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

Electronic Funds Transfer (EFT) Enrollment – Important Reminder

CIGNA Government Services reminds any supplier that has not submitted a valid EFT Authorization Agreement (CMS-588) form to CIGNA Government Services to do so as soon as possible. EFT Authorization Agreements between suppliers and other Medicare contractors are not transferable to CIGNA Government Services. To access the form, visit [http://www.cignagovernmentservices.com/jc/forms/pdf/JC_EFT_form.pdf](http://www.cignagovernmentservices.com/jc/forms/pdf/JC_EFT_form.pdf). Failure to submit this form may result in termination of EFT payments and payments being withheld. Suppliers who submit a form that is rejected due to missing or incorrect information must resubmit the entire corrected form. Common errors that cause forms to be rejected include:

- Multiple suppliers are listed on a single form. Use a separate form for each supplier (PTAN) number.
- The contractor name in Section V is not CIGNA Government Services.
- The Medicare Identification Number is not provided or is not valid.
- The authorized signature is missing.
- Banking information on the form does not match the voided check or deposit slip.
- Neither of the following forms of banking information is provided
  - Voided check
  - Confirmation of account information on bank letterhead.

To submit a question about EFT applications, use the Online Help Center located at [www.cignagovernmentservices.com](http://www.cignagovernmentservices.com).
Modifier A1-A9 Reminder

CIGNA Government Services (CGS) edits claims for review to ensure that coverage, reimbursement and documentation requirements in National and Local Coverage Determinations (NCDs and LCDs) and in CMS interpretive manuals (i.e., Internet Only Manuals) are met. This includes proper use of the A1-A9 modifiers which provides the number of wounds that should be utilized for surgical dressing supplies. CGS has noticed a trend where the A1 - A9 modifier is being left off of claims, which is resulting in unnecessary claim denials. To avoid unnecessary claim denials, refer to the Documentation Requirements section of each LCD.

Code A4595 - Medically Unlikely Edit (MUE) Postponed

CMS and its MUE contractor, Correct Coding Solutions, LLC, have determined that the MUE for HCPCS code A4595 should not have been implemented July 1, 2007. CMS has authorized the DME MACs to postpone the implementation of the MUE for code A4595 pending further review by the MUE contractor.

CIGNA Government Services has inactivated the MUE for code A4595. Claims denied as the result of this edit will be re-evaluated. Adjustment of inappropriately denied claims will occur within the next week. Suppliers should not request adjustments to correct these denials.

IVR Enhancement - Payment Floor Information by Claim Now Available

CIGNA Government Services has heard your feedback and has made changes to enhance the offerings of our Interactive Voice Response (IVR) system. A feature was added to the IVR that provides suppliers with the total number of claims, the total submitted amount, and the total expected payment amount of all claims residing on the payment floor for a particular PTAN. This is similar to the Pending Claim information that was provided by Palmetto GBA IVR under the Financial Information section. To access this feature, choose option 3 from the IVR Main Menu and option 4 from the Payment Information menu.

Now suppliers may also receive payment floor information on an individual claim bases. The Claim Status option of the IVR has been enhanced to inform suppliers if a claim is residing on the payment floor and the expected payment amount and expected check receipt date for that claim. To access Claim Status, choose option 1 from the IVR Main Menu and option 1 from the Claim Information menu.

Attached is an updated summary flow chart that should help provide guidance on how to navigate the IVR. (Page 34)

Telephone Reopenings Update

The CIGNA Government Services DME MAC Jurisdiction C telephone reopening line operational hours are 8:00 a.m. - 11:00 a.m. and 12:00 p.m. - 4:00 p.m., Central Standard Time. The telephone reopening line is partially available so that resources can aid with the high volume of calls to our call center. To minimize impact to suppliers, CIGNA Government Services will continue to accept faxed request for a re-opening. You can fax or mail your request by using the Medicare DME MAC Jurisdiction C Reopening Request form that is found at www.cignagovernmentservices.com Web site under the DME MAC Jurisdiction C link. Reopening request submitted via fax should be sent to 615.782.4505.
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- Changes to the Mandatory Medigap (“Claim-Based”) Crossover Process  
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- Negative Pressure Wound Therapy LCD Documentation  
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- LCD Revisions Summary Article July 2007  
- Power Mobility Devices - Frequently Asked Questions (FAQs) - July 2007  
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Update of Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) and Enhancement of Medicare Remit Easy Print (MREP)

MLN Matters Number: MM5634
Related Change Request (CR) #: 5634
Related CR Release Date: June 15, 2007
Effective Date: July 1, 2007
Related CR Transmittal #: R1267CP
Implementation Date: July 2, 2007

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

Provider Action Needed
This article is based on Change Request (CR) 5634 which instructs Medicare contractors that a Remittance Advice Remark Code (RARC) must be used with Claim Adjustment Reason Codes (CARCs) 16, 17, 96, 125, and A1. CR5634 also instructs that updated Medicare Remit Easy Print (MREP) software will be provided which incorporates enhancements approved by the Centers for Medicare & Medicaid Services (CMS) and the currently valid Claim Adjustment Reason and Remittance Advice Remark Codes.

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

Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) Update
As a reminder, Medicare policy states that:

- Claim Adjustment Reason Codes (CARCs) are required in the remittance advice and coordination of benefits transactions, and
- Remittance Advice Remark Codes (RARCs) are required in the remittance advice for both paper and electronic formats.
- When the payment differs from the amount being billed, Payers communicate the reason for any adjustment using:
  - Group Codes (which identify who is financially responsible for the amount that the payer is not reimbursing),
  - CARCs (which provide an explanation why an amount is being adjusted), and
  - RARCs (which provide a supplemental explanation about the adjustment) Any RARC that has the word “Alert” is an informational remark code that does not provide any supplemental explanation for a specific adjustment but provides general information related to adjudication.

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

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

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

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

<table>
<thead>
<tr>
<th>CARC</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>16</td>
<td>Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)</td>
</tr>
<tr>
<td>17</td>
<td>Payment adjusted because requested information was not provided or was insufficient/incomplete. Additional information is supplied using the remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)</td>
</tr>
<tr>
<td>96</td>
<td>Non-covered charge(s). This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)</td>
</tr>
<tr>
<td>125</td>
<td>Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>CARC</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>A1</td>
<td>Claim denied charges</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>CARC</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>204</td>
<td>This service/equipment/drug is not covered under the patient’s current benefit plan</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>CARC</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>N130</td>
<td>Consult plan benefit documents for information about restrictions for this service</td>
</tr>
</tbody>
</table>

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

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

### Medicare Remit Easy Print (MREP) Enhancement

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

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

### Additional Information

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

If you have any questions, please contact your Medicare carrier, FI, RHHI, A/B MAC, or DME MAC at their toll-free number, which may be found on the CMS website at [http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip](http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip).
Medicare Contractor Annual Update of the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)

MLN Matters Number: MM5643
Related Change Request (CR) #: 5643
Related CR Release Date: June 15, 2007
Effective Date: October 1, 2007
Related CR Transmittal #: R1269CP
Implementation Date: October 1, 2007

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

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

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

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

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

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

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

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

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

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

Appeals Transition - BIPA
Section 521 Appeals

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

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

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

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

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

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

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

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

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

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

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

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

Additional Information
The official instruction, CR5460, issued to your Medicare contractor regarding this change may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R1274CP.pdf on the CMS website. The revised portions of the Medicare Claims Processing Manual are attached to that CR. If you have any questions, please contact your Medicare contractor at their toll-free number, which may be found on the CMS website at http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip on the CMS website.

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

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

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

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

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

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

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

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

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

ASP Methodology
Beginning January 1, 2005, the payment allowance limits for Medicare Part B drugs and biologicals that are not paid on a cost or prospective payment basis are 106 percent (106%) of the ASP. Beginning January 1, 2006, payment allowance limits are paid based on 106 percent (106%) of the ASP for the following:
The payment allowance limits for blood and blood products (other than blood clotting factors) that are not paid on a prospective payment basis are 95 percent (95%) of the average wholesale price (AWP) as reflected in the published compendia. The payment allowance limits will not be updated in 2007. Payment allowance limits for infusion drugs furnished through a covered item of durable medical equipment (DME) that were not listed in the published compendia as of October 1, 2003, (i.e., new drugs) are 95 percent (95%) of the first published AWP unless the drug is compounded.

The payment allowance limits for influenza, Pneumococcal and Hepatitis B vaccines are 95 percent of the AWP as reflected in the published compendia except where the vaccine is furnished in a hospital outpatient department and, then, is paid at reasonable cost.

The payment allowance limits for drugs and biologicals that are not included in the ASP Medicare Part B Drug Pricing File or Not Otherwise Classified (NOC) Pricing File, other than new drugs that are produced or distributed under a new drug application approved by the Food and Drug Administration, are based on the published wholesale acquisition cost (WAC) or invoice pricing, except under OPPS where the payment allowance limit is 95 percent of the published AWP. The payment limit is 100 percent of the lesser of the lowest-priced brand or median generic WAC. For 2006, the blood clotting furnishing factor of $0.146 per I.U. is added to the payment amount for the blood clotting factor when the blood clotting factor is not included on the ASP file.

