Workshop Invitation Enclosed

Your invitation for Region C’s Spring 1997 workshop series is included in this advisory; invitations will not be mailed separately. The workshop series will cover the basics of billing durable medical equipment claims to Medicare.

Please turn to page 97-15 of this advisory for more information about the workshop series, including dates and locations. A registration form also is included to copy, fill out with the appropriate information, and mail in with payment.
Need for the National Provider Identifier

Currently, there is no universally accepted national identification and enumeration system for health service providers. Providers must use multiple identifiers for programs and organizations with which they do business. Data are not readily transportable among systems, and thus, must be collected redundantly. The problems and cost of exchanging provider data are great, hampering coordination of benefits and fraud and abuse efforts.

Organizations with a need to enumerate providers have joined in an effort, begun by the Health Care Financing Administration (HCFA) in 1993, to establish a national system for identifying and uniquely enumerating health service providers. The National Provider System has been designed to enumerate health service providers by assigning a National Provider Identifier (NPI) to each individual provider, group practice, and organization provider.

Participation in the National Provider Identifier effort

Representatives from Federal agencies that administer health programs, state Medicaid agencies, state health departments, medical professional associations, payers, claims clearinghouses, medical software vendors, and standards groups all worked with HCFA to define or comment on the requirements for the NPI. These organizations included:

♦ Department of Defense/CHAMPUS
♦ Department of Health and Human Services/ASPE, PHS, FDA
♦ Department of Labor
♦ Department of Veterans Affairs
♦ Drug Enforcement Administration
♦ Office of Personnel Management
♦ Social Security Administration
♦ State Medicaid agencies and health departments including those of Alabama, California, Minnesota and Virginia
♦ Medicare contractors
♦ Professional and medical associations, including the American Medical Association, American Hospital Association, Health Insurance Association of America and National Council of Prescription Drug Programs
♦ Regional consortia, including the Massachusetts Health Data Consortium, Utah Health Information Network and Administrative Uniformity Committee of Minnesota
NATIONAL PROVIDER IDENTIFIER

- Claims clearinghouses
- Standards groups, including the American National Standards Institute/Health Informatics Standards Planning Panel and the Accredited Standards Committee X12N workgroup on provider information

Consideration of existing identifiers

The NPI workgroup began its effort by adopting criteria recommended for a unique provider identifier by the Workgroup, on Electronic Data Interchange, Technical Advisory Group in October 1993 and recommended by the American National Standards Institute, Health Informatics Standards Planning Panel, Task Group on Provider Identifiers in February 1994. The NPI workgroup then examined existing identifiers and concluded that no existing identifier met all the criteria that had been recommended by the WEDI and ANSI workgroups.

Some existing identifiers, such as the Employer Identification Number or the Social Security Number, were established for other government programs and are not appropriate for identification of health service providers. Some, such as the National Supplier Clearinghouse number or the Unique Physician Identification Number, apply only to small segments of the provider community. Others, such as the Medicare provider number assigned to certified, mainly institutional, providers, have a format that will not accommodate a sufficient number of future health service providers. Some existing identifiers, such as the Health Industry number, developed by the Health Industry Business Communications Council, are proprietary. Workgroup members expressed concerns with cost of access, scope of use across the entire health service community, and continuity of a proprietary identifier. All existing identifiers lack an associated robust provider taxonomy that accommodates all types of health service providers.

Because of the limitations of existing identifiers, the NPI workgroup designed a new identifier that would be in the public domain and that would incorporate the recommendations of the WEDI and ANSI workgroups. The NPI will use the extensive provider taxonomy being developed by the Accredited Standards Committee X12N workgroup on provider information.

Format of the National Provider Identifier

The NPI is an eight-position alphanumeric identifier. The eighth position is an International Standards Organization-approved check digit, which will allow a calculation to detect keying or transmission errors. The National Provider System will assign the NPI and will also assign two-position alphanumeric location identifiers to indicate practice locations of the provider. Neither the NPI nor the location identifiers will have embedded intelligence. That is, information about the provider, such as the type of provider or state where the provider is located, will not be conveyed by the NPI. This information will be recorded in the system, but will not be part of the identifier.
Enumeration of individual and group providers

Individual and group providers will receive location identifiers for their office practice locations. Individuals and groups will not receive location identifiers for the hospitals or other organization providers where they practice, since these organization providers will receive their own NPIs. The NPIs of individual providers who are members of a group will be linked to the NPI of the group.

