A Medicare Newsletter for Region D DMEPOS Suppliers - A service of CIGNA Government Services

REGION D
DMERC DIALOGUE
DURABLE MEDICAL EQUIPMENT REGIONAL CARRIER

October 2005 (Fall) ***General Release 05-4***

Dr. Robert Hoover Leaves CIGNA Government Services

Dr. Robert Hoover has resigned his position as the DMERC Region D Medical Director. In his seven years with CIGNA Government Services, Dr. Hoover has made a significant contribution to the development of Durable Medical Equipment national policy for the Centers for Medicare & Medicaid Services (CMS). CIGNA Government Services has benefited greatly from his experience and his passion for excellence and innovation. Dr. Hoover's last day with CIGNA Government Services was Friday, July 29th and an external search is currently underway to fill this important leadership position. An interim organization structure has been established with Dr. Donald Norris assuming DMERC Region D Medical Director responsibilities in addition to his current role as Part B Idaho Medical Director.

CIGNA Government Services Launches MyCGS

CIGNA Government Services has developed a new Web site application called *My*CGS, which allows users of the Web site the opportunity to develop their own Web portal to view personalized messages from CIGNA Government Services. This new application, combined with the functionality of the CIGNA Government Services ListServ application, gives users the convenience of easily developing their own Internet launch page.

The application is quick and easy to use by starting at http://www.cignamedicare.com/medicare_dynamic/mycigna/Index.asp.

You will have to register and set-up a User ID and Password. You will also be asked to select your categories of interest, just like you would for the ListServ.

Upon registering and logging-in, you will be taken to your main *My*CGS page. On this page you will find three columns – *My Links, My News,* and *General News*.

The *My Links* area allows a user to personalize the page with their favorite Web links. There are two links available by default, but you can add a link to any Web page to this area by following the simple instructions on the page. There are also instructions on the page that will allow you to establish *My*CGS as your home page, so each time you open your Internet browser, *My*CGS will be the first page that appears. From there, you can launch to your favorite Web sites.

The middle column – *My News* – displays all of the articles published by CIGNA Government Services based upon the categories you selected on the registration page. The articles are listed with the newest articles first, descending down to the oldest, with articles automatically deleted after 14 days. However, you have the option to archive any of the articles that appear in the *My News* section.

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Subscribe to the CIGNA Government Services Electronic Mailing List

To receive automatic notification via e-mail of the posting of LCDs/Policy Articles, LMRPs, publications and other important Medicare announcements, subscribe to the CIGNA Government Services electronic mailing list at **www.cignagovernmentservices.com/mailer/subscribe.asp**.

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CIGNA Government Services Launches MyCGS (cont'd)

To archive an article, simply check the box next to the article and click the "Archive" button at the bottom of the column. To view all archived articles, go back to the *My Links* area and click on the *My Archive* link. The *My Archive* area will include all of the links and articles you have saved, and these articles will never be automatically deleted. The *My Archive* area allows you to save messages in this application instead of saving them and taking up valuable space in your Inbox.

The final section – *General News* – is reserved for important information that may not be specific to any of the categories you selected at registration. For example, if we have to close the provider call center due to a power outage, we can post this message in the *General News* column. We may also post information regarding Medicare reform, or occasional information about CIGNA Government Services.

Hopefully, *My*CGS will become your place to start each day for the latest Medicare news and information from CIGNA Government Services.

MEDICAL POLICY

Durable Medical Equipment

An Algorithmic Approach To Determine If Mobility Assistive Equipment Is Reasonable And Necessary For Medicare Beneficiaries With A Personal Mobility Deficit (CR 3791 - Mobility Assistive Equipment (MAE))

Medlearn Matters Article Number: MM3791

Provider Types Affected

Providers billing Medicare Durable Medical Equipment Regional Carriers (DMERCs) and/or Fiscal Intermediaries (FIs) for MAE

Provider Action Needed

Impact to You

This article includes information from Change Request (CR) 3791, in which the Centers for Medicare and Medicaid Services (CMS) addresses numerous items that it has termed Mobility Assistive Equipment (MAE).

What You Need to Know

MAE includes (but is not limited to) canes, crutches, walkers, manual wheelchairs, power wheelchairs, and scooters. CMS determines that MAE is reasonable and necessary for beneficiaries who have a personal mobility deficit sufficient to impair their participation in mobility-related activities of daily living such as toileting, feeding, dressing, grooming, and bathing in customary locations in the home.

Determination of the presence of a mobility deficit will be made by an algorithmic process (as outlined in the Clinical Criteria for MAE Coverage included in this article) to provide the appropriate MAE to correct the mobility deficit.

What You Need to Do

You should sequentially consider specific questions in CR 3791 that provide clinical guidance for the coverage of equipment (of appropriate type and complexity) to

restore the beneficiary's ability to participate in Mobility-Related Activities of Daily Living (MRADLs) (toileting, feeding, dressing, grooming, bathing, etc.) in customary locations in the home. These questions correspond to the numbered decision points on the Clinical Criteria for MAE Coverage flow chart in CR3791. That chart is also included in this article.

Background

Recently, considerable public interest has been focused on the provision of wheelchairs under the Medicare benefit. The agency has responded with a multi-faceted plan to ensure the appropriate prescription of wheelchairs to beneficiaries who need them. One facet of this plan is the delineation of suggested clinical conditions of wheelchair coverage. The Centers for Medicare & Medicaid Services (CMS) solicited public comment through a number of open door forums and other methods. Many advocacy groups suggested that the agency adopt a function-based interpretation of its historical "bed or chair confined" criterion for wheelchair coverage.

CMS believes that an algorithmic process that sequentially considers the appropriate "Mobility Assistive Equipment" (MAE) that corrects the mobility deficit is the appropriate process to follow in covering MAEs. CMS believes that the Clinical Criteria for MAE Coverage, in Section 280.3, Chapter 1, of Medicare Publication 100-03 (*Medicare National Coverage Determinations*), sufficiently describes this process. Utilizing such a process will ensure that the beneficiary (or caregiver) is able to maintain as much independence as physically and mentally possible, thereby ensuring the beneficiary's Mobility-Related Activities of Daily Living (MRADLs) are maintained.

CMS is extending national coverage regarding MAE for beneficiaries who have a personal mobility deficit sufficient to impair their participation in MRADLs such as toileting, feeding, dressing, grooming, and bathing in customary locations in the home. Determination of the presence of a mobility deficit will be made by an algorithmic process, as outlined in the Clinical Criteria for MAE Coverage, to provide the appropriate MAE to correct the mobility deficit. MAE includes, but is not limited to, canes, crutches, walkers, manual wheelchairs, power wheelchairs, and scooters.

CR 3791 instructs Medicare carriers, DMERCs, and RHHIs to:

• Disregard the "bed- or chair- confined" criterion which has been historically used to determine if a wheelchair is reasonable and necessary as defined by the Social Security Act (Section 1862(A)(1)(a)).

• Use the algorithmic approach as outlined in the *Medicare National Coverage Determinations Manual* (Pub. 100-03, Section 280.3), Clinical Criteria for MAE Coverage (and included below) to determine coverage eligibility of MAE. MAE includes, but is not limited to, canes, crutches, walkers, manual wheelchairs, power wheelchairs, and scooters.

As in other cases, if data analysis indicates potentially aberrant billing, Medicare DMERCs and FIs will use these standards when performing medical review of claims.

Medicare beneficiaries may require mobility assistance for a variety of reasons and for varying durations because the etiology of the disability may be due to a congenital cause, injury, or disease. Thus, some beneficiaries experiencing temporary disability may need mobility assistance on a short-term basis, while in contrast, those living with chronic conditions or enduring disabilities will require mobility assistance on a permanent basis.

In addition, Medicare beneficiaries who depend upon mobility assistance are found in varied living situations. Some may live alone and independently while others may live with a caregiver or in a care facility. The beneficiary's environment is relevant to the determination of the appropriate form of mobility assistance that should be employed.

For many patients, a device of some sort is compensation for the mobility deficit. However, some beneficiaries experience co-morbid conditions that can impact their ability to safely utilize MAE independently or to successfully regain independent function even with mobility assistance.

The functional limitation (as experienced by a beneficiary) depends on:

- The beneficiary's physical and psychological function,
- The availability of other support, and
- The beneficiary's living environment.

A few examples include muscular spasticity, cognitive deficits, the availability of a caregiver, and the physical layout, surfaces, and obstacles that exist in the beneficiary's living environment.

Nationally Covered Indications

Effective May 5, 2005, CMS finds that the evidence is adequate to determine that MAE is reasonable and necessary for beneficiaries who have a personal mobility deficit sufficient to impair their performance of Mobility-Related Activities of Daily Living (MRADL) such as toileting, feeding, dressing, grooming, and bathing in customary areas in the home. **Determination of the presence of a mobility deficit will be made by an algorithmic process, Clinical Criteria for MAE Coverage, to provide the appropriate MAE to correct the mobility deficit.**

Clinical Criteria for MAE Coverage

The beneficiary, the beneficiary's family or other caregiver, or a clinician, will usually initiate the discussion and consideration of MAE use. **Sequential consideration of the questions below provides clinical guidance for the coverage of equipment of appropriate type and complexity to restore the beneficiary's ability to participate in MRADLs such as toileting, feeding, dressing, grooming, and bathing in customary locations in the home.** These questions correspond to the numbered decision points on the accompanying flow chart.

1. Does the beneficiary have a mobility limitation that significantly impairs his/her ability to participate in one or more MRADLs in the home?

   A mobility limitation is one that:

   a. Prevents the beneficiary from accomplishing the MRADLs entirely, or,
   b. Places the beneficiary at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to participate in MRADLs, or,
   c. Prevents the beneficiary from completing the MRADLs within a reasonable time frame.

2. Are there other conditions that limit the beneficiary's ability to participate in MRADLs at home?

   a. Some examples are significant impairment of cognition or judgment and/or vision.
   b. For these beneficiaries, the provision of MAE might not enable them to participate in MRADLs if the comorbidity prevents effective use of the wheelchair or reasonable completion of the tasks even with MAE.

3. If these other limitations exist, can they be ameliorated or compensated sufficiently such that the additional provision of MAE will be reasonably expected to significantly improve the beneficiary's ability to perform or obtain assistance to participate in MRADLs in the home?

   a. A caregiver, for example a family member, may be compensatory, if consistently available in the beneficiary's home and willing and able to safely operate and transfer the beneficiary to and from the wheelchair and to transport the beneficiary using the wheelchair. The caregiver's need to use a wheelchair to assist the beneficiary in the MRADLs is to be considered in this determination.
   b. If the amelioration or compensation requires the beneficiary's compliance with treatment, for example medications or therapy, substantive non-compliance, whether willing or involuntary, can be grounds for denial of wheelchair coverage if it results in the beneficiary continuing to have a significant limitation. It may be determined that partial compliance results in adequate amelioration or compensation for the appropriate use of MAE.

4. Does the beneficiary or caregiver demonstrate the capability and the willingness to consistently operate the MAE safely?

   a. Safety considerations include personal risk to the beneficiary as well as risk to others. The determination of safety may need to occur several times during the process as the consideration focuses on a specific device.
   b. A history of unsafe behavior in other venues may be considered.

5. Can the functional mobility deficit be sufficiently resolved by the prescription of a cane or walker?

   a. The cane or walker should be appropriately fitted to the beneficiary for this evaluation.
   b. Assess the beneficiary's ability to safely use a cane or walker.

6. Does the beneficiary's typical environment support the use of wheelchairs including scooters/power operated vehicles (POVs)?

   a. Determine whether the beneficiary's environment will support the use of these types of MAE.
   b. Keep in mind such factors as physical layout, surfaces, and obstacles, which may render MAE unusable in the beneficiary's home.

7. Does the beneficiary have sufficient upper extremity function to propel a manual wheelchair in the home to participate in MRADLs during a typical day?

   The manual wheelchair should be optimally configured (seating options, wheelbase, device weight, and other appropriate accessories) for this determination.

   a. Limitations of strength, endurance, range of motion, coordination, and absence or deformity in one or both upper extremities are relevant.
   b. A beneficiary with sufficient upper extremity function may qualify for a manual wheelchair. The appropriate type of manual wheelchair, i.e. light weight, etc., should be determined based on the beneficiary's physical characteristics and anticipated intensity of use.
   c. The beneficiary's home should provide adequate access, maneuvering space and surfaces for the operation of a manual wheelchair.
   d. Assess the beneficiary's ability to safely use a manual wheelchair. (Note: If the beneficiary is unable to self-propel a manual wheelchair, and if there is a caregiver who is available, willing, and able to provide assistance, a manual wheelchair may be appropriate.)

8. Does the beneficiary have sufficient strength and postural stability to operate a POV/scooter?

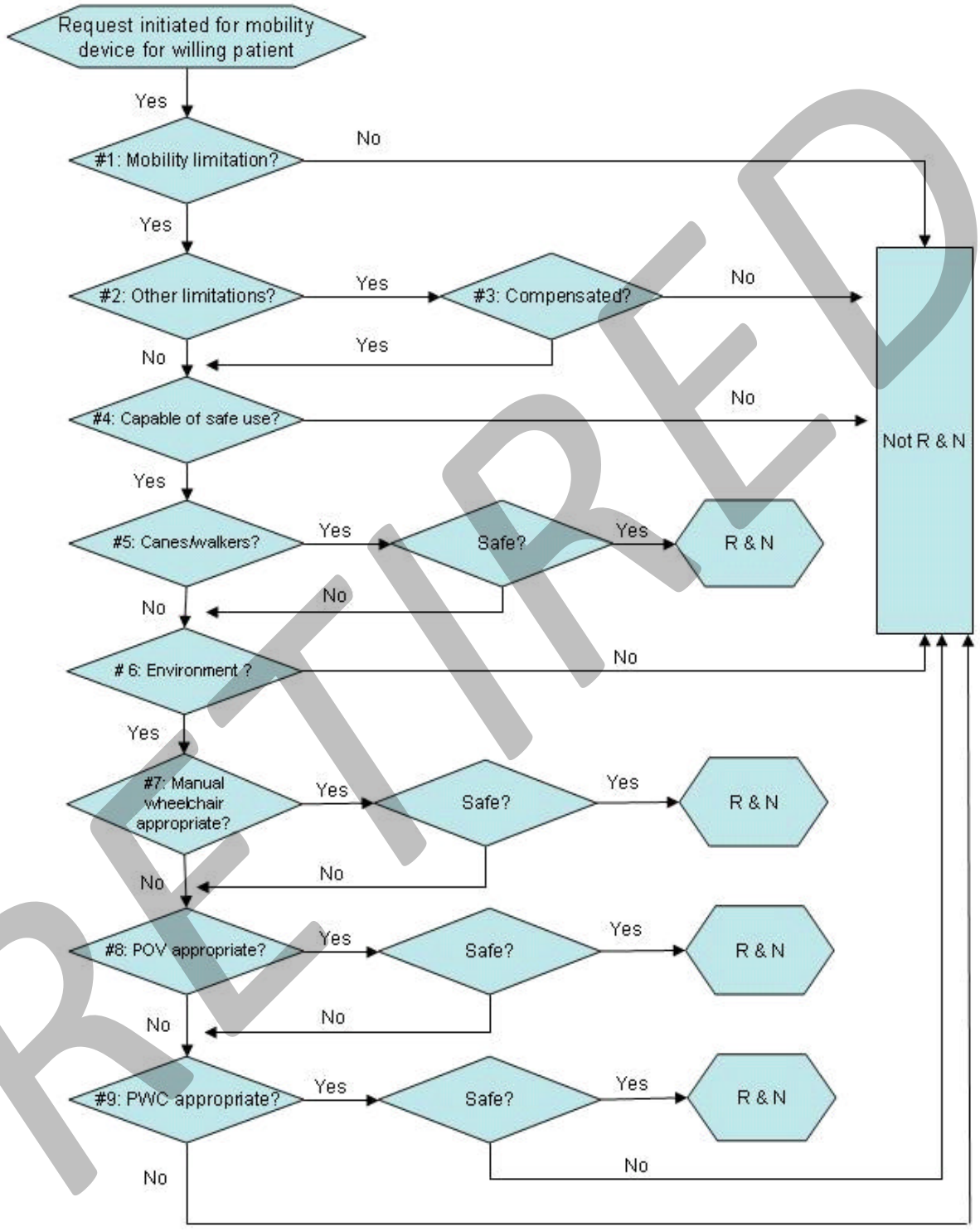
   a. A POV is a 3- or 4-wheeled device with tiller steering and limited seat modification capabilities. The beneficiary must be able to maintain stability and position for adequate operation.
   b. The beneficiary's home should provide adequate access, maneuvering space and surfaces for the operation of a POV.
   c. Assess the beneficiary's ability to safely use a POV/scooter.

9. Are the additional features provided by a power wheelchair needed to allow the beneficiary to participate in one or more MRADLs?

   a. The pertinent features of a power wheelchair compared to a POV are typically control by a joystick or alternative input device, lower seat height for slide transfers, and the ability to accommodate a variety of seating needs.
   b. The type of wheelchair and options provided should be appropriate for the degree of the beneficiary's functional impairments.
   c. The beneficiary's home should provide adequate access, maneuvering space and surfaces for the operation of a power wheelchair.
   d. Assess the beneficiary's ability to safely use a power wheelchair.

Note: If the beneficiary is unable to use a power wheelchair, and if there is a caregiver who is available, willing, and able to provide assistance, a manual wheelchair is appropriate. A caregiver's inability to operate a manual wheelchair can be considered in covering a power wheelchair so that the caregiver can assist the beneficiary.

Clinical Criteria for MAE Coverage



Nationally Non-Covered Indications - Medicare beneficiaries not meeting the clinical criteria for prescribing MAE as outlined above, and as determined by the beneficiary's physician, would not be eligible for Medicare coverage of the MAE.

Note: All other Durable Medical Equipment (DME) not meeting the definition of MAE as described in this instruction will continue to be covered, or noncovered, as is currently described in the NCD Manual at section 280, Medical and Surgical Supplies.

Also note that CR 3791 revises the *Medicare National Coverage Determinations Manual* (Pub. 100-03, Section 280.3), and this revision is a *National Coverage Determination* (NCD) made under the Social Security Act (section 1862(a)(1)).

NCDs are binding on all carriers, fiscal intermediaries, quality improvement organizations, health maintenance organizations, competitive medical plans, health care prepayment plans, the Medicare Appeals Council, and administrative law judges (see the Code of Federal Regulations (CRF), Title 42, Sections 405.732, 405.860). An NCD that expands coverage is also binding on a Medicare advantage organization. In addition, an administrative law judge may not review an NCD. (See the Social Security Act (Section 1869(f)(1)(A)(i).)

Implementation

The implementation date for this instruction is July 5, 2005. Your DMERC or FI will adjust claims affected by this change, but processed before July 5, 2005, if you bring such claims to the attention of the DMERC/FI.

Additional Information

For complete details, please see the official instruction issued to your DMERC or FI regarding this change. That instruction includes the complete section 280.3 and the instruction may be viewed by going to: http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp From that web page, look for CR 3791 in the CR NUM column on the right, and click on the files for that CR. You will note two files for CR 3791. The file reflecting transmittal number 37 contains the revisions to the *Medicare National Coverage Determinations Manual* and the file with transmittal number 574 contains the Medicare claims processing business requirements/instructions.

If you have any questions, please contact your DMERC/FI at their toll-free number, which may be found at http://www.cms.hhs.gov/medlearn/tollnums.asp

Transitioning To The Mobility Assistive Equipment National Coverage Determination

The Centers for Medicare and Medicaid Services (CMS) released a National Coverage Determination (NCD) addressing Mobility Assistive Equipment effective for dates of service on or after May 5, 2005. Use the information in this article as a roadmap through the transition.

General Information about the New NCD

In the NCD, **280.3 – Mobility Assistive Equipment (MAE)**, the clinical criteria for coverage of Mobility Assistive Equipment (MAE) are described in a series of nine questions and definitions. They are also illustrated in a flow chart to assist understanding the coverage criteria. Some of the issues addressed in the NCD are:

- What are mobility related ADLs?
- How does the NCD apply to different types of equipment?

This new NCD provides the foundation for all claims adjudication for dates of service on or after May 5, 2005. Previous national and local coverage criteria remain in effect for claims with dates of service prior to May 5, 2005. Please take the time to review the entire document and become familiar with its provisions. Suppliers are strongly encouraged to review the NCD with their referring physicians.

Implementation of the New NCD

Current LCDs

The basic coverage criteria contained in the Motorized/Power Wheelchair Bases and Power Operated Vehicles Local Coverage Determinations (LCDs) are no longer applicable for dates of service on or after May 5, 2005. However, the other provisions of each LCD remain in effect. The Policy Articles for these policies remain in effect, also.

The DMERCs plan to release a draft Power Mobility LCD for comment during the next few months and anticipate that it will be effective in January 2006.

The basic wheelchair coverage criteria contained in the Manual Wheelchair Base LCD are no longer applicable for dates of service on or after May 5, 2005. However, the provisions concerning specific manual wheelchair bases remain in effect.

The basic coverage criteria contained in the Walkers and Canes and Crutches LCDs are no longer applicable for dates of service on or after May 5, 2005. However, the provisions concerning specific items remain in effect. Revisions including the NCD criteria are planned for a future policy revision.

The LCDs on Wheelchair Options and Accessories and Wheelchair Seating and Positioning remain in effect.

Certificates of Medical Necessity

The DMERCs will continue to use the existing CMNs for Manual Wheelchairs (CMS 844), Motorized Wheelchairs (CMS 843), and Power Operated Vehicles (CMS 850) to facilitate claims adjudication.

For dates of service on or after May 5, 2005, question #1 on both the Manual Wheelchair and Motorized Wheelchair CMNs and question #6 on the POV CMN will refer to the newly released NCD provisions. Thus if a patient requires the use of a wheelchair to accomplish their mobility-related ADLs in the home, as described in the Mobility Assistive Equipment NCD, this question should be answered with a "Y".

Manual Wheelchair (CMS 844) questions 2 - 9 are still applicable under existing LCDs.

Motorized Wheelchair CMN (CMS 843) questions 2 - 5 and 7 are still applicable under existing LCDs. Question 6 is no longer applicable and may be left unanswered. Suppliers may enter a "D" in the answer field for electronic CMN submission when the question is unanswered.

