in hardcopy and downloadable formats.
- **An Overview of Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals:** An educational video program that provides an overview of coverage criteria for Medicare preventive benefits. This program can be viewed individually or as part of an education session at a conference or other provider meeting. (The program is 75 minutes in length and approved by CMS for continuing education credits for successful completion.)
- **Skilled Nursing Facility (SNF) Spell of Illness Quick Reference Chart:** Provides Medicare claims processing information related to SNF spells of illness. (January 2007); Available in downloadable format only.

Brochures

- **Changes in Medicare Coverage of Power Mobility Devices (PMDs): Power Wheelchairs and Power Operated Vehicles (POVs):** Addresses the CMS multi-faceted plan to ensure the appropriate prescription of wheelchairs to beneficiaries who need them. (May 2007)
- **Diabetes-Related Services** - This tri-fold brochure provides health care professionals with an overview of Medicare's coverage of diabetes screening tests, diabetes self-management training, medical nutrition therapy, and supplies and other services for Medicare beneficiaries with diabetes. (August 2007)

Fact Sheets

- **Critical Access Hospital Program:** Covers information related to the Critical Access Hospital Program. (March 2007).
- **Federally Qualified Health Center Fact Sheet:** Covers the Federally Qualified Health Center (FQHC) benefit under Medicare. (March 2007).
- **Implementation of the UB-04:** Reviews the new UB-04 paper claim form which is only accepted from institutional providers excluded from the mandatory electronic claims submission. It includes background information, the transition period and a crosswalk. (May 2007); Available in downloadable format only.
- **Inpatient Rehabilitation Facility Prospective Payment System Fact Sheet:** This fact sheet provides information about Inpatient Rehabilitation Facility Prospective Payment System rates and classification criterion. (March 2007).
- **Medicare Disproportionate Share Hospital Fact Sheet:** Covers the basics of the Medicare Disproportionate Share Hospital (DSH). (August 2007).
- **Medicare Physician Fee Schedule Fact Sheet:** Provides general information about the Medicare Physician Fee Schedule. (January 2007).
- **Medicare Secondary Payer Fact Sheet:** Provides a general overview of the Medicare Secondary Payer provision for individuals involved in the admission and billing procedures at provider, physician and other supplier settings. (June 2007).
- **Rural Health Clinic Fact Sheet:** Covers the basics of the Rural Health Clinic (RHC) Program. (June 2007).
- **Rural Referral Center Fact Sheet:** Covers the basics of the Rural Referral Center (RRC) Program. (March 2007)

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Key Medicare News for 2008 for Physicians and Other Health Care Professionals (SE0730) (Continued)

Web Based Training Programs

- **CMS Form 1450:** Provides information that will allow you to file Medicare Part A claims accurately and reduce your chances of receiving unprocessable rejections. (January 2007)
- **CMS Form 1500:** Provides information that will allow you to file Medicare Part B claims accurately and reduce your chances of receiving unprocessable rejections. (May 2007)
- **Diagnosis Coding:** Using the ICD-9-CM: Teaches you how to select accurate diagnosis codes from the ICD-9-CM volumes and how to use diagnosis codes correctly on Medicare claim forms. (May 2007)
- **Medicare Fraud and Abuse:** Teaches you how to identify Medicare fraud and abuse. You will also learn what safeguards to use to protect yourself against fraud and abuse and what liability and penalties you could face if you commit fraud or abuse. (April 2004)
- **Outpatient Code Editor (OCE):** Useful for physicians and other health care professionals. This course addresses the OCE in Medicare's Fiscal Intermediary Standard System, which processes outpatient claims. (January 2007)
- **Medicare Preventive Services Series: Part 1 Adult Immunizations:** This web-based training course provides information to help fee-for-service providers and suppliers understand Medicare's coverage and billing guidelines for influenza, pneumococcal, and hepatitis B vaccines and their administration. (Updated September 2007)

National Provider Identifier

- **Health Care Providers - Who are Sole Proprietors?:** A sole proprietor/sole proprietorship is an individual and, as such, is eligible for a single NPI. Read more about Sole Proprietors and the NPI. (July 2007)
- **Health Care Providers - Who are Organizations?:** Organization health care providers apply for NPIs as Organizations (Entity Type 2). Read more about Organization Providers and the NPI. (July 2007)
- **Tip Sheets - What the "Guidance on Compliance with the HIPAA National Provider Identifier (NPI) Rule" Means for Health Care Providers:** interprets the recently released contingency guidance into helpful steps for providers. (May 2007)
- **National Provider Identifier Training Package:** CMS has developed a Training package for NPI that will assist providers with self-education, as well as education of staff. This package is also useful to national and local medical societies for group presentations and training. The entire package will consist of five modules: General Information, Electronic File Interchange (EFI), Subparts, Data Dissemination and Medicare Implementation. Each Module consists of a PowerPoint presentation (with speaker's notes) and is designed to stand-alone or can be combined with other Modules for a training session tailored to the particular audience.
- **Enrolling in Medicare:** CMS has posted a document that will assist physicians in completing the CMS-855I, Medicare Provider Enrollment Application for Physicians and Non-Physician Practitioners. The document is available at **http://www.cms.hhs.gov/Medicareprovidersupenroll/downloads/EnrollmentNPI.pdf** on the CMS website.

Physician Quality Reporting Initiative (PQRI) Tool Kit

CMS has developed a "PQRI Tool Kit ~ Six Steps for Success" that will assist eligible professionals with successful reporting, as well as education of staff. This Tool Kit is also useful for group presentations and training programs. Currently, the Tool Kit consists of six educational resources (listed below). Each resource in the Tool Kit is designed to stand alone or can be combined with other resource for a training session tailored to the particular audience. The Tool Kit includes:

- **2007 PQRI Physician Quality Measures** - A numerical listing of all measures included in 2007 PQRI;
- ***MLN Matters* Article 5640** - Coding & Reporting Principles - A publication that introduces the coding and reporting principles underlying successful PQRI reporting;
- **2007 PQRI Code Master** - A numerical listing of all codes included in PQRI intended for incorporation into billing software;
- **2007 Coding for Quality Handbook** - A handbook that delineates coding and reporting principles and provides implementation guidelines for how to successfully report measures using clinical scenarios;
- **2007 Data Collection Worksheets** - Measure-specific worksheets that walk the user step-by-step through reporting for each quality measure; and
- **2007 PQRI Measure Finder Tool and User Guide** - A tool designed to assist eligible professionals and their practice staff to quickly search for applicable measures and their detailed specifications.

Physician Quality Reporting Initiative (PQRI) PowerPoint Presentations

CMS has developed PowerPoint presentation modules that will assist eligible professionals with successful reporting, as well as education of staff. These PowerPoint presentation modules are also useful for group presentations and training programs.

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Key Medicare News for 2008 for Physicians and Other Health Care Professionals (SE0730) (Continued)

Beneficiary Related News

MyMedicare.com

As announced in last year's article, Medicare beneficiaries can access Medicare's free secure online service to view their Medicare information by registering for MyMedicare.com. At this site, they can access their personalized information about their Medicare benefits and services, and can:

- View claim status (excluding Part D claims);
- Order a duplicate Medicare Summary Notice (MSN) or replacement Medicare card;
- View eligibility, entitlement, and preventive services information;
- View enrollment information including prescription drug plans;
- View or modify their drug list and pharmacy information;
- View address of record with Medicare and Part B deductible status; and
- Access online forms, publications, and messages sent by CMS.

Registration is simple. Medicare beneficiaries should go to **http://www.medicare.gov** and click on the box in the upper left of the screen to sign up for **MyMedicare.gov.**

Additional Information

If you have any questions, please contact your 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.

Medicare Provides Coverage for Many Preventive Services and Screenings (SE0752)

MLN Matters Number: SE0752
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 fee-for-service (FFS) physicians, providers, suppliers, and other health care professionals, who furnish or provide referrals for and/or file claims for Medicare-covered preventive services and screenings provided to Medicare beneficiaries.

Provider Action Needed

This article conveys no new Medicare policy but serves as a reminder of the many preventive services and screenings now covered by Medicare and provides a list of related provider educational resources developed by the Centers for Medicare & Medicaid Services (CMS) to inform FFS health care professionals and their staff about the preventive services and screenings now covered by Medicare. CMS needs your help in spreading the word about preventive health care and ensuring that people with Medicare take full advantage of preventive benefits covered by Medicare that are appropriate for them.

- Keep this Special Edition *MLN Matters* article and refer to it often.
- Order appropriate provider resources for yourself and your staff.
- Talk with your Medicare patients about their risk factors for disease and benefits of preventive health care, and encourage utilization of appropriate preventive services covered by Medicare for which they may be eligible.

Introduction

Heart disease, stroke, cancer, diabetes, osteoporosis, influenza, pneumonia, and other chronic diseases have a significant impact on the health and well-being of seniors in the United States. Yet the reality is, many of these diseases can be prevented and complications can be reduced. Medicare now provides coverage for a full range of preventive services and screenings that can help seniors and other people with Medicare stay healthy, detect disease early, and manage conditions to reduce complications. Preventive services and screenings now covered by Medicare include:

Medicare Provides Coverage for the Following Preventive Services and Screenings (subject to certain eligibility and other limitations)

- Adult Immunizations
  - Influenza (Flu)
  - Pneumococcal
  - Hepatitis B

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Medicare Provides Coverage for Many Preventive Services and Screenings (SE0752) (Continued)

- Bone Mass Measurements
- Cancer Screenings
  - Breast (mammogram and clinical breast exam)
  - Cervical & Vaginal (Pap test & pelvic exam)
  - Colorectal
  - Prostate
- Cardiovascular Disease Screening
- Diabetes Screening
- Diabetes Self-Management Training
- Diabetes Supplies
- Medical Nutrition Therapy (beneficiaries diagnosed with diabetes or renal disease)
- Glaucoma Screening
- Initial Preventive Physical Exam (IPPE) ("Welcome to Medicare" Physical Exam)
- Smoking and Tobacco-Use Cessation Counseling Services
- Ultrasound Screening for Abdominal Aortic Aneurysms (AAA)

Help in Spreading the Word

CMS recognizes the crucial role that health care professionals play in promoting, providing, and educating Medicare patients about potentially life saving preventive services and screenings. While Medicare now helps to pay for more preventive benefits than ever before, many Medicare beneficiaries are not yet taking full advantage of them, leaving significant gaps in their preventive health program. Statistics show that while Medicare beneficiaries visit their physician on an average of six or more times a year, many of them are not aware of their risk for disease or even that they may already have a condition that preventive services are intended to detect. As a health care professional, you can help your patients with Medicare understand the importance of disease prevention, early detection, and lifestyle modifications that support a healthier life.

CMS hopes that you will join with us in spreading the word about preventive health care by educating your patients about their risk for disease. Talk with them about the importance of preventive health care, early detection, and the preventive services covered by Medicare that are right for them, and encourage utilization of these benefits when appropriate. As people with Medicare increase their knowledge of their risk for disease and understand the benefits of early detection and disease prevention, they will be better prepared to take full advantage of the preventive benefits covered by Medicare.

Educational Products and Informational Resources for Health Care Professionals

As a trusted source, a physician's recommendation is one of the most important factors in increasing the use of preventive services and screenings by people with Medicare. However, we know the discussion can be complicated. Therefore, CMS has developed a variety of educational products to:

1) Help increase your awareness of Medicare's coverage of disease prevention and early detection;
2) Provide you with information and tools to help you communicate with your Medicare patients about these potentially life saving benefits for which they may be eligible; and
3) Give you resources to help you effectively file claims for these services.

These provider education products may be ordered, free of charge, from the CMS *Medicare Learning Network (MLN)*. All print products are available as downloadable PDF files and may be viewed online, reprinted, and redistributed as needed. Some print products may only be available as a downloadable PDF file. To order *MLN* products, 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.

