NOTE: Should you have landed here as a result of a search engine (or other) link, be advised that these files contain material that is copyrighted by the American Medical Association. You are forbidden to download the files unless you read, agree to, and abide by the provisions of the copyright statement. Read the copyright statement now and you will be linked back to here.
On July 1, 2004, new wheelchair cushion codes became effective. After coding the majority of cushions submitted for review, the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC), Durable Medical Equipment Regional Carriers (DMERCs) and Centers for Medicare & Medicaid Services (CMS) have determined that the HCPCS code descriptions do not adequately describe some adjustable seat cushions.

Effective immediately, adjustable seat cushions will be removed from both the skin protection seat cushion codes (K0652, K0653) and the combination skin protection and positioning seat cushion codes (K0656, K0657). Adjustable cushions are those which have all of the characteristics of a skin protection seat cushion or skin protection and positioning seat cushion as described in the Coding Guidelines section of the Policy Article and are adjustable by addition or removal of significant quantities of air, liquid, gel, or other fluid medium in physiologically appropriate areas of the cushion to promote pressure reduction. Adjustable cushions will be coded K0108 (Wheelchair component or accessory, not otherwise specified) until such time as an acceptable code description and test requirements can be determined.

For products that have already been coded as K0652, K0653, K0656, or K0657, the SADMERC will determine which of the products are adjustable cushions and the revised determination will be posted on the SADMERC Web site by November 5 and a new Coding Verification Review letter will be sent to the manufacturer. Manufacturers of adjustable products that have not yet been coded will receive letters assigning their products to K0108. Once that coding determination is made by the SADMERC, those products may be submitted as K0108 for dates of service on or after July 1, 2004. Fee schedule amounts will be established for categories of similar adjustable products. The DMERCs will process the claims as any other K0108 with the allowed payment amounts being equal to the lower of the actual charge or the fee schedule amount.

The Web address for the SADMERC Product Classification List is www.PalmettoGBA.com, then select Other Partners, SADMERC, then Product Classification Lists twice, then Wheelchair Cushions (new K codes).
If claims for products that are classified by the SADMERC as adjustable seat cushions have been submitted as K0652, K0653, K0656, and K0657 and paid based on the fee schedule amounts posted in early October, then beginning November 12, suppliers may request a payment adjustment. The procedure in Region C is to submit those claims as a redetermination request (first level appeal - telephone or written). For adjustable cushions, the supplier will need to provide all of the details about the cushion described in the next paragraph. Claims that were processed prior to early October were paid using individual consideration; those claims may not be submitted for a payment adjustment.

For an adjustable seat cushion to be covered, it must meet the coverage criteria (including ICD-9 codes) for a skin protection seat cushion or skin protection and positioning seat cushion (as applicable) as specified in the Wheelchair Seating Local Coverage Determination (LCD). If the criteria are not met but the coverage criteria for another type of cushion are met, payment will be based on the allowance for the least costly medically appropriate alternative; if the criteria for another type of seat cushion are not met, the provided cushion will be denied as not medically necessary. If the narrative coverage criteria have been met, a KX modifier should be added to HCPCS code K0108. Claims for cushions billed with HCPCS code K0108 must clearly state "cushion" and must include the name of the manufacturer, the product name, the model number, and the width of the cushion which was provided. This information should be entered in the narrative field of an electronic claim or attached to a hard copy claim. Suppliers should make sure that the product name/number that they list exactly matches the complete product name/number that is listed in the Product Classification List on the SADMERC Web site. If a cushion submitted as K0108 has not received coding verification as such from the SADMERC, the claim line will be rejected or denied as incorrect coding.

There is no change in the coding of general use seat cushions (K0650, K0651), positioning seat cushions (K0654, K0655), custom fabricated seat cushions (K0658), general use back cushions (K0660, K0661), positioning back cushions (K0662-K0665), or custom fabricated back cushions (K0666). Those HCPCS codes include both adjustable and nonadjustable cushions.

Effective immediately, the HCPCS codes for custom fabricated seat cushions (K0658) and custom fabricated back cushions (K0666) will be paid on an individual consideration basis, rather than using the fee schedule allowances established in early October. All claims for HCPCS codes K0658 and K0666 must include the manufacturer and model name/number of the product if applicable, or if not, a detailed description of the product that was provided. The submitted charge and the product description must include whatever mounting hardware is used for the cushion.

Fee schedule allowances for all HCPCS codes other than K0658 and K0666 will be recalculated based on products that have received confirmation of coding from the SADMERC. This includes a recalculation of the allowances for HCPCS codes K0652, K0653, K0656, and K0657 with the adjustable products removed. The new allowances will be effective on all claims for these HCPCS codes that are processed on or after November 12, 2004.

If claims for HCPCS codes K0650-K0666 are processed before November 12 and are paid based on the October fee schedule allowances, then beginning November 12, suppliers may request a payment adjustment. The procedure in Region C is to submit those claims as a redetermination request. For cushions except custom fabricated, it may be a telephone or written appeal and the supplier does not need to provide details of the cushion that was dispensed. For custom fabricated cushions, it must be a written redetermination request and must include the manufacturer and product name/number (if applicable) or a detailed description of the product. Claims that were processed prior to early October were paid using individual consideration; those claims may not be submitted for a payment adjustment.

A revision of the Wheelchair Seating LCD and Policy Article incorporating these changes will be published in the Winter 2004 Region C DMEPOS Supplier Manual Updates.
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This bulletin should be shared with all health care practitioners and managerial members of the provider/supplier staff.
Update to Medicare Deductible, Coinsurance, and Premium Rates for Calendar Year (CY) 2005

Related Change Request (CR) #: 3463
Medlearn Matters Number: MM3463
Related CR Release Date: September 10, 2004
Related CR Transmittal #: 10

Effective Date: January 1, 2005
Implementation Date: January 3, 2005

Provider Types Affected
Physicians, providers, and suppliers

Provider Action Needed
This instruction updates Medicare deductibles, coinsurance, and premium rates for CY 2005.

Background
Most individuals age 65 and older (and many disabled individuals under age 65) are insured for Health Insurance (HI) or Part A benefits without a premium payment. The Social Security Act provides that certain aged and disabled persons who are not insured may voluntarily enroll, but they are subject to the payment of a monthly premium. Since 1994, voluntary enrollees may qualify for a reduced premium if they have 30-39 quarters of covered employment. When voluntary enrollment takes place more than 12 months after a person's initial enrollment period for HI benefits, the monthly premium is increased by 10 percent.

Under the Supplementary Medical Insurance (SMI) plan or Part B, all enrollees are subject to a monthly premium. Most SMI services are subject to an annual deductible and coinsurance (percent of costs that the enrollee must pay) that are set by statute. When SMI enrollment by a beneficiary takes place more than 12 months after the initial enrollment period, the monthly premium increases by 10 percent for each full 12-month period during which the individual could have been enrolled, but was not.

Beneficiaries who use covered Part A services may be subject to deductible and coinsurance requirements.

Inpatient Hospital Services
A beneficiary is responsible for an inpatient hospital deductible amount for inpatient hospital services furnished in a spell of illness (which is deducted from the amount payable by the Medicare program to the hospital).

• More than 60 Days. When a beneficiary receives such services for more than 60 days during a spell of illness, he/she is responsible for a coinsurance amount equal to one-fourth of the inpatient hospital deductible per day for the 61st-90th day spent in the hospital.

• After the 90th Day. An individual has 60 lifetime reserve days of coverage, which he or she may elect to use after the 90th day in a spell of illness. The coinsurance amount for these days is equal to one-half of the inpatient hospital deductible.

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

For CY 2005, the premium, deductible, and coinsurance amounts are as follows:

Year 2005 Medicare Part A Deductible, Coinsurance, and Premium Amounts:
• Deductible: $912.00 per benefit period
• Coinsurance:
  • $228.00 a day for days 61-90 in each period
  • $456.00 a day for days 91-150 for each lifetime reserve day used
  • $114.00 a day in a SNF for days 21-100 in each benefit period
• Premium per month:
  • $375.00 for those who must pay a premium
  • $412.50 for those who must pay both a premium and a 10 percent increase
  • $206.00 for those who have 30-39 quarters of coverage
  • $226.60 for those with 30-39 quarters of coverage who must pay a 10 percent increase
Update to Medicare Deductible, Coinsurance, and Premium Rates for Calendar Year (CY) 2005 cont.

Year 2005 Medicare Part B Deductible, Coinsurance, and Premium Amounts:
- Deductible: $110.00 per year
- Coinsurance: 20 percent
- Premium per month: $78.20

The following table compares Medicare Part A Deductible, Coinsurance, and Premium Amounts for Years 2001 through 2005:

<table>
<thead>
<tr>
<th>Year</th>
<th>Inpatient Hospital Deductible, 1st 60 Days ($)</th>
<th>Inpatient Hospital Coinsurance, 61st-90th Days ($)</th>
<th>60 Lifetime Reserve Days Coinsurance ($)</th>
<th>SNF Coinsurance ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001</td>
<td>792</td>
<td>198</td>
<td>396</td>
<td>99</td>
</tr>
<tr>
<td>2002</td>
<td>812</td>
<td>203</td>
<td>406</td>
<td>101.5</td>
</tr>
<tr>
<td>2003</td>
<td>840</td>
<td>210</td>
<td>420</td>
<td>105</td>
</tr>
<tr>
<td>2004</td>
<td>876</td>
<td>219</td>
<td>438</td>
<td>109.5</td>
</tr>
<tr>
<td>2005</td>
<td>912</td>
<td>228</td>
<td>456</td>
<td>114</td>
</tr>
</tbody>
</table>

Implementation
The implementation date for this instruction is January 3, 2005.

Related Instructions
CR 3121 (Transmittal 3), "New Part B Annual Deductible," was issued on March 12, 2004. CR 3121 updated the 2005 Part B deductible based on section 629 of the Medicare Prescription Drug, Improvement and Modernization Act. The same information held in CR 3121 is being communicated in CR 3463. Therefore, CR 3463 is replacing CR 3121 to prevent unintended consequences that may result from implementing both CR 3463 and CR 3121 together.

Additional Information
The Medicare General Information, Eligibility, and Entitlement Manual (Pub. 100-01), Chapter 3 (Deductibles, Coinsurance Amounts, and Payment Limitations) has been revised and the updated manual instructions are attached to the official instruction released to your carrier/intermediary. You may view that instruction by going to: http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp

From that Web page, look for CR3463 in the CR NUM column on the right, and click on the file for that CR. If you have any questions, please contact your carrier/intermediary at their toll-free number, which may be found at: http://www.cms.hhs.gov/medlearn/tollnums.asp

This bulletin should be shared with all health care practitioners and managerial members of the provider/supplier staff.
MMA-Medicare Replacement Drug Demonstration

Related Change Request (CR) #: N/A  
Related CR Release Date: SE0443 (REVISED)  
Related CR Transmittal #: 

Effect Date: Immediately  
Implementation Date: Immediately

IMPORTANT: This is an updated version of this article. The article has been revised to reflect two additional drugs (Somavert and Mesnex) that are covered under this demonstration, as noted in the revised table, and to announce that there are still many enrollment slots available. It is not too late to request or submit an application!

We need your help to reach beneficiaries who could benefit from this demonstration. These beneficiaries include people who have been diagnosed with rheumatoid arthritis, multiple sclerosis, osteoporosis, pulmonary hypertension, secondary hyperparathyroidism, Paget’s Disease, Hepatitis C, CMV retinitis, or certain kinds of cancer. If you treat Medicare beneficiaries who currently use or could benefit from the drugs listed in the table, Medicare may be able to help them pay for these drugs.

Provider Types Affected

All Medicare physicians and providers but we are especially interested in reaching out to physician specialists in family practice, internal medicine, geriatrics, rheumatology, oncology and neurology, as well as pharmacists, nurse practitioners, hospital outpatient departments, cancer and infusion centers, and group practice administrators.

Provider Action Needed

STOP - Impact to You

A new demonstration mandated under Section 641 of the Medicare Modernization Act allows up to 50,000 people with Medicare who have certain life-threatening diseases to obtain specified drugs they can take themselves at home for their condition.

CAUTION - What You Need to Know

A signed physician certification will need to be filled out for any of your patients who are applying to participate in this demonstration. By signing this certification, you are certifying that the patient has the condition indicated and you have prescribed or intend to prescribe a coverable drug for this condition in accordance with the demonstration requirements. Your signed certification is necessary for the patient’s application to participate in the demonstration to be considered complete. For your convenience, physician certification forms may also be faxed to (410) 683-2933. Please note that nurse practitioners who write prescriptions for these coverable drugs may also sign the certification form.

GO - What You Need to Do

Review the list of coverable conditions and drugs available under this demonstration. If you have any patients you think might be interested and eligible to apply, let them know. Be aware that both Fee-for-Service and Medicare Advantage beneficiaries are eligible to apply for the demonstration. If they would like to request an application or have any questions related to the demonstration, or need assistance completing the application, they can call a toll-free number: 1-866-563-5386 (TTY number: 1-866-563-5387). There is also helpful information on the Medicare Web site (www.medicare.gov), including an application package that can be downloaded.

Note to Hospitals: Please share this information with staff who come into contact with Medicare beneficiaries who may be eligible for this demonstration (e.g., social workers or staff who assist with Medicaid eligibility determinations).

Background

The Medicare Replacement Drug Demonstration is a time-limited Medicare demonstration that will cover certain drugs and biologicals that are prescribed as replacements for existing covered Medicare drugs and biologicals before Medicare’s prescription drug program begins in 2006. This demonstration was authorized by Section 641 of the Medicare Modernization Act.

The Centers for Medicare & Medicaid Services (CMS) has contracted with TrailBlazer Health Enterprises, a Medicare carrier, to assist in implementing the demonstration. TrailBlazer will manage the eligibility determination and enrollment process as well as coordinate outreach efforts to beneficiary advocacy groups, physicians,
and others interested in this demonstration. TrailBlazer has sub-contracted with Caremark to administer the drug benefit.

Medicare realizes the important role drugs play in treating serious diseases. When Medicare first began, drugs played a much smaller role in medical care. Only drugs that are administered in a physician’s office have been covered under Medicare Part B. In recent years, many new medications have been developed that replace some of these drugs, allowing patients with serious and life-threatening illnesses to take these drugs in their own home. For a beneficiary to be eligible for this demonstration, he or she must meet the following criteria:

- Beneficiary must have Medicare Part A and Part B.
- Medicare must be the beneficiary’s primary health insurance.
- Beneficiary must reside in one of the 50 states or the District of Columbia.
- Beneficiary must have a signed certification form from his/her doctor stating that he/she has prescribed or intends to prescribe for the beneficiary one of the covered medications for the specified condition.
- The beneficiary may not have any other insurance that has comprehensive drug coverage (such as Medicaid, an employer or union group health plan, or TRICARE) that would cover this medication.

The table to the right shows the drugs and conditions that will be covered under the demonstration.

For more information on this demonstration, please visit www.medicare.gov or call (toll free): 1-866-563-5386 (TTY number: 1-866-563-5387) between 8:00 a.m. and 7:30 p.m. Eastern time, Monday - Friday. You can also use the toll-free number if you have questions about the demonstration or the application. We also have a beneficiary brochure available that describes the demonstration and its benefits. Copies of the brochure can be requested at: outreach.mrdd@trailblazerhealth.com.

### DRUGS COVERED UNDER THE MEDICARE REPLACEMENT DRUG DEMONSTRATION (updated August 9, 2004)

<table>
<thead>
<tr>
<th>Demonstration Covered Indication</th>
<th>Drug/Biological—Compound Name (Brand Name)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rheumatoid Arthritis</td>
<td>Adalimumab (Humira)</td>
</tr>
<tr>
<td></td>
<td>Anakinra (Kineret)</td>
</tr>
<tr>
<td></td>
<td>Etanercept (Enbrel)</td>
</tr>
<tr>
<td>Multiple Sclerosis</td>
<td>Glatiramer acetate (Copaxone)</td>
</tr>
<tr>
<td></td>
<td>Interferon beta –1a (Rebif, Avonex)</td>
</tr>
<tr>
<td></td>
<td>Interferon beta –1b (Betaseron)</td>
</tr>
<tr>
<td>Osteoporosis (patient must be homebound)</td>
<td>Calcitonin – nasal (Miacalcin – nasal)</td>
</tr>
<tr>
<td>Pulmonary Hypertension</td>
<td>Bosentan (Tracleer)</td>
</tr>
<tr>
<td>Secondary Hyperparathyroidism</td>
<td>Doxercalciferol (Hectoral)</td>
</tr>
<tr>
<td>Paget’s Disease</td>
<td>Alendronate (Fosamax)</td>
</tr>
<tr>
<td></td>
<td>Risedronate (Actonel)</td>
</tr>
<tr>
<td>Hepatitis C</td>
<td>Pegylated interferon alfa-2a (Pegasys)</td>
</tr>
<tr>
<td></td>
<td>Pegylated interferon alfa-2a (PEG-Intron)</td>
</tr>
<tr>
<td>CMV Retinitis</td>
<td>Valcyte (Valganciclovir)</td>
</tr>
<tr>
<td>Acromegaly</td>
<td>Pegvisomant (Somavert)</td>
</tr>
<tr>
<td>Anti-Cancer</td>
<td></td>
</tr>
<tr>
<td>Cutaneous T-cell Lymphoma</td>
<td>Bexarotene (Targettin)</td>
</tr>
<tr>
<td>Non-small cell lung cancer</td>
<td>Gefitinib (Iressa)</td>
</tr>
<tr>
<td>Epithelial ovarian cancer</td>
<td>Alretamine (Hexalen)</td>
</tr>
<tr>
<td>Chronic Myelogenous Leukemia</td>
<td>Imatinib Mesylate (Gleevec)</td>
</tr>
<tr>
<td>GI Stromal Tumor</td>
<td>Imatinib Mesylate (Gleevec)</td>
</tr>
<tr>
<td>Multiple Myeloma</td>
<td>Thalidomide (Thalomid)</td>
</tr>
<tr>
<td>Breast Cancer</td>
<td>Hormonal therapy</td>
</tr>
<tr>
<td>Stage 2-4 only</td>
<td>Anastrozole (Arimidex)</td>
</tr>
<tr>
<td></td>
<td>Exemestane (Aromasin)</td>
</tr>
<tr>
<td></td>
<td>Letrozole (Femara)</td>
</tr>
<tr>
<td></td>
<td>Tamoxifen (Nolvadex)</td>
</tr>
<tr>
<td></td>
<td>Toremifene (Fareston)</td>
</tr>
<tr>
<td>Prophylactic agent to reduce ifosfamide-induced hemorrhagic cystitis</td>
<td>Mesna-oral tablets (Mesnex)</td>
</tr>
</tbody>
</table>
**MMA- Section 937 - Correction of Minor Errors and Omissions without Appeals**

**Related Change Request (CR) #:** N/A  
**Medlearn Matters Number:** SE0420  
**Effective Date:** N/A - Informational Only  
**Provider Types Affected**  
All Medicare physicians, providers, and suppliers

**Provider Action Needed**  
Understand the Medicare rules that enable you to correct minor errors and omissions on Medicare claims without having to go through the appeals process. This article will provide information needed to make such minor corrections to Medicare claims within existing procedures.

**Background**  
Section 937 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), Public Law 108-73, requires the Secretary of the Department of Health and Human Services to establish a process for physicians, providers, and suppliers to correct minor errors and omissions in claims without pursuing the formal appeals process. The Centers for Medicare & Medicaid Services (CMS) currently provides the following ways to make such corrections:

1. **Correcting Incomplete or Invalid Claims Submissions**  
Medicare instructions currently provide an opportunity for physicians, suppliers, and providers to correct errors or omissions in a submitted claim without the need to initiate a formal appeal, such as a review or, reconsideration. These processes are outlined in the *Medicare Claims Processing Manual, Pub. 100-4, Chapter 1 - General Billing Requirements, section 80.3.2 - Handling Incomplete or Invalid Claims and Section 70.2.3.1 - Incomplete or Invalid Submissions.*

   The instructions provide the rationale for determining whether a claim (Forms CMS-1450, CMS-1500 or their electronic equivalent) is considered complete for processing purposes and outlines the actions to be taken by contractors upon receipt of incomplete or invalid claim submissions.

   Basically, the instructions identify incomplete claims as ones submitted with required information missing, such as the provider’s name. Invalid submissions also are claims that contain complete and required information, but the information is illogical or incorrect (e.g., incorrect HIC # or invalid procedure code) or the information does not conform to required claim formats.

   The following definitions may be applied to determine whether data on submitted claims are incomplete or invalid:
   - **Required** - Any data element that is needed in order to process the submission, such as provider name.
   - **Not Required** - Any data element that is optional or is not needed to process the submission, such as the patient’s marital status.
   - **Conditional** - Any data element that must be completed if other conditions exist (e.g., if there is insurance primary to Medicare, then the primary insurer’s group name and number must be entered on a claim). If these conditions exist, the data element becomes required.

   Based on these instructions, if a claim is submitted with missing or incorrect information for certain specified items, it is considered to be unprocessable and is to be “returned” to the provider. Returning a claim as unprocessable does not mean that every claim is physically returned to the provider. The terms “return as unprocessable” or “return to provider” refer to the many processes utilized for notifying the provider or supplier of service that their claim cannot be processed, and that it must be corrected or resubmitted.