Power Operated Vehicle CMN (CMS 850) questions 7 - 14 are still applicable under the existing LCD.

Table 1 is included summarizing these CMN instructions.

Documentation

Section 1833(e) of the Social Security Act precludes payment to any provider of services unless "there has been furnished such information as may be necessary in order to determine the amounts due such provider" (42 U.S.C. section 1395l (e)). It is expected that the patient's medical records will reflect the need for the care provided. The patient's medical records include the physician's office records, hospital records, nursing home records, home health agency records, records from other healthcare professionals, and test reports. Suppliers are reminded that they may be asked to provide information that corroborates the medical need for the item provided in the event of a Medical Review audit or Benefit Integrity investigation. We encourage suppliers to work with their referral sources to ensure the adequacy of the medical record.

Additional information relating to documentation of medical necessity will be included in the Power Mobility LCD planned for later in 2005.

NCD 280.3 – Mobility Assistive Equipment (MAE) (Effective May 5, 2005)

A. General

The Centers for Medicare & Medicaid Services (CMS) addresses numerous items that it terms "mobility assistive equipment" (MAE) and includes within that category canes, crutches, walkers, manual wheelchairs, power wheelchairs, and scooters. This list, however, is not exhaustive.

Medicare beneficiaries may require mobility assistance for a variety of reasons and for varying durations because the etiology of the disability may be due to a congenital cause, injury, or disease. Thus, some beneficiaries experiencing temporary disability may need mobility assistance on a short-term basis, while in contrast, those living with chronic conditions or enduring disabilities will require mobility assistance on a permanent basis.

Medicare beneficiaries who depend upon mobility assistance are found in varied living situations. Some may live alone and independently while others may live with a caregiver or in a custodial care facility. The beneficiary's environment is relevant to the determination of the appropriate form of mobility assistance that should be employed. For many patients, a device of some sort is compensation for the mobility deficit. Many beneficiaries experience co-morbid conditions that can impact their ability to safely utilize MAE independently or to successfully regain independent function even with mobility assistance.

The functional limitation as experienced by a beneficiary depends on the beneficiary's physical and psychological function, the availability of other support, and the beneficiary's living environment. A few examples include muscular spasticity, cognitive deficits, the availability of a caregiver, and the physical layout, surfaces, and obstacles that exist in the beneficiary's living environment.

B. Nationally Covered Indications

Effective May 5, 2005, CMS finds that the evidence is adequate to determine that MAE is reasonable and necessary for beneficiaries who have a personal mobility deficit sufficient to impair their participation in mobility-related activities of daily living (MRADLs) such as toileting, feeding, dressing, grooming, and bathing in customary locations within the home. Determination of the presence of a mobility deficit will be made by an algorithmic process, Clinical Criteria for MAE Coverage, to provide the appropriate MAE to correct the mobility deficit.

Clinical Criteria for MAE Coverage - (Refer to the previous article entitled "An Algorithmic Approach To Determine If Mobility Assistive Equipment Is Reasonable And Necessary For Medicare Beneficiaries With A Personal Mobility Deficit (CR 3791 - Mobility Assistive Equipment (MAE))" for a list of the criteria including the flow chart.)

C. Nationally Non-Covered Indications

Medicare beneficiaries not meeting the clinical criteria for prescribing MAE as outlined above, and as documented by the beneficiary's physician, would not be eligible for Medicare coverage of the MAE.

D. Other

All other durable medical equipment (DME) not meeting the definition of MAE as described in this instruction will continue to be covered, or noncovered, as is currently described in the *NCD Manual* at section 280, Medical and Surgical Supplies. Also, all other sections not altered here and the corresponding policies regarding MAEs which have not been discussed here remain unchanged.

Cross-references: section 280.1 of the *NCD Manual*

Table 1. Requirements for CMN - Dates of Service on or after May 5, 2005

Manual Wheelchair	• Q 1 of the DMERC CMN (CMS 844) refers to the newly released NCD for identifying if the patient qualifies. If the patient requires the use of a wheelchair to accomplish mobility related ADLs in the home, question 1 is to be answered as Y. • Q 2 through 9 DMERC CMN (CMS 844) require answers.
Power Wheelchair	• Q 1 of the DMERC CMN (CMS 843) refers to the newly released NCD for identifying if the patient qualifies. If the patient requires the use of a wheelchair to accomplish mobility related ADLs in the home, question 1 is to be answered as Y. • Q 2 through 5 and 7 of the DMERC CMN (CMS 843) are still applicable and must be answered. • Q 6 of the DMERC CMN (CMS 843) is no longer applicable and may be left blank.
Power Operated Vehicle	• Q 6 of the DMERC CMN (CMS 850) refers to the newly released NCD for identifying if the patient qualifies. If the patient requires the use of a wheelchair to accomplish mobility related ADLs in the home, question 6 is to be answered as Y. • Q 7- 14 of the DMERC CMN (CMS 850) MUST be answered

• If a response is not required, it may be left blank by the physician.
• When transmitting the CMN electronically, if the physician leaves a field blank, providers may enter a "D".

Infusion Pumps: C-Peptide Levels As A Criterion For Use

Medlearn Matters Article Number: MM3705

Note: This article was revised on June 6, 2005, to show that the correct effective date (as shown above) was December 17, 2004.

Provider Types Affected - Physicians, suppliers, and providers providing continuous subcutaneous insulin infusion and related drugs/supplies in the treatment of diabetic patients in the home setting and billing Medicare carriers or Fiscal Intermediaries (FIs)

Provider Action Needed

Impact to You - This article and related CR 3705 adds beta cell autoantibody testing as an alternative diagnostic per the updated C-peptide testing requirement for the use of insulin infusion pumps, effective for services performed on or after December 17, 2004.

What You Need to Know - Providers/suppliers treating Medicare diabetic patients with infusion pumps should be aware of this new Medicare coverage policy.

What You Need to Do - Ensure that your staff is aware of this new coverage and that they bill according to the information in this article.

Background

On August 26, 1999, the Centers for Medicare & Medicaid Services (CMS) issued the first decision memorandum (DM) for continuous subcutaneous insulin infusion pumps (CSII) that utilized a C-peptide testing requirement for Medicare coverage of CSII pump therapy. On May 11, 2001, CMS issued a second DM for insulin pump: "C-Peptide Levels as a Criterion for Use," and on January 1, 2002, CMS revised the laboratory value for the C-peptide testing requirement for Medicare coverage of CSII pump therapy.

Effective for services performed on or after December 17, 2004, in addition to meeting criterion A or B, the beneficiary with diabetes must be insulinopenic per the fasting C-peptide testing requirement or, as an alternative must be beta cell autoantibody positive.

Insulinopenia is defined as a fasting C-peptide level that is less than or equal to 110% of the lower limit of normal of the laboratory's measurement method. For patients with renal insufficiency and a creatinine clearance (actual or calculated from age, gender, weight, and serum creatinine) $\leq$ 50 ml/minute, insulinopenia is defined as a fasting C-peptide level that is less than or equal to 200% of the lower limit of normal of the laboratory's measurement method.

CMS establishes that fasting C-peptide levels will only be considered valid when a concurrently obtained fasting glucose is $\leq$ 225 mg/dL.

Levels need only be documented once in the patient's medical records.

Coverage of all other uses of CSII that adheres with the Category B IDE clinical trials regulation (42 CFR 405.201) or routine cost under the clinical trials policy (*Medicare NCD Manual* Chapter 1, Part 4, Section 310.1) will continue.

Those billing for these services should note that Medicare carriers/intermediaries will accept, effective for services on or after December 17, 2004, CPT code 84681 (C-peptide) or CPT code 86337 (insulin antibodies) when diagnosis codes 250.00-250.93 are also reported on a claim.

Additional Information

The official instruction issued to your Medicare carrier/intermediary regarding this change may be found by going to: http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp

From that web page, look for CR 3705 in the CR NUM column on the right, and click on the file for that CR. If you have questions regarding this issue, contact your carrier/intermediary on their toll free number, which is available at: http://www.cms.hhs.gov/medlearn/tollnums.asp

Overnight Oximetry Testing

Effective August 22, 2005, beneficiaries may self-administer home-based overnight oximetry tests under the direction of a Medicare enrolled Independent Diagnostic Testing Facility (IDTF). A DME supplier or other shipping entity may deliver a pulse oximetry test unit and related technology to a beneficiary under the following circumstances:

• The beneficiary's treating physician has ordered an overnight pulse oximetry test.

• The Independent Diagnostic Testing Facility (IDTF) provides clear, written instructions to the beneficiary on

the proper operation of the test equipment and the beneficiary has access to the IDTF in case other questions arise.

• The DME supplier does not perform or participate in the conducting of the test or create instructions regarding the test for the beneficiary.

• The test unit is sealed, tamper-proof and only accessible by the IDTF who transmits the information to the treating physician. The DME supplier may use related technology to download and transmit those results to the IDTF but the DME supplier may in no way access or manipulate the test results.

Test results obtained under these circumstances will be accepted by DMERCs for the purpose of qualifying for home oxygen therapy.

No shipping and/or handling charges may be charged to or paid for by a beneficiary because these charges are included in the fee schedule payment for the overnight pulse oximetry test.

General

Policies Revised

The following policies have either been revised, or converted and revised from local medical review policies (LMRPs) to local coverage determinations (LCDs) and policy articles.

Effective for dates of service on or after April 4, 2005:

Oral Antiemetic Drugs (Replacement for Intravenous Antiemetics) (LCD and Policy Article revised)

- Added coverage criteria for aprepitant and dexamethasone.
- Added KX modifier requirement and other claims submission requirements for aprepitant.
- Revised supply fee coverage for multiple dosage forms of the same drug.

Effective for dates of service on or after April 27, 2005:

Osteogenesis Stimulators (LMRP converted and revised)

- LMRP converted to LCD and Policy Article.
- Revised policy to be consistent with NCD changes expanding coverage for ultrasonic stimulators.
- Added requirement for KF modifier for FDA Class III Devices.

Effective for dates of service on or after May 5, 2005:

Canes and Crutches (LCD and Policy Article revised)

- Updated to include NCD 280.3 (Mobility Assistive Equipment) criteria

Walkers (LMRP converted and revised)

- LMRP converted to LCD and Policy Article.
- Updated to include NCD 280.3 (Mobility Assistive Equipment) criteria.
- Added coverage statement for E0140.

Effective for dates of service on or after October 1, 2005:

Automatic External Defibrillators (LCD revised)

- Added ICD-9 996.04 and 996.61.
- Replaced ICD-9 426.89 with 426.82.
- Removed KX language about additional documentation.

Epoetin (LMRP converted and revised)

- Added the requirement to list the hematocrit on each claim.
- LMRP converted to LCD and Policy Article.

Facial Prosthesis (Policy Article revised)

- Added A5119 to list of codes that require the AV modifier.

Nebulizers (LCD and Policy Article revised)

- Added criterion for K0730 (controlled dose nebulizer) and Q4080 (iloprost).
- Added diagnoses codes 416.0, 416.8, necessary for codes K0730 and Q4080.
- Added KX modifier requirement for K0730 and Q4080.

Negative Pressure Wound Therapy Pumps (LMRP converted and revised)

- LMRP converted to LCD and Policy Article.
- Revised criteria D3 & D4.
- Revised instructions for use of KX modifier.
- Removed requirement for additional documentation being submitted in the 5th month.

Oral Anticancer Drugs (Policy Article revised)

- Revised supply fee coverage for multiple dosage forms of the same drug

Orthopedic Footwear (LMRP converted and revised)

- LMRP converted to LCD and Policy Article.
- Eliminated the requirement for an ICD-9 code on the order for L3250.
- Deleted reference to filing hard copy claims.

Pressure Reducing Support Surfaces - Group 2 (LMRP converted and revised)

- LMRP converted to LCD and Policy Article.
- Added ICD-9 707.02-707.05.

Wheelchair Seating (LCD revised)

- Revised coverage criteria for headrests (E0955).
- Eliminated listing of ICD-9 codes for headrests.
- Revised KX modifier requirements for headrests.
- Eliminated statement that additional documentation may be submitted with a claim if the KX modifier is not used.
- Add nonpayment statement when a headrest is used with a captain's seat.
- Added instructions for billing pediatric seating system codes E2291-E2294.

Visit http://www.cignamedicare.com/dmerc/lmrp_lcd/index.html to view the policies in their entirety. Policies with future effective dates are located at http://www.cignamedicare.com/dmerc/lmrp_lcd/future_effective.html. Suppliers are reminded that these policy revisions are published in the split format of a local coverage determination and policy article. Both documents taken together will constitute the "medical policy." Policies are also published on the Centers for Medicare & Medicaid Services Web site at http://www.cms.hhs.gov/mcd/indexes.asp.

Over the next year the DMERCs will convert all existing LMRPs into LCDs and policy articles. Until the conversion is complete the term LCD will refer to both standalone LCDs and the "reasonable and necessary" provisions of an LMRP. **Suppliers are strongly encouraged to read both the LCD and the policy article that accompanies the LCD for a full understanding of the coverage, coding and documentation requirements.**

COVERAGE AND BILLING

Durable Medical Equipment

Correct Coding For Items Used To Treat Edema

Edema is the swelling of subcutaneous tissues due to the accumulation of excessive fluid. Many items may be used in an attempt to provide treatment. Medicare limits reimbursement to pneumatic compression devices and certain types of multi-component compression bandage systems when the patient meets specified criteria in the Local Coverage Determinations (LCDs) – Pneumatic Compression Devices and Surgical Dressings, respectively.

Other items are non-covered by Medicare when used for the treatment of edema because they do not fall into a statutory benefit category. Some common examples of these non-covered items are (not all-inclusive):

- ReidSleeve (A4465 Non-elastic binder for extremity)
- Jobst mastectomy sleeve (L8010 Breast prosthesis, mastectomy sleeve)
- CircAid (A4465 Non-elastic binder for extremity)
- Isotoner gloves (A9270 Non-covered item or service)
- Compression stockings/leotards (L8100 – L8231)

For other items that do not fall within a specific code, A9270 (Non-covered item or service) is the appropriate code to bill Medicare. Code E1399 (Durable medical equipment, miscellaneous) must not be used for these items.

Consult the DMERC LCDs, SADMERC Product Classification List, or SADMERC Helpline at 877.735.1326 for additional information.

Coverage And Billing For Ultrasonic Stimulators For Nonunion Fracture Healing

Medlearn Matters Article Number: MM3836

NOTE: Osteogenic stimulators are listed as Class III devices by the FDA. If you are billing the DMERCs for a product that is listed by the FDA as a Class III device you must append modifier KF. Modifier KF must be appended to HCPCS codes E0760 and E1399 (for other ultrasound stimulation) referenced in this Medlearn Matters article.

This article was revised on July 15, 2005, to show that, effective for services performed on or after April 27, 2005 that meet the coverage criteria for CPT code 20979, payment will be made by Medicare carriers and RHHIs. Originally, the article incorrectly said carriers and FIs.

Provider Types Affected - Physicians, providers, and suppliers billing Medicare carriers and intermediaries, including Regional Home Health Intermediaries (RHHIs) and Durable Medical Equipment Regional Carriers (DMERCs), for ultrasonic osteogenic stimulators

Provider Action Needed

Impact to You - This article is based on Change Request (CR) 3836, which informs physicians, providers, and suppliers that the Centers for Medicare & Medicaid Services (CMS) announced a reconsideration of the National Coverage Determination (NCD) covering the use of Ultrasonic Osteogenic Stimulators, effective April 27, 2005.

What You Need to Know - Upon reconsideration of the existing policy, CMS determined that Ultrasound Stimulation for Nonunion Fracture Healing will remain covered with an additional expansion of coverage to patients without prior surgeries to the non-healing fracture.

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

Background

The Centers for Medicare & Medicaid Services (CMS) announced a Reconsideration of the National Coverage Determination (NCD) covering the use of Ultrasonic Osteogenic Stimulators, effective April 27, 2005.

An ultrasonic osteogenic stimulator is a non-invasive device that emits low intensity, pulsed ultrasound signal to stimulate fracture healing. The device is applied to the surface of the skin at the fracture site and ultrasound waves are emitted via a conductive coupling gel to stimulate fracture healing. An ultrasonic osteogenic stimulator:

- Is not to be used concurrently with other non-invasive osteogenic devices; and
- Is intended for use with cast immobilization.

Nationally Covered Indications

Ultrasonic osteogenic stimulators are covered as medically reasonable and necessary for the treatment of nonunion fractures when the following is demonstrated:

• A minimum of two sets of radiographs is obtained prior to starting treatment with the osteogenic stimulator, each separated by a minimum of 90 days. Each radiograph must include multiple views of the fracture site accompanied by a written interpretation by a physician stating that there has been no clinically significant evidence of fracture healing between the two sets of radiographs.

The national noncoverage policy relating to ultrasonic osteogenic stimulators for fresh fractures and delayed unions remains in place. In addition, nonunion fractures of the skull, vertebrae and tumor-related fractures are excluded from coverage.

Effective for services performed on or after April 27, 2005 Medicare will cover an osteogenic stimulator for beneficiaries who meet the criteria described above Carriers & RHHIs will allow payment for an osteogenic stimulator with the following CPT Code:

• 20979 Low intensity ultrasound stimulation to aid bone healing, noninvasive (nonoperative)
• Durable Medical Equipment Regional Carriers (DMERCs) will allow payment for osteogenic stimulators with the following HCPCS Codes :

• Healthcare Common Procedure Coding System (HCPCS) codes:

E0760 for low intensity ultrasound, or
E1399 for other ultrasound stimulation.

• Regional Home Health Intermediaries (RHHIs) pay for the Ultrasonic Osteogenic Stimulator only when the services are submitted on types of bills (TOBs) 32X, 33X, or 34X.

• **Home Health Agencies (HHAs) need to know** that this Ultrasonic Osteogenic Stimulator must be in the patient's home health plan of care if billed on TOBs 32X or 33X. HHAs billing on TOBs 32X, 33X and 34X for the osteogenic stimulator will be paid based on the Durable Medical Equipment Prosthetics, Orthotics, and Supplies (DMEPOS) fee schedule.

• **Hospitals need to know** that they can not bill for the Ultrasonic Osteogenic Stimulator. Hospitals may only instruct patients on how to use the Ultrasonic Osteogenic Stimulator and **not** provide the Ultrasonic Osteogenic Stimulator.

Implementation

The implementation date for this change is August 1, 2005.

Additional Information

See the *Medicare National Determinations Manual* (Pub. 100-03), Section 160.11 (Osteogenic Stimulators) at the following CMS web site: http://www.cms.hhs.gov/manuals/103_cov_determ/ncd103c1_Part2.pdf.

For more information about the medical coverage of clinical trials, see the following CMS web site: http://www.cms.hhs.gov/coverage/8d.asp.

For complete details on this change, please see the official instruction issued to your carrier/DMERC/intermediary regarding this change. That instruction may be viewed by going to http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp. From that web page, look for CR3836 in the CR NUM column on the right, and click on the files for that CR. You will note two files for CR3836. The file with transmittal number 41 is the NCD itself and the file with transmittal number 597 contains the billing requirements. If you have any questions, please contact your carrier/DMERC/intermediary at their toll-free number, which may be found at: http://www.cms.hhs.gov/medlearn/tollnums.asp.

Nebulizer Drugs – KP, KQ Modifiers

The medical policy on Nebulizers provides coding guidelines for the proper billing of nebulizer drugs using the KP and KQ modifiers. When a compounded multiple drug unit dose formulation is dispensed, the KP modifier is used with one drug and KQ is used with the other drug(s). According to the policy, in these situations, **the KP and KQ modifiers must be added to the appropriate drug codes in such a manner that it results in the lowest Medicare allowance**.

In order to determine the correct use of the KP and KQ modifiers, suppliers must do more than look at the Medicare fee for each drug. They must also take into account the number of milligrams of each drug in the unit dose vial. It is also important to note that the Medicare fee for drugs can change every quarter and suppliers must recalculate the values each time there is a change to determine the correct modifier placement. Quarterly updates to drug fees are posted on the DMERC Region D Fee Schedules page at http://www.cignagovernmentservices.com/dmerc/fsch/index.html.

The following is an example of the calculation for a unit dose formulation of albuterol (J7613) and ipratropium (J7644) for claims with dates of service from July through September 2005. For these drugs, the fees per milligram during that time are:

	KP	KQ
J7613	$0.066	$0.099
J7644	$0.184	$0.100

For the typical unit dose preparation of 2.5 mg of albuterol and 0.5 mg of ipratropium:

If J7613KP and J7644KQ were used, the fee would be $0.215 for one vial.

J7613KP	$0.066 x 2.5	=	$0.165
J7644KQ	$0.100 x 0.5	=	0.050
			$0.215

If J7613KQ and J7644KP were used, the fee would be $0.3395 for one vial.

J7613KQ	$0.099 x 2.5	=	$0.2475
J7644KP	$0.184 x 0.5	=	0.0920
			$0.3395

Therefore, for these two drugs at the stated doses and the stated fees, the correct billing would be J7613KP and J7644KQ for dates of service from 7/1/05 to 9/30/05.

The importance of recalculating each quarter is highlighted by the fact that because of the changing fees for codes J7613 and J7644, the correct use of modifiers for the albuterol 2.5/ipratropium 0.5 combination is:

For dates of service 1/1/05 to 3/31/05:

J7613KP and J7644KQ

For dates of service 4/1/05 to 6/30/05:

J7613KQ and J7644KP

For dates of service 7/1/05 to 9/30/05:

J7613KP and J7644KQ

The Medicare allowed charge is determined by multiplying the fee for the correct code/modifier combination times the units of service and then rounding to the nearest whole cent.

The correct coding for manufactured combinations of albuterol and ipratropium (e.g., DuoNeb) is J7616 without a KO, KP, or KQ modifier.

For additional details on coverage criteria, coding guidelines, and documentation requirements, refer to the Nebulizers LCD and Policy Article at http://www.cignagovernmentservices.com/dmerc/lmrp_lcd/index.html.