Attention: *The following educational products have been developed by CMS to be used by Medicare FFS health care professionals and their staff and* ***are not*** *intended for distribution to Medicare beneficiaries.*

Bookmark

Medicare Preventive Services Bookmark - This bookmark, available at **http://www.cms.hhs.gov/MLNProducts/downloads/medprevsrvcesbkmrk.pdf** on the CMS website, lists the preventive services and screenings covered by Medicare and serves as a handy reminder to health care professionals and their staff about the many preventive benefits covered by Medicare. Appropriate for use as a give away at conferences and other provider/supplier related education and outreach events. Available in print or as a downloadable PDF file.

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Medicare Provides Coverage for Many Preventive Services and Screenings (SE0752) (Continued)

Brochures

The Medicare Preventive Services Brochure Series for Physicians, Providers, Suppliers, and Other Health Care Professionals - This series of seven tri-fold brochures provides an overview of Medicare's coverage of preventive services and screenings. Available in print and as downloadable PDF files.

- *Adult Immunizations* (influenza, pneumococcal, and hepatitis B) available at **http://www.cms.hhs.gov/MLNProducts/downloads/adult_immunization.pdf;**
- *Bone Mass Measurements* available at **http://www.cms.hhs.gov/MLNProducts/downloads/bone_mass.pdf;**
- *Cancer Screenings* (colorectal, prostate, and breast cancer screenings, and pap tests and pelvic examinations) available at **http://www.cms.hhs.gov/MLNProducts/downloads/cancer_screening.pdf;**
- *Diabetes-Related Services* (diabetes screening tests, diabetes self-management training, medical nutrition therapy, and supplies and other covered services for beneficiaries with diabetes) available at **http://www.cms.hhs.gov/MLNProducts/downloads/DiabetesSvcs.pdf;**
- *Expanded Benefits* (initial preventive physical examination (IPPE), ultrasound screening for abdominal aortic aneurysms, and cardiovascular screening blood tests) available at **http://www.cms.hhs.gov/MLNProducts/downloads/expanded_benefits.pdf;**
- *Glaucoma Screening* available at **http://www.cms.hhs.gov/MLNProducts/downloads/expanded_benefits.pdf;** and
- *Smoking and Tobacco-Use Cessation Counseling Services* available at **http://www.cms.hhs.gov/MLNProducts/downloads/smoking.pdf** on the CMS website.

Guide

The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals, 2nd Edition - This updated comprehensive guide, available at **http://www.cms.hhs.gov/MLNProducts/downloads/mps_guide_web-061305.pdf,** for Medicare FFS providers/suppliers and their staff provides information on coverage, coding, billing, and reimbursement guidelines for preventive services and screenings covered by Medicare. Available as a downloadable PDF file.

Quick Reference Information Charts

Medicare Preventive Services - This two-sided laminated chart, available at **http://www.cms.hhs.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf,** gives Medicare FFS physicians, providers, suppliers, and other health care professionals a quick reference to Medicare's preventive services and screenings, identifies coding requirements, eligibility, frequency parameters, and copayment/coinsurance and deductible information for each benefit. Available in print or as a downloadable PDF file.

Medicare Immunization Billing - This two-sided laminated chart at **http://www.cms.hhs.gov/MLNProducts/downloads/qr_immun_bill.pdf** provides Medicare FFS physicians, providers, suppliers, and other health care professionals with quick information to assist with filing claims for the influenza, pneumococcal, and hepatitis B vaccines and their administration. Available in print and as a downloadable PDF file.

The ABCs of Providing the Initial Preventive Physical Examination - This two-sided laminated chart at **http://www.cms.hhs.gov/MLNProducts/downloads/MPS_QRI_IPPE001a.pdf** can be used by Medicare FFS physicians and qualified non-physician practitioners as a guide when providing the initial preventive physical examination (IPPE). This handy tool identifies the components and elements of the IPPE, and provides eligibility requirements, procedure codes to use when filing claims, FAQs, suggestions for preparing patients for the IPPE, and lists references for additional information. Available in print and as a downloadable PDF file.

Video Program

An Overview of Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals - This educational video program provides health care professionals and their staff with an overview of preventive services and screenings covered by Medicare. This educational video has been approved for .1 IACET* CEU for successful completion. This video program can be ordered, free of charge, through the *MLN* Product Ordering web page at **http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5** on the CMS website.

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Medicare Provides Coverage for Many Preventive Services and Screenings (SE0752) (Continued)

Web-Based Training Courses

Medicare Preventive Services Series Web-Based Training (WBT) Course -This series of three WBT courses has been designed to help fee-for-services providers/suppliers and their staff understand Medicare's coverage and billing guidelines for preventive services and screenings covered by Medicare. (To register, to take these WBT courses, free of charge, visit the *MLN* Product Ordering Page - **http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5**

- *Medicare Preventive Services Series: Part 1 Adult Immunizations Web-Based Training (WBT) Course* - This WBT course contains four learning modules that provide information about Medicare's coverage of influenza, pneumococcal, and hepatitis B vaccines and their administration. Information is also included about mass immunizers, roster billing, and centralized billing. This course was updated September 2007 and has been approved for .1 IACET* CEU for successful completion.
- *Medicare Preventive Services Series: Part 2 Women's Health Web-Based Training (WBT) Course* - This WBT course contains five learning modules that provide information about Medicare's coverage of mammography services, pap tests, pelvic exams, colorectal cancer screenings, and bone mass measurements. This course was updated October 2007 and has been approved for .2 IACET* CEUs for successful completion.
- *Medicare Preventive Services Series: Part 3 Expanded Benefits Web-Based Training (WBT) Course* - This WBT course contains seven learning modules that provide information about Medicare's coverage and billing guidelines for the three services added to the Medicare program in 2005, as a result of the Medicare Modernization Act of 2003: the initial preventive physical exam (a.k.a. "Welcome to Medicare" physical exam), and diabetes and cardiovascular disease screenings. The course also includes information about diabetes self management training, medical nutrition therapy and diabetes supplies covered by Medicare as well as detailed information on colorectal, prostate, and glaucoma screenings, and bone mass measurement services. This course was updated November 2007 and has been approved for .2 IACET* CEUs for successful completion.

Web Page

MLN Preventive Services Educational Products Web Page - This *Medicare Learning Network (MLN)* web page provides descriptions of all *MLN* preventive services related educational products and resources designed specifically for use by Medicare FFS providers/suppliers. PDF files provide product ordering information and links to all downloadable products. This web page is updated as new product information becomes available. Bookmark this page for easy access. **http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp#TopOfPage** on the CMS website.

Disclaimer This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article 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.

Other Useful Provider Resources:

The Medicare Learning Network (MLN) - is the brand name for official CMS educational products and information for Medicare fee-for-service providers. For additional information, visit the Medicare Learning Network's web page at **http://www.cms.hhs.gov/MLNGenInfo** on the CMS website.

CMS Prevention Web Pages - CMS has created preventive services web pages. For additional information, visit **http://www.cms.hhs.gov/home/medicare.asp** and scroll down to the "Prevention" section.

Preventive Benefit Information for Medicare Beneficiaries - For literature to share with your Medicare patients, please visit **http://www.medicare.gov.** Medicare beneficiaries can also obtain information about Medicare preventive benefits at this website or they may call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

*The Centers for Medicare & Medicaid Services (CMS) has been reviewed and approved as an Authorized provider by the International Association for Continuing Education and Training (IACET), 8405 Greensboro Drive, Suite 800, McLean, VA 22102. The authors of the video program and web-based training course have no conflicts of interest to disclose. The video program and web-based training course were developed without any commercial support.

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Medicare Summary Notice (MSN) Message: Revised 38.13 (MM5722)

MLN Matters Number: MM5722
Related CR Release Date: September 27, 2007
Related CR Transmittal #: R1347CP
Related Change Request (CR) #: 5722
Effective Date: October 29, 2007
Implementation Date: October 29, 2007

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

Provider Action Needed
This article is informational for providers and the article is based on Change Request (CR) 5722, which outlines a change to MSN message 38.13 that will advise beneficiaries that they may need to pay their provider before receiving their MSN due to the change to quarterly mailing schedule (see CR 5062.)

Background
In an effort to reduce overall operating costs, CR5062 changed the No-Pay MSN mailing schedule from a monthly schedule to a quarterly schedule. As a result, it is possible that a beneficiary may receive a bill from a provider before receiving the MSN and may not be able to wait for the MSN before provider payment is due. The change to MSN Message 38.13 clarifies this potential timing conflict to beneficiaries. The revised MSN message is as follows:

"If you aren't due a payment check from Medicare, your Medicare Summary Notices (MSN) will now be mailed to you on a quarterly basis. You will no longer get a monthly statement in the mail for these types of MSNs. You will now get a statement every 90 days summarizing all of your Medicare claims. Your provider may send you a bill that you may need to pay before you get your MSN. When you get your MSN, look to see if you paid more than the MSN says is due. If you paid more, call your provider about a refund. If you have any questions about the bill from your provider, you should call your provider."

Additional Information
You can review the official instruction issued to you're A/B MAC, FI, carrier, DME MAC, or RHHI regarding this message modification by going to CR 5722, located at **http://www.cms.hhs.gov/transmittals/downloads/R1347CP.pdf** on the CMS website.

You can review CR5062 at **http://www.cms.hhs.gov/transmittals/downloads/R955CP.pdf** on the CMS website. The related *MLN Matters* article (MM5062: Quarterly Medicare Summary Notice (MSN) Printing Cycle) is at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5062.pdf** on the CMS website.

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

Modification to the Model Medicare Redetermination Notice (for partly or fully unfavorable redeterminations) (MM5836)

MLN Matters Number: MM5836
Related CR Release Date: January 11, 2008
Related CR Transmittal #: R1408CP
Related Change Request (CR) #: 5836
Effective Date: January 1, 2008
Implementation Date: February 11, 2008

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

What You Need to Know
CR 5836, from which this article is taken, modifies the Reconsideration Request Form that is included with the model Medicare Redetermination Notice (for partly or fully unfavorable redeterminations), to clarify the minimum set of elements on the form that you must complete in order for the request to be considered valid for reconsideration.

You should make sure that your billing staffs are aware that they must complete items 1, 2a, 6, 7, 11 & 12 on this Reconsideration Request Form.

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Modification to the Model Medicare Redetermination Notice (for partly or fully unfavorable redeterminations) (MM5836) (Continued)

Background
The Reconsideration Request Form modification that CR 5836 requires is necessary because the current Medicare manual instructions do not clearly identify all of the elements required for a reconsideration request to be considered valid in accordance with Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) Section 405.964(b).

The modification to the form is as follows:
"Directions: If you wish to appeal this decision, please fill out the required information below and mail this form to the address shown below. At a minimum, you must complete/include information for items 1, 2a, 6, 7, 11 & 12 but to help us serve you better, please include a copy of the redetermination notice with your request."

Those elements that, as a minimum, you must complete in the form are:

1. Name of Beneficiary
2a. Medicare Number
6. Item or service you wish to appeal
7. Date of the service (From and To dates)
11. Name of Person Appealing
12. Signature of Person Appealing/Date

Additional Information
You can find more information about the modification to the model Medicare Redetermination Notice (for partly or fully unfavorable redeterminations) by going to CR 5836, located at **http://www.cms.hhs.gov/Transmittals/downloads/R1408CP.pdf** on the CMS website. The updated *Medicare Claims Processing Manual*, Chapter 29, Section 320.7 (Medicare Redetermination Notice (for partly or fully unfavorable redeterminations)) is an attachment to that CR. The Reconsideration Request Form is also attached to CR5836.

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

Remittance Advice Remark Code (RARC) and Claim Adjustment Reason Code (CARC) Update (MM5800)

MLN Matters Number: MM5800
Related CR Release Date: November 30, 2007
Related CR Transmittal #: R1384CP
Related Change Request (CR) #: 5800
Effective Date: January 1, 2008
Implementation Date: January 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), and Durable Medical Equipment Medicare Administrative Contractors (DME MACs)) for services.