   Different contractors use various techniques for returning claims as unprocessable. Following are just two examples:
   - If incomplete or invalid information is detected at the front-end of claims processing, the claim may be returned to the provider identifying the error(s) and explaining how to correct the errors prior to resubmission.
   - If incomplete or invalid information is detected at the front-end of the claims processing...
system, the claim may be suspended and developed; requested corrections and/or medical documentation must be submitted within a 45-day period. After the requested information is received, the claim is processed. Otherwise, the suspended portion is returned and the supplier or provider of service is notified by means of the remittance advice.

Under these instructions, carriers and fiscal intermediaries (FIs) typically either suspend claims with defective data for development and correction by the provider or send the claim back to the provider, noting the missing or incorrect items, for correction and resubmission. Claims submissions that are returned to the provider are not considered claims under Medicare regulations. Therefore, neither of these processes allows for the initiation of an appeal.

For more details on these sections, you may view Chapter 1, Sections 70.2.3.1 and 80.3.2, of the Medicare Claims Processing Manual, Pub. 100-04, at:
http://www.cms.hhs.gov/manuals/104_claims/clm104index.asp

Once at that site, scroll down to Chapter 1 and click on the type of file you wish to download.

3. Reopening Claims
A third process that providers can use is the Reopening Process. Section 1869(b) (1) (G) of the Act provides for the reopening and revision of any initial determination according to guidelines prescribed by the Secretary. The Medicare Claims Processing Manual, Pub. 100-4, Chapter 29 - Appeals of Claims Decisions, section 60.27 - Reopening and Revision of Claims Determinations and Decisions, distinguishes the reopening process from the appeals process.

The purpose for a reopening should be to change the determinations or decisions that result in either overpayments or underpayments. Reopenings have been misconstrued as a level of the appeals process. A reopening is not an appeal right; it is a discretionary action as defined under 42 CFR 405.841. Requests for adjustments to claims resulting from clerical errors must be handled through the reopening process. The request must be made within one year from the date of the notice of the initial determination. A provider has a four-year timeframe to initiate a reopening after the date of the initial determination if good cause exists.

4. Correcting HIPAA Compliance Issues
The fourth process relates to CMS's existing process for evaluating a claim's HIPAA compliance. This process can be found in the Medicare Claims Processing Manual, Pub. 100-4, Chapter 24 - EDI Support Requirements, sections 30.6 - Translators; 70.1 - FI Requirements; and 70.2 - Carrier/DMERC Requirements.

Currently, Medicare contractor translators validate the syntax compliance of the X12N 837 standard. The entire file will be rejected when the file is syntactically incorrect. The contractor will send to the provider the X12N 997 Functional Acknowledgment to report the syntax errors. If the file is syntactically correct, HIPAA-implementation guide-compliance validation of the X12N 837 is performed. Compliance validation edits check for required loops and segments, appropriate segments within a loop, valid calendar dates, qualifiers, and...
MMA- Section 937 - Correction of Minor Errors and Omissions without Appeals cont...

so on. Individual claims are rejected to the provider when they contain errors. The errors are then reported on contractor specific error reports.

To view the manual sections on reopening information or for the HIPAA information, use the same Web address as provided above and scroll to Chapters 29 and 24, respectively. Once at each chapter, select the version of the file you wish to review.

Additional Information
If you encounter problems or have any questions, please contact your carrier or FI on their toll-free number. If you do not have that number, you may find it at:
http://www.cms.hhs.gov/medlearn/tollnums.asp

Below are the most common GPNet Edit Status Codes:
- A W status code is displayed for Warning messages. A warning message will usually display for 30 to 60 days prior to upgrading to a reject message. Warning messages indicate the claim has been accepted for adjudication. However, data necessary for the claim to process correctly may be missing causing the claim to deny or reject in the standard system.
- An I status code is displayed for informational edits. Informational edits are used to indicate patient and claim type demographic information. The claim will be accepted for adjudication.
- An R status code is displayed when a claim is rejected. Rejected claims require additional information in order for the claims to be processed or do not meet IG or standard system requirements. Claims that receive an R status code will not be sent to the standard system and must be corrected and re-transmitted to GPNet.

The GPNet Edit Manual includes a list of GPNet Edit codes and descriptions that may appear on the GPNet Response Report. The GPNet Edit Manual is available for download through the Palmetto GBA Web site under Providers/EDI/(select your LOB)/Software & Manuals.

Please contact the Palmetto GBA Technology Support Center at 1-866-749-4301 with questions regarding GPNet edits.

GPNet Edit Manual

Palmetto GBA uses an EDI Gateway called GPNet for SC Part A, NC Part A, RHHI, SC Part B, DMERC & Railroad electronic transactions. Following the transmission of a claims file to Palmetto GBA, GPNet will perform a series of edits against the claim file. A GPNet Response Report will be issued with the accepted and rejected status of your claim file.

The GPNet Response Report can display different types of status codes for each edit performed against a claim. Examples of GPNet Edit Status Codes and GPNet Edit Codes pulled from a GPNet Response Report appears below.

RESPONSES - REPORT FORMAT
PATIENT: DOE FRED  PON: CL123  Status: REJECTED
INSURED: DOE  PON: CL123  Name: Doe, Fred
First DCS: 20040112 Charge: $90.00 Payor: Carrier
R MSG: IF3 RELEASE OR INFORMATION CODE INVALID:

PATIENT: WOLFE JANE  PON: JANE123  Status: ACCEPTED
INSURED: WOLFE JANE  ID: janessecard
First DCS: 20040124 Charge: $120.00 Payor: Carrier
W MSG: VTI Billing Provider ID Quality invalid

** End of Report **
Information and Education Resources for Medicare Providers, Suppliers, and Physicians

Related Change Request (CR) #: N/A
Medlearn Matters Number: SE0454

Effective Date: N/A
Implementation Date: N/A

Provider Types Affected
All Medicare physicians, providers, and suppliers

Provider Action Needed
This article is informational only and is intended to notify Medicare physicians and other providers about the information and education resources that the Centers for Medicare & Medicaid Services (CMS) have developed to help meet their Medicare business needs.

Background
One of the goals of CMS is to give Medicare’s 1.2 million physicians and other providers the information they need to understand the program, be aware of changes, and bill correctly. By making information and education resources easily accessible, understandable, and as timely as possible, physicians and other providers will be better able to submit bills correctly the first time, receive reimbursements more quickly, and spend less time dealing with paperwork. All of this can result in more time to spend on patient care. We are committed to accomplishing this goal by offering Medicare physicians and other providers a variety of educational products and services and using various information delivery systems to reach the broadest and most appropriate audiences possible.

Three-Pronged Provider Information and Outreach Approach
CMS relies on the cooperative efforts of its Medicare contractors, Regional Offices, and Central Office provider communications staff to deliver a seamless information and outreach approach to Medicare physicians and other providers.

1) Medicare Contractors
Medicare contractors, also called fiscal intermediaries and carriers, serve as the primary point of contact for most Medicare physicians and other providers. These contractors provide toll-free telephone lines for inquiries, conduct outreach and education, and often interact with local professional associations. Their outreach and education activities include in-person seminars, bulletins and newsletters, speaker appearances, and quick dissemination of timely information via Web sites and provider-specific electronic listservs (mailing lists).

If you have questions about the Medicare Program, you should first get in touch with your fiscal intermediary or carrier. To find fiscal intermediary and carrier contact information, please visit: http://www.cms.hhs.gov/medlearn/tollnums.asp

2) CMS Regional Offices
Staff at CMS’s Regional Offices provide oversight of Medicare contractors and play a key role in resolving issues that physicians and other providers cannot get resolved. Our Regional Offices are active with the physician and other provider communities at state and local levels through their relationships with state and local associations and big billers, and through outreach activities such as hosting provider-oriented meetings and furnishing speakers at professional conferences. CMS Regional Offices are located at various locations around the country. You can find their contact information at: http://www.cms.hhs.gov/about/regions/professionals.asp

3) CMS Central Office in Baltimore, Maryland
The provider communications staff at the CMS Central Office work closely with both Medicare contractor and Regional Office staff to ensure that consistent and coordinated Medicare information and resources are available to all physicians and other providers. Education and outreach activities from the CMS Central Office are generally targeted to national associations with consistency and timeliness as our top priorities. Given the hectic schedules of today’s health care professionals, most of our current initiatives are aimed at fostering a "self-service" environment so that physicians and other providers can access information and education 24 hours a day, seven days a week. As a result, we have significantly increased the use of the Internet as a key tool for continuous-improvement customer service.

Our efforts have resulted in a variety of products and services, such as:
Information and Education Resources for Medicare Providers, Suppliers, and Physicians cont...

**Medlearn Matters Articles** - One of the best sources for the latest Medicare information is "Medlearn Matters...Information for Medicare Providers" national articles, which are available at http://www.cms.hhs.gov/medlearn/matters. These articles are designed to give physicians and other providers and their staff easy to understand information related to new and recently changed Medicare rules and policies. The articles are written in consultation with clinicians and billing experts and focus on how these changes affect physician and other provider business functions. On the Medlearn Matters Web page, you'll find a searchable table for easy access to each article and its corresponding Program instructions, if applicable. You can join the Medlearn Matters listserv to receive electronic notification when new articles are released. Medicare contractors also publish Medlearn Matters articles in their bulletins and on their Web sites. This Central Office initiative serves to enhance and support contractors' local provider education efforts by promoting the availability of nationally consistent educational materials.

**Medicare Learning Network** - The Medlearn Matters articles are part of a broader inventory of physician and other provider educational products found under the Medicare Learning Network. The Medicare Learning Network is the brand name for official CMS physician and other provider educational products and is designed to promote national consistency of Medicare provider information developed for CMS initiatives. Products range from Web-based training courses, comprehensive training guides, brochures, and fact sheets to CD-ROMs and videos. All MLN products are free of charge and can be ordered or downloaded from the Medlearn Web page located at http://www.cms.hhs.gov/medlearn, which also gives easy access to other resources such as educational Web guides, electronic listservs, and provider-specific Web pages. Check back often for the latest products, resources, and provider-oriented links.

**CMS Provider Web Pages** - CMS has designed provider-specific Web pages to assist individual physician and other provider types in obtaining information relevant to them more quickly. These Web pages are a customized, one-stop Web-based resource for the provider, supplier, and physician audience that also includes highlights on items such as new regulations and hot topics, links to general information on enrollment, billing, conditions of participation, publications, education, data, and statistics, and links to “specialty” information. For example, the Medicare Physician Web Page at http://www.cms.hhs.gov/physicians includes links to the Medicare Physician Fee Schedule Look-Up Tool, National Correct Coding Initiative edits, Practicing Physicians Advisory Council, Physicians Regulatory Issues Team, Medicare Coverage Database, and the CMS Online Manual. We also have Specialty Physician Web Pages where we will continue to add links of special interest to physician specialties. The first Specialty Physician Web Page, "Medicare Information for Anesthesiologists," is available at http://www.cms.hhs.gov/physicians/anesthesiologist/default.asp.

From the CMS Home Page at http://www.cms.hhs.gov, you can access select physician and other provider pages from the "Professionals" drop-down menu. You can also see a complete listing of available provider and supplier Web pages by clicking on http://www.cms.hhs.gov/providers or http://www.cms.hhs.gov/suppliers. All pages have a comment section for you to electronically submit suggestions. We are always adding new pages, so check the site often.

**Other Popular Provider Web Pages** - In addition to the pages mentioned above, other frequently visited pages include the CMS Online Manual System at http://www.cms.hhs.gov/manuals; the CMS Quarterly Provider Update at http://www.cms.hhs.gov/providerupdate, which gives a listing of regulations and major policies currently under development during the quarter, regulations and major policies completed or cancelled, and new or revised manual instructions; the Medicare Coverage Homepage at http://www.cms.hhs.gov/coverage, which contains complete coverage information including links to CMS coverage databases, frequently asked questions, and “What’s New” lists.

**Listserv Messages** - CMS has a number of listservs that transmit important Medicare notices and reminders to subscribers. For example,
**Information and Education Resources for Medicare Providers, Suppliers, and Physicians cont...**

Listservs have been established for most provider-specific Web pages as well as for updates on the Medicare Prescription Drug, Improvement and Modernization Act of 2003, the Medicare Learning Network, and the Quarterly Provider Update. To view and subscribe to one or more listserv, please visit http://www.cms.hhs.gov/mailinglists.

**Open Door Forums** - CMS is very interested in hearing from and interacting with the physicians and other providers who deliver quality health care to our nation’s beneficiaries. We continue to emphasize our responsiveness through an ongoing series of Open Door Forums that provide an environment for interactive dialogue. Forums are chaired by senior-level Agency officials and co-chaired by CMS Regional Office officials. For more information, please visit http://www.cms.hhs.gov/opendoor.

**Exhibit Program** - CMS hosts exhibit booths at provider, supplier, and physician association meetings. The CMS Exhibit Program provides an excellent opportunity for CMS Central and Regional Office staff to have direct contact with the Medicare provider, supplier, and physician community to listen to issues, concerns, and challenges and to share timely and relevant information. If you are interested in having a CMS exhibit at your national conference, please contact David Clark at dclark@cms.hhs.gov.

**Physician and Other Provider Feedback**

Although we try our best to be responsive to the Medicare physician and other provider community’s education and information needs, we can’t do it alone. Your feedback on the effectiveness and usefulness of our educational resources is very important to us as it helps ensure that we are "getting it right." Please submit your comments or suggestions at http://www.cms.hhs.gov/providers by selecting "Feedback" from the blue template located at the top of the page. There is also a feedback link on the Medlearn Web Pages for your suggestions on new educational products at http://www.cms.hhs.gov/medlearn/suggestform.asp. We look forward to hearing from you.

**Tips for Beneficiaries Calling 1-800-MEDICARE**

Many beneficiaries have expressed concern about how difficult it is to get through to the appropriate person to speak with when calling 1-800-MEDICARE (1-800-633-4227). Below are step-by-step directions on how a beneficiary can reach a customer service representative when calling 1-800-MEDICARE specifically for information on durable medical equipment.

When calling 1-800-MEDICARE you will be asked a series of questions by the voice automated system. Please use the responses below to reach a customer service representative. These directions are specifically for durable medical equipment information.

**Step 1:** Say "**English**", to continue in English (also available in Spanish)
**Step 2:** Say "**Continue**", for other options
**Step 3:** Say "**Yes**", for Medicare
**Step 4:** Say "**Yes**", for Medical Services
**Step 5:** Say "**Medical Supplies**"
**Step 6:** Say your state of residence, (i.e. “Georgia”)

Your call will be connected to the next available representative.
Region C DMERC Implements New Toll-Free Line for Telephone Appeals

The DMERC Region C carrier has obtained a new toll free telephone number for the purpose of conducting telephone appeals. The new telephone appeals number is 1-866-813-7878 and will become operational on Monday, October 18, 2004, during the following hours:

Monday through Friday from 9:00 a.m. to 5:00 p.m. EST

This new telephone number is to be used for telephone appeals only! You should continue to contact the Team Service Representatives at 1-866-270-4909 or the Interactive Voice Response Unit (IVR) at 1-866-238-9650 for all other types of inquiries or problems. Please remember: You do not have appeal rights on claims that are denied as incomplete or invalid (Group/Reason code CO-16 on your remittance notice). These types of denials cannot be addressed in a telephone appeals.

When you call the telephone appeals line, the reviewer will ask you for the following information:

- The patient's name, Medicare number, and date of birth;
- Your Medicare Part B supplier number;
- The date of service for the item(s) or service(s) in question;
- The date of your remittance notice for the claim(s) in question;
- The CPT or HCPCS code for the charges(s) you are appealing; and
- Your name

Use of telephone appeals should be limited to resolving minor issues and correcting billing errors. The following problems are considered appropriate for telephone appeals:

- Correcting the number of units or services;
- Adding or changing certain modifiers;
- Correcting ICD-9 diagnosis codes;
- Fixing erroneous duplicate denials;
- Correcting certain CPT or HCPCS codes;
- Correcting place of service codes; or
- Correcting dates of service.

The following issues are not appropriate for telephone appeals:

- Limitation of liability problems;
- Corrections or problems involving claims that were denied as invalid or incomplete;
- Corrections that will result in an overpayment;
- Medical necessity denials;
- Problems that require the analysis of documents;
- Problems that involve other Medicare departments (for example: MSP denials, provider enrollment problems, or issues that must be addressed to Centers for Medicare & Medicaid Services (CMS));
- Adding modifiers that require the review of medical records;
- Problems involving changes in your provider number.

Timeliness of Appeals Requests

For claims made by a provider on or before October 1, 2002, providers have six months from the initial determination to request an appeal. The initial determination is the date that the claim was first processed. For claims made by a provider after October 1, 2002, providers have 120 days from the initial determination to appeal the claim.

Beneficiaries have six months from the initial determination to appeal claims made prior to January 3, 2003. For claims made on or after January 3, 2003, beneficiaries have 120 days from the initial determination to appeal.

Medicare guidelines only allow for an extension of the time limit if the claimant has "good cause" for late filing. CMS Publication 100-4, Chapter 29, Section 60.7 states that good cause can be found on provider-requested appeals if one of the following situations applies to the case:

- The provider was given incorrect or incomplete information about the claim or the appeal by an official source (CMS, the Medicare carrier, or the Social Security Administration); or
- Unavoidable circumstances prevented the provider from filing a timely request for an appeal. The term "unavoidable circumstances" is defined as situations that are beyond the provider's control, such as major floods, fires, tornadoes, and other catastrophes.

CMS Publication 100-4, Chapter 29, Section 60.7 states that good cause can be found on beneficiary-requested appeals if one of the following situations
Region C DMERC Implements New Toll-Free Line for Telephone Appeals cont...

applies to the case:

- Circumstances beyond the beneficiary’s control, including mental or physical impairment (e.g., disability, extended illness) or significant communication difficulties.
- Incorrect or incomplete information about the subject claim and/or appeal was furnished by official sources (CMS, carrier, intermediary, or the Social Security Administration) to the beneficiary (e.g., a party is not notified of her appeal rights or of the time limit for filing).

NOTE: Good cause will not be considered over the phone and is not applicable for telephone reviews. Request for good cause must be submitted in writing.

Requests for Medical Records

During the telephone review, we may ask you to fax us records to document the item(s) or services(s) that you are appealing. If you cannot fax the necessary records to us, you will be presented with two options: (1) transferring your appeal request to our written appeals area; or (2) sending in a written appeal request. You will also be given the choice of these two options if the telephone reviewer determines that the issue that you are appealing cannot be handled over the telephone.

If you elect to transfer your appeal request from the telephone area to the written appeals area, you will have 14 days to send us the necessary medical records via mail or fax. If we do not receive the records within this time frame, we will make our decision based on the information that we have on hand. If you disagree with that decision, you will have to request a hearing to obtain a further appeal of the claim. If you do not have the medical records on hand for the item(s) or service(s) in question, it may be to your benefit to submit the appeal request in writing when the records become available.

What Should Be Appealed Over the Telephone?

Telephone appeals are designed to help you obtain a quick resolution to simple problems that can be handled during a short telephone call. Appeal requests involving multiple claims or complicated issues should continue to be submitted in writing.

Filing Disaster Claims

When filing claims for beneficiary-owned equipment destroyed by a federal disaster (flood, hurricane, etc.), please remember to file a hardcopy claim with documentation stating the nature of the disaster and the damage the equipment suffered. At the top of the claim form, please indicate in large, bold letters, "DISASTER CLAIM" and the nature of the disaster, e.g., "flood claim." Equipment owned by the supplier (rental equipment) should be replaced by the supplier under the rental agreement.

MSP Team - Working toward Improving Customer Service

The Medicare Secondary Payer (MSP) Team is implementing a special overpayment form for MSP-specific unsolicited refunds. By using this form, providers will be directing their MSP-related unsolicited refunds to trained specialists who will apply the refunds appropriately.

To use this form simply print it, enter all the requested information and attach a copy of the Primary Insurers explanation of benefits. Be sure to complete the section on OIG Reporting and return the form, Primary Insurer’s explanation of benefits and your check to the address shown at the bottom of the form. The form can be found on the next page or in Chapter 12 of the Region C DMERC DMEPOS Supplier Manual.
Help us provide you with the best possible service. Please use this form when sending Palmetto GBA Region C DMERC MSP unsolicited or voluntary refunds that are owed to Medicare because a beneficiary has other health insurance coverage that is his or her primary policy. This form containing the information requested below should accompany every MSP unsolicited/voluntary refund.

**OVERPAYMENT REFUND FORM**

Help us provide you with the best possible service. Please use this form when sending Palmetto GBA Region C DMERC MSP unsolicited or voluntary refunds that are owed to Medicare because a beneficiary has other health insurance coverage that is his or her primary policy. This form containing the information requested below should accompany every MSP unsolicited/voluntary refund.

**IMPORTANT:** List all claim numbers involved. Use a separate sheet, if necessary. A copy of the primary insurer’s Explanation of Benefits (EOB) for each claim must be included. Please be sure to attach that portion of the EOB listing the primary insurer’s name, address, phone number, and key explaining any adjustment/denial/reason codes.