Orthotics/Prosthetics

Orthosis Billing Reminder

We would like to remind suppliers:

• The reasonable useful lifetime of an orthosis is 5 years. This is considered no less than 5 years beginning with the date of delivery of the equipment to the beneficiary, not the actual age of the equipment. If a provider bills for an orthotic and the patient received one in the past 5 years the current claim will be denied as same or similar equipment.

• Replacements however, may be allowed in cases of loss or irreparable damage. Irreparable damage is defined as damage that has been caused by a specific accident or natural disaster. In cases where loss or irreparable damage has occurred, replacement may be reimbursed. A physician's order is needed to reaffirm the medical necessity of the item

• Irreparable wear is the deterioration sustained from day-to-day usage over time and cannot be specifically identified. If the item of equipment has been in continuous use for the equipment's useful lifetime, the beneficiary may elect to obtain a new piece of equipment. A new physician's order is needed to reaffirm the medical necessity of the item. Replacement due to wear is not covered during the reasonable useful lifetime of the equipment.

• If the patient's medical condition changes thus necessitating a change in equipment, remember the need to document the change. Replacement of a complete orthosis or component of an orthosis due to a significant change in the patient's condition is covered if the device is still medically necessary. The reason for the replacement must be documented in the supplier's record and made available to the DMERC on request.

The DMERC realizes there are instances where a beneficiary may require multiple joint supports or where similar orthotics may be needed; however, in these cases, clear and conclusive documentation is needed to substantiate that the items are reasonable and necessary for the patient.

Pharmacy

Anti-Cancer Chemotherapy For Colorectal Cancer

Medlearn Matters Article Number: MM3742

Note: This article was revised on June 21, 2005, to reflect a revision to CR3742. The CR was revised to show that Medicare fiscal intermediaries (FIs) will implement the change on or before July 5, 2005, instead of April 18, 2005. The effective date of CR3742 and all other information remains the same, but providers should take note that their Medicare FI may not be ready to process claims in accordance with CR3742 until July 5, 2005.

Provider Types Affected - Providers and suppliers billing Medicare carriers, including Durable Medical Equipment Regional Carriers (DMERCs), and fiscal intermediaries (FIs) for anti-cancer chemotherapy

Provider Action Needed

This article is based on information contained in Change Request (CR) 3742, which states that the Centers for Medicare & Medicaid Services (CMS) will cover the off-label use of Oxaliplatin (Eloxatin™), Irinotecan (Camptosar®), Cetuximab (Erbitux™), or Bevacizumab (Avastin™) in clinical trials identified by CMS and sponsored by the National Cancer Institute (NCI).

This national coverage decision does not:

• Modify existing requirements for coverage of these and other anti-cancer chemotherapeutic agents for FDA-approved indications or for off-label indications listed in an approved compendium; or
• Change existing coverage for any off-label uses of these drugs provided outside the clinical trials identified.

Medicare carriers, DMERCs, and intermediaries will continue to make local coverage determinations for medically accepted uses of off-label indications based on guidance provided by the Secretary of the Department of Health and Human Services (DHHS).

Background

On January 28, 2005, CMS announced a National Cov-

erage Determination (NCD) covering the off-label use of certain colorectal anti-cancer drugs in identified clinical trials of colorectal cancer and other cancer types. These clinical trials study the use of one or more off-label uses of these four drugs in colorectal and other cancer types.

Note: The clinical trials for which these drugs and other items and services are covered appear in Appendix A in the NCD at http://www.cms.hhs.gov/mcd/viewdecisionmemo.asp?id=90 on the CMS web site.

Anti-cancer chemotherapeutic agents are eligible for coverage in a clinical trial setting when the following occurs:

- They are used in accordance with Food and Drug Administration (FDA)-approved labeling;
- Their use is supported in one of the authoritative drug compendia; or
- The Medicare contractor (carriers, Fiscal Intermediaries (FIs), DMERCs) determines an off-label use is medically accepted based on guidance provided by Secretary of DHHS.

Effective for services provided on or after January 28, 2005, CMS covers the following anti-cancer chemotherapeutic agents, which have been approved by the FDA for the treatment of colorectal cancer, when used in clinical trials identified by CMS and sponsored by the National Cancer Institute:

- Oxaliplatin (Eloxatin™)
- Irinotecan (Camptosar®)
- Cetuximab (Erbitux™)
- Bevacizumab (Avastin™)

Under the concept of linking Medicare coverage determinations to clinical studies, the investigational items and services provided in qualified scientific studies are covered (including clinical trials, practical trials, and systematic data collection systems) when:

- They provide for the accrual of supporting evidence of medical necessity; and
- They collect data to support decisions about whether or not a technology is reasonable and necessary.

Note: The list of identified clinical trials for which the routine costs of the items and services are covered appears in the Clinical Trials section, at http://www.cms.hhs.gov/coverage on the CMS web site. Non-routine clinical costs include items and services that are provided in either the investigational or the control arms of a clinical trial specified by CMS for coverage. The following non-routine items and services **are not covered** and include items and services:

- Provided solely to satisfy data collection, and that are not used in the direct clinical management of the patient;
- Provided solely to determine trial eligibility;
- Customarily provided by the research sponsors free-of-charge for any enrollee in the trial;
- That are statutorily excluded from Medicare coverage; or
- That do not fall into a benefit category.

This NCD, issued on January 28, 2005, does not withdraw Medicare coverage for items and services that may be covered according to the existing national coverage policy for Routine Costs in a Clinical Trial (See *National Coverage Determination Manual*, Section 310.1 at http://www.cms.hhs.gov/manuals/103_cov_determ/ncd103index.asp on the CMS web site.

Note: The existing requirements for coverage of oxaliplatin, irinotecan, cetuximab, bevacizumab, or other anticancer chemotherapeutic agents for FDA-approved indications or for indications listed in an approved compendium are not modified.

Medicare contractors will continue to make reasonable and necessary coverage determinations under the Social Security Act (Section 1861(t)(2)(B)(ii)(II))based on guidance provided by CMS for medically accepted uses of off-label indications of Oxaliplatin, Irinotecan, Cetuximab, Bevacizumab, or other anticancer chemotherapeutic agents provided outside of the identified clinical trials appearing on the CMS website noted previously.

Some important points to remember when billing Medicare for these anti-cancer drugs are as follows:

- FIs will accept claims for these drugs on types of bill (TOB) 11x, 12x, 13x, 18x, 21x, 22x, 23x, and 85x. Use revenue code 0636 used for anti-cancer drugs furnished during a clinical trial for outpatient claims and use revenue code 0250 for inpatient claims.
- When billing carriers, DMERCs and FIs, on a claim other than an inpatient claim, include the QR modifier to show the drug was furnished during a clinical trial.
- Claims submitted to FIs should also contain an ICD-9-CM diagnosis code of V70.7 in the second diagnosis code position to show that the claim involves a clinical trial.
- When using the QR modifier, also be sure to include a HCPCS code of J9035, J9055, J9206, J9263, J8520, J8521, J9190, or J9201, as appropriate for the anti-cancer drug being billed.

• Providers are also to include a QR modifier when billing for nonroutine costs associated with these clinical trials.
• DMERCs will accept claims with HCPCS codes of J8520 and J8521 as clinical trial codes for **oral anti-cancer** drugs, when accompanied by the QR modifier to show use in a clinical trial.
• When billing for covered routine costs associated with clinical trials as described in section 310 of the *NCD Manual*, be sure to include a QV modifier on the claim.
• Submit an appropriate cancer diagnosis code for the clinical trial on the claim.

Note: While this NCD is effective as of January 28, 2005, Medicare systems will be unable to process claims containing the QR modifier received before April 1, 2005. For that reason, do not send in claims for drugs or other nonroutine services covered under this NCD until April 1, 2005. Do not hold claims for nonroutine services containing the QV modifier associated with this NCD.

Additional Information

For complete details, please see the official instruction issued to your carrier/DMERC/intermediary regarding this change. That instruction includes the NCD section 110.17 and it may be viewed by going to: http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp

From that web page, look for CR 3742 in the CR NUM column on the right, and click on the file for that CR. You should see two versions of CR 3742 ob this web site. The version of CR 3742 with a transmittal number of R38NCD will contain the NCD information and the version with a transmittal number of R588CP will contain the Medicare claims processing instructions.

If you have any questions, please contact your carrier/DMERC/intermediary at their toll-free number, which may be found at: http://www.cms.hhs.gov/medlearn/tollnums.asp

Coverage Of Aprepitant For Chemotherapy-Induced Emesis

Medlearn Matters Article Number: MM3831

Note: This article was revised on July 5, 2005, to add some clarifying language, but no substantive changes were made to the billing or coverage requirements.

Provider Types Affected - Providers and suppliers rendering services to beneficiaries with cancer chemotherapy-induced nausea and vomiting (CINV)

Provider Action Needed

Impact to You - Effective April 4, 2005, you may submit claims for the use of the oral anti-emetic drug Aprepitant (Emend®), when used in combination with a 5-HT3 antagonist and dexamethasone in beneficiaries receiving certain cancer chemotherapeutic agents as outlined below.

What You Need to Know - CMS has announced a National Coverage Determination (NCD) that covers the use of Aprepitant (Emend®), an orally administered neurokinin-1 (NK1) antagonist, in both acute and delayed phases of chemotherapy-induced emesis. Effective April 4, 2005, CMS will cover the use of the oral anti-emetic drug combination of Aprepitant (Emend®), a 5-HT3 antagonist, and dexamethasone in beneficiaries receiving certain cancer chemotherapeutic agents (see *Background* section below).

What You Need to Do - Make sure that your billing staffs are aware of this new coverage.

Background

Aprepitant (Emend®), a human substance P/neurokinin-1 (NK1) receptor antagonist, is the first Food and Drug Administration-approved anti-emetic drug of its type. It has been approved to function in combination with other oral anti-emetics for the prevention of both acute and delayed chemotherapy-induced nausea and vomiting (CINV) associated with initial and repeat courses of highly emetogenic chemotherapeutic agents.

CINV can range in severity from mild to severe, with the most severe cases resulting in dehydration, malnutrition, metabolic imbalances, and potentially requiring withdrawal from future chemotherapy treatments. CINV incidence and severity are influenced by the specific chemotherapeutic agent(s) used, their dosage, schedule and route of administration, and by drug combinations. In addition, they can also be affected by patient-specific risk factors such as sex, age, history of motion sickness, and prior exposure to chemotherapeutic agents.

While progress has been made in reducing CINV, symptoms that occur more than a day after chemotherapy, during repeat cycles of chemotherapy, and when chemotherapy is given on more than one day or in very high doses remain hard to control. No single anti-emetic agent is completely effective in all patients.

CMS has determined that the evidence is adequate to conclude that use of the oral anti-emetic drug combination of Aprepitant (Emend®), a 5-HT3 antagonist, and dexamethasone is reasonable and necessary for a specified patient population receiving one or more of the following anti-cancer chemotherapeutic agents:

- Carmustine
- Cisplatin
- Cyclophosphamide
- Dacarbazine
- Mechlorethamine
- Streptozocin
- Doxorubicin
- Epirubicin
- Lomustine

Note: The evidence is adequate to conclude that aprepitant cannot function alone as a full replacement for intravenously administered anti-emetic agents for patients who are receiving highly emetogenic chemotherapy.

Important Billing Information - You must bill your claims for Aprepitant (Emend®), on Form CMS-1450 (UB-92), or the electronic equivalent, with the appropriate cancer diagnosis and HCPCS code of J8501 (Aprepitant, oral, 5mg) or appropriate CPT code. Those providers submitting claims to Medicare fiscal intermediaries (FIs) should also include Revenue Code 0636 (Drugs requiring detailed coding).

For FIs, the following payment methodologies apply when Aprepitant is provided by a hospitals or skilled nursing facility (SNF) outpatient department:

- Based on Ambulatory Payment Classification (APC) for hospitals subject to the outpatient prospective payment system (OPPS);
- Under current payment methodologies for hospitals not subject to OPPS; or
- On a reasonable cost basis for SNFs.

Critical access hospital (CAH) claims will be paid as follows:

- Method I – technical services are paid at 101% of reasonable cost;
- Method II – technical services are paid at 101% of reasonable cost, and professional services are paid at 115% of the Medicare Physician Fee Schedule Data Base.

Claims submitted to Medicare's durable medical equipment regional carriers (DMERCs) will be paid based on the Average Sales Price (ASP) pricing file for claims with dates of service on or after April 4, 2005.

Effective January 1, 2005, the payment allowance limit is based on the ASP + 6%.

Note: Inpatient claims submitted for oral anti-emetic drugs are processed under the current payment methodologies.

Your Medicare DMERC or FI will adjust claims with dates of service 04/04/05 (effective date) through 07/04/05 (implementation date), if brought to their attention.

Additional Information - You can find more information about the coverage of Aprepitant (Emend®) for chemotherapy-induced emesis by going to http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp. From that web page, look for CR 3831 in the CR NUM column on the right, and click on the file(s) for that CR. The file with transmittal number 40 will contain the National Coverage Determination and the file with transmittal number 590 will contain the claims processing instructions. Finally, if you have any questions, please contact your DMERC/FI at their toll-free number, which may be found at http://www.cms.hhs.gov/medlearn/tollnums.asp.

Update To The Place Of Service (POS) Code Set To Add A Code For Pharmacy

Medlearn Matters Article Number: MM3819

Provider Types Affected - Medicare providers billing Medicare carriers, including durable medical equipment regional carriers (DMERCs)

Provider Action Needed

Impact to You - The *Medicare Claims Processing Manual* and claims processing systems are being revised to include a new Place of Service (POS) code for pharmacy of 01.

What You Need to Know - Claims for covered services rendered using the new POS code for a pharmacy setting will be paid at the nonfacility rate. Your carrier's medical directors will develop policies, as needed, to adjudicate claims containing this new code.

What You Need to Do - Stay current on POS coding in order to remain compliant with HIPAA.

Additional Information - The new POS code for pharmacy is 01. In the POS code set, pharmacy is defined as a facility or location where drugs and other medically related items and services are sold, dispensed, or

otherwise provided directly to patients. The POS code set with the pharmacy place of service code can be found in the *Medicare Claims Processing Manual, Chapter 26, Section 10.5*, which is attached to CR3819, the official instruction issued to your carrier/DMERC regarding this change.

That instruction may be found by going to: http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp on the CMS website. From that web page, look for CR3819 in the CR NUM column on the right, and click on the file for that CR. For additional information relating to this issue, please refer to your local carrier/DMERC. To find that toll free phone number, go to http://www.cms.hhs.gov/medlearn/tollnums.asp on the CMS website.

Supplies

Gauze Dressings Used For Home Dialysis

HCPCS codes A6216 and A6402 (gauze dressings) used for home dialysis have been added to the list of HCPCS codes that require modifier AX. This coding instruction will be included in the next revision of the Home Dialysis Supplies and Equipment policy article.

General

Fee For Service Medicare's Transition To The National Provider Identifier (NPI)

Medicare has the following announcements on plans for transitioning to the National Provider Identifier (NPI) in the Fee-for Service Medicare Program:

Between May 23, 2005 and January 2, 2006 our claims processing systems will accept an existing legacy Medicare number and reject, as unprocessable, any claim that includes only an NPI.

Beginning January 3, 2006, and through October 1, 2006, CMS systems will accept an existing legacy Medicare number **or** an NPI as long as it is accompanied by an existing legacy Medicare number.

Beginning October 2, 2006, and through May 22, 2007, CMS systems will accept an existing legacy Medicare number **and/or** an NPI. This will allow for 6-7 months of provider testing before only an NPI will be accepted by the Medicare Program on May 23, 2007.

Beginning May 23, 2007 our systems will **only** accept an NPI. To apply for an NPI, visit: https://nppes.cms.hhs.gov on the CMS website. To request a paper application, call 1-800-465-3203.

Instructions For Provider Notification Regarding National Provider Identifier (NPI)

Starting May 23, 2005, all health care providers can apply for their National Provider Identifier (NPI). The NPI will replace health care provider identifiers in use today in standard health care transactions. All Health Insurance Portability and Accountability Act (HIPAA) covered entities except small health plans must begin using the NPI on May 23, 2007; small health plans have until May 23, 2008. For additional information, and to complete an application, visit https://nppes.cms.hhs.gov on the web. It is important to note that the Medicare program is not accepting the NPI in standard transactions yet. Explicit instructions on time frames and implementation of the NPI for Medicare billing will be issued later in 2006. Other health plans with whom you do business will instruct you as to when you may begin using the NPI in standard transactions.

Also, an instructional web tool, called the NPI Viewlet, is now available for viewing at http://www.cms.hhs.gov/medlearn/npi/npiviewlet.asp and under "HIPAA Latest News" at www.cms.hhs.gov/hipaa/hipaa2 on the Centers for Medicare & Medicaid Services' (CMS) website. This tool provides an overview of the NPI, a walk-through of the application, as well as live links to the National Plan and Provider Enumeration System's (NPPES) website where the learner can apply for an NPI. This tool is designed for all health care providers. In the near future, you will also be able to access the viewlet at https://nppes.cms.hhs.gov on the web.

Instructions For Provider Notification - Quarterly Reminder To Apply For A National Provider Identifier (NPI)

Reminder—Health care providers are required by law to apply for a National Provider Identifier (NPI). To apply online, visit: https://nppes.cms.hhs.gov, or call 1-800-465-3203 to request a paper application.

Visit www.cms.hhs.gov/hipaa/hipaa2 for the latest information regarding the NPI, including a transcript from CMS' recent NPI Roundtable conference call.

July Quarterly Update To 2005 Annual Update Of HCPCS Codes Used For Skilled Nursing Facility (SNF) Consolidated Billing (CB) Enforcement

Medlearn Matters Article Number: MM3873

Provider Types Affected - Physicians, providers, and suppliers billing services to carriers and intermediaries

Provider Action Needed

Impact to You - This article is based on information from Change Request (CR) 3873, which corrects the effective date of excluded Healthcare Common Procedure Coding System (HCPCS) L5781 for Skilled Nursing Facility (SNF) Consolidated Billing (CB).

What You Need to Know - The correct effective date of excluded HCPCS L5781 for SNF CB should be January 1, 2003.

What You Need to Do - See the Background section of this article to find out further details regarding this change.

Background

The Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of CPCS codes that are subject to the CB provision of the SNF PPS. Claims for services appearing on this list (which are submitted to Medicare Fiscal Intermediaries (FIs) and carriers, including Durable Medical Equipment Regional Carriers (DMERCs)) will not be paid by Medicare to providers, other than a SNF, when **included** in SNF CB.

- For non-therapy services, SNF CB applies only when the services are furnished to a SNF resident during a covered Part A stay;
- For physical and occupational therapies and speech-language pathology services, SNF CB applies whenever they are furnished to a SNF resident, regardless of whether Part A covers the stay; and
- Services **excluded** from SNF PPS and CB may be paid to providers (other than SNFs) for beneficiaries, even when in a SNF stay.

Separate instructions are published for FIs and carriers/DMERCs for the annual notice on SNF CB each January. The 2005 Annual Update can be found on the following CMS web sites for:

- FIs at http://www.cms.hhs.gov/manuals/pm_trans/R360CP.pdf (Transmittal R360CP, CR3542, dated November 5, 2004); and
- Carriers at http://www.cms.hhs.gov/medlearn/snfcode.asp

Quarterly updates now apply to both FIs and carriers/DMERCs. An April 2005 Quarterly Update for FIs and carriers has been published subsequent to the 2005 annual update, and it is available at the CMS web site for 2005 transmittals at http://www.cms.hhs.gov/manuals/pm_trans/R449CP.pdf (transmittal R449CP, CR3683 dated January 21, 2005).

CR3873 provides one HCPCS correction under Major Category III. D. Customized Prosthetic Devices. HCPCS L5781 was previously excluded under the 2005 Annual Update to SNF CB with an incorrect effective date of January 1, 2005. The effective date for excluded HCPCS L5781 should be January 1, 2003.

Suppliers may bill L5781 retroactively to January 1, 2003. However, there may be situations in which a SNF has already reimbursed a supplier for L5781. Providers and suppliers cannot collect money from a SNF and Medicare Part B twice for the same service, equipment, or device for the same date of service. Suppliers that now receive payment from Medicare Part B are expected in all cases to refund any money they received from the SNF for the same item.

Effective for claims with dates of service on or after January 1, 2003 to December 31, 2004, your Medicare carrier and FI will reopen and reprocess claims with the code L5781 and override timely filing when necessary. The carrier/FI will only do this, however, when you bring such claims to their attention.

Implementation

The implementation date for this instruction is July 5, 2005.

Additional Information - For complete details, please see the official instruction issued to your carrier/intermediary regarding this change. That instruction may be viewed by going to: http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp

From that web page, look for CR3873 in the CR NUM column on the right, and click on the file for that CR. If you have any questions, please contact your carrier/intermediary at their toll-free number, which may be found at: http://www.cms.hhs.gov/medlearn/tollnums.asp

Medicare Beneficiaries In State Or Local Custody Under A Penal Authority

I. GENERAL INFORMATION

A. Background:

Under Sections 1862(a)(2) and (3) of the Social Security Act (the Act), the Medicare program does not pay for services if the beneficiary has no legal obligation to pay for the services and if the services are paid for directly or indirectly by a governmental entity. These provisions are implemented by regulations 42 CFR 411.4(a) and 411.4 (b), respectively.

Regulations at 42 CFR 411.4(b) state that "Payment may be made for services furnished to individuals or groups of individuals who are in the custody of the police or other penal authorities or in the custody of a government agency under a penal statute only if the following conditions are met: (1) State or local law requires those individuals or groups of individuals to repay the cost of medical services they receive while in custody, and (2) The State or local government entity enforces the requirement to pay by billing all such individuals, whether or not covered by Medicare or any other health insurance, and by pursuing the collection of the amounts they owe in the same way and with the same vigor that it pursues the collection of other debts."

A recent Office of Inspector General audit of Medicare payments identified a vulnerability for the Medicare trust fund with respect to this issue. The study identified payments for beneficiaries who, on the date of service on the claim, were in state or local custody under the authority of a penal statute. To address this vulnerability, CMS is establishing claim level editing using data received from the Social Security Administration (SSA).

