Contents:

**CIGNA Government Services Articles**

2008 HCPCS Updates – New, Discontinued, and Verbiage Changes .................................................. 2
What Every Supplier Should Know… ................................................................................................... 6
Comprehensive Error Rate Testing (CERT) ....................................................................................... 6
DME MAC Jurisdiction C Redetermination Request Required Information ....................................... 6
Offset Details Information .................................................................................................................. 7
Medical Review Activities Transitioning from DME PSC to DME MAC ........................................... 8
Medicare Claims Returned as Unprocessable Due to Missing, Incomplete or Invalid NPI and/or NSC (PTAN). ....................................................................................................................... 8

**TrustSolutions, LLC (PSC) Articles**

Budesonide (Pulmicort) – Coverage and Coding ............................................................................. 9
TrustSolutions, LLC to Discontinue Voice Mail Telephone Line .......................................................... 9
Letter from TrustSolutions, LLC A Program Safeguard Contractor .................................................... 17

**CMS Medlearn Matters Articles**

Application of Administrative Simplification Compliance Act (ASCA) Enforcement Review Decisions Made by Other Medicare Contractors to the Same Providers When Selected for ASCA Review by the Railroad Medicare Carrier, Elimination of References to Claim Stat .................................................................................. 18
How to Handle the National Provider Identifier (NPI) for Ordering/Referring and Attending/Operating/Other/Service Facility for Medicare Claims .............................................................. 19
NCPDP Inbound Claim and COB Companion Documents Updated for NPI Reporting .......................... 20
Rejection of Electronic Claim Status Requests that Lack National Provider Identifiers (NPIs). ........ 21
Reasonable Charge Update for 2008 for Splints, Casts, Dialysis Supplies, Dialysis Equipment, and Certain Intraocular Lenses .............................................................................................................. 22
Revised Guidance for Completing Form CMS-1500 ............................................................................ 24
VMS Modifications to Implement the Common Electronic Data Interchange (CEDI) System ................. 24
Durable Medical Equipment Medicare Administrative Contractors (DME MACs) - Discontinuance/Cancellation of the Use of a “WL” Modifier on Claims for the DeWall Posture Protector Orthotic Body Jacket HCPCS Code (L0430) ........................................................................................................... 25
Items and Special Services Having Special DME Review Considerations ........................................ 26
Handling Personally Identifiable Information (PII) on the Medicare Summary Notice (MSN) .............. 26
Reporting a National Provider Identifier (NPI) and the “EY” Modifier on Claims for Durable Medical Equipment, Prosthetic, and Orthotic Supplies (DMEPOS) Items Dispensed without a Physician’s Order to Obtain a Medicare Denial for Coordination of Benefits (COB) ................................................................. 27
Update to Place of Service (POS) Code Set: New Code for Temporary Lodging .............................. 28
Crossover of Assignment of Benefits Indicator (CLM08) From Paper Claim Input ............................ 29
Remittance Advice Remark Code (RARC) and Claim Adjustment Reason Code (CARC) Update ........... 30
Fee Schedule Update for 2008 for Durable Medical Equipment, Prosthetics, Orthotics and Supplies .......................................................................................................................... 32
Nebulized Beta Adrenergic Agonist Therapy for Lung Diseases ......................................................... 34
Annual Update of Healthcare Common Procedure Codes System (HCPCS) Codes Used for Home Health Consolidated Billing Enforcement .......................................................... 35
Update to Medicare Deductible, Coinsurance and Premium Rates for 2008 ........................................ 36
January 2008 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files ........................................................................................................... 37
Skilled Nursing Facility Consolidated Billing and Preventive/Screening Services .............................. 40
An Overview of Medicare Covered Diabetes Supplies and Services .................................................. 42
Special “Skilled Nursing Facility” (SNF) Definition Used in Determining Durable Medical Equipment (DME) Coverage, and in Ending a Benefit Period or “Spell of Illness” .............................................. 46
Individuals Authorized Access to CMS Computer Services - Provider Community (IACS-PC): THE FIRST IN A SERIES OF ARTICLES 2007 - 2008 Influenza (Flu) Season Resources for Health Care Professionals .................................................................................................................. 53
Centers for Medicare & Medicaid Services (CMS) Seeks Provider Input on Satisfaction with Medicare Fee-for-Service Contractor Services ............................................................................................................. 55
Clarification on the National Provider Identifier (NPI) Enumerator’s Responsibilities ....................... 56
Medicare Provides Coverage for Many Preventive Services and Screenings ........................................ 58
Individuals Authorized Access to CMS Computer Services - Provider Community (IACS-PC): THE SECOND IN A SERIES OF ARTICLES ON THE IACS PC .................................................................................. 61
Individuals Authorized Access to CMS Computer Services - Provider Community (IACS-PC): THE THIRD IN A SERIES OF ARTICLES ON THE IACS-PC ............................................................................... 63
DME MAC Jurisdiction C Contact Information ................................................................................... 66
Maximizing your Reimbursement Medicare Workshop ......................................................................... 67
DME MAC Jurisdiction C Interactive Voice Response (IVR) System ................................................... 68
## 2008 HCPCS Updates – New, Discontinued, and Verbiage Changes

### New HCPCS Codes

The following new codes are effective for dates of service on or after January 1, 2008. If billed before January 1, 2008, the code will be returned as unprocessable or denied as an invalid code. The appearance of a HCPCS code in the list below does not necessarily indicate coverage.

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A4252</td>
<td>BLOOD KETONE TEST OR REAGENT STRIP, EACH</td>
</tr>
<tr>
<td>A5083</td>
<td>CONTINENT DEVICE, STOMA ABSORPTIVE COVER FOR CONTINENT STOMA</td>
</tr>
<tr>
<td>A6413</td>
<td>ADHESIVE BANDAGE, FIRST-AID TYPE, ANY SIZE, EACH</td>
</tr>
<tr>
<td>A7027</td>
<td>COMBINATION ORAL/NOSE/NOSE MASK, USED WITH CONTINUOUS POSITIVE AIRWAY PRESSURE DEVICE, EACH</td>
</tr>
<tr>
<td>A7028</td>
<td>ORAL CUSHION FOR COMBINATION ORAL/NOSE/NOSE MASK, REPLACEMENT ONLY, EACH</td>
</tr>
<tr>
<td>A7029</td>
<td>NASAL PILLOWS FOR COMBINATION ORAL/NOSE/NOSE MASK, REPLACEMENT ONLY, PAIR</td>
</tr>
<tr>
<td>A9274</td>
<td>EXTERNAL AMBULATORY INSULIN DELIVERY SYSTEM, DISPOSABLE, EACH, INCLUDES ALL SUPPLIES AND ACCESSORIES</td>
</tr>
<tr>
<td>A9276</td>
<td>SENSOR; INVASIVE (E.G. SUBCUTANEOUS), DISPOSABLE, FOR USE WITH INTERSTITIAL CONTINUOUS GLUCOSE MONITORING SYSTEM, ONE UNIT = 1 DAY SUPPLY</td>
</tr>
<tr>
<td>A9277</td>
<td>TRANSMITTER; EXTERNAL, FOR USE WITH INTERSTITIAL CONTINUOUS GLUCOSE MONITORING SYSTEM</td>
</tr>
<tr>
<td>A9278</td>
<td>RECEIVER (MONITOR); EXTERNAL, FOR USE WITH INTERSTITIAL CONTINUOUS GLUCOSE MONITORING SYSTEM</td>
</tr>
<tr>
<td>A9283</td>
<td>FOOT PRESSURE OFF LOADING/SUPPORTIVE DEVICE, ANY TYPE, EACH</td>
</tr>
<tr>
<td>B4087</td>
<td>GASTROSTOMY/JEJUNOSTOMY TUBE, STANDARD, ANY MATERIAL, ANY TYPE, EACH</td>
</tr>
<tr>
<td>B4088</td>
<td>GASTROSTOMY/JEJUNOSTOMY TUBE, LOW-PERF, ANY MATERIAL, ANY TYPE, EACH</td>
</tr>
<tr>
<td>E0328</td>
<td>HOSPITAL BED, PEDIATRIC, MAN halves, 360 DEGREE SIDE ENCLOSURES, TOP OF HEADBOARD, FOOTBOARD AND SIDE RAILS UP TO 24 INCHES ABOVE THE SPRING, INCLUDES MATTRESS</td>
</tr>
<tr>
<td>E0329</td>
<td>HOSPITAL BED, PEDIATRIC, ELECTRIC OR SEMI-ELECTRIC, 360 DEGREE SIDE ENCLOSURES, TOP OF HEADBOARD, FOOTBOARD AND SIDE RAILS UP TO 24 INCHES ABOVE THE SPRING, INCLUDES MATTRESS</td>
</tr>
<tr>
<td>E0856</td>
<td>CERVICAL TRACTION DEVICE, CERVICAL COLLAR WITH INFLATABLE AIR BLADDER</td>
</tr>
<tr>
<td>E2227</td>
<td>MANUAL WHEELCHAIR ACCESSORY, GEAR REDUCTION DRIVE WHEEL, EACH</td>
</tr>
<tr>
<td>E2228</td>
<td>MANUAL WHEELCHAIR ACCESSORY, WHEEL BRAKING SYSTEM AND LOCK, COMPLETE, EACH</td>
</tr>
<tr>
<td>E2312</td>
<td>POWER WHEELCHAIR ACCESSORY, HAND OR CHIN CONTROL INTERFACE, MINI-PROPORTIONAL REMOTE JOYSTICK, PROPORTIONAL, INCLUDING FIXED MOUNTING HARDWARE</td>
</tr>
<tr>
<td>E2313</td>
<td>POWER WHEELCHAIR ACCESSORY, HARNESS FOR UPGRADE TO EXPANDABLE CONTROLLER, INCLUDING ALL FASTENERS, CONNECTORS AND MOUNTING HARDWARE, EACH</td>
</tr>
<tr>
<td>E2397</td>
<td>POWER WHEELCHAIR ACCESSORY, LITHIUM-BASED BATTERY, EACH</td>
</tr>
<tr>
<td>J0220</td>
<td>INJECTION, AGLUCOSIDASE ALFA, 10 MG</td>
</tr>
<tr>
<td>J0400</td>
<td>INJECTION, ARIPIPRAZOLE, INTRAMUSCULAR, 0.25 MG</td>
</tr>
<tr>
<td>J1300</td>
<td>INJECTION, ECUULIZUMAB, 10 MG</td>
</tr>
<tr>
<td>J1561</td>
<td>INJECTION, IMMUNE GLOBULIN, (GAMUNEX), INTRAVENOUS, NON-LYOPHILIZED (E.G. LIQUID), 500 MG</td>
</tr>
<tr>
<td>J1568</td>
<td>INJECTION, IMMUNE GLOBULIN, (OCTAGAM), INTRAVENOUS, NON-LYOPHILIZED (E.G. LIQUID), 500 MG</td>
</tr>
<tr>
<td>J1569</td>
<td>INJECTION, IMMUNE GLOBULIN, (GAMMAGARD LIQUID), INTRAVENOUS, NON-LYOPHILIZED, (E.G. LIQUID), 500 MG</td>
</tr>
<tr>
<td>J1571</td>
<td>INJECTION, HEPATITIS B IMMUNE GLOBULIN (HEPAGAM B), INTRAMUSCULAR, 0.5 ML</td>
</tr>
<tr>
<td>J1572</td>
<td>INJECTION, IMMUNE GLOBULIN, (FLEBOGAMMA), INTRAVENOUS, NON-LYOPHILIZED (E.G. LIQUID), 500 MG</td>
</tr>
<tr>
<td>J1573</td>
<td>INJECTION, HEPATITIS B IMMUNE GLOBULIN (HEPAGAM B), INTRAVENOUS, 0.5 ML</td>
</tr>
<tr>
<td>J1743</td>
<td>INJECTION, IDURSULFASE, 1 MG</td>
</tr>
<tr>
<td>J2323</td>
<td>INJECTION, NATALIZUMAB, 1 MG</td>
</tr>
<tr>
<td>J2724</td>
<td>INJECTION, PROTEIN C CONCENTRATE, INTRAVENOUS, HUMAN, 10 IU</td>
</tr>
<tr>
<td>HCPCS Code</td>
<td>Description</td>
</tr>
<tr>
<td>------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>J2778</td>
<td>INJECTION, RANIBIZUMAB, 0.1 MG</td>
</tr>
<tr>
<td>J2791</td>
<td>INJECTION, RHOTROPIC IMMUNE GLOBULIN (HUMAN), RHOPHYLAC, INTRAMUSCULAR OR INTRAVENOUS, 100 IU</td>
</tr>
<tr>
<td>J3488</td>
<td>INJECTION, ZOLEDRONIC ACID (RECLAST), 1 MG</td>
</tr>
<tr>
<td>J7307</td>
<td>ETONOGESTREL (CONTRACEPTIVE) IMPLANT SYSTEM, INCLUDING IMPLANT AND SUPPLIES</td>
</tr>
<tr>
<td>J7321</td>
<td>HYALURONAN OR DERIVATIVE, HYALGAN OR SUPARTZ, FOR INTRA-ARTICULAR INJECTION, PER DOSE</td>
</tr>
<tr>
<td>J7322</td>
<td>HYALURONAN OR DERIVATIVE, SYNVISC, FOR INTRA-ARTICULAR INJECTION, PER DOSE</td>
</tr>
<tr>
<td>J7323</td>
<td>HYALURONAN OR DERIVATIVE, EUFLEXA, FOR INTRA-ARTICULAR INJECTION, PER DOSE</td>
</tr>
<tr>
<td>J7324</td>
<td>HYALURONAN OR DERIVATIVE, ORTHOVISC, FOR INTRA-ARTICULAR INJECTION, PER DOSE</td>
</tr>
<tr>
<td>J7347</td>
<td>DERMAL (SUBSTITUTE) TISSUE OF NONHUMAN ORIGIN, WITH OR WITHOUT OTHER BIOENGINEERED OR PROCESSED ELEMENTS, WITHOUT METABOLICALLY ACTIVE ELEMENTS (INTEGRA MATRIX), PER SQUARE CENTIMETER</td>
</tr>
<tr>
<td>J7348</td>
<td>DERMAL (SUBSTITUTE) TISSUE OF NONHUMAN ORIGIN, WITH OR WITHOUT OTHER BIOENGINEERED OR PROCESSED ELEMENTS, WITHOUT METABOLICALLY ACTIVE ELEMENTS (TISSUEMEND), PER SQUARE CENTIMETER</td>
</tr>
<tr>
<td>J7349</td>
<td>DERMAL (SUBSTITUTE) TISSUE OF NONHUMAN ORIGIN, WITH OR WITHOUT OTHER BIOENGINEERED OR PROCESSED ELEMENTS, WITHOUT METABOLICALLY ACTIVE ELEMENTS (PRIMATRIX), PER SQUARE CENTIMETER</td>
</tr>
<tr>
<td>J7602</td>
<td>ALBUTEROL, ALL FORMULATIONS INCLUDING SEPARATED ISOMERS, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, CONCENTRATED FORM, PER 1 MG (ALBUTEROL) OR PER 0.5 MG (LEVALBUTEROL)</td>
</tr>
<tr>
<td>J7603</td>
<td>ALBUTEROL, ALL FORMULATIONS INCLUDING SEPARATED ISOMERS, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, UNIT DOSE, PER 1 MG (ALBUTEROL) OR PER 0.5 MG (LEVALBUTEROL)</td>
</tr>
<tr>
<td>J7604</td>
<td>ACETYLCYSTEINE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER GRAM</td>
</tr>
<tr>
<td>J7605</td>
<td>ARFORMOTEROL, INHALATION SOLUTION, FDA APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, UNIT DOSE FORM, 15 MICROGRAMS</td>
</tr>
<tr>
<td>J7632</td>
<td>CROMOLYN SODIUM, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER 10 MILLIGRAMS</td>
</tr>
<tr>
<td>J7676</td>
<td>PENTAMIDINE ISETHIONATE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER 300 MG</td>
</tr>
<tr>
<td>J9226</td>
<td>HISTRELIN IMPLANT (SUPPRELIN LA), 50 MG</td>
</tr>
<tr>
<td>J9303</td>
<td>INJECTION, PANITUMUMAB, 10 MG</td>
</tr>
<tr>
<td>L3925</td>
<td>FINGER ORTHOSIS, PROXIMAL INTERPHALANGEAL (PIP)/DISTAL INTERPHALANGEAL (DIP), NON-TORSION JOINT/SPRING, EXTENSION/FLEXION, MAY INCLUDE SOFT INTERFACE MATERIAL, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT</td>
</tr>
<tr>
<td>L3927</td>
<td>FINGER ORTHOSIS, PROXIMAL INTERPHALANGEAL (PIP)/DISTAL INTERPHALANGEAL (DIP), WITHOUT JOINT/SPRING, EXTENSION/FLEXION (E.G. STATIC OR RING TYPE), MAY INCLUDE SOFT INTERFACE MATERIAL, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT</td>
</tr>
<tr>
<td>L3929</td>
<td>HAND FINGER ORTHOSIS, INCLUDES ONE OR MORE NONTORSION JOINT(S), TURNBUCKLES, ELASTIC BANDS/SPRINGS, MAY INCLUDE SOFT INTERFACE MATERIAL, STRAPS, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT</td>
</tr>
<tr>
<td>L3931</td>
<td>WRIST HAND FINGER ORTHOSIS, INCLUDES ONE OR MORE NONTORSION JOINT(S), TURNBUCKLES, ELASTIC BANDS/SPRINGS, MAY INCLUDE SOFT INTERFACE MATERIAL, STRAPS, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT</td>
</tr>
<tr>
<td>L7611</td>
<td>TERMINAL DEVICE, HOOK, MECHANICAL, VOLUNTARY OPENING, ANY MATERIAL, ANY SIZE, LINED OR UNLINED, PEDIATRIC</td>
</tr>
<tr>
<td>L7612</td>
<td>TERMINAL DEVICE, HOOK, MECHANICAL, VOLUNTARY CLOSING, ANY MATERIAL, ANY SIZE, LINED OR UNLINED, PEDIATRIC</td>
</tr>
<tr>
<td>L7613</td>
<td>TERMINAL DEVICE, HAND, MECHANICAL, VOLUNTARY OPENING, ANY MATERIAL, ANY SIZE, PEDIATRIC</td>
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<tr>
<td>L7614</td>
<td>TERMINAL DEVICE, HAND, MECHANICAL, VOLUNTARY CLOSING, ANY MATERIAL, ANY SIZE, PEDIATRIC</td>
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<tr>
<td>L7621</td>
<td>TERMINAL DEVICE, HOOK OR HAND, HEAVY DUTY, MECHANICAL, VOLUNTARY OPENING, ANY MATERIAL, ANY SIZE, LINED OR UNLINED</td>
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<tr>
<td>L7622</td>
<td>TERMINAL DEVICE, HOOK OR HAND, HEAVY DUTY, MECHANICAL, VOLUNTARY CLOSING, ANY MATERIAL, ANY SIZE, LINED OR UNLINED</td>
</tr>
</tbody>
</table>
### Discontinued Codes With Replacement Crosswalk HCPCS Codes