The payment allowance limits for new drugs and biologicals that are produced or distributed under a new drug application (or other new application) approved by the Food and Drug Administration and that are not included in the ASP Medicare Part B Drug Pricing File or Not Otherwise Classified (NOC) Pricing File are based on 106 percent of the WAC, or invoice pricing if the WAC is not published, except under OPPS where the payment allowance limit is 95 percent of the published AWP. This policy applies only to new drugs that were first sold on or after January 1, 2005.

The payment allowance limits for radiopharmaceuticals are not subject to ASP. Medicare contractors determine payment limits for radiopharmaceuticals based on the methodology in place in November 2003 in the case of radiopharmaceuticals furnished in other than the hospital outpatient department. Radiopharmaceuticals furnished in the hospital outpatient department are paid charges reduced to cost by the hospital’s overall cost to charge ratio.

On or after June 19, 2007, revised January 2007 and April 2007 ASP payment files and the July 2007 ASP file will be available for retrieval from the CMS ASP webpage. The payment limits included in the revised ASP and NOC payment files supersede the payment limits for these codes in any publication published prior to this document. The CMS ASP webpage is located at http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/ on the CMS website. The revised files are applicable to claims based on dates of service as shown in the following table:

<table>
<thead>
<tr>
<th>Payment Allowance Limit Revision Date</th>
<th>Applicable Dates of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>July 2007</td>
<td>July 1, 2007 through September 30, 2007</td>
</tr>
<tr>
<td>April 2007</td>
<td>April 1, 2007 through June 30, 2007</td>
</tr>
</tbody>
</table>

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

Drugs Furnished During Filling or Refilling an Implantable Pump or Reservoir

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

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

**Additional Information**

The official instruction (CR5646) issued to your Medicare carrier, FI, A/B MAC, DME MAC, DMERC, or RHHI is available at [http://www.cms.hhs.gov/Transmittals/downloads/R1270CP.pdf](http://www.cms.hhs.gov/Transmittals/downloads/R1270CP.pdf) on the CMS web site. If you have questions, please contact your Medicare carrier, FI or A/B MAC, DME MAC, DMERC or RHHI at their toll-free number which may be found at: [http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip](http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip) on the CMS website.

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**Electronic Funds Transfer Standardizations and Revisions to the Medicare Claims Processing Manual (Chapter 24)**

MLN Matters Number: MM5586
Related Change Request (CR) #: 5586
Related CR Release Date: July 9, 2007
Effective Date: July 1, 2007
Related CR Transmittal #: R1284CP
Implementation Date: October 1, 2007

**Provider Types Affected**

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

**Provider Action Needed**

STOP – Impact to You

This article is based on Change Request (CR) 5586 which revises the Medicare Claims Processing Manual, Chapter 24 (General Electronic Data Interchange (EDI) and EDI Support Requirements, Electronic Claims and Coordination of Benefits Requirements, Mandatory Electronic Filing of Medicare Claims).

CAUTION – What You Need to Know

Effective July 1, 2007, your Medicare contractor will conduct Administrative Simplification Compliance Act (ASCA) reviews annually of at least 20% of providers submitting CMS 1500 paper claims who were not already reviewed in the past 2 years and found to have fewer than 10 FTEs employed by the practice. In addition, contractors will insure that the addenda record is sent with the Medicare claim payment when an ACH format is used to transmit an EFT payment to a financial institution but the remittance advice is separately transmitted to a provider. This will assist with reconciliation of the payment and the information that explains the payment. The EFT format will be the National Automated Clearinghouse Association (NACHA) format CCP - Cash Concentration/Disbursement plus Addenda (CCD+) (ACH) as mentioned in the X12N 835 version 004010A1 implementation guide.

GO – What You Need to Do

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

**Background**

Change Request (CR) 5586 provides the following revisions to the Medicare Claims Processing Manual (Chapter 24, Sections 40.7 and Section 90.5.3) regarding electronic funds transfer (EFT) and the identification of providers to be reviewed.

Contractor Roles in Administrative Simplification Compliance Act (ASCA) Reviews and Identification of Providers to be Reviewed Each carrier, DME MAC and B MAC (not FIs or RHHIs at this time) conducts an ASCA review annually of 20% of those providers still submitting CMS 1500 paper claims. Medicare contractors will not select a provider for a quarterly review if:

- A prior quarter review is underway and has not yet been completed for that provider;
- The provider has been reviewed within the past two years, determined to be a “small” provider as fewer than 10 FTEs are employed in that practice and there is no reason to expect the provider’s "small" status
Electronic Funds Transfer (EFT)
Although EFT is not mandated by the Health Insurance Portability and Accountability Act (HIPAA), EFT is the required method of Medicare payment for all providers entering the Medicare program for the first time and any existing providers, not currently receiving payments by EFT, who are submitting a change to their existing enrollment data. Providers must submit a signed copy of Form CMS-588 (Electronic Funds Transfer Authorization Agreement) to their Carriers, DME MACs, A/B MACs, FIs, and/or RHHIs. For changes of information, DME MACs will verify the authorized official on the CMS-855 form. In addition, Medicare contractors will not approve any requests to change the payment method from EFT to check. Carriers, DME MACs, A/B MACs, FIs and RHHIs must use a transmission format that is both economical and compatible with the servicing bank. If the money is traveling separately from an X12 835 transaction, then the NACHA format CCP (Cash Concentration/Disbursement plus Addenda –CCD+) is used to make sure that the addenda record is sent with the EFT, because providers need the addenda record to re-associate dollars with data. Carriers, DME MACs, A/B MACs, FIs, and RHHIs must:

- Transmit the EFT authorization to the originating bank upon the expiration of the payment floor applicable to the claim, and
- Designate a payment date (the date on which funds are deposited in the provider’s account) of two business days later than the date of transmission.

Note: Medicare contractors will not approve any requests to change payment method from EFT to check.

Additional Information
The official instruction, CR5586, issued to your carrier, intermediary, RHHI, A/B MAC, or DME MAC regarding this change may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R1284CPpdf on the CMS website. If you have any questions, please contact your Medicare carrier, intermediary, RHHI, A/B MAC, or DME MAC at their toll-free number, which may be found on the CMS website at http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip.

Revision to Medicare Publication 100-09, Chapter 3 – Provider Inquiries and Chapter 6 - Provider Customer Service Program Updates
MLN Matters Number: MM5597
Revised Related Change Request (CR) #: 5597
Related CR Release Date: July 13, 2007
Effective Date: May 23, 2007
Related CR Transmittal #: R20COM
Implementation Date: July 30, 2007

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

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

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

**Overlapping Claims—New Rules**

- Medicare often receives multiple claims for the same beneficiary with the same or similar dates of service. An overlap occurs when the date of service or billing period of one claim seems to conflict with the date on another claim, indicating that one of the claims may be incorrect.
- When an inquiry regarding an overlapping claim is received, only the Medicare contractor initially contacted by the provider can authenticate the provider. The provider will be authenticated by verifying the name, PTAN/legacy number or NPI, beneficiary name, Health Insurance Claim Number (HICN), and date of service for post-claim information, or date of birth for pre-claim information. Authentication does not need to be repeated when the second contractor is contacted.
- Contractors shall release overlapping claim information whether a provider inquires about a claim that was rejected for overlapping information, or if the provider found overlapping information when checking eligibility for a new admittance.

**Information Available on the IVR**

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

**Information Available on the Remittance Advice (RA)**

- USE THE RA whenever possible. If a CSR or written inquiry correspondent receives an inquiry about information that is available on an RA, the CSR/correspondent will discuss with the inquirer how to read the RA in order to independently find the needed information. The CSR/correspondent will inform the inquirer that the RA is necessary in order to answer any specific questions for which the answers are available on the RA. Providers should also be aware that any billing staff or representatives that make inquiries on his/her behalf will need to have a copy of the RA.

- To make your job easier you may use the Medicare Remit Easy Print (MREP) software. Information about MREP is available at: http://www.cms.hhs.gov/AccessToDataApplication/02_MedicareRemitEasyPrint.asp on the CMS website.
- Providers may also take advantage of national training materials available to educate themselves and their representatives about reading an RA. The national training materials include the MLN product, Understanding the Remittance Advice: A Guide for Medicare Providers, Physicians, Suppliers, and Billers which is available at http://www.cms.hhs.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf on the CMS website.
- Also available is a website that serves as a resource allowing providers to check the definitions of Claim Adjustment Reason Codes and Remittance Advice Remark Codes. This information is available at http://www.wpc-edi.com/products/codelists/alertservice on the Washington Publishing Company website.
- There is a web-based training course, Understanding the Remittance Advice for Professional Providers, which is available at: http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5 on the CMS website. The course provides continuing education credits and contains general information about RAs, instructions to help interpret the RA received from Medicare and reconcile it against submitted claims, instructions for reading Electronic Remittance Advices (ERAs) and Standard Paper Remittance Advices, and an overview of the MREP software that Medicare provides free to providers for viewing ERAs.