Enumeration of organization providers

The relationships defined among organization providers differ, depending upon the specific business rules of different health programs. The National Provider System will enumerate organization providers at the elemental level, so that different health programs can link these providers according to their program-specific business rules. Each organization provider in a separate location will receive a separate NPI. Each Member of an organization chain and each part of an organization provider that needs to be identified will receive a separate NPI. The National Provider System will have a query facility that will link organization providers that have a common Employer Identification Number. Organization providers will have only one active location identifier.

Data privacy and security

The lack of intelligence embedded in the identifier and the ability to encrypt identifiers where necessary will prevent unauthorized access to detailed information about individual providers. Identifiable data will be released only after execution of appropriate data release agreements with research organizations or organizations that process standard health data transactions. Files will not be released for marketing or mailing purposes.

Subscriber organizations (organizations with access to on-line data) will be required to have their employees sign confidentiality agreements. User IDs will be assigned to individuals rather than organizations, and these will be inactivated for individuals who no longer work for a subscriber. The National Provider System will maintain sophisticated technical and physical safeguards for the data.

Data integrity

Data integrity will be controlled on three levels: error prevention, on-going monitoring, and active auditing. Error prevention will be assured by building into the system adequate data edits and logic checks, as well as by setting pre-editing standards for entities and organizations that provide the data. On-going monitoring will track the consistency and validity of the data and resolve discrepancies resulting from the receipt of data from multiple sources. Periodic auditing will be established to ensure that the data are not just reasonable or logically possible, but are, in fact, correct.

Articles from HCFA are printed as received, with no edits made. Refer to the summary following this article if you have difficulty understanding the terminology and/or phrasing used.
NATIONAL PROVIDER IDENTIFIER

Timeliness of enumeration and ease of maintenance

The National Provider System will include online enumeration screens with standardized data elements and definitions. To speed up processing and enhance data integrity, both initial enumerations and data updates will be performed as interactive, online processes. Standard queries and reports will be available to subscribers. Providers will be furnished with copies of their provider file records, on request, so that inaccuracies may be quickly identified and corrected. Daily extracts will be available to appropriate parties, showing all provider records which have been added or updated since the last extract. The National Provider System will provide subscribers with tutorial training software, user manuals, and access to a Help Desk, to encourage timely and accurate submission of enumeration data.

Provider data

The National Provider System will contain the data necessary to identify and uniquely enumerate providers. It will not contain all data needed to carry out provider functions of health programs. It is assumed that this data is program-specific, and will continue to be housed in program-specific files. The data that will be part of the National Provider System include:

♦ Identifiers, such as the NPI, Social Security Number, Employer Identification Number, and Identifying numbers from other health programs

♦ Provider names

♦ Addresses and associated practice location identifiers

♦ Demographics (date of birth, date of death, gender)

♦ Provider type, classification, area of specialization

♦ Education, license, and board certification information

♦ Sanction information

NPS Standard Record Format (as of November 24, 1996)

This is the format through which NPS will:

♦ Accept for an initial load of providers

♦ Communicate the crosswalk from NPI to other corresponding Provider Numbers

♦ Communicate updates to its provider records

Available Draft Formats:

♦ Adobe Portable Document File (.PDF) Format
(RECFORM.PDF 197K)
NATIONAL PROVIDER IDENTIFIER

WordPerfect 6.1 for Windows in self-extracting (.EXE) PKZIP™ Format (RECFMWPD.EXE 63K–283K when uncompressed)

