Medicare Payment Hold, September 22 - 30, 2006


MLN Matters Number: MM5047
Related Change Request (CR) #: 5047
Related CR Release Date: May 10, 2006
Effective Date: September 22, 2006
Related CR Transmittal #: R944CP
Implementation Date: July 3, 2006

Provider Types Affected
Providers and physicians who bill Medicare contractors (fiscal intermediaries (FIs) including regional home health intermediaries (RHHIs), and carriers) for their services

Key Points
• A brief hold will be placed on Medicare payments for ALL claims (e.g., initial claims, adjustment claims, and Medicare Secondary Payer (MSP) claims) for the last nine days of the federal fiscal year, i.e., September 22, 2006-September 30, 2006.

Changes to Region C DMERC DMEPOS Supplier Manual

Effective September 1, 2006, the Medical Policy section of the Region C DMERC DMEPOS Supplier Manual will be eliminated. The current Region C DMERC DMEPOS Supplier Manual is located on the Palmetto GBA Web site at www.PalmettoGBA.com/dme/manuals.

All medical policy information will be available on the TrustSolutions, LLC (TrustSolutions) Web site at http://www.trustsolutionsllc.com/Info_DME_Suppliers.asp.

TrustSolutions is the Program Safeguard Contractor (PSC) responsible for performing the medical affairs, medical review and benefit integrity work for the states and territories in Region C. Currently, Region C is comprised of Alabama, Arkansas, Colorado, Florida, Georgia, Louisiana, Mississippi, New Mexico, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Puerto Rico and the Virgin Islands. Additional information regarding TrustSolutions is available at www.trustsolutionsllc.com.

Get an Overview of this Advisory

Region C DMERC will offer an online workshop to provide clarification on the articles in this DMERC Medicare Advisory. The course will be offered on September 7 at 3:00 p.m. and on October 19 at 2:00 p.m. Eastern Time. For online workshop registration and attendance instructions, see “Online Learning Events — How to Register” in this Advisory. The course name for these workshops is “DMERC Autumn 2006 Advisory.”
In essence, no payments on claims will be made from September 22-30, 2006. Providers need to be aware of these payment delays, which are mandated by Section 5203 of the Deficit Reduction Act (DRA) of 2006.

- Accelerated payments using normal procedures will be considered.
- No interest will be accrued or paid, and no late penalty will be paid to an entity or individual for any delay in a payment by reason of this one-time hold on payments.
- All claims held as a result of this one-time policy that would have otherwise been paid on one of these nine days will be paid on October 2, 2006.

Additional Information
This policy applies only to claims subject to payment. It does not apply to full denials and no-pay claims. It also does not apply to periodic interim payments, home health requests for anticipated payments, cost report settlements and other non-claim payments.

Additionally, Medicare contractors will continue to apply the 14-day electronic claim payment floor and the 29-day paper claim payment floor. On a case-by-case basis, Medicare FIs, RHHIs or carriers may make adjustments, after October 1, 2006, for extenuating circumstances raised by a provider. For example, adjustments may be made to not charge a provider interest on an overpayment for those days for which offsets could not be made due to the hold of payments required by this DRA provision.

Please note that:
- Payments will not be staggered; and
- No advance payments during the nine-day hold will be allowed.

CR5047 is the official instruction issued to your FI, RHHI, or carrier regarding changes mentioned in this article. CR5047 may be found by going to http://www.cms.hhs.gov/Transmittals/downloads/R944CP.pdf on the CMS Web site.

Please refer to your local FI/RHHI or carrier if you have questions about this issue. To find their toll-free phone number, go to http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip on the CMS Web site.
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Oxygen/Respiratory

MMA — Coverage for Home Use of Oxygen Included in Clinical Trials

MLN Matters Number: MM4389
Related Change Request (CR) #: 4389
Related CR Release Date: May 26, 2006
Effective Date: March 20, 2006
Related CR Transmittal #: R57NCD and R961CP
Implementation Date: October 3, 2006

Provider Types Affected
Providers, physicians, and suppliers who bill Medicare regional home health intermediaries (RHHIs) and/or durable medical equipment regional carriers (DMERCs) for home use of oxygen services

Key Points
- On March 20, 2006, the Centers for Medicare & Medicaid Services (CMS) announced a National Coverage Determination (NCD) covering the home use of oxygen for Medicare beneficiaries who are enrolled in a CMS approved clinical trial sponsored by the National Heart, Lung & Blood Institute (NHLBI), with arterial oxygen partial pressure measurements from 56 to 65 mmHg, or whose oxygen saturation is at or above 89%.
- Please note that this decision does not change coverage for the home use of oxygen provided outside the clinical trials currently identified in Pub. 100-03, the National Coverage Determinations (NCD) Manual, Chapter 1, Part 4, Section 240.2, Home Use of Oxygen (Please see Additional Information section below for link to CR4389.)
- Your RHHI or DMERC will continue to make local determinations of reasonable and necessary services (based on existing guidance provided by CMS policy) for medically accepted home uses of oxygen that are not addressed in section 240.2, Home Use of Oxygen of the NCD Manual.

Billing Guidelines
- Beginning March 20, 2006, to be paid for the home use of oxygen (in the above described situation), the patient must be participating in an approved clinical trial and this must be reflected on the Medicare claim.
- To report this on a claim to a DMERC, use

Bulletins issued after October 1, 1999 are available at no cost from our Web site at www.PalmettoGBA.com/dme.
MMA - Coverage for Home Use of Oxygen Included in Clinical Trials, cont.

Modifier “QR” when reporting the home use of oxygen furnished during an approved clinical trial identified by CMS and sponsored by the NHLBI, for fee-for-service (FFS) beneficiaries who have arterial oxygen partial pressure measurements from 56 to 65 mmHg, or oxygen saturation at or above 89%. When modifier QR is attached to a HCPCS code, it generally means the service is part of a CMS-related clinical trial, demonstration or study.

- For claims submitted to RHHIs, use condition code 30 and ICD-9-CM diagnosis code of V70.7 in the second diagnosis code position for reporting home use of oxygen furnished during an approved clinical trial for beneficiaries (in FFS or under a Medicare Advantage (MA) plan) who have arterial oxygen partial pressure measurements from 56 to 65 mmHg or oxygen saturation at or above 89%.

- Healthcare Common Procedure Coding System (HCPCS) codes recognized as clinical trial codes for home use of oxygen when the modifier “QR” (DMERC claims) or when condition code 30 and ICD-9-CM diagnosis code of V70.7 are present in the second diagnosis code (RHHI claims) include:
  

- Providers and suppliers should note that any accessory codes listed above are included in the base oxygen fee and are not separately payable under the current policy.

- Note that Medicare will apply applicable coinsurance for MA plan beneficiaries when reporting home use of oxygen furnished during an approved clinical trial.

- Additionally, you must use the Oxygen Certificate of Medical Necessity (CMN) (Form CMS-484, also known as the DMERC 484.2) for claims submitted for the approved clinical trial for the home use of oxygen. Subsequent claims will be paid based upon the initial date and status of the initial CMN.

- Clinical trial services claims under MA plans shall continue to be billed separately from non-clinical trial services.

Additional Information

Additional information about this policy can be found in the following manual sections attached to the two transmittals for CR4389.


- Claims processing instructions are available in Transmittal 961, CR4389, which is available at http://www.cms.hhs.gov/Transmittals/downloads/R961CP.pdf on the CMS site.

Please refer to your local RHHI or DMERC if you have questions about this issue.

To find the toll-free phone number of your RHHI or DMERC, go to http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip on the CMS Web site.

Drugs and Other Biologicals

Competitive Acquisition Program for Drugs and Biologicals: Beneficiary Fact Sheet

Visit http://www.cms.hhs.gov/CompetitiveAcquisitionBios to download the Beneficiary Fact Sheet for the Competitive Acquisition Program (CAP) for Part B Drugs and Biologicals. Physicians who elect to participate in the CAP are required to provide the CAP Beneficiary Fact Sheet to Medicare beneficiaries who are receiving certain Part B physician-administered drugs.


**Mobility**

New Temporary “K” Code for Power Mobility Device (PMD) Batteries

MLN Matters Number: MM4253  
Related Change Request (CR) #: 4253  
Related CR Release Date: February 1, 2006  
Effective Date: July 1, 2006  
Related CR Transmittal #: R823CP  
Implementation Date: July 3, 2006

**Provider Types Affected**
Suppliers and providers billing Medicare durable medical equipment regional carriers (DMERCs) and/or fiscal intermediaries (FIs) for services related to power mobility devices.

**Provider Action Needed**
This article is based on Change Request (CR) 4253, which establishes a new temporary “K” code for PMD batteries.

**Background**
Effective July 1, 2006, a new “K” code will be established for a 12- to 24-hour battery for power mobility devices. Effective July 1, 2006, the following K code will be added to the system:

<table>
<thead>
<tr>
<th>K Code</th>
<th>Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>K0733</td>
<td>Power wheelchair accessory, 12 to 24 amp hour sealed lead acid battery, each. (e.g., gel cell, absorbed glassmat)</td>
</tr>
</tbody>
</table>

**Note:** K codes describe temporary durable medical equipment (DME) and drug codes. Once these codes are approved for permanent inclusion into the Healthcare Common Procedure Coding System (HCPCS), they usually become “A”, “E” or “J” codes:

- “A” codes — ambulance and transportation services; medical and surgical supplies; and administrative, miscellaneous and investigational services/supplies;
- “E” codes — DME such as walkers, hospital beds, infusion supplies, etc.; and
- “J” codes — injectable drugs that can be injected subcutaneously, intramuscularly or intravenously with the dosage injected indicated.

The pricing category for K code K0733 is “32” (inexpensive or routinely purchased items), and the type of service (TOS) includes “A” (Used DME), “P” (Lump Sum Purchase of DME, Prosthetics, Orthotics), and “R” (Rental of DME). In addition, the place of service (POS) for K code K0733 is listed in the following table:

<table>
<thead>
<tr>
<th>Place of Service</th>
<th>Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>04</td>
<td>Homeless Shelter</td>
</tr>
<tr>
<td>12</td>
<td>Patient’s Home</td>
</tr>
<tr>
<td>13</td>
<td>Assisted Living Facility</td>
</tr>
<tr>
<td>14</td>
<td>Group Home</td>
</tr>
<tr>
<td>33</td>
<td>Custodial Care Facility</td>
</tr>
<tr>
<td>54</td>
<td>Intermediate Care Facility/Mentally Retarded</td>
</tr>
<tr>
<td>55</td>
<td>Residential Substance Abuse Treatment Center</td>
</tr>
<tr>
<td>56</td>
<td>Psychiatric Residential Treatment Center</td>
</tr>
</tbody>
</table>

**Implementation**
The implementation date for the instruction is July 3, 2006.

**Additional Information**
For complete details, please see the official instruction issued to your DMERC/intermediary regarding this change. That instruction may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R823CP.pdf on the CMS Web site.

If you have any questions, please contact your DMERC/intermediary at their toll-free number, which may be found at http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip on the CMS Web site.
NPI

Countdown Has Begun ... Do You Have Your NPI?

Don't risk disruption to your cash flow — Get your NPI now. National Provider Identifiers (NPIs) will be required on claims sent on or after May 23, 2007. Every healthcare provider needs to get an NPI. Learn more about NPI and how to apply by visiting www.cms.hhs.gov/NationalProvIdentStand/ on the CMS Web site.

This page also contains a section for Medicare Fee-For-Service (FFS) providers with helpful information on the Medicare NPI implementation. A Countdown Clock is now available on this page to remind health care providers of the number of days left before the compliance date; bookmark this page as new information and resources will continue to be posted.

For more information on private industry NPI outreach, visit the Workgroup for Electronic Data Interchange (WEDI) NPI Outreach Initiative Web site at http://www.wedi.org/npioi/index.shtml.

General

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

MLN Matters Number: MM5142
Related Change Request (CR) #: 5142
Related CR Release Date: June 23, 2006
Effective Date: October 1, 2006
Related CR Transmittal #: R990CP
Implementation Date: October 2, 2006

Provider Types Affected
Physicians, suppliers, and providers billing Medicare contractors (carriers, durable medical equipment regional carriers (DMERCs), and fiscal intermediaries (FIs) including regional home health intermediaries (RHHIs))

Provider Action Needed
STOP – Impact to You
Medicare has issued the annual update of the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) to Medicare contractors. This update will apply for claims with service dates on or after October 1, 2006, as well as discharges on or after October 1, 2006, for institutional providers.

CAUTION – What You Need to Know
An ICD-9-CM code is required for all professional claims, e.g., physicians, non-physician practitioners, independent clinical diagnostic laboratories, occupational and physical therapists, independent diagnostic testing facilities, audiologists, ambulatory surgical centers (ASCs), and for all institutional claims, but is not required for ambulance supplier claims.

GO – What You Need to Do
Be ready to use the updated codes on October 1, 2006. Please refer to the Background and Additional Information sections of this article for further details regarding this instruction.

Background
This instruction is a reminder that Medicare carriers, DMERCs, FIs and RHHIs will use the annual International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) coding update effective for:

• Dates of service on or after October 1, 2006; and
• Discharges on or after October 1, 2006 for institutional providers

Effective for dates of service on and after October 1, 2004, the Centers for Medicare & Medicaid Services (CMS) no longer provided a 90-day grace period for physicians, practitioners and suppliers to use in billing discontinued ICD-9-CM diagnosis codes on Medicare claims. The Health Insurance Portability and Accountability Act (HIPAA) requires that medical code sets be date-of-service compliant, and ICD-9-CM diagnosis codes are a

This bulletin should be shared with all health care practitioners and managerial members of the provider/supplier staff.
Medicare Contractor Annual Update of the ICD-9-CM, cont.


Implementation
The implementation date for this instruction is October 2, 2006.

Additional Information
Publication of ICD-9-CM Codes
• The CMS places the new, revised and discontinued codes at http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/07_summarytables.asp#TopOfPage on the CMS Web site. The update should be available at this site in June.

• The updated codes can also be viewed at the National Center for Health Statistics (NCHS) Web site at http://www.cdc.gov/nchs/icd9.htm. This posting should be available at this site in June.

• Providers are also encouraged to purchase a new ICD-9-CM book or CD-ROM on an annual basis.

The ICD-9-CM codes are updated annually as stated in Pub. 100-04, Medicare Claims Processing Manual, Chapter 23 (Fee Schedule Administration and Coding Requirements), Section 10.2 (Relationship of ICD-9-CM Codes and Date of Service). Chapter 23 may be accessed at http://www.cms.hhs.gov/manuals/downloads/clm104c23.pdf on the CMS Web site.

To view CR5142, the official instruction issued to your Medicare carrier/DMERC or FI/RHHI, regarding changes mentioned in this article. CR5142 may be found at http://www.cms.hhs.gov/Transmittals/downloads/R990CP.pdf on the CMS Web site.

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

Claim Status Category Code and Claim Status Code Update

MLN Matters Number: MM5137
Related Change Request (CR) #: 5137
Related CR Release Date: June 23, 2006
Effective Date: October 1, 2006
Related CR Transmittal #: R987CP
Implementation Date: October 2, 2006

Provider Types Affected
Physicians, providers, and suppliers who submit Health Care Claim Status Transactions to Medicare contractors (carriers, durable medical equipment regional carriers (DMERCs), fiscal intermediaries (FIs), and regional home health intermediaries (RHHIs))

Provider Action Needed
STOP – Impact to You
This article is based on Change Request (CR) 5137, which provides the October 2006 updates of the Claim Status Codes and Claim Status Category Codes for use by Medicare contractors (carriers, DMERCs, FIs, and RHHIs).

CAUTION – What You Need to Know
Medicare contractors are to use codes with the “new as of 10/06” designation and prior dates, and they must inform affected providers of the new codes. CR5137 applies to Chapter 31 of the Medicare Claims Processing Manual, Section 20.7 - Health Care Claim Status Category Codes and Health Care Claims Status Codes for Use with the Health Care Claim Status Request and Response ASC X12N 276/277.

GO – What You Need to Do
Please refer to the Background section of this article for further details.

Background
Claim Status Category codes indicate the general category of a claim’s status (accepted, rejected, additional information requested, and so on). Further detail is provided by the Claim Status Code(s).