The following codes will be deleted effective for dates of service on or after January 1, 2008. There is no grace period for the deletions, therefore, if these codes are billed on or after January 1, 2008, they will be returned as unprocessable or denied as an invalid code.

<table>
<thead>
<tr>
<th>Discontinued HCPCS Code</th>
<th>Replacement Crosswalk Code(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>B4086</td>
<td>B4087 or B4088</td>
</tr>
<tr>
<td>J7345</td>
<td>J7347, J7348, or J7349</td>
</tr>
<tr>
<td>K0553</td>
<td>A7027</td>
</tr>
<tr>
<td>K0554</td>
<td>A7028</td>
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<td>K0555</td>
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<td>Q4094</td>
<td>J7603</td>
</tr>
<tr>
<td>Q4095</td>
<td>J3488</td>
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### Discontinued Codes Without Replacement Codes

<table>
<thead>
<tr>
<th>Discontinued HCPCS Code</th>
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<tr>
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<tr>
<td>L3855</td>
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<tr>
<td>L3860</td>
</tr>
</tbody>
</table>

### Verbiage Changes for 2008

The following list contains HCPCS codes for which verbiage will be changed effective January 1, 2008.

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>New Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A4206</td>
<td>SYRINGE WITH NEEDLE, STERILE, 1 CC OR LESS, EACH</td>
</tr>
<tr>
<td>A5105</td>
<td>URINARY SUSPENSORY WITH LEG BAG, WITH OR WITHOUT TUBE, EACH</td>
</tr>
<tr>
<td>B4034</td>
<td>ENTERAL FEEDING SUPPLY KIT, SYRINGE FED, PER DAY</td>
</tr>
<tr>
<td>E0604</td>
<td>BREAST PUMP, HOSPITAL GRADE, ELECTRIC (AC AND / OR DC), ANY TYPE</td>
</tr>
<tr>
<td>E0630</td>
<td>PATIENT LIFT, HYDRAULIC OR MECHANICAL, INCLUDES ANY SEAT, SLING, STRAP(S) OR PAD(S)</td>
</tr>
<tr>
<td>E0705</td>
<td>TRANSFER DEVICE, ANY TYPE, EACH</td>
</tr>
<tr>
<td>E1801</td>
<td>STATIC PROGRESSIVE STRETCH ELBOW DEVICE, EXTENSION AND/OR FLEXION, WITH OR WITHOUT RANGE OF MOTION ADJUSTMENT, INCLUDES ALL COMPONENTS AND ACCESSORIES</td>
</tr>
<tr>
<td>E1806</td>
<td>STATIC PROGRESSIVE STRETCH WRIST DEVICE, FLEXION AND/OR EXTENSION, WITH OR WITHOUT RANGE OF MOTION ADJUSTMENT, INCLUDES ALL COMPONENTS AND ACCESSORIES</td>
</tr>
<tr>
<td>E1811</td>
<td>STATIC PROGRESSIVE STRETCH KNEE DEVICE, EXTENSION AND/OR FLEXION, WITH OR WITHOUT RANGE OF MOTION ADJUSTMENT, INCLUDES ALL COMPONENTS AND ACCESSORIES</td>
</tr>
<tr>
<td>E1816</td>
<td>STATIC PROGRESSIVE STRETCH ANKLE DEVICE, FLEXION AND/OR EXTENSION, WITH OR WITHOUT RANGE OF MOTION ADJUSTMENT, INCLUDES ALL COMPONENTS AND ACCESSORIES</td>
</tr>
<tr>
<td>E1818</td>
<td>STATIC PROGRESSIVE STRETCH FOREARM PRONATION / SUPINATION DEVICE, WITH OR WITHOUT RANGE OF MOTION ADJUSTMENT, INCLUDES ALL COMPONENTS AND ACCESSORIES</td>
</tr>
</tbody>
</table>
### HCPCS Code | New Description
--- | ---
E1841 | STATIC PROGRESSIVE STRETCH SHOULDER DEVICE, WITH OR WITHOUT RANGE OF MOTION ADJUSTMENT, INCLUDES ALL COMPONENTS AND ACCESSORIES
E2205 | MANUAL WHEELCHAIR ACCESSORY, HANDRIM WITHOUT PROJECTIONS (INCLUDES ERGONOMIC OR CONTOURED), ANY TYPE, REPLACEMENT ONLY, EACH
E2373 | POWER WHEELCHAIR ACCESSORY, HAND OR CHIN CONTROL INTERFACE, COMPACT REMOTE JOYSTICK, PROPORTIONAL, INCLUDING FIXED MOUNTING HARDWARE
J0702 | INJECTION, BETAMETHASONE ACETATE 3MG AND BETAMETHASONE SODIUM PHOSPHATE 3MG
J1562 | INJECTION, IMMUNE GLOBULIN (VIVAGLOBIN), 100 MG
J1566 | INJECTION, IMMUNE GLOBULIN, INTRAVENOUS, LYOPHILIZED (E.G. POWDER), NOT OTHERWISE SPECIFIED, 500 MG
J2545 | PENTAMIDINE ISETHONATE, INTRAVENOUS SOLUTION, FDA-APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER 300 MG
J3487 | INJECTION, ZOLEDRONIC ACID (ZOMETA), 1 MG
J7187 | INJECTION, VON WILLEBRAND FACTOR COMPLEX (HUMATE-P), PER IU VWF:RCO
J7608 | ACETYLCYSTEINE, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER GRAM
J7631 | CROMOLYN SODIUM, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER 10 MILLIGRAMS
J7639 | DORNASE ALPHA, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM
J9225 | HISTRELIN IMPLANT (VANTAS), 50 MG
L3806 | WRIST HAND FINGER ORTHOSIS, INCLUDES ONE OR MORE NONTORSION JOINT(S), TURNBUCKLES, ELASTIC BANDS/SPRINGS, MAY INCLUDE SOFT INTERFACE MATERIAL, STRAPS, CUSTOM FABRICATED, INCLUDES FITTING AND ADJUSTMENT
L7360 | SIX VOLT BATTERY, EACH
L7362 | BATTERY CHARGER, SIX VOLT, EACH
L7364 | TWELVE VOLT BATTERY, EACH
L7366 | BATTERY CHARGER, TWELVE VOLT, EACH
Q4080 | ILOPROST, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, UNIT DOSE FORM, 20 MICROGRAMS

### New Modifiers for 2008
The following new modifiers are effective January 1, 2008.

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>EA</td>
<td>ERYTHROPOETIC STIMULATING AGENT (ESA) ADMINISTERED TO TREAT ANEMIA DUE TO ANTI-CANCER CHEMOTHERAPY</td>
</tr>
<tr>
<td>EB</td>
<td>ERYTHROPOETIC STIMULATING AGENT (ESA) ADMINISTERED TO TREAT ANEMIA DUE TO ANTI-CANCER RADIOTHERAPY</td>
</tr>
<tr>
<td>EC</td>
<td>ERYTHROPOETIC STIMULATING AGENT (ESA) ADMINISTERED TO TREAT ANEMIA NOT DUE TO ANTI-CANCER RADIOTHERAPY OR ANTI-CANCER CHEMOTHERAPY</td>
</tr>
<tr>
<td>ED</td>
<td>HEMATOCRIT LEVEL HAS EXCEEDED 39% (OR HEMOGLOBIN LEVEL HAS EXCEEDED 13.0 G/DL) FOR 3 OR MORE CONSECUTIVE BILLING CYCLES IMMEDIATELY PRIOR TO AND INCLUDING THE CURRENT CYCLE</td>
</tr>
<tr>
<td>EE</td>
<td>HEMATOCRIT LEVEL HAS NOT EXCEEDED 39% (OR HEMOGLOBIN LEVEL HAS NOT EXCEEDED 13.0 G/DL) FOR 3 OR MORE CONSECUTIVE BILLING CYCLES IMMEDIATELY PRIOR TO AND INCLUDING THE CURRENT CYCLE</td>
</tr>
<tr>
<td>FC</td>
<td>PARTIAL CREDIT RECEIVED FOR REPLACED DEVICE</td>
</tr>
<tr>
<td>GD</td>
<td>UNITS OF SERVICE EXCEEDS MEDICALLY UNLIKELY EDIT VALUE AND REPRESENTS REASONABLE AND NECESSARY SERVICES</td>
</tr>
<tr>
<td>KV</td>
<td>DMEPOS ITEM SUBJECT TO DMEPOS COMPETITIVE BIDDING PROGRAM THAT IS FURNISHED AS PART OF A PROFESSIONAL SERVICE</td>
</tr>
<tr>
<td>KW</td>
<td>DMEPOS ITEM SUBJECT TO DMEPOS COMPETITIVE BIDDING PROGRAM NUMBER 4</td>
</tr>
<tr>
<td>KY</td>
<td>DMEPOS ITEM SUBJECT TO DMEPOS COMPETITIVE BIDDING PROGRAM NUMBER 5</td>
</tr>
<tr>
<td>Q0</td>
<td>INVESTIGATIONAL CLINICAL SERVICE PROVIDED IN A CLINICAL RESEARCH STUDY THAT IS IN AN APPROVED CLINICAL RESEARCH STUDY</td>
</tr>
<tr>
<td>Q1</td>
<td>ROUTINE CLINICAL SERVICE PROVIDED IN A CLINICAL RESEARCH STUDY THAT IS IN AN APPROVED CLINICAL RESEARCH STUDY</td>
</tr>
</tbody>
</table>
Modifiers Deleted for 2008
The following modifiers will be deleted effective for dates of service on or after January 1, 2008.

QA  QR  QV

Modifier Verbiage Changes for 2008
The following list contains modifiers for which verbiage will be changed effective January 1, 2008.