Impact on Providers
CR 5800, from which this article is taken, announces the latest update of Remittance Advice Remark Codes used in electronic and paper remittance advice and Claim Adjustment Reason Codes used in electronic and paper remittance advice and coordination of benefits (COB) claim transactions. These changes will be effective January 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 transactions.

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

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Remittance Advice Remark Code (RARC) and Claim Adjustment Reason Code (CARC) Update (MM5800) (Continued)

Both code lists are updated three times a year, and are posted at **http://wpc-edi.com/codes** on the Internet. The lists at the end of this article summarize the latest changes to the remark code lists, as announced in CR 5800, effective on January 1, 2008. As a reminder, CMS notes that the claim adjustment reason code of A2 (Contractual adjustment) is deactivated effective January 1, 2008.

CMS has developed a new website to help navigate the RARC database more easily. A tool is provided to help search if you are looking for a specific category of code. At this site, you can find some other information that is also available from the Washington Publishing Company (WPC) website. The new website address is **http://www.cmsremarkcodes.info/** on the Internet.

Note that this website does not replace the Washington Publishing Company (WPC) site and, should there be any discrepancies between this site and the WPC site, consider the WPC site to be correct.

Additional Information

You may see the official instruction (CR5800) issued to your Medicare Carrier, A/B MAC, FI, DME MAC or RHHI by going to **http://www.cms.hhs.gov/Transmittals/downloads/R1384CP.pdf** on the CMS website.

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

For 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.

Remittance Advice Remark Code Changes

New Codes

Code	Current Narrative	Comment
N388	Missing/incomplete/invalid prescription number. **Note: (New Code 8/1/07)**	Medicare initiated
N389	Duplicate prescription number submitted. **Note: (New Code 8/1/07)**	Medicare initiated
N390	This service cannot be billed separately. **Note: (New Code 8/1/07)**	Medicare initiated
N391	Missing emergency department records. **Note: (New Code 8/1/07)**	Not Medicare initiated
N392	Incomplete/invalid emergency department records. **Note: (New Code 8/1/07)**	Not Medicare initiated
N393	Missing progress notes or report. **Note: (New Code 8/1/07)**	Not Medicare initiated
N394	Incomplete/invalid progress notes or report. **Note: (New Code 8/1/07)**	Not Medicare initiated
N395	Missing laboratory report. **Note: (New Code 8/1/07)**	Not Medicare initiated
N396	Incomplete/invalid laboratory report. **Note: (New Code 8/1/07)**	Not Medicare initiated
N397	Benefits are not available for incomplete service(s)/undelivered item(s). **Note: (New Code 8/1/07)**	Not Medicare initiated
N398	Missing elective consent form. **Note: (New Code 8/1/07)**	Not Medicare initiated
N399	Incomplete/invalid elective consent form. **Note: (New Code 8/1/07)**	Not Medicare initiated
N400	Alert: Electronically enabled providers should submit claims electronically. **Note: (New Code 8/1/07)**	Not Medicare initiated
N401	Missing periodontal charting. **Note: (New Code 8/1/07)**	Not Medicare initiated
N402	Incomplete/invalid periodontal charting. **Note: (New Code 8/1/07)**	Not Medicare initiated
N403	Missing facility certification. **Note: (New Code 8/1/07)**	Not Medicare initiated
N404	Incomplete/invalid facility certification. **Note: (New Code 8/1/07)**	Not Medicare initiated
N405	This service is only covered when the donor's insurer(s) do not provide coverage for the service. **Note: (New Code 8/1/07)**	Not Medicare initiated

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Remittance Advice Remark Code (RARC) and Claim Adjustment Reason Code (CARC) Update (MM5800) (Continued)

Code	Current Narrative	Comment
N406	This service is only covered when the recipient's insurer(s) do not provide coverage for the service. **Note: (New Code 8/1/07)**	Not Medicare initiated
N407	You are not an approved submitter for this transmission format. **Note: (New Code 8/1/07)**	Medicare Initiated
N408	This payer does not cover deductibles assessed by a previous payer. **Note: (New Code 8/1/07)**	Not Medicare initiated
N409	This service is related to an accidental injury and is not covered unless provided within a specific time frame from the date of the accident. **Note: (New Code 8/1/07)**	Not Medicare initiated
N410	This is not covered unless the prescription changes. **Note: (New Code 8/1/07)**	Not Medicare initiated
N411	This service is allowed one time in a 6-month period. (This temporary code will be deactivated on 2/1/09. Must be used with Reason Code 119.) **Note: (New Code 8/1/07)**	Not Medicare initiated
N412	This service is allowed 2 times in a 12-month period. (This temporary code will be deactivated on 2/1/09. Must be used with Reason Code 119.) **Note: (New Code 8/1/07)**	Not Medicare initiated
N413	This service is allowed 2 times in a benefit year. (This temporary code will be deactivated on 2/1/09. Must be used with Reason Code 119.) **Note: (New Code 8/1/07)**	Not Medicare initiated
N414	This service is allowed 4 times in a 12-month period. (This temporary code will be deactivated on 2/1/09. Must be used with Reason Code 119.) **Note: (New Code 8/1/07)**	Not Medicare initiated
N415	This service is allowed 1 time in an 18-month period. (This temporary code will be deactivated on 2/1/09. Must be used with Reason Code 119.) **Note: (New Code 8/1/07)**	Not Medicare initiated
N416	This service is allowed 1 time in a 3-year period. (This temporary code will be deactivated on 2/1/09. Must be used with Reason Code 119.) **Note: (New Code 8/1/07)**	Not Medicare initiated
N417	This service is allowed 1 time in a 5-year period. (This temporary code will be deactivated on 2/1/09. Must be used with Reason Code 119.) **Note: (New Code 8/1/07)**	Not Medicare initiated
N418	Misrouted claim. See the payer's claim submission instructions. **Note: (New Code 8/1/07)**	Not Medicare initiated
N419	Claim payment was the result of a payer's retroactive adjustment due to a retroactive rate change. **Note: (New Code 8/1/07)**	Not Medicare initiated
N420	Claim payment was the result of a payer's retroactive adjustment due to a Coordination of Benefits or Third Party Liability Recovery. **Note: (New Code 8/1/07)**	Not Medicare initiated
N421	Claim payment was the result of a payer's retroactive adjustment due to a Peer Review Organization decision. **Note: (New Code 8/1/07)**	Not Medicare initiated
N422	Claim payment was the result of a payer's retroactive adjustment due to a payer's contract incentive program. **Note: (New Code 8/1/07)**	Not Medicare initiated
N423	Claim payment was the result of a payer's retroactive adjustment due to a non standard program. **Note: (New Code 8/1/07)**	Not Medicare initiated

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Remittance Advice Remark Code (RARC) and Claim Adjustment Reason Code (CARC) Update (MM5800) (Continued)

Code	Current Narrative	Comment
N424	Patient does not reside in the geographic area required for this type of payment. **Note: (New Code 8/1/07)**	Medicare initiated
N425	Statutorily excluded service(s). **Note: (New Code 8/1/07)**	Medicare initiated
N426	No coverage when self-administered. **Note: (New Code 8/1/07)**	Medicare initiated
N427	Payment for eyeglasses or contact lenses can be made only after cataract surgery. **Note: (New Code 8/1/07)**	Medicare initiated
N428	Service/procedure not covered when performed in this place of service. **Note: (New Code 8/1/07)**	Medicare initiated
N429	This is not covered since it is considered routine. **Note: (New Code 8/1/07)**	Medicare initiated

Note: Some remark codes may provide only information. They may not necessarily supplement the explanation provided through a reason code, or, in some cases another/other remark code(s), for an adjustment. Codes that are informational will have "Alert" in the text to identify them as informational rather than explanatory codes. For example, this informational code is sent per state regulation, but does not explain any adjustment:

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

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

Modified Codes

Code	Current Modified Narrative	Comment
M27	**Alert:** The patient has been relieved of liability of payment of these items and services under the limitation of liability provision of the law. The provider is ultimately liable for the patient's waived charges, including any charges for coinsurance, since the items or services were not reasonable and necessary or constituted custodial care, and you knew or could reasonably have been expected to know, that they were not covered. You may appeal this determination. You may ask for an appeal regarding both the coverage determination and the issue of whether you exercised due care. The appeal request must be filed within 120 days of the date you receive this notice. You must make the request through this office.	Modified 10/1/02, 8/1/05, 4/1/07, 8/1/07
M70	**Alert:** The patient is a member of an employer-sponsored prepaid health plan. Services from outside that health plan are not covered. However, as you were not previously notified of this, we are paying this time. In the future, we will not pay you for non-plan services.	Modified 4/1/07, 8/1/07
MA14	**Alert:** The patient is a member of an employer-sponsored prepaid health plan. Services from outside that health plan are not covered. However, as you were not previously notified of this, we are paying this time. In the future, we will not pay you for non-plan services.	Modified 4/1/07, 8/1/07
M62	**Alert:** This is a telephone review decision.	Modified 4/1/07, 8/1/07
N12	Policy provides coverage supplemental to Medicare. As the member does not appear to be enrolled in the applicable part of Medicare, the member is responsible for payment of the portion of the charge that would have been covered by Medicare.)	Modified 8/1/07
N84	**Alert:** Further installment payments are forthcoming.	Modified 4/1/07, 8/1/07
N85	**Alert:** This is the final installment payment.	Modified 4/1/07, 8/1/07
N129	Not eligible due to the patient's age.	New Code 10/31/02, Modified 8/1/07

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Revised Guidance for Completing Form CMS-1500 (MM5749))

MLN Matters Number: MM5749 - Revised
Related CR Release Date: December 14, 2007
Related CR Transmittal #: R1393CP
Related Change Request (CR) #: 5749
Effective Date: January 1, 2008
Implementation Date: January 7, 2008

Note: *This article was revised on January 8, 2008, to show that items 32a and 32b are completed if required by Medicare claims processing policy. All other information remains the same.*

Provider Types Affected
All physicians, providers, and suppliers who submit claims using Form CMS-1500 to Medicare contractors (carriers, Medicare Administrative Contractors (A/B MACs), and durable medical equipment Medicare Administrative Contractors (DME/MACs)).

Provider Action Needed
Impact to You
The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 5749 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 submission instructions for completing boxes 32a and 32b of Form CMS-1500.

What You Need to Know
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 the Form.

Background
The Form CMS-1500 claim completion instructions are being revised in order to provide guidance **related to the submission of service facility identifiers.**

The Form CMS-1500 answers the needs of many health insurers. It is the basic form prescribed by CMS for the Medicare program and is only accepted from physicians and suppliers that are excluded from the mandatory electronic claims submission requirements set forth in the Administrative Simplification Compliance Act (ASCA) and the implementing regulation at 42 CFR 424.32.

Key Points
Providers note the changes in Chapter 26 of the *Medicare Claims Processing Manual* that impact the Form CMS-1500 boxes 32a and 32b.

- **Box 32a:** If required by Medicare claims processing policy, enter the National Provider Identifier (NPI) of the service facility.
- **Box 32b:** If required by Medicare claims processing policy, **enter the legacy Provider Identification Number (PIN)** of the service facility preceded by the **ID qualifier 1C**. There should be one blank space between the qualifier and the PIN.

Additional Information
To see the official instruction (CR5749) issued to your carrier, DME/MAC, or A/B MAC refer to **http://www.cms.hhs.gov/Transmittals/downloads/R1393CP.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.

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

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Special "Skilled Nursing Facility" (SNF) Definition Used in Determining Durable Medical Equipment (DME) Coverage, and in Ending a Benefit Period or "Spell of Illness" (SE0745)

MLN Matters Number: SE0745
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
Skilled Nursing Facilities (SNFs), Durable Medical Equipment (DME) Suppliers billing Medicare fiscal intermediaries (FIs), Medicare Administrative Contractors (A/B MACs), or DME MACs.