Under the Health Insurance Portability and
Claim Status Category Code and Claim Status Code Update, cont.

Accountability Act (HIPAA), all payers (including Medicare) must use Claim Status Category and Claim Status codes approved by a recognized code set maintainer (instead of proprietary codes) to explain any status of a claim(s) sent in the Version 004010X093A1 Health Care Claim Status Request and Response transaction.

The Health Care Code Maintenance Committee maintains the Claim Status Category and Claim Status codes. The committee meets at the beginning of each X12 trimester meeting and makes decisions about additions, modifications, and retirement of existing codes.

The updated Claim Status Category and Claim Status codes list is posted three times a year (after each Health Care Code Maintenance Committee X12 trimester meeting) at the Washington Publishing Company Web site at http://www.wpc-edi.com/codes. At this Web site, select “Claim Status Codes” or “Claim Status Category Codes” to access the updated code list. Included in the code lists are specific details, including the date when a code was added, changed or deleted. All code changes approved in June 2006 are to be listed to this Web site approximately thirty (30) days after the meeting concludes. For this update, Medicare will begin using the codes in place as of October 2006 in claim status responses issued on or after October 2, 2006.

Implementation
The implementation date for this instruction is October 2, 2006.

Additional Information
For complete details, please see CR5137, the official instruction issued to your Medicare carrier/DMERC or FI/RHHI regarding changes mentioned in this article.

CR5137 may be found at http://www.cms.hhs.gov/Transmittals/downloads/R987CP.pdf on the CMS Web site.

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

Additional Requirements Necessary to Implement the Revised Health Insurance Claim Form CMS-1500

MLN Matters Number: MM5060
Related Change Request (CR) #: 5060
Related CR Release Date: July 28, 2006
Effective Date: January 1, 2007
Related CR Transmittal #: R1010CP
Implementation Date: January 2, 2007

Provider Types Affected
Physicians and suppliers who bill Medicare carriers including durable medical equipment regional carriers (DMERCs) for their services using the Form CMS-1500.

Key Points
• The Centers for Medicare & Medicaid Services (CMS) is implementing the revised Form CMS-1500, which accommodates the reporting of the National Provider Identifier (NPI).

• The Form CMS-1500 (08-05) version will be effective January 1, 2007, but will not be mandated for use until April 2, 2007.

• During this transition time there will be a dual acceptability period of the current and the revised forms.

• A major difference between Form CMS-1500 (08-05) and the prior form CMS-1500 is the split provider identifier fields.

• The split fields will enable NPI reporting in the fields labeled as NPI, and corresponding legacy number reporting in the unlabeled block above each NPI field.

• There will be a period of time where both versions of the CMS-1500 will be accepted (08-05 and 12-90 versions). The dual acceptability timeline period for Form CMS-1500 is as follows:
Additional Requirements Necessary to Implement the Revised Health Insurance Claim Form CMS-1500, cont.

<table>
<thead>
<tr>
<th>Date</th>
<th>Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>January 2, 2007 –</td>
<td>Providers can use either the current Form CMS-1500 (12-90) version or the revised Form CMS-1500 (08-05) version.</td>
</tr>
<tr>
<td>March 30, 2007</td>
<td></td>
</tr>
<tr>
<td>Note: Health plans,</td>
<td></td>
</tr>
<tr>
<td>clearinghouses and</td>
<td></td>
</tr>
<tr>
<td>other information</td>
<td></td>
</tr>
<tr>
<td>support vendors</td>
<td></td>
</tr>
<tr>
<td>should be able to</td>
<td></td>
</tr>
<tr>
<td>handle and accept</td>
<td></td>
</tr>
<tr>
<td>the revised Form</td>
<td></td>
</tr>
<tr>
<td>CMS-1500 (08-05) by</td>
<td></td>
</tr>
<tr>
<td>January 2, 2007</td>
<td></td>
</tr>
<tr>
<td>April 2, 2007</td>
<td>The current Form CMS-1500 (12-90) version of the claim form is discontinued; only the revised Form CMS-1500 (08-05) is to be used.</td>
</tr>
<tr>
<td>Note: All rebilling</td>
<td></td>
</tr>
<tr>
<td>of claims should use</td>
<td></td>
</tr>
<tr>
<td>the revised Form</td>
<td></td>
</tr>
<tr>
<td>CMS-1500 (08-05) from</td>
<td></td>
</tr>
<tr>
<td>this date forward,</td>
<td></td>
</tr>
<tr>
<td>even though earlier</td>
<td></td>
</tr>
<tr>
<td>submissions may have</td>
<td></td>
</tr>
<tr>
<td>been on the current</td>
<td></td>
</tr>
<tr>
<td>Form CMS-1500 (12-90).</td>
<td></td>
</tr>
</tbody>
</table>

Background

Form CMS-1500 is one of the basic forms prescribed by CMS for the Medicare program. It is only accepted from physicians and suppliers that are excluded from the mandatory electronic claims submission requirements set forth in the Administrative Simplification Compliance Act, Public Law 107-105 (ASCA), and the implementing regulation at 42 CFR 424.32. The CMS-1500 form is being revised to accommodate the reporting of the National Provider Identifier (NPI).

Note that a provision in the HIPAA legislation allows for an additional year for small health plans to comply with NPI guidelines. Thus, small plans may need to receive legacy provider numbers on coordination of benefits (COB) transactions through May 23, 2008. CMS will issue requirements for reporting legacy numbers in COB transactions after May 22, 2007.

In a related Change Request, CR4023, CMS required submitters of the Form CMS-1500 (12-90 version) to continue to report Provider Identification Numbers (PINs) and Unique Physician Identification Numbers (UPINs) as applicable.

There were no fields on that version of the form for reporting of NPIs in addition to those legacy identifiers. Change Request 4293 provided guidance for implementing the revised Form CMS-1500 (08-05). This article, based on CR 5060, provides additional Form CMS-1500 (08-05) information for Medicare carriers and DMERCs, related to validation edits and requirements.

Billing Guidelines

- When the NPI number is effective and required (May 23, 2007, although it can be reported starting January 1, 2007), claims will be rejected (in most cases with reason code 16 – “claim/service lacks information that is needed for adjudication”) in tandem with the appropriate remark code that specifies the missing information, if

  - The NPI of the billing provider or group is not entered on Form CMS-1500 (08-05) in items:
    - 24J (replacing item 24K, Form CMS-1500 (12-90));
    - 17B (replacing item 17 or 17A, Form CMS-1500 (12-90));
    - 32a (replacing item 32, Form CMS-1500 (12-90)); and
    - 33a (replacing item 33, Form CMS-1500 (12-90)).

Additional Information

**When the NPI Number is Effective and Required (May 23, 2007)**

To enable proper processing of Form CMS-1500 (08-05) claims and to avoid claim rejections, please be sure to enter the correct identifying information for any numbers entered on the claim.

Legacy identifiers are pre-NPI provider identifiers such as:

- PINs (Provider Identification Numbers)
- UPINs (Unique Physician Identification Numbers)
- OSCARs (Online Survey Certification & Reporting System numbers)
- NSC (National Supplier Clearinghouse) supplier numbers for DMERC claims.
Additional Requirements Necessary to Implement the Revised Health Insurance Claim Form CMS-1500, cont.

Additional NPI-Related Information
Additional NPI-related information can be found at http://www.cms.hhs.gov/NationalProvIdentStand/ on the CMS Web site.

The change log which lists the various changes made to the Form CMS-1500 (08-05) version can be viewed at the NUCC Web site at http://www.nucc.org/images/stories/PDF/change_log.pdf.

MLN Matters article MM4320, “Stage 1 Use and Editing of National Provider Identifier Numbers Received in Electronic Data Interchange Transactions via Direct Data Entry Screen, or Paper Claim Forms,” can be found at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4320.pdf on the CMS Web site.


MLN Matters article MM4023, “Stage 2 Requirements for Use and Editing of National Provider Identifier (NPI) Numbers Received in Electronic Data Interchange (EDI) Transactions, via Direct Data Entry (DDE) Screens, or Paper Claim Forms,” can be found at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4023.pdf on the CMS Web site.

CR5060 is the official instruction issued to your carrier or DMERC regarding changes mentioned in this article, MM5060. CR 5060 may be found by going to http://www.cms.hhs.gov/Transmittals/downloads/R1010CP.pdf on the CMS Web site.

Please refer to your local carrier or DMERC if you have questions about this issue. To find their toll-free phone number, please go to http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip on the CMS Web site.

Beneficiary MSN Format Changes, Effective July 1, 2006

Effective July 1, 2006, the DMERCs and the DME MACs were instructed to change their Medicare Summary Notices (MSNs) to reflect the DMERC or the new DME MAC appeals address and to reflect a new centralized inquiry address located in the Customer Service Information box for all other beneficiary inquiries. General Medicare will handle and process all beneficiary telephone and written inquiries until the Beneficiary Contact Centers have been fully implemented in 2007. Changes will be made for both English and Spanish MSNs.

The address in the Customer Service Information box will read as follows on all MSNs printed on or after July 1, 2006:

Palmetto GBA
P.O. Box 100297
Columbia, SC 29202-3297

Notice of New Interest Rate for Medicare Overpayments and Underpayments

Medicare Regulation 42 CFR §405.378 provides for the assessment of interest at the higher of the current value of funds rate (2 percent for calendar year 2006) or the private consumer rate as fixed by the Department of the Treasury. Effective July 19, 2006, the interest rate for Medicare overpayments and underpayments is 12.625 percent.
Collection of Fee-for-Service Payments Made During Periods of Managed Care Enrollment (Previously CR2801 Program Memorandum Transmittal AB-03-101) — MANUALIZATION

MLN Matters Number: MM5105
Related Change Request (CR) #: 5105
Related CR Release Date: July 3, 2006
Effective Date: October 1, 2003
Related CR Transmittal #: R100FM
Implementation Date: June 26, 2006

Provider Types Affected
Physicians, providers, and suppliers submitting fee-for-service claims to Medicare carriers, durable medical equipment regional carriers (DMERCs), fiscal intermediaries (FIs), and/or regional home health intermediaries (RHHIs) for services furnished to Medicare beneficiaries enrolled in Medicare Advantage (MA) Organizations.

Impact on Providers
This article is based on Change Request (CR) 5105, which was issued to manualize the process that ensures that any duplicate payments for services rendered to Medicare beneficiaries are collected. CR5105 ensures that any fee-for-service claims that were approved for payment during a period when the beneficiary was enrolled in a Managed Care Organization are submitted to the normal collection process used by the Medicare contractors (carriers/DMERCs/FIs) for overpayments.

Background
The Centers for Medicare & Medicaid Services (CMS) pays for a beneficiary’s medical services more than once when a specific set of circumstances occurs. When CMS data systems recognize a beneficiary has enrolled in an MA Organization, the MA Organization receives capitation payments for the Medicare beneficiary. In some cases, enrollments with retroactive payments are processed.

The result is that Medicare may pay for the services rendered during a specific period twice:

- First, for the specific service that was paid by the fee-for-service Medicare contractor to the provider; and
- Second, by the MA Payment Systems in the monthly capitation rate paid to the MA plan for the beneficiary.

Overview of the MA plan Enrollment Process
When an MA plan enrollment is processed retroactively:

- Fee-for-service claims with dates of service that fall under the managed care plan enrollment period are identified by Medicare’s Common Working File (CWF); and
- An Informational Unsolicited Response (IUR) record is created.

In essence, the retroactive enrollment triggers a search for fee-for-service claims that were incorrectly paid for services rendered when the beneficiary was covered by the managed care plan. If such claims are found, the system generates an adjustment and initiation by Medicare systems of overpayment recovery procedures. The current policy/procedures, as outlined in CR2801 (Transmittal AB-03-101, dated July 18, 2003) and CR 5105, dictates that:

- Claims paid in error (due to enrollment or disenrollment corrections) will be adjusted; and
- Medicare contractors will initiate overpayment recovery procedures.


Because of the inherent retroactivity in the enrollment process, (e.g., beneficiaries can enroll in plans up to the last day of the month, and the effective date would be the first of the following month), the CWF may receive this information after the enrollment is effective. For this reason, these kinds of adjustments occur routinely.

A variety of the CMS systems issues over the past 18 months have prompted CMS to recently synchronize MA enrollment and disenrollment information for the period September 2003 to April 2006. As a result, providers may have claims that were affected by this synchronization. For details of the impact of this synchronization on providers, please see MLN Matters article SE0638, which is
Collection of Fee-for-Service Payments Made During Periods of Managed Care Enrollment (Previously CR2801 Program Memorandum Transmittal AB-03-101) — MANUALIZATION, cont.


When claims are identified as needing payment recovery, the related remittance advice for the claim adjustment will indicate Reason Code 24, which states: “Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan.” Upon receipt, providers are to contact the managed care plan for payment.

• Providers who bill carriers will be alerted by their carrier (via letter or alternate method) of the following:
  • That the beneficiary was in a managed care plan on the date of service;
  • That the provider should bill the managed care plan;
  • What the plan identification number is; and
  • Where to find the plan name and address associated with the plan number on the CMS Web site.

• For providers who bill FIs, the adjustment will occur automatically and information on which plan to contact must be determined through an eligibility inquiry or by contacting the beneficiary directly.

Note: To associate plan identification numbers with the plan name, go to http://www.cms.hhs.gov/HealthPlansGenInfo/claims_processing_20060120.asp#TopOfPage on the CMS Web site.

In summary, CMS issued CR5105 to:
• Ensure that any fee-for-service claims that were approved for payment erroneously are submitted to the normal collection process used by the Medicare contractors (carriers, DMERCs, FIs, and RHHIs) for overpayments; and
• Instruct Medicare contractors to follow the instructions outlined in the Medicare Financial Management Manual (Publication 100-06, Chapter 3, Section 190), which is included as part of CR5105. Instructions for accessing CR5105 are in the Additional Information section of this article.

Implementation
The implementation date for the instruction is June 26, 2006.

Additional Information
For complete details, please see the official instruction issued to your carrier, DMERC, intermediary, or RHHI regarding this change. That instruction may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R100FM.pdf on the CMS Web site.

Also, if you have any questions, please contact your carrier/DMERC/intermediary/RHHI at their toll-free number, which may be found at http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip on the CMS Web site.

Modifications to Online Medicare Secondary Payer Questionnaire:
This CR Rescinds and Replaces CR4098

MLN Matters Number: MM5087
Related Change Request (CR) #: 5087
Related CR Release Date: June 9, 2006
Effective Date: September 11, 2006
Related CR Transmittal #: R53MSP
Implementation Date: September 11, 2006

Provider Types Affected
Medicare physicians/providers/suppliers that, upon providing services to a Medicare patient, use a questionnaire to determine other insurance coverage that may be primary to Medicare

Provider Action Needed
STOP – Impact to You
Questions have arisen over Part V of the model Medicare Secondary Payer Questionnaire.
Modifications to Online Medicare Secondary Payer Questionnaire: This CR Rescinds and Replaces CR4098, cont.

CAUTION – What You Need to Know
CR5087 provides clarification regarding Part V, provides major revisions to other parts of the model Medicare Secondary Payer Questionnaire, and rescinds and replaces CR4098.

GO – What You Need to Do
You should replace any previous versions of the model questionnaire with the new version, available as an attachment to CR5087.

Background
In 1980, Congress enacted provisions that made Medicare the secondary payer to certain additional primary plans (group health plans, workers' compensation plans, liability insurance, or no-fault insurance). To help you identify such Medicare Secondary Payer (MSP) situations, CMS has developed a model Medicare Secondary Payer Questionnaire (found in IOM 100.05 (Medicare Secondary Payer Manual) Chapter 3, Section 20.2.1). You can use this model questionnaire as a guide at each inpatient and outpatient admission to help identify other payers that may be primary to Medicare.

CR4098 (released October 21, 2005) made changes to this model questionnaire that have generated several questions, specifically regarding Part V (Disability). In response, CR 5087 (from which this article is taken) incorporates the changes that were made in CR 4098, modifies the changes previously made to Part V to address the questions that have arisen, and makes additional changes to other parts of the model questionnaire to improve the wording and sequencing of questions in these parts.