**Authentication of Beneficiary Elements—additions to current rules.**

CR5597 contains, within its attachments, a detailed table showing the data elements that are released in response to provider inquiries for beneficiary information. A key new provision allows Medicare contractors to release abdominal aortic aneurysm screening information to providers. CR5597 is available at http://www.cms.hhs.gov/Transmittals/downloads/R20COM.pdf on the CMS website.

**Additional Key Points of CR5597**

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

Additional Information
For complete details regarding this Change Request (CR) please see the official instruction (CR5597) issued to your Medicare carrier, FI, A/B MAC, DME MAC, or RHHI. That instruction may be viewed by going to http://www.cms.hhs.gov/Transmittals/downloads/R20COM.pdf on the CMS website. If you have questions, please contact your Medicare carrier, FI or A/B MAC, DME MAC, or RHHI at their toll-free number which may be found at http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip on the CMS website.

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

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

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

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

Basic Instructions
All suppliers submitting a bid must:

- Be in good standing and have an active National Supplier Clearinghouse number (NSC#);
- Meet any local or State licensure requirements, if any, for the item being bid;
- Be accredited or be pending accreditation. CMS cannot accept a bid from any supplier that is not accredited or that has not applied for accreditation. The accreditation deadline for the first round of competitive bidding is August 31, 2007. Suppliers should apply for accreditation immediately to allow adequate time to process their applications. (For a listing of CMS-approved accrediting organizations, please visit http://www.cms.hhs.gov/CompetitiveAcqforDMEPOS/downloads/DMEPOS_Accreditation_Organizations.pdf on the CMS Web site. MLN Matters article SE0713 provides additional information on accreditation and is located at http://www.cms.hhs.gov/MLNMattersArticles/downloads/13.pdf SE07); and
- Complete initial registration in the internet application (Individuals Authorized Access CMS computer Services, IACS) to get a USER ID and password.

Suppliers need to complete this initial registration process early to avoid delays in being able to submit bids. The

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

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

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

Provider Action Needed
This Special Edition (SE) article, SE0714, outlines the pre-bidding activities that DME suppliers need to follow in order to participate in the Medicare DMEPOS Competitive Bidding Program.
initial registration process requires the authorized official, as identified in Section 15 of the CMS 855S, to complete the information required in the internet application. The authorized official's information must match the information on file at the National Supplier Clearinghouse. To complete this initial registration and obtain a USER ID and password, please go to https://applications.cms.hhs.gov.

All suppliers submitting a bid should:

- Review MLN Matters article SE0717, Initial Supplier Registration for Competitive Bidding Program is Now Open, which provides important information about the registration process. SE0717 can be viewed at http://www.cms.hhs.gov/MLNMattersArticles/downloads/17.pdf SE07 on the CMS website;
- Review the information in the Bid Application Tool Kit to facilitate a better understanding of the bidding process and rules. This information is located on the CBIC website at http://www.dmecompetitivebid.com/cbic/cbic.nsf/(subpages)/CBICSuppliersBid%20Application%20Tool%20Kit;
- View the educational webcast to learn more about the Medicare DMEPOS Competitive Bidding Program and detailed information on the bid application process. This information is located on the CBIC website at http://www.dmecompetitivebid.com/cbic/cbic.nsf/(subpages)/CBICSuppliersEducational%20Tools and CMS encourages you to register to receive updates on the Competitive Bidding Program. You may do so by going to http://www.cms.hhs.gov/apps/mailinglists on the Web.

Additional Information

MLN Matters article SE0713, Accreditation Information for Suppliers of Durable Medical Equipment, Orthotics, Prosthetics, and Supplies (DMEPOS), relates to this article and provides an overview of the Medicare Modernization Act legislation and how it impacts this competitive bidding program. It also outlines the quality standards for suppliers, describes the status of accreditation, and provides the web addresses of the ten accrediting organizations. SE0713 can be viewed at http://www.cms.hhs.gov/MLNMattersArticles/downloads/13.pdf SE07 on the CMS website. Another article, MM5574, provides more overview information regarding the DMEPOS Competitive Bidding Program and that article is at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5574.pdf on the CMS site.
Background
As Medicare begins to implement the NPI into its systems, several enumeration and billing errors have been identified that may result in claim rejections.

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

- Errors in Employer Identification Number (EIN): As a reminder, providers that are organizations are required to report the EIN when they apply for an NPI (on-line, paper, and electronic file interchange (EFI)). That EIN may also be the Taxpayer Identification Number (TIN). With the revised NPI Application/Update Form (CMS-10114) (to be used beginning July 10, 2007, for on-line, paper, and EFI), organizations that are subparts will be required to report the legal business name (LBN) of their “parent” and the “parent’s” TIN. The applicant will continue to be required to report its EIN. If the EIN error is on the Medicare provider enrollment record, the provider should submit a CMS-855 to the Medicare contractor to correct it.

- Invalid or incomplete data within the ‘Other Provider Identifiers’ section of the NPPES online application, such as:
  - The absence of the Medicare legacy number,
  - Not having the ‘Type’ listed as Medicare for a Medicare provider number, and/or
  - Reporting Medicare provider numbers that do not belong to the provider applying for the NPI and, therefore, should not be linked to the assigned NPI.

- Reporting an Incomplete Identifier: Medicare providers/suppliers need to ensure that, if reporting their Medicare legacy identifiers to NPPES, they report the full identifier. This means that suffixes to the OSCAR/Certification Numbers are to be reported. If the full identifier is not reported, it will be impossible for Medicare to establish the linkage from the NPI to that particular Medicare legacy identifier when using NPPES data and the NPI crosswalk.

- Having More than the Allowable Number of Legacy Numbers: At the present time, the NPPES can capture a grand total of 20 “Other Provider Identification Numbers.” While this adequately accommodates the majority of providers/suppliers, it does not accommodate all of them. NPPES will be expanded to capture more than 20 “Other Provider Identification Numbers” at a future date. Medicare providers/suppliers who have more than 20 Medicare legacy identifiers that need to be linked directly to the NPI to be assigned should contact their Medicare fee-for-service contractors to determine how best to inform those contractors of all of the Medicare legacy identifiers.

- Listing Legacy Numbers that Do Not Belong to the Applicant: The provider/supplier should make sure that any Medicare legacy identifier(s) (OSCAR/Certification Number, Provider Identification Number (PIN), Unique Physician Identification Number (UPIN), and National Supplier Clearinghouse (NSC) Number) entered in that field in NPPES are those that will need to be linked directly to the NPI to be assigned. That is, do not list in the “Other Provider Identification Numbers” section identifiers that belong to providers other than the one that is applying for the NPI. Specific examples follow in the “Do’s and Don’ts” section below.

Dos and Don’ts When Reporting “Other Provider Identification Numbers” in NPPES

- For a Medicare physician or other practitioner applying for an NPI: DO include your UPIN (if one was assigned) and your PIN when applying for an NPI. DO NOT include the PIN of your group practice or clinic if you are affiliated with a group practice or clinic.

- For a Medicare group practice or clinic applying for an NPI: DO include your PIN. DO NOT include the PINs or UPINs of any of the members of the group practice or clinic.

- For a Medicare pharmacy that is enrolled as both a pharmacy and a DME supplier that is applying for an NPI as a pharmacy/DME supplier: DO include both NSC Numbers (pharmacy and DME supplier). For a Medicare pharmacy that is enrolled as both a pharmacy and a DME supplier that is applying for an NPI as a pharmacy: DO include the NSC number assigned to the pharmacy, but DO NOT include the NSC number assigned to the DME supplier.

- For a Medicare pharmacy that is applying for an NPI as a DME supplier: DO include the NSC Number assigned to the DME supplier. DO NOT include the NSC Number assigned to the pharmacy.

- For a Medicare hospital swing bed unit that is applying for an NPI as a swing bed unit: DO include the OSCAR/Certification Number assigned to the swing bed unit. DO NOT include the OSCAR/Certification Number assigned to the hospital.

- For a Medicare hospital that is applying for an NPI but does not want swing bed units or rehabilitation units (if they have these units) to have their own NPIs: DO include the OSCAR/Certification number assigned to the hospital and the OSCAR/Certification Numbers assigned to both the swing bed unit and the rehabilitation unit.