What You Need to Know
This article is for informational purposes only and does not represent any change in policy. Instead, it reinforces existing policy by providing legal, regulatory, and Medicare manual references for:

- The definitions of SNFs and NFs;
- The policies applicable to restricting payment for DME coverage in SNFs; and
- The definition of the benefit period and of how one benefit period ends and another begins, especially as it applies to residents of SNFs.

Skilled Nursing Facility (SNF) Restriction on Coverage of Durable Medical Equipment (DME)
Coverage of a beneficiary's skilled nursing facility (SNF) stay under Part A (the Original Medicare Plan's hospital insurance program) encompasses the overall package of institutional care that the SNF furnishes during the course of the beneficiary's Medicare-covered stay. This comprehensive Part A coverage includes durable medical equipment (DME) under the heading of "...drugs, biologicals, supplies, appliances, and equipment..." as stated in Section 1861(h)(5) of the Social Security Act (the Act). (The Social Security Act is available at **http://www.ssa.gov/OP_Home/ssact/ssact-toc.htm** on the Internet.)

When a beneficiary's SNF stay does not qualify for Part A coverage (no qualifying 3-day hospital stay, SNF level of care not met, etc.), Part B (the supplementary medical insurance program) generally can still provide limited coverage for certain individual "medical and other health services" described in Section 1861(s) of the Act. However, as explained below, the scope of coverage under the Part B benefit for DME (Section 1861(s)(6) of the Act) specifically excludes items that are furnished for use in the SNF setting.

Section 1861(n) of the Act limits Part B coverage under the DME benefit to those items that are furnished for use in a patient's home. This provision further specifies that any institution meeting the basic definition of a hospital in Section 1861(e)(1) of the Act, or of an SNF in Section 1819(a)(1) of the Act, cannot be considered a patient's "home" for this purpose. Section 1819(a)(1) (formerly Section 1861(j)(1)) of the Act, in turn, defines an "SNF" broadly as any institution that is primarily engaged in providing skilled nursing (clause (A)) or rehabilitation services (clause (B)) to its residents.

This expansive SNF definition omits the specific, more restrictive elements contained in the remainder of Sections 1819(a)-(d) of the Act, which list the detailed requirements that an institution must meet in order to participate in the Medicare program as a *certified* SNF. Thus, in excluding Part B coverage for DME furnished in "SNFs" as defined broadly in Section 1819(a)(1) of the Act, Congress intended for this exclusion to encompass not only all *Medicare-participating* SNFs, but also any other institutions which, though not participating in Medicare, do provide the type of care described in that section of the law. This policy is also reflected in the regulations in title 42 of the Code of Federal Regulations (42 CFR) at §410.38(b), and in Chapter 15, Section 110.1.D of the *Medicare Benefit Policy Manual*, which is available at **http://www.cms.hhs.gov/manuals/iom/list.asp** on the CMS website.

The blanket prohibition that Congress imposed on any separate Part B payment for DME furnished in this setting (See §144(d) of the Social Security Amendments of 1967, Public Law 90-248) would appear to reflect the view that any institution whose primary function is to provide skilled care to its residents would have an inherent responsibility to dispense DME, when needed. This would mean that payment for such items is already an integral part of the skilled facility's basic inpatient rate. Accordingly, any separate, additional DME payment under Part B in this situation would be redundant. Modifying or eliminating the statutory prohibition on Part B payment for DME furnished in this setting would require legislation to amend the law itself.

Additional Considerations for DME Furnished in Medicaid-Only Nursing Facilities (NFs)
Additional considerations apply in determining whether a Medicaid-only nursing facility (NF) would meet the basic SNF definition in this context. Medicaid NFs were created when the Omnibus Budget Reconciliation Act of 1987 (OBRA 1987, Public Law 100-203) enacted nursing home reform legislation that combined the previously separate Medicaid categories of SNFs and intermediate care facilities (ICFs) into a single category. Prior to the OBRA 1987 changes, Medicaid SNFs were always considered to meet the law's basic definition of an SNF, while pursuant to a U.S. District Court decision in *Kron v. Heckler* (E.D. La., October 17, 1983), those facilities licensed or certified solely as ICFs were never considered to meet the basic SNF definition.

The parallel Medicare SNF and Medicaid NF definitions that OBRA 1987 established in Sections 1819(a)(1) and 1919(a)(1) of the Act, respectively, both turn on the type of care that the facility is primarily engaged in furnishing. However, while the NF definition in Section 1919(a)(1) of the Act contains a clause (A) for skilled nursing and a clause (B) for rehabilitation services that are identical to their SNF counterparts in Section 1819(a)(1) of the Act, it also contains an additional clause (C) for health-related institutional care above the level of room and board (comparable to the type of care furnished by ICFs prior to OBRA 1987), which is not found in the SNF definition.

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Special "Skilled Nursing Facility" (SNF) Definition Used in Determining Durable Medical Equipment (DME) Coverage, and in Ending a Benefit Period or "Spell of Illness" (SE0745) (Continued)

Thus, if a Medicaid NF is primarily engaged in furnishing skilled care under either clauses (A) or (B) of Section 1919(a)(1) of the Act, it would meet the basic SNF definition and cannot be considered a "home" for purposes of DME coverage under Part B. Alternatively, if the NF is primarily engaged in furnishing essentially ICF-level care under clause (C) of this provision, it *would not* meet the basic SNF definition and can be considered a home for DME coverage purposes. Thus, because some NFs meet the basic SNF definition while others do not, NFs cannot as a class automatically be regarded as either qualifying or not qualifying as a "home" for DME coverage purposes and, therefore, must be evaluated individually under the administrative criteria discussed below.

Administrative Criteria

Administrative criteria to identify those institutions that meet the basic SNF definition are used by each of the State agencies that survey the individual institutions within their jurisdictions, and appear in Chapter 2, Section 2166 of the *State Operations Manual.* This manual is also available at **http://www.cms.hhs.gov/manuals/iom/list.asp** on the CMS website. These criteria also were published in the *Federal Register* as HCFA Rulings 83-2 (47 FR 54551, December 3, 1982) and 83-3 (49 FR 10710, March 22, 1984). Historically, it has been the State survey agency's responsibility to evaluate an institution in terms of these criteria. This evaluation reflects the type of care that the institution provides to its residents *generally* (rather than the type of care that an individual resident may be receiving at a given point in time), because the requirements of the law relate to the type of care that an institution is *primarily engaged* in providing to its overall resident population.

Further, as indicated in Chapter 2, Section 2164 of the *State Operations Manual*, States can choose to incorporate the requirements of Section 1819(a)(1) of the Act directly into their own facility licensure standards. In a State that elects to adopt this approach, simply ascertaining that a particular nursing home is licensed under the applicable facility category of State law can also serve to confirm that the facility meets the basic SNF definition in Section 1819(a)(1) of the Act.

Applying the Criteria in Institutions That Contain a Participating "Distinct Part"

Generally, the determination of whether an institution meets the basic SNF definition is made by evaluating it as a *single unit* rather than by separately evaluating and classifying individual areas within the institution. In order to categorize a particular portion of an institution separately from the remainder of that institution, it is necessary for that portion to constitute a "distinct part," i.e., a separate, physically identifiable unit consisting of all the beds in a particular building, floor, wing, or ward (see the regulations at 42 CFR 483.5(b)).

In this situation, if the participating distinct part of an institution meets the basic SNF definition and the remainder of the institution does not, DME payment would be available under Part B only in the portion of the institution that qualifies as a "home" for DME coverage purposes by virtue of *not meeting* the basic SNF definition. Part B payment would not be available for DME furnished in any part of the institution that is identified as meeting the basic SNF definition, regardless of the type of care that a particular resident may be receiving there.

A more detailed discussion of situations in which part of an institution meets the basic SNF definition and part of it does not appears in Chapter 5, Section 1 of the *Medicare Program Integrity Manual*, also available at **http://www.cms.hhs.gov/manuals/iom/list.asp** on the CMS website. This is the same material that originally appeared in Section 4105.1 of the *Medicare Carriers Manual*, Part 3 (CMS Publication 14-3).

The Basic SNF Definition and the Medicare Policy on Ending a Benefit Period, or "Spell of Illness"

The special, broad definition of an SNF discussed above in connection with the DME coverage exclusion also figures in another aspect of Medicare policy, regarding the ending of a benefit period in an SNF. The law (at Section 1812(a)(2)(A) of the Act) provides for a maximum of 100 days of SNF benefits in a benefit period, or "spell of illness" (see Section 1861(a) of the Act). Medicare uses the benefit period concept to keep track of how many of these 100 days of SNF coverage a beneficiary has used, and how many are still available. A benefit period starts on the day that a beneficiary begins receiving Part A hospital or SNF benefits. Once the 100 days of SNF benefits available in the benefit period have been exhausted, they cannot be renewed until the current benefit period ends. Under Section 1861(a)(2) of the Act, this occurs when a period of 60 consecutive days has elapsed throughout which the beneficiary has not been an inpatient of a hospital or an SNF.

There is no limit to the number of benefit periods that a beneficiary can have. However, after a given benefit period ends, the beneficiary must once again meet all of the requirements for SNF coverage (3-day qualifying hospital stay, timely transfer to a Medicare-participating SNF, etc.) in order to begin utilizing the 100 days of renewed SNF benefits. The law's reference to a benefit period as a "spell of illness" sometimes leads to the mistaken belief that a benefit period is linked to a particular medical episode or type of condition, so that the onset of a new and unrelated condition could serve to end the benefit period. In fact, however, this does not end the benefit period, which can occur in an SNF only under the circumstances described below.

As noted previously, Section 1861(a)(2) of the Act provides, in part, that a benefit period ends after a beneficiary has not been an inpatient of an SNF for 60 consecutive days. In defining an "SNF" for this purpose, this provision uses the same broad SNF definition described in the preceding discussion on the DME coverage exclusion. This is reflected in the benefit period regulations at 42 CFR 409.60(b)(1)(iii), and in Chapter 3, Section 10.4.3.2 of the *Medicare General Information, Eligibility and Entitlement Manual*. This manual is available at **http://www.cms.hhs.gov/manuals/iom/list.asp** on the CMS website.

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Special "Skilled Nursing Facility" (SNF) Definition Used in Determining Durable Medical Equipment (DME) Coverage, and in Ending a Benefit Period or "Spell of Illness" (SE0745) (Continued)

Special "Inpatient" Definition for Ending a Benefit Period in an SNF

However, unlike in the DME context, the benefit period policy additionally uses a special definition of the term "inpatient" as well. The instructions in Chapter 3, Section 10.4.4 of the *Medicare General Information, Eligibility and Entitlement Manual* indicate that a beneficiary in an institution that meets the basic SNF definition would be considered an "inpatient," for benefit period purposes, only while actually receiving a skilled level of care there. These instructions also contain a set of administrative presumptions that simplify the process for determining whether the beneficiary is, in fact, receiving this level of care. This means that a beneficiary who remains in an SNF can nonetheless end a benefit period, after 60 consecutive days elapse during which the beneficiary does not receive a skilled level of care there (and, thus, is not considered an "inpatient" of the SNF for benefit period purposes).

This special "inpatient" definition, which reflects regulations at 42 CFR 409.60(b)(2), (c), and (d), and the Federal circuit court decision in *Mayburg v. Heckler* (740 F.2d 100 (1st Cir. 1984)), is intended to address situations in which a beneficiary essentially uses the SNF as a place of residence rather than as a provider of ongoing medical care. It is important to note as well that, under this policy, a beneficiary would still be considered an SNF "inpatient" (and his or her current benefit period would continue) for as long as the beneficiary keeps receiving a skilled level of care in the SNF—even if Medicare has stopped paying for the SNF stay due to the beneficiary's exhaustion of Part A benefits.