<table>
<thead>
<tr>
<th>To Be Completed by Provider/Physician/Supplier</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Request:</td>
</tr>
<tr>
<td>Provider Name:</td>
</tr>
<tr>
<td>Provider Number:</td>
</tr>
<tr>
<td>Phone Number:</td>
</tr>
<tr>
<td>Address:</td>
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<td>City/State/Zip:</td>
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<tr>
<td>Contact Name:</td>
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<td>Extension:</td>
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<td>Check Number:</td>
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<tr>
<td>Check Date:</td>
</tr>
<tr>
<td>Check Amount:</td>
</tr>
<tr>
<td>For OIG Reporting Requirements:</td>
</tr>
<tr>
<td>Do you have a Corporate Integrity Agreement with OIG? (circle one)</td>
</tr>
<tr>
<td>Are you a participant in the OIG Self-Disclosure Protocol? (circle one)</td>
</tr>
</tbody>
</table>

### Refund Information

*Please use one form per beneficiary*

<table>
<thead>
<tr>
<th>Patient Name:</th>
<th>Medicare Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare Claim #:</td>
<td>Claim Amount Refunded: $</td>
</tr>
<tr>
<td>Medicare Claim #:</td>
<td>Claim Amount Refunded: $</td>
</tr>
<tr>
<td>Medicare Claim #:</td>
<td>Claim Amount Refunded: $</td>
</tr>
</tbody>
</table>

**Reason Code(s), please select from list below (enter number here):**

| 01 – MSP Group Health Plan Insurance | 04 – MSP Workers’ Comp. (incl. Black Lung) |
| 02 – MSP No Fault Insurance         | 05 – Veterans’ Administration              |
| 03 – MSP Liability Insurance        | 06 – Other (specify)                       |

**To Be Completed by Palmetto GBA**

<table>
<thead>
<tr>
<th>Contractor Number: 00885</th>
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</thead>
<tbody>
<tr>
<td>Date of Deposit:</td>
</tr>
<tr>
<td>Deposit Control Number:</td>
</tr>
</tbody>
</table>

Mail this form and supporting documentation with your check to:

**Palmetto GBA DMERC MSP**

P. O. Box 100183
Columbia, SC 29202-3183

**Bulletins issued after October 1, 1999 are available at no cost from our Web site at www.PalmettoGBA.com.**
MMA - Processing Part B Claims for the Indian Health Services (IHS)

Related Change Request (CR) #: 3288
Medlearn Matters Number: MM3288
Related CR Release Date: July 23, 2004
Related CR Transmittal #: 241

Effective Date: January 1, 2005
Implementation Date: January 3, 2005

Provider Types Affected
Indian Health Services, tribe and tribal organizations (non-hospital or non-hospital based) facilities

Provider Action Needed
This instruction notifies affected providers and suppliers that beginning January 1, 2005 IHS facilities can bill Medicare for other Part B services, such as Durable Medical Equipment (DME), prosthetics, orthotics, therapeutic shoes, clinical laboratory services, and ambulance services. Coverage of these other Part B items and service are for a five-year period beginning January 1, 2005.

Background
The Social Security Act (SSA) provides for payment to IHS facilities for services paid under the physician fee schedule. Additionally, the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA, Section 630) allows IHS, tribe and tribal organization facilities to bill for other Part B services that are not covered under the SSA (Section 1848). Therefore, the Centers for Medicare & Medicaid Services (CMS) is amending the Medicare Claims Processing Manual (Pub 100-04), to allow IHS, tribe and tribal organization facilities to bill for all other Part B services that are not for under the physician fee schedule. (See the Additional Information section below.) This expansion of scope of services is for a five-year period beginning January 1, 2005. IHS, tribe and tribal organization facilities may bill for all other Part B services that are not for under the physician fee schedule and that are not included in the Medicare IHS all-inclusive rate. Specifically, for the five-year period beginning January 1, 2005, IHS, tribe and tribal organization facilities may bill Medicare for the following Part B services:

- DME
- Prosthetics and orthotics
- Prosthetic devices
- Surgical dressings, splints, and casts
- Therapeutic shoes
- Drugs (those normally billed under Part B and to DME Regional Carriers (DMERCs))
- Clinical laboratory services
- Ambulance services

IHS and tribally operated hospitals and clinics associated with hospitals that meet the definition of provider-based in regulations at 42 Code of Federal Regulations (CFR) 413.65, and are currently reimbursed under the all-inclusive rate for services paid under the physician fee schedule, will continue this practice. If and when these facilities decide to bill for items on the Durable Medical Equipment, Prosthetics, Orthotics, and Equipment (DMEPOS) fee schedule, they must enroll as a supplier through the National Supplier Clearinghouse (NSC) and bill the appropriate DMERC.

An IHS tribe or tribal organization facility furnishing clinical laboratory services must accomplish the following:
- Meet the applicable requirements of the Clinical Laboratory Improvement Amendment (CLIA) requirements as specified in 42 CFR, Section 493(f.f)
- Enroll with TrailBlazer and bill that carrier

An IHS tribe or tribal organization facility furnishing ambulance services (which will be paid based on the ambulance fee schedule) must accomplish the following:
- Meet the requirements of 42 CFR, Section 410.41
- Enroll with and bill Trailblazers

Outpatient Clinics (freestanding) operated by the IHS and furnishing DMEPOS will:
- Enroll with the NSC as a “DME supplier”
- Comply with the supplier standards specified in 42 CFR, Section 424.57
- Submit all DMEPOS claims to the CIGNA DMERC, or (at the facility’s option) submit DME claims to the appropriate DMERC based
MMA - Processing Part B Claims for the Indian Health Services (IHS) cont..

on current DME jurisdiction rules
• DMEPOS claims submitted to the DMERC must be billed with a place of service “12” (home).
• Claims submitted to the DMERC must have a specialty code from the NSC of “A9”. The “A9” must not be transmitted as the “primary specialty” on DMEPOS claims.

Such outpatient clinics should note that to bill drugs to DMERCs, the supplier must be a pharmacy and a pharmacy license must be on file with the NSC. The NSC will give the pharmacy supplier a specific identifier. Also, if claims are submitted to CIGNA, note that CIGNA will not perform any other DMERC functions for non-CIGNA claims. CIGNA will only route the non-CIGNA claims to the appropriate DMERC and that DMERC will be the point of contact for the supplier.

Implementation
The implementation date for this instruction is January 3, 2005.

Additional Information
For complete details, including the revised sections of the Medicare Claims Processing Manual, please see the official instruction issued to your fiscal intermediary regarding this change. That instruction may be viewed at: http://www.cms.hhs.gov/manuals/transmittals.comm_date_dsc.asp

From that Web page, look for CR 3288 in the CR NUM column on the right, and click on the file for that CR.

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

Important News about Flu Shots for Beneficiaries

Medlearn Matters #: SE0464

Provider Types Affected
Physicians, providers, and suppliers

Provider Action Needed
This instruction provides important information to physicians and other providers regarding flu vaccinations for Medicare beneficiaries for the 2004 – 2005 influenza season. Despite the flu vaccine shortage, Medicare beneficiaries are being encouraged to obtain the flu vaccine from their regular physician.

Background
One of the principal pharmaceutical companies manufacturing flu vaccine was unable to provide the quantity of vaccine needed for this flu season, and this caused the flu vaccine supply to be reduced by almost one half of the expected amount. This shortage does not, however, include pneumococcal vaccine.

Because of the limited availability of flu vaccines this season, the Centers for Disease Control and Prevention (CDC) is recommending that individuals be given priority for getting the flu vaccine who are 1) at high risk for serious flu complications; or 2) in contact with people at high risk for serious flu complications.

Individuals in the following groups are included in the high-risk category, and they should receive a flu vaccination this season:
• Individuals age 65 or older
• Individuals with a chronic condition such as heart or lung disease
• Nursing home residents
• Pregnant women
• Health care workers who provide direct patient care
• Infants and toddlers ages 6-23 months
• Children on aspirin therapy
• Individuals who care for or live with infants younger than 6 months of age.

Please note that the CDC also recommends that the majority of individuals with Medicare should not take FluMist because it is approved only for people ages 5 - 49. The only Medicare beneficiaries who should take FluMist are healthy disabled persons ages 5 - 49.
Important News about Flu Shots for Beneficiaries cont.

These recommendations and other information for health care professionals, including Qs & As developed by the CDC, can be found at: http://cdc.gov/flu/ on the Web.

Medicare Billing for Flu Vaccines
Because Medicare beneficiaries generally fall into this high-risk category, they are being encouraged to obtain the flu vaccine from their regular physician. Beneficiaries can receive a flu vaccine from any licensed physician or provider. However, the billing procedure will vary depending on whether the physician or provider is enrolled in the Medicare Program.

If you are a Medicare-enrolled physician or provider and have the flu vaccine available, you must bill Medicare for the cost of the vaccine and the beneficiary will pay nothing; i.e., there is no deductible or coinsurance payment. Medicare rules require you to bill the Medicare Program on an assignment basis. Please remember that Medicare allows for roster billing when you administer flu vaccine to a number of beneficiaries at one location (e.g., a physician’s office).

The specific rules to follow for roster billing can be found in Chapter 18, Section 10.3 of the Claims Processing Manual, at: http://www.cms.hhs.gov/manuals/104_claims/clm104index.asp

In order to receive reimbursement, you will need to provide the beneficiary with a receipt for the flu vaccine that has the following information written or printed on it:
- The doctor's or provider's name and address
- Service provided (“flu vaccine”)
- Date flu vaccine received
- Amount paid.

If you are currently not enrolled in Medicare but want to enroll to bill Medicare directly for the flu vaccine, your enrollment application will be expedited. CMS 855 enrollment applications and carrier contact information can be found on the following CMS Web site: http://www.cms.hhs.gov/providers/enrollment.

Additional Information
Please note that beneficiaries have been advised to contact the Inspector General's hotline at 1-800-HHS-TIPS (1-800-447-8477) to file a complaint if they believe their physician or provider charged an unfair amount for a flu vaccine.

If your patients have questions regarding flu vaccine, please refer them to http://www.medicare.gov on the Web or 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you are not a Medicare-enrolled physician or provider who gives a flu vaccine to a Medicare beneficiary, you can ask the beneficiary for payment at the time of service. The beneficiary can then request Medicare reimbursement. Medicare reimbursement will be approximately $18 for each flu vaccine. To request reimbursement, the beneficiary will need to obtain and complete form CMS 1490S by calling 1-800-MEDICARE, or they may access and download the form at http://www.cms.hhs.gov/forms on the Web.
Clarification of Proof of Delivery Requirements

The following is an update of an article originally posted in May 2004 and published in the Spring 2004 DMERC Medicare Advisory. The update is based on CMS Transmittal 71. The May 2004 article did not reflect the correct revision number and revision dates.

One of the requirements for suppliers of DMEPOS requires suppliers to maintain a proof of delivery for DMEPOS items provided to Medicare beneficiaries. A recent revision to the CMS Program Integrity Manual restates the requirement and provides examples of these proofs that the supplier may use. This revision clarifies and eases the burden of the suppliers for this requirement. Proof of delivery information is to be made available to the DMERC only upon request as supportive documentation and is not included in the processing of claims.

The following revised material was incorporated into the CMS Manual System, Pub 100-8, Medicare Program Integrity, Chapter 4.

4.26 - Supplier Proof of Delivery Documentation Requirements (Rev. 71, 04-09-04)
Suppliers are required to maintain proof of delivery documentation in their files. Documentation must be maintained in the supplier’s files for 7 years.

Proof of delivery is required in order to verify that the beneficiary received the DMEPOS. Proof of delivery is one of the supplier standards as noted in 42 CFR, 424.57(12). Proof of delivery documentation must be made available to the DMERC upon request. For any services, which do not have proof of delivery from the supplier, such claimed items and services shall be denied and overpayments recovered. Suppliers who consistently do not provide documentation to support their services may be referred to the OIG for investigation and/or imposition of sanctions.

4.26.1 - Proof of Delivery and Delivery Methods (Rev. 71, 04-09-04)
For the purpose of the delivery methods noted below, designee is defined as:

"Any person who can sign and accept the delivery of durable medical equipment on behalf of the beneficiary."

Suppliers, their employees, or anyone else having a financial interest in the delivery of the item are prohibited from signing and accepting an item on behalf of a beneficiary (i.e., acting as a designee on behalf of the beneficiary). The relationship of the designee to the beneficiary should be noted on the delivery slip obtained by the supplier (i.e., spouse, neighbor, etc.). The signature of the designee should be legible. If the signature of the designee is not legible, the supplier/shipping service should note the name of the designee on the delivery slip.

Suppliers may deliver directly to the beneficiary or the designee. An example of proof of delivery to a beneficiary is having a signed delivery slip, and it is recommended that the delivery slip include: 1) The patient’s name; 2) The quantity delivered; 3) A detailed description of the item being delivered; 4) The brand name; and 5) The serial number. The date of signature on the delivery slip must be the date that the DMEPOS item was received by the beneficiary or designee. In instances where the supplies are delivered directly by the supplier, the date the beneficiary received the DMEPOS supply shall be the date of service on the claim.

If the supplier utilizes a shipping service or mail order, an example of proof of delivery would include the service’s tracking slip, and the supplier’s own shipping invoice. If possible, the supplier’s records should also include the delivery service’s package identification number for that package sent to the beneficiary. The shipping service’s tracking slip should reference each individual package, the delivery address, the corresponding package identification number given by the shipping service, and if possible, the date delivered. If a supplier utilizes a shipping service or mail order, suppliers shall use the shipping date as the date of service on the claim.

Suppliers may also utilize a return postage-paid delivery invoice from the beneficiary or designee as a form of proof of delivery. The descriptive information concerning the DMEPOS item (i.e., the patient’s name, the quantity, detailed description, brand name, and serial number) as well as the required signatures from either the beneficiary or the beneficiary’s designee should be included on this invoice as well.

For DMEPOS products that are supplied as refills to the original order, suppliers must contact the beneficiary prior to dispensing the refill. This shall be done to ensure that the refilled item is necessary and to confirm any changes/modifications to the
Clarification of Proof of Delivery Requirements cont...

order. Contact with the beneficiary or designee regarding refills should take place no sooner than approximately 7 days prior to the delivery/shipping date. For subsequent deliveries of refills, the supplier should deliver the DMEPOS product no sooner than approximately 5 days prior to the end of usage for the current product. This is regardless of which delivery method is utilized. DMERCs shall allow for the processing of claims for refills delivered/shipped prior to the beneficiary exhausting his/her supply.

For those patients that are residents of a nursing facility, upon request from the DMERC, suppliers should obtain copies of the necessary documentation from the nursing facility to document proof of delivery or usage by the beneficiary (e.g., nurse’s notes).

4.26.2 – Exceptions
(Rev. 71, 04-09-04)
Exceptions to the preceding statements concerning the date(s) of service on the claim occur when the items are provided in anticipation of discharge from a hospital or nursing facility. A supplier may deliver a DMEPOS item to a patient in a hospital or nursing facility for the purpose of fitting or training the patient in the proper use of the item. This may be done up to 2 days prior to the patient’s anticipated discharge to their home. The supplier shall bill the date of service on the claim as the date of discharge and shall use the Place of Service (POS) as 12 (Patient’s Home). The item must be for subsequent use in the patient’s home. No billing may be made for the item on those days the patient was receiving training or fitting in the hospital or nursing facility.

A supplier may not bill for drugs or other DMEPOS items used by the patient prior to the patient’s discharge from the hospital or a Medicare Part A nursing facility stay. Billing the DMERC for surgical dressings, urological supplies, or ostomy supplies that are provided in the hospital or during a Medicare Part A nursing facility stay is not allowed. These items are payable to the facility under Part A of Medicare. This prohibition applies even if the item is worn home by the patient from the hospital or nursing facility. Any attempt by the supplier and/or facility to substitute an item that is payable to the supplier for an item that, under statute, should be provided by the facility, may be considered to be fraudulent. These statements apply to durable medical equipment delivered to a patient in hospitals, skilled nursing facilities (Place of Service = 31), or nursing facilities providing skilled services (Place of Service = 32).

A supplier may deliver a DMEPOS item to a patient’s home in anticipation of a discharge from a hospital or nursing facility. The supplier may arrange for actual delivery of the item approximately 2 days prior to the patient’s anticipated discharge to their home. The supplier shall bill the date of service on the claim as the date of discharge and should use the Place of Service (POS) as 12 (Patient’s Home).

If the supplier utilizes a shipping service or mail order, an example of proof of delivery would include the service’s tracking slip, and the supplier’s own shipping invoice. If possible, the supplier’s records should also include the delivery service’s package identification number for the package sent to the beneficiary. The shipping service's tracking slip should reference each individual package, the delivery address, the corresponding package identification number given by the shipping service, and if possible, the date delivered. If a supplier utilizes a shipping service or mail order, suppliers shall use the shipping date as the date of service on the claim.

For Durable Medical Equipment Prosthetics, Orthotics, and Supplies (DMEPOS) products that are supplied as refills to the original order, suppliers must contact the beneficiary prior to dispensing the refill. This shall be done to ensure that the refilled item is necessary and to confirm any changes/modifications to the order. Contact with the beneficiary or designee regarding refills should take place no sooner than approximately seven days prior to the delivery/shipping date. For
Clarification of Proof of Delivery Requirements Simplified cont...

subsequent deliveries of refills, the supplier should deliver the DMEPOS product no sooner than approximately five days prior to the end of usage for the current product. This is regardless of which delivery method is utilized. **DMERCs shall allow for the processing of claims for refills delivered/shipped prior to the beneficiary exhausting his/her supply.**

**What this means to you:**

- **For initial shipments** - for items **delivered directly to the patient** the **date of service** will be the **date of delivery**. For items **shipped to the patient**, the **date of service** will be the **ship date**.

- **For refills** - for items **delivered directly to the patient** the **date of service** will be the **date of delivery**. For items **shipped to the patient**, the **date of service** will be the **ship date**.

- For refills, the supplier may ship/deliver the supplies up to five days prior to the end of the usage period if the patient has indicated their supply is nearly exhausted. The supplier may contact the patient up to seven days prior to the shipping/delivery date to determine this.

- **The DMERCs process claims when there is a date overlap. This overlap may not be any greater than five days.**

**Comprehensive Error Rate Testing (CERT) Request**

The CERT contractor will select a random sample of claims processed by each Medicare contractor. The CERT contractor's medical review staff (nurses, physicians, and other qualified healthcare practitioners) will then verify that contractor decisions regarding the claims were accurate and based on sound policy. The Centers for Medicare & Medicaid Services (CMS) will use the CERT contractor's findings to determine underlying reasons for errors in claims payments or denials and implement appropriate corrective actions aimed toward improvements in the accuracy of claims and the system of claims processing.

Suppliers of the sampled claims will be asked during the course of the CERT contractor review to provide additional information (e.g., medical records, certificates of medical necessity, physician's orders, diagnostic test results, home health progress notes, physical therapy notes, proof of delivery, etc.) for the CERT contractor's staff to verify delivery of billed services, medical necessity, and appropriateness of claims processing procedures. If contacted, you will be provided with the details regarding the needed information. A CERT request should be responded to as if it were a Medical Review additional documentation request (ADR). This means providing documentation beyond the physician's order such as clinical documentation. Information regarding specific Medicare medical criteria may be found in the individual local coverage determinations (LCD) or local medical review policies (LMRP) in the Medicare Region C DMEPOS Supplier Manual.

General questions regarding the CERT initiative may be directed to the CERT Operation Center's Customer Service Line at (804) 264-1778, ext. 164. Additional information about the CERT program can be found at http://www.cms.gov/cert.

Request for information will be sent by mail with detailed claim information. The request needs to be returned by mail **within 90 days of the request date** along with appropriate documentation to the address indicated in the letter you receive.

Participating in the CERT Program will ensure the carrier is processing claims correctly and consistently. (Not submitting documentation will result in a recoupment of paid claims.) Failure to send the requested information may result in a
referral to the Medicare contractor fraud unit and to the Office of Inspector General.

Claims that are recouped due to non-response to CERT do have appeal rights. The appeal request must be sent to the carrier where your claim was initially processed. Claims for amounts under $100 may go to redeterminations and claims for amounts over $100 may go to hearings. For additional appeals information, please refer to Chapter 14 - Appeals in the Medicare Region C DMEPOS Supplier Manual.

The CERT contractor sends CERT letters to the address on file with the National Supplier Clearinghouse (NSC). Supplier Standard 2 states that suppliers must notify the NSC of any changes to their supplier file within 30 days of the change. If you have moved and haven’t yet sent in a Change of Information form, be sure to get your new address in to the NSC immediately.

Below is a copy of the first request letter and enclosures.

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

Medicare Part B/DMERC Provider
Provider Number #: 9999999999999999 Sample Provider
RE: CMS 500-99-0009/0002 PSC CERT - REQUEST FOR MEDICAL RECORDS

Initial Request

Dear Doctor/Medicare Provider:

This request for medical records/documentation is sent to you under a federally mandated program to monitor and improve the accuracy of Medicare payments to physicians and other providers. This is NOT a fraud investigation. This request for your records is the result of a random selection of billing records. Your cooperation in responding to this information request is essential to assuring and improving the accuracy of your Medicare payments. If you fail to provide the requested information, we will interpret your lack of response as services not rendered, and your local Medicare contractor will be directed to recover Medicare payment for these services.

Medicare - Comprehensive Error Rate Testing Program

The purpose of the CERT program is to determine the national, contractor specific, benefit category and provider type paid claim error rates. In accordance with Section 1833 of the Social Security Act, Medicare providers and/or suppliers must provide documentation and medical records to the CERT contractor upon request to support claims for Medicare services.