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

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

Common Error in Reporting Change of Ownership to Medicare

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

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

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

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

Below is a guide to use when submitting primary NPI’s:

<table>
<thead>
<tr>
<th>Name/Loop</th>
<th>Legacy Information</th>
<th>NPI Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Billing Provider 2010AA Loop</td>
<td>OSCAR</td>
<td>Provider NPI</td>
</tr>
<tr>
<td>Pay to Provider 2010AB Loop</td>
<td>OSCAR</td>
<td>Provider NPI</td>
</tr>
<tr>
<td>Attending Physician 2310A Loop</td>
<td>PIN, UPIN</td>
<td>Provider NPI</td>
</tr>
<tr>
<td>Operating Physician 2310B Loop</td>
<td>PIN, UPIN</td>
<td>Physician NPI</td>
</tr>
</tbody>
</table>

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

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

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

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

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>32104</td>
<td>The NPI and the legacy (OSCAR) number are present on the claim and the NPI is present in the Crosswalk File, but the associated legacy (OSCAR) number in the Crosswalk file does not match the legacy (OSCAR) number on the claim. Please verify billing number and, if appropriate, correct. ***Online providers – Press PF9 to store the claim. ***Other providers – Return to the intermediary.</td>
</tr>
<tr>
<td>32105</td>
<td>The NPI is present in the Crosswalk File but the NPI corresponds to more than one legacy (OSCAR) number. Enter the OSCAR number associated with the NPI submitted. Please verify billing number and, if appropriate, correct. ***Online providers – Press PF9 to store the claim. ***Other providers – Return to the intermediary.</td>
</tr>
<tr>
<td>32107</td>
<td>The NPI for the attending physician on the claim is not present in the Crosswalk File. Please verify billing number and, if appropriate, correct. ***Online providers – Press PF9 to store the claim. ***Other providers – Return to the intermediary.</td>
</tr>
<tr>
<td>32108</td>
<td>The attending physician’s NPI and UPIN are present on the claim and the attending physician’s NPI is present in the Crosswalk File, but the attending physician’s UPIN in the Crosswalk File does not match the attending physician’s UPIN on the claim. Please verify the UPIN and, if appropriate, correct. ***Online providers – Press PF9 to store the claim. ***Other providers – Return to the intermediary.</td>
</tr>
<tr>
<td>32109</td>
<td>The operating physician’s NPI on the claim is not present in the Crosswalk File. Please verify billing number and, if appropriate, correct. ***Online providers – Press PF9 to store the claim. ***Other providers – Return to the intermediary.</td>
</tr>
<tr>
<td>32110</td>
<td>The operating physician’s NPI and UPIN are present on the claim and the operating physician’s NPI is present in the Crosswalk File, but the operating physician’s UPIN in the Crosswalk File does not match the operating physician’s UPIN on the claim. Please verify the UPIN and, if appropriate, correct. ***Online providers – Press PF9 to store the claim. ***Other providers – Return to the intermediary.</td>
</tr>
<tr>
<td>32111</td>
<td>The other physician NPI on the claim is not present in the Crosswalk File. Please verify the billing number and, if appropriate, correct. ***Online providers – Press PF9 to store the claim. ***Other providers – Return to the intermediary.</td>
</tr>
<tr>
<td>32112</td>
<td>The other physician’s NPI and UPIN are present on the claim and the other physician’s NPI is present in the Crosswalk File, but the other physician’s UPIN in the Crosswalk File does not match the other physician’s UPIN on the claim. Please verify the UPIN and, if appropriate, correct. ***Online providers – Press PF9 to store the claim. ***Other providers – Return to the intermediary.</td>
</tr>
<tr>
<td>32113</td>
<td>The taxonomy code entered is invalid. Or, a taxonomy code is required when the NPI is present in the Crosswalk File and the NPI corresponds to more than one legacy (OSCAR) number. Please verify the billing number and, if appropriate, correct. ***Online providers – Press PF9 to store the claim. ***Other providers – Return to the intermediary.</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Edit Number</th>
<th>Loop</th>
<th>Edit Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99</td>
<td>2010AA</td>
<td>The NPI/Legacy combination does not match the NPI crosswalk.</td>
</tr>
<tr>
<td>99</td>
<td>2010AB</td>
<td>The NPI/Legacy combination does not match the NPI crosswalk.</td>
</tr>
<tr>
<td>99</td>
<td>2310A,B,C</td>
<td>The NPI/Legacy combination does not match the NPI crosswalk.</td>
</tr>
<tr>
<td>99</td>
<td>2420A</td>
<td>The NPI/Legacy combination does not match the NPI crosswalk.</td>
</tr>
</tbody>
</table>

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

For providers who submit electronic professional claims to Medicare Part B carriers and A/B MACs, CMS test data indicates that a high volume of claims have been received where the NPI/legacy identifier combinations cannot be validated by the Medicare NPI crosswalk.
Even if you have validated your NPPES data, failure to properly submit the NPI in the correct loops may cause the claim to reject. Group providers should utilize the GROUP NPI in the 2010AA or 2010AB loop. The INDIVIDUAL or MEMBER OF GROUP NPI should only be submitted in the 2310B or 2420A loops.

Below is a guide to use when submitting primary NPI's:

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

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

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

<table>
<thead>
<tr>
<th>Edit Number</th>
<th>Loop</th>
<th>Edit Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>M340</td>
<td>2010AA</td>
<td>The NPI/Legacy combination does not match the NPI crosswalk.</td>
</tr>
<tr>
<td>M341</td>
<td>2010AB</td>
<td>The NPI/Legacy combination does not match the NPI crosswalk.</td>
</tr>
</tbody>
</table>

**Important Reminders Regarding 835 Remittance Advice Changes Effective July 2, 2007 for DME Suppliers Submitting**

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

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

When you do not report your NPI, but report your legacy National Supplier Clearinghouse (NSC) number on a claim, Medicare will continue to report legacy numbers in generating your remittance advice. Further information regarding the remittance changes may be found in CR5452, which is at http://www.cms.hhs.gov/Transmittals/downloads/R1241CP.pdf or in the related MLN Matters article, MMS5452, at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5452.pdf on the CMS website. Important NOTE: The 835 Remittance Advice changes listed above will be effective for other providers submitting Part A Institutional claims and Part B Professional claims, at a later date. Medicare will notify submitters when a date is determined.
Additional Information
You may also want to review MLN Matters article SE0679, which has additional information on the overall NPI activity. This article is at http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0679.pdf on the CMS website. Important information regarding current NPI implementation contingency plan is in article MM5595, which is available at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5595.pdf. If you have any questions, please contact your Medicare contractor at their tollfree number, which may be found at http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip on the CMS website.

Clarification About the Medical Privacy of Protected Health Information
MLN Matters Number: SE0726
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

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

Provider Action Needed
The purpose of this Special Edition (SE) article, SE0726, is be sure that health care providers are aware of the helpful guidance and technical assistance materials the U.S. Department of Health and Human Services (HHS) has published to clarify the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), specifically, the educational material below.

- Remind individuals within your organization of:
  - the Privacy Rule’s protections for personal health information held by providers and the rights given to patients, who may be assisted by their caregivers and others, and
  - that providers are permitted to disclose personal health information needed for patient care and other important purposes.

HHS’ educational materials include a letter to healthcare providers with the following examples to clarify the Privacy Rule:

**HIPAA does not require patients to sign consent forms before doctors, hospitals, or ambulances can share information for treatment purposes:** Providers can freely share information with other providers where treatment is concerned, without getting a signed patient authorization or jumping through other hoops. Clear guidance on this topic can be found in a number of places:

- Review the answers to frequently asked questions (FAQs) in the “Treatment/Payment/Health Care Operations” subcategory, or search the FAQs on a likely word or phrase such as “treatment.” The link to the FAQs may be found at http://www.hhs.gov/hipaafaq/ on the HHS website.
- Consult the Fact Sheet, “Uses and Disclosures for Treatment, Payment, and Health Care Operations,” which is at http://www.hhs.gov/ocr/hipaa/guidelines/sharingfortpo.pdf on the HHS website.

**HIPAA does not require providers to eliminate all incidental disclosures:**

- The Privacy Rule recognizes that it is not practicable to eliminate all risk of incidental disclosures. That is why, in August 2002, HHS adopted specific modifications to that Rule to clarify that incidental disclosures do not violate the Privacy Rule when providers and other covered entities have common sense policies which reasonably safeguard and appropriately limit how protected health information is used and disclosed.

- OCR guidance explains how this applies to customary health care practices, for example, using patient sign-in sheets or nursing station whiteboards, or placing patient charts outside exam rooms. At the HHS/OCR website, see the FAQs in the “Incidental Uses and Disclosures” subcategory; search the FAQs on terms like “safeguards” or “disclosure”; or review the Fact Sheet on “Incidental Disclosures.” The fact sheet is at http://www.hhs.gov/ocr/hipaa/guidelines/incidentalud.pdf on the HHS website.

**HIPAA does not cut off all communications between providers and the families and friends of patients:**

- Doctors and other providers covered by HIPAA can share needed information with family, friends, or with anyone else a patient identifies as involved in his or her care as long as the patient does not object.

- The Privacy Rule also makes it clear that, unless a patient objects, doctors, hospitals and other providers can disclose information when needed to notify a family member, or anyone responsible for the patient’s care, about the patient’s location or general
condition.
- Even when the patient is incapacitated, a provider can share appropriate information for these purposes if he believes that doing so is in the best interest of the patient.
- Review the HHS/OCR website FAQs http://www.hhs.gov/hipaafaq/notice/488.html in the sub-category “Disclosures to Family and Friends.”

