



CIGNA Government Services



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DME MAC Jurisdiction C

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CIGNA Government Services, Jurisdiction C Durable Medical Equipment Medicare Administrative Contractor (DME MAC), provides a quarterly publication to all suppliers in the coverage area (Jurisdiction C includes: Alabama, Arkansas, Colorado, Florida, Georgia, Louisiana, Mississippi, New Mexico, North Carolina, Oklahoma, Puerto Rico, South Carolina, Tennessee, Texas, U.S. Virgin Islands, Virginia, and West Virginia). The *DME MAC Jurisdiction C Insider* contains important information that will assist the supplier community in day to day operations. It will include information published during the previous quarter by the Centers of Medicare and Medicaid Services (CMS), TrustSolutions, LLC., and by CIGNA Government Services.

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Articles from CIGNA Government Services

Modifier KX Billing Errors

CIGNA Government Services has received a very large volume of claim reopening requests citing clerical errors and minor omissions due to failure to use modifier KX (Specified required documentation on file) correctly. Suppliers are reminded that several Local Coverage Determinations (LCDs), including but not limited to Manual Wheelchair Bases, Power Mobility Devices, Continuous Positive Airway Pressure System (CPAP), Respiratory Assist Devices, and Hospital Beds and Accessories, require the use of modifier KX when LCD coverage criteria are met. Refer to the Documentation Requirements section of each LCD for information about correct modifier KX usage.

Medicare Claims Returned as Unprocessable Due to Missing NPI or NSC (PTAN)

For Medicare claims submitted on the CMS 1500 (08/05) form that include the National Provider Identifier (NPI), the NPI must be entered in block 33A. The National Supplier Clearinghouse (NSC) number (also referred to as PTAN) must be entered in block 33B. Claims will be returned as unprocessable if an NPI or NSC number is not in the appropriate block on the claim form.

Suppliers submitting claims electronically must enter in block 33B the ID qualifier "1C" followed by one blank space and then the PTAN of the billing provider.

The NPI and the NSC number (also referred to as PTAN) must be on the crosswalk. Claims will be returned as unprocessable if not on the crosswalk.

Suppliers who do not have an NPI should visit the National Plan and Provider Enumerator System (NPPES) Web site at <https://nppes.cms.hhs.gov> to obtain one. Suppliers must register the NSC number (PTAN) in NPPES.

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Important NPI Notice: DME MAC To Start Rejecting Claims When NPI and Legacy Provider Identifier Pair Are Not Found on Medicare Crosswalk

Effective October 29, 2007, CIGNA Government Services, the Jurisdiction C DME MAC, will require a valid NPI/legacy ID combination. Claims for which a valid match cannot be located on the NPI Crosswalk will be returned as unprocessable.

Suppliers have been encouraged to submit both the NPI and Medicare legacy identifier (i.e., NSC number, PTAN, PIN) on claims since October 2, 2006. During this period edits that return Medicare claims for invalid or missing NPI/legacy ID combinations have been turned off.

Suppliers currently billing with an NPI can verify, through the National Plan and Provider Enumeration System (NPPES) <https://nppes.cms.hhs.gov>, the following information is accurate and make corrections if necessary:

- ★ EIN (for organizational providers)
- ★ SSN (for individual providers)
- ★ Date of Birth
- ★ Medicare Legacy Number
- ★ Practice Address
- ★ Master Address
- ★ Other Address
- ★ Physical Location Phone Number
- ★ Legal Name or Legal Business Name

Suppliers who have an NPI but are not using it on their claims should begin to do so by sending in a small volume of claims using only the NPI. If the claims are not rejected, the submitter/supplier may increase their NPI claim volume.

For suppliers who have not obtained an NPI, contact NPPES at <https://nppes.cms.hhs.gov> to apply, as claims billed without NPI after October 29 th will be returned to the supplier.

Note: It is important for suppliers who use a billing service for claim submission to verify with the billing service that they are using NPI correctly.

Overpayment Recovery

CIGNA Government Services is driven to provide our customers with a high level of service. In this and upcoming publications, the Overpayment Recovery Department will address topics about the overpayment recovery process to help you better understand what you can do to ensure resolution of any overpayment issues that arise.

The Voluntary Overpayment Refund Form

A useful tool for refunding an overpayment identified by the supplier is the Voluntary Overpayment Refund form. It is located on the CIGNA Government Services Web site at http://www.cignagovernmentservices.com/jc/forms/pdf/JC_overpay_form.pdf.

The fully completed form assists the Overpayment/Recovery analyst with processing claims in a timely manner, and provides the supplier with the means to reconcile records more efficiently.

Additional Suggestions

- ★ Include all documentation relevant to the refund with the refund submission.
- ★ Include a copy of the explanation of benefits from the other insurance company if the refund is due to another insurance paying primary.
- ★ Include a copy of your Remittance Advice with all refunds submitted.
- ★ Place an asterisk or star next to the beneficiary's name on the Remittance Advice to identify which beneficiary's payment is being refunded. Do not use highlighters because they do not appear on scanned images, resulting in processing delays.
- ★ Include no more than 20 beneficiaries per refund check to expedite the overpayment request process.
- ★ Do not combine refunds requested by CIGNA Government Services and refunds that you are voluntarily sending.

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Articles from TrustSolutions, LLC.

Additional Documentation Request (ADR) Letters

As a Durable Medical Equipment (DME) Program Safeguard Contractor (PSC), TrustSolutions performs prepayment medical reviews. Suppliers with claims involved in a prepayment medical review will receive an ADR letter that indicates the specific information the supplier must submit in order for the PSC to complete the review process.

Suppliers are required to respond to the ADR letter with the specific documentation which must be received by TrustSolutions within thirty (30) days from the date of the letter. If the requested documentation is not received timely by TrustSolutions, the claim included in the prepayment medical review will be denied as not reasonable and necessary. The supplier will receive a denial statement in a remittance notice from CIGNA Government Services advising the following:

"This claim has been denied without reviewing the medical record because the requested records were not received or were not received timely."

If you subsequently obtain all of the documentation requested by TrustSolutions and wish to appeal the denial, please submit the documentation accompanied with a completed CIGNA "Redeterminations Request" form directly to CIGNA at the following address:

CIGNA Government Services
P.O. Box 20009
Nashville, TN 37202

Power Mobility Devices: Frequently Asked Questions

Question 1: Must the face-to-face order and the detailed product description always be two separate documents in an audit for power mobility devices?

Answer 1: Yes, the seven-element order specified in the Medicare Modernization Act and the detailed product description (DPD) must always be two separate pieces of paper. The seven-element order is a document that is written by the physician after completion of the face-to-face examination. The DPD is a document that is prepared by the supplier and sent to the physician AFTER the supplier receives the seven-element order

and the report of the face-to-face examination from the physician. Some suppliers refer to a prescription, given at the time of the initial office visit for a mobility evaluation, as the "face-to-face order." This prescription seems based on the concept of the "dispensing order" that is applicable to other DME items. For Power Mobility Devices (PMDs), a dispensing order is not applicable based upon the statutory requirements for the seven-element order.

Question 2: May a supplier format the seven-element order upon receipt of a verbal order for power mobility and have the physician sign and date?

Answer 2: No, a supplier cannot draft a form or template to have the physician date and sign. The physician must write, sign, and date the seven-element order. The supplier can draft instructions about the requirements for the seven-element order to help educate the physician. However, suppliers cannot complete the information required in the order. As described in the previous question, no verbal dispensing orders are acceptable.

Question 3: A physician writes an order for "power wheelchair" but the client only qualifies for a scooter. Does the supplier need to get a new order for the scooter or will the home assessment and detailed product description substantiate why the patient received a scooter?

Answer 3: Yes, in the scenario described, the supplier would need to obtain a new seven-element order from the physician. Because the supplier is providing an item that meets Medicare coverage criteria (i.e., a POV), the seven-element order must address this item in order for the item to be covered. In the scenario described, if the seven-element order were more general (e.g., "power mobility device"), then a new order would not be required, and the detailed product description would be sufficient to indicate physician agreement with a POV. Given a different scenario in which the seven-element order indicated a POV and this met the coverage criteria, a new order would not be required if the supplier provided a power wheelchair. In that scenario, the supplier must bill for the power wheelchair using the "upgrade" instructions.

Question 4: If Dr. "A" performs a face-to-face assessment and orders a PT/OT evaluation and the PT/OT evaluation is sent back to Dr. A for concurrence but Dr. A is on vacation for two weeks, must we wait for Dr. A to return, or may another physician within the practice sign for the prescribing physician?

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Answer 4: If a doctor involved in a practice is on vacation, another doctor within the practice can sign the OT/PT assessment; however, there should be a notation in the patient chart indicating why a different physician is completing the info rather than the prescribing physician.

Question 5: Can the supplier facilitate the PT/OT evaluation when the physician faxes the request for PT/OT evaluation to the supplier?

Answer 5: The physician must see the patient prior to writing an order for PMD. The physician should take care of the referral directly. If the supplier receives the PT/OT order, they may pass it along to the physician-selected therapist. The supplier should NOT choose the therapist. In addition, the supplier may not tell the PT/OT what to write in the evaluation.

Question 6: If a supplier does an "internal audit" and discovers there is missing patient chart information, may the Physician draft a statement on letterhead or on a script pad and add it to the chart?

Answer 6: No, information must be contained within the patient chart record and cannot be done as an addendum to the medical record at a later point in time due to an internal audit. It is inappropriate to amend or modify the medical record "after the fact."

Question 7: If a new PMD is needed after 5 years of use, what documentation must be obtained; must we start the complete process or just obtain a new order?

Answer 7: All new PMD requirements must be met. Many new products are available, the codes have changed, and a patient's functional status must be assessed through a face-to-face evaluation in order to establish need.

Question 8: What is reported as the date of the face-to-face examination if the examination involves more than one visit?

Answer 8: The face-to-face examination process may involve more than one visit to one or more clinicians. If so, the date of the face-to-face (FTF) examination that is entered on the seven-element order by the physician is the date of completion of the FTF examination. The following is a common scenario: A physician sees a patient to begin the FTF examination and then refers the patient to a physical therapist (PT) or occupational therapist (OT) to perform another part of the examination. The physician receives and reviews the report from the PT/OT, indicates agreement or disagreement on the report, and then signs and dates

the report. In this scenario, the date that the physician signs and dates the report is considered the date of completion of the FTF examination. That signature date is the date that the physician enters on the seven-element order as the date of the FTF examination, not the original date that the physician initially saw the patient to begin the process.

Question 9: Is the "specialty evaluation" that is required for rehab power wheelchairs considered to be part of the face-to-face examination?

Answer 9: No, the "specialty evaluation" that is described in the Power Mobility Devices LCD is considered a separate component in documenting the medical necessity of a rehab power wheelchair (PWC). (A rehab PWC is a Group 2 Single Power Option or Multiple Power Option PWC, a Group 3 or Group 4 PWC, or a push-rim activated power assist device.) The purpose of the FTF examination is to document the medical necessity for either a power-operated vehicle (POV) or a power wheelchair. The purpose of the "specialty evaluation" is to document the medical necessity for a specific rehab-type PWC base and its special features (e.g., power seating system, alternative drive control interface, etc.). In a case in which the physician sees a patient who needs a rehab PWC to begin the face-to-face examination and then refers the patient to a PT/OT to perform another part of the FTF exam, the PT/OT will typically also perform the specialty evaluation during that visit. In this situation, it is acceptable for the PT/OT to include the FTF exam components and the specialty evaluation components on the same report.

Repair and Replacement Frequently Asked Questions

Question 1: Will Medicare pay for repairs to a piece of equipment that was obtained prior to the client being covered by Medicare?

Answer 1: The beneficiary must meet current Medicare reimbursement criteria for the equipment in order to be repaired if Medicare did not purchase the item. If it was obtained prior to Medicare coverage or if another payer purchased the equipment, the supplier must obtain the required documentation to verify coverage and to determine if the item is covered by a warranty.

Question 2: How is a product replaced prior to the 5-year life expectancy?

Answer 2: The replacement of a product before the

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5-year life expectancy can only be done if the item is irreparably damaged, for example by a natural disaster such as fire, flood, etc. Replacement due to wear and tear before the 5-year lifetime is not covered. Refer to the September 2003 articles for additional information.

Question 3: For Repairs, may travel time be charged using the A9900 procedure code for DME supply or A9270 non-covered service?

Answer 3: Travel time is included in the reimbursement of parts and labor and MAY NOT be paid separately. If a supplier chooses to bill separately, code A9901 (DME delivery, set-up, and/or dispensing service component of another HCPCS code) must be used. This code is auto-denied as a CO denial. HCPCS Code A9270 must not be used.

Question 4: Is a re-manufactured part with a warranty from the manufacturer considered new or used equipment?

Answer 4: A re-manufactured part with a warranty is considered used. It should be billed using the appropriate modifier, UE.