<table>
<thead>
<tr>
<th>MODIFIER</th>
<th>NEW DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>FB</td>
<td>ITEM PROVIDED WITHOUT COST TO PROVIDER, SUPPLIER OR PRACTITIONER, OR FULL CREDIT RECEIVED FOR REPLACED DEVICE (EXAMPLES, BUT NOT LIMITED TO, COVERED UNDER WARRANTY, REPLACED DUE TO DEFECT, FREE SAMPLES)</td>
</tr>
<tr>
<td>GK</td>
<td>REASONABLE AND NECESSARY ITEM/SERVICE ASSOCIATED WITH A GA OR GZ MODIFIER</td>
</tr>
<tr>
<td>GL</td>
<td>MEDICALLY UNNECESSARY UPGRADE PROVIDED INSTEAD OF NON-UPGRADED ITEM, NO CHARGE, NO ADVANCE BENEFICIARY NOTICE (ABN)</td>
</tr>
<tr>
<td>GY</td>
<td>ITEM OR SERVICE STATUTORILY EXCLUDED, DOES NOT MEET THE DEFINITION OF ANY MEDICARE BENEFIT OR, FOR NON-MEDICARE INSURERS, IS NOT A CONTRACT BENEFIT</td>
</tr>
</tbody>
</table>

What Every Supplier Should Know . . . Comprehensive Error Rate Testing (CERT)
The Centers for Medicare and Medicaid Services (CMS) implemented a process for measuring claim error rates at the national, contractor, and service-specific levels; this process is called CERT (Comprehensive Error Rate Testing). Participation in this process is important to CMS, Medicare Contractors, and all Medicare suppliers. There are two contractors hired by CMS to perform the CERT process, the CERT Documentation Contractor (CDC) and the CERT Review Contractor (CRC). The CDC is responsible for requesting and collecting the required medical record documentation from providers. The CRC is responsible for reviewing selected claims and associated documentation.

CERT is a random audit of Medicare contractors' accuracy of processing medical claims. In order to measure the accuracy of Medicare claims, it is necessary for the CDC to request documentation from identified suppliers to review the appropriateness of claims adjudication. Any errors identified are reported to the contractor for correction. It is imperative for suppliers to respond to the CDC if a documentation request is received. To ensure that the request letters are submitted to the appropriate address, please review the CDC's Provider Address Directory to make any necessary address changes. To submit requested documentation to the CDC, it is preferred that providers fax legible copies of documentation to 240.568.6222; please include the bar code page from the original documentation request as the cover sheet for the fax. Documentation may also be submitted via mail to:

CERT Documentation Office
Attn: CID # (include the request ID from the documentation request)
9090 Junction Dr., Suite 9
Annapolis, MD 20701

Non-responses and incomplete documentation will cause refund requests for the claims in question and increases possibility of future expanded audits. Providing medical documentation to the CERT contractor is compliant with Health Insurance Portability and Accountability Act (HIPAA). If additional time to collect data is needed, please contact the CDC as soon as possible to avoid receiving a non-response error. Extension requests may be faxed to 301.957.2380. If documentation has been destroyed in a natural or manmade disaster, a Disaster Attestation form may be completed and submitted with explanation of why the documentation is not accessible.

For additional CERT information please review the following Web sites:
- CERT Contractor Information
  http://www.certcdc.com/certproviderportal/
- CERT Overview
- CERT Newsletter
- Sample CERT Letters
- Provider Address Directory
- Disaster Attestation Letter

CIGNA Government Services CERT information:
http://www.cignagovernmentservices.com/jc/claims/cert
- CERT Process Overview
- HIPAA
- CERT Sample Letters
- Physician Documentation Letter Request

CMS CERT information:
http://www.cms.hhs.com/cert
- CERT Overview
- CERT Reports

DME MAC Jurisdiction C Redetermination Request Required Information
All Redetermination requests must contain the following information:
- The printed name (including the last name) and signature of the person filing the request
- The beneficiary’s name
- The Medicare health insurance claim number of the beneficiary
The specific service(s) and/or item(s) for which the redetermination is being requested and the specific date(s) of service

We are aware that the Redetermination Request Form used by the previous contractor did not contain all of the elements required by CMS for a Redetermination request, specifically the signature of the person filing the request. Therefore, the requirement for this element will be temporarily suspended until February 29, 2008. We will no longer dismiss cases currently in our inventory for lack of a signature.

Effective March 1, 2008, all Redetermination requests received by CIGNA Government Services that do not contain all of the required elements will be dismissed with an explanation of the missing information. Suppliers will be instructed to resubmit the request and include all missing elements in order to have their case considered for a Redetermination. Incomplete requests that are resubmitted for appeal must be submitted within the 120-day timely filing limit. Incomplete requests that are resubmitted past the 120-day timely filing limit will be dismissed.

You may request a Redetermination by submitting a completed Medicare DME MAC Jurisdiction C Redetermination Request Form (http://www.cignagovernmentservices.com/jc/forms/pdf/JC_redetermination_form.pdf) or a CMS-20027 (05/05) form, which may be obtained online at: http://www.cms.hhs.gov/cmsforms/downloads/CMS20027.pdf. (A supply of the CMS-20027 form can be ordered by writing to Superintendent of Documents, United States Government Printing Office, Washington, DC, 20402.) Additional information that the supplier wishes to be considered during the Redetermination should be mailed with the written Redetermination request. Redetermination requests should be mailed to:

CIGNA Government Services
DME MAC Jurisdiction C
PO Box 20009, Nashville, TN 37202

Redetermination Fully Favorable Appeal Reversals Notification

CIGNA Government Services has been notified by CMS that DME MACs are no longer required to mail or otherwise transmit written notices on fully favorable appeal reversals. The supplier’s receipt of Remittance Advices and beneficiary receipts of MSNs will suffice as notice of the reversal.

If you have any questions, please contact Customer Service at 1.866.270.4909.

Offset Details Information

This publication will provide a general overview of two of the most common forms utilized by the Overpayment Recovery Department. The offset request form is used to request immediate offset for overpayments Medicare has requested. The Medicare DME MAC Jurisdiction C – reopening request form is used to request adjustments to a claim that has been identified as paid incorrectly.

When you receive a demand letter, the offset request form is a useful tool for requesting an overpayment be placed in immediate offset. It can be found on the DME MAC Jurisdiction C Forms page located at: http://www.cignagovernmentservices.com.

When completed properly, this form assists the Overpayment Recovery Analyst with processing the request more efficiently. Remember to:

- Include all documentation relevant to the overpayment with the Offset Request Form submission.
- Include a copy of the first page of the demand letter.
- Complete all requested information on the form.
- Submit and attach a separate form for each overpayment to be offset.
- Fax request to: 1.615.782.4477.

Offset detail can be tracked with the information provided on the Medicare Remittance Notice (MRN). The offset detail indicate if the claim was offset (OF) or adjusted (AJ). Other details can be found in the Glossary listed below the offset detail on the MRN. If the claim is offset, a number will be listed in the Financial Control Number (FCN) column. This number is used to match the MRN to the corresponding overpayment letter previously received. The FCN is located in the lower right hand corner of the overpayment letter. The Amount field details the dollars offset or adjusted depending on the indicator in the Offset Detail column. If the claim is offset, the amount is the difference between the Total Provider Paid column and the Amount of Check column minus any adjustments involved.

The Medicare DME MAC Jurisdiction C – reopening request form is used for requesting a claim correction. It can be found on the DME MAC Jurisdiction C Forms page located at: http://www.cignagovernmentservices.com.

This form should be used to request simple, clerical-level corrections that need to be made to a claim, and also to request an adjustment to correct an overpayment. Simple, clerical-level corrections may include, but are not limited to, corrections to the number of services, incorrect modifiers, and changes in date of service, gender, place of service, etc.
If you are requesting an adjustment to correct an overpayment, please be sure to include the amount of overpayment and to provide a clear reason for the refund. You can also select the immediate offset box to initiate a request for immediate offset of an overpayment.

When filling out this form, be sure to complete all applicable fields:

- Include a copy of your Remittance Advice with all corrections submitted.
- Place an asterisk or star next to the beneficiary’s name on the Remittance Advise to identify which beneficiary’s payment is being corrected. Do not use highlighters because they do not appear on scanned images, resulting in processing delays.
- Complete all requested information on form.
- Include overpayment amount to be requested.
- Send any supporting documentation that will assist with corrections.
- Make sure to include the reason for the request.

For simple corrections that do not require additional documentation, feel free to contact our Telephone Re-opening line: 1-866-813-7878.

Medical Review Activities Transitioning from DME PSC to DME MAC

Medical review activities (not in support of Benefit Integrity) and medical policy work will transition to the DME MACs effective March 1, 2008. Since early 2006, the Program Safeguard Contractors (PSCs) have been performing all medical review activities for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS). The Centers for Medicare & Medicaid Services (CMS) now has decided to transfer the responsibilities for traditional medical review activities to the DME MACs.

Suppliers should note the following changes effective March 1, 2008 for Jurisdiction C:

- All requests for Advance Determination of Medicare Coverage (ADMC) should be submitted to CIGNA Government Services (CGS). Clearly indicate “ADMC” on the first page of all requests. Submit your requests in writing or by fax to:

  CIGNA Government Services
  Attn: ADMC
  PO Box 20010, Nashville, TN 37202
  FAX: 1.615.782.4647

- Both CGS and TrustSolutions, LLC will send requests for medical records and documentation. Pay special attention to the request letter to determine where your response should be submitted. Send your response to the office specified in the letter.

Following is additional information about the transition:

- CGS will perform Jurisdiction C medical review activities (not in support of Benefit Integrity) starting March 1, 2008. These activities include: ADMC, prepay claims processing, and probe reviews. The focus for medical review is to reduce the fee for service payment error rate.
- The Medical Director functions, including development and revision of Local Coverage Determinations, have also been moved to the DME MACs. CIGNA Government Services is pleased to announce that Robert Hoover, MD returned as the Jurisdiction C Medical Director effective March 1st. Dr. Hoover was the former Medical Director at CGS for DMERC Region D.
- TrustSolutions, LLC, the Jurisdiction C PSC, will continue to perform medical review in support of Benefit Integrity (BI). The focus of BI activities is to detect and prevent fraud, waste, and abuse in the Medicare program.

Please refer to the CIGNA Government Services Web site at: http://www.cignagovernmentservices.com for further details regarding this transition.

Medicare Claims Returned as Unprocessable Due to Missing, Incomplete or Invalid NPI and/or NSC (PTAN)

CIGNA Government Services has identified an increase in claims being submitted with incomplete or invalid information in Block 33. Since the advent of the NPI the process for completing the CMS 1500 (08/05) form has changed, which has resulted in a number of claims being returned as unprocessable. Previously block 33 was for the purpose of supplier number only. The block is now differentiated into block 33A and 33B. To avoid claims being returned as unprocessable, please adhere to the following.

The 10 digit National Provider Identifier (NPI) must be entered in block 33A. The 10 digit National Supplier Clearinghouse (NSC) number (also referred to as PTAN), must be entered in block 33B. The ID qualifier “1C” is not required when submitting the claim in paper form. Claims will be returned if the NPI or NSC number is not in the appropriate block on the claim form or, if either of these numbers is incomplete or invalid.
When an NPI and an NSC number (also referred to as PTAN) are both submitted, there must be a valid match on the crosswalk. Claims will be returned as unprocessable if a valid match is not found on the crosswalk.

Suppliers should verify their information in the National Plan and Provider Enumerator System (NPPES) and the National Suppliers Clearinghouse (NSC) to prevent delays in claims processing and possible claim rejections.

**TrustSolutions, LLC (PSC) Articles**

**Budesonide (Pulmicort) – Coverage and Coding**

Pulmicort Respules (budesonide) (J7626) is the only FDA-approved corticosteroid inhalation solution. Utilization guidelines for budesonide were included in the revised Nebulizers LCD which was effective for claims with dates of service on or after July 1, 2007. Those guidelines specified a maximum of 62 units of service per month – 2 units of service per day.

Pulmicort Respules is available in unit dose vials containing 0.25 mg, 0.5 mg, and 1.0 mg of budesonide. The unit of service for code J7626 is "up to 0.5 mg". Therefore, the following guidelines apply to billing unit dose vials of budesonide:

- 0.25 mg vial = 1 unit of service
- 0.5 mg vial = 1 unit of service
- 1.0 mg vial = 2 units of service

According to the package insert, the highest recommended dose of budesonide is 1 mg per day administered as either a single inhalation dose or as 0.5 mg twice daily. There is no medical advantage to administering budesonide as 0.25 mg four times per day. There is also no proven medical benefit to administering budesonide in doses greater than 1 mg per day. Therefore, coverage of FDA-approved unit dose formulations of budesonide (J7626) is limited to 2 units of service per day.

TrustSolutions, the Jurisdiction C DME PSC, is focusing review activities on suppliers billing excess quantities of budesonide (J7626).

Compounded formulations of budesonide – unit dose form (J7627) and concentrated form (J7634) – are denied as not medically necessary.

**TrustSolutions, LLC to Discontinue Voice Mail Telephone Line**

Effective December 1, 2007, TrustSolutions, LLC, the DME Jurisdiction C Program Safeguards Contractor (PSC), will discontinue their voice mail telephone number for Medical Review (MR) and Advanced Determination of Medicare Coverage (ADMC) (317.863.3736). CIGNA Government Services DME MAC Jurisdiction C Provider Customer Service will handle MR and ADMC telephone inquiries for suppliers in DME MAC Jurisdiction C.

The provider customer service telephone number for CIGNA Government Services DME MAC Jurisdiction C is 1.866.270.4909.

**HCPCS Update – 2008**

The following list identifies changes to level II Healthcare Common Procedure Coding System (HCPCS) for 2008.

- **Added**
  - Codes that have been added are effective only for dates of service on or after January 1, 2008.
  - **Footnote (N)** - This notation is used for items that are statutorily noncovered by Medicare for reasons other than medical necessity.
  - **Footnote (X)** - This notation is used for items that are denied as not medically necessary based on Medicare national policy.

- **Discontinued**
  - Codes listed in this article that are discontinued will continue to be valid for claims with dates of service on or before December 31, 2007, regardless of the date of claim submission. If there is a direct crosswalk for a discontinued code, it is listed in the table. If the crosswalk is not an exact crosswalk (i.e., if there has been a significant change in the narrative description or unit of service), the phrase "with changes" follows the code. Most of the crosswalked codes are also "added" codes that are effective for dates of service on or after January 1, 2008.
  - There is no grace period that would allow submission of the discontinued code for dates of service in 2008.
  - K codes that were previously published or codes that have been invalid for claim submission to the DME MAC and that are being officially discontinued in 2008 are not listed in this article.

- **Changed**
  - A description change for an existing code is effective for dates of service on or after January 1, 2008
The appearance of a code in this list does not necessarily indicate coverage.