The changes to the model questionnaire are too numerous to list here. As such, please refer directly to the revised section in the Medicare Secondary Payer (MSP) Manual, Chapter 3 (MSP Provider, Physician, and Other Supplier Billing Requirements), Section 20.2.1 (Admission Questions to Ask Medicare Beneficiaries) which contains the complete updated model questionnaire. The changes are identified in redline and italics.

Please keep in mind the following:

1. This questionnaire is a model. Other questions may be added to help identify other payers that may be primary to Medicare.

2. If you choose to use this model questionnaire, please be aware that it was developed to be used in sequence. The Instructions listed after the questions are to direct the patient to the next appropriate question to facilitate transition between questions.

Additional Information
You can find more information about the Medicare Secondary Payer Questionnaire by viewing CR5087 at http://www.cms.hhs.gov/Transmittals/downloads/R53MSP.pdf. Attached to the CR is the revised section of the Medicare Secondary Payer (MSP) Manual, Chapter 3 (MSP Provider, Physician, and Other Supplier Billing Requirements), Section 20.2.1 (Admission Questions to Ask Medicare Beneficiaries) which contains the complete updated model questionnaire.

If you have any questions, please contact your carrier (including durable medical equipment regional carrier), fiscal intermediary, or regional home health intermediary at their toll-free number, which may be found at http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip on the CMS Web site.
Disclosure Desk Reference for Provider Contact Centers

MLN Matters Number: MM5089
Related Change Request (CR) #: 5089
Related CR Release Date: July 21, 2006
Effective Date: October 1, 2006
Related CR Transmittal #: R16COM
Implementation Date: October 2, 2006

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

Provider Action Needed

STOP – Impact to You
When you call or write a Medicare fee-for-service provider contact center (PCC) to request beneficiary protected health information, the PCC staff, in order to comply with the requirements of the Privacy Act of 1974 and the Health Insurance Portability and Accountability Act, will authenticate your identity prior to disclosure.

CAUTION – What You Need to Know
CR5089 revises Medicare Contractor Beneficiary and Provider Communications Manual, Chapter 3, Section 30, and Chapter 6, Section 80, to update the guidance to PCCs for authenticating providers who call or write to request beneficiary protected health information, and to clarify the information they may disclose after authentication.

GO – What You Need to Do
Be prepared to supply the required authentication information when contacting a PCC to request protected health information.

Background
In order to protect the privacy of Medicare beneficiaries and to comply with the requirements of the Privacy Act of 1974 and the Health Insurance Portability and Accountability Act, customer service staff at Medicare PCCs must first authenticate the identity of providers/staff that call or write to request beneficiary protected health information before disclosing it to the requestor.

CR5089, from which this article is taken, completely revises Section 30 in Chapter 3 and Section 80 in Chapter 6 of the Medicare Contractor Beneficiary and Provider Communications Manual (Publication 100-9). It updates the PCC Disclosure Desk Reference, the main purpose of which is to protect the privacy of Medicare beneficiaries by ensuring that protected health information is disclosed to providers only when appropriate, to include:

- Guidance for authenticating providers who call or write to request beneficiary protected health information; and
- Clarification of the information that may be disclosed after authentication of writers and callers.

Please note that while new subsections have been added to each chapter/section, this reflects reformatting and revision of existing information rather than new requirements.

Below is the authentication guidance that the PCCs will be using:

**Telephone Inquiries, Provider Authentication**
CRSR Telephone Inquiries — Through May 22, 2007, Customer Service Representatives (CSRs) will authenticate providers using provider number and provider name.

**Interactive Voice Response (IVR) Telephone Inquiries** — Through May 22, 2007, IVRs will authenticate providers using only the provider number.

**Written Inquiries, Provider Authentication**
Through May 22, 2007, for written inquiries, PCCs will authenticate providers using provider number and provider name.

Note: See “Final Note” below to learn more about provider authentication after May 22, 2007.

There is one exception for the requirement to authenticate a written inquiry. An inquiry received on the provider’s official letterhead (including e-mails with an attachment on letterhead) will meet provider authentication requirements (no provider identification number required) if the provider’s name and address are included in the letterhead and clearly establish the provider’s identity.

This bulletin should be shared with all health care practitioners and managerial members of the provider/supplier staff.
Disclosure Desk Reference for Provider Contact Centers, cont.

Further, if multiple addresses are on the letterhead, authentication is considered met as long as one of the addresses matches the address that Medicare has on record for that provider. Thus, make sure that your written inquiries contain all provider practice locations or use the letterhead that has the address that Medicare has on record for you.

Also, please note that requests submitted via fax on provider letterhead will be considered to be written inquiries and are subject to the same authentication requirements as those received in regular mail. However, for such fax (and also for e-mail) submissions, even if all authentication elements are present, the PCC will not fax or e-mail their responses back to you.

Rather, they will send you the requested information by regular mail, or respond to these requests by telephone. In either of these response methods, or if they elect to send you an automated e-mail reply (containing no beneficiary-specific information), they will remind you that such information cannot be disclosed electronically via e-mail or fax and that, in the future, you should send a written inquiry through regular mail or use the IVR for beneficiary-specific information.

And lastly, inquiries received without letterhead, including hardcopy, fax, e-mail, pre-formatted inquiry forms, or inquiries written on Remittance Advice (RAs) or Medicare Summary Notices (MSNs), will be authenticated the same as written inquiries (explained above), using the provider name and the provider number.

**Insufficient or Inaccurate Requests**

You should also understand that for any protected health information request in which the PCC determines that the authentication elements are insufficient or inaccurate, you will have to provide complete and accurate input before the information will be released to you.

Such requests that are submitted in written form and those on pre-formatted inquiry forms will be returned in their entirety by regular mail with a note stating that the requested information will be supplied upon submission of all authentication elements, and identifying which elements are missing or do not match the Medicare record.

Alternatively, if you sent the request by e-mail (containing no protected health information), the PCC may return it by e-mail, or may elect to respond by telephone to obtain the rest of the authentication elements.

**Beneficiary Authentication**

Regardless of the type of telephone inquiry (CSR or IVR) or written inquiry, PCCs will authenticate four beneficiary data elements before disclosing any beneficiary information:

1. Last name;
2. First name or initial;
3. Health Insurance Claim Number; and
4. Either date of birth (eligibility, next eligible date, Certificate of Medical Necessity (CMN)/Durable Medical Equipment Medicare Administrative Contractor Information Form (DIF) [pre-claim]) or date of service (claim status, CMN/DIF [post-claim]).

Please refer to the disclosure charts attached to CR5089 for specific guidance related to these data elements as well as details on the beneficiary information that will be made available in response to authenticated inquiries. CR5089 is available at http://www.cms.hhs.gov/Transmittals/downloads/R16COM.pdf on the CMS Web site.

**Special Instances**

Below are three special instances that you should know about.

**Overlapping Claims**

Overlapping claims (multiple claims with the same or similar dates of service or billing period) occur when a date of service or billing period conflicts with another, indicating that one or the other may be incorrect.

Sometimes this happens when the provider is seeking to avoid having a claim be rejected, for example:

- When some End State Renal Disease (ESRD) facilities prefer to obtain the inpatient hospital benefit days for the month, prior to the ESRD monthly bill being generated, thus allowing the facility to code the claim appropriately and bill around the inpatient hospital stay/stays; or
Disclosure Desk Reference for Provider Contact Centers, cont.

• Skilled nursing facility and inpatient hospital stays.

These situations fall into the category of disclosing information needed to bill Medicare properly, and information can be released as long as all authentication elements are met.

Pending Claims
A pending claim is one that is being processed, or has been processed and is pending payment. CSRs can provide information about pending claims, including Internal Control Number (ICN), pay date/amount or denial, as long as all authentication requirements are met.

Providers should note, however, that until payment is actually made or a remittance advice is issued, the information provided could change.

Deceased Beneficiaries
Although the Privacy Act of 1974 does not apply to deceased individuals, the HIPAA Privacy Rule concerning protected health information applies to individuals, both living and deceased. Therefore, PCCs will comply with authentication requirements when responding to requests for information related to deceased beneficiaries.

Final note: More information will be provided in a future MLN Matters article about authentication on and after May 23, 2007, the implementation date for the National Provider Identifier or NPI.

Additional Information
You can find more information about Provider Contact Center guidelines concerning authentication by going to http://www.cms.hhs.gov/Transmittals/downloads/R16COM.pdf on the CMS Web site.

Attached to that CR, you will find the updated Medicare Contractor Beneficiary and Provider Communications Manual (Publication 100.09), Chapter 3 (Provider Inquiries), Section 30 (Disclosure of Information); and Chapter 6 (Provider Customer Service Program), Section 80 (Disclosure of Information).

If you have any questions, please contact your carrier, durable medical equipment (DME) regional carrier, DME Medicare Administrative Contractor (DME MAC), fiscal intermediary, or regional home health intermediary at their toll-free number, which may be found at http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip on the CMS Web site.

CMS Electronic Mailing List Fact Sheet

The CMS Electronic Mailing Lists (listservs) can help you with your business! We encourage you to obtain copies of CMS’s new Electronic Mailing List Fact Sheet from the MLN Web site to use as handouts at your association conferences and other events.

Section 2: LCD Policy Information & Updates

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Power Mobility Devices, Wheelchair Options/Accessories, Wheelchair Seating

The new medical policy for Power Mobility Devices was released on August 15. The new policy is effective for claims with dates of service on or after October 1, 2006. It includes the 64 new HCPCS codes for POVs and power wheelchairs.

The new policy identifies a number of situations in which a least costly alternative determination may be made. Because the fee schedule allowances for the new HCPCS codes had not been released at the time that the new policy was published, it was not possible to state specifically which codes will be downcoded and to what other codes. After the publication of the allowances, the DME PSCs will develop an article that will provide additional information on this subject.

Suppliers should note that the policy requires the use of the KX modifier if all of the coverage criteria specified in the LCD have been met. If the HCPCS code does not have a KX modifier, the claim line will be denied. If the patient does not meet the coverage criteria for the item that is provided but meets the coverage criteria for another device, the KX may not be used. After receiving a denial, the supplier may utilize the appeals process to seek payment for the least costly alternative device.

The LCD specifies that the EY modifier must be used if the supplier has not received an order for the power mobility device, containing all the required elements, with 45 days after completion of the face-to-face examination. It also specifies that the GY modifier must be used if the PMD will be used only outside the home or if the supplier has not received the report of the face-to-face examination within 45 days after completion of the examination. If the EY or GY modifier is used, the KX modifier must not be used. If the EY or GY modifier is used, the claim line will be denied as statutorily noncovered. If neither the EY, GY, nor the KX modifier is used, the claim line will be denied as not medically necessary.

The LCD also specifies that the EY, GY, and KX modifiers must be used as described above for accessories that are provided at the time of initial issue of the power wheelchair.

The LCDs and Policy Articles for Motorized/Power Wheelchairs and Power Operated Vehicles are retired for claims with dates of services on or after October 1, 2006. The HCPCS codes listed in those policies will be invalid for claim submission for dates of service on or after October 1, 2006.

Revisions of the Wheelchair Options and Accessories LCD and Policy Article and the Wheelchair Seating LCD and Policy Article were also released on August 15, 2006 with the revisions effective for claims with dates of service on or after October 1, 2006. The Revision History sections of those policies are shown below. Suppliers should review the entire LCD and Policy Article for complete information.

Note: To view the new policy or the revised policies on the CMS Coverage Database prior to October 1,
Power Mobility Devices, Wheelchair Options/Accessories, Wheelchair Seating, cont.

2006, remember to search under the Review Future Effective Documents link.

Wheelchair Options/Accessories

* **LCD**
  Revision Effective Date: 10/01/2006

**INDICATIONS AND LIMITATIONS OF COVERAGE:**
- Deleted codes for nonstandard seat frame dimensions for power wheelchairs.
- Added coverage criteria for power tilt and/or recline power seating systems.
- Removed code reference for attendant control.
- Noted that push-rim activated power assist devices are addressed in the Power Mobility Devices policy.

**HCPCS CODES:**
- Added: KX
- Removed: E0986, E2320, E2340-E2343.

**DOCUMENTATION REQUIREMENTS:**
- Added requirement for detailed product description for items provided at the time of issue of a power wheelchair.
- Added instructions for use of the GY and KX modifiers.

Policy Article

* **Revision Effective Date: 10/01/2006**

**NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:**
- Added stair climbing, electronic balance, two wheel balance and remote operation to list of noncovered features.

**CODING GUIDELINES:**
- Added requirements for basic equipment packages for power wheelchairs and POVs.
- Added E2320 and E2340-E2343 to the list of invalid codes.
- Revised statements about nonstandard seat dimensions for power wheelchairs.
- Moved definition of push rim activated power assist device to Power Mobility Devices Policy Article.
- Removed mention of codes E1019 and E1021 which have been discontinued.
- Revised definitions of controllers.
- Revised coding guidelines for remote joysticks, attendant controls, and E2399.

- Added definitions for power wheelchair tires.
- Added new power mobility device codes to the bundling table.

Wheelchair Seating

* **LCD**
  Revision Effective Date: 10/01/2006

**INDICATIONS AND LIMITATIONS OF COVERAGE:**
- Added least costly alternative statement regarding general use cushions.
- Revised coverage criteria for all seat/back cushions and positioning accessories to identify their coverage with specific types of power mobility devices.
- Revised statement concerning coverage of a headrest.
- Revised wording which describes the clinician who performs the evaluation for a custom fabricated cushion.
- Added a statement concerning coverage of a seat cushion solid support base (E2618).

**ICD-9 CODES THAT SUPPORT MEDICAL NECESSITY:**
- Substituted ICD-9 333.71 for 333.7 in three of the diagnosis sets.

**DOCUMENTATION REQUIREMENTS:**
- Added requirement for detailed product description for items provided at the time of issue of a power wheelchair.
- Revised wording which describes the clinician who performs the evaluation for a custom fabricated cushion.

Policy Article

* **Revision Effective Date: 10/01/2006**

**NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:**
- Moved statement concerning coverage of seat cushion solid support base (E2618) to the LCD.
- Deleted statement about separate coverage for headrests because this is not addressed in the LCD.
Advance Determination of Medicare Coverage — Wheelchairs

Certificates of Medical Necessity for Manual and Power Wheelchair Bases were discontinued effective April 1, 2006. As a result, questions have arisen about what information ought to be submitted to support an ADMC request.

Since CMNs are not required and will no longer be used for the submission of claims for wheelchairs, the first page of the ADMC request must contain all of the following demographic information:

- Beneficiary information
  - Name
  - HICN
  - Address
  - Date of birth
- Place of service
- ICD-9 diagnosis code (narrative description is not sufficient)
- Supplier information
  - Name
  - NSC number
  - Address
  - Phone number
- Physician’s information
  - Name
  - UPIN
  - Address
  - Phone number

For ADMC requests that are received by the DME PSCs on or after August 10, 2006, if the information listed above is not present, the request will be rejected.

I. For power wheelchairs, the supplier must include all of the following items (1-4):

1. The order that the supplier received within 45 days following the completion of the face-to-face examination. This order must contain the following elements:
   - Beneficiary name
   - Description of the item. This may be general — e.g., “power wheelchair” or “power mobility device” — or may be more specific.
   - Date of the face-to-face examination. If the evaluation involved multiple visits, enter the date of the last visit. Refer to the Power Wheelchairs policy for additional information.

- Pertinent diagnoses/conditions that relate to the need for the power wheelchair.
- Length of need
- Physician’s signature
- Date of physician signature

There must be a date stamp or equivalent on the order to indicate when it was received by the supplier.

2. A detailed product description (which includes information previously contained in the detailed written order) that lists the specific wheelchair base that is to be provided and each option/accessory that will be separately billed. This document must also specify which HCPCS code is associated with each item on the list. This information may be entered by the supplier but the document must be signed and dated by the physician. (The signature date on this document does not have to be within 45 days following the face-to-face exam.) For ADMC requests that are received on or after August 24, 2006, the document must also include the supplier's charge and the Medicare fee schedule allowance for each item. If there is no fee schedule allowance, enter Not Applicable.