Compliant with HIPAA

The Health Insurance Portability and Accountability Act (HIPAA) does not preclude you from sending requested medical records or documentation. Medicare beneficiaries, upon enrollment in the program, are informed of Medicare’s use of their personal health information to carry out health care operations.

Medical Records/Documentation Request

We are requesting medical records regarding the claim that is identified on the enclosed Medical Records/Documentation Attachment Pull List. A Medical Records/Documentation Attachment barcoded cover sheet is included with a control number that corresponds to the record on the Medical Records/Documentation Attachment Pull List. Please submit the applicable documents in the following list for the selected claim. Please adhere to the following directions when photocopying, packaging, and mailing the requested records. NOTE: Documents may be FAXED to (804) 864-9980 or (804) 264-3268.

1) Complete copies should include specific records to support the services on the claim identified on the Medical Records/Documentation Attachment Pull List, and would include as applicable the following documents:

- Physician Orders
- Diagnostic Test Results (regardless of where they are performed)
- Physicians Progress Notes
- Medication Records
- Graphic Reports
- Emergency Room Records
- History and Physical Notes
- Operative Reports
- All Lab Reports
Medicare CERT Operations

Medicare Part B/DMERC Provider
Provider #: 999999999999999 Sample Provider

Page 2
Report Date: 6/28/2004

1) Applicable Documents (continued).
- Nurses Notes
- Hospice Records
- Pathology Reports
- Progress Notes
- Verbal Orders
- Skilled Nursing Facility Records
- Ambulance Records (with mileage)
- Home Health Progress Notes
- Certificate of Medical Necessity
- Any additional information pertinent to this medical review

2) Photocopy each record. Please make sure all copies are complete, legible, and contain both sides of each page, including page edges. Complete copies should include specific records to support the services on the claim identified on the Medical Records/Claim Attachment Pull List.

3) Complete and return the enclosed CERT Operations barcoded Medical Records/Claim Attachment Cover Sheet. A Medical Records/Claim Attachment Cover Sheet should be attached to each set of documentation. If documentation for more than one claim is included in the response, please attach each Medical Records/Claim Attachment Cover Sheet to the appropriate documentation.

4) Mail the records to the following CERT Operations address. NOTE: You may FAX records to (804) 864-9980 or (804) 264-3268.

CERT Operations Center
Attn: Disposition Department - Distribution
1530 E. Parham Road
Richmond, VA 23228

We are not authorized to reimburse providers/suppliers for the cost of claims/medical records duplication or mailing. If you use a photocopy service, please ensure that the service does not invoice the CERT Operations Center.

The requested documentation is due within 90 days of receipt of this letter. If the requested information is not received within this time period, CERT Operations will assume that the services on the claim were not rendered. Your local Medicare contractor will pursue overpayment recoupment for these undocumented services.

Thank you for your cooperation and prompt attention in this matter. If you have questions or comments, please contact the CERT Operations Center at 804-264-1778, ext 164.

Sincerely yours,

Charles Shasky, R.Ph., M.B.A
Program Director
CERT Operations Center
Medicare CERT Operations
CMS 500-99-0009/0002 PSC CERT
Medical Records/Claim Attachment Pull List

Medicare Part B/DMERC Provider
Provider #: 99999999999999 Sample Provider

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Report Date: 6/28/2004

Patient Name: First M Lastname
Service From/To Dates: 1/1/2004 - 1/1/2004
HICNUM: 99999999999999999999
Claim Control Number (CCN): 99999999999999999999

Date of Birth: 1/1/1900
CERT Claim ID (CID): 999996
Claim Date: 6/30/2004

This bulletin should be shared with all health care practitioners and managerial members of the provider/supplier staff.
## Medicare CERT Operations

**CMS 500-99-0009/0002 PSC CERT**

**Medical Records/Claim Attachment Cover Sheet**

**Medicare Part B/DMERC Provider**

**Provider #: 999999999999**  **Sample Provider**

**Report Date: 6/28/2004**

Please fill in the requested information below:

- Request filled by:
- Contact Phone Number:
- Fax Number:
- Date:

**Please copy both sides of each page and please DO NOT cut off page edges when copying.** Please attach the original copy of this barcoded cover sheet to a copy of the medical record noted below. The record must be clipped or rubber-banded with the original cover sheet in order to ensure proper validation of receipt by the CERT Operations Center. No staples please.

Please fax documentation to: (804) 864-9980 or (804) 254-3268  
or send documentation to:  
**CERT Operations Center**  
Attn: Disposition Dept - Distribution  
1530 E. Parham Road  
Richmond, VA 23228

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**Scan Area**

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**CID:** 999996  
**Mail Sequence: Initial Request**
Message to Pharmacists Regarding Medicare Approved Discount Drug Card  Automatic Enrollment

Dear Pharmacist -

As a pharmacy that participates in the Medicare-approved drug card program, you are aware of the savings that are available to people who enroll in Medicare. In October, more than a million people with Medicare will be getting the attached "Important Message from Medicare" and a Medicare-approved drug discount card in the mail. People receiving this important message are likely to qualify for up to $1,200 in credits from Medicare to help pay for their prescription drug costs.

These people will also receive a Medicare-approved drug discount card that they will be able to begin using on November 1, 2004.

The purpose of this letter is to enlist your support in assisting people with Medicare who come to you with questions about this "Important Message from Medicare" and need additional information about how to apply for the $1,200 credit potentially available to them through the Medicare-approved drug card. The attached copy of the important message will help you answer these questions. Assisting a beneficiary could be as simple as instructing him or her to call either the company shown on the card or 1-800-MEDICARE (1-800-633-4227). The beneficiary will be asked during this call if he or she has any other health insurance that includes prescription drug coverage, as well as some additional eligibility questions to see if he or she qualifies for more help.

We have also enclosed a flyer appropriate for public display in your pharmacy. The purpose of this flyer is to encourage people who may qualify for the $1,200 credit to call and find out if they are eligible to receive this important benefit. If you need any additional information or resources, please visit www.cms.hhs.gov/partnerships; click on the box on the far right with the symbol.

We appreciate your help in this important effort. Questions from people with Medicare may be directed to 1-800-MEDICARE (1-800-633-4227 or TTY 1-877-486-2048).
An Important Message from Medicare…

Medicare now offers Medicare-approved drug discount cards that can help you pay for prescription drugs. We are writing to you because Medicare records show you very likely qualify for a $600 credit in 2004 and another $600 next year. You can use this $1,200 credit to pay for your prescriptions this year and next. To make it as easy as possible for you to get this Medicare benefit, included in this package is a Medicare-approved discount drug card from [Company Name].

Here's what you need to do NOW to get the $1,200 credit:

Call [Company Name] at 1-xxx-xxxx-xxxx or 1-800-MEDICARE (1-800-633-4227) as soon as possible. TTY users should call 1-877-486-2048. If you don't call one of these numbers, you will not receive this benefit.

When you call, you will be asked:
• if you have any other health insurance with prescription drug coverage, and
• for other information that will help us find out if you qualify for even more help.

If you don't want to be in this card, call [Company Name] at 1-xxx-xxxx-xxxx as soon as possible. TTY users should call 1-XXX-XXX-XXXX. If you want to choose another Medicare-approved drug discount card, contact 1-800-MEDICARE (1-800-633-4227). An operator can also tell you about other cards that are available to you.

Remember, you must call NOW to get the $1,200 credit. If you qualify, the enclosed card is free.

Si desea información en español sobre las tarjetas de descuento para recetas médicas aprobadas por Medicare, llame al 1-800-MEDICARE (1-800-633-4227).
Watch Your Mail…

More than a million people with Medicare will be getting an Important Message from Medicare and a Medicare-approved drug discount card in the mail this October. If your State helps pay your Medicare premiums or deductibles, watch your mail for this Important Message from Medicare.

Call Today…

It's easy. If you receive an Important Message from Medicare in the mail, you are likely to qualify for up to $1,200 in credits to use for your prescription drug costs. Just call the toll-free phone number in the letter and answer a few questions. There are no enrollment forms to complete. Don't wait—call today.

Start Saving…

You will also receive a Medicare-approved drug discount card and information about how to use it. You can start using your card as early as November 1, 2004 to save on your prescription drugs.

For more information about Medicare-approved drug discount cards, call 1-800-MEDICARE (1-800-633-4227) or visit www.medicare.gov on the web.
MMA - Medicare-Approved Drug Discount Cards and Transitional Assistance Program: A Summary of New Initiative of Interest to Pharmacists and Pharmacy Professionals for DMERC

Related Change Request (CR) #: N/A
Medlearn Matters #: SE0423
Related CR Release Date: N/A
Revised

Note: This article was revised on October 22 to correct the Web address for State Health Insurance Counseling and Assistance Programs.

Provider Types Affected
Pharmacists and other pharmacy professionals

Provider Action Needed
This instruction provides important information on a new initiative to automatically enroll certain Medicare beneficiaries in the Medicare-Approved Drug Discount Card program.

Background
In an earlier Medlearn Matters article (SE 0422), an overview of the Medicare-approved Drug Discount Card Program was provided. (See SE0423 at:

This program is authorized by the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA). The program is designed to help people who are covered by Medicare with the cost of prescription drugs, and the regulation outlining the new drug discount card program is the first action resulting from the MMA. It emphasizes the importance of eliminating the practice of Medicare beneficiaries having to pay full price for prescription drugs. Beginning in May 2004, individuals began enrolling in the program.

Seniors and individuals with disabilities will be able to use these cards to save 10 to 15 percent on their total drug costs, with savings of up to 25 percent or more on individual prescriptions. All Medicare beneficiaries, except those who already have Medicaid outpatient drug coverage, will be able to enroll in Medicare-approved drug discount card programs with benefits beginning in June 2004, and possibly continuing until the Medicare prescription drug benefit is implemented in 2006.

Medicare beneficiaries will also have a choice of at least two Medicare-approved cards, but they will be allowed to enroll in only one drug card program at a time. The cost of enrollment can be no more than $30 annually, and beneficiaries can change cards during an open enrollment period prior to 2005 or under special circumstances. Beginning in 2006, all people with Medicare will have access to a voluntary prescription drug benefit.

Transitional Assistance Program
A key part of the Medicare-approved prescription drug discount card program is a subsidy of up to $600 a year for eligible low-income beneficiaries. Individuals may qualify for the $600 credit on their discount card to help pay for prescription drugs if they:

- Have an annual income in 2004 of no more than $12,569 if single or $16,862 if married; and
- Receive help from their state in paying their Medicare premiums or cost sharing.

Note that these income limits can change every year. Also, residents of Puerto Rico or a U.S. territory are not eligible for the $600 credit from Medicare. However, they may be eligible for similar assistance provided by the territory in which they reside. Beneficiaries cannot qualify for the $600 if they already have outpatient prescription drug coverage from certain other sources.

Under the Medicare-Approved Drug Discount Card Program, Medicare beneficiaries are deemed to meet the income requirement for the $600 credit in 2004 and 2005 if they are:

- Enrolled in Medicare Savings Programs as Qualified Medicare Beneficiaries (QMBs);
- Specified Low-income Medicare Beneficiaries (SLMBs); or
- Qualifying Individuals (QI-1s).

Current Initiative
The Centers for Medicare & Medicaid Services (CMS) current initiative facilitates enrollment and provides a streamlined process for the $600 credit. Participating national Medicare-approved drug discount card sponsors will agree to follow simple procedures to facilitate the $600 credit enrollment for about 1.1 million Medicare Savings Programs beneficiaries.
On September 14, 2004, CMS issued interim guidance to all Medicare-approved drug discount card sponsors outlining the process for Medicare Savings Programs auto-enrollment. National sponsors have notified CMS of their intention to participate.

CMS will randomly assign those eligible Medicare Savings Programs beneficiaries who have not already enrolled in a card to participating Medicare-approved drug discount card sponsors.

Starting in mid-October, card sponsors will mail an enrollment kit to each Medicare Savings Programs enrolled individual. The enrollment kit will contain the following information:

- Pre-enrollment materials: (Card Program, Member Handbook, Membership Card, Discount Drug List, Pharmacy Directory).
- A notice advising the Medicare Savings Programs beneficiary of the automatic assignment, effective date of enrollment, eligibility for the $600 credit, information about their right to decline and/or switch to another Medicare-approved drug discount card, and a toll-free number.

The card begins providing discounts on November 1. To activate the $600 credit, the beneficiary makes one call to 1-800-MEDICARE or to the card sponsor's 800 number. On the call, the beneficiary answers two questions to confirm they are eligible for the credit:

- Does the beneficiary have other health insurance with any outpatient prescription drug coverage?; and
- Does the beneficiary have annual income (including spouse, if married) above or below $12,569 for singles and $16,862 for couples?

Medicare Savings Programs beneficiaries who wish to choose another card can call 1-800-MEDICARE to learn about their other choices.

If a beneficiary is not eligible for the $600 credit because of other drug coverage, they will still be able to use the drug card they received and benefit from any associated discounts.

Medicare Savings Programs beneficiaries who wish to cancel enrollment in a card must call the drug card sponsor at the toll free number provided and request their enrollment be canceled. As a result of this new program for enrollment in the drug card program, all beneficiaries in Medicare Savings Programs can start getting large savings on their drug costs.

Additional Information

Where to Refer Medicare Beneficiaries for Information on Prescription Drug Discount Programs

In addition to the Medicare-approved drug discount cards, there are other programs available that provide assistance in paying for prescription drugs. Alternatives such as individual state pharmacy assistance programs and manufacturers’ discount programs may be a better fit for certain individuals. Medicare recognizes that pharmacists and other pharmacy professionals have limited time available to counsel beneficiaries. The following resources are available to help individuals with questions about the Medicare-approved drug discount cards:

- The 1-800-MEDICARE (1-800-633-4227) Toll-Free Call Center:
  Beneficiaries can get information about how the discount drug card program operates, who can qualify and how to join, as well as some comparative information on card sponsors at 1-800 MEDICARE (1-800-633-4227; TTY users should call 1-877-486-2048).

- This Call Center is available 24 hours per day, seven days per week, and it connects beneficiaries with customer service representatives who can answer questions and perform price comparisons for discount cards and other assistance programs. Beneficiaries should prepare a list of current prescription drugs and dosages prior to contacting the Call Center. Also, beneficiaries may request a copy of their individualized price comparison results. Customer service representatives will also be able to refer to appropriate sponsor or other resources (such as, make appropriate referrals for eligibility determination or to their State Pharmacy Assistance Program).

- The Prescription Drug and Other Assistance Programs Web site at:
MMA - Medicare-Approved Drug Discount Cards and Transitional Assistance Program: A Summary of New Initiative of Interest to Pharmacists and Pharmacy Professionals for DMERC cont.

At this site, beneficiaries can find eligibility, enrollment, and price comparison information for each available discount card in a particular area, as well as their state pharmacy assistance programs. It also has a tool that helps beneficiaries determine the best savings program based on their prescription drug needs. The negotiated prices displayed will be a drug’s maximum price for an approved sponsor’s service area. Actual prices may vary, but will not be more than the posted prices.

- **Medicare's Guide to Choosing a Medicare-Approved Drug Discount Card**
  This resource can be found at: http://www.medicare.gov/publications. It provides beneficiaries with information on choosing a card, enrolling, and submitting complaints. This guide also features sample enrollment forms and worksheets to assist beneficiaries in selecting the discount card that is right for them.

- **State Health Insurance Counseling and Assistance Programs (SHIP)**
  Beneficiaries may also contact their SHIP counselor for information on prescription drug cost assistance programs. To find the telephone number for the nearest SHIP, call 1-800-MEDICARE (1-800-633-4227) or visit: http://www.medicare.gov/contacts/Static/SHIPs.asp?dest=NAV.

**For More Information**
The following information resources are available for pharmacists and other pharmacy professionals:

- Download a free patient-education brochure at http://www.medicare.gov (or call 1-800-MEDICARE to order a limited number of free copies).
- This page includes a variety of useful publications.
- Attend CMS Open Door Forums in person or by telephone (toll-free). These forums address concerns and issues of the pharmaceutical industry. Visit http://www.cms.hhs.gov/opendoor for further details.
- Visit http://www.cms.hhs.gov/medicare/reform for the latest information on MMA.

Medicare-Approved Drug Discount Card Program & Transitional Assistance (TA) Program: Resources to Help Increase TA Enrollment

Under the Medicare-Approved Drug Discount Card Program & Transitional Assistance (TA) Program, Medicare beneficiaries who are enrolled in Medicare Savings Programs (MSPs) as Qualified Medicare Beneficiaries (QMBs), Specified Low-income Medicare Beneficiaries (SLMBs), or Qualifying Individuals (QI-1s) are deemed to meet the income requirement to receive TA ($600/year both in 2004 and in 2005 toward the purchase of prescription drugs).

CMS is undertaking an initiative to increase TA enrollment for this low-income population by facilitating enrollment and providing a streamlined process for making the required attestations for TA. National drug card sponsors that are willing to participate will agree to follow simple procedures to facilitate TA enrollment for MSP beneficiaries.

Starting in mid-October, over one million people with Medicare will receive an "Important Message from Medicare" and a Medicare-approved discount drug card in the mail. People receiving this important message are likely to qualify for up to $1,200 in credits from Medicare to help pay for their prescription drug costs.

CMS has developed a "tool kit" of materials for health care professionals, and other partners to assist people with Medicare who can benefit from this opportunity to save money on their prescription drugs. Visit http://www.cms.hhs.gov/
Medicare-Approved Drug Discount Card Program & Transitional Assistance (TA) Program: Resources to Help Increase TA Enrollment cont.

partnerships/news/autoenroll/default.asp to access the tool kit, which includes downloadable, printable materials:

- **MSP Facilitated Enrollment Flyer** - A flier suitable for distribution in pharmacies, physician offices, and other public places.
- **Letter to Beneficiaries** - This letter has been sent to people with Medicare from all approved drug card sponsors involved in the automatic enrollment effort.
- **ABC Coalition Partners** - Listing of the Access to Benefits Coalition (ABC) members who are partnering with CMS to help beneficiaries understand the new choices coming their way.
- **Article from the Secretary** - A question and answer with Secretary Tommy Thompson. This article is suitable for placement in community and local papers.
- **Public Service Announcements (PSAs)** - The public service announcements are suitable for reading on the radio, and are 10, 30 and 60-second spots. (English version and Spanish version available.)
- **Call! Enroll! Save!** - This pamphlet provides basic information about the simple steps to get a Medicare-approved drug discount card and encourages people to enroll. It was mailed to low-income beneficiaries in early October.
- **Letter to Pharmacists** - This letter has been electronically distributed through national pharmacy organizations and other interested parties to individual pharmacists, providing them with the letter to beneficiaries, and asking them to distribute a fact sheet.
- **MedLearn Matters Articles for Physicians & Other Health Care Professionals, and Pharmacists and Other Pharmacy Professionals** - Articles from MedLearn (www.cms.hhs.gov/medlearn/matters) targeted to physicians and other health care professionals (SE0457) and at pharmacists (SE0458) with information about the discount card and $600 credit.

Payment to Providers/Suppliers Qualified to Bill Medicare for Prosthetics and Certain Custom-Fabricated Orthotics

**Related Change Request (CR) #:** 3373  
**Medlearn Matters Number:** MM3373  
**Related CR Release Date:** October 22, 2004  
**Related CR Transmittal #:** 329  

**Effective Date:** July 1, 2005  
**Implementation Date:** July 5, 2005

**Provider Types Affected**  
Physicians, providers, and suppliers who bill durable medical equipment regional carriers (DMERCs)

**Provider Action Needed**  
This instruction puts new edits in the Medicare claims processing system to look for specialty codes 51, 52, 53, 55, 56, and 57 when processing claims for prosthetics and custom-fabricated orthotics. These new edits will ensure that those providers specifying Prosthetist and Orthotist (P & O) on their enrollment application are the only entities billing Medicare for P & O supplies.

Claims listing specialty codes other than those just mentioned and representing billings for prosthetics and certain custom-fabricated orthotics will be denied by Medicare. If you did not enter the appropriate specialty code on the National Supplier Clearinghouse (NSC) application, you must reenroll with the NSC.
Payment to Providers/Suppliers Qualified to Bill Medicare for Prosthetics and Certain Custom-Fabricated Orthotics con't.

Any supplier qualified to distribute the prosthetics and customized-fabricated orthotics in question that did not select one of the covered specialties in its initial enrollment can submit a revised CMS 855S enrollment form to the NSC.

Background
Section 1834(h)(F) of the Social Security Act titled “Special Payment Rules for Certain Prosthetics and Custom-Fabricated Orthotics,” states that no payment will be made for such items unless provided by a qualified practitioner. Currently, DMERCs are processing these claims from all enrolled and approved providers/suppliers without regard to specialty identified on the Enrollment Application Form (Form 855S).

Effective for claims with dates of service of July 1, 2005 or later, DMERCs will process claims for prosthetics and certain customized-fabricated orthotics only when the DMERC provider/supplier files show a specialty code that authorizes billing for prosthetics and these orthotics. The specialties identified as involving orthotics and prosthetics are as follows:

- Medical Supply Company with Certified Orthotist – Specialty Code 51
- Medical Supply Company with Certified Prosthetist – Specialty Code 52
- Medical Supply Company with Certified Orthotist and Prosthetist – Specialty Code 53
- Certified Orthotist – Specialty Code 55
- Certified Prosthetist – Specialty Code 56
- Certified Orthotist and Prosthetist – Specialty Code 57.