Question 5: A beneficiary is prescribed a new power wheelchair to replace his existing chair, which is 8 years old. It is impossible to repair the old unit for less than 50% of the replacement allowable for a new chair. Assuming the repairs carry a limited warranty, would

the patient ONLY qualify for repairs or would the 5-year useful lifetime apply?

Answer 5: If a chair has reached its 5-year life expectancy, the chair can be replaced. However, if a chair reaches its 5-year life expectancy, is in good working order, and meets the beneficiary's medical needs, it should not automatically be replaced.

Documentation – Development Letters from TrustSolutions

This is a revision of a previously published article. The instruction concerning documentation of verbal orders has been changed to indicate that the supplier may either initial or sign the entry in their records.

TrustSolutions, the Program Safeguard Contractor (PSC) for Jurisdiction C, performs both Medical Review and Benefit Integrity (Fraud) audits. These audits may be either widespread (focusing on specific HCPCS codes and/or geographic areas) or supplier-specific. The audits may be conducted either at the time of claim submission

(pre-payment) or at a later time (post-payment).

For pre-payment audits, CIGNA Government Services (CGS) sends a development letter to the supplier on behalf of TrustSolutions. For post-payment audits, TrustSolutions directly sends the notification letter requesting records. The development/notification letter provides general directions on the type of documentation that must be submitted. However, many suppliers do not provide all of the information that has been requested. This results in denial of the claim or recoupment of an overpayment. This article gives additional guidance on the documentation that must be sent to the PSC in response to a development/notification letter. More information on each of the elements discussed below can be found in the DME MAC Jurisdiction C Supplier Manual, Chapter 3, Supplier Documentation.

Detailed written order

The detailed written order must contain either:

- ★ A narrative description of the item including all significant options and features that are described in the base code or that will be separately billed using an add-on code; or
- ★ The manufacturer name and product name/number.

For items that are provided on a periodic basis (e.g., supplies, accessories, dressings, ostomy/urological products, drugs, nutrients, etc.), the detailed written order must contain appropriate information concerning the quantity used at one time and the frequency of use/replacement. Some Local Coverage Determinations (LCDs) provide specific information on the type of documentation required for items addressed by those medical policies.

The detailed written order must be signed and dated by the ordering physician. Individual LCDs specify whether the detailed written order must be signed and dated prior to claim submission or prior to delivery of the item.

Dispensing order

If the detailed written order is not obtained prior to delivery of the item, there must be a separate dispensing order. A more general description of the item is sufficient on the dispensing order. This may be either a written order signed and dated by the physician or supplier documentation of a verbal order from the physician which is signed or initialed and dated by the supplier.

A copy of the dispensing order must be submitted only when it is specifically requested in the development

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letter. If the development letter doesn't specify a dispensing order, the detailed written order is sufficient for purposes of that audit.

Certificate of Medical Necessity

If the item requires a CMN, a copy of the CMN must be submitted. The CMN can serve as the detailed written order if it contains all of the information specified for a detailed written order.

Patient Medical Records

This is the element that is most often missing in the response to development letters.

Suppliers must provide a copy of documentation from the patient's medical record that identifies the condition/diagnosis for which the item is being ordered and other pertinent information relating to the medical necessity for the item. The ICD-9 code submitted on the claim should reflect this condition/diagnosis.

The medical record may be:

- ★ A physician office note; or
- ★ A hospital, nursing home, or home health note; or
- ★ A note from a nonphysician practitioner, such as a physical therapist or occupational therapist. This person must be someone who is practicing within his/her scope of practice, who can bill Medicare for his/her services (i.e., is a Medicare-enrolled provider), and who has no financial relationship with the supplier.

The date of the visit must be noted in the record and must be prior to the date of service on the claim. For items that are being newly provided, the date of the visit must generally be within 3 months prior to the initial dispensing of the item.

For items addressed in LCDs, there must be information to document that all coverage criteria specified in the medical policy have been met. This may include copies or laboratory or other diagnostic test results or x-ray reports. For items that are provided on a rental basis, this may include documentation of continued medical necessity – e.g., the continued presence of an ulcer for patients on a Group 2 support surface.

The medical record must be in the usual format for that physician's/provider's medical records. Supplier-created forms, attestations or similar documents are not sufficient to document medical necessity, even if completed and signed by the physician.

If the development letter lists specific information that is needed, suppliers must include that in their response.

Supplier Records

Suppliers may submit any other information that they think would be helpful in documenting the medical necessity for the specific item that was provided. This is optional.

Delivery Slips

Another element that is frequently missing, or incomplete, is documentation proving that the patient received the items ordered by the physician. Proof of delivery includes the following documentation:

- ★ When items are delivered by the supplier directly to the patient

The delivery slip should include:

- 1) Patient's name
- 2) Detailed description of the items being delivered or the brand name
- 3) Serial numbers, if applicable
- 4) Quantity delivered
- 5) Signature of the patient or designee. A designee is any person who can sign and accept delivery of the item on behalf of the patient. If it is a designee, the relationship of that person to the patient should be noted on the delivery slip – e.g., spouse, neighbor, etc. The signature of the designee should be legible. If it is not, the supplier should print the name of the designee on the delivery slip.
- 6) Date of the signature. This must be the date that the items were received by the patient or designee.

It is unacceptable for the supplier to leave or hand over the items without first obtaining the required signature. Audits have indicated that often packages have been delivered to the wrong address or have been left at the door or on the porch of the patient's residence. Patients often indicate that they did not receive the items that were shipped by the supplier. In situations in which the patient denies receipt of the items, the claim will be denied or an overpayment will be requested unless the supplier proves delivery with the detailed documentation described above.

- ★ When items are delivered by a shipping service (e.g., UPS)

The following documents are required:

- 1) Supplier's shipping invoice. This should include:
 - a) Patient's name
 - b) Detailed description of the items being delivered

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or the brand name

c) Serial numbers, if applicable

d) Quantity delivered

2) Shipping service tracking slip. This should reference each individual package, the delivery address, the corresponding package identification number given by the service, and if possible, the date delivered.

or

Instead of the shipping service tracking slip, suppliers may have the patient or designee sign and date the shipping invoice and return it to them postage-paid.

If the patient or designee is not available to sign for the items delivered by a shipping service, it is acceptable for the service to leave the package at the door.

- ★ Alternative documentation when items are delivered to a nursing facility on behalf of the patient

Suppliers should work with the nursing facility staff to implement an inventory control procedure that ensures the following:

- 1) Items are identified and retained for use only by the specific patient for which they are intended;
- 2) Items are utilized by the patient for which they are issued;
- 3) The medical records in the nursing home document the use of all items billed to Medicare. The documentation may be in the nurse's notes or in a special treatment record or form.

For patients in a nursing facility, documentation in the medical records of usage by the patient may substitute for the signature of the patient/ designee (for directly delivered items) or shipping service tracking slip (when a shipping service is used). However, the supplier must still have a shipping invoice with:

a) Patient's name

b) Detailed description of the items being delivered or the brand name

c) Serial numbers, if applicable

d) Quantity delivered

Both the supplier's shipping invoice and the medical records to document usage by the patient must be submitted upon request from the DME PSC.

If the supplier does not provide proof of delivery when requested by the DME PSC, the claim for the item will be denied or an overpayment will be recovered.

Dispensing DMEPOS Items: Quantity Limits

Updated June 2007

In December 2006 we published information regarding acceptable billing cycles for various items. Since that time several items have been identified for which monthly billing is appropriate. The article has been modified accordingly.

For items that are provided on a recurring basis, including but not limited to DME accessories or supplies, nebulizer drugs, urological and ostomy supplies, the general rule is that suppliers may dispense no more than a 3 month supply at any one time. The exceptions to that rule are:

- ★ Surgical dressings
- ★ Enteral and parenteral nutrients and supplies
- ★ Immunosuppressive drugs
- ★ Oral Anti-cancer Drugs
- ★ Oral Antiemetic Drugs

For these items, only a one month quantity of supplies may be dispensed.

In addition, suppliers should be alert for situations in which the quantity of the item may change – for example, early in the course of treatment, an improving or worsening condition, etc. In such situations, suppliers should adjust the quantity and frequency of their dispensing based on a beneficiary's anticipated needs.

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Medicare Learning Matters Articles from CMS

Skilled Nursing Facility Consolidated Billing As It Relates to Ambulance Services

MLN Matters Number: SE0433 Revised

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

Note: This article was revised on October 9, 2007, to provide clarification on page 3, regarding “trips for excluded outpatient services”. This clarification is intended to state explicitly that the CB exclusion for ambulance trips related to the receipt of excluded outpatient hospital services would apply to the **entire ambulance roundtrip** (the SNF-to-hospital trip **plus** the return trip back to the SNF), and not just to the outbound (SNF-to-hospital) portion alone. All other information remains the same.

Provider Types Affected

Skilled Nursing Facilities (SNFs), physicians, ambulance suppliers, and providers

Provider Action Needed

This Special Edition article describes SNF Consolidated Billing (CB) as it applies to ambulance services for SNF residents.

Clarification: The SNF CB requirement makes the SNF responsible for including on the Part A bill that it submits to its Medicare intermediary almost all of the services that a resident receives during the course of a Medicare-covered stay, except for a small number of services that are specifically excluded from this provision. These “excluded” services can be separately furnished to the resident and billed under Medicare Part B by a variety of outside sources. These sources can include other providers of service (such as hospitals), which would submit the bill for Part B services to their Medicare intermediary, as well as practitioners and suppliers who would generally submit their bills to a Medicare Part B carrier. (Bills for certain types of items or equipment would be submitted by the supplier to their Durable Medical Equipment Medicare Administrative Contractor (DME MAC).

Background

When the SNF Prospective Payment System (PPS)

was introduced in 1998, it changed not only the way SNFs are paid but also the way SNFs must work with suppliers, physicians, and other practitioners. CB assigns the SNF the Medicare billing responsibility for virtually all of the services that the SNF residents receive during the course of a covered Part A stay. Payment for this full range of service is included in the SNF PPS global per diem rate.

The only exceptions are those services that are specifically excluded from this provision, which remain separately billable to Medicare Part B by the entity that actually furnished the service. See MLN Matters Edition SE0431 for a detailed overview of SNF CB, including a section on services excluded from SNF CB. This instruction can be found at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0431.pdf> on the CMS Web site.

Ambulance services have not been identified as a type of service that is categorically excluded from the CB provisions. However, certain types of ambulance transportation have been identified as being separately billable in specific situations, i.e. based on the reason the ambulance service is needed. This policy is comparable to the one governing ambulance services furnished in the inpatient hospital setting, which has been subject to a similar comprehensive Medicare billing or “bundling” requirement since 1983. Since the law describes CB in terms of services that are furnished to a “resident” of a SNF, the initial ambulance trip that brings a beneficiary to a SNF is not subject to CB, as the beneficiary has not yet been admitted to the SNF as a resident at that point.

Similarly, an ambulance trip that conveys a beneficiary from the SNF at the end of a stay is not subject to CB when it occurs in connection with one of the events specified in regulations at 42 CFR 411.15(p)(3)(i)-(iv) as ending the beneficiary’s SNF “resident” status. The events are as follows:

- ★ A trip for an inpatient admission to a Medicare-participating hospital or critical access hospital (CAH) (See discussion below regarding an ambulance trip made for the purpose of transferring a beneficiary from the discharging SNF to an inpatient admission at another SNF);
- ★ A trip to the beneficiary’s home to receive services from a Medicare-participating home health agency under a plan of care;
- ★ A trip to a Medicare-participating hospital or CAH for the specific purpose of receiving emergency services or certain other intensive outpatient services that are not included in the SNF’s

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comprehensive care plan (see further explanation below); or

- ★ A formal discharge (or other departure) from the SNF that is not followed by readmission to that or another SNF by midnight of that same day.

Ambulance Trips to Receive Excluded Outpatient Hospital Services

The regulations specify the receipt of certain exceptionally intensive or emergency services furnished during an outpatient visit to a hospital as one circumstance that ends a beneficiary's status as an SNF resident for CB purposes. Such outpatient hospital services are, themselves, excluded from the CB requirement, on the basis that they are well beyond the typical scope of the SNF care plan.

Currently, only those categories of outpatient hospital services that are specifically identified in Program Memorandum (PM) No. A-98-37, November 1998 (reissued as PM No. A-00-01, January 2000) are excluded from CB on this basis. These services are the following:

- ★ Cardiac catheterization;
- ★ Computerized Axial Tomography Imaging (CT) scans;
- ★ Magnetic Resonance Imaging (MRI) services;
- ★ Ambulatory surgery involving the use of an operating room (the ambulatory surgical exclusion includes the insertion of percutaneous esophageal gastrostomy (PEG) tubes in a gastrointestinal or endoscopy suite);
- ★ Emergency room services;
- ★ Radiation therapy;
- ★ Angiography; and
- ★ Lymphatic and venous procedures.