3. A copy of the report of the face-to-face examination by the physician — and other licensed/certified medical professionals (LCMPs), if applicable. There must be a date stamp or equivalent on the report(s) to indicate when they were received by the supplier. For ADMC requests received on or after August 10, 2006, reports of LCMPs that are to be considered part of the face-to-face examination must include an attestation statement from the supplier indicating that the LCMP has no financial relationship with the supplier. Refer to the Power Wheelchairs policy for guidance on the type of documentation to be included. **Note:** If the power wheelchair is a replacement within 5 years of one billed with the same HCPCS code that was previously covered by Medicare, a face-to-face examination is not required.

4. A home assessment which establishes that
Advance Determination of Medicare Coverage - Wheelchairs, cont.

the beneficiary is able to use the wheelchair ordered to assist with ADLs in the home.

II. For manual wheelchairs, the supplier must include the following (1-3):

1. Detailed written order that lists the specific wheelchair base that is to be provided and each option/accessory that will be separately billed. The order must also specify which HCPCS code is associated with each item on the order. This information may be entered by the supplier but the order must be signed and dated by the physician.

2. Information from the patient's medical record that documents that the coverage criteria defined in the medical policy on Manual Wheelchairs have been met.

3. A home assessment which establishes that the beneficiary or caregiver is able to use the wheelchair ordered to assist with ADLs in the home.

III. Additional guidance:

• Any information that is provided that explains the medical necessity for separately billed options and accessories must use the same short description for the item that is used in the detailed product description or detailed written order.

• If the patient's weight and/or height are needed to support the medical necessity for items that are ordered, that information should be included on the first page of the ADMC request.

• Even if the majority of the face-to-face examination is performed by an LCMP, the ADMC request must also include the report of the face-to-face examination with the physician.

• Include the manufacturer, the product name, the model number, and the width of wheelchair cushion(s) that are provided. Make certain that the product is listed on the SADMERC Product Classification List and that the HCPCS code on the ADMC is the one specified by the SADMERC.

• Suppliers are reminded that if an affirmative determination is made on the wheelchair base but individual options/accessories are denied, there may be no resubmission or other request for an ADMC determination on these. If these items are provided and denied at the time of claim submission, the supplier may present additional information to justify coverage through the appeals process.

Refer to the ADMC section in the Supplier Manual for information about the codes that are eligible for prior authorization and details of the process.

Glucose Monitors — Documentation Requirements

This is a revision of an article posted on the Palmetto GBA Web site on June 15, 2006.

Prior to July 1, 2005, the Glucose Monitors policy contained a requirement that a new order for test strips, lancets, and other supplies be obtained at least every 12 months. That requirement was eliminated in the LCD that was effective for claims with dates of service on or after July 1, 2005. As stated in the current LCD, a new order is now required when there is a change in the frequency of testing. A new order would also be required if there is a new supplier.

Suppliers have requested clarification about the requirement for a physician visit. According to the LCD, if the physician orders quantities of test strips and lancets that exceed the utilization guideline (i.e., one per day for non-insulin treated diabetics and three per day for insulin-treated diabetics), the physician must have seen and evaluated the patient within six months prior to that order. Although regular evaluation by a physician is an important component of diabetes management, the LCD does not require additional physician visits.
Oxygen Policy Revision

An article titled “Oximetry Testing — Supplier Involvement” was published in the Summer 2006 Advisory. It provided additional information regarding Change Request 3751, Transmittal 173, published on August 16, 2005.

One of the statements made in that article was: “The IDTF may send the test results only to the physician. It must not send them to the supplier.” Those statements require further clarification — i.e.: The IDTF should send the results to the physician. Because this is considered protected health information, the supplier may not receive a copy of the test report until the physician has reviewed the results, made the decision to order oxygen for the patient, and contacted the supplier with that order.

The information from the June article as well as this clarification has been incorporated in a revision of the Oxygen medical policy which will be included in the next policy revision.

The policy revision includes a statement concerning coverage for patients who are enrolled in clinical trials sponsored by the National Heart, Lung, and Blood Institute. However, these clinical trials are in the development stage and have not begun.

The policy includes a revised definition for a portable oxygen concentrator (E1392). This definition is effective for claims with dates of service on or after October 1, 2006.

Code E1392 describes an oxygen concentrator which is designed to be portable, weighs less than 20 pounds, is capable of delivering 85% or greater oxygen concentration, is capable of operating on either AC or DC (e.g., auto accessory outlet) power, has an integrated battery that is capable of providing at least 2 hours of remote portability at a minimum of 2 LPM equivalency on a single charge, and has an integrated battery charger. HCPCS code E1392 includes the device itself, one battery, an AC power adapter, a DC power adapter, and a carry bag and/or cart. If a concentrator meets all of these criteria and is also capable of functioning as a stationary concentrator, operating 24 hours per day, 7 days per week, code E1392 is billed in addition to the stationary concentrator code (E1390).

Finally, it announces a new HCPCS code that is effective for claims with dates of service on or after October 1, 2006:

K0738 Portable gaseous oxygen system, rental; home compressor used to fill portable oxygen cylinders, includes portable containers, regulator, flowmeter, humidifier, cannula or mask, and tubing

HCPCS code K0738 describes a feature of an oxygen concentrator that allows the beneficiary to fill portable gaseous oxygen cylinders from a stationary concentrator. This feature may be integrated into the stationary concentrator or be a separate component. When HCPCS code K0738 is billed, HCPCS code E0431 (portable gaseous oxygen system, rental) must not be used.

Surgical Dressings — Revised Coding Guidelines

The revised definitions described in this article are effective for claims with dates of service on or after October 1, 2006.

The SADMERC and DME PSCs have identified a number of surgical dressings in which the size of dressing slightly exceeds 16 square inches — for example, 4¼ x 4¼. This has resulted in coding these products in a higher priced category. These dressings are not functionally different than 4 x 4 dressings and therefore a decision has been made that they should be coded using the “16 square inches or less” codes. A similar determination has been made for dressings that slightly exceed 48 square inches. If a manufacturer or supplier has a question about the correct coding of a specific product, they should contact the SADMERC for a Coding Verification Review.

Suppliers are reminded that, as stated in the Surgical Dressings LCD, the dressing size must be appropriate for the size of the wound. For wound covers, it would not be appropriate for the pad size to be more than 2 inches greater than the
Surgical Dressings — Revised Coding Guidelines, cont.

dimension of the wound. This means that a dressing greater than 16 square inches would not be medically necessary if the wound was less than 2 inches (5 cm) across. A dressing greater than 48 square inches would not be medically necessary if the wound was less than 4 inches (10 cm) across. Small adhesive bandages (e.g., Band-Aid or similar product) are not primarily used for the treatment of wounds addressed in the Surgical Dressings policy. Therefore, these dressings are noncovered under the surgical dressing benefit. If suppliers choose to submit claims for these products, they must be billed with HCPCS code A9270 (noncovered item or service). If a manufacturer or supplier has a question about the correct coding of a specific product, they should contact the SADMERC for a Coding Verification Review.

Wound cover HCPCS codes are described as either “without adhesive border” or “with adhesive border.” In order to be billed using the “with adhesive border” HCPCS code, the adhesive border must be present along all sides of the dressing and must be proportionate to the size of the dressing pad and at least ½ inch wide.

HCPCS codes for composite dressings without adhesive border (A6200, A6201, and A6202) will be invalid for claim submission to the DMERC. One of the required features of a composite dressing is that it have a bacterial barrier. If a dressing has a waterproof top layer to act as a bacterial barrier but has no adhesive border, there is no assurance that it will prevent bacterial access to a wound when it is applied. Dressings previously coded as A6200, A6201, and A6202 will be coded as specialty absorptive dressings without adhesive border — A6251, A6252, and A6253, respectively. Composite dressings with adhesive border (A6203, A6204, and A6205) must have (a) a physical (not chemical) bacterial barrier that is present over the entire dressing pad and extends out into the adhesive border, (b) an absorptive layer other than an alginate or other fiber-gelling dressing, foam, hydrocolloid, or hydrogel, and (c) either a semi-adherent or nonadherent property over the wound site.

A foam dressing (A6209-A6215) is a sterile, nonlinting, absorptive dressing which is made of open cell, medical grade expanded polymer. It has a nonadherent property over the wound site.

The SADMERC has received requests for Coding Verification Review for products with features that go beyond the usual scope of surgical dressings. One example, not all-inclusive, is a product that is intended to provide protection for an indwelling venous catheter. The product is a large wound cover with a slit in the middle and a plastic pouch which covers the dressing and is intended to protect the catheter. For this or other products, the SADMERC/DME PSC coding determination will be based on the dominant component that falls under the Surgical Dressings benefit category and the intended use of the product. If it is decided that a product meets the definition of a surgical dressing, the coding determination will reflect those features which are appropriate for the management of the wound itself.

These changes will be incorporated in a future revision of the Surgical Dressings medical policy.

Maternity Support Garments

Products that are designed to provide support for the abdomen during pregnancy do not meet the definition of a brace. These products are coded using A9270 (noncovered item or service). L codes for orthoses must not be used for these items. If a manufacturer or supplier has a question about the correct coding of a specific product, they should contact the SADMERC for a coding determination.
Certificates of Medical Necessity - Revision

As previously announced by CMS, a number of changes are being made to Certificates of Medical Necessity (CMNs). All of the policies listed below will be revised in upcoming policy updates. The new CMNs/DIFs (DME Information Forms) will be attached to the LCDs and the instructions in the Documentation Requirements section of the LCDs that relate to the CMN or DIF will be revised. Note: There have been some slight changes to the CMNs/DIFs from the documents that were referenced in Change Request 4296 that was released on March 2, 2006. Be sure to use the current forms. All of the forms may also be found on the CMS Web site: http://www.cms.hhs.gov/CMSForms/CMSForms/list.asp#TopOfPage. The CMS Form numbers are 10125, 10126, 484, 846, 847, 848, and 849.

It is important to carefully review each new CMN and DIF. The numbering and wording of some of the questions have been changed from the current version.

CMNs for Hospital Beds and Pressure Reducing Support Surfaces — Group 3 are being eliminated. These CMNs will not be required for claims received on or after October 1, 2006.

CMNs for Osteogenesis Stimulators, Oxygen, Pneumatic Compression Devices, Seat Lift Mechanisms, and Transcutaneous Electrical Nerve Stimulators (TENS) are being revised. The new Osteogenesis Stimulators CMN applies to ultrasonic stimulators as well as electrical stimulators. The new TENS CMN is just required for purchases, not for rentals. There is a three-month transition period. The old CMNs will continue to be accepted for claims received before January 1, 2007 but will not be accepted for claims received on or after January 1, 2007. The new CMNs will be accepted for claims received on or after October 1, 2006 and will be required for claims received on or after January 1, 2007.

CMNs for Enteral Nutrition, Parenteral Nutrition, and External Infusion Pumps are being replaced by DIFs. The significance is that DIFs are completed by the supplier and physicians do not have to review and sign them. However, since the CMNs usually served as the detailed written order, suppliers will now have to obtain the detailed written order using a different document. There is a three-month transition period. The old CMNs will continue to be accepted for claims received before January 1, 2007 but will not be accepted for claims received on or after January 1, 2007. The new DIFs will be accepted for claims received on or after October 1, 2006 and will be required for claims received on or after January 1, 2007.

The Section C Continuation Form (CMS Form 854) was also revised. However, since the CMNs for wheelchairs have been eliminated, there is no current use for this form.
This bulletin should be shared with all health care practitioners and managerial members of the provider/supplier staff.
Section 3: HCPCS Codes and Fee Updates

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Revisions to January 2006 and April 2006 Quarterly ASP Medicare Part B Drug Pricing
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Revised 2006 Durable Medical Equipment Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule Files — Correction

MLN Matters Number: SE0650
Related Change Request (CR) #: N/A
Effective Date: N/A
Implementation Date: N/A

Provider Types Affected
Physicians, suppliers, and providers billing Medicare carriers, including durable medical equipment (DME) regional carriers (DMERCs) and DME Medicare Administrative Contractors (DME MACs), and/or fiscal intermediaries (FIs), including regional home health intermediaries (RHHIs), for services paid under the DMEPOS Fee Schedule.

Background
The purpose of this Special Edition article is to alert providers to the revision to the fee schedule regarding DME Fee Schedule Amounts for Transcutaneous Electrical Joint Stimulation Device System Healthcare Common Procedure Coding System (HCPCS) code E0762.

Key Points
• In accordance with Transmittal 928 (CR5017), July Quarterly Update for 2006 DMEPOS Fee Schedule, DMEPOS fee schedule files, which included fee schedule amounts for HCPCS code E0762 were released for claims with dates of service on or after January 1, 2006. (There is an MLN Matters article associated with CR5017 at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5017.pdf on the CMS site.)

• To allow for additional time to address technical concerns raised regarding the calculation of fee schedule amounts for code E0762, the Centers for Medicare & Medicaid Services (CMS) is revising the files to remove the fee schedule amounts for code E0762.

• Until further notice, Medicare contractors (carriers, FIs, DMERCs and DME MACs) will determine the Medicare allowed payment amount for claims submitted using a HCPCS code based on their individual consideration of each claim. This code remains in the DME category for inexpensive or routinely purchased items in accordance with Transmittal 928.

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

Transmittal 928 can be found at http://www.cms.hhs.gov/Transmittals/downloads/R928CP.pdf on the CMS Web site.
2006 3rd Quarter Average Sales Price (ASP) Update

Listed below are the 2006 3rd Quarter ASP fees provided by the Centers for Medicare and Medicaid Services (CMS). Revisions from the previous quarter are reflected in bold red text. Fees are effective July 1, 2006 for services rendered on or after July 1, 2006 through September 31, 2006. Inclusion or Exclusion of a fee does not indicate Medicare coverage. TBD = To Be Determined.

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</tr>
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2006 3rd Quarter Average Sales Price (ASP) Update, cont.

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2006 Average Sales Price (ASP) Revisions, Effective July 1, 2006

The Centers for Medicare and Medicaid Services (CMS) has revised the 2006 first and second quarter Medicare Part B ASP drug fees. Inclusion or exclusion of a fee does not indicate Medicare coverage.

Listed below are the revised fees implemented July 1, 2006 for services rendered on or after January 1, 2006 through March 31, 2006.

Listed below are the revised fees implemented July 1, 2006 for services rendered on or after April 1, 2006 through June 30, 2006.

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MLN Matters Number: MM5110
Related Change Request (CR) #: 5110
Related CR Release Date: June 9, 2006
Effective Date: July 1, 2006
Related CR Transmittal #: R974CP
Implementation Date: July 3, 2006

Provider Types Affected
Physicians, providers, and suppliers who submit Part A or Part B Fee-for-Service claims to Medicare contractors (fiscal intermediaries (FIs) including regional home health intermediaries (RHHIs), and carriers including durable medical equipment regional carriers (DMERCs)) for services.

Provider Action Needed
STOP – Impact to You
CR5110 provides notice of the updated payment allowance limits for Medicare Part B drugs, effective July 1, 2006 through September 30, 2006, as well as revised payment files for the January 2006 and April 2006 Quarterly ASP Medicare Part B Drug Pricing Files.

CAUTION – What You Need to Know
Certain Medicare Part B drug payment limits have been revised and the Centers for Medicare & Medicaid Services (CMS) updates the payment allowance quarterly. The revised payment limits included in the revised ASP and Not Otherwise Classified (NOC) payment files supersede the payment limits for these codes in any publication published prior to CR5110.

GO – What You Need to Do
Make certain that your billing staffs are aware of this change.

Background
According to Section 303(c) of the Medicare Modernization Act of 2004 (MMA), CMS will update the payment allowances for Medicare Part B drugs on a quarterly basis.

As mentioned in previous articles (see MM4319 at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4319.pdf), beginning January 1, 2005, Part B drugs (that are not paid on a cost or prospective payment basis) are paid based on 106 percent of the average sales price (ASP).

Pricing for compounded drugs is performed by the local Medicare contractor.

ESRD Drugs
Additionally, in 2006, all ESRD drugs furnished by both independent and hospital based ESRD facilities, as well as specified covered outpatient drugs, and drugs and biologicals with pass-through status under the OPPS, are paid based on the ASP methodology.

The ASP methodology is based on quarterly data submitted to CMS by manufacturers. CMS will supply Medicare contractors with the ASP drug pricing files for Medicare Part B drugs on a quarterly basis.

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.