This instruction puts new edits in the claims processing system to look for specialty codes 51, 52, 23, 55, 56, and 57. These new edits will ensure that those providers specifying P & O on their enrollment application are the only entities billing Medicare for P & O supplies.

Claims listing other specialty codes billing for prosthetics and certain custom-fabricated orthotics will be denied, effective for claims with dates of service on or after July 1, 2005.

Any supplier qualified to distribute the prosthetics and customized-fabricated orthotics in question that did not select one of the covered specialties in its initial enrollment can submit a revised CMS 855S enrollment form to the National Supplier Clearinghouse.

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

Additional Information
The CMS 855 forms may be found at:
http://www.cms.hhs.gov/providers/enrollment/forms/

If you have any questions regarding this issue, please contact your DMERC or intermediary at their toll free number. You may find that number at:
http://www.cms.hhs.gov/medlearn/tollnums.asp

The Medicare Claims Processing Manual (Pub 100-04), Chapter 20 (Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DME/POS), Parenteral and Enteral) Section 130.1 (Provider Billing for Prosthetic and Orthotic Devices), has been revised to include a paragraph regarding editing for P & O claims. The updated manual instructions are included in the official instruction issued to your carrier, and can be found by going to:

Once at that site, scroll down the CR NUM column on the right and click on CR3373.

A comprehensive list of the HCPCS for customized orthotics and prosthetics that need to be used with these specialty codes can also be found at as an attachment to CR3373.
Application of the MSP for the Working Aged Provision to Former Spouses and the MSP for the Disabled Provision to Former Spouses and Certain Family Members with Coverage under the FEHB Program

Related Change Request (CR) #: 3120
Medlearn Matters Number: MM3120
Related CR Release Date: August 27, 2004
Related CR Transmittal #: 18

Effective Date: November 29, 2004
Implementation Date: November 29, 2004

Provider Types Affected
All Medicare providers

Provider Action Needed
This is an informational article to alert providers that former spouses of certain federal employees, former employees, or annuitants, may qualify to enroll in a health benefits plan under the Federal Employees Health Benefit Plan (FEHB) and the correct order of payment. A determination has been made that Medicare will be the primary payer for such former spouses, once they are entitled to Medicare based on age or disability.

Background
Certain former spouses of people who have Federal Employees Health Benefits are entitled to coverage under the Spouse Equity Act because their divorce decree gives them the right to a portion of a future retirement annuity and/or to a survivor annuity, and because their former spouse is either an active worker, someone who is entitled to a future annuity, or is an annuitant.

The Medicare law in Section 1862 (b)(1)(A) of the Social Security Act, states that Medicare is secondary payer for individuals age 65 or over who have group health coverage by virtue of their own or a spouse’s current employment status. The question was raised as to whether FEHB coverage provided to former spouses under the Spouse Equity Act is secondary to Medicare under this provision. Also, the question has been raised as to whether FEHB coverage provided to the spouse and family members under the Spouse Equity Act is secondary to Medicare under the disability provision.

Under the Spouse Equity Act, the individual is no longer on the former spouse’s policy. The coverage is considered to be a separate, self-only policy, i.e., not dependent coverage but a policy separate from the former spouse. The employer makes no contributions to the coverage. Since the language in the Spouse Equity Act gives the former spouse the right to enroll in FEHB whether or not the spouse himself or herself is enrolled, the FEHB former spouse coverage is not considered employment based. Consequently, Medicare is the primary payer for the former spouse, once they are entitled to Medicare under the working aged provision. Under the Medicare secondary for the disabled provision, Medicare would be primary for the former spouse as well as any covered family members since the coverage is not considered employment based.

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

From that Web page, look for CR 3120 in the CR NUM column on the right, and click on the file for that CR.
Clarification of Medicare Secondary Payer (MSP) Rules in Relation to a Temporary Leave of Absence

Related Change Request (CR) #: 3447
Medlearn Matters Number: MM3447
Related CR Release Date: September 24, 2004
Related CR Transmittal #: 19

Effective Date: October 25, 2004
Implementation Date: October 25, 2004

Provider Types Affected
All providers

Provider Action Needed
STOP - Impact To You
MSP rules state that if an employee retains their employment status, Medicare remains the secondary payer.

CAUTION - What You Need to Know
There has been confusion regarding MSP rules when an employee takes a company-approved leave of absence. Because the employee still has employee status, health coverage through their employer is retained.

GO - What You Need to Do
Stay current with rules pertaining to employees and retained employment rights to ensure accurate billing and claims processing. This article clarifies that Medicare remains a secondary payer for employees on an approved leave of absence.

Background
Examples of retained employment rights can include: company-approved temporary leave of absence for any reason, furlough, temporary layoff, sick leave, short-term or long-term disability, leave for teachers and seasonal workers who normally do not work year round, and for employees who have health coverage that extends beyond or between active employment periods. The employees in the latter category are sometimes referred to as having an “hours bank” arrangement.

Additional Information
You may also refer to the revised Publication 100-05, Chapter 1, Section 50B, which is part of the official instruction issued to your carrier/intermediary regarding this change. That instruction may be found at: http://www.cms.hhs.gov/manuals/transmittals/com_m_date_dsc.asp

On the above page, scroll down while referring to the CR NUM column on the right to find the link for CR3447. Click on the link to open and view the file for the CR.

If you have questions regarding this issue, you may also contact your carrier or fiscal intermediary at their toll free number, which may be found at: http://www.cms.hhs.gov/medlearn/tollnums.asp
Section 2: LCD Policy Information & Updates

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Policies Revised

Effective for dates of service on or after January 1, 2005, the following policies have either been revised or converted from local medical review policies (LMRPs) to local coverage determinations (LCDs) and policy articles:

- Automatic External Defibrillators
- Canes and Crutches
- CPAP Devices
- Patient Lifts
- Respiratory Assist Devices
- Refractive Lenses
- Spinal Orthoses
- Surgical Dressings
- Wheelchair Seating

Effective for dates of service on or after April 1, 2005, the following policies have either been revised or converted from LMRPs to LCDs and policy articles:

- Commodes

Please refer to your Region C DMERC DMEPOS Supplier Manual or DMERC section of the Palmetto GBA Web site for further details. Suppliers are reminded that these policy revisions are published in the split format of an LCD and policy article. Both documents taken together will constitute the “medical policy”. In the Centers for Medicare & Medicaid Services database (www.cms.hhs.gov/mcd/indexes.asp), the Policy Article can be accessed both as an attachment to the LCD and also as a separate article in the Articles section of the database.

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

Wheelchair Options - New Modifier (CR 3574)

HCPCS codes E2320-E2330 describe nonstandard power wheelchair drive control interfaces. Effective for claims with dates of service on or after January 1, 2005, a new modifier has been created:

KC Replacement of special power wheelchair interface

This modifier is added to the HCPCS codes listed above if they are replacing an existing interface because of non-repairable damage or a change in the patient’s condition. The KC modifier must not be used when a nonstandard interface is provided at the time of initial issue of the wheelchair.
### Wheelchair Seating - Policy Revision

A revision of the Durable Medical Equipment Regional Carrier (DMERC) Local Coverage Decision (LCD) and Policy Article on Wheelchair Seating is included in the Region C DMERC DMEPOS Supplier Manual updated through Winter 2004. That revision includes all of the following changes.

Effective for dates of service on or after January 1, 2005, all of the recently-established K codes for wheelchair cushions (except K0669) are being replaced with E codes.

<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>K0650</td>
<td>General use wheelchair seat cushion, width less than 22 inches, any depth</td>
<td>E2601</td>
</tr>
<tr>
<td>K0651</td>
<td>General use wheelchair seat cushion, width 22 inches or greater, any depth</td>
<td>E2602</td>
</tr>
<tr>
<td>K0652</td>
<td>Skin protection wheelchair seat cushion, width less than 22 inches, any depth</td>
<td>E2603</td>
</tr>
<tr>
<td>K0653</td>
<td>Skin protection wheelchair seat cushion, width 22 inches or greater, any depth</td>
<td>E2604</td>
</tr>
<tr>
<td>K0654</td>
<td>Positioning wheelchair seat cushion, width less than 22 inches, any depth</td>
<td>E2605</td>
</tr>
<tr>
<td>K0655</td>
<td>Positioning wheelchair seat cushion, width 22 inches or greater, any depth</td>
<td>E2606</td>
</tr>
<tr>
<td>K0656</td>
<td>Skin protection and positioning wheelchair seat cushion, width less than 22 inches, any depth</td>
<td>E2607</td>
</tr>
<tr>
<td>K0657</td>
<td>Skin protection and positioning wheelchair seat cushion, width 22 inches or greater, any depth</td>
<td>E2608</td>
</tr>
<tr>
<td>K0658</td>
<td>Custom fabricated wheelchair seat cushion, any size</td>
<td>E2609</td>
</tr>
<tr>
<td>K0659</td>
<td>Wheelchair seat cushion, powered</td>
<td>E2610</td>
</tr>
<tr>
<td>K0660</td>
<td>General use wheelchair back cushion, width less than 22 inches, any height, including any type mounting hardware</td>
<td>E2611</td>
</tr>
<tr>
<td>K0661</td>
<td>General use wheelchair back cushion, width 22 inches or greater, any height, including any type mounting hardware</td>
<td>E2612</td>
</tr>
<tr>
<td>K0662</td>
<td>Positioning wheelchair back cushion, posterior, width less than 22 inches, any height, including any type mounting hardware</td>
<td>E2613</td>
</tr>
<tr>
<td>K0663</td>
<td>Positioning wheelchair back cushion, posterior, width 22 inches or greater, any height, including any type mounting hardware</td>
<td>E2614</td>
</tr>
<tr>
<td>K0664</td>
<td>Positioning wheelchair back cushion, posterior-lateral, width less than 22 inches, any height, including mounting hardware</td>
<td>E2615</td>
</tr>
<tr>
<td>K0665</td>
<td>Positioning wheelchair back cushion, posterior-lateral, width 22 inches or greater, any height, including any type mounting hardware</td>
<td>E2616</td>
</tr>
<tr>
<td>K0666</td>
<td>Custom fabricated wheelchair back cushion, any size, including any type mounting hardware</td>
<td>E2617</td>
</tr>
<tr>
<td>K0668</td>
<td>Replacement cover for wheelchair seat cushion or back cushion, each</td>
<td>E2619</td>
</tr>
</tbody>
</table>

There is no grace period allowing use of these K codes for dates of service in 2005.

In addition, three new HCPCS codes are being established for dates of service on or after January 1, 2005:

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>E2618</td>
<td>Wheelchair accessory, solid seat support base (replaces sling seat) for use with manual wheelchair or lightweight power wheelchair, includes any type mounting hardware</td>
</tr>
<tr>
<td>E2620</td>
<td>Positioning wheelchair back cushion, planar with lateral supports, width less than 22 inches, any height, including any type mounting hardware</td>
</tr>
<tr>
<td>E2621</td>
<td>Positioning wheelchair back cushion, planar back with lateral supports, width 22 inches or greater, any height, including any type mounting hardware</td>
</tr>
</tbody>
</table>

Coding guidelines for these HCPCS codes can be found in the Policy Article in Chapter 71 of the Region C DMERC DMEPOS Supplier Manual.

In the ICD-9 code section of the LCD, the diagnosis set for HCPCS codes E2607 and E2608 were corrected as previously described in a September 2004 Web site notice.

Coverage criteria, coding guidelines, and documentation requirements relating to adjustable cushions, as described in the accompanying article, have been incorporated into the revised medical policy.

Refer to the Revision History Explanation sections at the end of the LCD and Policy Article for a listing of other changes.
Enteral Nutrition - HCPCS Code Changes

Effective for dates of service on or after January 1, 2005, the following new HCPCS codes have been established:

B4102 Enteral formula, for adults, used to replace fluids and electrolytes (e.g. clear liquids), 500 ml = 1 unit

B4103 Enteral formula, for pediatrics, used to replace fluids and electrolytes (e.g. clear liquids), 500 ml = 1 unit

B4104 Additive for enteral formula (e.g. fiber)

B4149 Enteral formula, blended natural foods with intact nutrients includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit

B4157 Enteral formula, nutritionally complete, for special metabolic needs for inherited disease of metabolism, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit

B4158 Enteral formula, for pediatrics, nutritionally complete with intact nutrients includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber and/or iron, administered through an enteral feeding tube, 100 calories = 1 unit

B4159 Enteral formula, for pediatrics, nutritionally complete soy based with intact nutrients includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber and/or iron, administered through an enteral feeding tube, 100 calories = 1 unit

B4160 Enteral formula, for pediatrics, nutritionally complete calorically dense (equal to or greater than 0.7 kcal/ml) with intact nutrients includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit

B4161 Enteral formula, for pediatrics, hydrolyzed/amino acids and peptide chain proteins includes fats carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit

B4162 Enteral formula, for pediatrics, special metabolic needs for inherited disease of metabolism, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit

The narrative description of the following existing codes has been revised effective for dates of service on or after January 1, 2005.

B4150 Enteral formula, nutritionally complete with intact nutrients includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit.

B4152 Enteral formula, nutritionally complete calorically dense (equal to or greater than 1.5 kcal/ml) with intact nutrients includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit.

B4153 Enteral formula, nutritionally complete hydrolyzed proteins (amino acids and peptide chain) includes fats carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit.

B4154 Enteral formula, nutritionally complete special metabolic needs, excludes inherited disease of metabolism, includes altered composition of proteins, fats, carbohydrates, vitamins and/or minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit.

B4155 Enteral formula, nutritionally incomplete/modular nutrients, includes specific nutrients carbohydrates (e.g. glucose polymers), proteins/amino acids (e.g., glutamine, arginine), fat (e.g. medium chain triglycerides) or combination, administered through an enteral feeding tube, 100 calories = 1 unit.

HCPCS codes B4151 and B4156 have been discontinued for claims with dates of service after December 31, 2004. There is no grace period allowing use of these codes for dates of service in 2005. Manufacturers or suppliers of products that had been billed using those codes may request a new Coding Verification Review from the SADMERC.

HCPCS codes B4102 and B4103 describe electrolyte-containing fluids that are noncovered by Medicare.
**Enteral Nutrition - HCPCS Code Changes cont.**

HCPCS code B4104 is an enteral formula additive. The enteral formula codes include all nutrient components, including vitamins, mineral, and fiber. Therefore HCPCS code B4104 will be denied as not separately payable.

HCPCS code B4149 describes formulas containing natural foods that are blenderized and packaged by a manufacturer. HCPCS code B4149 must not be used for foods which have been blenderized by the patient or caregiver for administration through a tube. Self-blenderized formulas are noncovered by Medicare.

New HCPCS codes B4149 and B4157-B4162 will require a CMN; HCPCS codes B4102-B4104 will not require a CMN.

Questions concerning the correct coding of specific enteral nutrition products should be directed to the SADMER.

A revision of the Enteral Nutrition medical policy incorporating these codes will be published in a future Region C DMERC DMEPOS Supplier Manual update.

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**Infusion Therapy - Billing for Denial**

Many suppliers provide infusion drugs and supplies that are not covered under the External Infusion Pumps policy (DME benefit) or under another specific statutory benefit - i.e., intravenous immune globulin for primary immunodeficiency, home dialysis supplies, immunosuppressive drugs following organ transplant. The following provides guidance on the correct billing in these situations.

**Drug is not administered with a durable infusion pump (i.e., it is administered by drip infusion or by using an elastomeric or other disposable infusion pump [A4305, A4306])**

A CMN does not need to be submitted in this situation.

If the supplies and/or drug are not eligible for coverage under any Medicare benefit, then the GY modifier (Item or service statutorily excluded or does not meet the definition of any Medicare benefit) must be added to the code. In addition, a brief explanation for use of the GY modifier must be included on the claim - e.g., "not administered with a durable infusion pump." The GY modifier must not be used for a drug or related supplies when that drug is administered with a DME infusion pump - even if the supplier knows that the claim will be denied based on medical policy or individual consideration.

HCPCS codes submitted in this way will be denied as statutorily noncovered.

**Drug is administered with a durable infusion pump (E0779-E0791, K0455)**

A claim for the pump must be submitted and the initial claim for the pump must include a Certificate of Medical Necessity (CMN). If a CMN is not submitted, the claim will be rejected as insufficient information.

**Supplies are submitted using the appropriate HCPCS code(s) - A4221, A4222, K0552.**

If the drug has a specific HCPCS code, it must be used; if not, use HCPCS code J7799. If HCPCS code J7799 is submitted, the claim must include the name of the drug and the indications for its use.
Infusion Therapy - Billing for Denial cont.

The GY modifier must not be used in these situations.

If the DMERC determines that the drug is not medically necessary for the stated indication or if it determines that the pump is not necessary to administer the drug even though the drug itself may be medically necessary, the pump, the drug and related infusion supplies are all denied as not medically necessary. There is no way for the supplier to obtain a "coverage" denial in these situations.

Nebulizer - New Inhalation drug codes

Effective for dates of service on or after January 1, 2005, seven new HCPCS codes have been established for albuterol, levalbuterol, and ipratropium inhalation solutions:

- **J7611**: Albuterol, inhalation solution, administered through DME, concentrated form, 1mg
- **J7612**: Levalbuterol, inhalation solution, administered through DME, concentrated form, 0.5mg
- **J7613**: Albuterol, inhalation solution, administered through DME, unit dose, 1mg
- **J7614**: Levalbuterol, inhalation solution, administered through DME, unit dose, 0.5mg
- **J7616**: Albuterol, up to 5 mg and ipratropium bromide up to 1 mg, compounded inhalation solution, administered through DME
- **J7617**: Levalbuterol, up to 2.5 mg and ipratropium bromide up to 1mg compounded inhalation solution, administered through DME

HCPCS codes J7618, J7619, and J7621 are discontinued for claims with dates of service after December 31, 2004. There is no grace period allowing use of these codes for dates of service in 2005.

HCPCS codes J7616 and J7617 may only be used when these drugs are provided in combination by a manufacturer or repackager in a vial with a single NDC number. DuoNeb is one example of J7616. Despite the narrative description of the HCPCS code, J7616 and J7617 must not be used for inhalation solutions of these drugs that are compounded by pharmacies. For combination unit dose preparations compounded by pharmacies and for situations in which these drugs are provided in separate unit dose vials, suppliers should use HCPCS code J7613 for albuterol, J7614 for levalbuterol, and J7644 for ipratropium with the appropriate modifier - KO, KP, or KQ.

The KO, KP, and KQ modifiers should not be used with HCPCS codes J7616 and J7617.

CPAP and RAD - Clarification of Apnea-Hypopnea Index

A revision of the medical policies on Continuous Positive Airway Pressure Devices (CPAP) and Respiratory Assist Devices (RAD) in the Region C DMERC DMERPOS Supplier Manual updated through Winter 2004 includes a clarification of the definition of the Apnea-Hypopnea Index (AHI). It says that although there is a requirement for a minimum of two hours of recording time without use of a positive airway pressure device, the AHI is calculated based on the number of hours of sleep within that recording time. An example of the calculation is also included. The two policies were also converted into the new format of Local Coverage Determinations (LCD) and Policy Articles. The definition of the AHI can be found in the Appendices section of the LCDs.
Completion of Medicare Certificates of Medical Necessity

Dear Physician:

Certificates of Medical Necessity, commonly known as CMNs, are documents used by the DMERCs to assist in gathering information about the medical necessity of an item. It is your responsibility to determine both the medical need for, and the utilization of, all healthcare services.

Suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) are your partners in caring for your patient. They will not receive payment for their services until you return the completed, signed and dated CMN. If you have ordered equipment or supplies as part of your patient's treatment plan, completing the CMN accurately and in a timely manner helps insure that your treatment plan will be carried out. Moreover, your cooperation is a legal requirement as outlined in the Social Security Act, the law governing Medicare. Section 1842(p)(4) of the Act provides that:

[i]n case of an item or service…ordered by a physician or a practitioner…but furnished by another entity, if the Secretary (or fiscal agent of the Secretary) requires the entity furnishing the item or service to provide diagnostic or other medical information in order for payment to be made to the entity, the physician or practitioner shall provide that information to the entity at the time that the item or service is ordered by the physician or practitioner.

Remember, everyone has tight cashflow these days - help your DMEPOS supplier continue good service to your patients by prompt completion and return of the CMN.

Sincerely,

Stacey V. Brennan, MD
Durable Medical Equipment Regional Carrier
Medical Director
Section 3: HCPCS Codes and Fee Updates

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2005 Healthcare Common Procedure Coding System (HCPCS)
Annual Update Reminder

Related Change Request (CR) #: 3422
Medlearn Matters #: MM3422
Related CR Release Date: August 27, 2004
Related CR Transmittal #: 283

Effective Date: January 1, 2005
Implementation Date: January 3, 2005

Provider Types Affected
Physicians, providers, and suppliers

Provider Action Needed
This instruction is a reminder that the complete HCPCS file is updated and released annually by the Centers for Medicare & Medicaid Services (CMS) to the Medicare contractors. The 2005 version of the HCPCS file contains existing, new, revised, and discontinued HCPCS codes for 2005. Your Medicare contractor will use the file for processing claims for services on or after January 1, 2005.

All Medicare physicians, providers, and suppliers: there is no longer a 90-day grace period for billing discontinued HCPCS codes as of January 1, 2005.