Specifically, the data will contain the names of the Medicare beneficiaries and time periods where the beneficiary is in such state or local custody. This data will be compared to the data on the incoming claims. The Common Working File (CWF) will reject claims where the dates from the SSA file and the dates of service on the claim overlap. Any claims rejected by CWF will contain a trailer to the Medicare contractor indicating the date span covered.

B. Policy:

Exclusion from Coverage - Medicare excludes from coverage items and services furnished to beneficiaries in state or local government custody under a penal statute, unless it is determined that the state or local government enforces a legal requirement that all prisoners/patients repay the cost of all healthcare items and services rendered while in such custody and also pursues collection efforts against such individuals in the same way and with the same vigor as it pursues other debts. CMS presumes that a state or local government that has custody of a Medicare beneficiary under a penal statute has a financial obligation to pay for the cost of healthcare items and services.

Therefore, Medicare denies payment for items and services furnished to beneficiaries in state or local government custody. Denial messages are:

ANSI Reason code: CO 96 - Non covered charge(s).

Remark code: N103 - Social Security records indicate that this patient was a prisoner when the service was rendered. This payer does not cover items and services furnished to an individual while they are in State or local custody under a penal authority, unless under State or local law, the individual is personally liable for the cost of his or her health care while incarcerated and the State or local government pursues such debt in the same way and with the same vigor as any other debt.

However, providers and suppliers that render services or items to a prisoner or patient in a jurisdiction that meets the conditions of 42 CFR 411.4(b) should indicate this fact by appending the modifier referenced in section C below to the procedure code when submitting a claim.

Appeals - A party to a claim denied in whole or in part under this policy may appeal the initial determination on the basis that, on the date of service, (1) The conditions of 42 CFR 411.4(b) were met, or (2) The beneficiary was not, in fact, in the custody of a State or local government under authority of a penal statute.

C. Implementation:

Providers that render services to a prisoner or patient in a jurisdiction that meets the conditions of 42 CFR 411.4(b) should indicate this fact on the claim. Providers should use the following modifier:

QJ - Services/items provided to a prisoner or patient in State or local custody, however, the State or local government, as applicable, meets the requirements in 42 CFR 411.4(b).

This modifier indicates that the provider has been in-

structed by the state or local government agency that requested the healthcare items or services provided to the patient that it is the policy of the State or local government that the prisoner or patient is responsible to repay the cost of medical services, and that it pursues collection of debts incurred for furnishing such items or services with the same vigor and in the same manner as any other debt.

Medicare Contractor Annual Update Of The International Classification Of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)

Medlearn Matters Article Number: MM3888

Note: This article was revised on July 1, 2005. The original article indicated that Chapter 23, Section 10.2 of the *Medicare Claims Processing Manual* was revised as a result of CR3888. In fact, the manual was not revised, but was only referenced by CR3888.

Provider Types Affected - Physicians, suppliers, hospitals and other providers billing Medicare contractors (carriers, Durable Medical Equipment Regional Carriers (DMERCs), and Fiscal Intermediaries (FIs)

Provider Action Needed

Impact to You - Medicare will soon issue the annual update of the *International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)* to Medicare contractors. This update will apply for claims with service dates on or after October 1, 2005 and discharges and through dates on or after October 1, 2005 for institutional providers.

What You Need to Know - An ICD-9-CM code is required for all professional claims, e.g., physicians, non-physician practitioners, independent clinical diagnostic laboratories, occupational and physical therapists, independent diagnostic testing facilities, audiologist, ambulatory surgical centers (ASCs), and for all institutional claims, but **not** for ambulance supplier claims. Remember that as of October 1, 2004, Medicare no longer provides a 90-day grace period for physicians, practitioners and suppliers to use in billing discontinued ICD-9-CM diagnosis codes.

What You Need to Do - Be ready to use the updated codes on October 1, 2005. Please refer to the *Background* and *Additional Information* sections of this article for further details regarding this instruction.

Background - This instruction is a reminder that Medicare carriers, DMERCS, and Fiscal Intermediaries will use the annual *International classification of diseases, Ninth Revision, Clinical Modification (ICD-9-CM)* coding update effective for:

- Dates of service on or after October 1, 2005, and
- Discharges and through dates on or after October 1, 2005 for institutional providers

The use of ICD-9-CM codes at The Centers for Medicare & Medicaid Services (CMS) has evolved as follows:

• Beginning in 1979, ICD-9-CM codes became mandatory for reporting provider services on Form CMS-1450.
• On April 1, 1989, the use of ICD-9-CM diagnosis codes became mandatory for all physician services submitted on Form CMS-1500.
• Effective October 1, 2003, an ICD-9-CM diagnosis code was required on all paper and electronic claims billed to Medicare carriers with the exception of ambulance claims (specialty type 59) (see Change Request (CR) 2725, dated June 6, 2003, at http://www.cms.hhs.gov/manuals/pm_trans/B03045.pdf).

Important Note: Effective for dates of service on and after October 1, 2004, CMS no longer provided a 90-day grace period for physicians, practitioners and suppliers to use in billing discontinued ICD-9-CM diagnosis codes on Medicare claims. The Health Insurance Portability and Accountability Act (HIPAA) requires that medical code sets be date-of-service compliant, and ICD-9-CM diagnosis codes are a medical code set (see CR 3094, dated February 6, 2004 at: http://www.cms.hhs.gov/manuals/pm_trans/R95CP.pdf)

Additional Information

Publication of ICD-9-CM Codes

• Updated ICD-9-CM codes are published in the Federal Register in April/May of each year as part of the Proposed Changes to the Hospital Inpatient Prospective Payment System, and are effective each October first. Physicians, practitioners, and suppliers must use the current and valid diagnosis code that is in effect beginning October 1, 2005.
• After the ICD-9-CM codes are published in the Federal Register, CMS places the new, revised, and discontinued codes on the following web site: http://www.cms.hhs.gov/medlearn/icd9code.asp. The update should be available at this site in June.

• The updated ICD-9-CM diagnosis codes can also be viewed at the National Center for Health Statistics (NCHS) web site at: http://www.cdc.gov/nchs/icd9.htm. This posting should be available at this site in June.
• Providers are also encouraged to purchase a new ICD-9-CM book or CD-ROM on an annual basis.

Implementation

The implementation date for this instruction is October 3, 2005.

Related Instructions

The ICD-9-CM codes are updated annually as stated in the *Medicare Claims Processing Manual*, Pub. 100-04, Chapter 23 (Fee Schedule Administration and Coding Requirements), Section 10.2 (Relationship of ICD-9-CM Codes and Date of Service). That manual may be accessed at http://www.cms.hhs.gov/manuals/104_claims/clm104index.asp on the CMS web site. The official instruction issued to your carrier can be found by going to: http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp. From that web site, look for CR3888 in the CR NUM column on the right, and click on the file for that CR. For additional information relating to this issue, please refer to your local carrier or intermediary at their tollfree number which may be found at: http://www.cms. hhs.gov/medlearn/tollnums.asp

Time Limit For Filing Claims

Claims for services provided between October 1, 2003 and September 30, 2004 must be received at the carrier by December 31, 2005. Claims that are not submitted within these time limits will be denied. Effective December 31, 2004, Medicare no longer accepts Statements of Intent (SOIs) to extend the timely filing limit for filing initial claims.

HCPCS UPDATES

New Healthcare Common Procedure Coding System (HCPCS) Drug Codes

Medlearn Matters Article Number: MM3847

Note: This article was revised on July 1, 2005, because of changes made to CR3847, which was re-issued on June 30, 2005. The article was revised to include additional billing information as noted by the three bullet points (in bold print) on page 2 of this article.

Provider Types Affected - Physicians, providers, and suppliers billing Medicare carriers, including Durable Medical Equipment Regional Carriers (DMERCs), or Fiscal Intermediaries (FIs) for high osmolar contrast material and iloprost inhalation solution

Provider Action Needed

Effective July 1, 2005, for dates of service on or after July 1, 2005, HCPCS code Q4080, for iloprost inhalation solution, and HCPCS codes Q9958 – Q9964, for high osmolar contrast material, are being added to the HCPCS. Be aware of the new codes for iloprost inhalation solution and high osmolar contrast material when reporting these services to Medicare.

Additional Information

Effective July 1, 2005, the following codes are being added to the HCPCS for iloprost inhalation solution and high osmolar contrast material.

HCPCS Code	Short Descriptor	Long Descriptor
Q4080	Iloprost inhalation solution	Iloprost, inhalation solution, administered through DME, 20 mcg
Q9958	HOCM <=149 mg/ml iodine, 1 ml	High osmolar contrast material (HOCM), up to 149 mg/ml iodine concentration, per ml
Q9959	HOCM 150-199 mg/ml iodine,1 ml	High osmolar contrast material, 150 - 199 mg/ml iodine concentration, per ml
Q9960	HOCM 200-249 mg/ml iodine,1 ml	High osmolar contrast material, 200 - 249 mg/ml iodine concentration, per ml
Q9961	HOCM 250-299 mg/ml iodine,1 ml	High osmolar contrast material, 250 - 299 mg/ml iodine concentration, per ml
Q9962	HOCM 300-349 mg/ml iodine,1 ml	High osmolar contrast material, 300 - 349 mg/ml iodine concentration, per ml
Q9963	HOCM 350-399 mg/ml iodine,1 ml	High osmolar contrast material, 350 - 399 mg/ml iodine concentration, per ml
Q9964	HOCM >= 400 mg/ml iodine,1 ml	High osmolar contrast material, 400 or greater mg/ml iodine concentration, per ml

Also, please note the following:

• As stated in Section 30 of Chapter 13 of the *Medicare Claims Processing Manual* (Publication 100-04), payment for HOCMs is included in the payment for the procedure and separate payment for the HOCMs is not allowed.

• As stated in CR3846, the payment allowance limits for new drugs and biologicals not included in the Average Sales Price (ASP) Medicare Part B Drug Pricing File or Not Otherwise Classified (NOC) Pricing File are based on 106 per cent of the Wholesale Acquisition Cost (WAC). A Medlearn Matters article related to CR3846 is available at www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3846.pdf on the CMS web site.

• Those billing Medicare carriers may note that code Q4080 will be assigned to status indicator "E" and codes Q9958-Q9964 will be assigned status indicator "B" in the Medicare Physician Fee Schedule Database.

• While Medicare carriers and DMERCs will accept Q4080 to report iloprost inhalation solution, only Medicare DMERCs will make payment for Q4080.

• **Where appropriate, revenue code 0636 should be assigned when billing these HOCM HCPCS codes.**

• **Critical Access Hospital outpatient departments should bill for codes Q4080 and Q9958-Q9964 using type of bill (TOB) 85X. Payment for such services will be based on reasonable cost and beneficiary deductible and coinsurance does apply.**

• **Skilled Nursing Facilities billing under Medicare Part B should use TOB 22X (for inpatient Part B) and 23X (outpatient) for codes Q4080 and Q9958-Q9964. Payments to the SNFs will also be made on a reasonable cost basis and beneficiary deductible and coinsurance does apply.**

The official instruction issued to your carrier/DMERC/FI regarding this change may be found by going to: http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp.

From that web page, look for CR 3847 in the CR NUM column on the right, and then click on the file for that CR.

If you have questions regarding this issue, contact your carrier/DMERC/FI on their toll free number, which is available at: http://www.cms.hhs.gov/medlearn/tollnums.asp

FEE SCHEDULE

The Number Of Durable Medical Equipment Pricing Files That Must Be Maintained Online For Medicare – DMERC, FI, And RHHI Only

Medlearn Matters Article Number: MM3792

Provider Types Affected - Providers and suppliers who bill Durable Medical Equipment Regional Carriers (DMERCs) and Fiscal Intermediaries (FIs), including Regional Home Health Intermediaries (RHHIs) for Durable Medical Equipment, Supplies, Prosthetics and Orthotics (DMEPOS)

Provider Action Needed - This article is informational only. Providers/suppliers need take no action, but Medicare encourages you to submit claims to Medicare as soon as possible after services are supplied.

Background

Medicare created a new minimum standard for the number of online price determination files that a Medicare DMERC or RHHI will maintain. The new minimum standard is eight fee screens/pricing files (the current period and seven prior files) for payment on a fee-for-service DMEPOS that you bill. This will allow Medicare to be more precise in paying the rate in effect at the time services are provided.

While this allows for more accurate pricing, this change does not alter Medicare's timely filing requirements and providers/suppliers should bill Medicare as promptly as possible.

Additional Information

The official instruction issued to your DMERC/FI/RHHI regarding this change may be found at: http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp

From that web page, look for CR 3792 in the CR NUM column on the right, and click on the file for the desired CR. For additional information relating to this issue, please contact your DMERC/FI/RHHI via their toll free number. That number may be found at: http://www.cms.hhs.gov/medlearn/tollnums.asp

MMA – New April 2005 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing File And Revisions To January 2005 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing File

Medlearn Matters Article Number: MM3846

Provider Types Affected - All Medicare providers billing Medicare carriers, including Durable Medical Equipment Regional Carriers (DMERCs) and Fiscal Intermediaries (FIs)

Provider Action Needed

Impact to You - CR 3846 revises payment allowance limits in the January 2005 and the April 2005 drug pricing files. For the codes listed below, the revised payment limits supersede the payment limits cited in any previously published document.

What You Need to Know - Effective January 1, 2005, the payment allowance limits for Medicare Part B drugs and biologicals (that are not paid on a cost or prospective payment basis) are 106 percent of the Average Sales Price (ASP).

What You Need to Do - Make sure that your billing staffs are aware of these changes.

Background

The Medicare Modernization Act of 2003 (MMA), Section 303, revises the payment methodology for Part B covered drugs and biologicals that are not paid on a cost or prospective payment basis. Effective January 1, 2005, these drugs and biologicals are paid based on the new Average Sales Price (ASP) drug payment methodology.

The ASP file, used in the ASP methodology, is based on data that CMS receives quarterly from manufacturers. Each quarter, CMS will update your carrier and Fiscal Intermediary (FI) payment allowance limits with the ASP drug pricing files based on these manufacturers' data.

Beginning January 1, 2005, the payment allowance limits for Medicare Part B drugs and biologicals that are not paid on a cost or prospective payment basis are 106 percent of the ASP. However, you should be aware that there are exceptions to this general rule as summarized below:

• For **blood and blood products** (with certain exceptions like blood clotting factors), payment allowance limits are determined in the same manner they were determined on October 1, 2003. Specifically, the payment allowance limits for blood and blood products are 95 percent of the Average Wholesale Price (AWP) as reflected in the published compendia. **The payment allowance limits will be updated quarterly.**

• For **infusion drugs** furnished through a covered item of Durable Medical Equipment (DME) on or after January 1, 2005, payment allowance limits will continue to be 95 percent of the AWP reflected in the published compendia as of October 1, 2003, regardless of whether or not the DME is implanted. **The payment allowance limits will not be updated in 2005.**

Note: For infusion drugs (furnished through a covered item of durable medical equipment) that were not listed in the published compendia as of October 1, 2003 (i.e., new drugs), the payment allowance limits are 95 percent of the first published AWP.

• For **influenza, pneumococcal, and hepatitis B vaccines,** payment allowance limits are 95 percent of the AWP as reflected in the published compendia. **The payment allowance limits will be updated quarterly.**

• For **drugs (other than new drugs) not included in the ASP Medicare Part B Drug Pricing File or Not Otherwise Classified (NOC) Pricing File,** payment allowance limits are based on the published Wholesale Acquisition Cost (WAC) or invoice pricing. In determining the WAC-based payment limit, carriers/DMERCs/FIs will follow the methodology specified in the *Medicare Claims Processing Manual* for calculating the AWP, but substitute WAC for AWP. Please see Pub. 100-04, Chapter 17 (Drugs and Biologicals) at the following CMS web site: http://www.cms.hhs.gov/manuals/104_claims/clm104c17.pdf. The payment limit is 100 percent of the lesser of the lowest brand or median generic WAC.

Your carrier or FI may, at their discretion, contact CMS to obtain payment limits for drugs not included in the quarterly ASP or NOC files. If available, CMS will provide the payment limits either directly to the requesting carrier/FI or will post them in an MS Excel file on the CMS web site. If the payment limit is available from CMS, carriers/FIs will substitute the CMS-provided payment limits for pricing based on WAC or invoice pricing.

• For **new drugs and biologicals not included in the ASP Medicare Part B Drug Pricing File or NOC Pricing File,** payment allowance limits are based on 106 percent of the WAC. This policy applies only to new drugs that were first sold on or after January 1, 2005.

Table 1 below displays the revised 1st Quarter 05 payment allowance limits for the indicated codes, effective for services provided on or after January 1, 2005.

HCPCS	Short Description	HCPCS Code Dosage	1Q05 Payment Limit	1Q05 Independent ESRD Limit
90371	Hep B ig, im	1 ML	$115.878	$115.878
J2790	Rho d immune globulin, inj	300 MCG	$101.733	$101.733
J2792	Rho (D) immune globulin	100 IU	$13.101	$13.101
Q0187	NovoSeven	Per 1.2 MG	$1,211.050	$1,211.050

Table 2 below displays the revised 2nd Quarter 05 payment allowance limits for the indicated codes, effective for services provided on or after April 1, 2005.

HCPCS	Short Description	HCPCS Code Dosage	2Q05 Payment Limit	2Q05 Independent ESRD Limit	2Q05 Vaccine Limit	2Q05 Blood Limit
90747	Hep B vacc, ill pat 4 dose im	40 MCG	$113.915	$113.915	$113.915	
J0135	Adalimumab injection	20 MG	$294.632	$294.632		
J0287	Amphotericin b lipid complex	10 MG	$11.724	$11.724		
J0725	Chorionic gonadotropin	1000 UNITS	$2.976	$2.976		
J2597	Inj desmopressin acetate	1 MCG	$2.493	$2.493		
J7190	Factor viii	1 IU	$0.641	$0.641		
J7192	Factor viii recombinant	1 IU	$1.063	$1.063		
J7193	Factor IX non-recombinant	1 IU	$0.882	$0.882		
J7194	Factor ix complex	1 IU	$0.650	$0.650		
J7195	Factor IX recombinant	1 IU	$0.982	$0.982		
J7197	Antithrombin iii injection	1 IU	$1.543	$1.543		
J7198	Anti-inhibitor	1 IU	$1.241	$1.241		
J7344	Nonmetabolic active tissue	1 SQ	$52.777	$52.777		
J9098	CM Cytarabine liposome	10 MG	$359.359	$359.359		
J9245	Inj melphalan hydrochl	50 MG	$513.694	$513.694		
J9266	Pegaspargase single dose vial	1 EA	$1,499.306	$1,499.306		
P9041	Albumin (human),5%	50 ML	$14.545	$14.545		$14.545
P9043	Plasma protein fraction, 5%	50 ML	$14.545	$14.545		$14.545
P9046	Albumin (human), 25%	20 ML	$14.545	$14.545		$14.545
P9048	Plasma protein fraction, 5%	250 ML	$29.099	$29.099		$29.099
Q0187	NovoSeven Per	1.2 MG	$1,228.438	$1,228.438		
Q2002	Elliotts b solution per ml	1ML	$3.350	$3.350		
Q2005	Corticorelin ovine triflutat	1 EA	$379.067	$379.067		
Q2012	Pegademase bovine	25 IU	$158.048	$158.048		
Q2018	Urofollitropin, 75 iu	75 IU	$43.865	$43.865		
Q9941	IVIG lyophil	1 G	$38.735	$38.735		
Q9942	IVIG lyophil	10 MG	$0.387	$0.387		
Q9943	IVIG non-lyophil	1 G	$56.221	$56.221		
Q9944	IVIG non-lyophil	10 MG	$0.562	$0.562		
Q9954	Oral MR contrast	100 ML	$8.844	$8.844		

Notice that J2910 is no longer included in the April 2005 pricing file.

You should note that the new April 2005 ASP drug pricing files will contain three decimal places in the currency fields. You can find more information on the April 2005 ASP data format in CR 3436, which instructs the carriers/DMERCs/FIs to accommodate 3 places after the decimal point, and to follow standard rounding procedure, round to 2 decimal places, after multiplying the number in the "units" field of the line item by the payment allowance applicable to the HCPCS code.

You should also note that the absence or presence of a HCPCS code and its associated payment limit in the payment files do not indicate Medicare coverage of the drug or biological. Nor does inclusion of a payment limit within a specific column indicate Medicare coverage of the drug in that specific category. The carrier/DMERC/FI processing your claim will make these determinations.

To comply with these requirements, your carrier, DMERC, or FI will:

- Use the new April 2005 ASP drug pricing file to pay for Medicare Part B drugs, effective April 1, 2005 for dates of service from April 1, 2005 through June 30, 2005;

- Determine (for any drug or biological not listed in the ASP or NOC drug pricing files) the payment allowance limits in accordance with the policies described in CR3232, dated December 16, 2004 (corrected). See http://www.cms.hhs.gov/manuals/pm_trans/R397CP.pdf.

- Use the new April 2005 ASP drug pricing file for (1) those claims where the provider asks the carrier/DMERC/FI to retroactively adjust claims processed with the original April 2005 file, and (2) those claims with dates of service on or after April 1, 2005 and before July 1, 2005 that are processed after July 4, 2005. Your carrier or FI will not search and adjust claims that have already been processed unless brought to their attention.

Additional Information

The new April 2005 and revisions to the January ASP Pricing Files are available at: http://ww.cms.hhs.gov/providers/drugs/asp.asp For complete details of CR 3846, on which this article is based, please see the official instruction issued to your FI/intermediary regarding this change. That instruction may be viewed at: http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp

From that web page, look for CR 3846 in the CR NUM column on the right, and click on the file for that CR.

Finally, if you have any questions, please contact your carrier/DMERC/intermediary at their toll-free number, which may be found at: http://www.cms.hhs.gov/medlearn/tollnums.asp

October Fee Schedule Quarterly Update

The following fees will change effective October 3, 2005. The code E0971 (Anti-tipper device wheelchairs) has been revised to reflect a base billing unit of "each". The description for codes E1038 and E1039 has been revised to read as follows:

E1038 - Transport Chair, Adult Size, less than or equal to 300 lbs
E1039 - Transport Chair, Adult Size, greater than 300 lbs

The fees for codes E1038 and E1039 have been revised to reflect the above description. The fee for code E1238 has been revised by CMS. The fee has been established for L5685.