Thus, if a particular nursing home does not meet the basic SNF definition, a beneficiary's stay in that nursing home would not serve to prolong the current benefit period, regardless of the type of care being received there. Further, even when a beneficiary is in a nursing home that *does* meet the basic SNF definition, the beneficiary can nonetheless end a benefit period there after 60 consecutive days elapse during which he or she is not an "inpatient" of the SNF for benefit period purposes (that is, does not receive a skilled level of care). Accordingly, a nursing home stay would serve to prolong a benefit period *only if both* of the following two conditions are met:

- The nursing home meets the basic SNF definition; *and*
  The beneficiary remains an "inpatient," for benefit period purposes, by continuing to receive a skilled level of care there.

Additional Information

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

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Medical Review Disclaimer

Information in this section only pertains to medical review (MR) not for benefit integrity (BI) functions. The BI functions continue to be the responsibility of the Program Safeguard Contractors/Zone Program Integrity Contractors.

Medical Review Function Change - Transition of Medical Review Not In Support of Benefit Integrity from the PSCs to the DME MACs

Effective March 1, 2008, the medical review (MR) not for benefit integrity (BI) functions that currently have been the responsibility of the DME Program Safeguard Contractors (PSCs) will be transitioned to the Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for all DME MAC Jurisdictions. This transition does not include the PSC Benefit Integrity functions and is only in relation to the transition of the PSC MR not for BI functions.

Currently, the PSC for both the Jurisdiction A DME MAC (NHIC, Corp.) and the Jurisdiction B DME MAC (National Government Services, Inc.) is TriCenturion. TriCenturion assumed the MR function for Jurisdiction A in 2001 and for Jurisdiction B in March 2006. The MR functions that are currently being performed by TriCenturion will be transitioned individually to the Jurisdiction A DME MAC and to the Jurisdiction B DME MAC.

The Centers for Medicare and Medicaid Services (CMS) released *Medicare Learning Network (MLN)* Matters article 5765 on November 2, 2007, which was the first notification to the supplier community regarding the MR not for BI transition.

Due to the transition, the DME MACs will assume full responsibility of the following workload:

- Performance of MR not for BI functions as outlined in *MLN Matters* article 5765 and the *Medicare Program Integrity Manual* (PIM), Chapter 5 - Items and Services Having Special DME Review Considerations;
- Comprehensive Error Rate Testing (CERT);
- Local Coverage Determinations (LCDs)
- Advance Determination of Medicare Coverage (ADMC);
- Healthcare Common Procedure Coding System (HCPCS);
- Medical Review not for BI Claim Edits;
- Probe Reviews;
- Supplier Education and
- Medical Review of Claims (not for BI purposes)

Effective March 1, 2008, information relating to LCDs, the HCPCS and any MR education will be published on the DME MACs' respective Web sites versus TriCenturion's Web site.

Due to the MR not for BI transition, all MR additional documentation request letters and requests for medical records, not in support of Benefit Integrity, sent to the supplier community will be issued by the DME MACs. Suppliers will also submit ADMC requests to the DME MACs and not to TriCenturion. Also, as a result of the MR not for BI transition, the DME Medical Directors will be employed by the DME MACs.

As previously noted, the PSCs will continue to perform the Benefit Integrity functions, however, beginning in 2008, the PSCs performing BI functions will transition the BI work to Zone Program Integrity Contractors (ZPICs). This transition of PSC BI functions to ZPICS is noted in *MLN Matters* article 5765 and the PIM Chapter 5 revision.

As a result of the MR transition, the supplier community will be impacted as process changes occur. NHIC, Corp. and National Government Services, Inc., along with TriCenturion, will keep our supplier communities apprised of these changes and will communicate transition related information by utilizing all available educational avenues (i.e., listserv, Web site, seminars, etc.). The PSCs and DME MACs are working closely together to ensure a smooth transition with minimal disruption to the supplier community.

For additional details relating to the upcoming MR not for BI transition, please refer to the following:

MLN Matters Article:
http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5765.pdf

CMS Transmittal:
http://www.cms.hhs.gov/transmittals/downloads/R226PI.pdf

Medicare Program Integrity Manual:
http://www.cms.hhs.gov/manuals/downloads/pim83c05.pdf

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ADMC Process Change for Jurisdiction A

As a result of the medical review (MR) not for benefit integrity (BI) transition from the PSCs to the DME MACs, a process change will occur for the submission of Advance Determination of Medicare Coverage (ADMC) requests. Effective **February 18, 2008,** all ADMC requests for Jurisdiction A are to be submitted to NHIC, Corp. via fax to: 781-741-3991 or via mail to: NHIC, Corp., ATTN: ADMC, P O Box 9170, Hingham, MA 02043-9170. An ADMC Request Cover Sheet is available at: **http://www.medicarenhic.com/dme/dme_forms.shtml#Forms.** NHIC will process and respond to all Jurisdiction A requests. Additional information about the MR transition can be obtained through the NHIC DME MAC Web site at: **http://www.medicarenhic.com/dme.**

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Clarification on the National Provider Identifier (NPI) Enumerator's Responsibilities (SE0751)

MLN Matters Number: SE0751
Related CR Release Date: N/A
Related CR Transmittal #: N/A
Related Change Request (CR) #: N/A
Effective Date: N/A
Implementation Date: N/A

Provider Types Affected
All physicians, providers, and suppliers who submit claims to Medicare Contractors (Fiscal Intermediaries (FIs), Carriers, and Medicare Administrative Contractors (A/B MACs))

Provider Action Needed
Impact to You
The Centers for Medicare & Medicaid Services (CMS) is issuing this Special Edition (SE) 0751 article to clarify the type of assistance that the NPI Enumerator can and cannot provide to health care providers.

What You Need to Know
CMS is providing this information so you and your staff will know what issues should be referred to the NPI Enumerator and to identify issues on which the NPI Enumerator will not be able to help you. This will save you valuable time in resolving your Medicare questions.

What You Need to Do
Please share this information with your office staff.

Background
The NPI Enumerator is responsible for assisting health care providers in applying for their NPIs and updating their information in the National Plan and Provider Enumeration System (NPPES). The NPI Enumerator's responsibilities include:

- Processing NPI applications/updates/deactivations;
- Providing blank NPI application forms to health care providers upon request;
- Assisting health care providers with questions or problems regarding the processing of their NPI applications, updates, or deactivations (web-based or paper);
- Resolving errors on applications/updates/deactivations;
- Investigating potential duplicate applications/updates/deactivations to ensure the uniqueness of the provider;
- Resetting web users' NPPES passwords;
- Tracking NPPES accessibility and reporting NPPES inaccessibility issues to the CMS;
- Maintaining a call center for health care providers' questions regarding NPI application processing; and
- Working with Electronic File Interchange Organizations (EFIOs) (approval of EFIOs, resolving problems with EFI files).

Health care providers needing the above types of assistance may contact the NPI Enumerator at 1-800-465-3203, TTY 1-800-692-2326 or email the request to the NPI Enumerator at **CustomerService@NPIEnumerator.com** on the Internet. Please note that application processing times may vary based on current inventories. Please allow 15 working days to process your application/updates before contacting the NPI Enumerator.

Health care providers should **NOT contact** the NPI Enumerator for the following issues:

- The NPI Enumerator cannot provide assistance with the Medicare NPI Crosswalk and Medicare claims processing issues.
  - The NPI Enumerator does **not** generate, maintain or have access to the Medicare NPI Crosswalk.
  - The NPI Enumerator does **not** have the means/authority to alter/add/remove any information on the Medicare NPI Crosswalk.
  - The NPI Enumerator **cannot** report problems to CMS or to the Medicare Fee-for-Service contractors concerning the Medicare NPI Crosswalk or claims processing problems.
  - The NPI Enumerator does **not** send updates to the Medicare NPI Crosswalk.
  - The NPI Enumerator does **not** know how/when the Medicare NPI Crosswalk will be updated.
  - The NPI Enumerator **cannot** advise a provider as to how to complete the paper or electronic claim.
  - The NPI Enumerator **cannot** tell a provider how many legacy numbers to report on the NPPES record in order to assist in populating information on the Medicare NPI Crosswalk.
- The NPI Enumerator cannot provide assistance with information disseminated or not disseminated via the NPI Registry or the NPPES downloadable file:
  - The NPI Enumerator **cannot** assist providers with questions regarding "temporarily suppressed" information found on the NPI Registry or downloadable file.
  - Although the NPI Enumerator can confirm whether or not the information still exists in the provider's active NPPES record; this confirmation is limited to the health care provider or contact person on the provider's NPPES record. Third party sources, including Medicare contractors, **cannot** call the NPI Enumerator for confirmation of information in a health care provider's NPPES record. If this type of confirmation is needed, the third party should request the information from the provider directly.

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Clarification on the National Provider Identifier (NPI) Enumerator's Responsibilities (SE0751) (Continued)

- The NPI Enumerator cannot provide assistance with Medicare-related provider enrollment information:
  - The NPI Enumerator **cannot** determine how providers are enrolled with Medicare (e.g., as an individual or as a group).
  - The NPI Enumerator **cannot** determine which identifiers (Unique Physician Identification Number (UPIN), Provider Identification Number (PIN), Online Survey Certification and Reporting System (OSCAR), or National Supplier Clearinghouse (NSC)) should be included on health care providers' NPPES records.
  - The NPI Enumerator has no way of knowing which type(s) of legacy number(s) were assigned to a provider by the Medicare contractor(s).
  - The NPI Enumerator **cannot** tell a provider how many legacy numbers to report on the NPPES record in order to assist in populating information on the Medicare NPI Crosswalk.
- The NPI Enumerator cannot provide assistance with NPI-to-legacy number linkages (i.e., how to properly link multiple legacy numbers to one NPI or how to properly link one legacy number to multiple NPIs).
- The NPI Enumerator cannot provide assistance with questions related to:
  - Defining subparts;
  - Which subparts should receive NPIs;
  - Where NPIs or legacy identifiers are to be placed in claims transactions;
  - Health Insurance Portability and Accountability Action (HIPAA) regulations or regulatory policies;
  - Proper use of NPIs in transactions with health plans; and
  - Determining if the provider is a sole proprietor or an incorporated individual.

Additional Information
CMS advises providers to read the information available at **http://www.cms.hhs.gov/NationalProvIdentStand/** on the CMS NPI website. Included on this site are NPI Frequently Asked Questions and Answers that can assist you with issues for which the NPI Enumerator is not responsible.

In addition, the NPI Application/Update form itself is also a good source of information. Providers should refer to the instructions (they are part of the form) for clarification on information to be submitted in order to obtain NPIs or update their records. You can also refer to the *"Application Help"* tab located at: **https://nppes.cms.hhs.gov** on the NPPES website for additional assistance when you are online.

If you have questions related to Medicare issues, please contact your Medicare Carrier, FI, 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.

How to Handle the National Provider Identifier (NPI) for Ordering/Referring and Attending/Operating/Other/Service Facility for Medicare Claims (MM5674)

MLN Matters Number: MM5674 - Revised
Related CR Release Date: October 26, 2007
Related CR Transmittal #: R225PI

Related Change Request (CR) #: 5674
Effective Date: May 23, 2008
Implementation Date: April 7, 2008

Note: *This article was revised on December 18, 2007, to add DME MACs as affected providers. In addition, references to CR5328, CR5416 and CR4169 at the end of the article were remove. These CRs were incorrect. All other information remains unchanged.*

Provider Types Affected
Physicians and providers who bill Medicare Carriers, Fiscal Intermediaries (FIs), Durable Medical Equipment Medicare Administrative Contractors (DME MACs) and Part A/B MACs for claims for services provided to Medicare beneficiaries.

What Providers Need to Know
Be cognizant of the fact that in accordance with the NPI final rule, when an identifier is reported on a claim for ordering/referring/attending provider, operating/other/service facility provider, or for any provider that is not a billing, pay-to or rendering provider, that identifier **must be an NPI. For Medicare purposes, this means that submission of an NPI for an ordering/referring provider is mandatory effective May 23, 2008. Legacy numbers cannot be reported on any claims sent to Medicare on or after May 23, 2008.**

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How to Handle the National Provider Identifier (NPI) for Ordering/Referring and Attending/Operating/Other/Service Facility for Medicare Claims (MM5674) (Continued)

Medicare has always required that a provider identifier be reported for ordering/referring providers. Effective May 23, 2008, that number **must be an NPI,** regardless of whether that referring or ordering provider participates in the Medicare program or not or is a covered entity.