Background
Medicare providers submitting claims to Medicare contractors for Part B services use a HCPCS code to indicate the service that was provided. HCPCS consist of Level I codes, which are the American Medical Association's (AMA’s) Current Physician Terminology Codes (CPT-4) and Level II codes, which are alpha-numeric and maintained by CMS. The alpha-numeric index and the table of drugs will be posted to the CMS Web site by the end of October. The CMS Web site address for that posting will be:
http://www.cms.hhs.gov/providers/pufdownload/default.asp#alphanum

There is no longer a 90-day grace period for discontinued codes in order to be compliant with HIPAA standards. To view further information regarding the elimination of this 90-day grace period, see the Medlearn Matters article MM3093, which may be found at:

Implementation
The implementation date for this instruction is January 3, 2005.

Additional Information
For complete details, please see the official instruction issued to your carrier and fiscal intermediary regarding this change. That instruction may be viewed by going to:

From that Web page, look for CR3422 in the CR NUM column on the right, and click on the file for that CR.

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

Bulletins issued after October 1, 1999 are available at no cost from our Web site at www.PalmettoGBA.com.
October Quarterly Update for 2004 DMEPOS Fee Schedule

Related Change Request (CR) #: 3377
Medlearn Matters Number: MM3377
Related CR Release Date: August 10, 2004
Related CR Transmittal #: 272

Effective Date: January 1, 2004 for revised 2004 fee schedule amounts
Implementation Date: October 4, 2004

Provider Types Affected
Physicians, providers, and suppliers

Provider Action Needed
This instruction provides information for updating and implementing the October Quarterly 2004 fee schedule amounts for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS). It implements fee schedule amounts for new HCPCS codes and revises any fee schedule amounts for existing HCPCS codes that were calculated in error.

Background
Payment on a fee schedule basis is required for Durable Medical Equipment (DME), prosthetic devices, orthotics, prosthetics, and surgical dressings (Social Security Act, Sections 1834(a), (h), and (i)). In addition, payment on a fee schedule basis is required for Parenteral and Enteral Nutrition (PEN) by regulations contained in 42 CFR 414.102.

This instruction implements fee schedule amounts for new HCPCS codes, deletes certain HCPCS codes, and revises any fee schedule amounts for existing HCPCS codes that were calculated in error in prior updates. Specifically, the changes for this update are as follows:

- HCPCS codes A4363, E1400 through E1404, K0137 through K0139, K0168 through K0181, K0190 through K0192, K0277 through K0279, K0284, K0400, K0417, K0419 through K0439, and K0530 were deleted from the Healthcare Common Procedure Coding System (HCPCS) effective 12/31/1999. These HCPCS codes were inadvertently included in the 2004 fee schedule file, and they are being removed with this update.
- HCPCS codes E1019 and E1021 are also being removed as they are not valid 2004 HCPCS codes.
- The 2004 Puerto Rico schedule amounts for HCPCS codes A4351 and A4352 were based on incorrect pricing information. The Durable Medical Equipment Regional Carriers (DMERCs) must revise the base fee schedule amounts for these codes as part of the October quarterly update.
- HCPCS codes K0630 through K0649, representing Lumbar Sacral Orthosis products were added to the HCPCS effective April 1, 2004 and their fee schedule amounts were implemented on July 1, 2004. However, the Centers for Medicare & Medicaid Services has determined that the fee schedule amounts for HCPCS codes K0630, K0631, K0632, K0634, K0635, K0636, K0637, K0639, K0640, K0642, K0644, K0645, and K0646 were based on incorrect pricing information and have recalculated those fee schedule amounts. The revised amounts will be implemented on October 4, 2004 as part of this update.
- HCPCS codes K0650 thru K0669 were added to the HCPCS effective July 1, 2004. Because data is not yet available, implementation of the fee schedule amounts for these items will be delayed until the January 2005 update.

Implementation
The implementation date for this instruction is October 4, 2004.

Additional Information
To view the official instruction issued to your DMERC or intermediary on this issue, please see: http://www.cms.hhs.gov/manuals/pm_trans/R272CP.pdf

Also, the quarterly update process for the DMEPOS fee schedule is located in Section 60 of Chapter 23 of the Medicare Claims Processing Manual, which may be found at: http://www.cms.hhs.gov/manuals/104_claims/clm104index.asp

If you have any questions, please contact your DMERC or intermediary at their toll-free number, which may be found at: http://www.cms.hhs.gov/medlearn/tollnums.asp
Coverage by Medicare Advantage Organizations for National Coverage Determination (NCD) Services Not Previously Included in the Medicare Advantage’s Capitated Rates

Related Change Request (CR) #: 3301  
Medlearn Matters #: MM3301  
Related CR Release Date: N/A (CR is not available)  
Related CR Transmittal #: N/A  

Effective Date: January 1, 2005  
Implementation Date: January 3, 2005  

Provider Types Affected  
Physicians, providers, and suppliers billing for the services mentioned below.  

Provider Action Needed  
STOP - Impact to You  
Medicare Advantage (MA) rates were recently adjusted to account for three National Coverage Determination (NCD) services. These services are implantable automatic defibrillators (effective 10/1/03), ventricular assist devices (effective 1/1/04), and lung volume reduction surgery (effective 1/1/04). MA organizations are liable for payment for these NCD services beginning January 1, 2005.

CAUTION - What You Need to Know  
For services rendered prior to January 1, 2005, payment for services relating to the three NCD services mentioned above are paid by Medicare on a fee-for-service basis for MA plan enrollees. Note that, prior to January 1, 2005, beneficiaries are not responsible for Part A or Part B deductibles associated with these services, although they are responsible for coinsurance amounts appropriate under Medicare fee-for-service rules.

GO - What You Need to Do  
Be aware that these services will not be paid on a fee-for-service basis for dates of service on or after January 1, 2005. Instead, the MA plan will be responsible for making payment. Note also that MA enrollees receiving services for lung volume reduction surgery services must receive these services in designated hospitals.

Background  
When Medicare initially issued these NCDs, new coverage was introduced and the cost of that coverage was not reflected in the rates paid to MA plans. Thus, Medicare paid for these services separately on a fee-for-service basis until such time as the cost could be considered in determining MA rates. The Centers for Medicare & Medicaid Services (CMS) will factor these costs into the MA payment rates as of January 1, 2005. At that time, Medicare will no longer pay for these services on the fee-for-service basis.

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

October 1, 2004 Oral Anticancer Drug Fee Update

Due to the enactment of section 626(a) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, (MMA) on December 8, 2003, Oral Anti-Cancer Drug (OACD) pricing will remain unchanged throughout calendar year 2004; however, we will continue to provide new and deleted sources quarterly.

Three new sources were included in the August 2004 Redbook database. There are two sources for Methotrexate (2.5 mg) manufactured by Quality Care Products and DispensExpress. One source was identified for Alkeran (2 mg) manufactured by Celgene Corporation. The following table reflects the added National Drug Codes (NDCs) and the dates:

<table>
<thead>
<tr>
<th>NDC</th>
<th>Drug Name</th>
<th>Manufacturer</th>
<th>Added Date</th>
<th>2004 Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>59572-0302-50</td>
<td>Alkeran, 2 mg</td>
<td>Celgene Corporation</td>
<td>4/22/2004</td>
<td>$2.24</td>
</tr>
<tr>
<td>49999-0380-24</td>
<td>Methotrexate, 2.5 mg</td>
<td>Quality Care Products</td>
<td>6/9/2004</td>
<td>$2.64</td>
</tr>
<tr>
<td>68115-0632-00</td>
<td>Methotrexate, 2.5 mg</td>
<td>DispensExpress</td>
<td>4/19/2004</td>
<td>$2.64</td>
</tr>
</tbody>
</table>
MMA-Reasonable Charge Update for 2005 for Splints, Casts, Dialysis Supplies, Dialysis Equipment, Therapeutic Shoes, and Certain Intraocular Lenses for DMERC

Related Change Request (CR) #: 3430
Medlearn Matters Number: MM3430
Related CR Release Date: September 10, 2004
Related CR Transmittal #: 297

Effective Date: January 1, 2005
Implementation Date: January 3, 2005

Provider Types Affected
Physicians, providers, and suppliers

Provider Action Needed
This instruction provides details regarding the calculation of reasonable charges for the payment of claims for splints, casts, dialysis supplies, dialysis equipment, and intraocular lenses furnished in calendar year 2005.

Background
Payment on a reasonable charge basis is required for splints, casts, dialysis supplies, dialysis equipment, and intraocular lenses by regulations contained in 42 Code of Federal Regulations (CFR) 405.501. This instruction provides details regarding the calculation of reasonable charges for payment of claims for splints, casts, dialysis supplies, dialysis equipment, and intraocular lenses furnished in calendar year 2005.

For splints and casts: The 2005 gap-filled amounts will be based on the 2004 amounts increased by 3.3 percent, the percentage change in the consumer price index for all urban consumers for the 12-month period ending June 30, 2003.

For splints and casts furnished by hospital outpatient departments, payment is built into the Outpatient Prospective Payment System (OPPS) payment amounts.

For splint or cast materials, payment is only made on a reasonable charge basis for splint or cast materials used by physicians or other practitioners to reduce a fracture or dislocation, and this payment is in addition to the payment made under the physician fee schedule for the procedure for applying the splint or cast.

• For intraocular lenses (HCPCS codes of V2630, V2631, and V2632), payment is only made on a reasonable charge basis for lenses implanted at a physician’s office.

Implementation
The implementation date for this instruction is January 3, 2005.

Additional Information
For complete details, please see the official instruction issued to your fiscal intermediary regarding this change. That instruction may be viewed by going to:

From that Web page, look for CR3430 in the CR NUM column on the right, and click on the file for that CR.

That CR has a detailed list of HCPCS codes for splints and casts with associated gap-filled payment amounts that the DMERCs will use in making payment in 2005 based on the lower of the actual charge or the gap-filled payment amount.

If you have any questions, please contact your regional home health intermediary, carrier, or DMERC at their toll-free number, which may be found at:
http://www.cms.hhs.gov/medlearn/tollnums.asp
MMA Drug Pricing Update – Payment Limit for J9045 (Carboplatin Injection) and J9310 (Rituximab Cancer Treatment)

Related Change Request (CR) #: 3419
Medlearn Matters #: MM3419
Related CR Release Date: August 24, 2004
Related CR Transmittal #: 106

Effective Date: April 1, 2004
Implementation Date: September 24, 2004

Provider Types Affected
Physicians, suppliers, and providers.

Provider Action Needed
Affected providers are advised that Medicare carriers are updating the payment limits (listed in this article) for HCPCS drug code J9045 (Carboplatin injection) and J9310 (Rituximab cancer treatment), effective with dates of service on or after April 1, 2004, and on or before December 31, 2004.

Background
The payment limits for Carboplatin injection and Rituximab cancer treatment, Medicare Part B drugs meeting the exceptions process described in Section 303(b) of Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) are being updated for claims with such services provided between April 1, 2004 through December 31, 2004, inclusive. The old and new rates for J9045 (Carboplatin injection) and J9310 (Rituximab cancer treatment) with the new rate for dates of service on or after April 1, 2004 and on or before December 31, 2004 are as follows where payment is not made on a cost or prospective payment basis:

<table>
<thead>
<tr>
<th>Status</th>
<th>HCPCS Code</th>
<th>Short Description</th>
<th>AWP%</th>
<th>2004 Payment Limit for Drugs (other than ESRD drugs separately billed independent ESRD Facilities and drugs infused through DME)</th>
</tr>
</thead>
<tbody>
<tr>
<td>OLD</td>
<td>J9045</td>
<td>Carboplatin injection</td>
<td>88</td>
<td>$137.54</td>
</tr>
<tr>
<td>NEW</td>
<td>J9045</td>
<td>Carboplatin injection</td>
<td>86</td>
<td>$135.15</td>
</tr>
<tr>
<td>OLD</td>
<td>J9310</td>
<td>Rituximab cancer treatment</td>
<td>81</td>
<td>$427.28</td>
</tr>
<tr>
<td>NEW</td>
<td>J9310</td>
<td>Rituximab cancer treatment</td>
<td>83</td>
<td>$438.38</td>
</tr>
</tbody>
</table>

The payment limits for J9045 and J9310 supercede the payment limits published in Change Request (CR) 3161 (Transmittal 119) dated March 15, 2004. Note that the absence or presence of a HCPCS code and its associated payment limit does not indicate Medicare coverage of the drug.

Implementation
The implementation date for this instruction is September 24, 2004.

Additional Information
For complete details, please see the official instruction issued to your carrier regarding this change. That instruction may be viewed by going to:

From that Web page, look for CR3419 in the CR NUM column on the right, and click on the file for that CR.

If you have any questions, please contact your carrier at their toll-free number, which may be found at:
http://www.cms.hhs.gov/medlearn/tollnums.asp
Invalid Diagnosis Code Editing – Second Phase

**Related Change Request (CR) #: 3260**
**Medlearn Matters #: MM3260**
**Related CR Release Date:** October 22, 2004
**Related CR Transmittal #: 326**

**Effective Date:** April 1, 2005
**Implementation Date:** April 4, 2005

**Provider Types Affected**
All physicians, providers, and suppliers who bill Medicare carriers, including Durable Medical Equipment Regional Carriers (DMERCs)

**Provider Action Needed**

**STOP - Impact To You**
New edits will be added to the Medicare claims processing systems to prevent acceptance of inbound claims with invalid diagnosis codes.

**CAUTION - What You Need To Know**
Diagnosis codes must always be valid on the date that the service was provided. Medicare systems will reject claims with diagnosis codes that were not valid on the date of service.

**GO - What You Need To Do**
As Medicare strengthens its edit processes to detect and reject claims with invalid diagnosis codes, ensure that your billing staff know the rules for diagnosis codes and that they submit diagnosis codes that are in compliance with HIPAA.

**Background**
To edit diagnosis accurately codes for validity, Medicare systems will apply date range edits to ensure that diagnosis codes are valid for the period of time for which they are reported on claims sent to Medicare. These edits will apply whether or not Medicare actually uses the reported diagnosis code in its claims processing.

HIPAA rules require that Medicare make sure that such codes are HIPAA-compliant, especially because these codes are passed on to other payers under Medicare’s Coordination of Benefits processes. To be compliant, the diagnosis code must be valid on the date for which it is reported. These policy changes include validation of diagnosis codes on the National Council for Prescription Drug Program (NCPDP) claims and on 837 professional claims.

**Additional Information**
Additional information regarding this topic can be found in Transmittal 86 (CR 3050). The official instruction issued to your carrier regarding this change may be found by going to:

From that Web page, look for CR 3260 in the CR NUM column on the right, and click on the file for that CR.
MMA - Instructions for Pricing Treprostinil (Q4077)

Related Change Request (CR) #: 3533
Medlearn Matters Number: MM3533
Related CR Release Date: October 29, 2004
Related CR Transmittal #: 123

Effective Date: January 1, 2004
Implementation Date: November 29, 2004

Provider Types Affected
All Durable Medical Equipment (DME) suppliers

Provider Action Needed
STOP - Impact to You
Medicare’s Durable Medical Equipment Regional Carriers (DMERCs) will use the specific payment for Healthcare Common Procedure Coding System (HCPCS) drug code Q4077 (Treprostinil) located in the 2004 MMA Payment Limits Pricing File.

CAUTION - What You Need to Know
The 2004 pricing allowance for Q4077 is $61.75.

GO - What You Need to Do
Make sure that your billing offices are aware of this instruction.

Background
This article and the related change request advise suppliers that the DMERCs will use the 2004 MMA Payment Limits Pricing File when pricing the drug Treprostinil (Q4077). That 2004 pricing allowance for Q4077 is $61.75 and is effective for claims with dates of service on or after January 1, 2004.

This change will ensure consistency among the four regional DMERCs and continuity of care for Medicare beneficiaries requiring Treprostinil.

NOTE: The DMERCs will not search their files to either retract payment for claims already paid or to retroactively pay claims. However, contractors will adjust claims brought to their attention.

Implementation
The implementation date is November 29, 2004.

Related Instructions
The 2004 MMA Payment Limits Pricing File is available at:
http://www.cms.hhs.gov/providers/drugs/default.asp

Additional Information
The official instruction issued to your DMERC regarding this change may be found at:
http://www.cms.hhs.gov/manuals/transmittals/com m_date_dsc.asp

From that Web page, look for CR 3533 in the CR NUM column on the right and click on the file for that CR.

If you have any questions, please contact your DMERC at their toll-free number, which may be found at:
http://www.cms.hhs.gov/medlearn/tollnums.asp
MMA - January 2005 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing File, Effective January 1, 2005

Related Change Request (CR) #: 3539  
Medlearn Matters Number: MM3539  
Related CR Release Date: October 29, 2004  
Related CR Transmittal #: 348  

Effective Date: January 1, 2005  
Implementation Date: January 3, 2005  

Provider Types Affected  
All providers  

Provider Action Needed  
No provider action is necessary. This article is informational only and explains how Medicare pays for certain drugs that are not paid on a cost or prospective payment basis, effective January 1, 2005.  

Background  
According to Section 303 of the Medicare Modernization Act of 2003 (MMA), beginning January 1, 2005 drugs and biologicals not paid on a cost or prospective payment basis will be paid based on the Average Sales Price (ASP) plus six (6) percent. The Centers for Medicare & Medicaid Services (CMS) will supply its carriers/intermediaries with the ASP drug pricing file for Medicare Part B drugs. The ASP is based on quarterly drug information supplied to CMS by drug manufacturers.  

Thus, beginning January 1, 2005, the payment allowance limits for Medicare Part B drugs and biologicals that are not paid on a cost or prospective payment basis are 106 percent of the ASP. CMS will update the payment allowance limits quarterly.  

Exceptions  
There are exceptions to this general rule, as summarized below:  
1. The payment allowance limits for blood and blood products, with certain exceptions such as blood clotting factors, are determined in the same manner the payment allowance limits were determined on October 1, 2003. Specifically, the payment allowance limits for blood and products are 95 percent of the average wholesale price (AWP) as reflected in the published compendia. The payment allowance limits will be updated on a quarterly basis.  
2. The payment allowance limits for infusion drugs furnished through a covered item of durable medical equipment on or after January 1, 2005 will continue to be 95 percent of the AWP reflected in the published compendia as of October 1, 2003 regardless of whether or not the durable medical equipment is implanted. The payment allowance limits will not be updated in 2005.  
3. The payment allowance limits for influenza, pneumococcal and hepatitis B vaccines are 95 percent of the AWP as reflected in the published compendia. The payment allowance limits will be updated on a quarterly basis.  
4. The payment allowance limits for drugs not included in the ASP Medicare Part B Drug Pricing File are based on the published wholesale acquisition cost (WAC) or invoice pricing.  

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

Implementation  
The implementation date is January 3, 2005.  

Additional Information  
The official instruction issued to your carrier/intermediary regarding this change may be found at:  

From that Web page, look for CR 3539 in the CR NUM column on the right and click on the file for that CR.  

If you have any questions, please contact your carrier/intermediary at their toll-free number, which may be found at:  
http://www.cms.hhs.gov/medlearn/tollnums.asp
Annual Update of HCPCS Codes Used for Home Health Consolidated Billing Enforcement

CPT codes, descriptors and other data only are copyright 2004 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS apply.

Related Change Request (CR) #: 3525
Medlearn Matters Number: MM3525
Related CR Release Date: October 29, 2004
Related CR Transmittal #: 340

Effective Date: January 1, 2005
Implementation Date: January 3, 2005

Provider Types Affected
Physicians, providers, home health agencies (HHAs), and suppliers

Provider Action Needed
The Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of HCPCS codes subject to the consolidated billing provision of the Home Health Prospective Payment System (HH PPS).

This article provides the annual HH consolidated billing update effective January 1, 2005. Affected providers should be aware of these changes.

Background
Section 1842(b)(6) of the Social Security Act (SSA) requires that payment for home health services provided under a home health plan of care be made to the HHA. As a result, billing for all such items and services is to be made by a single HHA oversee that plan. This HHA is known as the primary agency for HH PPS for billing purposes.

With the exception of therapies performed by physicians, supplies incidental to physician services, and supplies used in institutional settings, services appearing on this list that are submitted on claims to Medicare contractors will not be paid separately on dates when a beneficiary for whom such a service is being billed is in a home health episode (i.e., under a home health plan of care administered by an HHA).

Medicare periodically publishes Routine Update Notifications, which contain updated lists of non-routine supply and therapy codes that must be included in HH consolidated billing. The lists are always updated annually, effective January 1, as a result of changes in HCPCS codes that Medicare also publishes annually. This list may also be updated as frequently as quarterly if required by the creation of new HCPCS codes during the year.