Since a beneficiary's departure from the SNF to receive one of these excluded types of outpatient hospital services is considered to end the beneficiary's status as an SNF resident for CB purposes with respect to those services,, any associated ambulance trips are, themselves, excluded from CB as well. Therefore, an ambulance trip from the SNF to the hospital for the receipt of such services should be billed separately under Part B by the outside supplier. Moreover, once the beneficiary's SNF resident status has ended in this situation, it does not resume until the point at which the beneficiary actually arrives back at the SNF; accordingly, the return ambulance trip from the hospital to the SNF would also be excluded from CB.

Other Ambulance Trips

By contrast, when a beneficiary leaves the SNF to receive offsite services other than the excluded types of

outpatient hospital services described above and then returns to the SNF, he or she retains the status of a SNF resident with respect to the services furnished during the absence from the SNF. Accordingly, ambulance services furnished in connection with such an outpatient visit would remain subject to CB, even if the purpose of the trip is to receive a particular type of service (such as a physician service) that is, itself, categorically excluded from the CB requirement.

However, effective April 1, 2000, the Balanced Budget Refinement Act of 1999 (BBRA 1999, Section 103) excluded from SNF CB those ambulance services that are necessary to transport an SNF resident offsite to receive Part B dialysis services (Social Security Act, Section 1888(e)(2)(A)(iii)(I)).

Transfers Between Two SNFs

A beneficiary's departure from an SNF is not considered to be a "final" departure for CB purposes if he or she is readmitted to that or another SNF by midnight of the same day (see 42 CFR 411.15(p)(3)(iv)). Thus, when a beneficiary travels directly from SNF 1 and is admitted to SNF 2 by midnight of the same day, that day is a covered Part A day for the beneficiary, to which CB applies. Accordingly, the ambulance trip that conveys the beneficiary would be bundled back to SNF 1 since, under §411.15(p)(3), the beneficiary would continue to be considered a resident of SNF 1 (for CB purposes) up until the actual point of admission to SNF 2.

However, when an individual leaves an SNF via ambulance and does not return to that or another SNF by midnight, the day is not a covered Part A day and, accordingly, CB would not apply.

Roundtrip to a Physician's Office

If an SNF's Part A resident requires transportation to a physician's office and meets the general medical necessity requirement for transport by ambulance (i.e., using any other means of transport would be medically contraindicated) (see 42 CFR 409.27(c)), then the ambulance roundtrip is the responsibility of the SNF and is included in the PPS rate. The preamble to the July 30, 1999 final rule (64 Federal Register 41674-75) clarifies that the scope of the required service bundle furnished to Part A SNF residents under the PPS specifically encompasses coverage of transportation via ambulance under the conditions described above, rather than more general coverage of other forms of transportation.

Additional Information

See MLN Matters Special Edition SE0431 for a detailed overview of SNF CB. This article lists services excluded from SNF CB and can be found at <http://www.cms.hhs>.

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[gov/MLNMattersArticles/downloads/SE0431.pdf](http://www.cms.gov/MLNMattersArticles/downloads/SE0431.pdf) on the CMS Web site.

The Centers for Medicare & Medicaid Services (CMS) MLN Consolidated Billing Web site is at <http://www.cms.hhs.gov/SNFConsolidatedBilling/> on the CMS Web site.

It includes the following relevant information:

- ★ General SNF CB information;
- ★ HCPCS codes that can be separately paid by the Medicare carrier (i.e., services not included in CB);
- ★ Therapy codes that must be consolidated in a non-covered stay; and
- ★ All code lists that are subject to quarterly and annual updates and should be reviewed periodically for the latest revisions.

The SNF PPS Consolidated Billing Web site can be found at <http://www.cms.hhs.gov/SNFPSPS/05ConsolidatedBilling.asp> on the CMS Web site.

It includes the following relevant information:

- ★ Background;
- ★ Historical questions and answers;
- ★ Links to related articles; and
- ★ Links to publications (including transmittals and Federal Register notices).

Delete References to Required Reporting of the National Provider Identifier (NPI) on or after May 23, 2007 and Revise to a “When Effective” Date

MLN Matters Number: MM5678

Related Change Request (CR) #: 5678

Related CR Release Date: August 31, 2007

Effective Date: October 1, 2007

Related CR Transmittal #: R1328CP

Implementation Date: October 1, 2007

Provider Types Affected

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

Provider Action Needed

This article is informational in nature and is based on Change Request (CR) 5678 which updates Chapter 80

of the Medicare Claims Processing Manual to delete references to the May 23, 2007 mandatory date for entry of the National Provider Identifier (NPI) on claims. The effective date for providers to use only the NPI on Medicare claims will be officially announced at a later date, as previously communicated to providers in the MLN Matters article corresponding to CR5595. That article is available at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5595.pdf> on the CMS Web site.

Background

The National Provider Identifier (NPI) final rule, published in the Federal Register on January 23, 2004 (http://www.access.gpo.gov/su_docs/fedreg/a040123c.html; Health and Human Services Department Rules), established the standard for a unique identifier for each health care provider for use in health care transactions. Medicare contractors were to be required to enter NPI in certain items and fields of paper claim forms and electronic equivalents on or after May 23, 2007. However, on April 2, 2007, the Department of Health and Human Services (DHHS) provided guidance regarding contingency planning for the implementation of the NPI. For some time after May 23, 2007, Medicare Fee for Service (FFS) will allow continued use of legacy numbers (Unique Physician Identification Numbers (UPINs) and Provider Identification Numbers (PINs)), as well as accepting transactions with only NPIs. The effective date for providers to use only the NPI only on claims and to cease entering UPINs and PINs will be officially announced at a later date, as previously communicated to providers in the MLN Matters article corresponding to CR5595. That article is available at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5595.pdf> on the CMS Web site. This article reflects CR5678, which simply amends Chapter 80 of the Medicare Claims Processing Manual to reflect that the use of the NPI will be mandated for Medicare FFS claims at a future date.

Additional Information

The official instruction, CR5678, issued to your carrier, A/B MAC, or DME MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1328CP.pdf> on the CMS Web site. If you have any questions, please contact your Medicare carrier, DMERCs, A/B MAC, or DME MAC at their toll-free number, which may be found on the CMS Web site at <http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS Web site.

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2008 Annual Update of HCPCS Codes for Skilled Nursing Facility (SNF) Consolidated Billing (CB) for the Common Working File (CWF), Medicare Carriers and Fiscal Intermediaries (FIs))

MLN Matters Number: MM5696

Related CR Release Date: August 17, 2007

Related CR Transmittal #: R1317CP

Related Change Request (CR) #: 5696

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), Part A/B Medicare Administrative Contractors (Part A/B MACs) and fiscal intermediaries (FIs)) for services provided to Medicare beneficiaries in SNFs.

Provider Action Needed

STOP – Impact to You

This article is based on Change Request (CR) 5696, which provides the 2008 annual update of HCPCS Codes for SNF CB and how the updates affect edits in Medicare claims processing systems.

CAUTION – What You Need to Know

CR5696 provides updates to HCPCS codes that will be used to revise CWF edits to allow carriers and FIs to make appropriate payments in accordance with policy for SNF CB in the Medicare Claims Processing Manual, Chapter 6, Section 110.4.1 for carriers and Chapter 6, Section 20.6 for FIs.

GO – What You Need to Do

See the Background and Additional Information sections of this article for further details regarding this update.

Background

Medicare's claims processing systems currently have edits in place for claims received for beneficiaries in a Part A covered SNF stay as well as for beneficiaries in a non-covered stay. Changes to Healthcare Common Procedure Coding System (HCPCS) codes and Medicare Physician Fee Schedule designations are used to revise these edits to allow carriers, A/B MACs, DME MACs, and FIs to make appropriate payments in accordance with policy for SNF CB contained in the Medicare Claims Processing Manual. These edits only allow services that are excluded from CB to be separately paid by Medicare contractors.

Physicians and providers are advised that, by the first week in December 2007, new code files will be posted to the at <http://www.cms.hhs.gov/SNFConsolidatedBilling/> on the CMS Web site. Institutional providers note that this site will include new Excel® and PDF format files.

Note: It is important and necessary for the provider community to view the "General Explanation of the Major Categories" PDF file located at the bottom of each year's FI update listed at <http://www.cms.hhs.gov/SNFConsolidatedBilling/> on the CMS Web site in order to understand the Major Categories including additional exclusions not driven by HCPCS codes.

Additional Information

The official instruction, CR5696, issued to your Medicare contractor regarding this change can be found at <http://www.cms.hhs.gov/Transmittals/downloads/R1317CP.pdf> on the CMS Web site.

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 Web site.

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The 2007 Medicare Contractor Provider Satisfaction Survey (MCPSS) Shows Positive Results for Medicare's Fee for-Service Contractors

MLN Matters Number: SE0733

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

Provider Types Affected

All Medicare physicians, providers, and suppliers billing the Medicare program.

Provider Action Needed

No action is needed. This article is informational only and provides a summary of the findings from the second annual survey by Medicare to assess provider satisfaction with service from Medicare contractors (carriers, fiscal intermediaries (FIs), Medicare Administrative Contractors (MACs), and Durable Medical Equipment Medicare Administrative Contractors (DME MACs)).

Background

The Centers for Medicare & Medicaid Services (CMS) reports that most Medicare health care providers continue to find satisfaction with the services provided by Medicare contractors.

The Medicare Contractor Provider Satisfaction Survey (MCPSS), recently conducted by CMS for the second year, is designed to garner objective, quantifiable data on provider satisfaction with the fee-for-service contractors that process and pay Medicare claims. The survey revealed that 85 percent of respondents rated their contractors between 4 and 6 on a 6-point scale, with "1" representing "not at all satisfied" and "6" representing "completely satisfied." The national average score for 2007 is 4.56.

Contractors received an overall composite score for the seven business functions of the provider-contractor relationship: provider communications, provider inquiries, claims processing, appeals, provider enrollment, medical review, and provider audit and reimbursement. For all contractor types, a contractor's handling of provider inquiries surpassed claims processing as the key predictor of a provider's satisfaction. CMS has provided contractors information for process improvement based on individual MCPSS results.

The MCPSS was sent early this year to more than 36,000 randomly selected providers, including physicians, suppliers, health care practitioners and institutional facilities that serve Medicare beneficiaries across the country. The survey was expanded this year to include hospice locations and federally qualified health centers.

The full results of the 2007 survey are now available at: <http://www.cms.hhs.gov/MCPSS> on the CMS Web site.

In January 2008, the next MCPSS will be distributed to a new sample of Medicare providers. The views of each provider in the survey are important because they represent many other organizations similar in size, practice type and geographical location. If you are one of the providers randomly chosen to participate in the 2008 MCPSS implementation, you have an opportunity to help CMS improve service to all providers.

Additional Information

Remember, your Medicare contractor is available to assist you in providing services to Medicare beneficiaries and in being reimbursed timely for those services. Whenever you have questions, contact your contractor at their toll free number, which is available at <http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS Web site.

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

MLN Matters Number: SE0555 Revised

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

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

Required Use of Tamper-Resistant Prescription Pads for Outpatient Drugs Prescribed to Medicaid Recipients on or After October 1, 2007

MLN Matters Number: SE0736 Revised

Related Change Request (CR) #: N/A

Related CR Release Date: N/A

Effective Date: October 1, 2007

Related CR Transmittal #: N/A

Implementation Date: N/A

Note: This article was revised on October 2, 2007, to change the effective date from October 1, 2007, to April 1, 2008. This change was a result of the "Extenders Law", which was signed September 29, 2007, delaying the implementation date for all paper Medicaid prescriptions to be written on tamper-resistant paper. Under the new law, all written Medicaid prescriptions must be on tamper-resistant prescription pads as of April 1, 2008. CMS will issue additional guidance on this implementation delay as it becomes available. All other information remains the same.

Provider Types Affected

This issue impacts all physicians, practitioners, and other providers who prescribe Medicaid outpatient drugs, including over-the-counter drugs, in States that reimburse for prescriptions for such items. Pharmacists and pharmacy staff especially should be aware of this requirement as it may affect reimbursement for prescriptions. The requirement is applicable regardless of whether Medicaid is the primary or secondary payer of the prescription being filled.

Background

Section 7002(b) of the U.S. Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations Act of 2007 was signed into law on May 25, 2007. Section 7002 (b) of that Act addresses the use of tamper-resistant prescription pads and offers guidance to State Medicaid agencies.

On August 17, 2007, the Centers for Medicare & Medicaid Services (CMS), issued a letter to State Medicaid Directors with guidance on implementing the new requirement.