**HIPAA does not stop calls or visits to hospitals by family, friends, clergy or anyone else:**
- Unless the patient objects, basic information about the patient can still appear in the hospital directory so that when people call or visit and ask for the patient, they can be given the patient’s phone and room number, and general health condition.
- Clergy, who can access religious affiliation if the patient provided it, do not have to ask for patients by name.
- See the FAQs in the “Facility Directories” at http://www.hhs.gov/hipaafaq/administrative/ on the HHS website.

**HIPAA does not prevent child abuse reporting:**
Doctors may continue to report child abuse or neglect to appropriate government authorities. See the explanation in the FAQs on this topic, which can be found, for instance, by searching on the term “child abuse;” or review the fact sheet on “Public Health” that can be reviewed at http://www.hhs.gov/ocr/hipaa/guidelines/publichealth.pdf on the HHS website.

**HIPAA is not anti-electronic:**
Doctors can continue to use e-mail, the telephone, or fax machines to communicate with patients, providers, and others using common sense, appropriate safeguards to protect patient privacy just as many were doing before the Privacy Rule went into effect. A helpful discussion on this topic can be found at http://www.hhs.gov/hipaafaq/providers/smaller/482.html on the HHS website.

**Additional Information**
The HHS complete listing of all HIPAA medical privacy resources is available at http://www.hhs.gov/ocr/hipaa/ on the HHS website. For a full list of educational materials, visit http://www.hhs.gov/ocr/hipaa/assist.html on the HHS website.

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

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

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

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

**Background**
CR 5624 instructs Medicare carriers, A/B MACs, and DME MACs (effective April 1, 2001) to bypass SNF CB Part B and Part B/DME MAC edits when certain inpatient claims are present on Medicare's history. These revisions will allow Medicare SNF CB editing to take into account periods of SNF stays that are non-covered by Medicare Part A when services should be payable outside of CB by the Medicare Part B contractor.

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

Medicare contractors (carrier, A/B MAC, or DME MAC) will re-open and re-process appropriately denied claims for dates of service on or after April 1, 2001 through January 1, 2008 when you bring such claims to their attention. You should contact your Medicare contractor to have claims re-processed that you feel were erroneously subject to these consolidated billing edits, and denied. The change will be implemented on January 7, 2008 and claims will be processed correctly as of that date.
Additional Information
You can find the official instruction, CR5624, issued to your carrier, A/B MAC, or DME MAC on the CMS website at http://www.cms.hhs.gov/Transmittals/downloads/R1289CP.pdf. As an attachment to CR5624, you will find updated Medicare Claims Processing Manual (100-04), Chapter 6 (SNF Inpatient Part A Billing), Sections 110.2.2 (A/B Crossover Edits), 110.2.4 (Edit for Ambulance Services), and 110.2.5 (Edit for Clinical Social Workers (CSWs)).

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

Update to the Place of Service (POS) Code Set to Add a Code for Prison/Correctional Facility - VMS Only
MLN Matters Number: MM5331
Related Change Request (CR) #: 5331
Related CR Release Date: July 13, 2008
Effective Date: July 1, 2006
Related CR Transmittal #: R1288CP
Implementation Date: January 7, 2008

Provider Types Affected
Suppliers who bill Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for services provided in prison/correctional facility settings.

What you need to know
CR 5331, from which this article is taken, announces the addition of place of service (POS) code "09" for a prison/correctional facility setting.

Background
As a Health Insurance Portability and Accountability Act of 1996 (HIPAA) covered entity, Medicare must comply with the statute's standards and implementation guides. The currently adopted professional implementation guide for the ASC X12N 837 standard requires that each electronic claim transaction include a Place of Service (POS) code from the POS code set that the Centers for Medicare & Medicaid Services (CMS) maintains. Further, as a payer, Medicare must be able to recognize, as valid, any code from the CMS-maintained, HIPAA-standard POS code set that appears on the HIPAA standard claim transaction.

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

CR 5331, from which this article is taken, updates the current Medicare fee-for-service POS code set to add a new code (POS code "09") for prison/correctional facility and will implement the systems and contractor-level changes needed for Medicare to adjudicate claims with the new code.

Your DME MAC will develop the necessary policies to adjudicate claims containing this new code, and will accept it as valid. You should also be aware that your DME MAC must continue to comply with CMS current policy that, in most cases, does not allow payment for Medicare services in a penal institution. The addition of a POS code for a prison/correctional facility setting does not supersede this policy. (See Medicare Claims Processing Manual (100-04, Section 10.4, Chapter 1, available at http://www.cms.hhs.gov/manuals/downloads/clm104c01.pdf on the CMS website.)

The implementation of this change will be based on claims processed on or after January 7, 2008, even though the effective date shows July 1, 2006. The effective date is based on HIPAA requirements for nonmedical data code sets, but the changes in CR5331 apply to claims Medicare processes on or after January 7, 2008.

Additional Information
You can find more information about the prison/correctional facility POS code update to the POS code set by going to CR 5331, located at http://www.cms.hhs.gov/Transmittals/downloads/R1288CP.pdf on the CMS website.

If you have any questions, please contact your carrier at their toll-free number, which may be found at http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip.
**Provider Education for Handling Issues Related to Deceased Providers**

MLN Matters Number: MM5508  
Revised Related Change Request (CR) #: 5508  
Related CR Release Date: March 30, 2007  
Effective Date: May 23, 2007  
Related CR Transmittal #: R1216CP  
Implementation Date: April 30, 2007

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

**Background**  
This article and related Change Request (CR) 5508 addresses NPI issues related to deceased providers. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires the Secretary of the Department of Health and Human Services adopt standards providing for a standard unique health identifier for each health care provider for use in the healthcare system and to specify the purpose for which the identifiers may be used. All entities covered under HIPAA must comply with the requirements of the NPI final rule no later than May 23, 2007. Among these requirements are the following:

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

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

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

- If a provider dies before obtaining an NPI and claims for that provider are received by a Medicare contractor after May 23, 2007, and Medicare (the Medicare contractor, the Medicare Online Survey and Certification Reporting System (OSCAR), of the National Supplier Clearinghouse (NSC)) has not been notified of the death, the claims will reject when received by Medicare due to the absence of the provider’s NPI.
- At that point, the claim submitter would be expected to contact the Medicare contractor to which the claims were submitted to discuss payment of the claims and report the provider’s death. Toll free number of the Medicare contractors are available at http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip on the CMS website.
- The State in which a provider furnishes care will continue to be responsible for notification of Medicare of the death of a provider following existing procedures. Since some States send such notifications on a quarterly basis, CMS is implementing the following procedures to enable affected claims to be paid more promptly:
  - Because Medicare will reject an electronic claim received without an NPI after May 23, 2007, in cases where the provider died prior to obtaining an NPI, the provider’s representative will need to submit the claim on paper.
  - A representative of the estate should then contact the claims processing contractor, who will notify the provider that they must submit the claims on paper and that they must annotate the claim to state that the provider is deceased in Item 19.

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

You may view the official instruction (CR5508) issued to your Medicare carrier, DME/MAC, DME/DMAC, and/or A/B MAC by going to http://www.cms.hhs.gov/Transmittals/downloads/R1216CP.pdf on the CMS website.
National Provider Identifier (NPI) Required to Enroll in Electronic Data Interchange (EDI), and Update of Telecommunication and Transmission Protocols for EDI

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

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

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

CAUTION – What You Need to Know
CR 5637, from which this article is taken, announces that providers must obtain an NPI, as a condition for initial enrollment, for the use of EDI.

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

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

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

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

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

In summary, these changes are:

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

Additional Information
You can find more information about the requirement for an NPI in order to be able to use EDI transactions, by going to CR 5637, located at http://www.cms.hhs.gov/Transmittals/downloads/R1283CP.pdf on the CMS website. As an attachment to CR 5637, you will find updated Medicare Claims Processing Manual, Section 24 (General EDI and EDI Support Requirements, Electronic Claims and Coordination of Benefits Requirements, Mandatory Electronic Filing of Medicare Claims), Sections 20 (EDI Enrollment) and 30.3 (Telecommunications and Transmission Protocols). You can find more information about EDI on the CMS website at http://www.cms.hhs.gov/ElectronicBillingEDITrans/, and more information about the NPI at http://www.cms.hhs.gov/NationalProvIdentstand/ on the CMS website. If you have any questions, please contact your carrier, FI, RHHI, A/B MAC, or DME MAC at their toll-free number, which may be found at http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip.
Differentiating Mass Adjustments from Other Types of Adjustments and Claims for Crossover Purposes and Revising the Detailed Error Report Special Provider Notification Letters

MLN Matters Number: MM5472
Related Change Request (CR) #: 5472
Related CR Release Date: February 28, 2007
Effective Date: July 1, 2007
Related CR Transmittal #: R1189CP
Implementation Date: July 2, 2007

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

Provider Action Needed

STOP – Impact to You
This article is based on Change Request (CR) 5472 which implements changes to Medicare contractor systems so that their claim transmissions to the Coordination of Benefits Contractor (COBC) for mass adjustments and other kinds of adjustments may be differentiated from all other types of claims sent for crossover.