Additional Information
This notification provides the annual HH consolidated billing update effective January 1, 2005. The following table describes the HCPCS codes and the specific changes to each that this notification is implementing on January 3, 2005:

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Description of HCPCS Code</th>
<th>Type Change</th>
<th>Replacement Code or Code Being Replaced</th>
</tr>
</thead>
<tbody>
<tr>
<td>A4347</td>
<td>Male external catheter</td>
<td>Delete</td>
<td>Replacement code: A4349</td>
</tr>
<tr>
<td>A4324</td>
<td>Male ext cath w/adh coating</td>
<td>Delete</td>
<td>Replacement code: A4349</td>
</tr>
<tr>
<td>A4325</td>
<td>Male ext cath w/adh strip</td>
<td>Delete</td>
<td>Replacement code: A4349</td>
</tr>
<tr>
<td>A4349</td>
<td>Male ext catheter, with or without adhesive, disposable, each</td>
<td>Add</td>
<td>Replaces code: A4347, A4324, A4325</td>
</tr>
<tr>
<td>A7040</td>
<td>One way chest drain valve</td>
<td>Add</td>
<td></td>
</tr>
<tr>
<td>A7041</td>
<td>Water seal drainage container and tubing for use with implanted chest tube</td>
<td>Add</td>
<td></td>
</tr>
<tr>
<td>A7045</td>
<td>Exhalation port with or without swivel used with accessories for positive airway devices, replacement only</td>
<td>Add</td>
<td></td>
</tr>
<tr>
<td>A7527</td>
<td>Tracheostomy/laryngectomy tube plug/stop, each</td>
<td>Add</td>
<td></td>
</tr>
</tbody>
</table>
### Annual Update of HCPCS Codes Used for Home Health Consolidated Billing Enforcement cont.

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Description of HCPCS Code</th>
<th>Type Change</th>
<th>Replacement Code or Code Being Replaced</th>
</tr>
</thead>
<tbody>
<tr>
<td>97601</td>
<td>Wound care selective</td>
<td>Delete</td>
<td>Replacement code: 97597, 97598</td>
</tr>
<tr>
<td>97597</td>
<td>removal of devitalized tissue from wound(s), selective debridement; surface area less than or equal to 20 square centimeters</td>
<td>Add</td>
<td>Replaces code: 97601</td>
</tr>
<tr>
<td>97598</td>
<td>removal of devitalized tissue from wound(s), selective debridement; surface area greater than or equal to 20 square centimeters</td>
<td>Add</td>
<td>Replaces code: 97601</td>
</tr>
<tr>
<td>97605</td>
<td>removal of devitalized tissue from wound(s), selective debridement; surface area less than or equal to 50 square centimeters</td>
<td>Add</td>
<td></td>
</tr>
<tr>
<td>97606</td>
<td>removal of devitalized tissue from wound(s), selective debridement; surface area greater than or equal to 50 square centimeters</td>
<td>Add</td>
<td></td>
</tr>
</tbody>
</table>

The last update to the HH consolidated billing was issued under Transmittal 226, CR 3350. This CR can be found at: [http://www.cms.hhs.gov/manuals/pm_trans/R226CP.pdf](http://www.cms.hhs.gov/manuals/pm_trans/R226CP.pdf)

The official instruction issued to your carrier/intermediary (including Durable Medical Equipment Carriers (DMERCs) and Regional Home Health Intermediaries (RHHIs)) regarding this change may be found by going to: [http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp](http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp)

From that web page, look for CR 3525 in the CR NUM column on the right, and click on the file for that CR.

If you have any questions regarding this issue, please contact your carrier/intermediary at their toll free number, which may be found at: [http://www.cms.hhs.gov/medlearn/tollnums.asp](http://www.cms.hhs.gov/medlearn/tollnums.asp)

CPT codes, descriptors and other data only are copyright 2004 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS apply.
## 2004 Fee Schedule Amounts For Wheelchair Seat and Back Cushions

Effective November 12, 2004, the following fee schedule amounts will be used to pay claims with dates of service from July 1, 2004, thru December 31, 2004.

Refer to the article posted on website, for more information concerning the coding and pricing.

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Purchase New</th>
<th>Rental</th>
<th>Purchase Used</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(NU)</td>
<td>(RR)</td>
<td>(UE)</td>
</tr>
<tr>
<td>All States and Territories</td>
<td>All States and Territories</td>
<td>All States and Territories</td>
<td></td>
</tr>
<tr>
<td>K0650</td>
<td>$92.29</td>
<td>$9.23</td>
<td>$69.22</td>
</tr>
<tr>
<td>K0651</td>
<td>$238.62</td>
<td>$23.86</td>
<td>$178.97</td>
</tr>
<tr>
<td>K0652</td>
<td>$223.04</td>
<td>$22.30</td>
<td>$167.28</td>
</tr>
<tr>
<td>K0653</td>
<td>$315.76</td>
<td>$31.58</td>
<td>$236.82</td>
</tr>
<tr>
<td>K0654</td>
<td>$321.69</td>
<td>$32.17</td>
<td>$241.27</td>
</tr>
<tr>
<td>K0655</td>
<td>$436.07</td>
<td>$43.61</td>
<td>$327.05</td>
</tr>
<tr>
<td>K0656</td>
<td>$302.31</td>
<td>$30.23</td>
<td>$226.73</td>
</tr>
<tr>
<td>K0657</td>
<td>$365.31</td>
<td>$36.53</td>
<td>$273.98</td>
</tr>
<tr>
<td>K0658</td>
<td>IC</td>
<td>IC</td>
<td>IC</td>
</tr>
<tr>
<td>K0659</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

Following are the fee schedule allowances for the adjustable seat cushions billed under HCPCS code K0108.

<table>
<thead>
<tr>
<th>HCPCS Codes</th>
<th>Description</th>
<th>Modifier</th>
<th>2004 Fee All States and Territories</th>
</tr>
</thead>
<tbody>
<tr>
<td>K0108</td>
<td>Skin Protection Wheelchair Seat Cushion, Adjustable, Width 22 inches or greater, any depth</td>
<td>NU</td>
<td>$389.54</td>
</tr>
<tr>
<td>K0108</td>
<td>Skin Protection Wheelchair Seat Cushion, Adjustable, Width 22 inches or greater, any depth</td>
<td>RR</td>
<td>$38.95</td>
</tr>
<tr>
<td>K0108</td>
<td>Skin Protection Wheelchair Seat Cushion, Adjustable, Width 22 inches or greater, any depth</td>
<td>UE</td>
<td>$292.16</td>
</tr>
<tr>
<td>K0108</td>
<td>Skin Protection Wheelchair Seat Cushion, Adjustable, Width less than 22 inches, any depth</td>
<td>NU</td>
<td>$330.81</td>
</tr>
<tr>
<td>K0108</td>
<td>Skin Protection Wheelchair Seat Cushion, Adjustable, Width less than 22 inches, any depth</td>
<td>RR</td>
<td>$33.08</td>
</tr>
<tr>
<td>K0108</td>
<td>Skin Protection Wheelchair Seat Cushion, Adjustable, Width less than 22 inches, any depth</td>
<td>UE</td>
<td>$248.11</td>
</tr>
<tr>
<td>K0108</td>
<td>Skin Protection and Positioning Wheelchair Seat Cushion, Adjustable, Width 22 inches or greater, any depth</td>
<td>NU</td>
<td>$435.56</td>
</tr>
<tr>
<td>K0108</td>
<td>Skin Protection and Positioning Wheelchair Seat Cushion, Adjustable, Width 22 inches or greater, any depth</td>
<td>RR</td>
<td>$43.56</td>
</tr>
<tr>
<td>K0108</td>
<td>Skin Protection and Positioning Wheelchair Seat Cushion, Adjustable, Width 22 inches or greater, any depth</td>
<td>UE</td>
<td>$326.67</td>
</tr>
<tr>
<td>K0108</td>
<td>Skin Protection and Positioning Wheelchair Seat Cushion, Adjustable, Width less than 22 inches, any depth</td>
<td>NU</td>
<td>$378.68</td>
</tr>
<tr>
<td>K0108</td>
<td>Skin Protection and Positioning Wheelchair Seat Cushion, Adjustable, Width less than 22 inches, any depth</td>
<td>RR</td>
<td>$37.87</td>
</tr>
<tr>
<td>K0108</td>
<td>Skin Protection and Positioning Wheelchair Seat Cushion, Adjustable, Width less than 22 inches, any depth</td>
<td>UE</td>
<td>$284.01</td>
</tr>
</tbody>
</table>
**Section 4: HIPAA Information**

Guidance Regarding Elimination of Standard Paper Remittance (SPR) Advice Notices in the Old Format ................................................................. 231
Inappropriate Access to or Use of Electronic Data Interchange (EDI) Transaction Data by Third Party Entities ......................................................... 228
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**Revision to CR 2631 for Durable Medical Equipment Carriers Only**

**Related Change Request (CR) #:** 3261  
**Medlearn Matters Number:** MM3261  
**Related CR Release Date:** November 3, 2004  
**Related CR Transmittal #:** 353

**Effective Date:** April 1, 2005  
**Implementation Date:** April 4, 2005

**Provider Types Affected**  
Durable medical equipment suppliers

**Provider Action Needed**

**STOP - Impact to You**  
Effective April 1, 2005, instead of the 2010AA Billing Provider loop to document place of service (POS) in your Durable Medical Equipment Carrier (DMERC) claims, you must use the 2420C Service Facility loop (line level) or 2310D (claim level). If you use the 2010AA loop and not one of these latter two loops, your claims will be returned as unprocessable when the place of service is other than home.

**CAUTION - What You Need to Know**  
In your DMERC claims, if the place of service reported in either the 2300.CLM05 or the 2400.SV105 is anything other than Home - 12 (or CMS equivalent POS codes of 4-homeless shelter, 13-assisted living, and 14-group home), the Medicare claims processing system will only use the 2420C and 2310D loops to make the appropriate place of service determination. The Medicare System will not use the 2010AA loop to determine the valid place of service in these instances. Likewise, optical Character Reader and Keyshop claims submitted in the ANSI 4010A1 format must utilize the 2310D to report the facility.

**GO - What You Need to Do**  
Make sure that your billing staff knows that, on your DMERC claims, they must use the 2420C and 2310D loops (and not the 2010AA Billing Provider loop) to document the place of service when that place is other than the home of the beneficiary.

**Background**  
This article addresses Change Request 3261 that revises an earlier one (CR 2631). CR 2631 (Transmittal 1813B3, dated August 1, 2003) implemented procedures to follow when the POS on your claim is other than home (Code – 12 or equivalent as mentioned earlier).

It required that, on version 4010/4010A of the ASC X12N 837 electronic claim format, you provide the name, address, and zip code of the location where the service was performed, for all claims received on or after April 1, 2004. More specifically, it required that Billing Provider loop 2010AA always be completed, and was to be heavily relied on to serve as the documentation of a valid place of service.

The problem with this requirement in CR 2361 is that if the POS is not actually “home,” the 2010AA
This bulletin should be shared with all health care practitioners and managerial members of the provider/supplier staff.

Revision to CR 2631 for Durable Medical Equipment Carriers Only cont.

loop billing may not be where the service was provided. It could actually be supplier information and not the place of service.

Although all claims must have a completed 2010AA Billing Provider loop, beginning April 1, 2004, this does not ensure that your claim has been properly submitted, because the Billing or Pay To Provider’s location may not be where the services were rendered.

Therefore, in order to process claims correctly, the following change must be made for DMERC claims only:

- The Medicare system will not use the 2010AA loop to make the appropriate facility determination. It will only use the 2420C and 2310D loops to determine POS. Requirements for the required information for these two loops are not being changed with these instructions.

- The Medicare system will provide edits that require you to supply complete facility information at either the 2310D or the 2420C loops if the place of service reported in either the 2300.CLM05 or the 2400.SV105 is other than Home – 12 (or the equivalent POS codes as determined by CMS). If you don’t, the claim will be returned to you with the appropriate remarks code as stated in CR2631.

- Likewise, OCR and Keyshop claims submitted in the ANSI 4010A1 format must utilize the 2310D to report the facility information from block 32 because line level facility information is not readily available on a 1500 form. Medicare will edit these claims accordingly.

NOTE: The Medicare Standard System first looks to the line item/2420C and then looks to the claim item/2310D for POS information. Currently, it then looks to the Header Information at 2010AA.

Implementation Date
The implementation date for these changes will be April 4, 2005.

Additional Information
You can find CR 3261 by going to: http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp

From that Web page, look for CR 3261 in the CR NUM column on the right, and click on the file for that CR number. The revised pages of the online manual Pub 100-4, Chapter 1, Section 10 are attached to that CR. In addition you can find CR 2631 at:

Finally, if you have any questions, please contact your carrier/intermediary at their toll-free number, which may be found at:
http://www.cms.hhs.gov/medlearn/tollnums.asp
Remittance Advice Remark Code and Claim Adjustment Reason Code Update

Related Change Request (CR) #: 3466
Medlearn Matters Number: MM3466
Related CR Release Date: October 15, 2004
Related CR Transmittal #: 313

Effective Date: January 1, 2005
Implementation Date: January 3, 2005

Provider Types Affected
All providers

Provider Action Needed

STOP: Impact to You
The June 2004 updates have been posted for the X12N 835 Health Care Remittance Advice Remark Codes and the X12 N 835 Health Care Claim Adjustment Reason Codes.

CAUTION: What You Need to Know
The most current and complete list will be found online at: http://www.wpc-edi.com/codes/Codes.asp Please note that in case of a discrepancy, the code text included on the Washington Publishing Company (WPC) Web site will supersede any corresponding text in a CR.

In addition, with respect to Health Care Claim Adjustment Reason Codes, few temporary reason codes (D16-D20) were added for the cases where commercial payers do not make use of the available remark codes when the reason code used is too generic to help providers decide on the follow-up action. Medicare will not use these new temporary reason codes but rather will continue the current use of the combination of reason and appropriate remark codes.

GO: What You Need to Do
The above noted codes are updated three times a year. Please advise billing staff to stay current with the latest approved and valid codes, in accordance with effective and implementation dates, to ensure accurate Medicare claims processing.

Background
The Remittance Advice Remark Code list is one of the code lists mentioned in the ASC X12 transaction 835 (Health Care Claim Payment/Advice) version 4010A1 Implementation Guide (IG). This list is maintained by The Centers for Medicare & Medicaid Services (CMS) and is updated three times a year.

The complete list of current codes is available online at the WPC Web site: http://www.wpc-edi.com/codes/Codes.asp

The Health Care Claim Adjustment Codes are maintained by the Claim Adjustment Reason Code and Status Code Maintenance Committee. The Committee meets at the beginning of each X12 trimester meeting (February, June, and October) and decides on any additions, modifications, or retirement of reason codes. The updated list is posted three times a year and the complete list of current codes is available online at the WPC Web site: http://www.wpc-edi.com/codes/Codes.asp

Additional Information
The most recent changes approved for the Remittance Advice Remark Codes and the Claim Adjustment Reason Codes can be found in the official instruction issued to your carrier or fiscal intermediary, including Durable Medical Equipment Regional Carriers (DMERCs). That official instruction is found in CR 3466, which is available at: http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp

Once at that page, scroll down the CR NUM column on the right to find the link for CR 3466. Click on the link to open and view the file for the CR.

The CR attachments also include information on the process of decision making that results in updates to the X12N 835 Health Care Remittance Advice Remark Codes and the X12 N 835 Health Care Claim Adjustment Reason Codes. It also includes a table of changes; however, please note that the most current and complete list is online at the WPC Web site. This CR includes changes made only from March through June of 2004.

If you have questions regarding this issue, you may also contact your carrier or fiscal intermediary at their toll free number at: http://www.cms.hhs.gov/medlearn/tollnums.asp.
Inappropriate Access to or Use of Electronic Data Interchange (EDI) Transaction Data by Third Party Entities

Related Change Request (CR) #: N/A
Medlearn Matters Number: SE0461
Related CR Release Date: N/A

Provider Types Affected
All physicians, suppliers, and providers.

Provider Action Needed
STOP - Impact to You
Failure to abide by Medicare security requirements for EDI access could lead to suspension of EDI capabilities.

CAUTION - What You Need to Know
This article clarifies and reminds affected physicians, providers, and suppliers of existing Medicare requirements and prohibitions concerning use of EDI numbers and passwords.

GO - What You Need to Do
Be sure you and your third party partners are aware of and abide by these requirements to protect your EDI access and to maintain your ability to submit timely claims to Medicare.

Background
Medicare contractors (carriers and intermediaries) support electronic data interchange (EDI) to enable providers, either directly or through third party agents to:

- Verify patient eligibility to determine if a claim should be submitted to Medicare;
- Submit claims to Medicare electronically;
- Determine the status of a previously submitted claim; and
- Post adjudication decisions and payments to patient accounts.

It is important to note that these functions are the only functions for which a provider or a third party entity is entitled to send EDI transactions directly to Medicare contractors (carriers, DMERCs, or fiscal intermediaries) or receive EDI transactions directly from Medicare contractors.

Third-party entities that request permission to access Medicare EDI records directly generally fall into one of the following categories:

1. A clearinghouse as defined by the Health Insurance Portability and Accountability Act (HIPAA) that transfers and may translate claim, eligibility, claim status, and/or payment and remittance advice data for EDI transactions being transmitted between providers and one or more Medicare contractors;
2. An agent a provider has hired to prepare claims and possibly other EDI transactions for submission to one or more Medicare contractors, and possible posting to patient records/provider accounts of eligibility, claim status, and adjudication/payment data issued by one or more Medicare contractors;
3. A clearinghouse as in #1 above that also performs agent services as in #2 above; and
4. A third party that does not perform clearinghouse or agent services as described in #1-3, but that may want direct access to outbound Medicare EDI transactions for alternate functions. Entities included in this category include collection agents in pursuit of delinquent beneficiary payments to providers and vendors that market payment data analysis services to providers that serve Medicare patients.

Third parties in categories 1, 2, and 3 perform functions that qualify them for direct access to Medicare contractor EDI systems. If a provider elects to use the services of a third party to perform permitted Medicare EDI functions, the provider must complete an EDI Agreement and furnish the Medicare contractor with a signed authorization specifying the EDI services each third party may perform on their behalf. The third party must comply with existing requirements to obtain their own EDI number and password from the Medicare contractor that services each provider being represented.

Medicare contractors can issue EDI numbers and passwords to category 1, 2, and 3 entities and permit them to submit and/or obtain EDI data directly to/from the Medicare contractor EDI systems. Third parties in category 4 do not perform functions that qualify them for direct access to Medicare systems, and may not be issued EDI numbers or passwords.

Medicare requires that providers and third party entities to which EDI numbers and passwords are
Inappropriate Access to or Use of Electronic Data Interchange (EDI) Transaction Data by Third Party Entities cont.

Bulletins issued after October 1, 1999 are available at no cost from our Web site at www.PalmettoGBA.com.

Issued protect the security of those numbers and passwords to prevent use by unauthorized individuals.

Furthermore, providers and third party entities of any category are prohibited from accessing Medicare systems using an EDI number or password not directly issued to them by a Medicare contractor.

This instruction is being issued to clarify and remind affected parties of existing CMS requirements and prohibitions concerning access to and use of EDI numbers and passwords.

Issues

Although they may qualify for direct access to Medicare contractor EDI systems, the read, write and use rights vary for entities in categories 1, 2, and 3. Third parties in categories 2 or 3 are allowed to review data within transactions, whereas category 1 entities are limited to review of “electronic envelope” data that contains routing information for the transactions. Some category 1 entities may be confused regarding this limitation.

The Centers for Medicare & Medicaid Services (CMS) recently discovered that at least one third-party entity in category 4 has been using EDI numbers and passwords furnished them by providers to download electronic remittance advice (ERA) transactions for those providers. The data was not being used to post adjudication and payment data to patient accounts, but was being used solely for automated analysis to detect information such as payment patterns and to generate reports. The providers were using the paper remittance advice notices they received, and not the ERAs, to post their accounts. CMS has been advised that other companies may also be marketing similar services and may be using EDI numbers and passwords issued to providers to obtain outbound EDI transactions from Medicare contractor systems for use in ways other than intended by Medicare.

CMS Policy

The following manual instructions contain CMS requirements that apply to these issues:

- The Medicare Claims Processing Manual (Pub. 100-04, Chapter 24 (EDI Support Requirements)) contains CMS requirements for EDI access. This can be accessed at: http://www.cms.hhs.gov/manuals/104_claims/clm104c24.pdf
- The Business Partners Systems Security Manual (BPSSM) (Appendix A, Section 2.9.10 of the Core Security Requirements (CSR)) contains further requirements applicable to use of passwords issued to permit system access. These can be found at: http://www.cms.hhs.gov/manuals/117_systems_security/117_systems_security_atchA.pdf
  These password requirements apply to entities to which Medicare contractors issue passwords, as well as to Medicare contractors themselves.
- The Medicare Claims Processing Manual (Pub. 100-04), Chapter 24 (EDI Support Requirements), Section 90 contains instructions concerning mandatory electronic submission of claims to Medicare as required by ASCA. This information is available at: http://www.cms.hhs.gov/manuals/104_claims/clm104c24.pdf
- The Medicare Claims Processing Manual (Pub.100-04), Chapter 1 (General Billing Requirements), Section 80 (Carrier and FI Claims Processing Timeliness) contains Medicare’s payment floor requirements at: http://www.cms.hhs.gov/manuals/104_claims/clm104c01.pdf

In regard to access policies for entities in categories 1-4:

- Category 1 third parties that transfer EDI data to and/or from providers, but do not translate that data into or from a format that complies with the HIPAA requirements are not permitted to:
  - Open the electronic envelope of the transmitted data; or
  - Generate reports that include data from within those transmission envelopes.

- Category 2 and 3 agents are permitted to:
  - Open the electronic envelopes of the transmitted data; and
  - Use the data for analysis and generation of reports for the providers they serve, in
Inappropriate Access to or Use of Electronic Data Interchange (EDI) Transaction Data by Third Party Entities cont.

In addition to use of that data to prepare beneficiary claims, determine claim status or Medicare eligibility, and/or to post adjudication and payment data to patient accounts.