Key Points of the CMS Letter to Your State Medicaid Director

- ★ As of April 1, 2008, in order for outpatient drugs to be reimbursable by Medicaid, all written, non-electronic prescriptions must be executed on tamper-resistant pads.
- ★ CMS has outlined three baseline characteristics of tamper-resistant prescription pads, but each State will define which features it will require to meet those characteristics in order to be considered tamper-resistant. **To be considered tamper resistant on April 1, 2008, a**

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prescription pad must have at least one of the following three characteristics:

- » One or more industry-recognized features designed to prevent unauthorized copying of a completed or blank prescription form;
 - » One or more industry-recognized features designed to prevent the erasure or modification of information written on the prescription by the prescriber;
 - » One or more industry-recognized features designed to prevent the use of counterfeit prescription forms.
- ★ No later than October 1, 2008, to be considered tamper resistant, States will require that the prescription pad have all three characteristics.
 - ★ Several States have laws and regulations concerning mandatory, tamperresistant prescription pad programs, which were in effect prior to the passage of section 7002(b). CMS deems that the tamper-resistant prescription pad characteristics required by these States' laws and regulations meet or exceed the baseline standard, as set forth above.
 - ★ Your State is free to exceed the above baseline standard.
 - ★ Each State must decide whether they will accept prescriptions written in another state with different tamper proof standards.
 - ★ CMS believes that both e-prescribing and use of tamper-resistant prescription pads will reduce the number of unauthorized, improperly altered, and counterfeit prescriptions.

Situations in Which the New Requirement Does Not Apply

The requirement does not apply:

- ★ When the prescription is electronic, faxed, or verbal; (CMS encourages the use of e-prescribing as an effective means of communicating prescriptions to pharmacists.)
- ★ When a managed care entity pays for the prescription;
- ★ To refills of written prescriptions presented to a pharmacy before October 1, 2007; or
- ★ In most situations when drugs are provided in nursing facilities, intermediate care facilities for the mentally retarded, institutions for mental disease, and certain other institutional and clinical facilities.

Note: The letter issued by CMS to State Medicaid Directors states that emergency fills are allowed as long as a prescriber provides a verbal, faxed, electronic, or compliant prescription within 72 hours after the date on which the prescription is filled. PLEASE NOTE also that Drug Enforcement Administration (DEA) regulations regarding controlled substances may require a written prescription.

Additional Information

To review the letter from the Center for Medicaid and State Operations go to <http://www.cms.hhs.gov/SMDL/downloads/SMD081707.pdf> on the CMS Web site.

Quarterly October 2007 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files

MLN Matters Number: MM5710

Related Change Request (CR) #: 5710

Related CR Release Date: September 12, 2007

Effective Date: October 1, 2007

Related CR Transmittal #: R1334CP

Implementation Date: October 1, 2007

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 5710, which informs Medicare providers of the availability of the October 2007 Average Sales Price (ASP) drug pricing file for Medicare Part B drugs as well as the revised January 2007, April 2007, July 2007 and October 2006 ASP payment files (**if CMS determines that revisions are necessary to the latter files**). CR5710 also advises Medicare providers that ASP Not Otherwise Classified (NOC) files will be available for retrieval from the CMS ASP webpage as well as the revised January 2007, April 2007, July 2007 and October 2006 ASP NOC files (**if CMS determines that revisions are necessary to the latter files**). Providers should make certain that your billing staffs are aware of these changes.

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Background

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

The ASP methodology is based on quarterly data submitted to the Centers for Medicare & Medicaid Services (CMS) by manufacturers, and CMS supplies Medicare contractors (carriers, DME MACs, FIs, A/B MACs, and/or RHHs) with the ASP drug pricing files for Medicare Part B drugs on a quarterly basis. CMS also posts these files to its Web site at: <http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/>.

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

- ★ The Food and Drug Administration (FDA) approval, Therapeutic equivalents as determined by the FDA, - and -
- ★ The date of first sale in the United States.

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

be made operational through use of existing specific HCPCS codes or "not otherwise classified" HCPCS codes.

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

ASP Methodology

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

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

Exceptions are summarized as follows:

- ★ The payment allowance limits for blood and blood products (other than blood clotting factors) that are not paid on a prospective payment basis are 95 percent (95%) of the average wholesale price (AWP) as reflected in the published compendia. The payment allowance limits will be updated on a quarterly basis. Blood and blood products furnished in the hospital outpatient department are paid under OPPS at the amount specified for the APC to which the product is assigned.
- ★ Payment allowance limits **for infusion drugs furnished through a covered item of durable medical equipment** on or after January 1, 2005, will continue to be 95 percent (95%) of the AWP reflected in the published compendia as of October 1, 2003, unless the drug is compounded or the drug is furnished incident to a professional service. **The payment allowance limits were not updated in 2007.** Payment allowance limits for infusion drugs furnished through a covered item of durable medical equipment (DME) that were not listed in the published compendia as of October 1, 2003, (i.e., new drugs) are 95 percent (95%) of the first published AWP unless the drug is compounded or the drug is furnished incident to a professional service.
- ★ The payment allowance limits for influenza, Pneumococcal and Hepatitis B vaccines are 95 percent of the AWP as reflected in the published

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compendia except where the vaccine is furnished in a hospital outpatient department and, then, is paid at reasonable cost.

- ★ The payment allowance limits for drugs and biologicals that are not included in the ASP Medicare Part B Drug Pricing File or Not Otherwise Classified (NOC) Pricing File, other than new drugs that are produced or distributed under a new drug application (or other application) approved by the FDA, are based on the published wholesale acquisition cost (WAC) or invoice pricing, except under OPPS where the payment allowance limit is 95 percent of the published AWP. The payment limit is 100 percent of the lesser of the lowest-priced brand or median generic WAC. For 2006, the blood clotting furnishing factor of \$0.146 per I.U. is added to the payment amount for the blood clotting factor when the blood clotting factor is not included on the ASP file. For 2007, the blood clotting furnishing factor of \$0.152 per I.U. is added to the payment amount for the blood clotting factor when the blood clotting factor is not included on the ASP file.
- ★ The payment allowance limits for new drugs and biologicals that are produced or distributed under a new drug application (or other new application) approved by the FDA and that are not included in the ASP Medicare Part B Drug Pricing File or Not Otherwise Classified (NOC) Pricing File are based on 106 percent of the WAC, or invoice pricing if the WAC is not published, except under OPPS where the payment allowance limit is 95 percent of the published AWP. This policy applies only to new drugs that were first sold on or after January 1, 2005.
- ★ The payment allowance limits for radiopharmaceuticals are not subject to ASP. Medicare contractors determine payment limits for radiopharmaceuticals based on the methodology in place in November 2003 in the case of radiopharmaceuticals furnished in other than the hospital outpatient department. Radiopharmaceuticals furnished in the hospital outpatient department are paid charges reduced to cost by the hospital's overall cost to charge ratio.

On or after September 18, 2007, the October 2007 ASP file will be available for download from the CMS ASP Web site. If CMS determines that revisions are needed to the January 2007, April 2007, July 2007, and October 2006 ASP payment files, those revised files will also be available for retrieval from the CMS ASP webpage.

The payment limits included in the revised ASP and NOC payment files supersede the payment limits for these codes in any publication published prior to this document. The CMS ASP webpage is located at <http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/> on the CMS Web site.

These quarterly files are applicable to claims based on dates of service as shown in the following table:

Payment Allowance Limit Revision Date	Applicable Dates of Service for Claims Processed or Reprocessed on or after October 1, 2007
October 2006	October 1, 2006 through December 31, 2006
January 2007	January 1, 2007 through March 31, 2007
April 2007	April 1, 2007 through June 30, 2007
July 2007	July 1, 2007 through September 30, 2007
October 2007	October 1, 2007 through December 31, 2007

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

Drugs Furnished During Filling or Refilling an Implantable Pump or Reservoir

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

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

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treatment of the patient's illness or injury; there is a medical reason that the medication cannot be taken orally; and the skills of the nurse are needed to infuse the medication safely and effectively. Payment for drugs furnished incident to the filling or refilling of an implantable pump or reservoir is determined under the ASP methodology as described above. Note that pricing for compounded drugs is done by your local Medicare contractor.

Additional Information

To see the official instruction (CR5710) issued to your Medicare carrier, FI, A/B MAC, DME MAC, or RHHI. That instruction may be viewed by going to <http://www.cms.hhs.gov/Transmittals/downloads/R1334CP.pdf> on the CMS Web site.

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

Reasons for Provider Notification of Medicare Claims Disputed/Rejected by Supplemental Payers/Insurers

MLN Matters Number: SE0728 **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

Provider Types Affected

Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, fiscal intermediaries (FIs), Medicare Administrative Contractors (A/B MACs), and durable medical equipment MACs (DME MACs).

Provider Action Needed

Effective for claims processed on or after July 1, 2007, when claims crossed over by Medicare to a supplemental payer/insurer are rejected or disputed by that insurer, Medicare will add a standardized message to the notification to the provider. That message will be in the form of a Dispute Reason Code, which will explain why the supplemental insurer disputed the claim. Be sure your billing staff is aware of these codes, as described later in this article, and is ready to take corrective action, as appropriate.

Background

In MLN Matters article, MM3709, the Centers for Medicare & Medicaid Services (CMS) describes the notification process to Medicare providers when Medicare claims that should automatically cross to a supplemental payer/insurer-are not crossed over due to claim data errors. The notification is mailed to the correspondence address that is submitted by the provider, along with all other Medicare enrollment data, and is maintained by CMS' Medicare contractors.

(MM3709 may be referenced at: <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3709.pdf> on the CMS Web site.)

There are also situations where provider notifications are sent **after** the claim has crossed to the supplemental payer/insurer. This occurs in situations where the insurer may not be able to process the Medicare claim for supplemental payment and, therefore, rejects or disputes the claim back to CMS' Coordination of Benefits Contractor (COBC). When these situations occur, the COBC transmits a report containing the "disputed" claims to the Medicare contractor, which then notifies the provider, through a special automated correspondence, that the claim was not crossed automatically.

Beginning in July 2007, provider notifications will include standardized language for claims that

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have been disputed by the supplemental payer/insurer and the dispute has been accepted by the COBC. The standardized language will read: "Claim rejected by other insurer," and it will include a reason code. The following is a list of the reason codes that may be contained in the standardized language and the definition of each:-

Dispute Reason Codes:

- ★ 000100 - Duplicate Claim
- ★ 000110 - Duplicate Claim
(within the same ISA – IEA loop)
- ★ 000120 - Duplicate claim
(within the same ST-SE loop)
- ★ 000200 – Claim for Provider ID/State should have been excluded
- ★ 000300 - Beneficiary not on eligibility file
- ★ 000400 - Reserved for future use
- ★ 000500 - Incorrect claim count
- ★ 000600 - Claim does not meet selection criteria
- ★ 000700 - HIPAA Error
- ★ 009999 – Other

When Medicare providers receive this notification, they may need to take appropriate action to obtain payment from the supplemental payer/insurer for all Dispute Reason Codes **except** for 000100, 000110, 000120, and 000400.

Additional Information

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

Important Guidance on the New CMS-1500 and UB-04 Forms

MLN Matters Number: SE0729

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

Provider Types Affected

All providers using the new forms CMS-1500 or UB-04 to bill Medicare contractors (carriers, fiscal intermediaries (FI), or Medicare Administrative Contractors MACs)) for services provided to Medicare beneficiaries.

What You Need to Know

This *MLN Matters* article, SE0729, provides you valuable information about the new CMS 1500 and UB-04 forms.

Background

CMS Form 1500 Version 08-05 In 2006, the Centers for Medicare & Medicaid Services (CMS) introduced the revised Form CMS-1500 (08-05). This new version of the form, revised to accommodate the reporting of the National Provider Identifier (NPI), was developed through a collaborative effort headed up by the National Uniform Claim Committee (NUCC), which is chaired by the American Medical Association (AMA), in consultation with the CMS.

The committee includes representation from key provider and payer organizations, as well as standards setting organizations, one healthcare vendor, and the National Uniform Billing Committee (NUBC). As such, the committee is intended to have an authoritative voice regarding national standard data content and data definitions for non-institutional health care claims in the United States.

Although CMS prefers that you submit all claims to Medicare electronically, the Administrative Simplification Compliance Act Public Law 107-105 (ASCA) and the implementing regulation at 42 CFR 424.32 provide for exceptions to the mandatory electronic claim submission requirement. Therefore, Medicare will receive, and process, paper claims (using the new [08-05] version of the CMS-1500 form) only from physicians and suppliers who are excluded from the mandatory electronic claims submission requirements.

CMS began accepting the revised form CMS-1500 in January 1, 2007, planning to discontinue the older version on April 1, 2007; however formatting issues forced CMS to extend this date to July 2, 2007. At that time, CMS began returning the 12-90 version of the form. While the Government Printing Office (GPO) is not yet in a position to accept and fill orders for the revised CMS-1500 form, CMS' research indicates the form is widely available for purchase from print vendors.