### Ankle-Foot and Knee-Ankle-Foot Orthoses

<table>
<thead>
<tr>
<th>Code</th>
<th>Narrative</th>
</tr>
</thead>
<tbody>
<tr>
<td>A9283</td>
<td>FOOT PRESSURE OFF LOADING/SUPPORTIVE DEVICE, ANY TYPE, EACH (FOOTNOTE: N)</td>
</tr>
</tbody>
</table>

### Cervical Traction Devices

<table>
<thead>
<tr>
<th>Code</th>
<th>Narrative</th>
</tr>
</thead>
<tbody>
<tr>
<td>E0856</td>
<td>CERVICAL TRACTION DEVICE, CERVICAL COLLAR WITH INFLATABLE AIR BLADDER (FOOTNOTE: X)</td>
</tr>
</tbody>
</table>

### Continuous Positive Airway Pressure (CPAP) Systems

<table>
<thead>
<tr>
<th>Code</th>
<th>Narrative</th>
</tr>
</thead>
<tbody>
<tr>
<td>A7027</td>
<td>COMBINATION/ORAL/NASAL MASK, USED WITH CONTINUOUS POSITIVE AIRWAY PRESSURE DEVICE, EACH</td>
</tr>
<tr>
<td>A7028</td>
<td>ORAL CUSHION FOR COMBINATION/ORAL/NASAL MASK, REPLACEMENT ONLY, EACH</td>
</tr>
<tr>
<td>A7029</td>
<td>NASAL PILLOWS FOR COMBINATION/ORAL/NASAL MASK, REPLACEMENT ONLY, PAIR</td>
</tr>
</tbody>
</table>

**Discontinued Code**

<table>
<thead>
<tr>
<th>Code</th>
<th>Narrative</th>
<th>Crosswalk to Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>K0553</td>
<td>COMBINATION/ORAL/NASAL MASK, USED WITH CONTINUOUS POSITIVE AIRWAY PRESSURE DEVICE, EACH</td>
<td>A7027</td>
</tr>
<tr>
<td>K0554</td>
<td>ORAL CUSHION FOR COMBINATION/ORAL/NASAL MASK, REPLACEMENT ONLY, EACH</td>
<td>A7028</td>
</tr>
<tr>
<td>K0555</td>
<td>NASAL PILLOWS FOR COMBINATION/ORAL/NASAL MASK, REPLACEMENT ONLY, PAIR</td>
<td>A7029</td>
</tr>
</tbody>
</table>

### Enteral Nutrition

<table>
<thead>
<tr>
<th>Code</th>
<th>Narrative</th>
</tr>
</thead>
<tbody>
<tr>
<td>B4087</td>
<td>GASTROSTOMY/JEJUNOSTOMY TUBE, ANY MATERIAL, ANY TYPE, EACH</td>
</tr>
<tr>
<td>B4088</td>
<td>GASTROSTOMY/JEJUNOSTOMY TUBE, LOW PROFILE, ANY MATERIAL, ANY TYPE, EACH</td>
</tr>
</tbody>
</table>

**Narrative Change**

<table>
<thead>
<tr>
<th>Code</th>
<th>Narrative</th>
<th>New Narrative</th>
</tr>
</thead>
<tbody>
<tr>
<td>B4034</td>
<td>ENTERAL FEEDING SUPPLY; SYRINGE, PER DAY</td>
<td>ENTERAL FEEDING SUPPLY KIT; SYRINGE FED, PER DAY</td>
</tr>
</tbody>
</table>

**Discontinued Code**

<table>
<thead>
<tr>
<th>Code</th>
<th>Narrative</th>
<th>Crosswalk to Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>B4086</td>
<td>GASTROSTOMY/JEJUNOSTOMY TUBE, ANY MATERIAL, ANY TYPE, (STANDARD OR LOW PROFILE), EACH</td>
<td>B4087 or B4088</td>
</tr>
</tbody>
</table>

### External Infusion Pumps

<table>
<thead>
<tr>
<th>Code</th>
<th>Narrative</th>
<th>New Narrative</th>
</tr>
</thead>
<tbody>
<tr>
<td>J1562</td>
<td>INJECTION, IMMUNE GLOBULIN, SUBCUTANEOUS, 100 MG</td>
<td>INJECTION, IMMUNE GLOBULIN (VIVAGLOBIN), 100 MG</td>
</tr>
</tbody>
</table>

### Glucose Monitors

<table>
<thead>
<tr>
<th>Code</th>
<th>Narrative</th>
</tr>
</thead>
<tbody>
<tr>
<td>A9274</td>
<td>EXTERNAL AMBULATORY INSULIN DELIVERY SYSTEM, DISPOSABLE, EACH, INCLUDES ALL SUPPLIES AND ACCESSORIES (FOOTNOTE: N)</td>
</tr>
</tbody>
</table>

---
### Hospital Beds and Accessories

**Added Code**

<table>
<thead>
<tr>
<th>Code</th>
<th>Narrative</th>
</tr>
</thead>
<tbody>
<tr>
<td>E0328</td>
<td>HOSPITAL BED, PEDIATRIC, MANUAL, 360 DEGREE SIDE ENCLOSURES, TOP OF HEADBOARD, FOOTBOARD AND SIDE RAILS UP TO 24 INCHES ABOVE THE SPRING, INCLUDES MATTRESS</td>
</tr>
<tr>
<td>E0329</td>
<td>HOSPITAL BED, PEDIATRIC, ELECTRIC OR SEMI-ELECTRIC, 360 DEGREE SIDE ENCLOSURES, TOP OF HEADBOARD, FOOTBOARD AND SIDE RAILS UP TO 24 INCHES ABOVE THE SPRING, INCLUDES MATTRESS</td>
</tr>
</tbody>
</table>

### Lower Limb Orthoses

**Discontinued Codes**

<table>
<thead>
<tr>
<th>Code</th>
<th>Narrative</th>
<th>Crosswalk to Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>L1855</td>
<td>KNEE ORTHOSIS, MOLDED PLASTIC, THIGH AND CALF SECTIONS, WITH DOUBLE UPRIGHT KNEE JOINTS, CUSTOM-FABRICATED</td>
<td>L1846</td>
</tr>
<tr>
<td>L1858</td>
<td>KNEE ORTHOSIS, MOLDED PLASTIC, POLYCENTRIC KNEE JOINTS, PNEUMATIC KNEE PADS (CTI), CUSTOM-FABRICATED</td>
<td>L1846</td>
</tr>
<tr>
<td>L1870</td>
<td>KNEE ORTHOSIS, DOUBLE UPRIGHT, THIGH AND CALF LACERS WITH KNEE JOINTS, CUSTOM-FABRICATED</td>
<td>L1846</td>
</tr>
<tr>
<td>L1870</td>
<td>KNEE ORTHOSIS, DOUBLE UPRIGHT, NONMOLDED THIGH AND CALF CUFFS/LACERS WITH KNEE JOINTS, CUSTOM-FABRICATED</td>
<td>L1846</td>
</tr>
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### Miscellaneous

**Added Code**

<table>
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<tbody>
<tr>
<td>J1561</td>
<td>INJECTION, IMMUNE GLOBULIN, (GAMUNEX), INTRAVENOUS, NONLYOPHILIZED (E.G. LIQUID), 500 MG</td>
</tr>
<tr>
<td>J1568</td>
<td>INJECTION, IMMUNE GLOBULIN, (OCTOGAM), INTRAVENOUS, NONLYOPHILIZED (E.G. LIQUID), 500 MG</td>
</tr>
<tr>
<td>J1569</td>
<td>INJECTION, IMMUNE GLOBULIN, (GAMMAGARD LIQUID), INTRAVENOUS, NON-LYOPHILIZED, (E.G. LIQUID), 500 MG</td>
</tr>
<tr>
<td>J1572</td>
<td>INJECTION, IMMUNE GLOBULIN, (FLEBOGAMMA), INTRAVENOUS, NONLYOPHILIZED (E.G. LIQUID), 500 MG</td>
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**Narrative Change**

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<thead>
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<tbody>
<tr>
<td>E1801</td>
<td>BI-DIRECTIONAL STATIC PROGRESSIVE STRETCH ELBOW DEVICE WITH RANGE OF MOTION ADJUSTMENT, INCLUDES CUFFS</td>
<td>STATIC PROGRESSIVE STRETCH ELBOW DEVICE, EXTENSION AND/OR FLEXION, WITH OR WITHOUT RANGE OF MOTION ADJUSTMENT, INCLUDES ALL COMPONENTS AND ACCESSORIES</td>
</tr>
<tr>
<td>E1806</td>
<td>BI-DIRECTIONAL STATIC PROGRESSIVE STRETCH WRIST DEVICE WITH RANGE OF MOTION ADJUSTMENT, INCLUDES CUFFS</td>
<td>STATIC PROGRESSIVE STRETCH WRIST DEVICE, FLEXION AND/OR EXTENSION, WITH OR WITHOUT RANGE OF MOTION ADJUSTMENT, INCLUDES ALL COMPONENTS AND ACCESSORIES</td>
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<tr>
<td>E1811</td>
<td>BI-DIRECTIONAL STATIC PROGRESSIVE STRETCH KNEE DEVICE WITH RANGE OF MOTION ADJUSTMENT, INCLUDES CUFFS</td>
<td>STATIC PROGRESSIVE STRETCH KNEE DEVICE, EXTENSION AND/OR FLEXION, WITH OR WITHOUT RANGE OF MOTION ADJUSTMENT, INCLUDES ALL COMPONENTS AND ACCESSORIES</td>
</tr>
<tr>
<td>E1816</td>
<td>BI-DIRECTIONAL STATIC PROGRESSIVE STRETCH ANKLE DEVICE WITH RANGE OF MOTION ADJUSTMENT, INCLUDES CUFFS</td>
<td>STATIC PROGRESSIVE STRETCH ANKLE DEVICE, FLEXION AND/OR EXTENSION, WITH OR WITHOUT RANGE OF MOTION ADJUSTMENT, INCLUDES ALL COMPONENTS AND ACCESSORIES</td>
</tr>
<tr>
<td>E1818</td>
<td>BI-DIRECTIONAL STATIC PROGRESSIVE STRETCH FOREARM PRONATION/SUPINATION DEVICE WITH RANGE OF MOTION ADJUSTMENT, INCLUDES CUFFS</td>
<td>STATIC PROGRESSIVE STRETCH FOREARM PRONATION / SUPINATION DEVICE, WITH OR WITHOUT RANGE OF MOTION ADJUSTMENT, INCLUDES ALL COMPONENTS AND ACCESSORIES</td>
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<tr>
<td>E1841</td>
<td>MULTI-DIRECTIONAL STATIC PROGRESSIVE STRETCH SHOULDAR DEVICE, WITH RANGE OF MOTION ADJUSTABILITY, INCLUDES CUFFS</td>
<td>STATIC PROGRESSIVE STRETCH SHOULDAR DEVICE, WITH OR WITHOUT RANGE OF MOTION ADJUSTMENT, INCLUDES ALL COMPONENTS AND ACCESSORIES</td>
</tr>
<tr>
<td>J1566</td>
<td>INJECTION, IMMUNE GLOBULIN, INTRAVENOUS, LYOPHILIZED (E.G. POWDER), 500 MG</td>
<td>INJECTION, IMMUNE GLOBULIN, INTRAVENOUS, LYOPHILIZED (E.G. POWDER), NOT OTHERWISE SPECIFIED, 500 MG</td>
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**Discontinued Code**

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<tbody>
<tr>
<td>Q4087</td>
<td>INJECTION, IMMUNE GLOBULIN, (OCTAGAM), INTRAVENOUS, NON-LYOPHILIZED (E.G. LIQUID), 500 MG</td>
<td>J1568</td>
</tr>
<tr>
<td>Q4088</td>
<td>INJECTION, IMMUNE GLOBULIN, (GAMMAGARD LIQUID), INTRAVENOUS, NON-LYOPHILIZED, (E.G. LIQUID), 500 MG</td>
<td>J1569</td>
</tr>
<tr>
<td>Q4091</td>
<td>INJECTION, IMMUNE GLOBULIN, (FLEBOGAMMA), INTRAVENOUS, NON-LYOPHILIZED, (E.G. LIQUID), 500 MG</td>
<td>J1572</td>
</tr>
<tr>
<td>Q4092</td>
<td>INJECTION, IMMUNE GLOBULIN, (GAMUNEX), INTRAVENOUS, NON-LYOPHILIZED (E.G. LIQUID), 500 MG</td>
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### Nebulizers

#### Added Code

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<thead>
<tr>
<th>Code</th>
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<tbody>
<tr>
<td>J7602</td>
<td>ALBUTEROL, ALL FORMULATIONS INCLUDING SEPARATED ISOMERS, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NONCOMPONOUNDED, ADMINISTERED THROUGH DME, CONCENTRATED FORM, PER 1 MG (ALBUTEROL) OR PER 0.5 MG (LEVALBUTEROL)</td>
</tr>
<tr>
<td>J7603</td>
<td>ALBUTEROL, ALL FORMULATIONS INCLUDING SEPARATED ISOMERS, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NONCOMPONOUNDED, ADMINISTERED THROUGH DME, UNIT DOSE, PER 1 MG (ALBUTEROL) OR PER 0.5 MG (LEVALBUTEROL)</td>
</tr>
<tr>
<td>J7604</td>
<td>ACETYLCYSTEINE, INHALATION SOLUTION, COMPONOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER GRAM</td>
</tr>
<tr>
<td>J7605</td>
<td>ARFORMOTEROL, INHALATION SOLUTION, FDA APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, UNIT DOSE FORM, 15 MICROGRAMS</td>
</tr>
<tr>
<td>J7632</td>
<td>CROMOLYN SODIUM, INHALATION SOLUTION, COMPONOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER 10 MG</td>
</tr>
<tr>
<td>J7676</td>
<td>PENTAMIDINE ISETHIONATE, INHALATION SOLUTION, COMPONOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER 300 MG</td>
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#### Narrative Change

<table>
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<tr>
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<tr>
<td>J2545</td>
<td>PENTAMIDINE ISETHIONATE, INHALATION SOLUTION, PER 300 MG, ADMINISTERED THROUGH A DME</td>
<td>PENTAMIDINE ISETHIONATE, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER 300 MG</td>
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<tr>
<td>J7608</td>
<td>ACETYLCYSTEINE, INHALATION SOLUTION ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER GRAM</td>
<td>ACETYLCYSTEINE, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER GRAM</td>
</tr>
<tr>
<td>J7631</td>
<td>CROMOLYN SODIUM, INHALATION SOLUTION ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER 10 MILLIGRAMS</td>
<td>CROMOLYN SODIUM, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER 10 MILLIGRAMS</td>
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<tr>
<td>J7639</td>
<td>DORNASE ALPHA, INHALATION SOLUTION ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM</td>
<td>DORNASE ALPHA, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM</td>
</tr>
<tr>
<td>Q4080</td>
<td>ILOPROST, INHALATION SOLUTION, ADMINISTERED THROUGH DME, UP TO 20 MICROGRAMS</td>
<td>ILOPROST, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NONCOMPONOUNDED, ADMINISTERED THROUGH DME, UNIT DOSE FORM, 20 MICROGRAMS</td>
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#### Discontinued Code