NPI schedule

The Health Insurance Portability and Accountability Act of 1996, enacted in August 1996, requires that, within 18 months, the Secretary of the Department of Health and Human Services adopts standards for specified transactions and data elements, to enable health information to be exchanged electronically. One of the specified standards is a standard unique health identifier for each health care provider. Compliance with the standard is required no later than 24 months after adoption of the standard. The Secretary will consult with standard setting organizations and other affected parties in order to determine what the standard provider identifier will be. A regulation announcing the standard and seeking public comment will be published in the Federal Register. The regulation will also announce the date when HCFA will adopt the standard for use in Medicare transactions. Following is the schedule for publishing the regulation announcing the standard and for Medicare implementation of the NPI, if the NPI is adopted as the standard:

♦ Notice of Proposed Rulemaking Published in Federal Register ...........................................02/21/97
♦ Final Regulation Published in Federal Register ....07/02/97
♦ NPIs Issued to Medicare Providers No Later Than ...............................................................08/01/97
♦ Required Use of NPI for Medicare Claims ..........12/01/97

Endorsements

The NPI has been endorsed by several government and private organizations:

♦ The state of Minnesota endorsed use of the NPI in Minnesota Statutes Section 62J.54, dated February 1996.

♦ The National Committee on Vital and Health Statistics endorsed the NPI in its report on Core Health Data Elements in August, 1996.

♦ The Massachusetts Health Data Consortium’s Affiliated Health Information Networks of New England endorsed the NPI as the standard provider locator for electronic data interchange in March 1996.

♦ The USA Registration Committee approved the NPI as an International Standards Organization card issuer identifier in August 1996 for use on magnetic cards.

♦ The National Uniform Billing Committee endorsed the NPI in August 1996.
In short...

Instead of using UPINs, NSC supplier numbers and other identification numbers to specify providers when submitting claims, National Provider Identifiers (NPIs) will be required beginning December 1, 1997. Medicare providers will begin receiving their new NPIs no later than August 1, 1997.

National Provider Identifiers will improve the efficiency of submitting and processing claims. They will eliminate the need for a single provider to have multiple identifiers and facilitate the transfer of data across information systems, preventing duplication of effort when collecting data.

All Medicare providers will be assigned a 10-digit number. The National Provider Identifier is the first eight digits; the last two digits will identify location. DME suppliers can have only one active location identifier at a time.

Physicians who also are suppliers may receive two NPIs—one for the physician practice and one for the supplier practice.

Chain or parent organizations with separate branches, divisions and/or subsidiaries will receive an NPI for each part of the whole, where necessary. Providers with common Employer Identification Numbers will be linked in the system.

Specific information, such as type of service or address, will not be communicated by the 10-digit identifiers. However, this and other information will be on file in the NPS. Subscribers, or HCFA contractors, will be able to access this information. Providers will not subscribe to the NPS.

Public comment on the implementation of NPIs is being solicited. The final regulation will be published in the Federal Register July 2, 1997.
The Region C DMERC DMEPS Supplier Manual update which accompanies this advisory contains:

- the original nebulizer policy, effective April 1, 1997, as published in the December 1996 DMERC Medicare Advisory and
- a revised RMRP for nebulizers, effective July 1, 1997.

The revised policy is effective with dates of service on or after July 1, 1997. These revisions are addressed in following pages.

The manual revisions also include revised policies for:

- Home dialysis supplies and equipment and
- Immunosuppressive drugs.

There has been some misunderstanding about the documentation requirements associated with claims for billing intermittent catheters when used with the sterile technique of self-catheterization in the home setting. A physician letter is required attesting to the fact that the beneficiary has suffered recurrent urinary tract infections in the past. This letter should be dated no earlier than 6 months prior to the initial claim to the DMERC. This letter need be written only once, and only by one physician. Copies of the letter may subsequently be submitted with future claims. It is not necessary to obtain a new letter from a physician every six months.