For assistance in locating the form, you can contact the NUCC at <http://www.nucc.org/>, or you might consider using local print media directories to search for print vendors, contacting other providers to inquire on their source for the form, or searching for "CMS-1500 (08-05)" or "CMS-1500 08/05" on the internet to locate online print vendors. You should ask for samples before ordering to ensure that the formatting is correct.

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Some important details in completing the new CMS-1500 form are as follow:

- ★ If you previously populated boxes 17a (referring provider), 24j (rendering provider), and 33 (billing provider) with your legacy number, you should now begin using your NPI also.
- ★ The billing provider NPI goes in box 33a. In addition, if the billing provider is a group, then the rendering provider NPI must go in box 24j. If the billing provider is a solo practitioner, then box 24j is always left blank. A referring provider NPI goes in box 17b.
- ★ If the information in block 33 (billing) is different than block 32 (service facility), you should populate block 32 with the address information.

You can learn more about the new version of the CMS-1500 by reading MLN Matters article MM5060 (Additional Requirements Necessary to Implement the Revised Health Insurance Claim Form CMS-1500), released September 15, 2006.

You can find that article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5060.pdf>.

UB-04 Information

At its February 2005 meeting, the National Uniform Billing Committee (NUBC) approved the UB-04 (CMS-1450) as the replacement for the UB-92. The UB-04, the basic form that CMS prescribes for the Medicare program, incorporates the National Provider Identifier (NPI) taxonomy, and additional codes; and is only accepted from institutional providers 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.

Effective March 1, 2007, institutional claim filers such as hospitals, SNFs, hospices, and others were to have begun using the UB-04, with a transitional period between March 1, 2007, and May 22, 2007 (during which time either the UB-92 or the UB-04 may have been used). On and after May 23, 2007: 1) The UB-92 has become no longer acceptable (even as an adjustment claim); and 2) All institutional paper claims must be submitted on the UB-04.

You should note that while most of the data usage descriptions and allowable data values have not changed on the UB-04, many UB-92 data locations have changed and, in addition, bill type processing will change. Some details of the form follow:

- ★ The UB-04 (Form CMS-1450) is a uniform institutional provider bill suitable for billing multiple third party payers. A particular payer, therefore, may not need some of the data elements.
- ★ When filing, you should retain the copy designated "Institution Copy" and submit the remaining copies to your Medicare contractor, managed care plan, or other insurer.
- ★ Instructions for completing inpatient and outpatient claims are the same unless otherwise noted.
- ★ If you omit any required data, your contractor will either ask you for them or obtain them from other sources and will maintain them on its history record. It will not obtain data that are not needed to process the claim.
- ★ Data elements in the CMS uniform electronic billing specifications are consistent with the UB-04 data set to the extent that one processing system can handle both. The definitions are identical, although in some situations, the electronic record contains more characters than the corresponding item on the form because of constraints on the form size not applicable to the electronic record. Further, the revenue coding system is the same for both the Form CMS-1450 and the electronic specifications.
- ★ For the UB-04, the billing provider's NPI is entered in Form Locator (FL) 56. The attending provider's NPI is entered in FL76. The operating provider's NPI is entered in FL77. Up to 2 other provider NPIs can be entered in FL78 and FL79.

You can find more information about the UB-04 (Form CMS-1450) by reading MLN Matters article MM5072 (Uniform Billing (UB-04) Implementation – UB-92 Replacement), released November 3, 2006. You can find that article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5072.pdf>. The CR, from which that article was taken, contains a copy of the UB-04 form (front and back) in PDF format, a crosswalk between the UB-04 and the UB-92, and the revised portion of the Medicare Claims Processing Manual, Chapter 25 (Completing and Processing the CMS 1450 Data Set), Sections 70 (Uniform Bill - Form CMS-1450 (UB-04)) and 71 (General Instructions for Completion of Form CMS-1450 (UB-04)). These sections contain very detailed instructions for completing the form.

For assistance in obtaining UB-04s you can contact the NUBC at <http://www.nubc.org/>.

Additional Information

If you have any questions, please contact your FI, carrier, or MAC at their toll-free number, which may be found

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at <http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS Web site.

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

MLN Matters Number: MM5452 Revised
Related Change Request (CR) #: 5452
Related CR Release Date: September 21, 2007
Effective Date: July 2, 2007
Related CR Transmittal #: R1343CP
Implementation Date for DME suppliers: July 2, 2007.
Implementation Date for other providers: April 7, 2008

Note: This article was revised on September 21, 2007, to reflect a change made to the implementation dates in CR5452. For DME suppliers billing DME MACs, the implementation date remains the same. For other providers who bill Medicare carriers, fiscal intermediaries, including Regional Home Health Intermediaries, and/or Part A/B Medicare Administrative Contractors (A/B MACs), the implementation date is now April 7, 2008. The CR transmittal date, number, and Web address for accessing CR5452 were also changed. All other information remains the same.

Provider Types Affected

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

Provider Action Needed

STOP – Impact to You

Be aware that Stage 3 of the NPI implementation is nearing. This article discusses impact of the NPI Stage 3 implementation on remittance advice transactions.

CAUTION – What You Need to Know

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

GO – What You Need to Do

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

Background

This article discusses Stage 3 of Medicare's fee-for-service (FFS) processes for the NPI and reflects Medicare processing of claims submitted with NPIs.

Submitted NPIs will be crosswalked to the Medicare legacy number(s) for processing. Medicare's internal provider files will continue to be based upon records established in relation to the legacy identifiers. The crosswalk may result in:

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

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

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

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

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

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

- ★ **Electronic Remittance Advice (ERA)** - Under this scenario, Medicare will report the NPI at the Payee level as the Payee primary ID, and the TIN (Employer Identification Number (EIN) Social Security Number (SSN) (EIN/SSN)) in the REF segment as Payee Additional ID. Medicare will report any relevant Rendering Provider NPI at the claim level if different from the Payee NPI. A/B MACs, carriers, DME MACs, and DMERCs, as appropriate, will also report relevant Rendering NPI(s) at the service line level if different from the claim level Rendering Provider

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NPI. Under this scenario, there will be one remittance advice, and one check/Electronic Funds Transfer (EFT) per NPI.

- ★ **Standard Paper Remittance (SPR)** - Medicare will insert the appropriate Payee NPI at the header level. The ERA reporting requirements apply to the corresponding SPR fields. See above for additional note.
- ★ **PC Print Software** - Medicare will show the Payee NPI at the header level and add the relevant Rendering Provider NPI at the claim level if different from the Payee NPI.
- ★ **MREP Software** - Medicare will show the Payee NPI at the header level and add any relevant Rendering Provider NPI at the claim level if different from the Payee NPI, and any relevant Rendering NPI(s) at the service line level if different from the claim level Rendering Provider NPI.

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

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

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

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

Implementation

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

- ★ For claims submitted to DMERCs and/or DME MACs, the changes will be implemented on July 1, 2007.
- ★ For claims submitted to other Medicare contractors, the implementation will occur on **April 7, 2008**.

Additional Information

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

For complete details regarding this Change Request (CR) please see the official instruction (CR5452)

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issued to your Medicare FI, RHHI, DMERC, DME/MAC, or A/B MAC. That instruction may be viewed by going to <http://www.cms.hhs.gov/Transmittals/downloads/R1343CP.pdf> on the CMS web site. The revised sections of Chapter 22—Remittance Advice of the Medicare Claims Processing Manual are attached to CR5452.

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

MLN Matters Number: MM5721

Related CR Release Date: September 28, 2007

Related CR Transmittal #: R1345CP

Related Change Request (CR) #: 5721

Effective Date: October 1, 2007

Implementation Date: October 1, 2007

Provider Types Affected

Physicians, providers, and suppliers who submit claims to Medicare contractors (carriers, fiscal intermediaries (FIs), regional home health intermediaries (RHHs), Part A/B Medicare Administrative Contractors (A/B MACs), and DME Medicare Administrative Contractors (DME MACs)) for services

Provider Action Needed

CR 5721, from which this article is taken, announces the latest update of X12N 835 Health Care RARCs and X12N 835 and 837 Health Care CARCs, effective October 1, 2007. Be sure billing staff are aware of these changes.

Background

For transaction 835 (Health Care Claim Payment/Advice) and standard paper remittance advice, there are two code sets – Claim Adjustment Reason Code (CARC) and Remittance Advice Remark Code (RARC) – that must be used to report payment adjustments, appeal rights, and related information. Additionally, for transaction 837 coordination-of-benefits (COB), CARC must be used. These code sets are updated on a regular basis. Medicare contractors must use only currently valid codes, and make the necessary changes on a regular basis as per this recurring code update CR or the specific CR that describes the change in policy that resulted in the code change.

The RARC list is maintained by the Centers for Medicare & Medicaid Service (CMS), and used by all payers. Additions, deactivations, and modifications to the list 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.

As mentioned earlier in CR 5634, at least one remark code must be used with the following 5 CARCs:

- ★ **16** - Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)
- ★ **17** - Payment adjusted because requested information was not provided or was insufficient/incomplete. At least one Remark Code must be provided. (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)
- ★ **96** - Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)
- ★ **125** - Payment adjusted due to a submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)
- ★ **A1** - Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)

Both code lists are updated three times a year, and are posted at <http://wpc-edi.com/codes> on the

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Internet. Please note that in order to synchronize with the CARC update schedule, the RARC list will be updated in early November, March and July instead of the current schedule of early December, April and August. **The lists at the end of this article summarize the latest changes to these lists, as announced in CR 5721, to be effective on and after October 1, 2007 for Medicare.**

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

Additional Information

You can see the official instruction issued to you're A/B MAC, FI, carrier, DME MAC, or RHHI regarding these latest RARC and claim adjustment reason code updates by going to CR 5721, located at <http://www.cms.hhs.gov/transmittals/downloads/R1345CP.pdf> on the CMS Web site.

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

If you have any questions, please contact your Medicare contractor at their tollfree number, which may be found at <http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS Web site.

Remittance Advice Remark Code changes

New Remark Codes		
Code	Current Narrative	Medicare Initiated
N380	The original claim has been processed, submit a corrected claim.	No
N381	Consult our contractual agreement for restrictions/billing/payment information related to these charges.	No
N382	Missing/incomplete/invalid patient identifier.	No
N383	Services deemed cosmetic are not covered.	No
N384	Records indicate that the referenced body part/tooth has been removed in a previous procedure.	No
N385	Payment has been adjusted because notification of admission was not timely according to published plan procedures.	No
N386	This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at http://www.cms.hhs.gov/mcd/search.asp . If you do not have web access, you may contact the contractor to request a copy of the NCD.	Yes
N387	You should submit this claim to the patient's other insurer for potential payment of supplemental benefits. We did not forward the claim information.	Yes

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Modified Remark Codes

The following codes have been identified as “Informational” codes, and modified to add the word “Alert” in front of the current text.

M4	MA15	N59	N155	N353
M6	MA18	N84	N156	N355
M9	MA19	N85	N162	N358
M17	MA26	N88	N177	N360
M27	MA28	N89	N183	N363
M32	MA44	N130	N185	N364
M39	MA45	N132	N187	N367
M70	MA59	N133	N189	
M118	MA62	N134	N196	
MA01	MA68	N136	N202	
MA07	MA72	N137	N210	
MA08*	MA77	N138	N211	
MA10	N1	N139	N215	
MA13	N21	N140	N220	
MA14	N23	N154	N352	

* Code MA08 text has been modified further as follows:

Old Text for MA08	New Text for MA08
You should also submit this claim to the patient’s other insurer for potential payment of supplemental benefits. We did not forward the claim information as the supplemental coverage is not with a Medigap plan, or you do not participate in Medicare.	Alert: Claim information was not forwarded because the supplemental coverage is not with a Medigap plan, or you do not participate in Medicare.

Notes: Some remark codes may only provide general information that may not necessarily supplement the specific explanation provided through a reason code and 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. These informational codes should be used only if specific information about adjudication (like appeal rights) needs to be communicated. An example of an informational code:

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

The above information is sent per state regulation but does not explain any adjustment. These informational codes should be used only if specific information about adjudication (like appeal rights) needs to be communicated but not as default codes.

Code	Current Narrative	Notes
N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.	Deactivated effective 10/1/07. Consider using Reason Code 45.
N361	Payment adjusted based on multiple diagnostic imaging procedure rules.	Deactivated effective 10/1/07. Consider using Reason Code 59.