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<tr>
<td>Q4093</td>
<td>ALBUTEROL, ALL FORMULATIONS INCLUDING SEPARATED ISOMERS, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NONCOMPONOUNDED, ADMINISTERED THROUGH DME, CONCENTRATED FORM, PER 1 MG (ALBUTEROL) OR PER 0.5 MG (LEVALBUTEROL)</td>
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<tr>
<td>Q4094</td>
<td>ALBUTEROL, ALL FORMULATIONS INCLUDING SEPARATED ISOMERS, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NONCOMPONOUNDED, ADMINISTERED THROUGH DME, UNIT DOSE, PER 1 MG (ALBUTEROL) OR PER 0.5 MG (LEVALBUTEROL)</td>
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#### Crosswalk to Code

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<tbody>
<tr>
<td>J7602</td>
<td>Q4093</td>
</tr>
<tr>
<td>J7603</td>
<td>Q4094</td>
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### Orthopedic Footwear

#### Added Code

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<tbody>
<tr>
<td>A9283</td>
<td>FOOT PRESSURE OFF LOADING/SUPPORTIVE DEVICE, ANY TYPE, EACH (FOOTNOTE: N)</td>
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### Ostomy Supplies

#### Added Code

<table>
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<tbody>
<tr>
<td>A5083</td>
<td>CONTINENT DEVICE, STOMA ABSORPTIVE COVER FOR CONTINENT STOMA</td>
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## Patient Lifts

<table>
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<tbody>
<tr>
<td>E0630</td>
<td>PATIENT LIFT, HYDRAULIC, WITH SEAT OR SLING</td>
<td>PATIENT LIFT, HYDRAULIC OR MECHANICAL, INCLUDES ANY SEAT, SLING, STRAP(S) OR PAD(S)</td>
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## Surgical Dressings

### Added Code

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<th>Code</th>
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<tbody>
<tr>
<td>A6413</td>
<td>ADHESIVE BANDAGE, FIRST-AID TYPE, ANY SIZE, EACH (FOOTNOTE: N)</td>
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## Upper Limb Orthoses

### Added Code

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>L3925</td>
<td>FINGER ORTHOSIS, PROXIMAL INTERPHALANGEAL (PIP)/DISTAL INTERPHALANGEAL (DIP), NONTORSION JOINT/Spring, Extension/Flexion, May Include Soft Interface Material, Prefabricated, Includes Fitting and Adjustment</td>
</tr>
<tr>
<td>L3927</td>
<td>FINGER ORTHOSIS, PROXIMAL INTERPHALANGEAL (PIP)/DISTAL INTERPHALANGEAL (DIP), WITHOUT JOINT/Spring, Extension/Flexion (E.G. Static Or Ring Type), May Include Soft Interface Material, Prefabricated, Includes Fitting and Adjustment</td>
</tr>
<tr>
<td>L3929</td>
<td>HAND FINGER ORTHOSIS, INCLUDES ONE OR MORE NONTORSION JOINT(S), TURNBUCKLES, ELASTIC BANDS/SPRINGS, MAY INCLUDE SOFT INTERFACE MATERIAL, STRAPS, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT</td>
</tr>
<tr>
<td>L3931</td>
<td>WRIST HAND FINGER ORTHOSIS, INCLUDES ONE OR MORE NONTORSION JOINT(S), TURNBUCKLES, ELASTIC BANDS/SPRINGS, MAY INCLUDE SOFT INTERFACE MATERIAL, STRAPS, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT</td>
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### Narrative Changes

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<tr>
<td>L3806</td>
<td>WRIST HAND FINGER ORTHOSIS, INCLUDES ONE OR MORE NONTORSION JOINT(S), TURNBUCKLES, MAY INCLUDE SOFT INTERFACE MATERIAL, STRAPS, CUSTOM FABRICATED, INCLUDES FITTING AND ADJUSTMENT</td>
<td>WRIST HAND FINGER ORTHOSIS, INCLUDES ONE OR MORE NONTORSION JOINT(S), TURNBUCKLES, ELASTIC BANDS/SPRINGS, MAY INCLUDE SOFT INTERFACE MATERIAL, STRAPS, CUSTOM FABRICATED, INCLUDES FITTING AND ADJUSTMENT</td>
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<tbody>
<tr>
<td>L3800</td>
<td>WRIST HAND FINGER ORTHOSIS, SHORT OPPONENS, NO ATTACHMENTS, CUSTOMFABRICATED</td>
<td>L3808</td>
</tr>
<tr>
<td>L3805</td>
<td>WRIST HAND FINGER ORTHOSIS, LONG OPPONENS, NO ATTACHMENT, CUSTOMFABRICATED</td>
<td>L3808</td>
</tr>
<tr>
<td>L3810</td>
<td>WHFO, ADDITION TO SHORT AND LONG OPPONENS, THUMB ABDUCTION (&quot;C&quot;) BAR</td>
<td>NOT SEPARATELY PAYABLE. INCLUDED IN THE ALLOWANCE FOR THE ORTHOSIS BASE CODE.</td>
</tr>
<tr>
<td>L3815</td>
<td>WHFO, ADDITION TO SHORT AND LONG OPPONENS, SECOND M.P. ABDUCTION ASSIST</td>
<td>NOT SEPARATELY PAYABLE. INCLUDED IN THE ALLOWANCE FOR THE ORTHOSIS BASE CODE.</td>
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<tr>
<td>L3820</td>
<td>WHFO, ADDITION TO SHORT AND LONG OPPONENS, I.P. EXTENSION ASSIST, WITH M.P. EXTENSION STOP</td>
<td>NOT SEPARATELY PAYABLE. INCLUDED IN THE ALLOWANCE FOR THE ORTHOSIS BASE CODE.</td>
</tr>
<tr>
<td>L3825</td>
<td>WHFO, ADDITION TO SHORT AND LONG OPPONENS, M.P. EXTENSION STOP</td>
<td>NOT SEPARATELY PAYABLE. INCLUDED IN THE ALLOWANCE FOR THE ORTHOSIS BASE CODE.</td>
</tr>
<tr>
<td>L3830</td>
<td>WHFO, ADDITION TO SHORT AND LONG OPPONENS, M.P. EXTENSION ASSIST</td>
<td>NOT SEPARATELY PAYABLE. INCLUDED IN THE ALLOWANCE FOR THE ORTHOSIS BASE CODE.</td>
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<tr>
<td>L3835</td>
<td>WHFO, ADDITION TO SHORT AND LONG OPPONENS, M.P. SPRING EXTENSION ASSIST</td>
<td>NOT SEPARATELY PAYABLE. INCLUDED IN THE ALLOWANCE FOR THE ORTHOSIS BASE CODE.</td>
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<tr>
<td>L3840</td>
<td>WHFO, ADDITION TO SHORT AND LONG OPPONENS, SPRING SWIVEL THUMB</td>
<td>NOT SEPARATELY PAYABLE. INCLUDED IN THE ALLOWANCE FOR THE ORTHOSIS BASE CODE.</td>
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<tr>
<td>L3845</td>
<td>WHFO, ADDITION TO SHORT AND LONG OPPONENS, THUMB I.P. EXTENSION ASSIST, WITH M.P. STOP</td>
<td>NOT SEPARATELY PAYABLE. INCLUDED IN THE ALLOWANCE FOR THE ORTHOSIS BASE CODE.</td>
</tr>
<tr>
<td>L3850</td>
<td>WHFO, ADDITION TO SHORT AND LONG OPPONENS, ACTION WRIST, WITH DORSIFLEXION ASSIST</td>
<td>NOT SEPARATELY PAYABLE. INCLUDED IN THE ALLOWANCE FOR THE ORTHOSIS BASE CODE.</td>
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### Upper Limb Orthoses

#### Discontinued Code

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<tbody>
<tr>
<td>L3855</td>
<td>WHFO, ADDITION TO SHORT AND LONG OPPONENS, ADJUSTABLE M.P. FLEXION CONTROL</td>
<td>NOT SEPARATELY PAYABLE. INCLUDED IN THE ALLOWANCE FOR THE ORTHOSIS BASE CODE.</td>
</tr>
<tr>
<td>L3860</td>
<td>WHFO, ADDITION TO SHORT AND LONG OPPONENS, ADJUSTABLE M.P. FLEXION CONTROL</td>
<td>NOT SEPARATELY PAYABLE. INCLUDED IN THE ALLOWANCE FOR THE ORTHOSIS BASE CODE.</td>
</tr>
<tr>
<td>L3907</td>
<td>WRIST HAND FINGER ORTHOSIS, WRIST GAUNTLET WITH THUMB SPICA, CUSTOMFABRICATED</td>
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<tr>
<td>L3910</td>
<td>WRIST HAND FINGER ORTHOSIS, SWANSON DESIGN, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT</td>
<td>L3808</td>
</tr>
<tr>
<td>L3916</td>
<td>WRIST HAND FINGER ORTHOSIS, WRIST EXTENSION COCK-UP WITH OUTRIGGER, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT</td>
<td>L3931</td>
</tr>
<tr>
<td>L3918</td>
<td>HAND FINGER ORTHOSIS, KNUCKLE BENDER, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT</td>
<td>L3929</td>
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<tr>
<td>L3920</td>
<td>HAND FINGER ORTHOSIS, KNUCKLE BENDER WITH OUTRIGGER, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT</td>
<td>L3929</td>
</tr>
<tr>
<td>L3922</td>
<td>HAND FINGER ORTHOSIS, KNUCKLE BENDER, TWO SEGMENT TO FLEX JOINTS, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT</td>
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<td>WRIST HAND FINGER ORTHOSIS, OPPENHEIMER, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT</td>
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<td>WRIST HAND FINGER ORTHOSIS, THOMAS SUSPENSION, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT</td>
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<td>L3928</td>
<td>HAND FINGER ORTHOSIS, FINGER EXTENSION, WITH CLOCK SPRING, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT</td>
<td>L3931</td>
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<td>L3930</td>
<td>WRIST HAND FINGER ORTHOSIS, FINGER EXTENSION, WITH WRIST SUPPORT, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT</td>
<td>L3929</td>
</tr>
<tr>
<td>L3932</td>
<td>FINGER ORTHOSIS, SAFETY PIN, SPRING WIRE, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT</td>
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<tr>
<td>L3934</td>
<td>FINGER ORTHOSIS, SAFETY PIN, MODIFIED, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT</td>
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<tr>
<td>L3936</td>
<td>WRIST HAND FINGER ORTHOSIS, PALMER, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT</td>
<td>L3931</td>
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<tr>
<td>L3938</td>
<td>WRIST HAND FINGER ORTHOSIS, DORSAL WRIST, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT</td>
<td>L3931</td>
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<tr>
<td>L3940</td>
<td>WRIST HAND FINGER ORTHOSIS, DORSAL WRIST, WITH OUTRIGGER ATTACHMENT, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT</td>
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<tr>
<td>L3942</td>
<td>HAND FINGER ORTHOSIS, REVERSE KNUCKLE BENDER, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT</td>
<td>L3929</td>
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<td>L3944</td>
<td>HAND FINGER ORTHOSIS, REVERSE KNUCKLE BENDER, WITH OUTRIGGER, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT</td>
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<tr>
<td>L3946</td>
<td>HAND FINGER ORTHOSIS, COMPOSITE ELASTIC, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT</td>
<td>L3929</td>
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<tr>
<td>L3948</td>
<td>FINGER ORTHOSIS, FINGER KNUCKLE BENDER, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT</td>
<td>L3925</td>
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<tr>
<td>L3950</td>
<td>WRIST HAND FINGER ORTHOSIS, COMBINATION OPPENHEIMER, WITH KNUCKLE BENDER AND TWO ATTACHMENTS, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT</td>
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<td>L3952</td>
<td>WRIST HAND FINGER ORTHOSIS, COMBINATION OPPENHEIMER, WITH REVERSE KNUCKLE AND TWO ATTACHMENTS, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT</td>
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<tr>
<td>L3954</td>
<td>HAND FINGER ORTHOSIS, SPREADING HAND, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT</td>
<td>L3923</td>
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<tr>
<td>L3985</td>
<td>UPPER EXTREMITY FRACTURE ORTHOSIS, FOREARM, HAND WITH WRIST HINGE, CUSTOMFABRICATED</td>
<td>L3764</td>
</tr>
<tr>
<td>L3986</td>
<td>UPPER EXTREMITY FRACTURE ORTHOSIS, COMBINATION OF HUMERAL, RADIUS/ULNAR, WRIST, (EXAMPLE--COLLES' FRACTURE), CUSTOM FABRICATED</td>
<td>L3763</td>
</tr>
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### Upper Limb Prostheses

<table>
<thead>
<tr>
<th>Code</th>
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</thead>
<tbody>
<tr>
<td>L7611</td>
<td>TERMINAL DEVICE, HOOK, MECHANICAL, VOLUNTARY OPENING, ANY MATERIAL, ANY SIZE, LINED OR UNLINED, PEDIATRIC</td>
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<tr>
<td>L7612</td>
<td>TERMINAL DEVICE, HOOK, MECHANICAL, VOLUNTARY CLOSING, ANY MATERIAL, ANY SIZE, LINED OR UNLINED, PEDIATRIC</td>
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<tr>
<td>L7613</td>
<td>TERMINAL DEVICE, HAND, MECHANICAL, VOLUNTARY OPENING, ANY MATERIAL, ANY SIZE, PEDIATRIC</td>
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<td>L7614</td>
<td>TERMINAL DEVICE, HAND, MECHANICAL, VOLUNTARY CLOSING, ANY MATERIAL, ANY SIZE, PEDIATRIC</td>
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<td>L7621</td>
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<td>L7622</td>
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### Urological Supplies

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<th>Code</th>
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<th>New Narrative</th>
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<tbody>
<tr>
<td>A5105</td>
<td>URINARY SUSPENSORRY, WITH OR WITHOUT LEG BAG, WITH OR WITHOUT TUBE, EACH</td>
<td>URINARY SUSPENSORRY WITH LEG BAG, WITH OR WITHOUT TUBE, EACH</td>
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### Wheelchair Options and Accessories