- Category 4 third parties may use data prepared by Medicare, but the following requirements must be met as conditions for use:
  - The data must be forwarded to the entity by the provider;
  - A signed agreement must be in effect between the provider and the entity in which the provider authorizes the entity to use the data and specifying how the data may and may not be used;
  - The entity has furnished the provider with a signed confidentiality agreement that meets Medicare's and HIPAA's privacy and security requirements for protection of personally identifiable beneficiary health data;
  - The provider has notified the patients that their personally identifiable health data will be shared with the entity and how it will be used; and
  - The provider agrees not to furnish data to the entity for any patients who object.

- A category 4 entity:
  - May not be given an EDI number or password for direct access to Medicare data; and
  - Is never permitted to use a provider's EDI number or password for that or any other purpose.

As stated in the CSRs in BPSSM section 2.9.10, passwords (1) are “unique for specific individuals,” (2) must be “controlled by the assigned user and [are] not subject to disclosure.”

Contractor Actions if Improper Access is Identified

In the event a Medicare contractor becomes aware that improper access has been given, appropriate termination of EDI capabilities and notification must occur. For example:

- If an entity, previously issued an EDI number and password, falls under category 4, the Medicare contractor must immediately disable the EDI number and password of that entity, and then notify the entity and the provider why this has been done.

- If a third party entity is using a provider's EDI number and password to access Medicare systems, the Medicare contractor must immediately disable the EDI number and password, and then contact that provider by mail or phone to make them aware of Medicare's requirements and prohibitions.

During this contact, and while the EDI number and password are disabled, the Medicare contractor will remind the provider that:

- Loss of EDI privileges could result in termination of Medicare payment since the Administrative Simplification Compliance Act (ASCA) prohibits payment of claims submitted on paper that should have been submitted to Medicare electronically; and

- In those cases when ASCA permits claims to be submitted on paper, payment is delayed as result of the lengthier payment floor that applies to paper claims.

Additional Information

Providers can review appropriate requirements by checking the Web sites mentioned above.

Remember: The law requires most providers to bill Medicare electronically and EDI access is crucial to that process. Protect your access and protect your patients' confidentiality by abiding by Medicare's privacy and security requirements.

If you have any questions regarding this issue, contact the EDI department of your carrier/intermediary at their toll-free number. If you bill for Medicare Part A services, including outpatient hospital services, that number may be found at:

http://www.cms.hhs.gov/providers/edi/anum.asp

If you bill for Medicare Part B services, that number may be found at:

http://www.cms.hhs.gov/providers/edi/bnum.asp
Guidance Regarding Elimination of Standard Paper Remittance (SPR) Advice Notices in the Old Format

Related Change Request (CR) #: N/A
Medlearn Matters Number: SE0451

Effective Date: N/A
Implementation Date: January 1, 2005

Provider Types Affected
All Medicare physicians, providers, and suppliers.

Provider Action Needed
Be advised that only the most recent version of the Standard Paper Remittance (SPR) Advices will be used. The 835 version 4010A1 flat file is the appropriate format to produce SPRs. Also, no data may be included in paper remittance advices that are not included in an electronic remittance advice (ERA).

Background
The Centers for Medicare & Medicaid Services (CMS) prohibits the inclusion of data in paper remittance advice notices that is not included in the ERA transactions. The most recent version of the SPR Advice and the ERA contain the same information in the comparable fields and date elements, including the same codes. The same flat file is supposed to be used to produce both the SPR and 835 version 4010A1 ERA. CMS has issued a memorandum to all Medicare carriers and fiscal intermediaries, including durable medical equipment carriers and regional home health intermediaries, stating that, effective January 1, 2005, only the 835 version 4010A1 flat file is to be used to produce the SPRs; no other format for SPRs will be used.

Additional Information
Refer to Chapter 22 of the Medicare Claims Processing Manual, Publication 100-4, which can be found online at:

Additional information regarding the Fiscal Intermediary Part A 835 flat file, including a sample of the most recent SPR format, is available in CR 3344. You may view that CR at:
http://www.cms.hhs.gov/manuals/pm_trans/R252CP.pdf

If you have any questions regarding receipt of or conversion to ERAs, please contact your carrier/intermediary. If you bill an intermediary, their number may be found at:
http://www.cms.hhs.gov/providers/edi/anum.asp

If you bill a carrier, the number may be found at:
http://www.cms.hhs.gov/providers/edi/bnum.asp
The SADMERC is pleased to provide DMECS (Durable Medical Equipment Coding System), an online application that provides Healthcare Common Procedure Coding System (HCPCS) coding assistance and national pricing information 24 hours a day. DMECS is designed to help Medicare providers and suppliers quickly classify durable medical equipment, prosthetics/orthotics, and supplies (DMEPOS) by combining information from a variety of sources to make HCPCS coding determinations for claim submission to the DMERCs easier. Currently, DMECS includes a HCPCS and fee schedule look-up with capabilities to print or download information. Future enhancements will include SADMERC Classification Lists, sample product pictures, and a coding navigator tool that categorizes and combines HCPCS codes in a format that allows you to easily determine how to code your product.

You may access DMECS by selecting SADMERC from the Palmetto GBA home page at www.PalmettoGBA.com. From the SADMERC home page, click on the link for “Durable Medical Equipment Coding System (DMECS)” in the menu on the left side of the screen. Your feedback is vital to the success of this tool. Please e-mail us your feedback by selecting Contact Us from our Web site.

Physician Responsibility in Completing CMNs

Palmetto GBA asks suppliers to remind physicians of their responsibility in completing and signing the Certificate of Medical Necessity. It is the physician’s responsibility to determine both the medical need for, and the utilization of all health care services. The physician should ensure that information relating to the beneficiary’s condition is correct. The DMERC encourages suppliers to include language in their cover letters to remind physicians of their responsibilities.
<table>
<thead>
<tr>
<th>Topic</th>
<th>Tip</th>
</tr>
</thead>
<tbody>
<tr>
<td>MSP Team Tip</td>
<td>Electronic submitters may be experiencing a problem when Medicare Secondary Payer (MSP) is involved. In the ANSI format, if the Primary Allowed amount is missing, information submitted in the Primary Paid amount moves to the open Primary Allowed amount which causes the claim to be out of balance at the claim level, thereby resulting in a claim denial. When entering Primary Payer information, remember to enter Primary Allowed, Primary Paid and Obligated amounts at the line level and claim level. If you have a payment agreement with the Primary Payer, this information should be reflected at the both the line and claim levels as well. Please remember that MSP claims must balance at both the line and the claim level to ensure proper payment.</td>
</tr>
<tr>
<td>Dedicated Work Teams</td>
<td>Checks returned as “undeliverable” due to supplier address change will be issued within 14 days after the National Supplier Clearinghouse (NSC) has updated the address. Suppliers should remember to key their supplier number, upon request, when using the VRU. This allows the call to be directed to your Dedicated Work Team. Please be assured that all team associates are kept current on medical policies and billing issues. If you feel that incorrect information has been shared with you by a member of your Dedicated Work Team, please request a manager call back instead calling and hanging up in order to speak with a different representative.</td>
</tr>
<tr>
<td>Appeals</td>
<td>Please do not send claims, reviews and correspondence to the Hearings Department address (P.O. Box 100249, Columbia, SC 29202-3249). Sending claims, reviews and correspondence to this address might result in delays in processing your requests. In order to request a hearing, the amount in controversy must be $100.00 or more. You can combine claims to meet the amount in controversy. For assistance in determining your amount in controversy, please use the Amount in Controversy Calculator on the Palmetto GBA Web site at <a href="http://www.PalmettoGBA.com">www.PalmettoGBA.com</a>. Under “Providers” select “DMERC,” then “Tools and Calculators.” Please remember that a Redetermination Request must be filed and a decision rendered before you can file a Hearing Request or an Administrative Law Judge (ALJ) Request. A Hearing Request must be filed and a decision rendered before you can file an ALJ Request. If you have an open appeal request, you cannot re-file the claim or request a lower or higher level of appeal. If you want a copy of your Hearing Case File sent to yourself or your attorney, please indicate that you want a copy in your Hearing Request.</td>
</tr>
<tr>
<td>Telephone Appeals</td>
<td>All faxes to Appeals must include the Document Control Number (DCN) received during the telephone appeals call. You should use the redetermination request form when faxing. Any fax without the DCN will not be honored.</td>
</tr>
</tbody>
</table>
2005 Online Learning & Education Schedule
January - June 2005

January
5 - Nebulizer Coverage
6 - DMERC Winter 2004 Advisory
11 - Basic Billing Part 1
12 - Basic Billing Part 2
18 - Wheelchair Coverage
20 - DMERC Winter 2004 Advisory

February
2 - Diabetic Coverage
8 - Advance Beneficiary Notice
15 - Basic Billing Part 1
16 - Basic Billing Part 2
22 - Prosthetic and Orthotic Coverage

March
1 - CPAP and RAD
8 - DMERC Spring 2005 Advisory
9 - Oxygen
15 - Basic Billing Part 1
16 - Basic Billing Part 2
17 - DMERC Spring 2005 Advisory
23 - PC-ACE Pro-32

April
6 - Web Safari
12 - Basic Billing Part 1
13 - Basic Billing Part 2
19 - Vision
21 - Advance Beneficiary Notice

May
3 - PC-ACE Pro-32
11 - Parenteral and Enteral Nutrition
17 - Basic Billing Part 1
18 - Basic Billing Part 2
26 - Infusion

June
2 - Wheelchair Coverage
7 - DMERC Summer 2005 Advisory
15 - Surgical Dressings
16 - DMERC Summer 2005 Advisory
21 - Ostomy
23 - Walkers
28 - Basic Billing Part 1
28 - Basic Billing Part 2

TBA
Comprehensive Error Rate Testing Program

Quarterly Provider Update

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

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

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

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

Palmetto GBA is pleased to offer online learning opportunities to its Region C DMERC suppliers.

Two main types of online learning are available:

**Online Workshops:** Scheduled interactive online learning events conducted by Region C ombudsmen. Attendees will see and hear a slide presentation as the ombudsmen conduct it. Attendees can also ask questions via a chat feature, or aloud with a microphone.

**Tutorials:** Self-paced online courses that are available 24 hours a day, seven days a week.

Directions for registering for both types of events follow.

**Enrolling in a Palmetto GBA Online Learning Event**
To participate, you must first register as a conference user (there are never any fees) and enroll in the event to reserve your space. Go to www.PalmettoGBA.com. Under Providers, click on Learning & Education. Select Online Learning. Click on the Login button. First time users should register by clicking "Click Here to Register a New User." The form will request some basic information.

Once the account is created, log in using your new user name and password. Remember, your username and password are case-sensitive! You must type them in the way you created them.

After you’ve logged in, you’ll see your customized home page. This page gives you an introduction to the Knowledge Center on the Palmetto GBA Web site.

**Finding available events, learning opportunities and handouts**
Click on the burgundy Catalog button at the top of the screen to find the event or handout you are interested in. You may browse the catalog by type, group, category, or title. All of DMERC’s events, tutorials, online workshops and handouts can be found toward the bottom of the page under the bold Browse By Category section (select DMERC).

**Selecting your event, learning opportunity or handout**
You will see a list of all available DMERC events. Use your mouse to click on the boxes to the left of your choices. At the top right, click on the blue button, "Add to My Learning." In the pop-up window that opens up, click on Submit. The status bar will show "Added to My Learning" in green type. Click on the blue Close button to close the pop-up window. You now have access to participate in an event, take a tutorial, or print materials.

**Testing your system:**
Click on the burgundy My Learning button at the top of the page. Toward the top right of the following screen, click on the System Check button (it looks like a computer) to test your system. The minimum system requirements are listed below:

- Pentium class 133 MHz Processor
- 64 MB RAM
- 800x600, High Color 16 Bit
- Sound Card and Speakers or headset
- MS Windows 2000 Professional
- MS Windows XP Professional
- MS Windows XP Home Edition
- Internet Explorer 5.0 SP2
- 28.8 kbps

Follow the instructions in the System Check pop-up box. After completing the check, you may exit the Web site if you are registering in advance.

Centra Knowledge Center can work with several versions of popular browsers

**Browser Recommendations:**
- Internet Explorer:
  - Internet Explorer 5.x
  - Internet Explorer 6.x
- Netscape:
  - Netscape 4.5x or 4.7x
  - Netscape 7.x

**Participating in an event, starting a tutorial, or printing a handout**
1. If you have just finished registering for a workshop or tutorial, click on the My Learning button at the top of the screen.

2. If you have previously registered and are returning to the Palmetto GBA Web site, navigate from the Web site’s home page through Learning & Education/Online Learning. Log in to reach your customized home page.
Online Learning Events - How to Register cont...

3. Click on the My Learning button.

4. From the grey box you can search for all the items for which you have registered. In the first box it defaults to "Title." Change this to "Type."

5. In the second box (which now reads Learning Object), change to "All Learning Resources" (found at the top of the list).

6. Click the blue Search button (to the right).

7. All the items for which you have registered now appear in the window. To the right, click on the word "Attend" to join a workshop/meeting, or click "Start" to print a handout or begin a tutorial.

Handouts:
Handouts are posted separately from online workshop listings, so you have to add them separately. You can do this while registering for an event if the handout is available. However, handouts for an online workshop typically are not posted until 24 hours before the workshop is to begin. To view or print the handout, you must have the Adobe Acrobat program that can be downloaded free of charge by following the instructions.

First-time Workshop Attendance:
The first time you attend an event, a Java security notice may pop up. This is to be expected. Simply click on the box that reads "Remember this decision," and then "Grant." First-time users will then see the CentraOne Smart Client dialog box with a message stating "A software download is required to complete this operation. This may take some time over a slow network. Would you like to continue?" Click Yes. The Centra window will then appear.

Audio Check:
Please perform an Audio Check to verify your sound is functioning properly. The Sound Check button is located to the top left. It is colored black and white and has a +/- symbol.

Register on the Palmetto GBA Web site Listserv

Are you keeping up to date on the latest Medicare publications and information? By registering on the Palmetto GBA Web site (www.PalmettoGBA.com) and completing a user profile, you can be notified by e-mail when new or important information is added to our Web site. You only need to register once. It is quick and easy. You do NOT have to register to use our Web site, but registering lets you:

- Receive weekly e-mail notification of Medicare news and updates.
- Know when the next online workshop will be offered.
- Update your e-mail profile at any time.

To register, access the DMERC section of the Palmetto GBA Web site. From the Web site home page, select DMERC (under Providers). From the top of the screen, select the login option. Follow the on-screen instructions. Here are some helpful tips:

1. Note your User name and Password, as these items are case-sensitive.
2. Be sure to fill out all required fields, and check the boxes in the lower portion of the form for the topics in which you are interested.
3. After you register, you only need to log in when you want to update your profile.

If you have questions about this process, please use the Contact Us button (located at the top of your screen) to send an e-mail to Palmetto GBA via our Web site. Once on the Contact Us page, select DMERC (Region C), then "E-mail Palmetto GBA" for technical assistance (at the bottom). At the bottom of the page you will provide your name, e-mail address and nature of your concern.
Ombudsmen investigate complaints, report findings and facilitate problem solving through training and education of the supplier community.

Ombudsmen Addresses and Territories

**Alabama**
- Lia Bunch
- PMB 425
- 459 Main Street, Suite 101
- Trussville, AL 35173
- (205) 661-6988

**Arkansas/Oklahoma**
- Kendra Kerley
- 1050 E. 2nd Street, #356
- Edmond, OK 73034
- (405) 277-3875

**Colorado/New Mexico**
- Eric Carlson
- P.O. Box 2027
- Littleton, CO 80161-2027
- (720) 493-5301

**Florida (south)**
- (covers the southern portion of Florida to include Manatee, Hardee, Highlands, Okeechobee and Indian River counties, and all points south)
- Teresita Ortiz
- 934 N. University Dr., #447
- Coral Springs, FL 33071
- (561) 997-9210

**Florida (north)**
- (covers the northern portion of Florida to include Pinellas, Hillsborough, Polk, Osceola and Brevard counties, and all points north)
- Keith Smith
- PMB 112
- 11111-70 San Jose Blvd.
- Jacksonville, FL 32223-7946
- (904) 886-2887

**Georgia**
- Sharon Briggman
- 8200 Mail Pkwy #135 - 304
- Lithonia, GA 30058
- (770) 388-7380

**Kentucky**
- James Owens
- P.O. Box 224
- Albany, KY 42602
- (606) 387-4672

**Louisiana/Mississippi**
- Bobby Smith
- P.O. Box 9225
- Jackson, MS 39286
- (601) 856-4868

**North Carolina**
- Makisha Pressley-Callaham
- P.O. Box 5323
- Concord, NC 28027
- (704) 782-9600

**Puerto Rico/Virgin Islands**
- Carmen Soto-Ortiz
- PMB 256, 1357 Ashford Ave.
- San Juan, PR 00907-1420
- (787) 784-7390

**South Carolina**
- Elizabeth Ullman
- P.O. Box 100141, AG-520
- Columbia, SC 29202-3141
- (803) 763-5920

**Tennessee**
- Ronja F. Roland
- 5341 Mt. View Rd., PMB 122
- Antioch, TN 37013
- (615) 793-6873

**Texas (south)**
- (covers the southern portion of Texas to include area codes 210, 254, 325, 432, 512, 830, 915 and 956)
- Dana Causey
- PMB 604
- 20475 Highway 46 W, Suite 180
- Spring Branch, TX 78070-6124
- (830) 980-7749

**Texas (north)**
- (covers the northern portion of Texas to include area codes 214, 281, 409, 469, 713, 806, 817, 832, 903, 936, 940, 972 and 979)
- Peggy Miller
- 2601 Cartwright Rd., Suite D392
- Missouri City, TX 77459
- (281) 416-9688

**Out of Region C**
- Deidre Bibbs
- P.O. Box 100141, AG-520
- Columbia, SC 29202-3141
- (803) 763-5170
### Region C Directory

Please retain this list as your new DMERC telephone directory.

#### Palmetto GBA Contacts

<table>
<thead>
<tr>
<th>Mailing address</th>
<th>Telephone number</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Benefit Integrity Unit</strong>&lt;br&gt;Palmetto GBA, Medicare Region C DMERC&lt;br&gt;P.O. Box 100236&lt;br&gt;Columbia, SC  29202-3236</td>
<td>(877) 867-4852</td>
</tr>
<tr>
<td><strong>Multifunctional Teams/DMERC General Information</strong>&lt;br&gt;DMERC Interactive Voice Response Unit</td>
<td>(866) 270-4909</td>
</tr>
<tr>
<td><strong>Medicare Customer Service Center (Beneficiary Call Center)</strong>&lt;br&gt;Technology Support Center (Formerly EDI Help Desk)&lt;br&gt;Palmetto GBA, Medicare Region C DMERC&lt;br&gt;P.O. Box 100145&lt;br&gt;Columbia, SC  29202-3145</td>
<td>(866) 749-4301</td>
</tr>
<tr>
<td><strong>Hearings Department</strong>&lt;br&gt;Palmetto GBA, Medicare Region C DMERC&lt;br&gt;P.O. Box 100249&lt;br&gt;Columbia, SC  29202</td>
<td>(866) 238-9650</td>
</tr>
<tr>
<td><strong>Medicare Secondary Payer</strong>&lt;br&gt;Palmetto GBA&lt;br&gt;P. O. Box 100209&lt;br&gt;Columbia, SC  29202-3209</td>
<td>(866) 650-9129</td>
</tr>
<tr>
<td><strong>ADMC Department</strong>&lt;br&gt;Palmetto GBA, Medicare Region C DMERC&lt;br&gt;P.O. Box 100235&lt;br&gt;Columbia, SC  29202-3235</td>
<td>FAX: (803) 424-2622</td>
</tr>
<tr>
<td><strong>Professional Relations Department</strong>&lt;br&gt;Palmetto GBA, Medicare Region C DMERC&lt;br&gt;P.O. Box 100141&lt;br&gt;Columbia, SC  29202-3141</td>
<td>(803) 763-5744</td>
</tr>
</tbody>
</table>

*Inquiries regarding hearings or Advance Determination of Medicare Coverage should be directed to the Dedicated Work Teams.*

#### National Contacts

<table>
<thead>
<tr>
<th>Mailing address</th>
<th>Telephone number</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Social Security Administration (SSA)</strong></td>
<td>(800) 772-1213</td>
</tr>
<tr>
<td><strong>National Supplier Clearinghouse (NSC)</strong></td>
<td>(866) 238-9652</td>
</tr>
<tr>
<td><strong>Region A DMERC</strong></td>
<td>(866) 419-9458</td>
</tr>
<tr>
<td><strong>Region B DMERC</strong></td>
<td>(877) 299-7900</td>
</tr>
<tr>
<td><strong>Region D DMERC Interactive Voice Response Unit</strong></td>
<td>(877) 320-0390</td>
</tr>
<tr>
<td><strong>Region D DMERC Customer Service Representatives</strong></td>
<td>(866) 243-7272</td>
</tr>
<tr>
<td><strong>Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC)</strong></td>
<td>(877) 735-1326</td>
</tr>
<tr>
<td>Mail code: AG-370&lt;br&gt;2300 Springdale Drive, Bldg. One&lt;br&gt;Camden, SC 29020</td>
<td></td>
</tr>
<tr>
<td><strong>Railroad Medicare</strong></td>
<td>(877) 288-7600</td>
</tr>
</tbody>
</table>