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X12 N Health Care Claim Adjustment Reason Code Changes Explanation of Start, Last Modified, and Stop

- ★ **Start** - Every code has a start date. This is the date when the code was first available in the code list.
- ★ **Last Modified** - When populated, this is the date of the code list release when the definition of the specific code was last modified by the committee. This date represents a point when the definition changed from one wording to another.
- ★ **Stop** - When populated, this date identifies that the code can no longer be used in original business messages after that date. The code can only be used in derivative business messages (messages where the code is being reported from the original business message). For example, a CARC with a stop date of 02/01/2007 would not be able to be used by a health plan in a CAS segment in a claim payment/remittance advice transaction (835) dated after 02/01/2007 as part of an original claim adjudication. The code would still be able to be used after 02/01/2007 in derivative transactions, as long as the original usage was prior to 02/01/2007. Derivative transactions include: secondary or tertiary claims (837) from the provider or health plan to a secondary or tertiary health plan, an 835 from the original health plan to the provider as a reversal of the original adjudication. The deactivated code is usable in these derivative transactions because they are reporting on the valid usage (pre-deactivation) of the code in a previously generated 835 transaction.

New Reason Codes		
Code	Current Narrative	Notes
202	Payment adjusted due to non-covered personal comfort or convenience services.	Start: 02/28/2007
203	Payment adjusted for discontinued or reduced service.	Start: 02/28/2007
204	This service/equipment/drug is not covered under the patient's current benefit plan.	Start: 02/28/2007
205	Pharmacy discount card processing fee.	Start: 07/09/2007
206	NPI denial - missing.	Start: 07/09/2007
207	NPI denial - Invalid format.	Start: 07/09/2007 Stop: 05/23/2008
208	NPI denial - not matched.	Start: 07/09/2007
209	Per regulatory or other agreement, the provider cannot collect this amount from the patient. However, this amount may be billed to subsequent payer. Refund to patient if collected. (Use Group code OA).	Start: 07/09/2007
210	Payment adjusted because precertification/ authorization not received in a timely fashion.	Start: 07/09/2007
211	National Drug Codes (NDC) not eligible for rebate, are not covered.	Start: 07/09/2007

Modified Reason Codes		
Code	Current Narrative	Notes
59	Charges are adjusted based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.)	Start: 01/01/1995 Last Modified: 02/28/2007
197	Payment adjusted for absence of recertification/authorization. This change effective 1/1/2008: Payment adjusted for absence of precertification/ authorization/notification.	Start: 10/31/2006 Last Modified: 07/09/2007
115	Payment adjusted as procedure postponed or canceled. This change effective 1/1/2008: Payment adjusted as procedure postponed, canceled, or delayed.	Start: 01/01/1995 Last Modified: 07/09/2007

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Modified Reason Codes		
Code	Current Narrative	Notes
85	Interest amount. This change effective 1/1/2008: Patient Interest Adjustment (Use Only Group code PR) Notes: Only use when the payment of interest is the responsibility of the patient	Start: 01/01/1995 Last Modified: 07/09/2007

Deactivated Reason Codes		
Code	Current Narrative	Notes
A2	Contractual adjustment. Notes: Use Code 45 with Group Code 'CO' or use another appropriate specific adjustment code. The "Stop" date of 1/1/2008 may change.	Start: 01/01/1995 Stop: 01/01/2008 Last Modified: 02/28/2007
207	NPI denial - Invalid format	Start: 07/09/2007 Stop: 05/23/2008

In addition, CR5721 contains a comprehensive list of deactivated reason codes. These codes have been deactivated prior to publication of CR5721 and have been included in previous CRs. Because of a policy change, the deactivation date may have moved from a specific version to a specific date. Contractors will not use any of these codes in any original business messages, but these codes may be used in derivative business messages (messages where the code is being reported from the original business message). This list can be viewed by accessing CR5721 at the Web address cited in the "Additional Information" section (above) of this article.

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

MLN Matters Number: MM5740

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

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

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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 Web site.

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.

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		
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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 Web site.

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 Web site.

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 Web site.

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2007 Payment Limits for Splints and Casts	
Code	Payment Limit
A4565	\$7.38
Q4001	\$42.01
Q4002	\$158.81
Q4003	\$30.18
Q4004	\$104.49
Q4005	\$11.12
Q4006	\$25.08
Q4007	\$5.58
Q4008	\$12.54
Q4009	\$7.43
Q4010	\$16.72
Q4011	\$3.71
Q4012	\$8.36
Q4013	\$13.52
Q4014	\$22.81
Q4015	\$6.76
Q4016	\$11.40
Q4017	\$7.82
Q4018	\$12.47
Q4019	\$3.91
Q4020	\$6.24
Q4021	\$5.78
Q4022	\$10.44
Q4023	\$2.91
Q4024	\$5.22
Q4025	\$32.45
Q4026	\$101.30
Q4027	\$16.23
Q4028	\$50.66
Q4029	\$24.81
Q4030	\$65.31
Q4031	\$12.41
Q4032	\$32.65
Q4033	\$23.14
Q4034	\$57.56
Q4035	\$11.57
Q4036	\$28.79
Q4037	\$14.12
Q4038	\$35.37
Q4039	\$7.08

2007 Payment Limits for Splints and Casts	
Code	Payment Limit
Q4040	\$17.68
Q4041	\$17.16
Q4042	\$29.30
Q4043	\$8.59
Q4044	\$14.66
Q4045	\$9.96
Q4046	\$16.03
Q4047	\$4.97
Q4048	\$8.02
Q4049	\$1.82

Medicare Fee for Service (FFS) National Provider Identifier (NPI) Final Implementation

MLN Matters Number: MM5728

Related Change Request (CR) #: 5728

Related CR Release Date: October 5, 2007

Effective Date: No later than May 23, 2008

Related CR Transmittal #: R1349CP

Implementation Date: January 7, 2008 and April 7, 2008

Provider Types Affected

Physicians, providers, and suppliers who submit any HIPAA standard transactions to Medicare contractors (carriers, Fiscal Intermediaries, (FIs), including Regional Home Health Intermediaries (RHHIs), Medicare Administrative Contractors (A/B MACs), and DME Medicare Administrative Contractors (DME MACs))

Provider Action Needed

STOP – Impact to You

This article is based on CR5728, which describes the policy change brought about as a result of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, that requires issuance of a unique national provider identifier (NPI) to each physician, supplier, and other provider of health care who conducts HIPAA standard electronic transactions.

CAUTION – What You Need to Know

Once CMS ends its' NPI contingency, the legacy number will NOT be permitted on any inbound electronic and outbound electronic transaction (there are exceptions to the 835 remittance advice (see CR5452)). Medicare contractors will begin rejecting claims, electronic,

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including direct data entry, that contain legacy provider numbers for any primary provider instead of or in addition to the NPI number. The following HIPAA transactions are also affected:

- ★ X12N 276/277 Claim Status Inquiry/Response – (see CR5726 for details.)
- ★ X12N 837 Coordination of Benefits (COB) – NPI only will be sent on the 837 coordination of benefits. Legacy numbers are not allowed. An exception will exist for claims that have not cleared the system by the date that CMS ends its NPI contingency plan. Such claims may contain the legacy number and, therefore, the COB transaction will also include the legacy number.

GO – What You Need to Do

No later than May 23, 2008, providers should ensure that all HIPAA transactions sent to Medicare contractors contain only valid NPI numbers (no legacy provider numbers.)

Background

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 required issuance of a unique national provider identifier (NPI) to each physician, supplier, and other provider of health care who conducts HIPAA standard electronic transactions. The Centers for Medicare & Medicaid Services (CMS) began to issue NPIs on May 23, 2005. CMS has been allowing transactions adopted under HIPAA to be submitted with a variety of identifiers. They are:

- ★ NPI only;
- ★ Medicare legacy only; or
- ★ NPI and legacy combination.

On April 2, 2007, the Department of Health and Human Services (DHHS) provided guidance to covered entities regarding contingency planning for the implementation of the NPI. As long as a health plan is compliant, meaning they can accept and send NPIs on electronic transactions, they may establish contingency plans to facilitate the compliance of their trading partners. As a compliant health plan, Medicare fee for service (FFS) established a contingency plan on April 20, 2007, that followed this guidance. CR5728 directs Medicare contractors to begin rejecting HIPAA inbound claims when directed by CMS, if they contain legacy provider identifiers.

Since paper claims are not HIPAA transactions, these requirements do not apply to paper claims, however, providers should not submit legacy numbers on paper claims once CMS ends its NPI contingency plan.

Additional Information

The official instruction, CR5728, issued can be found at <http://www.cms.hhs.gov/Transmittals/downloads/R1349CP.pdf> on the CMS Web site.

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 Web site.

Clarification Concerning Provider Billing Procedures Related to the Transition of the Medigap claim-based Crossover Process to the Coordination of Benefits Contractor on October 1, 2007

MLN Matters Number: SE0743

Related Change Request (CR) #: CR5601 and CR5662

Related CR Release Date: N/A

Effective Date: October 1, 2007

Related CR Transmittal #: N/A

Implementation Date: N/A

Provider Types Affected

Physicians and suppliers submitting claims to Part B Medicare contractors (including carriers, Medicare Administrative Contractors (A/B MACs), and durable medical equipment MACs (DME MACs).

Provider Action Needed

As instructed in *MLN Matters* article MM5601, all providers that bill their claims to Part B carriers, A/B MACs, or DMACs should, effective with October 1, 2007, begin to include a new Coordination of Benefits Agreement (COBA) Medigap 5-byte COBA ID (range 55000 to 59999) on incoming Medicare paper claims (CMS- 1500), or incoming Health Insurance Portability and Accountability Act (HIPAA) 837 professional (version 4010A1), or National Council for Prescription Drug Programs (NCPDP) version 5.1 batch standard 1.1 claims to trigger crossovers to those Medigap insurers that are participating in the Centers for Medicare & Medicaid Services (CMS) new COBA Medigap claim-based process.

Providers should be including **only** the new 5-byte COBA Medigap claim-based ID on incoming Medicare claims effective October 1, 2007, for the purpose of triggering crossovers to those Medigap insurers that have been assigned a COBA Medigap claim-based ID

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that falls in the range of 55000 through 59999. The link to the Medigap Billing ID spreadsheet, which providers or their billing vendors should consult for this purpose, remains as <http://www.cms.hhs.gov/COBAgreement/Downloads/Medigap%20Claimbased%20COBA%20IDs%20for%20Billing%20Purpose.pdf> on the CMS Web site.

Though the number of entities that have requested COBA Medigap claimbased IDs is currently not very large, providers and their billing vendors should continue to consult this listing for purposes of noting changes. Please be assured the list is complete and accurate. Providers or their billing vendors should include only the Medigap COBA IDs on this list (range 55000 through 59999) on Medicare claims for purposes of triggering crossovers to Medigap insurers. Providers or their billing vendors should **not** include any of the eligibility file-based COBA IDs (ranges 00001-29999; 30000-54999; 60000-69999; 70000-79999; and 80000-89999) on inbound claims to Medicare.

Effective October 1, 2007, if a provider or its billing vendor files a Medicare claim with a COBA ID other than the COBA Medigap IDs on the above-referenced Medigap Billing ID list, Medicare will generate an MA-19 message on the provider's 835 electronic remittance advice (ERA) or other remittance advice in use. This message indicates: "Information was **not** sent to the Medigap insurer due to incorrect/invalid information you submitted concerning that insurer. Please verify your information and submit your secondary claim directly to that insurer."

As a reminder, all entities that participate in the COBA eligibility file-based crossover process or automatic complementary crossover process may be referenced at <http://www.cms.hhs.gov/COBAgreement/Downloads/Contacts.pdf> on the CMS Web site.

Providers should **not** contact those insurers or payers listed as participating in the automatic crossover process for purposes of determining whether CMS has assigned them a COBA Medigap claim-based ID. As aforementioned, providers or their billing vendors should also **not** utilize COBA ID information from this listing on their incoming Medicare claims for the purpose of triggering Medigap claim-based crossovers. **IMPORTANT:** Not every Medigap insurer is utilizing the automatic crossover process for the purpose of identifying **all** of its covered members or policyholders for crossover purposes and for receiving crossover claims for those Medicare beneficiaries. An example of this scenario is as follows: If the COBC was approached

by a new Medigap insurer that specified that it needed to apply for a Medigap claim-based ID (range 55000 to 59999) for various segments of its covered membership, but will utilize the automatic complementary crossover process for the remainder of its Medigap membership, the COBC would, following execution of the COBA crossover agreement with the insurer, assign it two COBA IDs—one for automatic crossover (range 30000 to 54999 for automatic Medigap eligibility file-based crossover) and the other for Medigap claim-based crossover (55000 to 59999). Thus, this Medigap insurer would appear on **both** the listing of automatic crossover insurers as well as the Medigap Billing ID listing at the respective URL links on the COB Web site, referenced above.

Background

All supplemental insurers are required to sign a national COBA crossover agreement with CMS' Coordination of Benefits Contractor (COBC) if they participate in CMS' automatic complementary crossover (COBA eligibility filebased crossover) process **or** in the COBA Medigap claim-based crossover process. Providers should know that it is **never** their responsibility to request or obtain new Medigap 5-byte IDs for their patients' Medigap insurers through the signing of a national COBA crossover agreement.