CAUTION – What You Need to Know
This will be accomplished through modifications to the 837 COB flat files and National Council for Prescription Drug Programs (NCPDP) Part B drug claim files, all of which are transmitted to the COBC on a daily basis.

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

Background
All Medicare contractors currently send processed claims, for which Medicare systems show the beneficiary has other insurance to the COBC for crossover under the national Coordination of Benefits Agreement (COBA) program. The Centers for Medicare & Medicaid Services (CMS) requires a method whereby its Coordination of Benefits Contractor (COBC) can differentiate among the various categories of adjustment crossover claims including:

- Mass adjustments - Medicare physician fee schedule (MPFS),
- Mass adjustments - other, and
- All other adjustments.

Having the ability to differentiate among the various categories of adjustment crossover claims will enable CMS (and the COBC) to better address the kinds of contingencies that arise with the passage of legislation such as the Deficit Reduction Act, which mandate changes for Medicare that can affect claims already processed.

CR5472 instructs that the COBC Detailed Error Report process be modified to ensure that the contractor-generated special provider letters which are created and sent in accordance with CR 3709 contain the specific Claimdi rejection code returned for the claim along with its description. (See the MLN Matters article at http://www.cms.hhs.gov/mlnMattersArticles/downloads/MM3709.pdf for information on CR3709.)

Providers may wish to contact their billing agent/vendor to obtain a better understanding of these error codes and accompanying descriptions, which, in turn, explains why their patients’ claims were not crossed over successfully. In addition, providers should notify their billing agent/vendor when they receive special provider letters or reports stating why their patients’ claims were not crossed over.

Additional Information
The official instruction, CR5472, issued to your carrier, FI, RHHI, A/B MAC, DMERC, or DME MAC regarding this change may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R1189CP.pdf on the CMS website. Attached
to CR5472, you will find the new chapter of the Medicare Claims Processing Manual explaining in detail the new special mass adjustment process for COB. In addition, you will also find revised chapters for other portions of that manual, which discuss the COB process. If you have any questions, please contact your carrier, FI, RHII, A/B MAC, DMERC, or DME MAC at their toll-free number, which may be found on the CMS website at: http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip.

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

Notifying Affected Parties Regarding Changes to the Mandatory Medigap (“Claim-Based”) Crossover Process
MLN Matters Number: MM5662
Revised Related Change Request (CR) #: 5662
Related CR Release Date: June 15, 2007
Effective Date: June 15, 2007
Related CR Transmittal #: R283OTN
Implementation Date: July 16, 2007

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

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

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

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

Providers should note the following: Effective October 1, 2007, the COBC will assume responsibility for the Medigap claim-based crossover, which is driven by information that participating providers enter on the incoming claim. The primary change for providers resulting from this transition will be that they will need to include a new Medigap identifier, even in advance of October 1, 2007, on their incoming Medicare claims to trigger crossovers to Medigap insurers. During June through August 2007, CMS will assign each Medigap insurer that does not provide an eligibility file to the COBC to identify all of its covered policy or certificate holders for crossover purposes a new 5-digit COBA Medigap claim-based identifier (ID). Providers may reference a weekly updated listing of the newly assigned COBA Medigap claim-based IDs for Medicare billing purposes at the following website: http://www.cms.hhs.gov/COBAgreement/Downloads/MedigapClaim-basedCOBAIDsforBillingPurpose.pdf. Once the COBC has assigned a new COBA Medigap claim-based ID to a Medigap insurer, participating providers that wish to trigger crossovers to Medigap insurers will be required to include that new identifier, as found on the CMS COB website, on their incoming Medicare claims. Failure to do so will result in their claims not being successfully crossed over to the Medigap insurer. If the older contractor-assigned number is included on the claim, Medicare will include the standard MA19 message—“Information was not sent to the Medigap insurer due to incorrect/invalid information you submitted concerning the insurer. Please verify your information and submit your secondary claim directly to that insurer”—on the provider’s electronic remittance advice (ERA) or other production remittance report. If you have any questions, please contact your contractor at their toll-free number, which may be found at http://www.cignagovernmentservices.com.

Addition Information

You can find the official instruction, CR5662, issued to your carrier, MAC, or DMAC by visiting http://www.cms.hhs.gov/Transmittals/downloads/R283OTN.pdf on the CMS website. If you have any questions, please contact your contractor at their toll-free number, which may be found at http://www.cms.hhs.gov/MLNP/products/downloads/CallCenterTollNumDirectory.zip.

Changes to the Mandatory Medigap (“Claim-Based”) Crossover Process

CMS’ Coordination of Benefits Contractor (COBC) will assume responsibility for the Medigap claim-based crossover, which is driven by information that participating providers enter on the incoming claim, effective October 1, 2007. During June through August 2007, CMS will assign each Medigap insurer that does not provide an eligibility file to the COBC to identify all of its covered policy or certificate holders for crossover purposes a new 5-digit Medigap identifier (ID). Providers may reference a weekly updated listing of the newly assigned COBA Medigap claim-based IDs on CMS’ Coordination of Benefits website at http://www.cms.hhs.gov/COBAgreement/Downloads/MedigapClaim-basedCOBAIDsforBillingPurpose.pdf. Once the COBC has assigned a new COBA Medigap claim-based ID to a Medigap insurer, participating providers that wish to trigger crossovers to Medigap insurers will be required to include that new identifier, as found on the CMS COB website, on their incoming Medicare claims. Failure to do so will result in their claims not being successfully crossed over to the Medigap insurer. If the older contractor-assigned number is included on the claim, Medicare will...
include the standard MA19 message—‘Information was not sent to the Medigap insurer due to incorrect/invalid information you submitted concerning the insurer. Please verify your information and submit your secondary claim directly to that insurer.’—on the provider’s electronic remittance advice (ERA) or other production remittance advice for the associated claim(s). Participating providers that are permitted under Administrative Simplification Compliance Act (ASCA) to bill Medicare on paper should include the newly assigned 5-digit COBA Medigap claim-based ID within block 9-D of the CMS-1500 claim form. Providers that are required to bill Medicare electronically using the Health Insurance Portability and Accountability Act (HIPAA) American National Standards Institute (ANSI) X12-N 837 professional claim shall include the newly assigned 5-byte only COBA Medigap claim-based ID (range=55000 to 59999) left-justified in field NM109 of the NM1 segment within the 2300B loop and followed by spaces. (See important note that follows regarding the submission of claims to Durable Medical Equipment Medicare Administrative Contractors [DMACs].) Retail pharmacies that bill National Council for Prescription Drug Programs (NCPDP) batch claims to Medicare shall include the newly assigned Medigap identifier left-justified within field 301-C1 of the T04 segment of their incoming NCPDP claims and followed by spaces.

IMPORTANT: For all of the claim submission situations discussed above, suppliers (including retail pharmacies) that bill DMACs must include an accompanying 4-byte “Z001”identifier with the newly assigned COBA Medigap claim-based crossover ID (for example, 55000Z001) when seeking to trigger Medigap claim-based crossovers during the interim transitional period, which runs from June through September 30, 2007. Providers should notify their vendors of the impending changes to the existing Medigap claim-based possible. The Medigap transitional announcement is posted on the CGS DME MAC website at http://www.cignagovernmentservices.com/jc/pubs/news/2007/0707/COPE6088.pdf.

ATTACHMENT A
Dear Medigap Insurer:

MEDIGAP CLAIM-BASED CROSSOVER MOVES TO A CONSOLIDATED, STANDARDIZED PROCESS.