Beginning January 1, 2006, the payment allowance limits for all ESRD drugs when separately billed by freestanding and hospital-based ESRD facilities, as well as specified covered outpatient drugs, and drugs and biologicals with pass-through status under the OPPS, will be paid based on 106 percent of the ASP. CMS will update the payment allowance limits quarterly.

Exceptions
There are exceptions to these general rules and those exceptions are outlined in MLN Matters article MM4319, which can be viewed at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4319.pdf on the CMS Web site.

With regard to the exceptions listed in MM4319, note that 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, unless the drug is compounded.

The payment allowance limits for infusion drugs

furnished through a covered item of durable medical equipment that were not listed in the published compendia as of October 1, 2003, (i.e., new drugs) are 95 percent of the first published AWP, unless the drug is compounded.

Drugs Furnished During Filling or Refilling an Implantable Pump or Reservoir
Physicians (or other authorized practitioners) may be paid for filling or refilling an implantable pump or reservoir when it is medically necessary for the physician (or other practitioner) to do so. Payment for drugs furnished incident to the filling or refilling of an implantable pump or reservoir, is determined under the ASP methodology.

Note that the use of the implantable pump or reservoir must be found medically reasonable and necessary in order to allow payment for the professional service to fill or refill the implantable pump or reservoir and to allow payment for drugs furnished incident to the professional service.

If a physician or other practitioner is prescribing medication for a patient with an implantable pump, a nurse may refill the pump if:

- The medication administered is accepted as a safe and effective treatment of the patient’s illness or injury;
- There is a medical reason that the medication cannot be taken orally; and
- The skills of the nurse are needed to infuse the medication effectively.

How the ASP Is Calculated
The ASP is calculated using data submitted to CMS by manufacturers on a quarterly basis and each quarter:

- The revised January 2006 payment allowance limits apply to dates of service January 1, 2006, through March 31, 2006.
- The revised April 2006 payment allowance limits apply to dates of service April 1, 2006, through June 30, 2006.

The absence or presence of a HCPCS (Healthcare Common Procedure Coding System) code and its associated payment limit does not indicate Medicare coverage of the drug or biological.

Similarly, the inclusion of a payment limit within a specific column does not indicate Medicare coverage of the drug in that specific category. The carrier processing your claim will make these determinations.

Implementation
The implementation date for the instruction is July 3, 2006.

Additional Information
The Medicare Claims Processing Manual, Publication 100-04, Chapter 17, Drugs and Biologicals, contains information that is pertinent to MM5110. It is located at http://www.cms.hhs.gov/manuals/downloads/clm104c17.pdf on the CMS Web site.

Quarterly Part B Drug Pricing files and information are also available at http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice on the CMS Web site.

CR5110 is the official instruction issued to your Medicare carrier/FI/RHHI/DMERC regarding changes mentioned in this article. CR5110 may be found at http://www.cms.hhs.gov/Transmittals/downloads/R974CP.pdf on the CMS Web site.

If you have questions, please contact your Medicare carrier/FI/RHHI/DMERC at their toll-free number, which may be found at http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip on the CMS Web site.
2006 3rd Quarter Oral Anti-Cancer Drug Fee Update and Revisions

The following drug allowables are being implemented effective July 1, 2006, and are subject to change on a quarterly basis. Currently, these drugs meet the requirements for coverage under OBRA ’93.

Included in this advisory are the 3rd Quarter updates, along with the revised fees for both the 1st and 2nd Quarter of 2006. Per CR5110, all are effective on July 1, 2006.


Oral Anti-Cancer drugs are billed using the National Drug Code (NDC) number.

Inclusion or exclusion of an allowable amount for an item or service does not imply Medicare coverage.

The fees changes are bolded on the table below:

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Strength</th>
<th>1st Quarter 2006 Revision</th>
<th>2nd Quarter 2006 Revision</th>
<th>3rd Quarter 2006 Update</th>
</tr>
</thead>
<tbody>
<tr>
<td>Busulfan</td>
<td>2 mg</td>
<td>1.969</td>
<td>1.973</td>
<td>2.127</td>
</tr>
<tr>
<td>Capecitabine</td>
<td>150 mg</td>
<td>3.638</td>
<td>3.631</td>
<td>3.751</td>
</tr>
<tr>
<td>Capecitabine</td>
<td>500 mg</td>
<td>12.086</td>
<td>12.089</td>
<td>12.471</td>
</tr>
<tr>
<td>Cyclophosphamide</td>
<td>25 mg</td>
<td>0.958</td>
<td>0.971</td>
<td>0.997</td>
</tr>
<tr>
<td>Cyclophosphamide</td>
<td>50 mg</td>
<td>1.916</td>
<td>1.942</td>
<td>1.994</td>
</tr>
<tr>
<td>Etoposide</td>
<td>50 mg</td>
<td><strong>32.168</strong></td>
<td><strong>33.039</strong></td>
<td>32.500</td>
</tr>
<tr>
<td>Melphan</td>
<td>2 mg</td>
<td>4.336</td>
<td>4.336</td>
<td>4.336</td>
</tr>
<tr>
<td>Methotrexate</td>
<td>2.5 mg</td>
<td>0.281</td>
<td>0.239</td>
<td>0.228</td>
</tr>
<tr>
<td>Methotrexate</td>
<td>5 mg</td>
<td>0.562</td>
<td>0.478</td>
<td>0.456</td>
</tr>
<tr>
<td>Methotrexate</td>
<td>7.5 mg</td>
<td>0.843</td>
<td>0.717</td>
<td>0.684</td>
</tr>
<tr>
<td>Methotrexate</td>
<td>10 mg</td>
<td>1.124</td>
<td>0.956</td>
<td>0.912</td>
</tr>
<tr>
<td>Methotrexate</td>
<td>15 mg</td>
<td>1.686</td>
<td>1.434</td>
<td>1.368</td>
</tr>
<tr>
<td>Temozolomide</td>
<td>5 mg</td>
<td>7.226</td>
<td>7.228</td>
<td>7.271</td>
</tr>
<tr>
<td>Temozolomide</td>
<td>20 mg</td>
<td>28.904</td>
<td>28.912</td>
<td>29.084</td>
</tr>
<tr>
<td>Temozolomide</td>
<td>100 mg</td>
<td>144.520</td>
<td>144.560</td>
<td>145.420</td>
</tr>
<tr>
<td>Temozolomide</td>
<td>250 mg</td>
<td>361.300</td>
<td>361.400</td>
<td>363.550</td>
</tr>
</tbody>
</table>
Ending the HIPAA Contingency for Remittance Advice

MLN Matters Number: SE0646
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

Provider Types Affected
All providers and suppliers who bill Medicare contractors (carriers, including durable medical equipment regional carriers (DMERCs), DME Medicare Administrative Contractors (DME MACs), and fiscal intermediaries (FIs), including regional home health intermediaries (RHHIs))

What You Need to Know
Effective October 1, 2006, Medicare will send only HIPAA-compliant Electronic Remittance Advice (ERA) transactions (Transaction 835 version 004010A1) to all electronic remittance advice receivers.

Background
In 2003, the Centers for Medicare & Medicaid Services (CMS) addressed compliance with the HIPAA transaction and code sets, and encouraged health plans (such as Medicare) to:

- Intensify their efforts toward compliance;
- Assess the readiness of their provider communities; and
- Determine the need to implement contingency plans to maintain the flow of payments while continuing toward compliance.

Consistent with that guidance, Medicare has aggressively worked with providers to achieve HIPAA compliance. Effective October 16, 2003, in order to ensure the continuation of normal program operations, CMS implemented a contingency plan through which Medicare continued to accept and send both HIPAA-compliant and non-HIPAA transactions from/to trading partners.

CMS ended the contingency plan that addressed inbound claims on October 1, 2005, and at that time began denying non-compliant electronic claims.

Now, CMS is moving to end the contingency plan for Electronic Remittance Advice (ERA) transactions. Currently, 99% of all Electronic Remittance Advice (ERA) receivers (providers, clearinghouses, billing agencies, and others who receive ERAs on behalf of providers) are receiving the HIPAA compliant ERA.

Further, the overall compliance rate for all Medicare providers in May 2006 was 96%. (The rate for professional providers was 97% and for institutional providers was 93%).

Therefore, CMS announces that, effective October 1, 2006, it will end the contingency plan for the remittance advice transaction.

After that date, your carriers, FIs, DMERCs, DME MACs, and RHHIs will send only HIPAA-compliant remittance advice (Transaction 835) to all electronic remittance advice receivers. In doing so,
Ending the HIPAA Contingency for Remittance Advice, cont.

Medicare will stop sending electronic remittance advice in any version other than the standard HIPAA version (835 version 004010A1), or in any other format (e.g., NSF).

Additional Information
You can find more information about HIPAA at http://www.cms.hhs.gov/HIPAAGenInfo/ on the CMS Web site.

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

End of Contingency for Electronic Remittance Advice (ERA) — ACTION

MLN Matters Number: SE0656
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

Provider Types Affected
Providers and physicians who bill Medicare fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), and carriers, including durable medical equipment regional carriers (DMERCs)

Current figures indicate that 99% of all ERA receivers (providers and other entities that receive the ERA on behalf of providers) are receiving a HIPAA compliant ERA format and they are unaffected by the end of the contingency plan. The remaining 1% of legacy ERA receivers need to transition to a HIPAA compliant ERA format between now and October 1, 2006. The following are the options available to you as a legacy ERA receiver:

- Start receiving HIPAA compliant ERAs beginning on October 1, 2006.
- Request to switch to Standard Paper Remittance (SPR) advice.
- If you are already receiving an SPR, and do not want to receive the HIPAA compliant ERA, notify your Medicare FI, DMERC, RHHI, or carrier to stop sending any ERA.
- If providers are not currently receiving SPR, and do not wish to switch to HIPAA compliant ERA, notify your Medicare FI, DMERC, RHHI, or carrier that you would like to start receiving SPR and not receive any ERA.

There are tools available to providers to view and
End of Contingency for Electronic Remittance Advice (ERA) — ACTION, cont.

print the remittance advice information using free Medicare software (PC Print for institutional providers and Medicare Remit Easy Print (MREP) for professional providers and suppliers). These free software packages are 835 version 00401A1 compatible and will not work with any legacy ERA. Both software packages have important advantages over the SPR. Both packages can also be used to generate a hard copy remittance to be sent for secondary/tertiary billing, and for accounts receivable reconciliation. See the Additional Information section of this article for MREP details.

Additional Information


MLN Matters Number: MM5081
Related Change Request (CR) #: 5081
Related CR Release Date: June 30, 2006
Effective Date: October 1, 2006
Related CR Transmittal #: R996CP
Implementation Date: October 2, 2006

Provider Types Affected
All Medicare physicians, providers, suppliers, and billing staff who submit claims for services to Medicare contractors (fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), carriers, and durable medical equipment regional carriers (DMERCs) and durable medical equipment administrative contractors (DME MACs))

Background
This article instructs the Shared System Maintainers and FIs, RHHIs, carriers, and DMERCs/DME MACs how to report Medicare legacy numbers and NPIs on a Health Insurance Portability and Accountability Act (HIPAA) compliant Electronic Remittance Advice (ERA) – transaction 835, and Standard Paper Remittance (SPR) advice, any output using PC Print or Medicare Remit Easy Print (MREP) between October 2, 2006 and May 22, 2007.

The Centers for Medicare & Medicaid Services (CMS) has defined legacy provider identifiers to include OSCAR, National Supplier Clearinghouse (NSC) supplier number, Provider Identification Numbers (PIN), National Council of Prescription Drug Plans (NCPDP) pharmacy identifiers, and Unique Physician Identification Numbers (UPINs). CMS’s definition of legacy numbers does not include taxpayer identifier numbers (TIN) such as Employer Identification Numbers (EINs) or Social Security Numbers (SSNs).

Medicare has published CR4320 (http://www.cms.hhs.gov/Transmittals/downloads/R204OTN.pdf) instructing its contractors how to properly use and edit NPIs received in electronic data interchange transactions, via Direct Data Entry screens, or on paper claim forms. Providers

need to be aware that these instructions that impact contractors will also impact the content of their SPR, ERA, and their PC print and MREP software.

The following dates outline the regulations from January 2006 forward and are as follows:

- January 3, 2006 – October 1, 2006: Medicare rejects claims with only NPIs and no legacy number.
- October 2, 2006 – May 22, 2007: Medicare will accept claims with a legacy number and/or an NPI, and will be capable of sending NPIs in outbound transaction, e.g., ERA.
- May 23, 2007 – Forward: Medicare will only accept claims with NPIs. Small health plans have an additional year to be NPI compliant.

Medicare providers may want to be aware of the following Stage 2 scenarios so that they are compliant with claims regulations and receive payments in a timely manner.

Key Points
During Stage 2, if an NPI is received on the claim, it will be crosswalked to the Medicare legacy number(s) for processing. The crosswalk may result in:

Scenario I: Single NPI crosswalked to single legacy number
Scenario II: Multiple NPIs crosswalked to Single Medicare legacy number
Scenario III: Single NPI crosswalked to Multiple Medicare legacy numbers

Note: The Standard Paper Remittance for institutional providers would include NPI information at the claim level. NPI information for professional providers and suppliers would be sent at the service level.

CMS will adjudicate claims based upon Medicare legacy number(s) even when NPIs are received and validated. The Remittance Advice (RA) may be generated for claims with the same legacy numbers but different NPIs. These claims with different NPIs will be rolled up and reported in a single RA accompanied by one check or electronic funds transfer (EFT).

During Stage 2, Medicare will report both the legacy number(s) and NPI(s) to providers enabling them to track payments and adjustments by both identifiers. The Companion Documents will be updated to reflect these changes and the updated documents will be posted at http://www.cms.hhs.gov/ElectronicBillingEDITrans/11_Remittance.asp#TopOfPage on the CMS Website.

Scenario I — Single NPI crosswalked to single legacy number:
1. ERA: Under this scenario, use the TIN (EIN/SSN) at the Payee level as the Payee ID, and the legacy number in the REF segment as Payee Additional ID. Then add the NPI at the claim and/or at the service level, if needed.
2. SPR: Insert the legacy number at the header level and the NPI at the claim and/or at the service level, if needed.
3. PC Print Software: Show the legacy number at the header level and the NPI at the claim and/or at the service level, if needed.
4. MREP software: Show the legacy number at the header level and the NPI at the claim and/or at the service level, if needed.

Scenario II — Multiple NPIs crosswalked to single Medicare legacy number:
1. ERA: Under this scenario, use the TIN (EIN/SSN) at the Payee level as the Payee ID, and the legacy number in the REF segment as Payee Additional ID. Then add the specific NPIs at the claim and/or at the service level, if needed. The specific NPI associate with the claim(s)/service lines included in the ERA will need to be identified using additional information provided on the claim.
2. SPR: Insert the legacy number at the header level. Add the specific NPIs at the claim and/or at the service level, if needed.

3. **PC Print Software**: Show the legacy number at the header level and the specific NPI at the claim and/or at the service level, if needed.

4. **MREP software**: Show the legacy number at the header level and the specific NPI at the claim and/or at the service level, if needed.

**Scenario III – Single NPI crosswalked to Multiple Medicare legacy numbers:**

1. **ERA**: Under this scenario, use the TIN (EIN/SSN) at the Payee level as the Payee ID, and the appropriate legacy number in the REF segment as Payee Additional ID. Then add the NPI at the claim and/or at the service level, if needed. (Under this scenario, if there are 50 claims with the same NPI and that NPI crosswalks to five legacy numbers, we will issue 5 separate RAs and five separate checks/EFTs per each legacy number.

2. **SPR**: Insert the appropriate legacy number at the header level and the NPI at the claim and/or at the service level, if needed.

3. **PC Print Software**: Show the appropriate legacy number at the header level and the NPI at the claim and/or at the service level, if needed.

4. **MREP software**: Show the appropriate legacy number at the header level and the NPI at the claim and/or at the service level, if needed.

**Implementation**
The implementation date for this instruction is October 2, 2006.

**Additional Information**
The official instructions issued to your Medicare FI, Carrier, RHHI, DMERC, or DME MAC regarding this change can be found at http://www.cms.hhs.gov/transmittals/downloads/R996CP.pdf on the CMS Web site. The revised sections of Chapter 22 — Remittance Advice of the Medicare Claims Processing Manual are attached to CR5081.