(See next page for updated fee schedule amounts.)

October Quarterly Update To 2005 DMEPOS Fee Schedule

States	E0971NU	E0971RR	E0971UE	E1038RR	E1039RR	E1238NU	E1238RR	E1238UE	L5685
AK	$43.39	$4.34	$32.56	$18.03	$34.20	$1638.73	$163.87	$1229.05	$100.83
AZ	$43.39	$4.34	$32.56	$18.03	$34.20	$1638.73	$163.87	$1229.05	$100.83
CA	$43.39	$4.34	$32.56	$18.03	$34.20	$1638.73	$163.87	$1229.05	$100.83
HI	$43.39	$4.34	$32.56	$18.03	$34.20	$1638.73	$163.87	$1229.05	$100.83
IA	$43.39	$4.34	$32.56	$18.03	$34.20	$1638.73	$163.87	$1229.05	$102.82
ID	$43.39	$4.34	$32.56	$18.03	$34.20	$1638.73	$163.87	$1229.05	$100.83
KS	$43.39	$4.34	$32.56	$18.03	$34.20	$1638.73	$163.87	$1229.05	$102.82
MO	$43.39	$4.34	$32.56	$18.03	$34.20	$1638.73	$163.87	$1229.05	$102.82
MT	$43.39	$4.34	$32.56	$18.03	$34.20	$1638.73	$163.87	$1229.05	$104.46
ND	$43.39	$4.34	$32.56	$18.03	$34.20	$1638.73	$163.87	$1229.05	$104.46
NE	$43.39	$4.34	$32.56	$18.03	$34.20	$1638.73	$163.87	$1229.05	$102.82
NV	$43.39	$4.34	$32.56	$18.03	$34.20	$1638.73	$163.87	$1229.05	$100.83
OR	$43.39	$4.34	$32.56	$18.03	$34.20	$1638.73	$163.87	$1229.05	$100.83
SD	$43.39	$4.34	$32.56	$18.03	$34.20	$1638.73	$163.87	$1229.05	$104.46
UT	$43.39	$4.34	$32.56	$18.03	$34.20	$1638.73	$163.87	$1229.05	$104.46
WA	$43.39	$4.34	$32.56	$18.03	$34.20	$1638.73	$163.87	$1229.05	$100.83
WY	$43.39	$4.34	$32.56	$18.03	$34.20	$1638.73	$163.87	$1229.05	$104.46

ELECTRONIC DATA INTERCHANGE (EDI)

Update To The National Council For Prescription Drug Program (NCPDP) Batch Standard 1.1 Billing Request Companion Document

Medlearn Matters Article Number: MM3882

Provider Types Affected - Durable medical equipment providers, billing agents, or clearinghouses that submit retail pharmacy drug claims electronically to Medicare Durable Medical Equipment Regional Carriers (DMERCs).

Provider Action Needed

Providers need to be aware that Medicare will only accept a value of "1" in field number 337-4C (Coordination of Benefits/Other Payments Count) of the NCPDP Companion Document. Previously the Coordination of Benefits/ Other Payments Count field accepted a value of 1-3. Medicare will only accept one primary payer and will reject claims with any value in field 337-4C other than "1." In addition, please note the following changes:

• For Data Element 412-DC (Dispensing fee Submitted), CMS has added codes G0369, G0370, G0371, and G0374 to the NCPDP Companion document along with associated pricing information. See the Medlearn Matters article MM3620 for an explanation of these codes. That article is available at http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3620.pdf on the CMS web site.

• CMS had added Data Element 438-E3 (Incentive Amount Submitted) to the NCPDP Companion Document, in which suppliers should include the $50.00 fee allowed by Medicare for G0369.

• For Data Element 451-EG (Compound Dispensing Unit Form Indicator), CMS has added the following values to the NCPDP Companion document:

- 1 = each
- 2 = gram
- 3 = milliliters

Implementation - Medicare will implement these changes on September 12, 2005.

Additional Information

The Centers for Medicare & Medicaid Services (CMS) published a companion document to supplement the *NCPDP VERSION 5.1 BATCH TRANSACTION STANDARD 1.1 BILLING REQUEST For Exchanges With Medicare DMERCs*. These are revised instructions and the companion document is available at: http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp. From that web page look for CR 3882 in the CR NUM column on the right and then click on that file. Within that file are the official instructions issued to your DMERC regarding this CR. If you have questions please contact your DMERC at their toll free number, which can be found at: http://www.cms.hhs.gov/medlearn/tollnums.asp

HIPAA

Access Process For Beneficiary Eligibility Inquiries/Replies (HIPAA 270/271 Transactions) (Extranet Only)

Medlearn Matters Article Number: MM3883

Note: This article was revised on June 17, 2005, because related CR 3883 was re-issued on June 15, 2005. The CR release date and transmittal number (above) have been revised, but no other changes were made to the article.

Provider Types Affected - All physicians, providers, and suppliers billing Medicare

Provider Action Needed

Impact to You - This article is based on information from Change Request (CR) 3883, which states that the Centers for Medicare & Medicaid Services (CMS) is making changes to its Information Technology (IT) infrastructure. The goal is to address standards for Medicare beneficiary eligibility inquiries to create the necessary database and infrastructure to provide a centralized Health Insurance Portability and Accountability Act (HIPAA) compliant 270/271 health care eligibility inquiry and response on a real-time transaction.

What You Need to Know - In June 2005, only clearinghouses, certain providers and trading partners will be permitted to send 270 transactions via the Extranet, a secure, closed, and private network used to transmit data between Medicare carriers and intermediaries and CMS. CMS expects to provide limited access via the Internet for 270/271 transactions later this year.

What You Need to Do - See the Background and Additional Information sections of this article for further details regarding these changes and manual revisions that explain how this access will work.

Background

Change Request (CR) 3883 states that CMS is making changes to its IT infrastructure to address standards for Medicare beneficiary eligibility inquiries. This IT change will create the necessary database and infrastructure to provide a centralized HIPAA-compliant 270/271 beneficiary health care eligibility inquiry and response in real-time.

Not only will these changes satisfy the current demand for a fully functioning HIPAA-compliant 270/271 eligibility transaction for FFS providers/submitters, they will also support (over time) a national provider telephone interactive voice response (IVR) as well as Internet eligibility queries.

The new infrastructure will support the 270/271 for Medicare and will use a central national Medicare eligibility database in processing these queries bypassing the current:

- Carriers,
- Durable Medical Equipment Regional Carriers (DMERCs), and
- Fiscal Intermediaries (FIs).

However, Medicare plans to continue to use the provider newsletters and web sites of the carriers, DMERCs, and FIs to share information on availability, enrollment, Internet use, and other pertinent information about the 270/271 as developments warrant.

The 270/271 implementation guide adopted for national use under HIPAA can be obtained at the Washington

Publishing Co. web site at: http://www.wpc-edi.com/HIPAA

A provider that prefers to obtain eligibility data in an electronic data interchange (EDI) format, but does not want to use the 270/271 Version 4010, may contract with a clearinghouse to translate the information on its behalf; however, that provider would be liable for those clearinghouse costs.

Access Process for Clearinghouses/Provider

To obtain access to the MDCN via the extranet, Clearinghouses and Providers must complete the 270/271 Access Form that can be found at http://www.cms.hhs.gov/it on the CMS web site. The 270/271 Access Form should be completed in full and submitted electronically. The electronic submitted form will be directed to both CMS staff and the CMS' Medicare Eligibility Integration Contractor (MEIC).

The CMS staff will ensure that all of the necessary information is provided on the form, as well as ensure the complete connectivity to the 270/271 application. The MEIC will be responsible for contacting the Clearinghouses, providers, and trading partners to authenticate the accessing entity's identity.

Once authentication has been completed, the MEIC will provide the Clearinghouses, Providers, and Trading Partners with a submitter ID that is required to be used on all 270/271 transactions. Testing will be coordinated by the MEIC. After successful testing, 270 production inquiries may be sent real-time.

Note: To access the MDCN, an entity must on its own obtain the necessary telecommunication software from the AT&T reseller. The current AT&T resellers are:

- IVANS: http://www.ivans.com
- McKesson: http://www.mckesson.com

Future Requirement

CMS is developing an Attestation that all Clearinghouses and Providers will be required to agree to provisions concerning adherence of the HIPAA Privacy and Security Rule. This Attestation will be available for review through the Paperwork Reduction Act Process and will be available for public comment in the near future.

Implementation

The implementation date for this instruction is August 22, 2005.

Additional Information

For complete details, including a list of data elements that will be provided in response to the 270 transaction, please see the official instruction issued to your Medicare carrier, including DMERCs, or FI regarding this change. That instruction may be viewed by going to http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp From that web page, look for CR 3883 in the CR NUM column on the right, and click on the file for that CR. If you have any questions, please contact your carrier/DMERC/intermediary at their toll-free number, which may be found at: http://www.cms.hhs.gov/medlearn/tollnums.asp

MISCELLANEOUS

Centers For Medicare & Medicaid Services (CMS) Comprehensive Error Rate Testing (CERT) Program - The Importance Of Complying With Requests For Claim Documentation

Medlearn Matters Article Number: SE0526

Note: This article was revised on May 2, 2005 to show the 2004 national gross paid claims error rate in the "STOP" section and to correct the phone number provided in the "Additional Information" section.

Provider Types Affected - Medicare Fee-for-Service (FFS) physicians, providers and suppliers

Provider Action Needed

Impact to You - The 2004 national gross paid claims error rate was 10.1 percent. A portion of this error rate was due to providers not sending requested supporting documentation to the designated CERT contractor. Medicare FFS physicians, providers and suppliers must provide documentation and medical records that support their claims for covered Medicare services to the designated CERT contractor upon request. If you fail to submit documentation, the claim will be considered an error and you will receive a demand letter requesting refund of payment received for the '"erroneous" claim.

What You Need to Know - During a CERT review, you may be asked to provide more information related to a claim you submitted, such as medical records or certificates of medical necessity, so that the CERT review

contractor (CRC) can verify that billing was proper. Be assured that forwarding specifically requested records to the designated CERT contractor does not violate privacy provisions under the Health Insurance Portability and Accountability (HIPAA) law.

What You Need to Do - If you receive a letter from CMS regarding a CERT request for medical documentation, you should respond promptly by submitting the requested supporting documentation within the time frame outlined in the request. Physicians, providers and suppliers do not need to obtain additional beneficiary authorization to forward medical records to the designated CERT contractor. This special edition article provides an overview of the CERT program and stresses the importance of providing the requested medical documentation for the CERT review.

Background

The Government Performance and Results Act of 1993 established performance measurement standards for Federal agencies. To achieve the goals of this Act, CMS established the Comprehensive Error Rate Testing (CERT) program in November 2003. The purpose of the CERT program is to measure and improve the quality and accuracy of Medicare claims submission, processing and payment. The results of these reviews are used to characterize and quantify local, regional and national error rate patterns. CMS uses this information to address the error rate through appropriate educational and interventional programs.

Methodology

The CERT program was originally administered by the Department of Health and Human Services, Office of the Inspector General (OIG) from 1996 - 2002. During this period, the OIG designed a sampling method that estimated only a national FFS paid claims error rate (the percentage of dollars that Medicare contractors erroneously allowed). Currently, CMS calculates a national paid claims error rate, a contractor specific error rate, services processed error rate (which measures whether the Medicare contractor made appropriate payment decisions on claims) and a **provider compliance error rate** (which measures how well providers prepared claims for submission). The CMS methodology includes:

- Randomly selecting a sample of claims submitted in a specific calendar year;
- Requesting medical records from providers who submitted the claims;
- Reviewing the claims and medical records to see if the claims complied with the Medicare coverage, coding, and billing rules; and
- **When providers fail to submit the requested documentation, treating the claims as errors and** sending the providers overpayment letters.

The designated CERT review contractor currently reviews over 140,000 randomly-selected claims and corresponding medical records each year, with a medical review staff that includes physicians and nurses who can use clinical judgment when necessary in reviewing medical records. Their medical review staff has access to national and local policies, contractor processing guidelines and automated edits.

If you fail to submit the requested information in a timely fashion, an "error" is registered against both the Medicare contractor (your Medicare Carrier or Fiscal Intermediary) and you, as the Medicare provider. (At this point, the CERT review contractor has no choice but to register the claim submission as "erroneous" because there is insufficient supporting documentation to determine otherwise.)

These errors have a corresponding negative impact on the other error rates that are calculated under the CERT program.

Your Role Is Critical To Improvement

Our research has shown that providers do not comply with the requests for information because:

- They believe it is a violation of the Health Insurance Portability and Accountability Act (HIPAA) to send patient records to the designated CERT contractor; or

- They are unaware of the CERT process, and they may not appreciate the importance of cooperating in a timely fashion.

Medicare beneficiaries have consented to the release of medical information necessary to process their Medicare claims. **Providers do not need to obtain additional beneficiary authorization to forward medical records to the designated CERT contractor.** Be assured that forwarding specifically requested records to the designated CERT contractor does not violate HIPAA Privacy statutes.

If You Receive A Letter From CMS Regarding A CERT Medical Review…

1. Don't ignore it! Respond promptly by submitting the requested supporting documentation within the time

frame outlined in the request. The letter will provide a clearly defined list of the documentation required and where to submit the information.

2. Include any additional material that you believe supports the service(s) billed to the Medicare program.

3. Make sure your address files and telephone numbers that are on file with your carrier or fiscal intermediary are accurate to ensure that CERT documentation requests are received and allow time for you to respond timely.

4. Remember that physicians, providers and suppliers do not need to obtain additional beneficiary authorization to forward medical records to the designated CERT contractor.

Additional Information

In an effort to assist Medicare physicians, providers and suppliers with CERT compliance, we have several resources available to explain the CERT process and how your responsiveness is in everyone's best interest.

- CERT Web page (http://www.cms.hhs.gov/cert)
- CERT Newsletters (http://www.cms.hhs.gov/cert/letters.asp)
- A designated telephone number for Medicare physicians, providers and suppliers for general information and questions regarding the CERT initiative — (804) 864-9940.

In addition, we are preparing a series of Fact Sheets, Frequently-Asked Questions, and future Medlearn Matters articles to provide further guidance regarding the CERT process.

REMEMBER:

Review can result in identification of overpayments as well as underpayments. If CERT changes the payment decision on your claim by denying or reducing payment, you can still file an appeal with your Medicare contractor.

It is in everyone's interest to code and pay claims correctly. Your support of this process helps protect the solvency of the Medicare Program.

Your cooperation also allows your Medicare contractor to provide individualized education to you on your specific CERT errors.

CMS Releases New Educational Guide On Remittance Advice (RA) Notices

Medlearn Matters Article Number: SE0540

Provider Types Affected - All Medicare physicians, providers, suppliers, and their billing staff who submit claims to Medicare Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), Carriers, and Durable Medical Equipment Regional Carriers (DMERCs)

Provider Action Needed

This special edition article describes the release of a national educational guide for Medicare-Fee-For-Service (FFS) providers, physicians, suppliers and their billing staff who may wish to use the guide to help increase their understanding of the Remittance Advice (RA). The Guide is available at http://www.cms.hhs.gov/medlearn/RA_Guide_05-27-05.pdf on the CMS website.

Background

The Medicare FFS program serves many of the more than 40 million Medicare beneficiaries enrolled in the Medicare Program. Under this program, more than 1 billion claims are submitted annually for reimbursement of health care services. The claims are processed by Medicare contractors, FIs, RHHIs, Carriers, and DMERCs. These Medicare contractors use the standard Remittance Advice (RA) as their means to communicate to providers claim processing decisions regarding payments, adjustments, and denials, as well as data that was missing or incorrect on the incoming claims which need to be submitted or corrected before a payment decision can be made on a claim.

Every day Medicare FFS contractors send thousands of RAs to providers. Each of these RAs conveys information that may impact the provider's Medicare business. CMS wants to be certain that providers understand how to read and interpret the RA; therefore, CMS has developed and is pleased to announce the release of *Understanding the Remittance Advice: A Guide for Medicare Providers, Physician, Suppliers and Billers.* This educational guide has useful information that is designed to be used as a self-help tool.

The Guide offers the user the following benefits:

- Easy access to general information about RAs without direct personal assistance from Medicare contractor customer service staff, thus saving valuable time

• Increased ability to understand and interpret the reasons for claim denials and claim adjustments

• Reduction in the resubmission of claims due to errors

• Rapid follow-up action, resulting in quicker payment

• A useful tool for training new staff or a refresher for experienced staff

The Guide is comprised of four chapters each highlighting a specific aspect of the RA, an acronym list, a glossary, important websites and phone numbers, and three comprehensive indices: 1) for key terms and concepts; 2) for institutional ERA and SPR field descriptions; 3) professional SPR field descriptions. Each chapter and/or section of the Guide can be printed according to the provider's specific needs.

Print What Fits Your Needs

• **Chapters 1 and 2** describe a RA and its components
• **Chapter 3** specifically targets institutional providers i.e., those who submit claims to FIs and RHHIs and includes a sample Electronic Remittance Advice (ERA) and Standard Paper Remittance Advice (SPR) with field descriptions.
• **Chapter 4** targets providers that submit claims to Carriers and DMERCS and includes a crosswalk between ERA and SPR fields and a sample SPR with field descriptions, specifically for professional providers. At the end of Chapters 3 and 4, providers can find information on remittance balancing.
• **Reference A: Acronyms,** a handy tool that contains acronyms used throughout the Guide
• **Reference B: Glossary,** a list that contains terms used throughout this Guide
• **Reference C: Websites and Phone Numbers,** a list of web page references and address and phone number references that assist with submitting Medicare claims and troubleshooting denials and claim rejections
• **Reference D: Resources,** a list of the resources that were used to compile the Guide and where to find them on the CMS website.

Additional Information

Print Copies of the Guide will be available late summer of 2005. Until print copies are available Understanding the Remittance Advice: A Guide for Medicare Providers, Physician, Suppliers and Billers can be accessed electronically at http://www.cms.hhs.gov/medlearn/RA_Guide_05-27-05.pdf on the CMS website.

Clarification For Carriers And Durable Medical Equipment Regional Carriers (DMERCs) About Correction And Recoupment Of Payments For Previously Processed Claims

Medlearn Matters Article Number: MM3772

Provider Types Affected - Providers and suppliers who bill Medicare Carriers, including Durable Medical Equipment Regional Carriers (DMERCs)

Provider Action Needed

Impact to You - This is a one-time notice that provides clarification about correction and recoupment of payments for previously processed Medicare claims.

What You Need to Know - Be aware of actions that could impact your payments.

What You Need to Do - When a previously processed claim needs to be adjusted, a full claim adjustment must be done. This will happen regardless of whether Medicare is primary or secondary.

Background

Previously, Medicare's CR 1523 required that carriers and DMERCs make a full claim adjustment whenever an adjustment was processed for a claim that was previously adjudicated. CR 3772 reiterates CR 1523 by requiring a full claim adjustment when money is recouped from providers whether the claim is a Medicare Secondary Payer (MSP) claim or non-MSP.

If money needs to be recouped, the previous payment is negated, and a new payment is recognized if payment is being reduced, and Medicare creates an account receivable in the amount that was overpaid. If there is no payment due, the previous payment is reversed, and an account receivable is created in the same amount as that previously paid.

Should you receive a demand letter from Medicare as a result of such an adjustment and overpayment, the letter will identify:

• The claim,
• The overpayment amount,
• When the overpayment must be repaid, and

• A Financial Control Number for tracking purposes.

If payment is made timely, Medicare will adjust its system to reflect the overpayment was made. However, if payment is not received timely, Medicare will adjust payments on future claims to obtain repayment.

Implementation - The implementation date for this instruction is January 3, 2006.

Related Instructions

Complete details of CR 1523, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Administrative Simplification - Implementation of Version 4010 of the Accredited Standards Committee X12 835 (Payment/Remittance Advice) Transaction Standard Format, may be viewed at: http://www.cms.hhs.gov/manuals/pm_trans/B0135.pdf

Additional Information

The official instruction issued to your carrier/DMERC regarding this change may be found at: http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp. From that web page, look for CR 3772 in the CR NUM column on the right and click on the file for the desired CR. For additional information relating to this issue, please contact your carrier/DMERC via their toll free number. That number may be found at: http://www.cms.hhs.gov/medlearn/tollnums.asp.

Cochlear Implantation

Medlearn Matters Article Number: MM3796

This article is being published as informational only. The DMERC does not process claims for services related to cochlear implantation.

Note: This article was revised on August 1, 2005, to correct the statement in item 3 at the top of page 3 to reflect the correct usage of the QV modifier.

Provider Types Affected - Physicians and providers billing Medicare carriers and Fiscal Intermediaries (FIs) for cochlear implantation services to Medicare patients

Provider Action Needed

Impact to You - The coverage for cochlear implantation has expanded and is effective for services performed on or after April 4, 2005.

What You Need to Know - CMS will cover treatment of bilateral pre- or post-linguistic, sensorineural, moderate-to-profound hearing loss for individuals with hearing test scores equal to or less than 40% correct in the best aided listening condition on tape-recorded tests of open-set sentence recognition. More detailed coverage requirements are further listed in this article.

Additionally, CMS will cover cochlear implants of individuals with open-set sentence recognition test scores of greater than 40% to less than or equal to 60% correct, where the device was implanted in an acceptable clinical trial/study. See further details listed below.

What You Need to Do - This revision is a binding national coverage determination (NCD) made under section 1862(a)(1) of the Social Security Act. The remainder of this article provides more detailed billing instructions for these services.

Background

A cochlear implant device is an electronic instrument, part of which is implanted surgically to stimulate auditory nerve fibers, and part of which is worn or carried by the individual to capture, analyze, and code sound. The purpose of implanting the device is to provide awareness and identification of sounds and to facilitate communication for persons who are moderately to profoundly hearing impaired. Cochlear implant devices are available in single-channel and multi-channel models.

Additional Information

The information in this section outlines the policy guidelines for cochlear implantation coverage, the coverage criteria for an acceptable clinical trial/study, billing requirements for cochlear implantation, and a listing of Healthcare Common Procedural Coding System (HCPCS) associated with cochlear implantation.

Nationally Covered Indications

Medicare coverage is provided only for those patients who meet all of the following selection guidelines.