<table>
<thead>
<tr>
<th>Code</th>
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<tbody>
<tr>
<td>E2227</td>
<td>MANUAL WHEELCHAIR ACCESSORY, GEAR REDUCTION DRIVE WHEEL, EACH</td>
</tr>
<tr>
<td>E2228</td>
<td>MANUAL WHEELCHAIR ACCESSORY, WHEEL BRAKING SYSTEM AND LOCK, COMPLETE, EACH</td>
</tr>
<tr>
<td>E2312</td>
<td>POWER WHEELCHAIR ACCESSORY, HAND OR CHIN CONTROL, INTERFACE, MINI-PROPORTIONAL REMOTE JOYSTICK, PROPORTIONAL, INCLUDING FIXED MOUNTING HARDWARE</td>
</tr>
<tr>
<td>E2313</td>
<td>POWER WHEELCHAIR ACCESSORY, HARNESS FOR UPGRADE TO EXPANDABLE CONTROLLER,INCLUDING ALL FASTENERS, CONNECTORS AND MOUNTING HARDWARE, EACH</td>
</tr>
<tr>
<td>E2397</td>
<td>POWER WHEELCHAIR ACCESSORY, LITHIUM-BASED BATTERY, EACH</td>
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<th>New Narrative</th>
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</thead>
<tbody>
<tr>
<td>E0705</td>
<td>TRANSFER BOARD OR DEVICE, ANY TYPE, EACH</td>
<td>TRANSFER DEVICE, ANY TYPE, EACH</td>
</tr>
<tr>
<td>E2205</td>
<td>MANUAL WHEELCHAIR ACCESSORY, HANDRIM WITHOUT PROJECTIONS, ANY TYPE, REPLACEMENT ONLY, EACH</td>
<td>MANUAL WHEELCHAIR ACCESSORY, HANDRIM WITHOUT PROJECTIONS (INCLUDES ERGONOMIC OR CONTOURED), ANY TYPE, REPLACEMENT ONLY, EACH</td>
</tr>
<tr>
<td>E2373</td>
<td>POWER WHEELCHAIR ACCESSORY, HAND OR CHIN CONTROL INTERFACE, MINIPROPORTIONAL, COMPACT, OR SHORT THROW REMOTE JOYSTICK OR TOUCHPAD, PROPORTIONAL, INCLUDING ALL RELATED ELECTRONICS AND FIXED MOUNTING HARDWARE</td>
<td>POWER WHEELCHAIR ACCESSORY, HAND OR CHIN CONTROL INTERFACE, COMPACT REMOTE JOYSTICK, PROPORTIONAL, INCLUDING FIXED MOUNTING HARDWARE</td>
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### Wheelchair Seating

<table>
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<th>Code</th>
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<tr>
<td>E2618</td>
<td>WHEELCHAIR ACCESSORY, SOLID SEAT SUPPORT BASE (REPLACES SLING SEAT), FOR USE WITH MANUAL WHEELCHAIR OR LIGHTWEIGHT POWER WHEELCHAIR, INCLUDES ANY TYPE MOUNTING HARDWARE</td>
</tr>
</tbody>
</table>

**Crosswalk to Code**

- For Manual Wheelchairs and Replacement on Power Wheelchairs: **K0108**
- Or -
- For Power Wheelchairs at initial issue: **Not separately billable.**
Power Wheelchairs – ATP Requirement

This is a 2nd revision to a recently published article. It adds the word “financial” to the sentence below that prohibits any “financial relationship” between the supplier and the clinician who performs the specialty evaluation.

The DME PSC medical directors received LCD reconsideration requests to revise the Power Mobility Devices LCD from the American Occupation Therapy Association, the American Physical Therapy Association, and the American Association for Homecare. Each group asked for deletion of the requirement that patients receiving rehab power wheelchairs on or after April 1, 2008 be evaluated by a RESNA-certified Assistive Technology Practitioner.

The current LCD lists two requirements that were scheduled to be implemented for claims with dates of service on or after April 1, 2008:

1. The specialty evaluation for patients receiving a Group 2 single power option or multiple power option PWC, any Group 3 or Group 4 PWC, or a push rim activated power assist device for a manual wheelchair must be performed by a RESNA-certified Assistive Technology Practitioner (ATP) specializing in wheelchairs or a physician who is board-certified in Physical Medicine and Rehabilitation.

   After consideration of the issues, the PSCs have decided to remove this requirement from the policy.

2. A Group 2 single power option or multiple power option PWC, any Group 3 or Group 4 PWC, or a push rim activated power assist device for a manual wheelchair must be provided by a supplier that employs a RESNA-certified Assistive Technology Supplier (ATS) or Assistive Technology Practitioner (ATP) who specializes in wheelchairs and who has direct, in-person involvement in the wheelchair selection for the patient.

   This requirement is being retained and will be effective for claims with dates of service on or after April 1, 2008.

The following requirement which is in the current LCD will remain in place - i.e., patients receiving a Group 2 single power option or multiple power option PWC, any Group 3 or Group 4 PWC, or a push rim activated power assist device for a manual wheelchair must have “a specialty evaluation that was performed by a licensed/certified medical professional, such as a PT or OT, or physician who has specific training and experience in rehabilitation wheelchair evaluations and that documents the medical necessity for the wheelchair and its special features. The PT, OT, or physician may have no financial relationship with the supplier.”

This information will be incorporated in a future revision of the Power Mobility Devices LCD.

Original Publication Date: 12/01/2007 with effective date of 12/01/2007
Revision Publication Date: 01/11/2008 with effective date of 12/01/2007
Dear Physician:

The Durable Medical Equipment Medicare Administrative Contractors (DME MACs) process claims for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) provided to Medicare beneficiaries. The Durable Medical Equipment Program Safeguard Contractors (DME PSCs) perform medical review of claims that are submitted to the DME MAC. It is your responsibility as the ordering physician to determine and document the medical need for all healthcare services.

For any DMEPOS item to be covered by Medicare, the patient’s medical record must contain sufficient documentation of the patient’s medical condition to substantiate the necessity for the type and quantity of items ordered and for the frequency of use or replacement (if applicable). The information should include the patient’s diagnosis and other pertinent information, as applicable, such as duration of the patient’s condition, clinical course (worsening or improvement), prognosis, nature and extent of functional limitation, other therapeutic interventions and results, past experience with related items, etc. For selected claims, the DME MAC or PSC may request that the supplier obtain this information from you in order that the DME MAC/PSC can verify that Medicare coverage criteria have been met.

DMEPOS suppliers are your partners in caring for your patient. They will not receive payment from Medicare for the items that are ordered if you do not provide information from your medical records when it is requested. Furthermore, not providing this information may result in your patients having to pay for the item themselves. Finally, your cooperation is a legal requirement as outlined in the Social Security Act, the law governing Medicare. Section 1842(p)(4) of the Act mandates that:

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

The Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule permits disclosure of protected health information without beneficiary authorization to carry out treatment, payment, or health care operations. The DME MAC and PSC perform health care operations as agents of the Centers for Medicare and Medicaid Services (CMS). Providing the requested documentation is in keeping with the HIPAA Privacy Rule.

You cannot charge the supplier or the beneficiary to provide this information to the supplier.

Help your DMEPOS supplier continue to provide good service to your patients by promptly providing the information from your medical records that is requested.

Sincerely,

Adrian M. Oleck, M.D., Medical Director
Durable Medical Equipment Program Safeguard Contractor, Jurisdiction C
**CMS Medlearn Matters Articles**

**Application of Administrative Simplification Compliance Act (ASCA) Enforcement Review Decisions Made by Other Medicare Contractors to the Same Providers When Selected for ASCA Review by the Railroad Medicare Carrier, Elimination of References to Claim Status and COB Medicare HIPAA Contingency Plans and Changes to Reflect Transfer of Responsibility for Medigap Claims to the COBC Contractor**

MLN Matters Number: MM5606  
Related Change Request (CR) #: 5606  
Related CR Release Date: October 15, 2007  
Effective Date: January 1, 2008  
Related CR Transmittal #: R1583CP  
Implementation Date: January 7, 2008

**Provider Types Affected**

Physicians, providers, and suppliers submitting claims to the Railroad Medicare carrier, and other Medicare carriers, Part A/B Medicare Administrative Contractors (A/B MACs), and/or DME Medicare Administrative Contractors (DME MACs) for services provided to both Railroad and non-Railroad Medicare beneficiaries.

**Provider Action Needed**

STOP – Impact to You  
This article is based on Change Request (CR) 5606, which implements a process to enable the application of the Administrative Simplification Compliance Act (ASCA) enforcement review decisions made by non-Railroad (non-RR) Medicare Contractors to the same providers when they bill the Railroad (RR) Medicare Carrier (RMC).

CAUTION – What You Need to Know  
Due to distribution of railroad (RR) retirees in the United States, however, few physicians/practitioners/suppliers treat a large number of RR Medicare beneficiaries. As result, many of these providers submit fewer than 10 claims a month to the RR Medicare Carrier (RMC), and they have been allowed to continue to submit paper claims to the RMC. In addition, the same providers generally treat non-RR Medicare beneficiaries and submit more than 10 claims a month to other Medicare contractors.

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

**Background**

The Administrative Simplification Compliance Act (ASCA) requires that providers submit claims to Medicare electronically to be considered for payment, with a limited number of exceptions including an exception that allows providers that submit fewer than 120 claims per year (no more than 10 claims per month or 30 claims per quarter) to Medicare to continue to submit paper claims. See the Medicare Claims Processing Manual, Chapter 24, Sections 90-90.6 at: http://www.cms.hhs.gov/manuals/downloads/clm104c24.pdf.

Due to the dispersion of railroad (RR) retirees in the United States, however, few physicians/practitioners/suppliers treat a large number of RR Medicare beneficiaries. As result, many of these providers submit fewer than 10 claims a month to the RR Medicare Carrier (RMC), and they have been allowed to continue to submit paper claims to the RMC. In addition, the same providers generally treat non-RR Medicare beneficiaries and submit more than 10 claims a month to other Medicare contractors.

However, ASCA electronic claim filing exceptions apply to Medicare overall, and do not differentiate based on contractors or between RR and non-RR contractors. Providers that submit paper claims to multiple Medicare contractors, including both RR and non-RR Medicare contractors, are subject to ASCA Enforcement Review by each of those contractors.

If a non-RR Medicare contractor 1) determines that a provider does not meet criteria which would permit that provider to continue to submit Medicare claims on paper and 2) notifies the provider that all paper claims submitted on or after a specific date will be denied, then that same decision is to be applied to that provider if submitting paper claims to the RMC even if that provider would not normally submit 10 or more paper claims to the RMC monthly.

If a provider reports that another Medicare contractor has reversed a decision that the provider is ineligible to submit paper claims, the RMC will ask that provider to submit a...
copy of the reversal letter from that contractor and to hold all new paper claims until such time as the RMC reviews the reversal letter and can advise the provider by letter that they can submit the paper claims.

Effective with the implementation date of CR5606, the Medicare Claims System (MCS) maintainer that prepares the provider files for transfer to the RMC will add ASCA Enforcement Review information when that information is in the non-RR provider files used to prepare the report for the RMC. Once added to the file, information concerning ASCA Enforcement decisions made by the non-RR Medicare contractors (such as providers are ineligible to submit paper claims) will be accessible to the RMC so the same decisions can be applied to the same providers when they bill the RMC.

CR5606 also updates the Medicare Claims Processing Manual to eliminate references to Claims Status and Coordination of Benefits (COB) Medicare HIPAA Contingency Plans and changes to reflect transfer of responsibility for Medigap claims to the COB contractor.

Additional Information
The official instruction, CR5606, issued to your Medicare carrier, A/B MAC, or DME MAC regarding this change may be viewed at: http://www.cms.hhs.gov/Transmittals/downloads/R1353CP.pdf on the CMS Web site.

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

How to Handle the National Provider Identifier (NPI) for Ordering/Referring and Attending/Operating/Other/Service Facility for Medicare Claims

MLN Matters Number: MM5674 Revised
Related Change Request (CR) #: 5674
Related CR Release Date: May 23, 2008
Effective Date: January 1, 2008
Related CR Transmittal #: R225PI
Implementation Date: April 7, 2008

Provider Types Affected
Physicians and providers who bill Medicare Carriers, Fiscal Intermediaries (FIs), Durable Medical Equipment Medicare Administrative Contractors (DME MACs) and Part A/B MACs for claims for services provided to Medicare beneficiaries.

What Providers Need to Know
Be cognizant of the fact that in accordance with the NPI final rule, when an identifier is reported on a claim for ordering/referring/attending provider, operating/other/service facility provider, or for any provider that is not a billing, pay-to or rendering provider, that identifier must be an NPI. For Medicare purposes, this means that submission of an NPI for an ordering/referring provider is mandatory effective May 23, 2008. Legacy numbers cannot be reported on any claims sent to Medicare on or after May 23, 2008.

Medicare has always required that a provider identifier be reported for ordering/referring providers. Effective May 23, 2008, that number must be an NPI, regardless of whether that referring or ordering provider participates in the Medicare program or not or is a covered entity.

Key Points
★ Medicare will not pay for referred/ordered services or items unless the name and NPI number of the referring/ordering/attending/operating/other/service facility provider is on the claim.
★ It is the responsibility of the claim/bill submitter to obtain the ordering/referring/attending/operating/other/service facility NPI for health care providers.
★ Providers whose business is largely based upon provision of services or items referred/ordered by other providers must be careful furnishing such services/items unless they first obtain the NPI of the referring/ordering individual. If they furnish services/items and do not obtain that person's NPI prior to billing Medicare, their claim will be denied.
★ If the NPI is not directly furnished by the ordering/referring provider at the time of the order, the provider expected to furnish the services or items should contact that provider for his/her NPI prior to delivery of the services/items.
★ Providers who have not obtained an NPI by May 23, 2008, are not permitted to refer/order services or items for Medicare beneficiaries.
★ Legacy numbers, such as provider identification numbers (PINs) or unique physician identification numbers (UPINs), cannot be reported on any claims sent to Medicare on or after May 23, 2008.
★ Physicians and the following non physician practitioners are the only types of providers allowed...
to refer/order services or items for beneficiaries:

» Nurse practitioners (NP);
» Clinical nurse specialists (CNS);
» Physician assistants (PA); and
» Certified nurse midwives (CNM).

Background
This article is based on Change Request (CR) 5674. Please note that the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandate the adoption of a standard unique health identifier for each health care provider. The (NPI) final rule, published on January 23, 2004, establishes the NPI as this standard. All health care providers covered under HIPAA must comply with the requirements of the NPI final rule (45 CFR Part 162, CMS-045-F). All entities covered under HIPAA must comply with the requirements of the NPI final rule.

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

You may see the official instruction (CR5674) issued to your Medicare A/B MAC, DME MAC, FI, or carrier by going to: http://www.cms.hhs.gov/Transmittals/downloads/R225PI.pdf on the CMS Web site.