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

The MLN Matters article that provides additional information about Stage 1 — Use of NPI is available at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4320.pdf on the CMS Web site.

Revision to Chapter 31 — Addition of Hospice Data to HIPAA 270/271 Eligibility Inquiry and Response Transactions

**MLN Matters Number**: MM4193
**Related Change Request (CR) #**: 4193
**Related CR Release Date**: December 29, 2005
**Effective Date**: January 23, 2006
**Related CR Transmittal #:** R793CP
**Implementation Date**: January 23, 2006

**Provider Types Affected**
Physicians, suppliers, and providers billing Medicare carriers, including durable medical equipment regional carriers (DMERCs) and/or fiscal intermediaries (FIs), including regional home health intermediaries (RHHIs) for Hospice services

**Provider Action Needed**
This article is based on Change Request (CR) 4193, which adds Hospice data to the Centers for Medicare & Medicaid Services (CMS) Health Insurance Portability and Accountability Act (HIPAA) Health Care Eligibility Benefit Inquiry and Response transaction (270/271). Hospice will be part of the core data elements returned on the 271 response.

**Background**
CMS is making changes to its Information Technology infrastructure to address standards for Medicare beneficiary eligibility inquiries. This
Revision to Chapter 31 — Addition of Hospice Data to HIPAA 270/271 Eligibility Inquiry and Response Transactions, cont.

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

approach will create the necessary database and infrastructure to provide a centralized Health Insurance Portability and Accountability Act (HIPAA) compliant 270/271 health care eligibility inquiry and response in real time.

CMS is using a phased approach for providing this eligibility transaction on a realtime basis:

- **Extranet**: Clearinghouses, certain providers, and trading partners (as described below) will be permitted to submit 270s via the CMS AT&T communication Extranet (the Medicare Data Communication Network or MDCN). This Extranet is a secure closed private network currently used to transmit data between Medicare Fee-for-Service (FFS) contractors and CMS.

- **Internet**: CMS expects to provide limited internet access to the 270/271 transaction this year. Instructions on accessing eligibility data via this method will be provided prior to the time internet access becomes available.

All electronic 270 files will be processed at the CMS data center, and the CMS data center will use a single consolidated national eligibility database to respond to the eligibility inquiries.

CR4193 revises the Medicare Claims Processing Manual (Pub. 100-04) Chapter 31 (ANSI X12 Formats Other than Claims or Remittance), Section 10.2 (Eligibility Extranet Workflow), by adding the following Hospice data to the CMS HIPAA Health Care Eligibility Benefit Inquiry and Response transaction (270/271).

**271 Response Data Elements**

If a service type code is submitted in a 270 that does not trigger additional Medicare data elements, the following data elements will be returned in the 271 as applicable:

<table>
<thead>
<tr>
<th>271 Information Returned</th>
<th>Loop</th>
<th>Segment</th>
<th>Element</th>
<th>Data Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospice Data</td>
<td>2110C</td>
<td>EB</td>
<td>EB01</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>EB03</td>
<td>45</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>EB04</td>
<td>MA</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>EB06</td>
<td>26</td>
</tr>
<tr>
<td></td>
<td></td>
<td>DTP</td>
<td>DTP01</td>
<td>292</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>DTP02</td>
<td>D8 or RD8</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>DTP03</td>
<td>Dates</td>
</tr>
</tbody>
</table>

**Implementation**
The implementation date for the instruction is January 23, 2006.

**Additional Information**

For complete details, please see the official instruction issued to your carrier/DMERC/intermediary regarding this change. That instruction may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R793CP.pdf on the CMS Web site.

If you have any questions, please contact your carrier/DMERC/intermediary at their toll-free number, which may be found at http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip on the CMS Web site.
Rules Governing Provider/Clearinghouse Protection of Medicare Beneficiary Eligibility Information

MLN Matters Number: MM5138  
Related Change Request (CR) #: 5138  
Related CR Release Date: June 23, 2006  
Effective Date: July 24, 2006  
Related CR Transmittal #: R991CP  
Implementation Date: July 24, 2006

Provider Types Affected  
Physicians, providers, suppliers, and clearinghouses who bill Medicare fiscal intermediaries (FIs), carriers, regional home health intermediaries (RHHIs), and durable medical equipment regional carriers (DMERCs), and who use the HIPAA 270/271 beneficiary eligibility transaction data in a real-time environment via the Centers for Medicare & Medicaid Services (CMS) AT&T communication Extranet

Background  
CMS is committed to maintaining the integrity and security of health care data in accordance with applicable laws and regulations. Disclosure of Medicare beneficiary eligibility data is restricted under the provisions of the Privacy Act of 1974 and the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

This article is a reminder to physicians/providers/suppliers of the importance of protecting Medicare beneficiary information and to use it only for authorized purposes. Be sure all your representatives and employees who have authorized access to this information are aware of the importance of protecting that information as well.

Key Points of CR5138  
Change Request (CR) 5138 reiterates the responsibilities of users in obtaining, disseminating, and using beneficiary’s Medicare eligibility data. The following key points outline those responsibilities:

EDI Enrollment  
The Medicare electronic data interchange (EDI) enrollment process must be executed by each physician/provider/supplier that submits/receives EDI either directly to or from Medicare or through a third party, such as a clearinghouse.

Each physician/provider/supplier that uses EDI, either directly or through a billing agent or clearinghouse to exchange EDI transactions with Medicare, must sign the EDI Enrollment Form and submit it to the carrier, DMERC, or FI with whom EDI transactions will be exchanged before any transaction is conducted.

Physicians/providers/suppliers should remember that they agreed to use sufficient security procedures (including compliance with all provisions of the HIPAA security regulations) to ensure that all transmissions of information are authorized and all beneficiary-specific data is protected from improper access. Acting on behalf of the beneficiary, physicians/providers/suppliers/users of Medicare data are expected to use and disclose protected health information according to the CMS regulations. The HIPAA Privacy Rule mandates the protection and privacy of all health information.

Authenticating Data Elements for HIPAA 270/271 Eligibility Data  
Authenticating data elements for HIPAA 270/271 Eligibility Data must be provided by the inquirer (physician, provider, supplier, or other authorized third party) prior to the release of any beneficiary-specific eligibility information and must include:

- Beneficiary last name (must match the name on the Medicare card);  
- Beneficiary first name or first initial (must match the information on the Medicare card);  
- Assigned Medicare Claim Number (also referred to as the Health Insurance Claim Number (HICN) including both alpha and numerical characters; and  
- Date of birth.

Medicare Beneficiary as First Source of Health Insurance Eligibility Information  
The Medicare beneficiary should be your first source of health insurance eligibility information. When scheduling a medical appointment for a Medicare beneficiary, remind the beneficiary to bring, on the day of the appointment, all health insurance cards showing his/her health insurance coverage. This will not only help you determine who to bill for services rendered, but also provide you with the proper spelling of the beneficiary’s
Rules Governing Provider/Clearinghouse Protection of Medicare Beneficiary Eligibility Information, cont.

first and last name and identify his/her Medicare Claim Number as reflected on the Medicare Health Insurance card. It is important to use the name as shown on the Medicare card.

If the beneficiary has Medicare coverage but does not have a Medicare Health Insurance card, encourage them to contact the Social Security Administration at 1-800-772-1213 to obtain a replacement Medicare Health Insurance card. Those beneficiaries receiving benefits from the Railroad Retirement Board (RRB) can call 1-800-808-0772 to request a replacement Medicare Health Insurance card from RRB.

Authorized Purposes for Requesting Medicare Beneficiary Eligibility Information
In conjunction with the intent to provide health care services to a Medicare beneficiary, authorized purposes include the following:

- Verify eligibility for Part A or Part B of Medicare;
- Determine beneficiary payment responsibility with regard to deductible/coinsurance;
- Determine eligibility for services such as preventive services;
- Determine if Medicare is the primary or secondary payer;
- Determine if the beneficiary is in the original Medicare plan or a Part C (Medicare Advantage) plan; and
- Determine proper billing.

Medicare eligibility data is only to be used for the business of Medicare, such as preparing an accurate Medicare claim or determining eligibility for specific services.

In order to obtain access to eligibility data, as a physician/provider/supplier you will be responsible for the following:

- Before you request Medicare beneficiary eligibility information and at all times thereafter, you will ensure sufficient security measures to associate a particular transaction with the particular employee.
- You will cooperate with CMS or its agents in the event that CMS has a security concern with respect to any eligibility inquiry.

- You will promptly inform CMS or one of CMS’s contractors (your carrier/DMERC/RHHI/FI) in the event you identify misuse of “individually identifiable” health information accessed from the CMS database.
- Each eligibility inquiry will be limited to requests for Medicare beneficiary eligibility data with respect to a patient currently being treated or served by you, or who has contacted you about treatment or service, or for whom you have received a referral from a health care provider that has treated or served that patient.

Note: Medicare health benefit beneficiary eligibility inquiries are monitored. Providers identified as demonstrating aberrant behavior (e.g., high inquiry error rate or high ratio of eligibility inquiries to claims submitted) may be contacted to verify proper use of the system, made aware of educational opportunities, or when appropriate referred for investigation of possible fraud and abuse or violation of HIPAA privacy law.

Criminal Penalties’ Provisions
Remember that a number of statutes provide for severe criminal and civil penalties for misuse of information, including:

1. Trading Partner Agreement Violation
   42 U.S.C. 1320d-6 authorizes criminal penalties against a person who, “knowingly and in violation of this part ... (2) obtains individually identifiable health information relating to an individual; or (3) discloses individually identifiable health information to another person.”

   Offenders shall “(1) be fined not more than $50,000, imprisoned not more than 1 year, or both; (2) if the offense is committed under false pretenses, be fined not more than $100,000, imprisoned not more than 5 years, or both; and (3) if the offense is committed with intent to sell, transfer, or use individually identifiable health information for commercial advantage, personal gain, or malicious harm, be fined not more than $250,000, imprisoned not more than 10 years, or both.”
Rules Governing Provider/Clearinghouse Protection of Medicare Beneficiary Eligibility Information, cont.

2. **False Claim Act**
   Under the False Claims Act, 31 U.S.C. §§ 3729-3733, those who knowingly submit, or cause another person or entity to submit, false claims for payment of government funds are liable for three times the government’s damages plus civil penalties of $5,500 to $11,000 per false claim.

3. **Health Insurance Portability and Accountability Act of 1996 (HIPAA)**
   HHS may impose civil monetary penalties on a covered entity of $100 per failure to comply with a Privacy Rule requirement. That penalty may not exceed $25,000 per year for multiple violations of the identical Privacy Rule requirement in a calendar year ... A person who knowingly obtains or discloses individually identifiable health information in violation of HIPAA faces a fine of $50,000 and up to one-year imprisonment. The criminal penalties increase to $100,000 and up to five years imprisonment if the wrongful conduct involves false pretenses, and to $250,000 and up to ten years imprisonment if the wrongful conduct involves the intent to sell, transfer, or use individually identifiable health information for commercial advantage, personal gain, or malicious harm. Criminal sanctions will be enforced by the Department of Justice.

**Implementation**
The implementation date for this instruction is July 24, 2006.

**Additional Information**
CR5138, the official instructions issued to your Medicare FI, carrier, RHHI, and DMERC regarding this change, can be found at http://www.cms.hhs.gov/Transmittals/downloads/R991CP.pdf on the CMS Web site. The revised section Chapter 31—ANSI X12N Formats Other than Claims or Remittance of the Medicare Claims Processing Manual is attached to CR5138.

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

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**Medicare Remit Easy Print (MREP) Version 1.8 Available**

Medicare Remit Easy Print (MREP) Version 1.8 is now available for download. Version 1.8 includes many improvements, including the latest version of the Claim Adjustment Reason Codes and the Remittance Advice Remark Codes, as well as:

- A new Coordination of Benefits (COB) report showing claims that were crossed over;
- An import functionality for the Claim Adjustment Reason Codes and Remittance Advice Remark Code updates, so a full version does not need to be reinstalled for code updates only;
- An enhanced search functionality, including for the date of service;
- An enhanced Deductible/Coinsurance report to show both deductible and coinsurance amounts greater than zero, as well as those claims with only the coinsurance dollar amount greater than zero;
- More claim detail on the reports;
- When a service line is denied, the number of submitted units will display. The paid units will display when a service line is paid;
- Display of check date instead of 835 production transaction date; and
- A late filing charge correction

In addition, there are some changes to the User Guide and install/uninstall instructions. Remember you can save time and money by taking advantage of FREE Medicare Remit Easy Print software available to view and print the HIPAA compliant 835!
Medicare’s Common Working File (CWF) Part C (Medicare Advantage Managed Care) Data Exchange and Data Display Changes

MLN Matters Number: MM5118
Related Change Request (CR) #: 5118
Related CR Release Date: June 30, 2006
Effective Date: October 1, 2006
Related CR Transmittal #: R995CP
Implementation Date: October 2, 2006

Provider Types Affected
Physicians, providers, and suppliers who provide services to Medicare beneficiaries enrolled under Medicare Part C

Impact on Providers
CR5118 provides notice that effective January 2006, Medicare Part C plan contract numbers can begin with a character other than an “H.”

As a result of changes in the assignment of Medicare Part C plan contract numbers, the entire five-position alpha/numeric Medicare Part C plan contract number will be provided to the common working file (CWF), which is a key file used by Medicare systems to provide beneficiary information to providers.

Currently, the CWF places an “H” in front of the Part C plan number, since prior to January 1, 2006, all plan numbers began with an “H.” Once this change is implemented, the correct and complete plan contract numbers will then be on the CWF and will be given to providers when they inquire about Medicare beneficiaries.

Background
CWF contains data indicating when a beneficiary is enrolled under a Medicare Part C contract. Medicare Part C contracts are Medicare Advantage Managed Care Plans that provide Part A and B benefits for beneficiaries enrolled under the contract. CWF receives this Part C data on a data feed from the Enrollment Database (EDB), another Medicare database. Effective January 1, 2006, Part C contract numbers can begin with a letter other than “H” and the Medicare CWF is being modified to handle this change, so correct numbers are sent to providers as part of beneficiary information.

To associate plan identification numbers with the plan name, go to http://www.cms.hhs.gov/HealthPlansGenInfo/claims_processing_20060120.asp#TopOfPage on the CMS Web site.

The number that will appear on CWF will begin with “H.” For the following 11 plans, the alpha prefix is actually an “R.” Prior to October, when using the Web page look-up tool, make sure to replace the “H” with an “R.” The 11 plans are the following:

R3175 R5566 R5863
R5287 R5595 R5941
R5342 R5674 R9943
R5553 R5826

Implementation
The implementation date for the instruction is October 2, 2006.

Additional Information
CR5118 is the official instruction issued to your Medicare carrier/durable medical equipment regional carrier (DMERC) or fiscal intermediary (FI) regarding changes mentioned in this article. CR5118 may be found at http://www.cms.hhs.gov/Transmittals/downloads/R995CP.pdf on the CMS Web site.

If you have questions please contact your Medicare carrier/FI/DMERC at their toll-free number, which may be found at http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip on the CMS Web site.
Chapter 24 Update to the National Council for Prescription Drug Program (NCPDP) Narrative Portion of Prior Authorization Segment

MLN Matters Number: MM5092
Related Change Request (CR) #: 5092
Related CR Release Date: May 26, 2006
Effective Date: August 28, 2006
Related CR Transmittal #: R958CP
Implementation Date: August 28, 2006

Provider Types Affected
Providers and suppliers billing Medicare durable medical equipment regional carriers (DMERCs) for locally prepared medication that contains compound ingredients.

Background
The Centers for Medicare & Medicaid Services (CMS) require providers to adhere to electronic data interchange (EDI) requirements for Medicare. Certain informational modifiers are required to identify compound ingredients in locally prepared medication. The NCPDP format does not currently support reporting modifiers in the compound segment. Therefore, the narrative portion in the prior authorization segment is being used to report these modifiers.

Key Points
This article and Change Request (CR) 5092 provide an update to Chapter 24 Section 40.3 (NCPDP Narrative Portion of Prior Authorization Segment). This article and CR 5092 also identify the additional modifiers needed for coordination of benefits (COB). Therefore, the narrative portion in the prior authorization segment is being used to report these modifiers.