Key Points

- Medicare will not pay for referred/ordered services or items unless the name and NPI number of the referring / ordering / attending / operating / other / service facility provider is on the claim.
- It is the responsibility of the claim/bill submitter to obtain the ordering / referring / attending / operating / other / service facility NPI for health care providers.
- Providers whose business is largely based upon provision of services or items referred / ordered by other providers must be careful furnishing such services/items unless they first obtain the NPI of the referring / ordering individual. If they furnish services/items and do not obtain that person's NPI prior to billing Medicare, their claim will be denied.
- If the NPI is not directly furnished by the ordering/referring provider at the time of the order, the provider expected to furnish the services or items should contact that provider for his/her NPI prior to delivery of the services / items.
- Providers who have not obtained an NPI by May 23, 2008, are not permitted to refer/order services or items for Medicare beneficiaries.
- Legacy numbers, such as provider identification numbers (PINs) or unique physician identification numbers (UPINs), cannot be reported on any claims sent to Medicare on or after May 23, 2008.
- Physicians and the following non physician practitioners are the only types of providers allowed to refer/order services or items for beneficiaries:
  - Nurse practitioners (NP);
  - Clinical nurse specialists (CNS);
  - Physician assistants (PA); and
  - Certified nurse midwives (CNM).

Background

This article is based on Change Request (CR) 5674. Please note that 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 (NPI) final rule, published on January 23, 2004, establishes the NPI as this standard. All health care providers covered under HIPAA must comply with the requirements of the NPI final rule (45 CFR Part 162, CMS-045-F). All entities covered under HIPAA must comply with the requirements of the NPI final rule.

Additional Information

If you have questions, please contact your Medicare A/B MAC, DME MAC, FI, 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 (CR5674) issued to your Medicare A/B MAC, DME MAC, FI, or carrier by going to **http://www.cms.hhs.gov/Transmittals/downloads/R225PI.pdf** on the CMS website.

Mandatory Reporting of the National Provider Identifier (NPI) on all Part B Claims (JSM 08048)

Effective March 1, 2008, your Medicare fee-for-service claims must include an NPI in the primary provider fields on the claim (i.e., the billing, pay-to provider, and rendering provider fields). You may continue to submit NPI/legacy pairs in these fields or submit only your NPI. The secondary provider fields (i.e., referring, ordering and supervising) may continue to include only your legacy number, if you choose. Failure to submit an NPI in the primary provider fields will result in your claim being rejected, beginning March 1, 2008.

In addition, if you already bill using the NPI/legacy pair in the primary provider fields and your claims are processing correctly, now is a good time to submit to your contractor a small number of claims containing only the NPI in the primary provider fields. This test will serve to assure your claims will successfully process when only the NPI is mandated on all claims.

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NCPDP Inbound Claim and COB Companion Documents Updated for NPI Reporting (MM5716)

MLN Matters Number: MM5716 - Revised
Related CR Release Date: November 2, 2007
Related CR Transmittal #: R299OTN

Related Change Request (CR) #: 5716
Effective Date: April 1, 2008
Implementation Date: April 7, 2008

Note: *This article was revised on December 4, 2007, to clarify the language in the bullet points on page 3 to more closely align with CR5716. All other information remains the same.*

Provider Types Affected
Suppliers who bill Medicare Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for providing Medicare Part B drugs to Medicare beneficiaries.

What You Need to Know
CR 5716, from which this article is taken, announces that the original Medicare fee-for-service National Council for Prescription Drug Programs (NCPDP) inbound claim and coordination of benefits (COB) companion documents have been updated to address the use of the National Provider Identifier (NPI).

You can find these updated documents (entitled "NCPDP 5.1/1.1 Inbound **NPI** Companion Document" and "NCPDP 5.1/1.1 COB **NPI** Companion Document") at **http://www.cms.hhs.gov/ElectronicBillingEDITrans/08_HealthCareClaims.asp** on the CMS website, and as attachments to CR5716.

Background
The Health Insurance Portability and Accountability Act (HIPAA) of 1996 adopted the NCPDP Telecommunication Standard 5.1 and NCPDP Batch Standard 1.1 as the national standard for submitting retail drug claims. Medicare DME MACs are responsible for processing all retail drug claims for those limited prescription drugs covered under Medicare Part B; and this national standard applies both to claims sent inbound to DME MACs as well as those sent outbound by the DME MACs to COB trading partners.

In addition to such national standards, HIPAA also mandated that covered entities use NPIs as the sole means to identify providers who prepare electronic data interchange (EDI) transactions. However, NCPDP standards were not designed to enable a health care provider to report more than one identifier during this transition period. Thus, in NCPDP claims, you can report either a provider's legacy number, such as National Supplier Clearinghouse (NSC) identification numbers used for retail pharmacy identification and the Unique Physician Identification Numbers (UPINs) used to identify prescribers of retail drugs, or the NPI, but not both.

Further, when the original Medicare fee-for-service NCPDP inbound claim and COB companion documents (which provide Medicare-specific information related to the use of the relevant HIPAA standards) were issued, they did not address use of NPIs. CR5716, from which this article is taken, announces that an updated version of those companion documents, that does include NPI reporting, is now available to be downloaded under the titles of "NCPDP 5.1/1.1 Inbound NPI Companion Document" and "NCPDP 5.1/1.1 COB NPI Companion Document" at:
http://www.cms.hhs.gov/ElectronicBillingEDITrans/08_HealthCareClaims.asp#TopOfPage.

You should be aware that for retail drug claims prior to May 23, 2008 (the date when the NPI is to be used exclusively to identify providers on NCPDP claims) the NCPDP implementation guide calls for the use of qualifiers to indicate the type of provider identifier being reported.

On NCPDP claims that you submit prior to May 23, 2008, you can choose to use either legacy numbers or NPIs for provider identification. If you choose to use legacy numbers, the pre-NPI companion document (not containing "NPI" in the title) applies. If you choose to use NPIs, the new companion documents (containing "NPI" in the titles) apply. Lastly, prior to May 23, 2008, if you use a legacy identifier for the retail pharmacy and an NPI for the prescriber (or vice versa); the non-NPI companion document will apply for reporting the legacy identifier, and the NPI companion document will apply for reporting the NPI.

There are some specific details related to the completion of NCPDP claims that will be of interest to you:

- Effective for claims received by Medicare on or after May 23, 2008, your inbound claims will be returned if they do not contain an 01 (NPI) qualifier in Transaction Header segments 202-B2 (retail pharmacy identification) and/or 466-EZ (prescriber identification), and if included in a claim, 468-2E (primary care provider identification) and 465-EY (pharmacy identification).
- If an inbound claim contains a reported NPI in a provider identification number field (210-B1, 411-DB, 421-DL, or 449-E9), but one or more of those numbers do not meet NPI validity criteria (i.e., does not begin with a 1, 2, 3, or 4; does not have 10-digits; includes any special characters; or does not have a valid check digit in the 10th position), the claim will reject.
- Medicare systems will not check the Medicare NPI Crosswalk to try to locate an NPI for any provider identification fields (qualifier and provider identification number fields) for any provider for which information is included in a claim in fields which are not used for Medicare claim processing (e.g., fields 468-2E and 421-DL or 465-EY and 449-E9). The editing for such provider qualifiers and identification numbers in the fields not used by Medicare will be limited to NPI validity edits.
- Medicare legacy numbers will not be reported on the outbound coordination of benefits (COB) transaction. However, an exception is permitted for those claims that have not cleared the system by the date CMS ends its' NPI contingency. Those "pending" claims may contain legacy number, so the COB will also include the legacy number.

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NCPDP Inbound Claim and COB Companion Documents Updated for NPI Reporting (MM5716) (Continued)

Additional Information
You can find the official instruction, CR5716, issued to your DME MAC by visiting **http://www.cms.hhs.gov/Transmittals/downloads/R299OTN.pdf** on the CMS website. The two updated companion documents: "NCPDP 5.1/1.1 Inbound NPI Companion Document" and "NCPDP 5.1/1.1 COB NPI Companion Document" are attached to that CR.

For more information on the NPI contingency, providers may visit **http://www.cms.hhs.gov/NationalProvIdentStand/08_NPI%20Contingency%20Planning.asp#TopOfPage** 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.

Rejection of Electronic Claim Status Requests that Lack National Provider Identifiers (NPIs) (MM5726)

MLN Matters Number: MM5726
Related CR Release Date: November 2, 2007
Related CR Transmittal #: R302OTN
Related Change Request (CR) #: 5726
Effective Date: May 23, 2008
Implementation Dates: January 7, 2008 and April 7, 2008

Provider Types Affected
Physicians, providers, and suppliers who submit claims status requests using the electronic data interchange (EDI) standard Health Insurance Portability and Accountability Act (HIPAA) transactions to Medicare contractors (carriers, Fiscal Intermediaries, (FIs), including Regional Home Health Intermediaries (RHHIs), Medicare Administrative Contractors (MACs), and DME Medicare Administrative Contractors (DME MACs))

Provider Action Needed
Impact to You
This article is based on CR5726, which describes policy changes that are a result of HIPAA requirements that prohibit the acceptance of EDI transactions that contain legacy provider numbers. CR5726 specifically address changes around the processing of electronic claim status requests and the responses to such requests.

What You Need to Know
Beginning May 23, 2008, Medicare will return to sender any electronic claim status request (X12 276 transactions) that contain legacy provider numbers instead of or in addition to the NPI number. This policy also applies to direct data entry (DDE) claim status inquiries and to Internet claim status screens operated as demonstration projects by some contractors.

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

Background
All electronics claim status requests submitted using the EDI standards (X12 276) adopted under HIPAA for national use must use the HIPAA-mandated NPI exclusively for provider identification no later than May 23, 2008. Those that do not are to be returned to the sender beginning May 23, 2008. All claims status responses (X12 277 transactions) will also contain only NPIs as of May 23, 2008. The same policy applies to direct data entry claim status inquiries and to those Internet claim status screens some contractors are permitted to operate under an Internet demonstration program. The absence of an NPI or the presence of a legacy number as of May 23, 2008, will result in rejection of the inquiry by these direct data entry processes.

Providers are advised that Medicare will return an NPI on the claims status response on or after May 23, 2008, even if the claim status request is received prior to May 23, 2008, using a legacy number. In returning the NPI, Medicare will use a crosswalk file that relates the legacy number to the provider's NPI. If the legacy number maps to more than one NPI, Medicare will return the first active NPI in the 277 response.

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Rejection of Electronic Claim Status Requests that Lack National Provider Identifiers (NPIs) (MM5726) (Continued)

To avoid confusion, Medicare encourages providers to begin including their NPIs in their X12 276 inquiries as soon as possible prior to May 23, 2008, particularly if the provider has more than one NPI, but was assigned only one legacy number by Medicare for claims submission purposes.

Additional Information
The official instruction, CR5726, issued to your Medicare contractor can be found at **http://www.cms.hhs.gov/Transmittals/downloads/R302OTN.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.

Reporting a National Provider Identifier (NPI) and the "EY" Modifier on Claims for Durable Medical Equipment, Prosthetic, and Orthotic Supplies (DMEPOS) Items Dispensed without a Physician's Order to Obtain a Medicare Denial for Coordination of Benefits (COB) (MM5771)

MLN Matters Number: MM5771
Related CR Release Date: November 2, 2007
Related CR Transmittal #: R1368CP
Related Change Request (CR) #: 5771
Effective Date: May 23, 2008
Implementation Date: April 7, 2008

Provider Types Affected
Suppliers who bill for DMEPOS for Medicare beneficiaries and require a Medicare Denial for COB purposes.