The DMERC Regional Medical Review Policy. “Therapeutic Shoes for Diabetics,” refers to three different types of individuals (physicians and/or suppliers) involved in the prescribing and supply of therapeutic shoes to beneficiaries:

1. CERTIFYING PHYSICIANS;
2. PRESCRIBING PHYSICIANS;
3. SUPPLIERS.

The CERTIFYING PHYSICIAN provides the medical care for the beneficiary’s diabetic condition. Only an M.D. or D.O. may sign the certifying statement that the patient has diabetes mellitus and one of the resultant foot conditions listed in the policy making such shoes reimbursable by Medicare. The certifying physician cannot be a podiatrist. The certifying statement (such as the recommended DMERC Statement of Certifying Physician for Therapeutic Shoes) must be kept on file by the ultimate supplier of the shoes.

The PRESCRIBING PHYSICIAN actually writes the order for the therapeutic shoe, modifications and inserts. The prescribing physician may be a podiatrist, M.D., or D.O. The prescribing physician may also be the supplier of the shoe. If the prescribing physician is the
supplier of the items, a separate order is not necessary, though the patient’s record must clearly document what has been furnished.

The **supplier** is the person or entity that actually furnishes the shoe, modification, and/or insert to the beneficiary and that bills Medicare. The supplier may be a podiatrist, pedorthist, orthotist, prosthetist, or other qualified individual. The **prescribing physician** may be the supplier. The **certifying physician** may *not* be the supplier unless he/she is practicing in a defined rural area or a defined health professional shortage area. The supplier must have on file both a statement from the certifying physician and an order from the prescribing physician, before the items may be furnished.

This bulletin serves as a clarification of already existing policy and is in response to many questions that have arisen over the relationships originally established therein. No new restrictions are being introduced, and therefore, there is no need of a notification period.

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**Nebulizer policy update**

Following are changes, corrections, clarifications and billing instructions relating to the DMERC regional medical review policy (RMRP) for Nebulizers, published in the December 1996 *DMERC Medicare Advisory*.

**Changes**

**Pharmacists claims for nebulizer drugs**

Because pharmacists may not be able to readily ascertain the nebulizer compressor/generator the patient is using with the nebulizer drugs being dispensed, it will not be necessary to include compressor/generator HCPCS codes on claims for these drugs. This paragraph is being removed from the published policy.

**HCPCS code E0575**

Large volume ultrasonic generators (HCPCS code E0575) will **not** be covered under the new DMERC nebulizer RMRP, unless payment for the equipment was made by a local carrier prior to transition to the DMERC. Because this represents a change to the policy published in December 1996, it will become effective with dates of service on or after July 1, 1997. (Reminder: new products coded HCPCS code E0575 will not be paid for dates of service on or after 4/1/97.) All accessories and supplies associated with denied equipment will also be denied. Monthly rentals of units placed with DOS prior to 4/1/97, will continue to be reimbursed until 7/1/97.

When submitting claims for grandfathered large volume ultrasonic generators (HCPCS code E0575) previously **approved by local carriers, each** claim must be submitted hard-copy, with a copy of documentation demonstrating previous payment for the equipment by the local carrier.
**MEDICAL AFFAIRS BULLETIN**

**Nebulizer policy update**

*(continued)*

### Clarifications

The purpose of clarifications in published policy is to facilitate better understanding of policy content within the supplier community. As such, clarifications involve no new changes or additions to policy, and therefore require no notification period.

**Dispensing fee and saline**

A dispensing fee (HCPCS code Q0132) should not be billed for the dispensing of saline used either as a diluent (HCPCS code J7051 or K0283) or for humidification treatment (HCPCS code K0182 or K0529).

**Extra physician narrative documentation**

Those situations for which additional physician documentation are required **WITH THE CLAIM** are when:

1. more than the usual maximum monthly quantity of nebulized medications are billed;
2. more than one beta-adrenergic bronchodilator is billed within the same period of time;
3. more than one anticholinergic bronchodilator is billed within the same period of time.

This additional physician documentation should be in narrative form, **FROM THE PHYSICIAN**, and not on a supplier-generated form (for example, check lists).

_in all the situations listed above where extra physician narrative documentation is required, a copy should be attached to EACH hard copy claim. Where extra documentation is required which does not have to be in the form of physician narrative, such as when supplier-furnished documentation might be sufficient (corroborated by medical records which do not have to be sent in with the claim), all information must be entered in the HAO record of EACH electronic claim or attached to EACH hard copy claim submitted._

**Grandfathering of APPROPRIATE accessories**

The policy states that accessories for grandfathered equipment also are covered. However, this applies to accessories that are considered appropriately related to the grandfathered equipment (compressors/generators) according to the DMERC RMRP.