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

WHAT DOES THIS MEAN TO YOU?
The CMS is expecting your organization to contact the COBC during June 2007 regarding your need to sign a national Coordination of Benefits Agreement (COBA) that will enable you to continue receiving Medigap claim-based crossover claims. You may reach the COBC for this purpose by dialing 1-646-458-6740. The executed COBA will address claim transfer protocols, the frequency of the claim transfers (available options include daily, weekly, bi-weekly, or monthly), and the standard crossover fee. After your organization has signed the COBA, you will be assigned a new 5-byte COBA Medigap claim-based identifier. All participating providers will then have access to the Medigap insurer’s new COBA Medigap claim-based identifier prior to October 1, 2007, and will be required to include this new identifier on your policy or certificate holders’ incoming Medicare claims to successfully trigger mandatory Medigap claim-based crossovers. With the transition of the Medigap claim-based crossover process to the COBC, Medigap insurers will enjoy the benefit of only needing to interact with one entity when they have questions or concerns. In addition, the Medigap insurers will now receive their claims and invoices from a single entity rather than individually from numerous Medicare contractors across the nation. Effective October 1, 2007, CMS will discontinue the use of all non-standard claim formats, including National Standard Format (NSF) and paper claims. As “covered entities” under the final Health Insurance Portability and Accountability Act (HIPAA) transactions and code sets rule, Medigap insurers must be able to accept the standard HIPAA American National Standards Institute (ANSI) X12-N 837 professional coordination of benefits (COB) version 4010-A1 claim. In addition, your organization should be able to accept National Council for Prescription Drug Programs (NCPDP) version 5.1 batch standard 1.1 Part B drug claims. However, CMS is not mandating receipt of NCPDP batch standard claims at this time. CMS will advise your organization when acceptance of these claims is required. Therefore, effective October 1, 2007, your organization will receive Part B physician and supplier claims in the HIPAA ANSI X12-N837 professional claim (with receipt of NCPDP batch standard claims to follow in the future). In accordance with volume 55, number 225 of the November 21, 1990, Federal Register Notice, CMS will exclude non-assigned, fully paid original and fully paid adjustment claims, fully denied original and fully denied adjustment claims, and non-monetary adjustment claims from its national COBA Medigap claim-based crossover process with your organization.
Medigap insurers will continue to receive their crossover claims from their associated Medicare contractors at their currently designated frequency and in their currently designated claims format during the interim period from June 1 to September 30, 2007. Until October 1, 2007, the only change to the current Medigap claim-based process is that the Medigap insurer will be replacing its current identifier that initiates claim-based crossover to the 5-byte COBA Medigap claim-based identifier for processing purposes. This change will occur shortly after execution of the COBA.

WHAT CAN MY ORGANIZATION DO TO BE PREPARED FOR THE OCTOBER 1, 2007, CHANGE?

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

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

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

WHAT OTHER DETAILS SHOULD MY ORGANIZATION KNOW?

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

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

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

**ATTACHMENT A—Additional Information**

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

**Healthcare Provider Taxonomy Codes (HPTC)**

**Update October 2007**

Related CR: CR5673  
CR Transmittal #: R1300CP  
Implementation Date: October 1, 2007

The Healthcare Provider Taxonomy Codes (HPTC) set is maintained by the National Uniform Claim Committee (NUCC) or standardized classification of health care providers. The NUCC updates the code set twice a year with changes effective April 1 and October 1. The HPTC list is available from the Washington Publishing Company (WPC) http://www.wpc-edi.com/codes/taxonomy in two forms.

* The first form is a free Adobe PDF download.  
* The second form, available for purchase, is an electronic representation of the code set that facilitates automatic loading of the codes.

Valid HPTCs are those codes approved by the NUCC for current use. Terminated codes are not approved for use after a specific date and newly approved codes are not approved for use prior to the effective date of the code set update in which each new code first appears. Although the NUCC generally posts their updates on the WPC Web page 3, months prior to the effective date, changes are not effective until April 1 or October 1 as indicated in each update. Specialty and/or provider type codes issued by any entity other than the NUCC are not valid and Medicare would be guilty of non-compliance with HIPAA if Medicare contractors accepted claims that contain invalid HPTCs. Taxonomy code changes are to be applied to claims processed on and after the implementation date of this CR.
Negative Pressure Wound Therapy LCD Documentation

Recent reviews of Negative Pressure Wound Therapy (NPWT) claims have identified supplier deficiencies in their documentation of compliance with the Local Coverage Determination (LCD) coverage criteria. The NPWT LCD is a complex policy containing items that, in the event of an audit, would require submission of information from the beneficiary’s medical record.

Elements of the LCD that require information from the medical record to justify coverage include:

- Complete description of the wound
- Description of prior care for the wound
- Complications with surgically created wounds
- Monthly monitoring of wound healing progress
- Need for more than four months therapy
- Need for a quantity of supplies that exceeds the expected amounts outlined in the LCD

Review the “Indications and Limitations of Coverage and/ or Medical Necessity” section of the LCD for a complete discussion of coverage criteria.

The “Documentation Requirements” section provides substantial guidance on the type of information that may be requested.

“Documentation of the history, previous treatment regimens (if applicable), and current wound management for which an NPWT pump is being billed must be present in the patient’s medical record and be available for review if requested by the DMERC. This documentation must include such elements as length of sessions of use, dressing types and frequency of change, and changes in wound conditions, including precise measurements, quantity of exudates, presence of granulation and necrotic tissue and concurrent measures being addressed relevant to wound therapy (debridement, nutritional concerns, support surfaces in use, positioning, incontinence control, etc.).

Documentation of wound evaluation and treatment, recorded in the patient’s medical record, must indicate regular evaluation and treatment of the patient’s wounds, as detailed in the Indications and Limitations of Coverage Section. Documentation of quantitative measurements of wound characteristics including wound length and width (surface area), and depth, and amount of wound exudate (drainage), indicating progress of healing must be entered at least monthly. The supplier of the NPWT equipment and supplies must obtain from the treating clinician, an assessment of wound healing progress, based upon the wound measurement as documented in the patient’s medical record, in order to determine whether the equipment and supplies continue to qualify for Medicare coverage. (The supplier need not view the medical records in order to bill for continued use of NPWT. Whether the supplier ascertains that wound healing is occurring from month to month via verbal or written communication is left to the discretion of the supplier. However, the patient's medical records may be requested by the DMERC in order to corroborate that wound healing is/ was occurring as represented on the supplier's claims for reimbursement.)

When NPWT therapy exceeds 4 months on the most recent wound and reimbursement ends, individual consideration for additional months may be sought using the appeals process. Documentation should be submitted with the appeal explaining the special circumstances necessitating the extended therapy time.”

Many suppliers create documents to facilitate their collection of information. In the event of an audit, forms that are developed by entities including but not limited to a supplier or a professional association are not sufficient, by themselves, to document that coverage criteria have been met. If forms are used, there must be documentation in the patient’s medical record that corroborates the information on the forms and verifies that coverage criteria have been met.

Refer to the Supplier Manual, LCD and Policy Article for additional information on NPWT and other general documentation requirements.

Electrical Joint Stimulation Devices – E0762 – Coding Guidelines

HCPCS code E0762 is used to bill Medicare for a transcutaneous electrical joint stimulation device system. The only products that may be billed using this code are those that have undergone Coding Verification Review by the SADMERC and that are listed in the DMECS Product Classification List on the SADMERC web site.

Currently, the only product that meets these requirements is the BioniCare Knee Device manufactured by BioniCare Medical Technologies. Suppliers may not submit claims using E0762 for any other item. For information on the correct coding of other items, contact the SADMERC.
Outlined below is a summary of the principal changes to the DME Local Coverage Determinations (LCDs) and Policy Articles (PAs) that have been revised for the July 2007 Publication. These policy revisions are effective for dates of service on and after July 1, 2007. Please review the entire LCD and each related PA for complete information.

**Ankle-Foot/Knee-Ankle-Foot Orthosis**

LCD

Revision Effective Date: 07/01/2007

**INDICATIONS AND LIMITATIONS OF COVERAGE:**

Removed: References to DMERC.

**DOCUMENTATION REQUIREMENTS:**

Removed: References to DMERC.

**Policy Article**

Revision Effective Date: 07/01/2007

**NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:**

Changed title of previous Therapeutic Shoes for Diabetics LMRP, to the new LCD title – Therapeutic Shoes for Persons with Diabetes.

**CODING GUIDELINES:**

Changed title of previous Therapeutic Shoes for Diabetics LMRP, to the new LCD title – Therapeutic Shoes for Persons with Diabetes.

Removed: Reference to DMERC.

**Hospital Beds and Accessories**

LCD

Revision Effective Date: 07/01/2007

**HCPCS CODES AND MODIFIERS:**

Added: GA, GK, Gl, and GZ modifiers

**DOCUMENTATION REQUIREMENTS:**

Clarified: Instructions for KX modifiers

Added: Modifier requirements for upgrades.

**Negative Pressure Wound Therapy Pumps**

LCD

Revision Effective Date: 07/01/2007

**INDICATIONS AND LIMITATIONS OF COVERAGE AND/OR MEDICAL NECESSITY**

Moved: Documentation requirements for extra supplies to the Documentation Requirements section of the LCD

Removed: DMERC references

**DOCUMENTATION REQUIREMENTS:**

Revised: Documentation requirements for extra supplies.

Removed: DMERC references

**Oxygen and Oxygen Equipment**

PA

Revision Effective Date: 06/01/2007

**NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:**

Revised: Statements concerning separate payment for portable contents.

In accordance with Section 911 of the Medicare Modernization Act of 2003, Virginia and West Virginia were transitioned from DME PSC TriCenturion (77011) to DME PSC TrustSolutions (77012).

**Refractive Lenses**

LCD

Revision Effective Date: 07/01/2007

**INDICATIONS AND LIMITATIONS OF COVERAGE:**

Clarified: Replacement lenses are covered for patients without an implanted intraocular lens (IOL).

Moved: Statement about coverage for patients with surgery prior to Medicare entitlement to the Policy Article.

Removed: DMERC references.

**ICD-9 CODES THAT SUPPORT MEDICAL NECESSITY:**

Moved: Covered ICD-9 codes to the Policy Article.