Provider Action Needed
- For Coordination of Benefit purposes, DMEPOS suppliers should use the modifier EY (no physician or other licensed health care provider order for this item or service) on each line item on the claim and report their own name and National Provider Identifier (NPI) in the "Ordering/Referring Provider Name" fields on claims submitted on or after May 23, 2008 to secure a Medicare denial. Failure to include the EY modifier on all line items will result in return of your claim as unprocessable. On such returned claims, the Medicare contractor will include Reason Code 4 to show that "The procedure code is inconsistent with the modifier used or a required modifier is missing."
- If you have obtained a physician's order for some, but not all, of the items provided to the Medicare beneficiary, submit a separate claim for the items dispensed without a physician's order.

Background
Chapter 5, section 5.2.1 of the *Medicare Program Integrity Manual* (PIM) states that a supplier must have an order (prescription) from the treating physician prior to dispensing any DMEPOS item to a beneficiary and must keep the prescription for the item on file. However, although Medicare requires a physician's order for payment of all DMEPOS items, not all secondary insurers maintain a similar requirement.

The Centers for Medicare & Medicaid Services (CMS) instituted modifier "EY" (no physician or other licensed health care provider order for this item or service) to allow DMEPOS suppliers to submit claims to Medicare for items without a prescription. Since there is no physician or provider information to report on claims for these items, the "EY" modifier is used in conjunction with a surrogate Unique Physician Identification Number (UPIN) in the ordering/referring provider name fields of the claim. This protocol was adopted so that suppliers could obtain a Medicare denial that could be sent to a secondary insurer for COB purposes.

In accordance with the NPI final rule, when an identifier is reported on a claim for the ordering/referring provider, i.e., any provider that is not a billing, pay-to or rendering provider, that identifier must be an NPI (See 45 CFR Part 162, CMS- 045-F). For Medicare purposes, this means that submission of an NPI for an ordering/referring provider is mandatory, effective May 23, 2008, and legacy numbers may not be reported on any claims sent to Medicare as of this date. Therefore, Medicare will discontinue the use of all surrogate values on claims with dates of service on or after May 23, 2008.

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Reporting a National Provider Identifier (NPI) and the "EY" Modifier on Claims for Durable Medical Equipment, Prosthetic, and Orthotic Supplies (DMEPOS) Items Dispensed without a Physician's Order to Obtain a Medicare Denial for Coordination of Benefits (COB) (MM5771) (Continued)

To assure prompt processing of your claims affected by this issue:

- Your name should be reported in item 17 and your NPI in 17b of the CMS-1500 claim form, version 08-05; or
- Your name and NPI should be reported in both the 2420E (ordering provider name) and 2420F (referring provider name) loops of the ASC X12N 837 professional claim format.
- Make sure the "EY" modifier is present on each line item on the claim.

Additional Information

You may see the official instruction (CR5771) issued to your Medicare DME MAC by going to **http://www.cms.hhs.gov/Transmittals/downloads/R1368CP.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.

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Advance Beneficiary Notice (ABN) Reminder

The Appeals Department has seen multiple invalid Advance Beneficiary Notice (ABN) forms submitted with Redetermination requests and therefore would like to issue the following reminder from the *Medicare Claims Processing Manual*, Publication 100-04 Chapter 30, Section 40.3.8 (**http://www.cms.hhs.gov/manuals/downloads/clm104c30.pdf**)

"Statements of reasons for predicting Medicare denial of payment at a level of detail similar to the approved "Medical Necessity" messages for MSNs are acceptable for ABN purposes. Simply stating "medically unnecessary" or the equivalent is not an acceptable reason, insofar as it does not at all explain why the physician or supplier believes the items or services will be denied as not reasonable and necessary. To be acceptable, the ABN must give the beneficiary a reasonable idea of why the notifier is predicting the likelihood of Medicare denial so that the beneficiary can make an informed consumer decision whether or not to receive the service and pay for it personally. Listing several reasons which apply in different situations without indicating which reason is applicable in the beneficiary's particular situation generally is not an acceptable practice, and **such an ABN may be defective and may not protect the notifier from liability.** However, if more than one reason for denial could apply (e.g., exceeding a frequency limit and "same day" duplication; cases where the reason for denial could depend upon the result of a test; etc.), the contractor will not invalidate an ABN on the basis of citing more than one reason for denial."

Billing Reminder for Electronic Billing of Select Oral Anti-Cancer Drugs

Follow the below instructions when billing electronic claims for oral anti-cancer drugs that are listed **without** a HCPCS code in the NDC to HCPCS Crosswalk. The list is available on the SADMERC Web site at **http://www.palmettogba.com/sadmerc.**

Loop 2400 Line Level Information
SV101>01 = ZZ
SV101>02 = XXXXX

Loop 2410 Drug Identification Information
LIN02 = N4
LIN03 = NDC CODE (11 Digits)

Please forward this information to your software vendor.

If you or your vendor have any questions regarding this billing reminder please, contact the EDI Support Staff at **866-563-0049.**

Comprehensive Error Rate Testing (CERT) Documentation Contractor (CDC) Telephone Inquiry Announcement

The CERT CDC has noted that from time to time they receive calls from providers that do not have access to long distance. When this occurs, the provider incurs costs that can be a financial burden especially on small providers. To assist those providers, the CDC is now offering a toll-free telephone number. **This number is for voice only and NOT for faxes.** The new number is **888-779-7477**. Providers can also continue to use the long distance number **301-957-2380**.

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DME MAC A ListServes

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

What are the benefits of joining the DME MAC A ListServes? By joining, you will be the first to learn about upcoming educational opportunities and training events. You will also be the first to know when our quarterly *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/**

DME MAC A Spring In-Person Seminar Schedule - COMING SOON

The DME MAC Jurisdiction A Outreach & Education Team is in the process of planning our Spring 2008 In-Person Educational Seminars. We will be providing seminars in eight different locations throughout our Jurisdiction. Once these dates and locations are available, the DME MAC A Web site will be updated to include a detailed schedule.

We encourage you to regularly check the Events and Seminars section on our Web site at **http://www.medicarenhic.com/dme/dmerc_seminars.shtml** for all educational opportunities. In addition, please be sure you are registered for the DME MAC A List Serves so that you can be notified of the seminar schedule as well as other very important announcements that may assist you in billing Medicare claims.

DME MAC Jurisdiction A to Attend Medtrade Spring 2008

The DME MAC Jurisdiction A will attend the Medtrade Spring 2008 Exposition and Conference being held May 7-8, 2008 in Long Beach, California. It is anticipated that all four DME MAC Jurisdictions and the National Supplier Clearinghouse (NSC) will again share booth space and, in addition, present at the DME MAC Update Session.

This joint effort by the Medicare Contractors gives the supplier community an opportunity to interact with all four Jurisdictions and the NSC in one location. Please visit us at **booth #1357**. We are looking forward to seeing you there.

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Fourth Quarter 2007 - Top Claim Submission Errors

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

Top Ten Claims Submission Errors	Number Received	Reason For Error
40022 - Procedure Code/Modifier Invalid	32,669	The procedure code and/or modifier used on this line is invalid.
20269 - Pointer 1 Diagnosis Invalid	20,569	Diagnosis pointer is invalid in first diagnosis field.
40068 - Invalid/Unnecessary CMN Question	14,599	The question number entered is not valid for the DME MAC CMN you are sending.
20011 - Billing Provider Secondary ID Invalid	11,176	Secondary provider ID is invalid.
40014 - Ordering Provider Information Missing	8,691	The ordering provider information is missing. This should be included with every service line.
20270 - Pointer 2 Diagnosis Invalid	7,165	Diagnosis pointer is invalid in second diagnosis field.
20143 - Ordering Provider Secondary ID Invalid	7,159	The provider number or Unique Physician Identification Number (UPIN) is invalid.
20110 - Procedure Code Invalid	6,074	Procedure Code is invalid or discontinued.
20322 - Submitter ID Invalid	5,754	The NPI (National Provider Identifier) is not found on crosswalk.
40021 - Capped Rental K Modifier Missing	5,628	Required capped rental K modifier is missing from the claim.

In an effort to reduce other initial claim denials, the below information represents the top ten (10) return/reject denials for the fourth quarter of 2007. Claims denied in this manner are considered to be unprocessable and have no appeal rights. An unprocessable claim is any claim with incomplete or missing, required information, or any claim that contains complete and necessary information, however, the information provided is invalid. Such information may either be required for all claims or required conditionally.

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Fourth Quarter 2007 - Top Claim Submission Errors (Continued)

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 October through December 2007.

Claims Submission Errors (Return/Reject Denials)	CMS 1500 Form (or electronic equivalent) Entry Requirement	Number Received
CO 16 N28 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/NSC pair on the crosswalk file.	12,733
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.	6,429
CO 16 MA130 Claim / service lacks information which is needed for adjudication. Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable.	**Item 11** - If other insurance is primary to Medicare, enter the insured's policy or group number. If no insurance primary to Medicare exists, enter "NONE."	5,628
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.	4,340
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.	2,909
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.	2,847
CO 16 M76, M81 Claim / service lacks information which is needed for adjudication. You are required to code to the highest level of specificity. Missing / incomplete / invalid diagnosis or condition.	**Item 21** - Enter the patient's diagnosis/condition. All physician specialties must use an ICD-9-CM code number, coded to the highest level of specificity.	1,191
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 but narrative description was not entered.	772
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.	311
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.	284

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Fourth Quarter 2007 - Top Claim Submission Errors (Continued)

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.

Heating Pads Billing Reminder

TriCenturion, the Jurisdiction A/B DME MAC Program Safeguard Contractor (PSC), has recently completed a widespread pre-payment probe review of HCPCS E0215 (Electric heat pad, moist) and HCPCS E0217 (Water circulating heat pad with pump).

Refer to TriCenturion's web site for the September 2007 publication entitled *"Heat/Cold Application Widespread Probe Results HCPCS E0215 and E0217"* which can be found at **http://www.tricenturion.com/content/pcalpet.cfm**

Based on findings of this audit, suppliers are reminded to reference the following publications related to coverage, documentation requirements, and the Medical Review Audit Process:

- The CMS *National Coverage Determinations (NCD) Manual* (280.1) states, "Covered if contractor's medical staff determines patient's medical condition is one for which the application of heat in the form of a heating pad is therapeutically effective." The *NCD manual* can be found on the CMS Web site at **http://www.cms.hhs.gov/manuals/downloads/ncd103c1_Part4.pdf**
- *DME MAC A Supplier Manual*, Chapter 10 **(http://www.medicarenhic.com/dme/dmemaca_sm_ch10-rev2007-10.pdf)**, regarding Documentation in the Patient's Medical Record and Supplier Documentation which addresses the following points relative to audit findings:

  Documentation in the Patient's Medical Record
  For any DMEPOS item 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 (if applicable). 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.

  Supplier Documentation
  The supplier should also obtain as much documentation from the patient's medical record as they determine they need to assure themselves that coverage criterion for an item has been met. If the information in the patient's medical record does not adequately support the medical necessity for the item, the supplier is liable for the dollar amount involved, unless a properly executed ABN of possible denial has been obtained.
- *"FAQs: The Medical Review Audit Process"* **(http://www.tricenturion.com/content/faq_dyn.cfm)** which is an article on TriCenturion's Web site regarding the Medical Review Audit Process.

Additionally, suppliers should be aware that the PSC does have the authority to review and make medical necessity determinations (including least costly alternative determinations) on individual claims, even in the absence of a Local Coverage Determination.

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Immunosuppressive Drugs Billing Clarification

The DME MAC Jurisdiction A Appeals and Claims Departments have identified claims for immunosuppressive drugs that were submitted when a transplant was not on file in the Medicare processing system. When submitting claims for immunosuppressive drugs, suppliers are encouraged to indicate in the Note (NTE) line level segment (2400 loop) for an electronic claim, or in box 19 of a paper claim, the following information to ensure efficient claim submission:

- Transplant date,
- Transplant facility name or number, **and**
- Discharge date

As a reminder, the Note (NTE) line level segment (2400 loop) is limited to 80 characters. Therefore, suppliers will need to eliminate unnecessary wording and abbreviate as much as possible. A list of suggested abbreviations is available on the DME MAC A Web site at **http://www.medicarenhic.com/dme/ediabbrev.shtml.**

If the above information is not provided and a transplant can not be found on file, the claim will be denied and additional information will need to be submitted at the appeal level.