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**Nebulizer equipment coding guide**

The DMERCs, in cooperation with the Statistical Analysis DMERC (SADMERC), intend to publish in the **AUTUMN 1997 DMERC Medicare Advisory**, a coding guideline which will list those products currently available on the market which fulfill the requirements defined in the nebulizer policy for:

♦ **HCPCS code E0565**: a pneumatic aerosol compressor which can be set for pressures above 30 psi at a flow rate of 6-8 liters/minute, and is capable of continuous operation.
MEDICAL AFFAIRS BULLETIN

Nebulizer equipment coding guide (continued)

♦ **HCPCS code K0269:** a pneumatic aerosol compressor which can be set for pressures above 30 psi at a flow rate of 6-8 liters/minute, but is capable only of intermittent operation.

♦ **HCPCS code K0501:** a portable compressor which delivers a fixed, low pressure and is used with a small volume nebulizer. It must have battery or DC power capability and may have an AC power option.

Suppliers who believe the particular nebulizer compressors for which they bill the DMERCs qualify for these three HCPCS codes, are encouraged to contact these products' manufacturers, who should submit their compressors' technical specifications to the SADMERC by June 1, 1997.

ONLY products listed in the Autumn 1997 coding guideline may be billed using either of these HCPCS codes thereafter. If a compressor for which a supplier is billing is not included on this list, it may only be billed with HCPCS code E0570. Prior to the guideline’s publication, suppliers must still abide by the coding definitions contained in the published nebulizer policy, which becomes effective for dates of service on or after 04/01/97. If suppliers have questions about the proper coding of their equipment, they should contact the SADMERC for coding determinations. After publication of the nebulizer coding guideline, manufacturers, whose products fail to appear on the list for HCPCS codes E0565, K0269 or K0501, may at any time submit their product information to the SADMERC for consideration of inclusion in future updates to the guideline.

Chiropractors

Medicare regulations do not allow for coverage of a service when a chiropractic physician is the prescribing physician. Durable medical equipment, prostheses, orthoses, and supplies (DMEPOS) are, therefore, not covered when prescribed by a chiropractor.
Dear Physician:

The following is a summary of the Durable Medical Equipment Regional Carrier's (DMERC) Regional Medical Review Policy (RMRP) on power operated vehicles. It describes the equipment, its usual clinical indications, and Medicare's coverage criteria for reimbursement. Hopefully it will help you to better understand the criteria Medicare uses in adjudicating these claims.

The DMERC strongly believes that the physician is still the "Captain of the Ship." We require a physician's order before reimbursing any item. Sometimes we require a Certificate of Medical Necessity (CMN) and extra documentation. While this may inconvenience you with additional paperwork, it is only through your cooperation that Medicare can provide beneficiaries with the equipment and supplies they need. You are also helping to protect the Medicare Trust Fund from abusive and fraudulent claims for items that are not medically necessary or physician-ordered.

The following Physician Information Sheet (PHYIS) is only a summary of the RMRP published in the DMERC Region C DMEPOS Supplier Manual. The definitive and binding coverage policy will always be the RMRP itself, which reflects national Medicare policy, and upon which actual claims adjudication is based. The physician information sheet is intended only as an effort to educate the physician community on conditions of coverage for items of durable medical equipment, prostheses, orthoses, and supplies when ordered for the care of Medicare beneficiaries.

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Power Operated Vehicles (POVs) are billed to the DMERC using the HCPCS code, E1230. This type of vehicle is primarily meant to function inside the home, and is characterized as being a “non-highway” vehicle. It may have three or four wheels.

Indications

A power operated vehicle (POV) is covered when all of the following criteria are met:

♦ The patient’s condition is such that a wheelchair is required for the patient to get around in the home,

♦ the patient is unable to operate a manual wheelchair,

♦ the patient is capable of safely operating the controls for the POV, and

♦ the patient can transfer safely in and out of the POV and has adequate trunk stability to be able to safely ride in the POV.