• Diagnosis of bilateral moderate-to-profound sensorineural hearing impairment with limited benefit (test scores of less than or equal to 40% correct in the best-aided listening condition on tape- recorded tests of open-set sentence cognition) from appropriate hearing (or vibrotactile) aids;
• Cognitive ability to use auditory clues and a willingness to undergo an extended program of rehabilitation;
• Freedom from middle ear infection, an accessible co-

chlear lumen that is structurally suited to implantation, and freedom from lesions in the auditory nerve and acoustic areas of the central nervous system;
• No contraindications to surgery; and
• The device must be used in accordance with Food and Drug Administration (FDA)-approved labeling.

Criteria for Acceptable Clinical Trials and Studies

The coverage criteria that allows for services for individuals meeting the above guidelines and with hearing test scores greater than 40% and less than or equal to 60% requires the provider to participate in and the patient to enroll in an acceptable clinical trial/study , which includes the following:

• Food and Drug Administration-approved category B investigational device exemption clinical trial as defined in 42 CFR 405.201;
• Trial under the CMS clinical trial policy as defined in Section 310.1 of the *Medicare National Coverage Determinations Manual*; or a
• Prospective, controlled comparative trial approved by CMS as consistent with the evidentiary requirements for national coverage analyses and meeting specific quality standards.

Billing Requirements for Cochlear Implantation When Billing FIs and Carriers

These services should be billed on an approved electronic claim form or a paper CMS form 1500. For services performed on and after April 4, 2005:

Medicare Contractors (FIs and Carriers) pay for:

1. Cochlear implant devices and services for moderate-to-profound hearing loss in patients with hearing test scores equal to or less than 40%.
2. Cochlear implant devices for patients with hearing test scores of greater than 40 % to less than or equal to 60% hearing provided in a clinical trial setting that is billed with the QR modifier.
3. Other services related to cochlear implantation, but not the device itself, for patients with hearing test scores of greater than 60% hearing who are in a clinical trial. (These services must be identified with a QV modifier.)
4. Services for patients with hearing test scores of greater than 40% to less than or equal to 60% hearing who are in a prospective, controlled comparative trial approved by CMS. (These services must be billed with the QR modifier.)
5. Any covered diagnostic audiology or therapy services related to the cochlear implant. (The QR or QV does not need to be applied to HCPCS 92601-92604 and 92506 and 92507)

Also, when billing FIs for cochlear implantations, follow these additional instructions:

1. Submit claims on the following bill types (TOB):

a. 11x
b. 12x
c. 13x
d. 83x (for non-OPPS providers)
e. 85x

2. Report diagnosis code V70.7 (Examination of participant in clinical trial) as the second or subsequent diagnosis code, along with the appropriate principal diagnosis code, for patients in a clinical trial.

HCPCS Associated with Cochlear Implantation

Some of the Healthcare Common Procedural Coding System (HCPCS) codes used when billing for cochlear implant services and devices provided by audiologists or physicians, and for the services of 92506 and 92507, by speech language pathologists include:

1. 69930 – Cochlear device implantation, with or without mastoidectomy.
2. L8614 – Cochlear Device/System
3. L8619 – Cochlear implant external speech processor, replacement.
4. L7500 – Repair of prosthetic device, hourly rate (excludes V5335 repair of oral laryngeal prosthesis or artificial larynx).
5. L7510 – Repair of prosthetic device, repair or replace minor parts.
6. 92506 – Evaluation of speech, language, voice, communication, auditory processing, and/or aural rehabilitation status.
7. 92507 – Treatment of speech, language, voice, communication, and/or auditory processing disorder (includes aural rehabilitation); individual.
8. 92601 – Diagnostic analysis of cochlear implant, patient under 7 years of age; with programming.
9. 92602 – Diagnostic analysis of cochlear implant, patient under 7 years of age; subsequent programming. **(Do not report 92602 in addition to 92601).**
10. 92603 – Diagnostic analysis of cochlear implant, age 7 years or older; with programming.

Note: Codes 92601 and 92603 describe post-operative analysis and fitting of previously placed external devices, connection to the cochlear implant, and programming of the stimulator.

Codes 92602 and 92604 describe subsequent sessions for measurements and adjustment of the external transmitter and re-programming of the internal stimulator.

Medicare beneficiaries not meeting all of the coverage criteria for cochlear implantation specified above, or the specific coverage criteria for cochlear implantation in the context of a clinical trial/study, also specified above, are deemed not eligible for Medicare coverage under section 1862(a)(1)(A) of the Social Security Act.

A National Coverage Determination revision is binding on all carriers, FIs, quality improvement organizations, health maintenance organizations, competitive medical plans, health care prepayment plans, the Medicare Appeals Council, and administrative law judges (see 42 CFR section 405.732, 405.860). Because it expands coverage, the NCD is also binding on a Medicare advantage organization. In addition, an administrative law judge may not review an NCD. (See section 1869(f)(1)(A)(i) of the Social Security Act.)

The official instruction issued to your FI or carrier regarding this change may be found by going to: http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp. From that web page, look for CR 3796 in the CR NUM column on the right, and click on the file(s) for that CR. You will note two files for CR3796. The file with transmittal number 42 is the NCD itself and the file with transmittal number 601 contains the claims processing instructions.

For additional information relating to this issue, please refer to your local carrier or FI. To find the toll free phone number for your local carrier, go to: http://www.cms.hhs.gov/medlearn/tollnums.asp

Medicare Provider Feedback Town Hall Meeting

To: Medicare Fee-For-Service (FFS) Providers and Suppliers

September 12, 2005 (2:00 - 4:00 PM EST)

The Centers for Medicare & Medicaid Services (CMS) would like to request your participation in a Town Hall meeting on September 12, 2005, from 2:00 PM to 4:00 PM (Eastern Standard Time). The meeting will be held in the auditorium at the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244 and by teleconference. The purpose of the meeting is to solicit the opinions of individual Medicare FFS physicians, providers and suppliers. The meeting will provide the Agency with an open and public venue to interact with individual Medicare providers and suppliers and obtain their feedback on a variety of Medicare policy and operational issues. All providers and suppliers that participate in the Medicare program, including physicians, hospitals, home health agencies, and other third-party billers, are invited to attend this meeting.

The agenda items for the meeting will be available in the August 26, 2005 Federal Register Notice announcing the meeting. CMS will also hold a question and answer session that offers meeting participants an opportunity to provide feedback, as well as make suggestions regarding how this process can be improved.

Meeting Registration Details

Registration for the meeting will open on **August 19, 2005**. Individuals interested in attending the meeting and providing feedback, either in person or by teleconference, must complete the on-line registration located at **http://registration.mshow.com/cms2/**. The on-line registration system will capture contact information and practice characteristics, such as names, email addresses, and provider/supplier types. Registered participants may be contacted for follow-up meetings to solicit additional opinions and clarify any issues that may arise during the September 12 Town Hall meeting.

The on-line registration system will generate a confirmation page to indicate the completion of your registration. Please print this page as your registration receipt. We encourage you to complete your registration as soon as possible. Registration after 12 p.m. on September 9, 2005 will delay confirmation and you may not be permitted entrance to the building. However, registrations received after September 9, 2005 will enable individuals to listen to a digital audio recording of the meeting. The digital audio recording will be available hours after the meeting and can be accessed through midnight on September 14, 2005 by dialing 1-800-642-1687 and entering the Conference ID 7970566.

Meeting Participation Details

The meeting will be held in a Federal Government building; therefore all persons attending the **meeting** in person will be required to show a photographic identification, preferably a valid driver's license, and be listed on an approved security list before entering.

Those participating by teleconference should dial: **1-877-357-7851** and enter the **Conference ID: 7970566.**

Note: TTY Communications Relay Services are available for the Hearing Impaired. For TTY services dial 7-1-1 or 1-800-855-2880, and for Internet Relay services visit http://www.consumer.att.com/relay/which/index.html. A Relay Communications Assistant will be available to assist you.

Additional Questions/Information

For questions or additional information about the Medicare Provider Feedback Town Hall Meeting, please send an email to MFG@cms.hhs.gov.

New Educational Products Available - The Fourth In The Medlearn Matters Series Of Articles On The Medicare Prescription Drug Coverage

Medlearn Matters Article Number: SE0537

Provider Types Affected - Physicians, providers, suppliers, and their staff providing service to people with Medicare

Important Points to Remember

• On January 1, 2006, new prescription drug coverage will be available to your Medicare patients.
• You should encourage your Medicare patients to learn more about this new coverage because it may save them money on prescription drugs.
• If your Medicare patients ask you questions about the new coverage, you can refer them to 1-800-MEDICARE and to http://www.medicare.gov for additional information and assistance.

This article announces new educational resources available to assist Medicare beneficiaries in their understanding of the new Medicare Prescription Drug Coverage.

Release of Notices to Medicare Beneficiaries Who Automatically Qualify for Extra Help

Starting at the end of May through June, the Centers for Medicare & Medicaid Services (CMS) is mailing notices to people who are automatically eligible for extra help paying for a Medicare prescription drug plan, including people with Medicare and Medicaid, Supplemental Security Income, and Medicare Savings Program coverage.

The notices will let these people know that Medicare prescription drug coverage is coming and that they will get extra help without needing to apply for it. The notices can be viewed at http://www.cms.hhs.gov/medicarereform/lir.asp on the CMS web site.

This summer, the Social Security Administration (SSA) will mail a different letter to other people who do not automatically qualify for the extra help but may be potentially eligible for it. The letter will include an application that people can fill out and return to find out if they qualify for extra help paying for a Medicare prescription drug plan. This letter can viewed at http://www.ssa.gov/organizations/medicareoutreach2/ on the Social Security Administration web site. Select "Application for Help with Medicare Prescription Drug Plan Costs."

Posters - Now Available for Display

Posters titled "Have Limited Income? Social Security Can Help with Prescription Costs" can be ordered free of charge on the CMS web site. The posters are suitable for display in a physician's, providers, or supplier's office; a pharmacy; or other health care setting where Medicare beneficiaries will see this information. The posters direct Medicare beneficiaries with limited income and resources to a toll free number where they can find out if they are eligible for help with prescription drug costs.

To view and order the posters, go to the Medlearn Prescription Drug Coverage web page located at http://www.cms.hhs.gov/medlearn/drugcoverage.asp on the CMS web site. We need your help in getting this information out to Medicare beneficiaries with limited income and resources. We encourage you to order and display the posters where Medicare beneficiaries will see them.

Information Tool Available on Web

The new prescription drug coverage informational tool, "Learn About Your Medicare Prescription Coverage Options" was recently released on http://www.medicare.gov. This awareness tool for people with Medicare provides information about what is coming and what actions they will need to take with regard to the new prescription drug coverage. By answering 2-3 questions, the individual will be provided with information such as: eligibility for extra help for people with limited income and resources, customized information based on the individual's current coverage, as well as educational resources and links to publications about the new drug coverage.

Summary

CMS understands the pressure on your clinical time with patients, which is why we ask that you inform your Medicare patients that this new prescription drug coverage could be valuable to them and worth exploring.

In addition to the products discussed in this article, CMS plans to provide you with access to information you could make available to your patients in your offices.

Additional Information

More information on provider education and outreach regarding drug coverage can be found at: http://www.cms.hhs.gov/medlearn/drugcoverage.asp on the CMS web site. Detailed drug coverage information for CMS partners and beneficiary advocates can be found at http://www.cms.hhs.gov/partnerships/news/mma/default.asp on the CMS web site. You can also find additional information regarding prescription drug plans at http://www.cms.hhs.gov/pdps/ on the CMS web site. Further information on CMS implementation of the MMA can be found at the following CMS web site: http://www.cms.hhs.gov/medicarereform/

More Web Based Educational Products Available On Medicare Prescription Drug Coverage – The Fifth In The Medlearn Matters Series

Medlearn Matters Article Number: SE0541

Provider Types Affected - Physicians, providers, suppliers, and their staff providing service to people with Medicare

Important Points to Remember

• On January 1, 2006, new prescription drug coverage will be available to your Medicare patients.

• It will cover brand name and generic drugs.

• This new drug coverage requires all people with Medicare to make a decision this fall. As a trusted source, your patients may turn to you for information about this new coverage. Because of this, we're looking to you and your staff to take advantage of this "teachable moment" and help your Medicare patients.

• You should encourage your Medicare patients to learn more about this new coverage because it may save them money on prescription drugs. There is extra help available for people with limited income and resources.

• If your Medicare patients ask you questions about the new coverage, you can refer them to 1-800-MEDICARE and to http://www.medicare.gov for additional information and assistance.

New Fact Sheets Available on http://www.medicare.gov

There are fact sheets now available that explain Medicare's new prescription drug coverage that can help your patients understand this new coverage:

• *Quick Facts about Medicare's New Coverage for Prescription Drugs* - Publication Number 11102. This fact sheet provides basic information about Medicare's new prescription drug coverage. (2 pages) http://www.medicare.gov/Publications/Pubs/pdf/11102.pdf

• *Quick Facts about Medicare's New Coverage for Prescription Drugs for People with Limited Income and Resources* – Publication Number 11105. This fact sheet provides basic information about Medicare's new prescription drug coverage for a person with limited income and resources. (2 pages) http://www.medicare.gov/Publications/Pubs/pdf/11105.pdf

• *Quick Facts about Medicare's New Coverage for Prescription Drugs If You Applied for Extra Help* – Publication Number 11130. This fact sheet explains what you need to know after applying for extra help paying Medicare prescription drug coverage costs. (2 pages) http://www.medicare.gov/Publications/Pubs/pdf/11130.pdf

• *Quick Facts about Medicare's New Coverage for Prescription Drugs for People Who Get Supplemental Security Income* – Publication Number 11116. This fact sheet provides basic information about Medicare's new prescription drug coverage for a person who gets Supplemental Security Income benefits or help from their state Medicaid program paying their Medicare premiums. (2 pages) http://www.medicare.gov/Publications/Pubs/pdf/11116.pdf

• *Quick Facts about Medicare's New Coverage for Prescription Drugs for People with Medicare and Medicaid* – Publication Number 11106. This fact sheet provides basic information about Medicare's new prescription drug coverage for a person with full Medicaid benefits. (2 pages) http://www.medicare.gov/Publications/Pubs/pdf/11106.pdf

• *Quick Facts about Medicare's New Coverage for Pre-*

scription Drugs for People Who are Nursing Home Residents – Publication Number 11121. This fact sheet explains how the new Medicare prescription drug coverage works for nursing home residents. (2 pages) http://www.medicare.gov/Publications/Pubs/pdf/11121.pdf

• *Quick Facts about Medicare's New Coverage for Prescription Drugs for People Who Get Help From Their State Pharmacy Program* – Publication Number 11108. This fact sheet explains what people who get help from their state pharmacy program to pay for their prescriptions need to know about the new Medicare prescription drug coverage. (2 pages) http://www.medicare.gov/Publications/Pubs/pdf/11108.pdf

• *Do You Have a Medigap Policy with Prescription Drug Coverage?* – Publication Number 11113. This fact sheet explains how the new Medicare prescription drug coverage works for people who have a Medigap policy with prescription drug coverage. (4 pages). http://www.medicare.gov/Publications/Pubs/pdf/11113.pdf

• *Medicare Covers America* - Publication Number 11141. This brochure provides basic information for people with Medicare about Medicare prescription drug coverage. This information includes how Medicare prescription drug coverage works, how to get coverage, and how to join a Medicare prescription drug plan. (2 pages) http://www.medicare.gov/Publications/Pubs/pdf/11141.pdf

• *Introducing Medicare Prescription Drug Coverage* - Publication Number 11142. This brochure provides basic information to people with Medicare about Medicare prescription drug coverage. This information includes who can join, when people can join, and when more information will be available. (2 pages) http://www.medicare.gov/Publications/Pubs/pdf/11142.pdf

New Fact Sheets and Tip Sheets Available on the CMS Web site at http://www.cms.hhs.gov/medicarereform/factsheets.asp

• *The Facts about Medicare Prescription Drug Plans* – Publication Number 11065. This fact sheet provides basic introductory information about Medicare's new prescription drug coverage. (2 pages) http://www.medicare.gov/Publications/pubs/pdf/11065.pdf

• Quick Facts about Medicare's New Coverage for Prescription Drugs (en Espanol) – Publication Number 11102-S. This fact sheet provides basic information about Medicare's new prescription drug coverage, in Spanish.

• http://www.cms.hhs.gov/medicarereform/elnewcovprescdrug.pdf

• *Medicaid Spend Down – Tip Sheet* (3 pages) This tip sheet provides an example of the spend down requirement for patients who have Medicaid because of high medical expenses. This sheet shows the qualifications for patients to receive extra help. *http://www.cms.hhs.gov/medicarereform/medicaid %20spend %20down.pdf*

• *Food Stamps – Tip Sheet* (3 pages) This tip sheet provides information on income limits, resource limits and qualifications for extra help for people who have Medicare and are also on food stamps. http://www.cms.hhs.gov/medicarereform/foodstamps.pdf

• *Medicare Prescription Drug Coverage and other Federal Means -Tested Programs – Tip Sheet* (2 pages) This tip sheet is intended to help explain how Medicare prescription drug coverage will work with other federal means-tested programs such as food stamps, HUD housing assistance, Medicaid, low income home energy assistance, and supplemental security income. http://www.cms.hhs.gov/medicarereform/lowincome.pdf

Other Publications/Products

• *Introducing Medicare's New Coverage for Prescription Drugs (bi-fold)* – This pamphlet provides general information about the New Medicare Prescription Drug Coverage, such as who can join, when, and the cost to join, as well as providing sources for additional information. This pamphlet is available at http://www.medicare.gov/Publications/Pubs/pdf/11103.pdf

• *Vignettes/Bios/Case Studies*– These vignettes can be used to help explain how Medicare prescription drug coverage works with and affects other types of health care coverage. They can be used to supplement other outreach materials. (10 pages). These vignettes are available at http://www.cms.hhs.gov/partnerships/news/mma/vignettesfinal.pdf

• *Introducing Medicare's New Coverage for Prescription Drugs (Russian, Korean, Vietnamese, and Chinese)*- To access this product, go to http://www.medicare.gov/medicarereform/default.asp. At the middle of the web page, select the language desired from the drop-down menu. This will reveal a link to the document in the desired language.

Outreach Toolkit

A new Outreach Toolkit is also available. This toolkit is designed to equip community-level organizations with the materials needed to provide clear, accurate information and assistance about Medicare prescription drug

coverage for their clients.

The toolkit contains basic, straightforward information that can be easily conveyed to people with Medicare.

You can view and download this kit online from the CMS web site, as well as order a copy to be shipped to your office, by visiting: **http://www.cms.hhs.gov/partnerships/tools/materials/medicaretraining/MPDCoutreachkit.asp** on the CMS web site.

Additional Information

More information on provider education and outreach regarding drug coverage can be found at: http://www.cms.hhs.gov/medlearn/drugcoverage.asp on the CMS web site.

Detailed drug coverage information for CMS partners and advocates for people with Medicare can be found at http://www.cms.hhs.gov/partnerships/news/mma/default.asp on the CMS web site. You can also find additional information regarding prescription drug plans at http://www.cms.hhs.gov/pdps/ on the CMS web site. Further information on CMS implementation of the MMA can be found at http://www.cms.hhs.gov/medicarereform/ on the CMS web site.

Message To Nursing Home Administrators On Medicare Prescription Drug Coverage - The Sixth In The Series Of Medlearn Matters Articles On The New Prescription Drug Coverage

Medlearn Matters Article Number: SE0544

Provider Types Affected - Skilled Nursing Facilities (SNFs) - This article contains important information for nursing home staff about the impact of the new prescription drug coverage on people who receive both Medicare and Medicaid.

Information for Nursing Home Administrators

The Centers for Medicare & Medicaid Services (CMS) released the following information via the Minimum Data Set (MDS) submission system's Welcome Page on July 6, 2005:

• Starting January 1, 2006, Medicare prescription drug coverage will be available to everyone with Medicare. Also starting January 1, 2006, state Medicaid programs will no longer provide drug coverage for people also covered by Medicare (also known as Full Benefit Dual Eligibles or FBDEs); instead, prescription drug coverage for people in this group will be provided by Medicare. Since two thirds of residents in nursing homes fall into this category, this Federal program will be critically important. State Medicaid coverage for **health care** coverage is not affected.

• All Medicaid beneficiaries who are eligible to receive benefits through both Medicare and Medicaid must enroll in a Medicare Prescription Drug Plan to get this coverage. They will receive information from Medicare and from the plans in their area this fall and they will need to choose and enroll in a plan that meets their needs. However, if they haven't joined a plan by December 31, 2005, Medicare will enroll them in a plan to make sure they don't miss a day of coverage. People in this group can switch to another plan at any time.

Important Points to Remember

• On January 1, 2006, new prescription drug coverage will be available to your Medicare residents. It will cover brand name and generic drugs.
• Starting January 1, 2006, state Medicaid programs will no longer provide drug coverage for people also covered by Medicare.
• All Medicaid beneficiaries who are eligible to receive benefits through both Medicare and Medicaid **must** enroll in a Medicare Prescription Drug Plan to get continuous coverage of their prescription drug costs.
• If Medicaid beneficiaries who are eligible to receive benefits through both Medicare and Medicaid do not enroll in a Medicare Prescription Drug Plan by December 31, 2005, Medicare will enroll them in a plan automatically to make sure they do not miss a day of coverage.
• Medicaid beneficiaries who live in a nursing home will pay nothing out of their pocket for Medicare prescription drug coverage.
• If your Medicare patients ask you questions about the new coverage, you can refer them to 1-800-MEDICARE and to http://www.medicare.gov for additional information and assistance.
• The Centers for Medicare & Medicaid Services (CMS) will use the Minimum Data Set (MDS) distribution system to keep nursing home administrators informed about Medicare prescription drug coverage as it applies to nursing home residents.
• All Medicare prescription drug plans will provide at least a standard level of coverage to all enrollees.
Coverage will be available through both Medicare "Pre-

scription Drug Plans" (PDPs), and as part of Medicare Advantage Plans or other Medicare Health Plans (MA-PDs). All plans will be required to cover enrollees in all nursing homes in their regions. They will also be required to meet specific service and performance criteria to ensure safe prescription drug administration in the nursing home setting. While plans may offer different formularies (lists of covered drugs), CMS will require plans to cover a range of drugs in the most commonly prescribed classes to make sure that people with different medical conditions can get the treatment they need.