In *MLN Matters* article, MM5662, CMS informed its affected provider community that, during June through August 2007, its COBC would assign a new 5-byte COBA Medigap claim-based identifier (range=55000 to 59999) to a Medigap insurer after it has signed a national crossover agreement with the COBC. Despite repeated outreach communications to the health insurance industry, not all Medigap insurers have, as instructed, contacted the COBC to specify which approach, among three available options, they will exercise to ensure continued receipt of crossover claims on and after October 1, 2007.

The three (3) options available to each Medigap insurer for addressing its receipt of Medicare crossovers remain as follows:

- ★ If applicable, continue to participate **fully** in the automatic crossover process (or COBA eligibility file-based crossover process) and discontinue use of any claim-based Medigap IDs;
- ★ Continue to participate in part in the automatic crossover process for a segment of the insurer's covered membership but request a COBA Medigap claim-based ID through the COBC to address crossovers for the remaining segments; or

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- ★ Request a new COBA Medigap claim-based crossover ID through the COBC, with the understanding that the Medigap insurer would prefer **not** to participate in the automatic crossover process.

To be clear, if a Medigap insurer is currently participating **fully** in the automatic (or COBA eligibility file-based) crossover process, it merely needs to inform the COBC of this decision. Upon doing so, that Medigap insurer will experience no disruption in its receipt of crossover claims. Based upon its most recent review of trending, CMS has noted that the vast majority of the larger, more commonly known Medigap insurers, which were already participating **fully** in the Medicare automatic crossover process, have informed CMS and the COBC that they plan to continue to participate fully in the automatic crossover process for purposes of fulfilling their mandatory Medigap crossover payment responsibilities on behalf of their Medigap policyholders. In other words, the majority of the larger, more commonly known Medigap insurers have exercised option #1, above.

Additional Information

You can find MLN Matters articles MM5061 and MM5662 at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5601.pdf> and <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5662.pdf> on the CMS Web site.

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

Correction to Revised HCPCS Codes Relating to Immune Globulin (CR 5635)

MLN Matters Number: MM5741 *Revised*

Related CR Release Date: October 5, 2007

Related CR Transmittal #: R1350CP

Related Change Request (CR) #: 5741

Effective Date: July 1, 2007

Implementation Date: November 5, 2007

Notes: This article was revised on October 15, 2007, to show that CR5741 and this article relate to suppliers billing DME MACs. Other provider types billing Medicare for Immune Globulin should continue to follow the information contained in article MM5635 at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5635.pdf> on the CMS Web site.

Provider Types Affected

Suppliers who bill Medicare Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for Immune Globulin.

What You Need to Know

CR 5741, from which this article is taken, corrects CR5635 to show that it applies to suppliers billing DME MACs. CR5635 revised Healthcare Common Procedure Coding System (HCPCS) codes relating to immune globulin. **(Basically, the information in this article restates the requirements of CR5635 that apply to suppliers billing Medicare DME MACs.)** CR 5741 announces that on and after July 1, 2007:

- ★ Code J1567 (injection, immune globulin, intravenous, non-lyophilized (e.g. liquid), 500mg) **is no longer payable by Medicare.**
- ★ It is being replaced by the following codes, which are effective for payment on July 1, 2007: Q4087 (Octagam Injection), Q4088 (Gammagard Liquid Injection), Q4091 (Flebogamma Injection), and Q4092 (Gamunex Injection).
- ★ In addition, two new codes are payable for services on or after July 1, 2007:
 - » **Q4089** (Rhopylac injection). Note that Currently, Rhophylac® is the only product that should be billed using code Q4089. If other products under the FDA approval for Rhophylac® become available, code Q4089 would be used to bill for such products.

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- » **Q4090** (HepaGam B injection). Note that currently, HepaGam B™, when given intramuscularly, is the only product that should be billed using code Q4090. If other products under the FDA's approval for HepaGam B™ IM become available, code Q4090 would be used to bill for such products. HepaGam B™ when given intravenously should be billed using an appropriate Not Otherwise Classified code in the absence of a specific HCPCS code.
- ★ As described in CR 5428, Medicare contractors will pay for preadministrationrelated services (G0332) associated with IVIG administration when Q4087, Q4088, Q4091, or Q4092 is billed in lieu of J1567.

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

Background

CR 5741 announces that effective July 1, 2007, Medicare will no longer pay for HCPCS code J1567 (injection, immune globulin, intravenous, non-lyophilized (e.g. liquid), 500 mg). In its place, effective July 1, 2007, codes Q4087, Q4088, Q4091, Q4092, and two new codes (Q4089, Q4090) become effective for payment. Table 1, below, displays these codes and their descriptions.

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

Additional Information

You can find the official instruction issued to your Medicare DME MAC about the revised HCPCS codes relating to Immune Globulin by going to CR5741, located at <http://www.cms.hhs.gov/Transmittals/downloads/R1350CP.pdf> on the CMS Web site.

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

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 Web site.

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Medicare Summary Notice (MSN) Message: Revised 38.13

MLN Matters Number: MM5722

Related Change Request (CR) #: 5722

Related CR Release Date: September 27, 2007

Effective Date: October 29, 2007

Related CR Transmittal #: R1347CP

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 Web site.

You can review CR5062 at <http://www.cms.hhs.gov/transmittals/downloads/R955CP.pdf> on the CMS Web site. 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 Web site.

If you have any questions, please contact your Medicare contractor at their tollfree number, which may be found at <http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS Web site.

Claim Status Category Code and Claim Status Code Update

MLN Matters Number: MM5687

Related Change Request (CR) #: 5687

Related CR Release Date: July 23, 2007

Effective Date: January 1, 2008

Related CR Transmittal #: R1314CP

Implementation Date: January 7, 2008

Provider Types Affected

Physicians, providers, and suppliers who submit Health Care Claim Status Transactions to Medicare contractors (carriers, Medicare administrative contractors (A/B MACs), durable medical equipment Medicare administrative contractors (DME MACs), fiscal intermediaries (FIs), and regional home health intermediaries (RHHIs)).

Provider Action Needed

STOP – Impact to You

This article is based on Change Request (CR) 5687, which provides the January 2008 updates of the Claim Status Codes and Claim Status Category Codes for use by Medicare contractors (carriers, A/B MACs, DME MACs, FIs, and RHHIs)..

CAUTION – What You Need to Know

Effective January 1, 2008, Medicare contractors are to use codes posted on July 9, 2007, at the <http://www.wpc-edi.com/codes> Web site. Chapter 31 of the *Medicare Claims Processing Manual*, Section 20.7 - Health Care Claim Status Category Codes and Health Care Claims Status Codes for Use with the Health Care Claim Status Request and Response ASC X12N 276/277

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discusses these codes in more detail. You may review section 20.7 at: <http://www.cms.hhs.gov/manuals/downloads/clm104c31.pdf> on the Centers for Medicare & Medicaid Services (CMS) Web site.

GO – What You Need to Do

See the *Background* section of this article for further details.

Background

Under the Health Insurance Portability and Accountability Act (HIPAA), all payers (including Medicare) must use Claim Status Category and Claim Status codes approved by a recognized code set maintainer (instead of proprietary codes) to explain any status of a claim(s) sent in the Version 004010X093A1 Health Care Claim Status Request and Response transaction. These codes indicate the general category of a claim's status (accepted, rejected, additional information requested, and so on). The national Code Maintenance Committee maintains the Claim Status Category and Claim Status codes.

The national Code Maintenance Committee meets at the beginning of each X12 trimester meeting (February, June, and October) and makes decisions about additions, modifications, and retirement of existing codes. The codes sets are available at <http://www.wpc-edi.com/content/view/180/223/>. This page has previously been referenced by the following URL address: <http://www.wpcedi.com/codes>. Included in the code lists are specific details, including the date when a code was added, changed, or deleted.

All code changes approved during the June 2007 committee meeting were posted on that site on July 9, 2007. One of the decisions made during this June meeting by this Maintenance Committee was to allow the industry more lead time for implementation of code changes. At least 6 months lead time will be allowed for industry implementation of all Claim Status-related code changes as well as Claim Adjustment Reason Code changes (the same committee maintains these code sets). As result, **changes approved in June 2007 will be effective January 1, 2008.**

Additional Information

For complete details regarding this Change Request (CR) please see the official instruction (CR5687) issued to your Medicare FI, carrier, DME MAC, RHHI or A/B MAC. That instruction may be viewed by going to <http://www.cms.hhs.gov/Transmittals/downloads/R1314CP.pdf> on the CMS Web site.

Timeliness Standards for Processing “Other-Than-Clean” Claims

MLN Matters Number: MM5513

Related Change Request (CR) #: 5513

Related CR Release Date: July 20, 2007

Effective Date: January 1, 2008

Related CR Transmittal #: R1312CP

Implementation Date: January 7, 2008

Provider Types Affected

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

Provider Action Needed

STOP – Impact to You

This article is based on Change Request (CR) 5513 which implements requirements for timeliness standards for processing other-than-clean claims. The article is informational in nature and requires no action on your part.

CAUTION – What You Need to Know

The Centers for Medicare & Medicaid Services (CMS) published instructions in a separate transmittal to implement requirements for all carriers and Medicare Administrative Contractors (MACs) for timeliness standards for processing other-than-clean claims, and CR5513 implements those same requirements for FIs, A/B MACs, DME MACs, and RHHIs, effective for claims received on or after January 1, 2008.

GO – What You Need to Do

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

Background

The Social Security Act (Section 1869(a)(2); http://www.ssa.gov/OP_Home/ssact/title18/1869.htm) mandates that Medicare process all “other-than-clean” claims and notify the provider/supplier filing such claims of the determination within 45 days of receiving such claims. The Social Security Act (Section 1869; http://www.ssa.gov/OP_Home/ssact/title18/1869.htm) further defines the term “clean claim” as meaning “a claim that has no defect or impropriety (including any lack of any required substantiating documentation) or particular

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circumstance requiring special treatment that prevents timely payment from being made on the claim under this title." Claims that do not meet the definition of "clean" claims are "other-than-clean" claims, and they require investigation or development external to the contractor's Medicare operation on a prepayment basis.

A Medicare contractor should process all "other-than-clean" claims and notify the provider and beneficiary of their determination within 45 calendar days of receipt. (See Medicare Claims Processing Manual, Publication 100-4, Chapter 1, Section 80.2.1 for the definition of "receipt date" and for timeliness standards for clean claims; <http://www.cms.hhs.gov/manuals/downloads/clm104c01.pdf>)

However, when the Medicare contractor develops the 'other-than-clean' claim by asking the provider/supplier or beneficiary for additional information, the Medicare contractor should cease counting the 45 calendar days on the day that the Medicare contractor sends the development letter to the provider/supplier and/or beneficiary. Upon receiving the materials requested in the development letter from the provider/supplier and/or beneficiary, the Medicare contractor should resume counting the 45 calendar days.

Example:

A Medicare contractor receives a claim on June 1st, but does not send a development letter to the provider/supplier/ and/or beneficiary until June 5th. In this example, 5 of the 45 allotted calendar days will have already passed before the Medicare contractor requested the additional information. Upon receiving the information back from the provider/supplier and/or beneficiary, the Medicare contractor has 40 calendar days left to process the claim and notify the individual that filed the claim of the payment determination for that claim.

Medicare contractors should follow existing procedures relative to both 1) the length of time the provider/supplier and/or beneficiary is afforded the opportunity to return information requested in the development letters and 2) situations where the provider/supplier and or beneficiary does not respond.

This timeliness standard does not apply:

- ★ Where the Social Security Administration blocks a beneficiary's Health Insurance Claim Number (HIC);
- ★ Where there is a problem with the beneficiary's record in Medicare's files **are not subject to this instruction;**
- ★ Where the claim is rejected by the translator software;

- ★ Where CMS instructs Medicare contractors to hold certain claims for processing, e.g., while system changes are being made to handle such claims correctly; or
- ★ To claims submitted by a hospice and these claims are to be processed per instructions in the Medicare Claims Processing Manual (Chapter 1, Section 50.2.3; <http://www.cms.hhs.gov/manuals/downloads/clm104c01.pdf>)

Additional Information

The official instruction, CR5513, issued to your FI, RHHI, A/B MAC, or DME MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1312CP.pdf> on the CMS Web site.

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

Medicare Clinical Trial Policy (CTP)

MLN Matters Number: MM5719

Related Change Request (CR) #: 5719

Related CR Release Date: September 7, 2007

Effective Date: July 9, 2007

Related CR Transmittal #: R74NCD

Implementation Date: October 9, 2007

Provider Types Affected

All physicians, providers, and suppliers who submit claims related to clinical trials to Medicare contractors (carriers, Medicare Administrative Contractors (A/B MACs), durable medical equipment Medicare Administrative Contractors (DME/MACs), fiscal intermediaries (FIs), and regional home health intermediaries (RHHIs)).