NPI Bypass Logic Claim Rejections

Effective October 29, 2007, DME MACs lifted the NPI bypass logic and began validating NPI/NSC pairs submitted against the crosswalk file. As a result, paper claims that included non-matching NPIs and legacy identifiers were being suspend in the claims processing system. These claims are now being processed and many are rejecting with a CO-16, N280 reason and remark code. The denial message will read, "Missing/incomplete/invalid pay-to provider primary identifier."

Electronic claims may also reject on the front end for issues with the crosswalk.

The following common reasons for rejections have been identified by NHIC:

Issue A - Invalid Entity Type:
Suppliers must complete their NPI application with the same entity code that is on file with the National Supplier Clearinghouse (NSC). DMEPOS suppliers and pharmacies are considered to be an Organization (entity type 2). Please refer to Section 1B of the NPI application **(http://www.cms.hhs.gov/cmsforms/downloads/CMS10114.pdf)** instructions for further details on choosing an entity code. Suppliers that listed an incorrect type code on their NPI application must complete a new application with the National Plan and Provider Enumeration System (NPPES). The NPI number with the incorrect type code should be deactivated. Suppliers are not able to update the entity type code on the NPPES Web site.

Issue B - NPI-NSC Mismatch:
Supplier information in NPPES may be inaccurate or may not match the NSC files. In this case, suppliers can update the below information via the NPPES Web site at: **https://nppes.cms.hhs.gov/NPPES/StaticForward.do?forward=static.npistart** or by contacting the Enumerator toll free at 1-800-465-3203.

- Supplier identifying information including the name, address, and Tax-ID/Employee Identification Number (EIN)/Social Security Number (SSN) may be inaccurate
- Verify that the PTAN (NSC number) is listed in the **"Medicare NSC"** field in the "Other Provider Identifier" record
- Verify that the "Entity Type" is set to "2 - Organization. If the "Entity Type" is set to "1-Individual," you may need to obtain a new "organization" NPI number from NPPES. (Please see instructions under Issue A)

Note: *For issues A and B, once the NPPES database has been updated, claims can be resubmitted with the correct NPI after 7 calendar days.*

Issue C - Incorrect Information with NSC:
If issue A and B (above) don't apply, the supplier information may be incorrect with the NSC. Suppliers should compare their original 855-S application to the information on the NPPES database to determine which information doesn't match. Incorrect information with the NSC will require a new 855-S form to be completed. In this circumstance, while suppliers are working to resolve an NPI Crosswalk issue with the NSC, claims can be resubmitted with only a legacy number (NSC) through February 29, 2008.

Effective March 1, 2008, all claims ***must*** include an NPI in the primary identifier field. For additional NPI information and deadlines, please refer to: **http://www.cms.hhs.gov/nationalprovidentstand/**

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Power Mobility Devices Billing Reminder

Please refer to the December 2007 article on TriCenturion's Web site (**http://www.tricenturion.com/content/pcalpet.cfm**), titled "Power Wheelchair Widespread Pre-payment Review 1st Quarter Results HCPCS K0823"

The following observations were made as a result of claims reviewed in the audit for Jurisdiction A:

- 10% of the claims were paid
- 86% of the claims were denied as Medicare policy criteria were not met.
- Of the 86% of the claims denied:
  - 39% were denied as there were no medical records submitted for review
  - 61% were denied as the information submitted did not meet policy criteria
- 4% of the claims were denied for non response

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

- NHIC, Corp. *DME MAC A Supplier Manual*, Chapter 10, regarding "Documentation in the Patient's Medical Record" and "Supplier Documentation" which can be found at **http://www.medicarenhic.com/dme/suppmandownload.shtml**
- The Local Coverage Determination (LCD) for Power Mobility Devices, (specifically the Documentation Requirements section), and the associated Policy article which are both found at **http://www.tricenturion.com/content/lcd_current_dyn.cfm**

The major claim denial reasons from this audit are italicized below and followed by the specific LCD documentation requirements, Policy Article references, or *Medicare Program Integrity Manual* references, which address the denials.

The physician order did not have all of the required seven elements.
As stated in the LCD, "The order that the supplier must receive within 45 days after completion of the face-to-face examination (see Policy Article) must contain all of the following elements:

1. Beneficiary's name
2. Description of the item that is ordered. This may be general - e.g., "power operated vehicle", "power wheelchair", or "power mobility device" - or may be more specific.
3. Date of the face-to-face examination
4. Pertinent diagnoses/conditions that relate to the need for the POV or power wheelchair
5. Length of need
6. Physician's signature
7. Date of physician signature"

It was not documented that a reason for the physician visit was for a mobility examination.
As stated in the LCD, "Physicians shall document the examination in a detailed narrative note in their charts in the format that they use for other entries. The note must clearly indicate that a major reason for the visit was a mobility examination."

Functional limitations were not addressed in the face-to-face evaluation.
As stated in the LCD, "The report should provide pertinent information about the following elements, but may include other details. Each element would not have to be addressed in every evaluation.

- Symptoms
- Related diagnoses
- History
  - How long the condition has been present
  - Clinical progression
  - Interventions that have been tried and the results
  - Past use of walker, manual wheelchair, POV, or power wheelchair and the results
- Physical exam
  - Weight
  - Impairment of strength, range of motion, sensation, or coordination of arms and legs
  - Presence of abnormal tone or deformity of arms, legs, or trunk
  - Neck, trunk, and pelvic posture and flexibility
  - Sitting and standing balance
- Functional assessment - any problems with performing the following activities including the need to use a cane, walker, or the assistance of another person
  - Transferring between a bed, chair, and PMD
  - Walking around their home - to bathroom, kitchen, living room, etc. - provide information on distance walked, speed, and balance"

Letters of attestation submitted without supporting information from the medical record.
As referenced in the *Medicare Program Integrity Manual*, 100-08, Chapter 5.7-Documentation in the Patient's Medical Record, "...neither a physician's order nor a CMN nor a DIF 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 or supplier. There must be information in the patient's medical record that supports the medical necessity for the item and substantiates the answers on the CMN (if applicable) or DIF (if applicable) or information on a supplier prepared statement or physician attestation (if applicable)."

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Power Mobility Devices Billing Reminder (Continued)

Supplier created mobility evaluation forms were submitted as a substitution for information from the medical record.
As stated in the LCD, "Many suppliers have created forms which have not been approved by CMS which they send to physicians and ask them to complete. Even if the physician completes this type of form and puts it in his/her chart, this supplier-generated form is not a substitute for the comprehensive medical record as noted above. Suppliers are encouraged to help educate physicians on the type of information that is needed to document a patient's mobility needs."

No date stamp or equivalent to verify supplier receipt of the physician order within 45 days.
As stated in the Policy Article, "For a power operated vehicle (POV) or power wheelchair (PWC) to be covered, the treating physician must conduct a face-to-face examination of the patient before writing the order and the supplier must receive a written report of this examination within 45 days after completion of the face-to-face examination and prior to delivery of the device. If this requirement is not met, the claim will be denied as non-covered. (Exceptions: If this examination is performed during a hospital or nursing home stay, the supplier must receive the report of the examination within 45 days after discharge. If the POV or PWC is a replacement during the 5 year useful lifetime of an item in the same performance group that was previously covered by Medicare, a face-to-face examination is not required. Note: Replacement during an item's useful lifetime is limited to situations involving loss or irreparable damage from a specific accident or natural disaster [e.g., fire, flood, etc.].)"

Additionally, per the LCD, "A date stamp or equivalent must be used to document receipt date."

Suppliers are also reminded to regularly visit the DME MAC A Events page (**http://www.medicarenhic.com/dme/dmerc_seminars.shtml**) for potential educational opportunities related to documentation and/or Power Mobility Devices (PMDs). This will ensure your understanding in order to prevent future claim denials.

Quarterly Provider Update

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

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Redetermination Requests Sent to Incorrect Jurisdiction

NHIC, Corp. DME MAC Jurisdiction A has been receiving numerous requests for redetermination in which the claims in question were not processed by Jurisdiction A. We would like to remind the supplier/provider community that we can not process redetermination requests for claims processed by the other DME MAC Jurisdictions. To avoid a delay in processing such requests, please be sure to reference the Medicare Remittance Advice to identify the appropriate DME MAC Jurisdiction that processed the initial claim, and to where the redetermination request needs to be submitted.

The address for submitting a redetermination request to each DME MAC Jurisdiction is as follows:

Jurisdiction A NHIC, Corp P.O. Box 9150 Hingham, MA 02043-9150	Jurisdiction B National Government Services P.O. Box 50403 Indianapolis, IN 46250-0403
Jurisdiction C CIGNA Government Services P.O. Box 20009 Nashville, TN 37202	Jurisdiction D Noridian Administrative Services P.O. Box 6727 Fargo, ND 58108-6727

Note: *We would also like to remind all suppliers/providers to be sure to submit claims to the correct DME MAC Jurisdiction based on the beneficiary's permanent residence.*

Secondary Ventilators Billing Reminder

Backup equipment must be distinguished from multiple medically necessary items which are defined as, identical or similar devices each of which meets a different medical need for the patient. Though Medicare does not pay separately for backup equipment, Medicare will make a separate payment for a second piece of equipment if it is required to serve a different purpose that is determined by the patient's medical needs.

The following are examples of situations in which a patient would qualify for both a primary ventilator and a secondary ventilator:

- A patient requires one type of ventilator (e.g. a negative pressure ventilator with a chest shell) for part of the day and needs a different type of ventilator (e.g. positive pressure ventilator with a nasal mask) during the rest of the day.
- A patient who is confined to a wheelchair requires a ventilator mounted on the wheelchair for use during the day and needs another ventilator of the same type for use while in bed. Without two pieces of equipment the patient may be prone to certain medical complications, may not be able to achieve certain appropriate medical outcomes, or may not be able to use the medical equipment effectively.

When billing for a secondary ventilator, Suppliers are urged to enter the reason for medical necessity of the secondary ventilator in the NTE 2400 loop, which is available on the line level segment of the electronic claim. This narrative field is limited to an 80 character byte. Therefore, Suppliers will need to eliminate unnecessary wording and abbreviate as much as possible. You can access a list of suggested abbreviations at **http://www.medicarenhic.com/dme/ediabbrev.shtml.**

For paper claims, this information can be added to Item 19 on the CMS-1500 form.

Note: *This information must be submitted to the DME MAC upon submission of each claim. If additional documentation is required, NHIC will develop the claim and request the additional information.*

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Secondary Ventilators Billing Reminder (Continued)

The following is an example demonstrating how a secondary ventilator should be billed. Two claim lines should be billed as shown below identifying the need for a secondary ventilator.

Example:

DOS	HCPCS	UNITS	CHARGE
02/11/07	E0450RR	1	350.00
02/11/07	E0450RR	1	350.00

Supplier Manual News

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 *DME MAC A Supplier Manual* 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.

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Customer Service Telephone
Interactive Voice Response (IVR) System - 866-419-9458

Customer Service Representatives - 866-419-9458

TTY/TDD - 888-897-7539

Outreach & Education
781-741-3950

Claims Submissions

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

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

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

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

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

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

Written Inquiries

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

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

Written Inquiry FAX: 781-741-3118

Appeals

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

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

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

Redetermination Requests FAX:
781-741-3118

Reconsiderations

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

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

ADMC Request

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

ADMC Request FAX:
Attn: ADMC
781-741-3991

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DME MAC Jurisdiction A Resource

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

March 2008
Number 7

Publication Information

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

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

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

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

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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