An "exceptions and appeals" process will be in place to ensure access to non-formulary drugs. The plans will arrange for medications to be packaged and made available to nursing homes through longterm care pharmacy providers. These will most likely include current pharmacy providers to nursing homes, as well as new organizations that are able to meet the CMS long-term care pharmacy standards. Nursing homes will be able to select from these pharmacy vendors to ensure that all of the residents have appropriate drug coverage.

• People who receive both Medicare and Medicaid and reside in a nursing home will receive continuous prescription drug coverage, with no premiums, no deductibles, and no co-payments.

• People with limited income and resources, who are **not** eligible for full Medicaid benefits, may qualify for extra help paying for Medicare prescription drug coverage. If they qualify, they will receive extra help to pay for premiums, deductibles, and co-payments. They **will** have to pay a copayment or coinsurance amount, depending on their income and resources.

• More information concerning Medicare prescription drug coverage as it applies to the long-term care population, and operational steps that will be necessary to ensure a seamless transition in 2006, will be forthcoming through the MDS distribution system. Additional information and resources are also available at: http://www.cms.hhs.gov on the CMS web site.

Additional Information

More information on provider education and outreach regarding Medicare prescription drug coverage can be found at: http://www.cms.hhs.gov/medlearn/drugcoverage.asp on the web. Detailed drug coverage information for CMS partners and beneficiary advocates can be found at http://www.cms.hhs.gov/partnerships/news/mma/default.asp on the web. You can also find additional information regarding prescription drug plans at http://www.cms.hhs.gov/pdps/ on the web.

Non-Physician Practitioner Questions And Answers

Medlearn Matters Article Number: SE0418

Note: This article was revised on July 6, 2005. The only change was the answer (A10) to question 10 (Q10) on page 3. All other information remains the same.

Provider Types Affected - Non-Physician Practitioners (NPPs), physicians, suppliers, and providers

Provider Action Needed

Be sure to understand the policies related to services for Skilled Nursing Facilities (SNF) and Nursing Facilities (NF) as they relate to Non-Physician Practitioners.

Background

The Balanced Budget Act of 1997 modified the way the Medicare program pays for Non-Physician Practitioner (NPP) services. Prior to January 1, 1998, these services were reimbursed by Medicare Part B only in certain geographical areas and health care settings. The Balanced Budget Act removed the restrictions on settings and effective January 1998, payment is allowed for non-physician practitioner services in all geographic areas and health care settings permitted under State licensing laws.

On November 13, 2003, CMS issued the Survey & Certification letter (S&C-04-08), which addresses the differences in requirements concerning the delegation of physician tasks in Skilled Nursing Facilities (SNFs) and Nursing Facilities (NFs) from a survey and certification perspective. Please note that reimbursement requirements for NPPs may differ from the survey and certification requirements. The following questions (Q1 through Q17) have been asked by NPPs, and each question has been answered (A1 through A17) by the Centers for Medicare & Medicaid Services (CMS).

Q1. Why do new regulations from CMS governing physician delegation of services differ between Skilled Nursing Facilities (SNFs) and Nursing Facilities (NFs)?

A1. The requirements addressing physician delegation of services are not new. The distinction made between the delegation of physician visits and tasks between SNFs and NFs is mandated by Congress in the law.

The original authority for 42 Code of Federal Regulations (CFR) § 483.40 was the sentence in section

1819(b)(6)(A) of the Social Security Act requiring that every SNF resident's medical care be under the supervision of a physician (the same sentence appeared in section 1919(b)(6)(A) of the Social Security Act for NFs). The requirements contained in 42 CFR, § 483.40, include a prescribed visit schedule and the requirement for the physician to perform the initial visit personally.

Section 483.40 of the CFR originally applied these same standards uniformly in both SNFs and NFs. However, in section 4801(d) of the Omnibus Budget Reconciliation Act of 1990 (OBRA '90), Congress subsequently amended the Medicaid provisions of the law (section 1919(b)(6)(A) of the Social Security Act) to allow, at the option of the State, all physician tasks (including the initial visit) to be delegated to physician extenders who are not employed by the facility but who are working in collaboration with the physician. In response, CMS amended the regulations to reflect this broader authority for delegating physician tasks in NFs (see § 483.40(f)). Since Congress declined to make a similar change in the statutory requirements for SNFs at section 1819(b)(6)(A) of the Social Security Act, the corresponding SNF requirements in § 483.40(c) and (e) remain unchanged.

Q2. When may non-physician practitioners (NPPs) begin to bill for medically necessary visits that occur prior to the initial comprehensive visit in a SNF and in a NF?

A2. CMS defined "initial comprehensive visit" in the November 13, 2003 S&C-04-08 and stated that NPPs may perform any medically necessary visits even if they occur prior to the initial comprehensive visits in both SNFs and NFs. Medically necessary visits that NPPs perform on or after November 13, 2003, may be billed to the carrier when collaboration and billing requirements are met in the SNF and NF setting. The Survey & Certification letter S&C-04-08, may be found at: http://www.cms.hhs.gov/medicaid/survey-cert/letters.asp

Q3. If State regulations require a physician co-signature for orders and/or notes written by an NPP, may the physician bill for this action?

A3. No. CMS only pays for medically necessary face-to-face visits by the physician or NPP with the resident. Since the NPP is performing the medically necessary visit, the NPP would bill for the visit.

Q4. If State regulations require more frequent visits than those that are federally mandated, are NPPs able to bill for those visits?

A4. CMS only reimburses physicians and NPPs for medically necessary visits and federally prescribed visits. Visits required to fulfill or meet State requirements are considered administrative requirements and are not medically necessary for the resident. Medicare pays for services that are reasonable and medically necessary for the treatment of illness or injury only, as stated in the Social Security Act, section 1862(a)(1)(A).

Q5. May NPPs who are employed by the facility bill for medically necessary visits?

A5. Payment may be made for the services of Nurse Practitioners (NPs) and Clinical Nurse Specialists (CNSs) who are employed by a SNF or NF when their services are rendered to facility residents. If NPs and CNSs employed by a facility opt to reassign payment for their professional services to the facility, the facility can bill the appropriate Medicare Part B carrier under the NPs' or CNSs' UPINs for their professional services. Otherwise, the NPs or CNSs who are employed by a SNF or NF bill the carrier directly for their services to facility residents.

On the other hand, Physician Assistants (PAs) who are employed by a SNF or NF cannot reassign payment for their professional services to the facility because Medicare law requires the employer of a PA to bill for the PA's services. Hence, the facility must always bill the Part B carrier under the PA's UPIN for the PA's professional services to facility residents.

Q6. May NPPs employed by the NF perform the initial comprehensive visit, sign initial orders, or perform other federally required visits in NFs?

A6. No. The statute specifies that the NPPs are prohibited from providing these services when **employed** by the facility. The Social Security Act states at section 1919(b)(6)(A) that the health care of every resident must be provided under the supervision of a physician or under the supervision of an NPP **not** employed by the facility who is working in collaboration with a physician.

Q7. May NPPs perform the initial comprehensive visit in SNFs?

A7. No. The Social Security Act states at Section 1819(b)(6)(A) "that the medical care of every resident must be provided under the supervision of a physician." Congress did not extend this benefit to NPPs in an SNF as was done under 1919(b)(6)(A).

Q8. When may NPPs sign the initial orders for a SNF resident?

A8. NPPs may not sign initial orders for an SNF resident. However, they may write initial orders for a resident (only) when they review those orders with the attending physician in person or via telephone conversation and have the orders signed by the physician.

Q9. Must a physician verify and sign orders written by an NPP who is employed by the NF?

A9. Yes. The regulation at 42 CFR, § 483.40(b)(3) states, the physician must "Sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications."

In accordance with 42 CFR, Section 483.40(f), required physician tasks, such as verifying and signing orders in an NF, can be delegated under certain circumstances to a physician assistant, nurse practitioner, or clinical nurse specialist who is **not** an employee of the facility but who is working in collaboration with a physician. Therefore, in order to comply with survey and certification requirements, the physician must sign all orders written by an NPP who **is** employed by the NF.

Q10. Why must a physician verify and sign orders written by an NPP in the SNF?

A10. In SNFs, depending on State law and the facility's policy, physicians do NOT have to verify and sign orders written by an NPP after the initial comprehensive visit. Nonetheless, the ultimate responsibility for delegated tasks remains with the physician, as indicated in § 483.40(e)(1)(iii). For a NF, depending upon State law, NPPs not employed by the facility but who are working in collaboration with a physician are not required to have their orders (initial or ongoing) cosigned by a physician.

Q11. Referring to S&C –04-08 issued on November 13, 2003, the chart under the "Other Medically Necessary Visits and Orders" column, it specifies the ability of the NPP to perform AND sign but in the column for "Other Required Visits" it does not address signing. Does CMS require a physician's signature in such cases?

A11. 'Other Required Visits' refers to the federally required visits. During these required visits, it is not always necessary to write orders. However, during a "Medically Necessary Visit," which is when the resident's condition may have changed, thus, warranting a visit outside the federally required schedule, the resident is exhibiting signs and/or symptoms that require medical attention. In these cases, CMS believes orders will often be required and, thus, expect orders to address the resident's change in condition.

Therefore, an NPP may sign the medically required orders. Please remain mindful that the survey and certification requirement that the physician must sign and date all orders remains in effect. (See Q&As 9 & 10.)

Q12. Why can't a PA, regardless of employment, sign certifications/re-certifications for SNF residents?

A12. Congress amended section 1814(a)(2) of the Social Security Act in 1989. The Social Security Act **specifies** that NPs and CNSs who are not employed by the facility may certify (and recertify) that the services the beneficiary requires may only be performed in the SNF. They did not extend this benefit to PAs. Therefore, by statute, PAs may not sign SNF certifications/re-certifications.

Q13. If a physician extender is not employed by the NF but is employed by an organization related to the NF, may he/she still provide services in the nursing home?

A13. The requirement in 42 CFR, § 483.40(f), is specific in that the physician tasks may be performed by a NP, PA, or CNS "who is not an employee of the facility." In this case, the NPP is not an employee of the NF and, thus, can perform physician tasks as long as they work in collaboration with the physician.

Q14. If an NP or CNS is not employed by the SNF but is employed by an organization related to the SNF, may he/she sign the certification and re-certifications?

A14. The requirement in 42 CFR § 424.20(e) is specific in that an NP or CNS "neither of whom has a direct or indirect employment relationship with the facility" may sign the certifications and re-certifications. In this case, the NP or CNS is not an employee, but has an indirect employment relationship and, thus, are not permitted to sign the certifications and re-certifications. (Social Security Act section 1814(a)(2))

Q15. If physician delegation responsibilities are based on payment source, what are the physician delegation responsibilities for private pay resident, VA contracts or managed care?

A15. If the resident's stay is being paid for by a source other than Medicare or Medicaid AND the resident is residing in a Medicare/Medicaid dually-certified facility, follow the most stringent requirement. If the resident is residing in a Medicare only or a Medicaid only certified facility, then follow the requirements for that specific

certified facility.

Q16. Are NPPs allowed to certify/recertify therapy plans of care under Medicare Part B?

A16. 42 CFR § 424.24(c)(3) states that if a physician or NPP establishes the plan of care, he/she must also certify the plan of care. If the plan of care is established by a physical or occupational therapist or speech language pathologist, a physician or NPP who has knowledge of the case must sign the plan of care. (This Q&A was **not** addressed in the November 13, 2003, Survey & Certification letter, S&C-04-08.) Should you have any questions concerning this article, please submit your inquiry via the CMS Web site as follows:

1) Click on Feedback in top tool bar of **http://www.cms.hhs.gov** (from Home page or any page on cms.hhs.gov).
2) Select and click "Site Feedback" in last paragraph.
3) User should:

   a. Enter his/her email address;
   b. At Category, select "Providers" from the drop down menu;
   c. At the sub-category, select Nursing Home Quality Initiative;
   d. Enter feedback in space provided; and
   e. Submit feedback.

Related Instructions

The CMS Web site contains considerable information regarding SNF billing procedures and NPP billing processes. Some of the specific sites are as follows:

The *Medicare Claims Processing Manual, Pub. 100-04, Chapter 7 (SNF Part B Billing (Including Inpatient Part B and Outpatient Fee Schedule))* can be found at the following CMS Website: http://www.cms.hhs.gov/manuals/104_claims/clm104c07.pdf

The *Skilled Nursing Facility Manual, Chapter V (Billing Procedures)* is located at the following CMS Website: http://www.cms.hhs.gov/manuals/12_snf/sn500.asp

The *Home Health Agency Manual*, Chapter IV (Billing Procedures) Website is located at: http://www.cms.hhs.gov/manuals/11_hha/hh400.asp.

Additional Information

The CMS Quarterly Provider Update Websites for Non-Physician Practitioners (NPPs) for 2004 can be found at:

http://www.cms.hhs.gov/providerupdate/january2004/nonphys.asp

http://www.cms.hhs.gov/providerupdate/april2004/nonphys.asp

http://www.cms.hhs.gov/providerupdate/July2004/nonphys.asp

http://www.cms.hhs.gov/providerupdate/october2004/nonphys.asp

In addition, the CMS Quarterly Provider Update Websites for NPPs for 2003 can be found at:

http://www.cms.hhs.gov/providerupdate/january2003/nonphys.asp

http://www.cms.hhs.gov/providerupdate/april2003/nonphys.asp

http://www.cms.hhs.gov/providerupdate/july2003/nonphys.asp

http://www.cms.hhs.gov/providerupdate/october2003/nonphys.asp

Acronyms

CFR = Code of Federal Regulations
CMS = Centers for Medicare & Medicaid Services
CNS = Clinical Nurse Specialist
NF = Nursing Facility
NP = Nurse Practitioner
NPP = Non-Physician Practitioner (NPs, CNSs, & Pas are considered NPPs)
OBRA '90 = Omnibus Budget Reconciliation Act of 1990
PA = Physician Assistant
S&C = Survey & Certification
SNF = Skilled Nursing Facility
VA = Veterans Administration

Posters Now Available!

Posters titled "Have Limited Income? Social Security Can Help with Prescription Costs" can be ordered free of charge on the Centers for Medicare and Medicaid Services' (CMS) website. The posters are suitable for display in a physician's, provider's, or supplier's office, a pharmacy, or other health care setting where Medicare beneficiaries will see this information. The posters direct Medicare beneficiaries with limited income to a

toll free number where they can find out if they are eligible for help with prescription drug costs. Flat posters are suitable for wall display. Easel posters are suitable for counter display. Order the size and style appropriate for your use. Artwork cannot be specified as posters will be sent based on availability at the time the order is received. To view and order the posters, go to the Medlearn Prescription Drug Coverage web page located at: http://www.cms.hhs.gov/medlearn/drugcoverage.asp on the CMS website. We need your help in getting this information out to Medicare beneficiaries with limited income and resources. We encourage you to order and display the posters where Medicare beneficiaries will see them.

Quarterly Provider Update

Medlearn Matters Article Number: SE0303

The Quarterly Provider Update is a comprehensive resource published by the Centers for Medicare & Medicaid Services (CMS) on the first business day of each quarter. It is a listing of all non-regulatory changes to Medicare including Program Memoranda, manual changes, and any other instructions that could affect providers. Regulations and instructions published in the previous quarter are also included in the Update. The purpose of the Quarterly Provider Update is to:

- Inform providers about new developments in the Medicare program;
- Assist providers in understanding CMS programs and complying with Medicare regulations and instructions;
- Ensure that providers have time to react and prepare for new requirements;
- Announce new or changing Medicare requirements on a predictable schedule; and
- Communicate the specific days that CMS business will be published in the Federal Register.

To receive notification when regulations and program instructions are added throughout the quarter, sign up for the Quarterly Provider Update list-serv (electronic mailing list) at: http://list.nih.gov/cgi-bin/wa?SUBED1=cms-qpu&A=1.

The Quarterly Provider Update can be accessed at http://www.cms.gov/providerupdate. We encourage you to bookmark this Web site and visit it often for this valuable information.

Understanding The Remittance Advice

A reference document titled *Understanding the Remittance Advice: A Guide for Medicare Providers, Physicians, Suppliers, and Billers* is now available on the Medicare Learning Network's (Medlearn) web page located at http://www.cms.hhs.gov/medlearn/RA_Guide_05-27-05.pdf on the CMS website. Chapters 1 and 2 describe a Remittance Advice (RA) and the components of an RA. For institutional providers, Chapter 3 includes a sample Electronic Remittance Advice (ERA) and Standard Paper Remittance Advice (SPR) with field descriptions. Chapter 4 includes a crosswalk between ERA and SPR fields and a sample SPR with field descriptions, specifically for professional providers. At the end of Chapters 3 and 4, providers can find information on remittance balancing. Print the chapter that fits your needs! The guide also includes informative resources such as an acronym list, a glossary, and important websites and phone numbers. Finally, the guide has three comprehensive indexes: 1) for key terms and concepts; 2) for institutional ERA and SPR field descriptions; 3) professional SPR field descriptions. Check it out today!

If you are currently receiving the Standard Paper Remittance Advice (SPR), consider utilizing the technology available to increase productivity by switching to the Electronic Remittance Advice (ERA). Take advantage of faster communication, payment information, and reduction of paperwork by receiving the ERA. If you are receiving both an SPR and ERA, consider canceling the SPR. Please contact our EDI department at 1.866.224.3094 and ask to receive the ERA and/or cancel the SPR today!

Remittance Advice Remark Code And Claim Adjustment Reason Code Update

Medlearn Matters Article Number: MM3923

Provider Types Affected - Physicians, providers, and suppliers who submit claims to Medicare contractors (carriers, Fiscal Intermediaries, Regional Home Health Intermediaries (RHHIs), and Durable Medical Equipment Regional Carriers (DMERCs)) for services

Provider Action Needed

Impact to You - The complete list, including changes made from November 1, 2004 through February 28, 2005,

of X12N 835 Health Care Remittance Advice Remark Codes and X12N 835 Health Care Claim Adjustment Reason Codes can be found at: http://www.wpc-edi.com/codes

What You Need to Know - Please refer to the Additional Information section of this article for remark and reason code changes approved February 28, 2005.

What You Need to Do - Be sure your staff is aware of these changes.

Background - Two code sets, reason and remark code sets, must be used to report payment adjustments, appeal rights, and related information for transactions 835 (Health Care Claim Payment/Advice), 837 Coordination of Benefits (COB), and on standard paper remittance advice. Medicare contractors must use currently valid codes. An updated code list is published 3 times per year. Medicare contractors are informed of these changes through recurring code updates (such as this article and corresponding CR3923), and/or through a specific CR that describes the change in policy that resulted in the code change.

The remittance advice remark code list is maintained by CMS. However additions, deactivations, and modifications to the code list may be initiated by Medicare and non-Medicare entities.

• Medicare contractors must use **modified codes** for codes currently used by Medicare even if the modification was initiated by an entity other than Medicare.
• Medicare contractors do not have to use **new codes** initiated by an entity other than Medicare, unless otherwise instructed by Medicare.
• Medicare contractors must stop using a code that has been deactivated either by the effective date of deactivation, or the effective date established by the code update CR.

The health care claim adjustment reason code list is maintained by a national Code Maintenance committee that meets three times a year when X12 meets for their trimester meetings to make decisions about additions, modifications, and retirement of existing reason codes. This updated list is posted thrice per year.

• Reason code changes requested by Medicare may be included in a Medicare instruction in addition to the regular code update notification.
• Reason codes may be retired if they are no longer applicable, or if a similar code exists.
• Retirements are effective for a specified future and succeeding versions, but Medicare contractors can also discontinue use of retired codes in prior versions.
• The regular code update notification will establish the deadline for Medicare contractors to retire a reason code that could be earlier than the version specified in the Washington Publishing Company (WPC) posting.

Additional Information

Remark and reason code changes approved by Medicare February 28, 2005 include:

Code Type	Code	New/ Modified/ Deactivated/ Retired	Current Narrative	Comment
Remark	N345	New	Date range not valid with units submitted	Not Medicare Initiated
Remark	N346	New	Missing/incomplete/invalid oral cavity designation code	Not Medicare Initiated
Remark	N347	New	Your claim for a referred or purchased service cannot be paid because payment has already been made for this same service to another provider by a payment contractor representing the payer.	Medicare Initiated
Remark	MA100	Modified	Missing/incomplete/invalid date of current illness or symptoms	Modified effective as of March 30, 2005.
Remark	MA128	Modified	Missing/incomplete/invalid FDA approval number	Modified effective on March 30, 2005.
Reason	166	New	These services were submitted after this payer's responsibility for processing claims under this plan ended.	New as of February, 2005.

Note: Typographic errors were also identified and corrected in reason codes 52, 57, 70, 76 and 146. No codes were retired.

Additional Information - 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/medlearn/RA_Guide_05-27-05.pdf

The official instruction issued to your FI/carrier/DMERC/RHHI regarding this change may be found by going to http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp. From that web page, look for CR3923 in the CR NUM column on the right, and click on the file for that CR. Please refer to your local Medicare contractor for more information about this issue. To find the toll free phone number, go to http://www.cms.hhs.gov/medlearn/tollnums.asp on the CMS web site.

Frequently Asked Questions

1. I remember reading something about the DMERC Information Form (DIF). Can you tell me where to locate this information?

   ANSWER: Current information regarding the DIF was published in the Summer 2005 DMERC Dialogue in the article entitled "Immuosuppressive Drugs - DIF Reinstated; Supply Fee Revised."

2. I have been billing an E0143 walker on a rental basis and my last claim was denied. Can you tell me why?

   ANSWER: In the absence of your specific claim details, we cannot accurately explain the denial. An E0143 walker is categorized as an Inexpensive or Other Routinely Purchased (IRP) item. Claims are processed as either a lump sum purchase or on a rental basis. Claims for rentals are paid up to the Medicare purchase allowable for the item. Your claim may have denied because it had previously reached the Medicare purchase allowable.