**DOCUMENTATION REQUIREMENTS:**

Removed: Requirement for date of surgery to accompany the claim.

Removed: DMERC references.
APPENDICES:
Moved: Definition of aphakia and pseudophakia to Indications and Limitations of Coverage section.

Policy Article
Revision Effective Date: 07/01/2007
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: Definitions of aphakic and pseudophakia.
Moved: Statement about coverage for patients with surgery prior to Medicare entitlement from the LCD.
ICD-9 CODES THAT ARE COVERED:
Moved: Codes 379.31, 743.35 and V43.1 from the LCD.

Respiratory Assist Devices
LCD
Revision Effective Date 07/01/2007
INDICATIONS AND LIMITATIONS OF COVERAGE:
Added: K0553-K0555 to usual quantities table.
Removed: DMERC references
Revised maximum amount for A7037.
HCPCS CODES ANDModifiers:
Added: Codes K0553-K0555
DOCUMENTATION REQUIREMENTS:
Removed: DMERC references

Policy Article
Revision Effective Date: 07/01/2007
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Removed: Code list of payable accessories.
CODING GUIDELINES:
Removed: Paragraph describing use of CPAP codes for RAD.
Added: Definition for K0553

Speech Generating Devices
LCD
Revision Effective Date: 07/01/2007
INDICATIONS AND LIMITATIONS OF COVERAGE:
Removed: DMERC reference.
DOCUMENTATION REQUIREMENTS:
Removed: DMERC references.

Policy Article
Revision Effective Date: 07/01/2007
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: Statement concerning non-coverage of replacements or upgrades during reasonable useful lifetime.
CODING GUIDELINES:
Revised: Definitions of E2511 and E2599.

Tracheostomy Care Supplies

LCD
Revision Effective Date: 07/01/2007
INDICATIONS AND LIMITATIONS OF COVERAGE:
Removed: DMERC references.
DOCUMENTATION REQUIREMENTS:
Removed: DMERC references.

Therapeutic Shoes for Persons with Diabetes
LCD
Revision Effective Date: 07/01/2007
INDICATIONS AND LIMITATIONS OF COVERAGE:
Moved: Requirement for an order to the Policy Article.
Moved: Statement about covered of modifications to the Policy Article.
Removed: DMERC references.
DOCUMENTATION REQUIREMENTS:
Removed: DMERC references.

Urological Supplies
PA
Revision Effective Date: 06/01/2007
CODING GUIDELINES:
Updated: Code narrative for A4349.
Removed: A4325 from the bundling table.
*The Urological Supplies as well as the Oxygen & Oxygen Equipment Policy Articles are effective June 1, 2007.
Notes:
The information contained in this article is only a summary of revisions to LCDs and PAs. For complete information on any topic, you must review the LCD and its related PA. These revised LCDs & PAs may be found on the CMS Medicare Coverage Database (MCD). Effective Wednesday, July 18, 2007, the revisions will be posted on the "Active Documents" section.
Power Mobility Devices - Frequently Asked Questions (FAQs) - July 2007

Q1. Can a form that is developed by an entity other than the supplier (e.g., the Power Mobility Device [PMD] evaluation forms that have been developed by the Texas Academy of Family Practitioners) and that is completed and signed by the physician and included in the patient’s chart be considered sufficient documentation of the required face-to-face examination for PMDs?

A1. No. As stated in the Documentation Requirements section of the PMD Local Coverage Determination (LCD), physicians must document the face-to-face examination “in a detailed narrative note in their charts in the format that they use for other entries.” Forms that are developed by other entities including but not limited to a supplier or professional association do not meet this requirement. Therefore, they are not sufficient by themselves to document that coverage criteria have been met. If a form is used, there must be documentation in the patient’s medical record that corroborates the information on the form and verifies that coverage criteria have been met.

Q2. A supplier pays a physical therapist (PT) or occupational therapist (OT) to do wheelchair evaluations of non-Medicare patients (e.g., Medicaid only, commercial insurance). The PT or OT performs an evaluation on a Medicare patient and the supplier does not pay the PT/OT for that evaluation. Does Medicare consider that therapist to have a “financial relationship” with the supplier in the context of the Power Mobility Devices policy?

A2. Yes. In the situation that is described, the PT/OT is considered to have a financial relationship with the supplier. Therefore, even though the supplier does not pay the therapist for the evaluation of the Medicare patient, the evaluation of that patient cannot be considered part of the required face-to-face examination for all PMDs or the required specialty evaluation for rehab PMDs (Group 2 single and multiple power options power wheelchairs [PWCs], all Group 3 and Group 4 PWCs, and push-rim activated power assist devices for manual wheelchairs).

Q3. Can a physical therapy assistant (PTA) or an occupational therapy assistant (OTA) who is RESNA-certified as an Assistive Technology Practitioner (ATP) provide the specialty evaluation that is required for rehab PMDs that are provided on or after April 1, 2008.

A3. No. As with all professional services, the evaluation must be within the scope of practice of the health care provider as defined by state professional practice laws. Independent evaluations are not within the scope of practice of PTAs and OTAs.
DME MAC Jurisdiction C Interactive Voice Response (IVR) System

USER GUIDE

Information you may need:
- PTAN - Same number as your NSC Supplier Number
- HICN - Press 1 if begins with Letter, Press 2 if begins with number
- Beneficiary’s First Initial
- Beneficiary’s Last Name - First 6 letters plus # sign
- Date of Birth
- HCPSC Code / Modifiers
- FCN - Located on your remittance notice
- Payment Date

Additional Feature:
May inquire on Multiple PTANs within the same phone transaction

To access the IVR, call 1.866.238.9650

You will be prompted for your PTAN, and then presented with the following options:
Press 1 for PTAN which contains a letter. Press 2 for PTAN without a letter

Claims Information [1]
- Enter HICN, Beneficiary Name, and date of service
- Available Information
  - Line-by-Line Information
  - Payment Floor (Claim Level)
  - Explanation of the Denial
  - Appeal Rights

Beneficiary Eligibility [2]
- Enter HICN, Beneficiary name, and date of birth
- Available Information
  - Part A entitlement date
  - Part B entitlement date
  - Medicare Advantage Plan information
  - Home Health information
  - Medicare Secondary Payer information

Payment Information [3]
- Enter State, HCPSC, and Modifier
- Available Information
  - Medicare allowed amount
  - Outstanding checks within last 30 days
  - Check date
  - Check amount

Payment Floor Information [4]
- Available Information
  - Number of claims
  - Submitted amount
  - Expected payment

Total Number of Claims in Process [2]
- Available Information
  - Number of claims in process
  - Total amount submitted

Beneficiary Part B Deductible [2]
Enter HICN, Beneficiary name, and date of birth
- Available Information
  - Amount of deductible applied for the current calendar year

Order a duplicate remittance notice [3]
- Enter Payment Date
- Available Information
  - Enter FCN

Available Information
- Information on your Appeal Right
- Customer Service hours of operation

General Information press [4]
- Standard Functions
  - = Repeat
  - = Main Menu
  - = New PTAN
Contact Information

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

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

<table>
<thead>
<tr>
<th>CIGNA Government Services – DME MAC Jurisdiction C</th>
<th>Contact Information:</th>
</tr>
</thead>
</table>
| **EDI – Electronic Claim Submission; Electronic Remittance Notices** | Jurisdiction C EDI Technology Support Center  
(Toll-free) 1-888-613-9271 Support hours – 8:00 a.m. – 5:00 p.m. EST, Monday – Friday  
Jurisdiction C EDI Website - www.palmettogba.com/jcedi  
Address for Written Communications Jurisdiction C EDI Operations P.O. Box 100170 Columbia, SC 29202 |
| **Paper Claim Submission** | CIGNA Government Services  
PO Box 20010  
Nashville, TN 37202 |
| **Provider Customer Service Calls** | 1-866-238-9650  
(IVR – interactive voice response)  
★ Hours – 24/7 (with allowances for normal IVR and system maintenance)  
★ 1-866-270-4909 (customer service)  
★ 8:00 a.m. to 6:00 p.m. ET  
★ 1-888-204-3771 (hearing impaired)  
★ 8:00 a.m. to 6:00 p.m. ET |
| **Beneficiary Customer Service Calls** | 1-800-Medicare |
| **Written Inquiries** | CIGNA Government Services  
PO Box 20010  
Nashville, TN 37202 |
| **Claim Reopenings (Adjustments)** | CIGNA Government Services  
PO Box 20010  
Nashville, TN 37202  
Fax: 615.782.4505  
Telephone requests for Reopenings: 1-866-813-7878. (8 – 11 a.m. and 12 – 4 p.m. Central time) |
| **Appeals – Redetermination Requests** | CIGNA Government Services  
PO Box 20010  
Nashville, TN 37202 |
| **Electronic Funds Transfer** | CIGNA Government Services  
Attn: EFT-DME  
PO Box 20010  
Nashville, TN 37202 |
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<td><a href="http://www.cignagovernmentservices.com">www.cignagovernmentservices.com</a></td>
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<tr>
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