Coverage and payment rules

Most POVs are ordered for patients who are capable of ambulation within the home but require a power vehicle for movement outside the home. POVs will be denied as not medically necessary in these circumstances.

A POV that is beneficial primarily in allowing the patient to perform leisure or recreational activities will be denied as not medically necessary.

If a POV is covered, a wheelchair provided at the same time or subsequently will usually be denied as not medically necessary.

A POV is usually covered only if it is ordered by a physician who is one of the following specialties: Physical Medicine, Orthopedic Surgery, Neurology, or Rheumatology. When such a specialist is not reasonably accessible, e.g. more than one day’s round trip from the beneficiary’s home, or the patient’s condition precludes such travel, a prescription from the beneficiary’s attending or other consulting physician may be acceptable.

Documentation

An order for a POV, signed and dated by the physician, must be received by the supplier prior to delivery of the item to the patient.

The supplier of your patient’s equipment must submit a Certificate of Medical Necessity (CMN) (DMERC 07) with the claim in order to obtain Medicare reimbursement. Section B of the CMN contains questions pertaining to the medical necessity of the equipment which may not be completed by the supplier. The physician or another health care clinician may complete Section B. But only the patient’s physician may sign the CMN, indicating that he/she has reviewed Section B of the CMN for accuracy and completeness.

The physician’s medical record of the patient must contain documentation substantiating that the patient’s condition meets the above coverage criteria and the answers given in Section B of the CMN. These records may be requested by the DMERC to confirm concurrence between the medical record and the information submitted to the DMERC.
POWER OPERATED VEHICLES (POVs)
Physician Information Sheet

Prior authorization

The POV is one of three items of DME which is available for prior authorization (PA). This allows a beneficiary and his or her physician to determine BEFORE PURCHASE whether Medicare will approve reimbursement BASED UPON MEDICAL NECESSITY CRITERIA (it is always possible that, subsequent to a PA approval, a claim may be denied for other technical reasons such as Medicare ineligibility, the discovery of Medicare's having paid for duplicate equipment, an invalid supplier number, etc).

In order to participate in the PA process, the physician completes the CMN PRIOR TO PURCHASE OF EQUIPMENT. The DMERC will respond directly to the physician's office and the beneficiary with a decision to approve or deny the request, or to further develop the request for information.

Whether or not the PA process is chosen, if the prescribing physician is not one of the four specialists required in the medical review policy (physiatrist, neurologist, rheumatologist, or orthopedic surgeon), it is essential that extra documentation in the form of a physician's letter accompany the CMN, explaining why the prescribing physician believes the patient requires a POV. The letter should also explain why the patient was not seen by one of these specialists for the purpose of ordering a POV.
The ABCs of Basic Billing
Palmetto GBA Workshop Series
Spring 1997

Palmetto GBA is sponsoring half-day workshops in April and May to prepare NEW suppliers with proper basic billing instructions for submitting DMERC Region C claims.

—THIS WORKSHOP IS DESIGNED FOR BEGINNERS—

What to Expect
Each attendee will receive comprehensive workshop materials covering the agenda topics. Region C ombudsmen will conduct each workshop and be available to answer questions.

Please Note
Because people have different comfort levels, bring a sweater or jacket in case you need it. While refreshments will be served, lunch is not provided nor is parking validated.

To Register
Complete the enclosed registration form and return it to Palmetto GBA, with the appropriate non-refundable registration fee of $45 per person. Only pre-registered individuals will be guaranteed a seat.

Workshop Agenda
8:30 a.m. - 9:00 a.m. Registration
9:00 a.m. - 9:45 a.m. DMERC Building Blocks
9:45 a.m. - 10:15 a.m. Documents/Resources/Requirements
10:15 a.m. - 10:30 a.m. Break
10:30 a.m. - 11:30 a.m. HCFA 1500 completion
11:30 a.m. - 12:30 p.m. Remittance Advice/Appeals Process