The following must be entered in positions 001-003 of the narrative (Example, MMN or MNF). Starting at position 355, indicate the two-byte ingredient number followed by the two-position modifier:

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMN</td>
<td>Indicates that the supporting documentation that follows is Medicare required CMN or DIF information</td>
</tr>
<tr>
<td>CNA</td>
<td>Indicates that the supporting documentation that follows is Medicare required CMN or DIF and narrative information</td>
</tr>
<tr>
<td>CFA</td>
<td>Indicates that the supporting documentation that follows is Medicare required CMN or DIF information and Facility Name and Address</td>
</tr>
<tr>
<td>CSA</td>
<td>Indicates that the supporting documentation that follows is Medicare required CMN or DIF information and Supplier Name and Address</td>
</tr>
<tr>
<td>CNF</td>
<td>Indicates that the supporting documentation that follows is Medicare required CMN or DIF information, narrative information, and Facility Name and Address</td>
</tr>
<tr>
<td>CNS</td>
<td>Indicates that the supporting documentation that follows is Medicare required CMN or DIF information, narrative information, and Supplier Name and Address</td>
</tr>
<tr>
<td>FAC</td>
<td>Indicates that the supporting documentation that follows is Medicare required Facility Name and address</td>
</tr>
<tr>
<td>FAN</td>
<td>Indicates that the supporting documentation that follows is Medicare required Facility Name and Address and narrative information</td>
</tr>
<tr>
<td>SAC</td>
<td>Indicates that the supporting documentation that follows is Medicare required Supplier Name and address</td>
</tr>
<tr>
<td>SAN</td>
<td>Indicates that the supporting documentation that follows is Medicare required Supplier Name and Address and narrative information</td>
</tr>
<tr>
<td>NAR</td>
<td>Indicates that the supporting documentation that follows is Medicare required Narrative Information</td>
</tr>
<tr>
<td>MMN</td>
<td>Indicates that the supporting documentation that follows is Medicare modifier Information and CMN or DIF information</td>
</tr>
<tr>
<td>MNA</td>
<td>Indicates that the supporting documentation that follows is Medicare modifier information, CMN or DIF information and narrative information</td>
</tr>
<tr>
<td>MFA</td>
<td>Indicates that the supporting documentation that follows is Medicare modifier information, CMN or DIF information and Facility Name and Address</td>
</tr>
</tbody>
</table>
Chapter 24 Update to the NCPDP Narrative Portion of Prior Authorization Segment, cont.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>MNS</td>
<td>Indicates that the supporting documentation that follows is Medicare modifier information, CMN or DIF information, narrative information and Supplier Name and Address</td>
</tr>
<tr>
<td>MAC</td>
<td>Indicates that the supporting documentation that follows is Medicare modifier information and Facility Name and Address</td>
</tr>
<tr>
<td>MAN</td>
<td>Indicates that the supporting documentation that follows is Medicare modifier information, narrative information and Facility Name and Address</td>
</tr>
<tr>
<td>MFA</td>
<td>Indicates that the supporting documentation that follows is Medicare modifier information, narrative information and Facility Name and Address</td>
</tr>
<tr>
<td>MOD</td>
<td>Indicates that the supporting documentation that follows is Medicare modifier information</td>
</tr>
</tbody>
</table>

**Implementation**
The implementation date for this instruction is August 28, 2006.

**Additional Information**
The official instructions, CR5092, issued to your Medicare DMERC regarding this change can be found at http://www.cms.hhs.gov/Transmittals/downloads/R958CP.pdf on the CMS Web site. The revised section 40.3 National Council for Prescription Drug Program Claim Requirements of the *Medicare Claims Processing Manual* is attached to CR5092. If you have questions, please contact your Medicare DMERC at their toll-free number which may be found at http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip on the CMS Web site.
Section 5: In Each Issue

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Register for Palmetto GBA Web Site Listservs

Did you know that articles can appear on Palmetto GBA’s Web site (www.PalmettoGBA.com/dme) up to three months before they are published in the DMERC Medicare Advisory? Make sure you are notified as soon as these articles are posted!

With Palmetto GBA’s listservs, Region C DMEPOS suppliers can receive same-day e-mail notification of updates posted to the Palmetto GBA Web site. Sign up and receive immediate notification of:

- DMERC updates
- Policy changes
- Workshops and seminars
- The latest on the Medicare Modernization Act
- Much more!

To register, go to www.PalmettoGBA.com/dme and click on “E-mail Updates.” 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 link (located at the top of your screen) to send an e-mail to Palmetto GBA via our Web site.

You can also find a listserv registration form on page 245 of this Advisory. Simply complete and fax to the number on the form, and you will be added to the www.PalmettoGBA.com/dme listserv.

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.
### Team Tips

<table>
<thead>
<tr>
<th>Future Date Billing</th>
<th>What items can I file using future date billing?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Only certain DMEPOS items can be filed using future dates or prospective billing. Those items are limited to diabetic supplies, enteral and parenteral nutrition, and administration kits. Only nebulizer, ostomy and diabetic supplies may be provided in 90-day increments.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Span Dates</th>
<th>What items require span dates?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The following items require span dates when filing claims to Medicare:</td>
</tr>
<tr>
<td></td>
<td>• Diabetic supplies (HCPCS codes A4253, A4256, A4259)</td>
</tr>
<tr>
<td></td>
<td>• Continuous passive motion (CPM)</td>
</tr>
<tr>
<td></td>
<td>• Enteral and parenteral nutrition</td>
</tr>
<tr>
<td></td>
<td>• Parenteral and enteral administration kits</td>
</tr>
<tr>
<td></td>
<td>• Tracheostomy care supplies</td>
</tr>
<tr>
<td></td>
<td>• External infusion pump supplies</td>
</tr>
<tr>
<td></td>
<td>Do not span dates on durable medical equipment.</td>
</tr>
</tbody>
</table>

| Ventilators | When filing claims for ventilators (HCPCS codes E0450, E0451, E0460, E0461), if the beneficiary qualifies to receive two, please bill both on the same line with the number of services as two and key the submitted amount for two as well. When these codes are billed on two separate lines, one will be denied as a duplicate. |

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### Seminarios por el Internet en Español - Spanish Online Workshops

Palmetto GBA se complace en invitarles a los siguientes seminarios a ser presentados en español a través de nuestro sistema Centra:

- **Septiembre 20** 2:00 p.m. Nebulizadores (Nebulizer Coverage)
- **Octubre 3** 3:00 p.m. Programa Comprensivo de Análisis de Porcentaje de Error (CERT)
- **Octubre 31** 1:00 p.m. Wheelchair and POV Coverage
- **Noviembre 7 & 8** 2:00 p.m. Facturación Básica I & II (Basic Billing I & II)
- **Diciembre 13** 10:00 a.m. Ostomía (Ostomy Coverage)

Es importante recordar que la hora indicada es la del Este de los Estados Unidos.

Para registrarse puede encontrar instrucciones detalladas en las últimas páginas de cada uno de los “Advisories” publicados por Palmetto GBA. En adición, puede llamar a su Ombudsman y le ayudaremos a registrarse. Si usted es un suplidor localizado en Puerto Rico o las Islas Vírgenes puede llamar a Carmen Ortiz al (787) 784-7390. De estar localizado en el Sur de la Florida puede comunicarse con Teresita Ortiz llamando al (561) 997-9210.
Online Learning Schedule, 2006

Region C DMERC’s instructor-led online workshops are a great resource for DMEPOS suppliers, with topics ranging from general basic billing to specific policy-related courses. Online workshops are led by Region C ombudsmen, who in addition to presenting course materials, are available to answer your questions afterward. For help with online workshop registration and attendance, see the instructions on the following pages. Check Palmetto GBA's Online Learning Center for course start times.

September
7 DMERC Autumn 2006 Advisory
12 Advance Beneficiary Notice (ABN)
14 PC-ACE Pro-32
20 Nebulizer Coverage (Spanish)
21 Prosthetic and Orthotic Coverage
27 Basic Billing 1
28 Basic Billing 2

October
3 Comprehensive Error Rate Testing (CERT) (Spanish)
5 Oxygen Coverage
11 Wheelchair and POV Coverage
19 DMERC Autumn 2006 Advisory
25 Basic Billing 1
26 Basic Billing 2
31 Wheelchair and POV Coverage (Spanish)

November
1 Web Safari
3 Infusion Coverage
7 Basic Billing 1 (Spanish)
8 Basic Billing 2 (Spanish)
16 PC-ACE Pro-32

December
7 DMERC Winter 2006 Advisory
13 Ostomy Coverage (Spanish)
20 Walker Coverage
27 Basic Billing 1
28 Basic Billing 2
Online Learning Events — How to Register

Via our Online Learning Center, Palmetto GBA offers Web-based tutorials, online workshops and learning materials designed to enhance knowledge of Medicare billing and coverage issues. Palmetto GBA’s Online Learning Center allows providers and suppliers to experience instructor-led courses over the Internet, or to take Web-based tutorials on their own. In online workshops, course attendees are able to interact with the instructor and with other attendees via microphone or text chatting, provide feedback on workshops and ask direct questions to complement their learning experience. Web-based tutorials allow providers and suppliers to take a course whenever their schedule allows.

Online workshops are conducted each month to cover a variety of topics helpful to the provider/supplier community. Users must register to attend each course separately. Registration can occur at any time prior to the scheduled date and time.

How do I register for online learning?
To register for online learning via Centra, access the Palmetto GBA Region C DMERC Web site at www.PalmettoGBA.com/dme/education.

1. Select Online Learning on the left hand menu.
2. Click the Login button. (This will take you to the Palmetto GBA Online Learning Home Page).
3. Select Click Here to Register a New User.
4. Complete the New User form and click Submit. (You will receive a message that states that your new user name and password have been accepted).
5. To log in, return to the Online Learning page and log in using your new user name and password.

Remember! Your new user name and password are case-sensitive. You must enter them in the same format used to create them.

How do I locate and register for courses?
Workshops and tutorials are listed in Centra according to presentation style and by line of business.

1. Select the Catalog tab to see a list of categories.
2. Choose the Category that pertains to your line of business (e.g., Durable Medical Equipment).
3. Upon selecting the category or type, a list of courses will display alphabetically. Scroll through the list and place a check mark beside each course you would like to attend. Once you complete your selection, scroll back to the top of the page and click on the Add to My Learning button on the right side of the category listing.
4. A pop-up window will appear with a list of all of the classes you have selected. Check your selections carefully and then click the Submit button to enroll in the course(s).

See next page for further instructions.
Online Learning Events - How to Register, cont.

5. Click on the My Learning tab to ensure that all workshops have been added to your schedule.

Don’t forget to mark your calendar if you have registered for a scheduled online workshop!

Attending a course
1. Log in to Palmetto GBA’s Online Learning Center.
2. Click on the My Learning tab to view courses.
3. Select the course you want to attend.
4. Click Attend to join the session.

To begin a tutorial, follow Steps 1-3, then click on Start to begin.

Helpful hints for online workshop attendance
- The tools at the top of the screen are for responding to prompts from the course instructor. Tools include buttons to Raise your Hand and answer Yes and No.
- The Text Chat feature allows the attendees to ask questions. Simply click on the Text Chat button (keyboard with a bubble) to participate. Enter the text in the Message window and click Send.

Using a microphone
We recommend you use a headset with a microphone when participating in online workshops. A microphone allows course attendees to speak directly with the instructor throughout the workshop.

During the workshop, you will not be able to speak unless granted a microphone by the course leader. You may raise your hand to signal to the instructor that you would like to have a microphone granted to you. Once the microphone has been granted, click on the Lock to talk button in the top left hand corner.

Please Note: You must release the Lock to talk button to allow the instructor to respond to you.

System requirements
Before attending an online workshop, test your system to make sure your computer can support the actual session. Click on the My Learning button at the top of the page. Toward the top right on 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:

- Operating System: Windows 2000 (SP4), or XP (SP1)
- Browser: Internet Explorer 5.x, 6.x; Netscape 4.5xa, 4.7xa, 7.x
- Processor: Pentium-class 500 MHz Processor
- Memory: 128 MB
- Disk: 40 MB free space
- Network: 28.8 kbps
- Display: 800 x 600; High Color 16-Bit
- Sound Card & Speakers: Yes

- Recommended System Requirements:
  - Browser: Internet Explorer 6.x
  - Memory: 256+ MB RAM
  - Disk: 200+ MB free (for content & recordings)
  - Network: 128+ kbps

Follow the instructions in the System Check pop-up box. After completing the system check, you may exit the Online Learning section.
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.hhs.gov/quarterlyproviderupdates/. We encourage you to bookmark this Web site and visit it often for this valuable information.

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 from the SADMERC home page at www.PalmettoGBA.com/sadmerc. Under Topics, click on DMECS. Your feedback is vital to the success of this tool. Please e-mail us your feedback by selecting Contact Us from our Web site.
Want to know about new policy changes, fee updates or Medicare updates without searching for it?

When you register with the PalmettoGBA.com listserv, you be notified when information is added to the Web site. This means you can stay up-to-date with current Medicare regulations.

Simply complete the registration form and fax it in. Once your registration information is entered, an e-mail confirmation will be sent to you.

Fax completed form to Communications Specialist at 803-935-0200

<table>
<thead>
<tr>
<th>First Name</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Last Name</td>
<td></td>
</tr>
<tr>
<td>Password</td>
<td>S3cret*1 (You will receive instructions for changing your password with your confirmation e-mail.)</td>
</tr>
<tr>
<td>Address First Line</td>
<td></td>
</tr>
<tr>
<td>Address Second Line</td>
<td></td>
</tr>
<tr>
<td>City</td>
<td></td>
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<tr>
<td>State</td>
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<td>Telephone Number</td>
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<tr>
<td>Email Address</td>
<td></td>
</tr>
<tr>
<td>Supplier Name</td>
<td></td>
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<tr>
<td>Supplier Number</td>
<td></td>
</tr>
</tbody>
</table>

Disclosure

We do not use or disclose information about your individual visits to www.PalmettoGBA.com or information that you may give us, such as your name, address, e-mail address or telephone number, to any outside company or organization.

For more information on our privacy policy visit www.PalmettoGBA.com.
Select each speciality topic of interest to you.

<table>
<thead>
<tr>
<th>Topic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Electronic Data Interchange (EDI)</td>
</tr>
<tr>
<td>General - DMEPOS</td>
</tr>
<tr>
<td>Home Care Equipment Supplies</td>
</tr>
<tr>
<td>Orthotics and Prosthetics</td>
</tr>
<tr>
<td>Oxygen</td>
</tr>
<tr>
<td>Pharmacies</td>
</tr>
<tr>
<td>Power Mobility</td>
</tr>
<tr>
<td>Respiratory</td>
</tr>
<tr>
<td>Vision</td>
</tr>
</tbody>
</table>
**PCOM Advisory Group**

Palmetto GBA is pleased to announce the implementation of the Provider Communications (PCOM) Advisory Group. The purpose of this group is to provide feedback regarding supplier education and training topics, as well as dissemination avenues and types and /or locations for educational forums. The PCOM Advisory Group is comprised of members throughout Region C who will meet to solicit input and feedback regarding these issues.

Provider and supplier education is very important to us. Please respond to the survey questions on both pages of this flyer to let us know what Palmetto GBA can do to best serve and educate its DMERC suppliers. Return your completed survey to Palmetto GBA by fax at (803) 935-0200, or mail it to:

Palmetto GBA  
DMERC Supplier Education, AG-520  
P.O. Box 100141  
Columbia, SC  29203-3141

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**Web-based Tutorials**

Palmetto GBA currently offers 15 Web-based tutorials on DMERC policy-specific topics such as home dialysis supplies, nebulizers and ostomy supplies. These tutorials are self-paced and available 24 hours a day, seven days a week at www.PalmettoGBA.com.

1. What topics would you like to see covered in future Web-based tutorials?

   ____________________________________________

   ____________________________________________

2. What presentation style do you prefer for Web-based tutorials?

   _____ Review questions throughout course, final quiz at end

   _____ No review questions during course, just final quiz at end

3. How much time should it take to complete a Web-based tutorial?

   ____________________________________________

---

**Online Workshops**

Palmetto GBA offers online workshops at least twice a month on DMERC policy-specific topics such as diabetic supplies and surgical dressings, as well as basic billing online workshops every other month. These workshops are instructor-led.