NCPDP Inbound Claim and COB Companion Documents Updated for NPI Reporting
MLN Matters Number: MM5716 Revised
Related Change Request (CR) #: 5716
Related CR Release Date: November 2, 2007
Effective Date: April 1, 2008
Related CR Transmittal #: R299OTN
Implementation Date: April 7, 2008

NOTE  This article was revised on December 4, 2007, to clarify the language in the bullet points on page 3 to more closely align with CR5716. All other information remains the same.

Provider Types Affected
Suppliers who bill Medicare Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for providing Medicare Part B drugs to Medicare beneficiaries

What You Need to Know
CR 5716, from which this article is taken, announces that the original Medicare fee-for-service National Council for Prescription Drug Programs (NCPDP) inbound claim and coordination of benefits (COB) companion documents have been updated to address the use of the National Provider Identifier (NPI).

You can find these updated documents (entitled “NCPDP 5.1/1.1 Inbound NPI Companion Document” and “NCPDP 5.1/1.1 COB NPI Companion Document”) at: http://www.cms.hhs.gov/ElectronicBillingEDITrans/08_HealthCareClaims.asp#TopOfPage on the CMS Web site, and as attachments to CR5716.

Background
The Health Insurance Portability and Accountability Act (HIPAA) of 1996 adopted the NCPDP Telecommunication Standard 5.1 and NCPDP Batch Standard 1.1 as the national standard for submitting retail drug claims. Medicare DME MACs are responsible for processing all retail drug claims for those limited prescription drugs covered under Medicare Part B; and this national standard applies both to claims sent inbound to DME MACs as well as those sent outbound by the DME MACs to COB trading partners.

In addition to such national standards, HIPAA also mandated that covered entities use NPIs as the sole means to identify providers who prepare electronic data interchange (EDI) transactions. However, NCPDP standards were not designed to enable a health care provider to report more than one identifier during this transition period. Thus, in NCPDP claims, you can report either a provider’s legacy number, such as National Supplier Clearinghouse (NSC) identification numbers used for retail pharmacy identification and the Unique Physician Identification Numbers (UPINs) used to identify prescribers of retail drugs, or the NPI, but not both.

Further, when the original Medicare fee-for-service NCPDP inbound claim and COB companion documents (which provide Medicare-specific information related to the use of the relevant HIPAA standards) were issued, they did not address use of NPIs. CR5716, from which this article is taken, announces that an updated version of those companion documents, that does include NPI reporting, is now available to be downloaded under the titles of “NCPDP 5.1/1.1 Inbound NPI Companion Document” and “NCPDP 5.1/1.1 COB NPI Companion Document” at: http://www.cms.hhs.gov/ElectronicBillingEDITrans/08_HealthCareClaims.asp#TopOfPage.

You should be aware that for retail drug claims prior to May 23, 2008 (the date when the NPI is to be used exclusively to identify providers on NCPDP claims) the NCPDP implementation guide calls for the use of qualifiers to indicate the type of provider identifier being reported.
On NCPDP claims that you submit prior to May 23, 2008, you can choose to use either legacy numbers or NPIs for provider identification. If you choose to use legacy numbers, the pre-NPI companion document (not containing “NPI” in the title) applies. If you choose to use NPIs, the new companion documents (containing “NPI” in the titles) apply. Lastly, prior to May 23, 2008, if you use a legacy identifier for the retail pharmacy and an NPI for the prescriber (or vice versa); the non-NPI companion document will apply for reporting the legacy identifier, and the NPI companion document will apply for reporting the NPI.

There are some specific details related to the completion of NCPDP claims that will be of interest to you:

- Effective for claims received by Medicare on or after May 23, 2008, your inbound claims will be returned if they do not contain an 01 (NPI) qualifier in Transaction Header segments 202-B2 (retail pharmacy identification) and/or 466-EZ (prescriber identification), and if included in a claim, 468-2E (primary care provider identification) and 465-EY (pharmacy identification).
- If an inbound claim contains a reported NPI in a provider identification number field (210-B1, 411-DB, 421-DL, or 449-E9), but one or more of those numbers do not meet NPI validity criteria (i.e., does not begin with a 1, 2, 3, or 4; does not have 10-digits; includes any special characters; or does not have a valid check digit in the 10th position), the claim will reject. Medicare systems will not check the Medicare NPI Crosswalk to try to locate an NPI for any provider identification fields (qualifier and provider identification number fields) for any provider for which information is included in a claim in fields which are not used for Medicare claim processing (e.g., fields 468-2E and 421-DL or 465-EY and 449-E9). The editing for such provider qualifiers and identification numbers in the fields not used by Medicare will be limited to NPI validity edits.
- Medicare legacy numbers will not be reported on the outbound coordination of benefits (COB) transaction. However, an exception is permitted for those claims that have not cleared the system by the date CMS ends its’ NPI contingency. Those “pending” claims may contain legacy number, so the COB will also include the legacy number.

Additional Information

You can find the official instruction, CR5716, issued to your DME MAC by visiting http://www.cms.hhs.gov/Transmittals/downloads/R299OTN.pdf on the CMS Web site. The two updated companion documents: “NCPDP 5.1/1.1 Inbound NPI Companion Document” and “NCPDP 5.1/1.1 COB NPI Companion Document” are attached to that CR.

For more information on the NPI contingency, providers may visit http://www.cms.hhs.gov/NationalProvIdentStand/08_NPI%20Contingency%20Planning.asp#TopOfPage on the CMS Web site.

If you have any questions, please contact your 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.

Rejection of Electronic Claim Status Requests that Lack National Provider Identifiers (NPIs)

MLN Matters Number: MM5726
Related Change Request (CR) #: 5726
Related CR Release Date: November 2, 2007
Effective Date: May 23, 2008
Related CR Transmittal #: R302OTN
Implementation Date: January 7, 2008 and April 7, 2008

Provider Types Affected

Physicians, providers, and suppliers who submit claims status requests using the electronic data interchange (EDI) standard Health Insurance Portability and Accountability Act (HIPAA) transactions to Medicare contractors (carriers, Fiscal Intermediaries, (FIs), including Regional Home Health Intermediaries (RHHIs), Medicare Administrative Contractors (MACs), and DME Medicare Administrative Contractors (DME MACs))

Provider Action Needed

STOP – Impact to You

This article is based on CR5726, which describes policy changes that are a result of HIPAA requirements that prohibit the acceptance of EDI transactions that contain legacy provider numbers. CRS726 specifically address changes around the processing of electronic claim status requests and the responses to such requests.

CAUTION – What You Need to Know

Beginning May 23, 2008, Medicare will return to sender any electronic claim status request (X12 276 transactions) that contain legacy provider numbers instead of or in addition to the NPI number. This policy also applies to direct data entry (DDE) claim status inquiries and to Internet claim status screens operated as demonstration projects by some contractors.
GO – What You Need to Do
No later than May 23, 2008, providers should ensure that all electronic claim status requests sent to Medicare contractors contain only NPI numbers (no legacy provider numbers.)

Background
All electronic claim status requests submitted using the EDI standards (X12 276) adopted under HIPAA for national use must use the HIPAA-mandated NPI exclusively for provider identification no later than May 23, 2008. Those that do not are to be returned to the sender beginning May 23, 2008. All claims status responses (X12 277 transactions) will also contain only NPIs as of May 23, 2008. The same policy applies to direct data entry claim status inquiries and to those Internet claim status screens some contractors are permitted to operate under an Internet demonstration program. The absence of an NPI or the presence of a legacy number as of May 23, 2008, will result in rejection of the inquiry by these direct data entry processes.

Providers are advised that Medicare will return an NPI on the claims status response on or after May 23, 2008, even if the claim status request is received prior to May 23, 2008, using a legacy number. In returning the NPI, Medicare will use a crosswalk file that relates the legacy number to the provider's NPI. If the legacy number maps to more than one NPI, Medicare will return the first active NPI in the 277 response.

To avoid confusion, Medicare encourages providers to begin including their NPIs in their X12 276 inquiries as soon as possible prior to May 23, 2008, particularly if the provider has more than one NPI, but was assigned only one legacy number by Medicare for claims submission purposes.

Additional Information
The official instruction, CR5726, issued to your Medicare contractor can be found at: http://www.cms.hhs.gov/Transmittals/downloads/R302OTN.pdf on the CMS Web site.

If you have 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.

Reasonable Charge Update for 2008 for Splints, Casts, Dialysis Supplies, Dialysis Equipment, and Certain Intraocular Lenses

MLN Matters Number: MM5740 Revised
Related Change Request (CR) #: 5726
Related CR Release Date: September 28, 2007
Effective Date: January 1, 2008
Related CR Transmittal #: R1344CP
Implementation Date: January 7, 2008

NOTE - This article was revised on November 7, 2007 to change the title to the chart showing the payment limits. That chart should have read “2008” and not “2007”. All other information is unchanged.

Provider Types Affected
Physicians, providers, and suppliers billing Medicare contractors (carriers, Fiscal Intermediaries, (FIs), Medicare Administrative Contractors (A/B MACs), and Durable Medical Equipment Medicare Administrative Contractors (DME MACs)) for splints, casts, dialysis equipment, and certain intraocular lenses.

Provider Action Needed
Affected providers may want to be certain their billing staffs know of these changes.

Background
For calendar year 2008, Medicare will continue to pay on a reasonable charge basis for splints, casts, dialysis supplies, dialysis equipment and intraocular lenses. For intraocular lenses, payment is only made on a reasonable charge basis for lenses implanted in a physician’s office. For splints and casts, the Q-codes are to be used when supplies are indicated for cast and splint purposes. This payment is in addition to the payment made under the Medicare physician fee schedule for the procedure for applying the splint or cast.

Change Request (CR) 5740 provides instructions regarding the calculation of reasonable charges for payment of claims for splints, casts, dialysis supplies, dialysis equipment, and intraocular lenses furnished in calendar year 2008. Payment on a reasonable charge basis is required for these items by regulations contained in 42 CFR 405.501 at: http://www.gpoaccess.gov/cfr/retrieve.html on the Internet. The 2008 payment limits for splints and casts will be based on the 2007 limits that were announced in CR 5382 last year, increased by 2.7 percent, the percentage change in the consumer price index for all urban consumers for the 12-month period ending June 30, 2007. The MLN Matters article related to CR 5382 can be viewed at: http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5382.pdf on the CMS Web site.
For intraocular lenses, payment is made only on a reasonable charge basis for lenses implanted in a physician’s office. Change Request 5740 instructs your carrier, or A/B MAC to compute 2008 customary and prevailing charges for the V2630, V2631, and V2632 (Intraocular Lenses Implanted in a Physician’s Office) using actual charge data from July 1, 2006, through June 30, 2007.

Carriers and A/B MACs will compute 2008 Inflation-Indexed Charge (IIC) amounts for the V2630, V2631, and V2632 that were not paid using gap-filled payment amounts in 2007.

DME MACs will compute 2008 customary and prevailing charges for the codes identified in the following tables using actual charge data from July 1, 2006, through June 30, 2007. For these same codes, they will compute 2008 IIC amounts for the codes identified in the following tables that were not paid using gap-filled amounts in 2007. These tables are:

### Dialysis Supplies Billed With AX Modifier

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Carriers and A/B MACs will make payment for splints and casts furnished in 2008 based on the lower of the actual charge or the payment limits established for these codes. Contractors will use the 2008 reasonable charges or the attached 2008 splints and casts payment limits to pay claims for items furnished from January 1, 2008 through December 31, 2008. **Those 2008 payment limits are in Attachment A at the end of this article.**

### Additional Information

Detailed instructions for Calculating:

- Reasonable charges are located in Chapter 23 (Section 80) of the Medicare Claims Processing Manual;
- Customary and prevailing charge are located in Section 80.2 and 80.4 of Chapter 23 of the Medicare Claims Processing Manual; and
- The IIC (Inflation Indexed Charge) are located in Section 80.6 of Chapter 23 of the Medicare Claims Processing Manual. The IIC update factor for 2008 is 2.7 percent.


For complete details regarding this Change Request (CR) please see the official instruction (CR5740) issued to your Medicare FI, carrier, DME MAC, or A/B MAC. That instruction may be viewed by going to: [http://www.cms.hhs.gov/transmittals/downloads/R1344CP.pdf](http://www.cms.hhs.gov/transmittals/downloads/R1344CP.pdf) on the CMS Web site.

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

### 2008 Payment Limits for Splints and Casts

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Revised Guidance for Completing Form CMS-1500

MLN Matters Number: MMS749 Revised
Related Change Request (CR) #: 5749
Related CR Release Date: December 14, 2007
Effective Date: January 1, 2008
Related CR Transmittal #: R1393CP
Implementation Date: January 7, 2008

NOTE: This article was revised on January 8, 2008, to show that items 32a and 32b are completed if required by Medicare claims processing policy. All other information remains the same.

Provider Types Affected
All physicians, providers, and suppliers who submit claims using Form CMS-1500 to Medicare contractors (carriers, Medicare Administrative Contractors (A/B MACs), and durable medical equipment Medicare Administrative Contractors (DME/MACs)).

Provider Action Needed
STOP – Impact to You
The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 5749 that notifies physicians and suppliers who use Claim Form CMS-1500 (those providers who qualify for a waiver from the Administrative Simplification Compliance Act (ASCA)) that changes are being made to submission instructions for completing boxes 32a and 32b of Form CMS-1500.

CAUTION – What You Need to Know
The Key Points section of this CR outlines the changes required in the Form CMS-1500.

GO – What You Need to Do
Make certain your office staffs are aware of these changes in the content requirements of the Form.

Background
The Form CMS-1500 claim completion instructions are being revised in order to provide guidance related to the submission of service facility identifiers.

The Form CMS-1500 answers the needs of many health insurers. It is the basic form prescribed by CMS for the Medicare program and 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 (ASCA) and the implementing regulation at 42 CFR 424.32.

Key Points
Providers note the changes in Chapter 26 of the Medicare Claims Processing Manual that impact the Form CMS-1500 boxes 32a and 32b.

Box 32a: If required by Medicare claims processing policy, enter the National Provider Identifier (NPI) of the service facility.
Box 32b: If required by Medicare claims processing policy, enter the legacy Provider Identification Number (PIN) of the service facility preceded by the ID qualifier 1C. There should be one blank space between the qualifier and the PIN.

Additional Information
To see the official instruction (CR5749) issued to your carrier, DME/MAC, or A/B MAC refer to: http://www.cms.hhs.gov/Transmittals/downloads/R1393CP.pdf on the CMS Web site.

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

VMS Modifications to Implement the Common Electronic Data Interchange (CEDI) System

MLN Matters Number: MM5755
Related Change Request (CR) #: 5755
Related CR Release Date: December 21, 2007
Effective Date: April 1, 2008
Related CR Transmittal #: R1402CP
Implementation Date: April 7, 2008

Provider Types Affected
Suppliers submitting claims to Medicare contractors (DME Medicare Administrative Contractors (DME MACs)) for services provided to Medicare beneficiaries.