Provider Action Needed

STOP – Impact to You

This article is based on Change Request (CR) 5719, which implements two changes to the 2000 clinical trial policy by: (1) modifying for clarity the language describing coverage of an investigational item/service in the context of a clinical trial, and, (2) adopting coverage with evidence development (CED). The remainder of the 2000 clinical trials policy continues without change.

CR 5719 states that for items and services furnished on and after July 9, 2007, the routine costs of a clinical trial include all items and services that are otherwise generally available to Medicare beneficiaries (i.e., there

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exists a benefit category, it is not statutorily excluded, and there is not a national non-coverage decision) that are provided in either the experimental or the control arms of a clinical trial. The investigational item or service itself is excluded, unless otherwise covered outside of the clinical trial.

CAUTION – What You Need to Know

In addition, the National Coverage Determination (NCD) is revised to add coverage with evidence development (CED). CED is for items and services in clinical research trials for which there is some evidence of significant medical benefit, but for which there is insufficient evidence to support a “reasonable and necessary” determination. CED is determined through the NCD process, and conditional upon meeting standards of patient safety and clinical evidence, items and services not otherwise covered would be considered “reasonable and necessary” in the context of a clinical trial. Coverage determined under CED is implemented via subsequent NCDs, CRs, and *MLN Matters* articles specific to the coverage issue.

GO – What You Need to Do

Make certain your billing staffs are aware of these changes. Medicare contractors will adjust claims processed prior to the implementation date of this change if you bring such claims to their attention.

Background

On June 7, 2000, the President of the United States issued an executive memorandum directing the Secretary of Health and Human Services to “explicitly authorize [Medicare] payment for routine patient care costs and costs due to medical complications associated with participation in clinical trials.” In keeping with the President’s directive, the Centers for Medicare & Medicaid Services (CMS) engaged in defining the routine costs of clinical trials and identifying the clinical trials for which payment for such routine costs should be made. On September 19, 2000, CMS implemented its initial Clinical Trial Policy through the NCD process. On July 10, 2006, CMS opened a reconsideration of its NCD on clinical trials in the NCD Manual, section 310.1. CR5719 communicates the findings resulting from that analysis.

Additional Information

To see the official instruction (CR5719) issued to your Medicare FI, carrier, DME/MAC, RHHI or A/B MAC, visit <http://www.cms.hhs.gov/transmittals/downloads/R74NCD.pdf> on the CMS Web site.

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

Discontinuance of the Unique Physician Identification Number (UPIN) Registry

MLN Matters Number: MM5584 *Revised*

Related Change Request (CR) #: 5584

Related CR Release Date: September 14, 2007

Effective Date: May 29, 2007

Related CR Transmittal #: R222PI

Implementation Date: June 29, 2007

Notes: This article was revised on September 17, 2007, to reflect changes made to CR5584, which CMS re-issued on September 14, 2007. The article was revised to show that the UPIN Registry Web site and lookup functionality will be available through May 23, 2008. Information was added regarding the release of information, including NPIs, via the NPPES. The CR transmittal number, Web address for accessing CR5584, and the CR release date were also changed. All other information remains the same.

Provider Types Affected

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

Provider Action Needed

STOP – Impact to You

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

CAUTION – What You Need to Know

The National Provider Identifier (NPI) is a requirement of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and the NPI will replace the use of UPINs and other existing legacy identifiers. (However, CMS recently announced a contingency plan that allows for use of legacy numbers for some period of

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time beyond May 23, 2007. Under the Medicare FFS contingency plan, UPINs and surrogate UPINs may still be used to identify ordering and referring providers and suppliers until further notice.) Information on that contingency plan is at http://www.cms.hhs.gov/NationalProvIdentStand/downloads/NPI_Contingency.pdf on the CMS site.)

GO – What You Need to Do

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

Background

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

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

Important Note:

Effective May 23, 2007, Medicare FFS is establishing a contingency plan for implementing the National Provider Identifier (NPI). In this plan, as soon as Medicare considers the number of claims submitted with an NPI for primary providers (Billing, pay-to and rendering providers) is sufficient, Medicare (after advance notification to providers) will begin rejecting claims without an NPI for primary providers. For more information on this contingency plan, please visit the NPI dedicated Web site at <http://www.cms.hhs.gov/NationalProvIdentStand/>. This contingency plan does not affect CMS plans to discontinue assigning UPINs on June 29, 2007 or to disable the UPIN “look-up” functionality as of May 23, 2008.

The CMS discontinued assigning UPINs on June 29, 2007, but CMS will maintain its UPIN public “look-up” functionality and Registry Web site (<http://www.upinregistry.com/>) through May 23, 2008. In addition, CMS published the NPPES Data Dissemination Notice (CMS-6060-N) in the Federal Register on May 30, 2007. This Notice describes the policy by which information, to include NPIs, may be disseminated by CMS from the National Plan and Provider Enumeration System (NPPES).

Additional Information

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

The official instruction, CR5584, issued to your carrier, intermediary, RHHI, A/B MAC and DME MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R222PI.pdf> on the CMS Web site.

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

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

MLN Matters Number: MM5601 *Revised*
Related Change Request (CR) #: 5601
Related CR Release Date: August 31, 2007
Effective Date: October 1, 2007
Related CR Transmittal #: R1332CP
Implementation Date: October 1, 2007

Notes: This article was revised on September 3, 2007, to reflect changes CMS made to CR5601, which was re-issued on August 31, 2007. The CR transmittal number, release date, and the web address for accessing CR5601 were revised in this article. All other information remains the same.

Provider Types Affected

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

Provider Action Needed

STOP – Impact to You

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

CAUTION – What You Need to Know

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

GO – What You Need to Do

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

Background

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

Key Points of CR5601

- ★ Be aware that during the transition period from June through September 2007 the COBC will assign new 5-byte claim-based Coordination of Benefits Agreement (COBA) IDs to the Medigap insurers on

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a graduated basis throughout the three month period prior to the actual transition. Until CMS' COBC assigns a new 5-digit COBA Medigap claim-based ID to a Medigap insurer, Medicare will continue to accept the older contractor-assigned OCNA or N-key identifiers for purposes of initiating Medigap claim-based crossovers. During June through September 2007, the affected contractors will also continue to cross claims over as normal to their Medigap claim-based crossover recipients. CMS will be regularly apprising the affected Medicare contractors when the COBC has assigned new COBA Medigap claim-based IDs to the Medigap insurers and will post this information on its COB Web site so that contractors **may direct providers to that link for purposes of obtaining regular updates.**

- ★ Effective with claims filed to Medicare on October 1, 2007:
 - » All participating providers that have been granted xxa billing exception under the Administrative Simplification Compliance Act (ASCA) should enter CMS' newly assigned COBA Medigap claim-based identifier (ID) within block 9-D of the incoming CMS-1500 claim for purposes of triggering Medigap claim-based crossovers.
 - » All other participating providers shall enter the xxnewly assigned COBA Medigap claim-based ID, left-justified and followed by spaces, within the NM109 portion of the 2330B loop of the incoming HIPAA ANSI X12-N 837 professional claim **and** within field 301-C1 of the T04 segment on incoming National Council for Prescription Drug Programs (NCPDP) claims for purposes of triggering Medigap claim-based crossovers.
 - » Providers will need to make certain that claims xxare submitted with the appropriate identifier that begins with a "5" and contains "5" numeric digits. Be mindful that claims for Medigap claim-based crossovers shall feature a syntactic editing of the incoming COBA claim-based Medigap ID to ensure that the identifier begins with a "5" and contains 5 numeric digits. If your claim does not follow the appropriate format, Medicare will continue to adjudicate your claim as normal but will notify you via the Electronic Remittance Advice (ERA) and the beneficiary via the Medicare Summary Notice (MSN) that the information reported was insufficient to cause the claim to be crossed over.
- ★ Your Medicare contractor's screening process will also -continue to verify that you participate with Medicare and that the beneficiary has assigned benefits to you as the provider.
- ★ If the claim submitted to the Medicare contractor indicates that (1) the claim contained an invalid claim-based HIPAA crossover ID, **the Medicare contractor** will send the following standard message to you, the provider.
 - "Information was **not** sent to the Medigap insurer due to incorrect/invalid information you submitted concerning the insurer. **Please verify your information and submit your secondary claim directly to that insurer."**
- ★ In addition, in these cases, if CMS' Common Working File (CWF) system determines that the beneficiary was identified for crossover on a Medigap insurer's eligibility file, the CWF system will suppress crossover to the Medigap insurer whose information was entered on the incoming claim.
- ★ Also, the Medicare contractor will include the following message on the beneficiary's
- ★ MSN in association with the claim: (MSN #35.3):
 - "A copy of this notice will not be forwarded to your Medigap insurer because the Medigap information submitted on the claim was incomplete or invalid. Please submit a copy of this notice to your Medigap insurer."
- ★ **REMEMBER:** As CMS's COBC assigns new 5-digit COBA Medigap claimbased identifiers to Medigap insurers, participating providers will be expected to include the new 5 digit identifier on incoming crossover claims for purposes of triggering claim-based Medigap crossovers. Additionally, effective with **October 1, 2007, Medigap claim-based crossovers will occur exclusively through the COBC in the HIPAA ANSI X12-N 837 professional claim format (version 4010A1 or more current standard) and NCPDP claim format.**

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Additional Information

For complete details regarding this Change Request (CR) please see the official instruction (CR5601) issued to your Medicare carrier, A/B MAC, or DME MAC. That instruction may be viewed by going to <http://www.cms.hhs.gov/Transmittals/downloads/R1332CP.pdf> on the CMS Web site.

If you have 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 Web site.

DME MAC Jurisdiction C Contact Information

Below is contact information for the new Jurisdiction C DME MAC. Also note the effective dates. Remember not to use the contact information below until on or after the specified effective date. As contact information is finalized, we will continue to provide updates to you.

All Written Inquiries – Remember to include an “attention to” note on the first page of each written inquiry. This will help us direct your inquiry to the correct department quickly.

I am trying to contact:	Contact Information is:
EDI – Electronic Claim Submission; Electronic Remittance Notices	<p>Jurisdiction C EDI Technology Support Center: 1.888.613.9271 Support hours: 8:00 a.m. to 5:00 p.m. EST, Monday – Friday</p> <p>Jurisdiction C EDI Web site: http://www.palmettogba.com/jcedi</p> <p>Address for Written Communications: Jurisdiction C EDI Operations PO Box 100170 , Columbia, SC 29202</p>
Paper Claim Submission	<p>Address: CIGNA Government Services PO Box 20010, Nashville, TN 37202</p>
Provider Customer Service Calls	<p>IVR – interactive voice response: 1.866.238.9650 Hours: 24 hours a day, 7 days a week (with allowances for normal IVR and system maintenance)</p> <p>Customer Service: 1.866.270.4909 Hours: 8:00 a.m. to 6:00 p.m. EST</p> <p>Hearing Impaired: 1.888.204.3771 Hours: 8:00 a.m. to 6:00 p.m. EST</p>
Beneficiary Customer Service Calls	<p>Telephone Number: 1.800.Medicare</p>
Written Inquiries	<p>Address: CIGNA Government Services PO Box 20010, Nashville, TN 37202</p>
Claim Reopenings (Adjustments)	<p>Address: CIGNA Government Services PO Box 20010, Nashville, TN 37202</p> <p>Fax: 1.615.782.4649</p> <p>Telephone requests for Reopenings: 1.866.813.7878 Hours: 9:00 a.m. to 12:00 p.m. and 1:00 p.m. to 5:00 p.m. EST</p>
Appeals – Redetermination Requests	<p>Address: CIGNA Government Services PO Box 20010, Nashville, TN 37202</p>

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I am trying to contact:	Contact Information is:
Electronic Funds Transfer	Address: CIGNA Government Services Attn: EFT-DME PO Box 20010, Nashville, TN 37202
Refunds	Address: CIGNA Government Services Jurisdiction C DME MAC PO Box 30629, New York, NY 10087-0629 Phone: 1.888.315.6930
Overnight or Special Shipping	Address: CIGNA Government Services DME MAC Jurisdiction C Two Vantage Way, Nashville, TN 37228
Jurisdiction C Web site	http://www.cignagovernmentservices.com
Advance Determination of Medicare Coverage (ADMC) - Requests	Address: TrustSolutions, LLC PO Box 50218, Indianapolis, IN 46250 Fax: 1.317.863.0054
Requests for Additional Information from TrustSolutions, LLC	Address: TrustSolutions, LLC PO Box 50218, Indianapolis, IN 46250 Fax: 1.317.863.0054
Supplier Enrollment	Address: National Supplier Clearinghouse Palmetto GBA * AG-495 PO Box 100142, Columbia, SC 29202-3142 Telephone Number: 1.866.238.9652