3. Can you tell me the covered diagnosis for a Medicare patient to receive eyeglasses?

   ANSWER: "Refractive lenses are covered when they are used to restore the vision normally provided by the natural lens of the eye of an individual lacking the organic lens because of surgical removal or congenital absence. Covered diagnoses are limited to pseudophakia (ICD-9 V43.1), aphakia (ICD-9 379.31), and congenital aphakia (ICD-9 743.35). Lenses provided for other diagnoses will be denied as noncovered." (Refractive Lenses Policy Article)

4. Why is my claim for the purchase of a TENS unit being denied?

   ANSWER: In the absence of your specific claim details, we cannot accurately explain the denial. When submitting claims for a TENS purchase, you should consider the following:

   In order for Medicare to cover the purchase of a TENS unit for chronic, intractable pain, a Medicare patient needs to complete at least a 30 day trial period for that item. After that trial period has been completed, the treating physician must determine that the patient will benefit from continuous use of that item over a long period of time. When you submit your claim for a TENS unit purchase, it requires a new CMN for that purchase. (Refer to the Transcutaneous Electrical Nerve Stimulators and Related Supplies policy for additional information.)

5. What type of Certificate of Medical Necessity (CMN) do I need to complete when adding a portable oxygen system to a CMN for a stationary unit?

   ANSWER: When a portable oxygen system is added subsequent to Initial Certification of a stationary system a revised CMN is required. (Refer to the Oxygen and Oxygen Equipment policy for additional information regarding coverage.)

6. Can you tell me how often Medicare will cover Therapeutic Shoes for Persons with Diabetes?

   ANSWER: "For patients meeting these criteria, coverage is limited to one of the following within one calendar year (January - December): 1) One pair of custom molded shoes (A5501) (which includes inserts provided with these shoes) and 2 additional pairs of inserts (K0628 or K0629); or 2) One pair of depth shoes (A5500) and 3 pairs of inserts (K0628 or K0629) (not including the non-customized removable inserts provided with such shoes)." (Refer to the Therapeutic Shoes for Persons with Diabetes policy for additional information regarding coverage.)

Frequently Asked Questions (cont'd)

7. I am billing for both G0371 and G0374 because I am giving the Medicare patient both a 30-day supply of one inhalation drug and a 90-day supply of another inhalation drug for the same date of service. Will I get paid for both fees?

   ANSWER: Both a G0371 and a G0374 dispensing fee are not covered on the same date of service. When a supplier dispenses a 90-day supply of one drug and a 30-day supply of another drug on the same day, code G0374 must be billed. (Spring 2005 DMERC Dialogue, "Dispensing Fees - Nebulizer Drugs")

8. I received a Medicare Remittance Notice (MRN) that showed interest had been paid. Can you tell me why interest was paid?

   ANSWER: Interest may be paid on a claim if the claim is not processed prior to the maximum time allowed by Medicare statute. (Refer to the DMERC Region D Supplier Manual, Chapter 6, "Clean Claims - Payments/Interest" for additional information.)

9. Can you tell me if a raised toilet seat is covered by Medicare?

   ANSWER: A raised toilet seat is a device that adds height to the toilet seat and can be a fixed height or adjustable. It can be attached to the toilet seat or unattached, resting on the bowl. This item is not primarily medical in nature and does not meet the definition of durable medical equipment. Therefore, it is denied for no benefit category. (Summer 2005 DMERC Dialogue, "Bathroom Aids - Raised Seats, Seat Lifts, and Lifts for Toilets.")

10. Do I need to get a new CMN when completing repairs on durable medical equipment?

    ANSWER: A new CMN and/or physician's order is not needed for repairs. (Refer to the DMERC Region D Supplier Manual, Chapter 3, "Repairs/Replacement Chart" and Chapter 5, "Repairs, Maintenance, and Replacement for details regarding documentation and coverage of repairs.)

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DMERC Region D Publications Designation Form

DMERC Region D quarterly publications are distributed via Internet (www.cignamedicare.com) and CD-ROM. The CD-ROM includes the *DMERC Dialogue*, *DMERC Region D Supplier Manual* and update and various other supplier resources. Suppliers may choose to receive a paper copy of the *DMERC Dialogue* only in lieu of a CD-ROM.

Suppliers with multiple sites and supplier numbers may choose to eliminate publication distribution to some or all of the sites by designating that one CD-ROM be mailed to the supplier's corporate address. The CD-ROM will be mailed to the designated "Mail To" address for the corporate office on the supplier's enrollment application.

Complete the applicable section(s) below to **change** the method of publications distribution preferred. You may also submit your request in writing on your company letterhead to: CIGNA Government Services, Communications Department, Two Vantage Way, Nashville, TN 37228 or by fax: 615.782.4445.

Request for Paper Copy – DMERC Dialogue (Opt-Out of CD-ROM distribution)

_____
SUPPLIER NUMBER

_____
SUPPLIER NAME

_____
ADDRESS

_____ _____ _____
CITY STATE ZIP

Reason for requesting paper version:
- ☐ No personal computer
- ☐ No CD-ROM drive
- ☐ Prefer paper copy
- ☐ Other _____

(List additional supplier numbers to be included in this request on the back of this form.)

Request for CD-ROM (Opt-In or return to CD-ROM distribution)

_____
SUPPLIER NUMBER

_____
SUPPLIER NAME

_____
ADDRESS

_____ _____ _____
CITY STATE ZIP

(List additional supplier numbers to be included in this request on the back of this form.)

Request for elimination of CD-ROM distribution to multiple sites-Corporate address designation

_____
SUPPLIER NUMBER TO REMAIN ON PUBLICATIONS MAIL LIST

_____
SUPPLIER NAME

_____
ADDRESS

_____ _____ _____
CITY STATE ZIP

- ☐ Eliminate CD-ROM for all supplier numbers with the same "mail to" address shown on this form. [When this option is selected all newly assigned supplier numbers will be included in this request.]
- ☐ Eliminate CD-ROM only for the supplier numbers listed on the back of this form.

(List supplier numbers to be excluded from the publications mail list on the back of this form.)

DMERC Region D Publications Designation Form (cont'd)

List additional supplier numbers to be included in the request on the front of this form.

SUPPLIER NUMBER(S):

SUPPLIER NUMBER(S):

The privacy of our customers is important to CIGNA Government Services. Personally identifying information that is collected will be used only in connection with the specified request. CIGNA Government Services will protect all personally identifying information, sensitive and non-sensitive, that you share with us.

DMERC Region D Publication Order Form

Name:

Company Name:

Address:

City:	**State:**	**Zip:**

Email:

Note: Government agencies, state associations, CMS, CIGNA employees and other insurance companies do not need to submit payment.

Subscription (4 quarterly publications) $40.00

Region D *DMERC Dialogue*_____ (quantity) ***Subtotal*** **$_____**

CD-ROM _____ (quantity) (Includes *DMERC Dialogue*, *DMERC Region D Supplier Manual* and updates and various other materials.) ***Subtotal*** **$_____**

Individual Publication Requests

Region D *DMERC Dialogue ($10.00 each issue)** (*Previous issues may include the supplier manual update.)

	Qty.	Year		Qty.	Year
Spring	_____	_____	Fall	_____	_____
Summer	_____	_____	Winter	_____	_____

Subtotal **$_____**

CD-ROM ($10.00 each)

	Qty.	Year		Qty.	Year
Spring	_____	_____	Fall	_____	_____
Summer	_____	_____	Winter	_____	_____

Subtotal **$_____**

DMERC Region D Supplier Manual
$40.00 per manual _____(quantity) ***Subtotal*** **$_____**

***DMERC Region D Supplier Manual Update** ($10.00 each)** (*Previous updates may include the *DMERC Dialogue.)*

	Qty.	Year		Qty.	Year
Spring	_____	_____	Fall	_____	_____
Summer	_____	_____	Winter	_____	_____

Subtotal **$_____**

NOTE: Beginning Spring 2003, hardcopies of supplier manual updates are no longer mailed and must be downloaded from our Web site at http://www.cignagovernmentservices.com/dmerc/dmsm/index.html. (Also, hardcopies are not available for the Summer and Fall 2002 updates, please download from the Web.)

DMERC DMEPOS Fee Schedule* ($10.00 each) (*DMERC DMEPOS suppliers do not need to submit payment for the fee schedule unless ordering more than one copy.)

Quantity_____ Year _____ ***Subtotal*** **$_____**

Total Amount Due **$_____**

Payment/Order Information

Checks or money orders should be made payable to CIGNA Government Services. Send completed order form and payment to:

Connecticut General Life Insurance Company
Attn: DMERC Publication Fulfillment Center
P. O. Box 360295
Pittsburgh, PA 15251-0295

If your order does not require a payment, send the completed order form to:

CIGNA Government Services
Attn: DMERC Region D Publications
P. O. Box 690
Nashville, TN 37202

If you have not billed CIGNA Government Services within the last 12 months, you will not be included on the current publication mailing list and will not receive your complementary CD-ROM or hardcopy *DMERC Dialogue*. Region D publications are available at http://www.cignagovernmentservices.com/dmerc/index.html.

(Rev. 07/2005)

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MEDICARE REDETERMINATION REQUEST FORM

DATE_____

Mail To: CIGNA Government Services
DMERC Region D
P. O. Box 22995
Nashville, TN 37202

PROVIDER INFORMATION	BENEFICIARY INFORMATION
Name	Name
Provider #	Medicare #
Address	Address
Phone # Area Code ( )	Phone # Area Code ( )

TYPE OF CLAIM: ☐DME ☐ Oxygen ☐ Supplies ☐ Orthotics ☐ Prosthetics ☐ ESRD ☐ PEN ☐ IV Therapy
☐ Other _____

CLAIM INFORMATION ☐ Assigned ☐ Non-Assigned

Service Date	HCPCS	Charge(s)	Claim Control Number	Denial Reason/ ANSI Code	Date of Initial Determination

REASON FOR REQUEST

SUPPORTING DOCUMENTATION

Please see the Summer 2000 *DMERC Dialogue* for additional documentation requirements.

_____ CMS 1500 Claim Form
_____ Medicare Summary Notice
_____ Advance Beneficiary Notice
_____ Medicare Remittance Notice
_____ Certificate of Medical Necessity
_____ Medical Documentation
Other_____

CONTACT INFORMATION

PROVIDER: (Contact Name and Signature)	BENEFICIARY: (Contact Name – Please Print)
Phone # ( )	Phone # ( )

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MEDICARE WRITTEN ADJUSTMENT REQUEST FORM

Mail To: CIGNA Government Services
DMERC Region D
P. O. Box 690
Nashville, TN 37202

DATE_____

PROVIDER INFORMATION	BENEFICIARY INFORMATION
Name	Name
Provider #	Medicare #
Address	Address
Phone # Area Code ( )	Phone # Area Code ( )

TYPE OF CLAIM: ☐ DME ☐ Oxygen ☐ Supplies ☐ Orthotics ☐ Prosthetics ☐ ESRD ☐ PEN ☐ IV Therapy
☐ Other _____

Service Date	HCPCS	Claim Control Number	Date of Initial Determination

REASON FOR REQUEST

SUPPORTING DOCUMENTATION

_____ CMS 1500 Claim Form
_____ Certificate of Medical Necessity
_____ Medical Documentation
_____ Medicare Remittance Notice
_____ Advance Beneficiary Notice
Other_____

CONTACT INFORMATION

PROVIDER: (Contact Name and Signature)	BENEFICIARY: (Contact Name – Please Print)
Phone # ( )	Phone # ( )

(Rev. 07/01/2005)

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved
OMB No. 0938-0626

AUTHORIZATION AGREEMENT FOR ELECTRONIC FUNDS TRANSFER (EFT)

Reason for Submission:
- ❑ New EFT Authorization
- ❑ Revision to Current Authorization *(i.e. account or bank changes)*
- ❑ EFT Termination Request

Chain Home Office:
- ❑ Check here if EFT payment is being made to the Home Office of Chain Organization *(Attach letter Authorizing EFT payment to Chain Home Office)*

Physician/Provider/Supplier Information

Physician's Name _____

Provider/Supplier Legal Business Name _____

_____

Chain Organization Name _____

Home Office Legal Business Name *(if different from Chain Organization Name)* _____

_____

Tax ID Number: *(Designate SSN* ❑ *or EIN* ❑*)* __ __ __ __ __ __ __ __ __

Doing Business As Name _____

Medicare Identification Number (*OSCAR, UPIN, or NSC only*) _____

Depository Information (Financial Institution)

Depository Name _____

Account Holder's Name _____

Street Address _____

City _____ State _____ Zip Code _____

Depository Telephone Number _____

Depository Contact Person _____

Depository Routing Transit Number *(nine digit)* __ __ __ __ __ __ __ __ __

Depositor Account Number _____

Type of Account *(check one)* ❑ Checking Account ❑ Savings Account

Please include a voided check, preprinted deposit slip, or confirmation of account information on bank letterhead with this agreement for verification of your account number.

Authorization

I hereby authorize the Medicare contractor, _____, hereinafter called the COMPANY, to initiate credit entries, and in accordance with 31 CFR part 210.6(f) initiate adjustments for any credit entries made in error to the account indicated above. I hereby authorize the financial institution/bank named above, hereinafter called the DEPOSITORY, to credit and/or debit the same to such account.

If payment is being made to an account controlled by a Chain Home Office, the Provider of Services hereby acknowledges that payment to the Chain Office under these circumstances is still considered payment to the Provider, and the Provider authorizes the forwarding of Medicare payments to the Chain Home Office.

If the account is drawn in the Physician's or Individual Practitioner's Name, or the Legal Business Name of the Provider/Supplier, the said Physician/Provider/Supplier certifies that he/she has sole control of the account referenced above, and certifies that all arrangements between the DEPOSITORY and the said Physician/Provider/Supplier are in accordance with all applicable Medicare regulations and instructions.

FORM CMS-588 (09/03)

This authorization agreement is effective as of the signature date below and is to remain in full force and effect until the COMPANY has received written notification from me of its termination in such time and such manner as to afford the COMPANY and the DEPOSITORY a reasonable opportunity to act on it. The COMPANY will continue to send the direct deposit to the DEPOSITORY indicated above until notified by me that I wish to change the DEPOSITORY receiving the direct deposit. If my DEPOSITORY information changes, I agree to submit to the COMPANY an updated EFT Authorization Agreement.

Signature Line

Authorized/Delegated Official Name *(Print)* _____

Authorized/Delegated Official Title _____

Authorized/Delegated Official Signature _____ Date _____

PRIVACY ACT ADVISORY STATEMENT

Sections 1842, 1862(b) and 1874 of title XVIII of the Social Security Act authorize the collection of this information. The purpose of collecting this information is to authorize electronic funds transfers.

The information collected will be entered into system No. 09-70-0501, titled "Carrier Medicare Claims Records," and No. 09-70-0503, titled "Intermediary Medicare Claims Records" published in the Federal Register Privacy Act Issuances, 1991 Comp. Vol. 1, pages 419 and 424, or as updated and republished. Disclosures of information from this system can be found in this notice.

Furnishing information is voluntary, but without it we will not be able to process your electronic funds transfer.

You should be aware that P.L. 100-503, the Computer Matching and Privacy Protection Act of 1988, permits the government, under certain circumstances, to verify the information you provide by way of computer matches.

Instructions for Completing the Authorization Agreement for EFT

The following instructions will guide you through the EFT Authorization process. If you are submitting multiple requests, a separate Authorization Agreement must be completed for each provider identification number (OSCAR, UPIN, or NSC). All EFT requests are subject to a 15-day pre-certification period in which all accounts are verified by the qualifying financial institution before any Medicare direct deposits are made. In the meantime, all payments will be mailed via hard copy checks directly to the "Pay To" address that the Medicare contractor currently has on file. Please contact the Provider Enrollment Unit to verify the "Pay To" address. This agreement must be completely filled out. Omission of any information will delay the processing of your request. If you have any questions, please contact your Medicare contractor. For a list of contractors see www.cms.hhs.gov/providers/enrollment/contacts/.

Please indicate your reason for completing this form: New EFT authorization; Change to your account information; or Termination of your EFT authorization.

If you are authorizing EFT payments to the Home Office of a Chain Organization of which you are a member, you must attach a letter authorizing the contractor to make payment due the provider of service to the account maintained by the Home Office of the Chain Organization. The letter must be signed by an authorized official of the provider of service and an authorized official of the chain home office.

Enter the Name of the Physician or Individual Practitioner, or the Legal Business Name of the Provider/Supplier as reported to the Internal Revenue Service (IRS). The account to which EFT payments are made must exclusively bear the Name of the Physician or Individual Practitioner, or the Legal Business Name of the person or entity enrolled with Medicare.

For EFT payments to the Home Office of a Chain Organization, the depository account must be established in the legal business name of the Home Office, and must match the Home Office name provided above on this form, as well as the Home Office name provided in the appropriate sections of the relevant Form CMS-855 (Provider/Supplier Enrollment Application).

Enter your Tax Identification Number as reported to the IRS. If the business is a corporation, provide the Federal Employer Identification Number (EIN), otherwise provide your SSN.

Enter your Medicare Identification Number. If you are a Part A Provider, or certified Supplier this will be your 6-digit OSCAR number. If you are enrolled as an individual practitioner or a group practice this will be the 6-position alphanumeric UPIN. If you are enrolled as a supplier of durable medical equipment, this will be the 10-digit National Supplier Clearinghouse number.

Enter your depository name (this is the name of the bank or qualifying financial institution that will receive the funds), address, name of a contact person, and contact person's telephone number.

Enter your electronic Routing Transit Number, Account Number, and the type of account in which deposits will be made (Checking or Saving). Attach a voided check, preprinted deposit slip, or confirmation of account information on bank letterhead for verification of your account number. The documentation on bank letterhead should confirm the name on the account, electronic routing transit number, account number and type, and the bank officer's name and signature.

If you do not submit this information, your EFT Authorization Agreement will be returned without further processing.

Read the Authorization carefully. By your signature on this form you are certifying:

1. That the account is drawn in the Name of the Physician or Individual Practitioner, or the Legal Business Name of the Provider/Supplier;
2. The Physician/Provider/Supplier has sole control of the account to which EFT deposits are made in accordance with all applicable Medicare regulations and instructions;
3. That all arrangements between the depository and the said Physician/Provider/Supplier are in accordance with all applicable Medicare regulations and instructions;
4. The effective date of the EFT authorization; and
5. That you will notify the Medicare contractor regarding any changes in the account in sufficient time to allow the contractor and the depository to act on the changes.

The EFT authorization form must be signed and dated by the same Authorized Representative or a Delegated Official named on Form CMS-855 which the Medicare contractor has on file.

Mail this form with the original signature (no Fax signatures can be accepted) to the Medicare Contractor that services your geographical area. For a listing of contractors, see www.cms.hhs.gov/providers/enrollment/contacts/.

Customer Service Available

Telephone Inquiries—Customer Service Agents are available from 8:00 am to 6:00 pm CST, Monday through Friday. The Interactive Voice Response (IVR) System is available any time as long as the mainframe system is functional.

IVR System*:* 877.320.0390 ***Supplier Help Line****:* 866.243.7272 ***Beneficiary Help Line****:* 1-800-MEDICARE (1-800-633-4227, Ask for Medical Supplies)

Paper Claim Submission & Written Inquiries:
CIGNA Government Services
DMERC Region D
PO Box 690
Nashville TN 37202

Review Requests:
CIGNA Government Services
DMERC Reviews
PO Box 22995
Nashville TN 37202

Hearing Requests:
CIGNA Government Services
DMERC Hearings
PO Box 22263
Nashville TN 37202

Local Medical Review Policies (LMRPs), Local Coverage Determinations (LCDs), and Policy Articles

LMRPs, LCDs and Policy Articles are available to view and download on the CIGNA Government Services Web site (http://www.cignagovernmentservices.com/dmerc/lmrp_lcd/index.html) and the Centers for Medicare & Medicaid Services (CMS) Web site (http://www.cms.hhs.gov/coverage). Region D maintains paper copies of current, previously revised, or retired policies. Paper copies of policies are available upon request by writing to: CIGNA Government Services, DMERC Region D, ATTN: Elesha Campbell, P.O. Box 690, Nashville, TN 37202; or call 866.243.7272.

Requests may also be made by contacting the CIGNA Government Services Online Help Center at http://www.cignagovernmentservices.com/dmerc/resource.html. Requests for retired policies must include the name of the policy and the date the desired policy was in effect. In addition, you must provide a contact name, phone number and an address to which the policy may be mailed. CIGNA Government Services regrets we will not be able to fax or e-mail copies of the retired policies to the requester.

Supplier Application Packages and Changes of Address—If you need a supplier number application package or if you have questions concerning supplier number requirements, contact the National Supplier Clearinghouse (NSC) at the following: National Supplier Clearinghouse, PO Box 100142, Columbia SC 29202-3142, Phone: 866.238.9652, Web site: www.palmettogba.com.

Also, remember that no checks will be issued if the address on file with the NSC is different than any forwarding order on file with the U.S. Postal Service. Please notify the NSC if you have an address change or are planning to move in the near future.

EDI—For information on implementing electronic claim transmission, including testing procedures, call our EDI representatives at 866.224.3094, or send us e-mail at www.cignagovernmentservices.com/customer_service.

Coding Questions—The Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) answers coding questions. Call 877.735.1326.

Overpayments/Refunds—When refunding a check, make it payable to CGLIC - Medicare and send it to:

CIGNA Federal Insurance Benefits—DMERC
PO Box 10927
Newark NJ 07193–0927

DMERC Dialogue *...a service of*

CIGNA Government Services
DMERC Region D
PO Box 690
Nashville TN 37202

Region D DMERC Serves. . .

Alaska, American Samoa, Arizona, California, Guam, Hawaii, Idaho, Iowa, Kansas, Mariana Islands, Missouri, Montana, Nebraska, Nevada, North Dakota, Oregon, South Dakota, Utah, Washington, Wyoming

The *DMERC Dialogue*, together with occasional special releases, serves as legal notice to suppliers concerning responsibilities and requirements imposed upon them by Medicare law, regulations, and guidelines.

CIGNA Government Services does not review or control the content and accuracy of Web sites referenced in this newsletter (except the CIGNA Government Services Web site) and is therefore not responsible for their content and accuracy.