4. What topics would you like to see covered in future online workshops?

   ____________________________________________

   ____________________________________________

5. What presentation style do you prefer for online workshops?

   _____ Interaction between instructor and students throughout workshop

   _____ Very little interaction between instructor and students during workshop

6. Currently, most online workshop sessions begin at 2:00 p.m., usually on Tuesdays. Please choose a response below.

   _____ This time works fine with my schedule

   _____ Another time/day would be better  
   (Indicate time/day: _______________)

---

**CMS**

Centers for Medicare & Medicaid Services

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**Palmetto GBA**

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OVER
<table>
<thead>
<tr>
<th><strong>Live Workshops</strong></th>
<th><strong>Advisories and Supplier Manual Updates</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Region C DMERC conducts live workshops in locations throughout Region C at least once a year. Usually, these workshops cover broad basic billing topics applicable to all DMEPOS suppliers.</td>
<td>Palmetto GBA sends its quarterly DMERC Advisories and Supplier Manual updates to suppliers on CD-ROM. These publications are also available at <a href="http://www.PalmettoGBA.com/dme">www.PalmettoGBA.com/dme</a>.</td>
</tr>
</tbody>
</table>

7. What topics would you like to see covered in future live workshops?

8. What presentation style do you prefer for live workshops?
   - Interaction between instructor and students throughout workshop
   - Very little interaction between instructor and students during workshop

9. What seating set-up do you prefer for live workshops?
   - Classroom style: fewer students, seating at tables
   - Theater style: more students, no tables

10. Which of the following statements applies to you?
   - I have access to the Internet and to a PC with a CD-ROM drive.
   - I have Internet access, but do not have access to a PC with a CD-ROM drive.
   - I have access to a PC with a CD-ROM drive, but not to the Internet.
   - I do not have access to a PC and require paper copies of Advisories and Supplier Manual revisions. (If this option applies to you, please provide the information requested below.)

Company Name: _______________________
Contact Person: __________________________
NSC Supplier Number: ____________________
Telephone number: (_______)______-______

**Comments/Suggestions**
If you have additional comments or suggestions about Palmetto GBA Region C DMERC educational efforts, please write them below:

__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
To access the IVR, call 1-866-238-9650

You will be prompted for your supplier number, and then presented with the following options:

### Claims Information - press 1

**Claims Information options:**
- For claims status, press 1
  - Enter the HICN and date of service
- For action or denial codes, press 2
  - Enter the CCN
- For crossover information, press 3
  - Enter the HICN and CCN
- For appeals/hearings information, press 4
  - Enter the HICN and CCN
- To order duplicate remittances, press 5
  Then press:
  1 for review status, or
  2 for hearing status
  - Enter the HICN and CCN

### Beneficiary Eligibility - press 2

For both participating and non-participating providers: enter a beneficiary's HICN, date of birth, gender, and five-digit ZIP code to determine Medicare Part B eligibility, Home Health Organization information, Home Health Episode information, Medicare Secondary Payer information, and deductible information.

### General Information - press 3

**General Information options:**
- For recent policy changes, press 1
  - Enter the HICN and CCN
- For team assignments and mailing addresses, press 2
  - Enter the CCN
- For other agency telephone numbers, press 3
- For other general items of interest, press 4

### Financial Information - press 4

**Financial Information options:**
- For pricing, press 1
  Then enter
  - HCPCS code
  - State
  - Date of service
- For the amounts of your last three checks from Medicare, press 2
- For your number of pending claims and your total submitted amount outstanding, press 3
- For overpayment information, press 4
  Then press:
  1 for Duplicate Overpayment Letter
  or
  2 for Information on a specific FCN
  - Enter the FCN

---

To speak to a customer service representative, please call 1-866-270-4909.

See next page for how to enter alpha characters
When keying any information that contains an alpha indicator (e.g., HICN, HCPCS/procedure codes, and state codes), you must use the star key and telephone key pad combination. For HICNs L667 to 1, key HICN would key HCPCS code would. For example, you would key HCPCS code 123456 as follows: A1 B2 C3 D4 E5 F6.

For HICNs with alpha-numerical suffixes, key the alpha symbol as above, then key the numeric character immediately after. For example, HICN 123456C1 would key HCPCS code would. For example, you would key HCPCS code 123456C1 as follows: A1 B2 C3 D4 E5 F6 C1.

### IVR Key Combinations for Each Letter of the Alphabet

<table>
<thead>
<tr>
<th>Alphabet</th>
<th>Key Combination</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>2</td>
</tr>
<tr>
<td>B</td>
<td>2</td>
</tr>
<tr>
<td>C</td>
<td>2</td>
</tr>
<tr>
<td>D</td>
<td>2</td>
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<tr>
<td>E</td>
<td>2</td>
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<tr>
<td>F</td>
<td>2</td>
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<td>G</td>
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<td>H</td>
<td>2</td>
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<tr>
<td>I</td>
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<td>J</td>
<td>2</td>
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<tr>
<td>K</td>
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<tr>
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<td>2</td>
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<td>2</td>
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<tr>
<td>Q</td>
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<td>U</td>
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<tr>
<td>V</td>
<td>2</td>
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<tr>
<td>W</td>
<td>2</td>
</tr>
<tr>
<td>X</td>
<td>2</td>
</tr>
<tr>
<td>Y</td>
<td>2</td>
</tr>
<tr>
<td>Z</td>
<td>2</td>
</tr>
</tbody>
</table>

GCCS/HCPCS procedures are available online. When keying any information that contains an alphabet, please note that Q and Z are exceptions to the key combinations.
# 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>Multifunctional Teams/DMERC</strong></td>
<td>(866) 270-4909</td>
</tr>
<tr>
<td><strong>General Information</strong></td>
<td></td>
</tr>
<tr>
<td><strong>DMERC Interactive Voice Response (IVR) Unit</strong></td>
<td>(866) 238-9650</td>
</tr>
<tr>
<td><strong>Paper claims mailing address</strong></td>
<td></td>
</tr>
<tr>
<td>Palmetto GBA</td>
<td></td>
</tr>
<tr>
<td>P.O. Box 100181</td>
<td></td>
</tr>
<tr>
<td>Columbia, SC 29202-3181</td>
<td></td>
</tr>
<tr>
<td><strong>Correspondence, appeals and other written inquiries mailing address</strong></td>
<td></td>
</tr>
<tr>
<td>Palmetto GBA</td>
<td></td>
</tr>
<tr>
<td>P.O. Box 100196</td>
<td></td>
</tr>
<tr>
<td>Columbia, SC 29202-3196</td>
<td></td>
</tr>
<tr>
<td><strong>Medicare Customer Service Center (Beneficiary Call Center)</strong></td>
<td>(800) 633-4227</td>
</tr>
<tr>
<td><strong>Technology Support Center (Formerly EDI Help Desk)</strong></td>
<td>(866) 749-4301</td>
</tr>
<tr>
<td>Palmetto GBA, Region C DMERC</td>
<td></td>
</tr>
<tr>
<td>P.O. Box 100145</td>
<td></td>
</tr>
<tr>
<td>Columbia, SC 29202-3145</td>
<td></td>
</tr>
<tr>
<td><strong>Medicare Secondary Payer</strong></td>
<td>(866) 650-9129</td>
</tr>
<tr>
<td>Palmetto GBA</td>
<td></td>
</tr>
<tr>
<td>P.O. Box 100209</td>
<td></td>
</tr>
<tr>
<td>Columbia, SC 29202-3209</td>
<td></td>
</tr>
<tr>
<td><strong>Supplier Education Department</strong></td>
<td>(803) 763-5744</td>
</tr>
<tr>
<td>Palmetto GBA, Region C DMERC</td>
<td></td>
</tr>
<tr>
<td>P.O. Box 100141</td>
<td></td>
</tr>
<tr>
<td>Columbia, SC 29202-3141</td>
<td></td>
</tr>
</tbody>
</table>

## 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>P.O. Box 100142</td>
<td>Columbia, SC 29202-3142</td>
</tr>
<tr>
<td><strong>Region A DME MAC</strong></td>
<td>(866) 419-9458</td>
</tr>
<tr>
<td><strong>Region B DME MAC</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><em>Program Safeguard Contractor (PSC)</em></td>
<td>Voicemail line: (317) 863-3736</td>
</tr>
<tr>
<td>TrustSolutions, LLC</td>
<td>Fax (general): (317) 863-3755</td>
</tr>
<tr>
<td>P.O. Box 50218</td>
<td>Fax (ADR and ADMC): (317) 863-0054</td>
</tr>
<tr>
<td>Indianapolis, IN 46250</td>
<td>Fax (Benefit Integrity): (317) 863-3755</td>
</tr>
<tr>
<td><strong>Office of Inspector General (OIG)</strong></td>
<td>1-800-447-8477</td>
</tr>
<tr>
<td><strong>Fraud Hotline</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Medicare Part B West/DME Qualified Independent Contractor (QIC)</strong></td>
<td>(803) 264-2574</td>
</tr>
<tr>
<td>Q2 Administrators, LLC</td>
<td></td>
</tr>
<tr>
<td>Medicare Contractor</td>
<td></td>
</tr>
<tr>
<td>P.O. Box 100213</td>
<td></td>
</tr>
<tr>
<td>Columbia, SC 29202-0213</td>
<td></td>
</tr>
<tr>
<td><strong>Statistical Analysis Durable Medical Equipment Regional Carrier (SADMC)</strong></td>
<td>(877) 735-1326</td>
</tr>
<tr>
<td>Mail code: AG-370</td>
<td></td>
</tr>
<tr>
<td>2300 Springdale Drive, Bldg. One</td>
<td></td>
</tr>
<tr>
<td>Camden, SC 29020</td>
<td></td>
</tr>
<tr>
<td><strong>Railroad Medicare</strong></td>
<td>(877) 288-7600</td>
</tr>
</tbody>
</table>

*Send Additional Documentation Request (ADR) responses and Advance Determination of Medical Coverage (ADMC) requests to this address.*
### Ombudsman Addresses and Territories

Ombudsmen investigate complaints, report findings and facilitate problem solving through training and education of the supplier community.

<table>
<thead>
<tr>
<th>Mailing address</th>
<th>Telephone number</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Alabama</strong></td>
<td></td>
</tr>
<tr>
<td>Lia Bunch</td>
<td>(205) 661-6988</td>
</tr>
<tr>
<td>PMB 425</td>
<td></td>
</tr>
<tr>
<td>459 Main Street, Suite 101</td>
<td></td>
</tr>
<tr>
<td>Trussville, AL 3517</td>
<td></td>
</tr>
<tr>
<td><strong>Arkansas/Oklahoma</strong></td>
<td>(405) 277-3875</td>
</tr>
<tr>
<td>Kendra Kerley</td>
<td></td>
</tr>
<tr>
<td>1050 E. 2nd Street, #356</td>
<td></td>
</tr>
<tr>
<td>Edmond, OK 73034</td>
<td></td>
</tr>
<tr>
<td><strong>Colorado/New Mexico</strong></td>
<td>(720) 493-5301</td>
</tr>
<tr>
<td>Eric Carlson</td>
<td></td>
</tr>
<tr>
<td>P.O. Box 2027</td>
<td></td>
</tr>
<tr>
<td>Littleton, CO 80161-2027</td>
<td></td>
</tr>
<tr>
<td><strong>Florida (south)</strong></td>
<td>(561) 997-9210</td>
</tr>
<tr>
<td>(covers the southern portion of Florida to include Manatee, Hardee, Highlands, Okeechobee and Indian River counties, and all points south)</td>
<td></td>
</tr>
<tr>
<td>Teresita Ortiz</td>
<td></td>
</tr>
<tr>
<td>934 N. University Dr., #447</td>
<td></td>
</tr>
<tr>
<td>Coral Springs, FL 3307</td>
<td></td>
</tr>
<tr>
<td><strong>Florida (north)</strong></td>
<td>(904) 886-2887</td>
</tr>
<tr>
<td>(covers the northern portion of Florida to include Pinellas, Hillsborough, Polk, Osceola and Brevard counties, and all points north)</td>
<td></td>
</tr>
<tr>
<td>Keith Smith</td>
<td></td>
</tr>
<tr>
<td>PMB 113</td>
<td></td>
</tr>
<tr>
<td>11111-70 San Jose Blvd.</td>
<td></td>
</tr>
<tr>
<td>Jacksonville, FL 32223</td>
<td></td>
</tr>
<tr>
<td><strong>Georgia</strong></td>
<td>(770) 388-7380</td>
</tr>
<tr>
<td>Sharon Briggman</td>
<td></td>
</tr>
<tr>
<td>1820 Hwy. 20, Ste 132, #303</td>
<td></td>
</tr>
<tr>
<td>Conyers, GA 30013</td>
<td></td>
</tr>
<tr>
<td><strong>Louisiana/Mississippi</strong></td>
<td>(601) 856-4368</td>
</tr>
<tr>
<td>Bobby Smith</td>
<td></td>
</tr>
<tr>
<td>P.O. Box 9225</td>
<td></td>
</tr>
<tr>
<td>Jackson, MS 39286</td>
<td></td>
</tr>
<tr>
<td><strong>North Carolina</strong></td>
<td>(704) 782-9600</td>
</tr>
<tr>
<td>Makisha Pressley-Callaham</td>
<td></td>
</tr>
<tr>
<td>P.O. Box 5323</td>
<td></td>
</tr>
<tr>
<td>Concord, NC 28027</td>
<td></td>
</tr>
<tr>
<td><strong>Out of Region C</strong></td>
<td>(803) 763-5170</td>
</tr>
<tr>
<td>Deidre Bibbs</td>
<td></td>
</tr>
<tr>
<td>P.O. Box 100141, AG-520</td>
<td></td>
</tr>
<tr>
<td>Columbia, SC 29202-3141</td>
<td></td>
</tr>
<tr>
<td><strong>Puerto Rico/Virgin Islands</strong></td>
<td>(787) 784-7390</td>
</tr>
<tr>
<td>Carmen Soto-Ortiz</td>
<td></td>
</tr>
<tr>
<td>PMB 256</td>
<td></td>
</tr>
<tr>
<td>1357 Ashford Ave.</td>
<td></td>
</tr>
<tr>
<td>San Juan, PR 00907-1420</td>
<td></td>
</tr>
<tr>
<td><strong>South Carolina</strong></td>
<td>(803) 763-5920</td>
</tr>
<tr>
<td>Elizabeth Ullman</td>
<td></td>
</tr>
<tr>
<td>P.O. Box 100141, AG-520</td>
<td></td>
</tr>
<tr>
<td>Columbia, SC 29202-3141</td>
<td></td>
</tr>
<tr>
<td><strong>Tennessee</strong></td>
<td>(615) 941-8797</td>
</tr>
<tr>
<td>Ronja F. Roland</td>
<td></td>
</tr>
<tr>
<td>5341 Mt. View Rd., Suite 122</td>
<td></td>
</tr>
<tr>
<td>Antioch, TN 37013</td>
<td></td>
</tr>
<tr>
<td><strong>Texas (south)</strong></td>
<td>(830) 980-7749</td>
</tr>
<tr>
<td>(covers the southern portion of Texas to include area codes 210, 254, 325, 361, 432, 512, 830, 915 and 956)</td>
<td></td>
</tr>
<tr>
<td>Dana Causey</td>
<td></td>
</tr>
<tr>
<td>PMB 604</td>
<td></td>
</tr>
<tr>
<td>20475 Highway 46 W, Suite 180</td>
<td></td>
</tr>
<tr>
<td>Spring Branch, TX 78070-6124</td>
<td></td>
</tr>
<tr>
<td><strong>Texas (north)</strong></td>
<td>(281) 416-9688</td>
</tr>
<tr>
<td>(covers the northern portion of Texas to include area codes 214, 281, 409, 469, 713, 806, 817, 832, 903, 936, 940, 972 and 979)</td>
<td></td>
</tr>
<tr>
<td>Peggy Miller</td>
<td></td>
</tr>
<tr>
<td>2601 Cartwright Rd., Suite D392</td>
<td></td>
</tr>
<tr>
<td>Missouri City, TX 77489</td>
<td></td>
</tr>
</tbody>
</table>

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![Palmetto GBA](https://example.com/palmetto-gba.png)

**Partners in Excellence**