Provider Action Needed
Change Request (CR) 5755 prescribes the requirements for the system changes necessary to prepare for the implementation of the DME MAC CEDI front end. CR5755 does not affect Fiscal intermediaries (FIs), carriers, Regional Home Health Intermediaries (RHHIs), the Fiscal Intermediary Standard System (FISS), or the Multi-Carrier System (MCS). This article is informational only for suppliers and suppliers need not make any changes to their claim submission processes.

Background
Currently, front-end electronic data interchange (EDI) processing for Durable Medical Equipment (DME) claims occurs in 4 separate systems. Two of these systems are operated by DME Medicare Administrative Contractor
(MACs), and two are operated by data center services contractors under direct contract with the Centers for Medicare & Medicaid Services (CMS).

The front-end EDI systems perform edits on incoming Medicare DME claims, and then it forwards the output data (from transactions that pass edits) to the core of the ViPS Medicare Shared System (VMS) claims processing environment. ViPS maintains the claim processing system used by your Durable Medical Equipment Medicare Administrative Contractor (DME MAC).

Each of the 4 systems used for DME front end transaction processing has been developed as a proprietary system, and logic specific to Medicare requirements was added to accommodate the Medicare claims transactions. Since each system is owned and developed by separate entities, variations exist in how individual front end systems process claims and in the results they produce. This can creates confusion for suppliers and beneficiaries.

Therefore, CMS requested a system analysis from ViPS regarding the system changes that would be required in order to remove or disable certain functionality of the current EDI front end systems. Removing or disabling certain functionality of the EDI front end systems would be in preparation for the implementation of the Common Electronic Data Interchange (CEDI) System, a common EDI front end at the DME MACs.

As a result of that analysis, CR5755 provides the requirements for the system changes necessary to prepare for the implementation of the DME MAC CEDI front end.

NOTE - CR5755 does not affect claims submitted to Medicare Fiscal intermediaries (FIs), carriers, Regional Home Health Intermediaries (RHIs), or Part A/B MACs.

Additional Information

The official instruction, CR5755, issued to your DME MAC regarding this change may be viewed at: http://www.cms.hhs.gov/Transmittals/downloads/R1402CP.pdf on the CMS Web site.

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

Durable Medical Equipment Medicare Administrative Contractors (DME MACs) - Discontinuance/Cancellation of the Use of a “WL” Modifier on Claims for the DeWall Posture Protector Orthotic Body Jacket HCPCS Code (L0430)

MLN Matters Number: MM5758
Related Change Request (CR) #: 5758
Related CR Release Date: October 15, 2007
Effective Date: July 16, 2007
Related CR Transmittal #: R295OTN
Implementation Date: November 16, 2007

Provider Types Affected

All suppliers who submit claims to durable medical equipment Medicare Administrative Contractors (DME MACs) for the DeWall Posture Protector Orthotic Body Jacket.

What Providers Need to Know

This article is based on Change Request (CR) 5758, which states that DME/MACs shall accept claims billed with Healthcare Common Procedure Coding System (HCPCS) Code L0430 with no modifier requirements for the DeWall Posture Protector Orthotic Body Jacket. See “Key Points” for specific details.

Background

On November 2, 2004, the Centers for Medicare & Medicaid Services (CMS) entered into a settlement agreement (“Stipulation for Compromised Settlement”) resolving the DeWall court case. The United States District Court for the District of Nebraska approved of the settlement and dismissed the DeWall case by Order dated November 3, 2004, (Filing 121). The settlement agreement stipulates that “code L0430 be reinstated for a period of five years from the date of reinstatement, with no modifiers, as a HCPCS L code, with a descriptor that indicates that it describes only the Dewall Posture Protector.”

On January 2, 2005, CMS reinsated code L0430 for the DeWall Posture Protector only, for a five-year period ending on December 31, 2009. By agreement of the parties, the five-year duration of the settlement agreement ending December 31, 2009, will be extended to August 1, 2012.

On July 16, 2007, CMS issued further instructions to the DME MACs to reiterate the terms of this court order and
ensure compliance with the stipulation to accept and process claims using the L0430 code, when the item furnished is a DeWall Posture Protector, without requiring any modifiers.

**Key Points**
In accordance with CR5758, DME MACs shall:

- Accept and process claims for the DeWall Posture Protector Spinal Orthosis, submitted using HCPCS code L0430, when the item furnished is a DeWall Posture Protector, without requiring any modifiers, including the "KX" or "WL" modifiers;
- Apply all other current applicable Medicare edits to such claims; and
- Upon implementation of CR5758, retire all use of the "WL" modifier.

**Additional Information**

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

**Items and Special Services Having Special DME Review Considerations**

**MLN Matters Number:** MM5765  
**Related Change Request (CR) #:** 5765  
**Related CR Release Date:** November 2, 2007  
**Effective Date:** April 1, 2008  
**Related CR Transmittal #:** R226PI  
**Implementation Date:** April 1, 2008

**Provider Types Affected**
Suppliers who submit claims to Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for DME items and services furnished to Medicare beneficiaries.

**What You Need to Know**
This article is informational for suppliers and is based on Change Request (CR) 5765 that alerts suppliers that the medical review (MR) function (Chapter 5 of the Program Integrity Manual (PIM) Items and Services Having Special DME Review Considerations) that was the responsibility of the DME Program Safeguard Contractors (PSCs) is being transitioned to the DME Medicare Affiliated Contractors (MACs).

**Background**
As a result of the MAC transition and effective April 1, 2008, the DME PSCs will be renamed Zone Program Integrity Contractors (ZPICs). This change of terminology from PSCs to ZPICs is noted in the PIM Chapter 5 revision. The PIM revision is attached to this CR5765 and the address is listed in the Additional Information section of this article.

**Key Points**

- DME/MACs will perform MR duties;
- DME/MACs will, at their discretion, recommend that the Centers for Medicare & Medicaid Services (CMS) initiate a potential Civil Monetary Penalty (CMP) case against the supplier; and
- DME/MACs will develop safeguards to investigate multiple claims for rental of the same or similar equipment from the same supplier within the same rental period.

**Additional Information**

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

**Handling Personally Identifiable Information (PII) on the Medicare Summary Notice (MSN)**

**MLN Matters Number:** MM5770  
**Related Change Request (CR) #:** 5770  
**Related CR Release Date:** December 19, 2007  
**Effective Date:** January 7, 2008  
**Related CR Transmittal #:** R1399CP  
**Implementation Date:** January 7, 2008

**Provider Types Affected**
Physicians, providers, and suppliers who submit claims to Medicare Carriers, Fiscal Intermediaries, (FIs), Medicare Administrative Contractors (A/B MACs), and Durable Medical Equipment Medicare Administrative Contractors (DME MACs)

**What You Need to Know**
When the Health Insurance Claim Number (HICN) and name of the beneficiary do not match on the submitted claim, Medicare carriers, intermediaries, and A/B MACs will return the claim to the provider as unprocessable. When non-institutional providers submit claims to Medicare...
carriers or A/B MACs that do not result in a match on name and HICN, the claim is returned with reason code 140 (Patient/Insured health identification number and name do not match).

In addition, effective January 7, 2008, on ALL MSNs, the first 5 digits of the HICN will be replaced with “XXX-XX” to avoid displaying the Medicare beneficiary’s personally identifiable information (PII). This applies to pay, no-pay, and duplicate copies of the MSN.

**Background**

This article is based on CR5770, which describes new procedures resulting from the Centers for Medicare & Medicaid Services (CMS) implementation of the Privacy Act and the Health Insurance Portability and Accountability Act (HIPAA). CR 5770 ensures that (1) MSNs are not issued when the HICN and name do not match, and (2) beneficiaries’ PII is protected on the MSN.

**Additional Information**


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

**Reporting a National Provider Identifier (NPI) and the “EY” Modifier on Claims for Durable Medical Equipment, Prosthetic, and Orthotic Supplies (DMEPOS) Items Dispensed without a Physician’s Order to Obtain a Medicare Denial for Coordination of Benefits (COB)**

**MLN Matters Number:** MM5771  
**Related Change Request (CR) #:** 5771  
**Related CR Release Date:** November 2, 2007  
**Effective Date:** May 23, 2008  
**Related CR Transmittal #:** R1368CP  
**Implementation Date:** April 7, 2008

**Provider Types Affected**

Suppliers who bill for DMEPOS for Medicare beneficiaries and require a Medicare Denial for COB purposes.

**Provider Action Needed**

- For Coordination of Benefit purposes, DMEPOS suppliers should use the modifier EY (no physician or other licensed health care provider order for this item or service) on each line item on the claim and report their own name and National Provider Identifier (NPI) in the “Ordering/Referring Provider Name” fields on claims submitted on or after May 23, 2008 to secure a Medicare denial. Failure to include the EY modifier on all line items will result in return of your claim as unprocessable. On such returned claims, the Medicare contractor will include Reason Code 4 to show that “The procedure code is inconsistent with the modifier used or a required modifier is missing.”
- If you have obtained a physician’s order for some, but not all, of the items provided to the Medicare beneficiary, submit a separate claim for the items dispensed without a physician’s order.

**Background**

Chapter 5, section 5.2.1 of the Medicare Program Integrity Manual (PIM) states that a supplier must have an order (prescription) from the treating physician prior to dispensing any DMEPOS item to a beneficiary and must keep the prescription for the item on file. However, although Medicare requires a physician’s order for payment of all DMEPOS items, not all secondary insurers maintain a similar requirement.

The Centers for Medicare & Medicaid Services (CMS) instituted modifier “EY” (no physician or other licensed health care provider order for this item or service) to allow DMEPOS suppliers to submit claims to Medicare for items without a prescription. Since there is no physician or provider information to report on claims for these items, the “EY” modifier is used in conjunction with a surrogate Unique Physician Identification Number (UPIN) in the ordering/referring provider name fields of the claim. This protocol was adopted so that suppliers could obtain a Medicare denial that could be sent to a secondary insurer for COB purposes.

In accordance with the NPI final rule, when an identifier is reported on a claim for the ordering/referring provider, i.e., any provider that is not a billing, pay-to or rendering provider, that identifier must be an NPI (See 45 CFR Part 162, CMS-045-F). For Medicare purposes, this means that submission of an NPI for an ordering/referring provider is mandatory, effective May 23, 2008, and legacy numbers may not be reported on any claims sent to Medicare as of this date. Therefore, Medicare will discontinue the use of all surrogate values on claims with dates of service on or after May 23, 2008.
To assure prompt processing of your claims affected by this issue:

- Your name should be reported in item 17 and your NPI in 17b of the CMS-1500 claim form, version 08-05; or
- Your name and NPI should be reported in both the 2420E (ordering provider name) and 2420F (referring provider name) loops of the ASC X12N 837 professional claim format.
- Make sure the “EY” modifier is present on each line item on the claim.

Additional Information

You may see the official instruction (CR5771) issued to your Medicare DME MAC by going to: http://www.cms.hhs.gov/Transmittals/downloads/R1368CP.pdf on the CMS Web site.

If you have questions, please contact your Medicare 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.

Update to Place of Service (POS) Code Set: New Code for Temporary Lodging

MLN Matters Number: MM5777
Related Change Request (CR) #: 5777
Related CR Release Date: November 2, 2007
Effective Date: April 1, 2008
Related CR Transmittal #: R1366CP
Implementation Date: April 7, 2008

Provider Types Affected

Providers, physicians, and suppliers who submit claims to Medicare carriers, Medicare Administrative Contractors (A/B MAC), or Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for services rendered to Medicare beneficiaries living in temporary lodging settings.

What You Need to Know

CR 5777, from which this article is taken updates the current Centers for Medicare & Medicaid Services (CMS) place of service (POS) code set to add a new code, “16,” for temporary lodging and implements the systems and local-contractor-level changes needed for Medicare to adjudicate claims with the new code.

You should make sure that your billing staffs are aware of this new POS code and also aware that (effective for claims initiated as of April 1, 2008) carriers, A/B MACs, and DME MACs will pay for covered services that are payable in the temporary lodging setting (POS code 16) at the non-facility rate.

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the effective date for nonmedical data code sets, of which the POS code set is one, is the code set in effect the date the transaction is initiated. It is not the date of service. Therefore, you may begin using this code, if appropriate, on claims initiated on or after April 1, 2008, regardless of date of service.

Background

Medicare, as a Health Insurance Portability and Accountability Act of 1996 (HIPAA) covered entity, must comply (by regulation) with the statute’s standards and their implementation guides. The implementation guide currently adopted for the ASC X12N 837 standard requires that each electronic claim transaction include a Place of Service (POS) code from the CMS POS code set.

One requirement of this standard’s implementation guide is that each professional claim contain a valid POS code from the POS code set maintained by CMS. Under HIPAA, as a payer, Medicare complies with this requirement by itself requiring a valid POS code on each 837 professional claim it receives. Similarly, when processing professional claims, Medicare must recognize as valid all valid codes from the POS code set. In addition, although not required by HIPAA, Medicare also requires a valid POS code on professional claims submitted on paper (the CMS 1500 form).

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

Effective for claims initiated on or after April 1, 2008, CMS is adding to the POS code set a new code for temporary lodging, “16,” and Medicare is preparing its systems to accept and adjudicate professional claims with this code when it is in effect. Under HIPAA, the effective date for nonmedical data code sets, of which the POS code set is one, is the code set in effect the date the transaction is initiated. It is not date of service.

Additional Information

You can find the official instruction, CR5777, issued to your

If you have any questions, please contact your carrier, A/B MAC, or DME MAC at their toll-free number, which may be found at: [http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip](http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip) on the CMS Web site.

### Crossover of Assignment of Benefits Indicator (CLM08) From Paper Claim Input

**MLN Matters Number:** MM5780  
**Related Change Request (CR) #:** 5780  
**Related CR Release Date:** November 2, 2007  
**Effective Date:** April 1, 2008  
**Related CR Transmittal #:** R1369CP  
**Implementation Date:** April 7, 2008

**Provider Types Affected**

Physicians and suppliers submitting paper claims to Medicare contractors (carriers, Durable Medical Equipment Medicare Administrative Contractors (DME MACs), and Part A/B Medicare Administrative Contractors (A/B MACs)) for services provided to Medicare beneficiaries.

**Provider Action Needed**

**STOP – Impact to You**

This article is based on Change Request (CR) 5780 which makes system changes to the manner in which the Medicare sets the CLM08 value in the Coordination of Benefits (COB) flat file for transmission of claims to COB partners.

**CAUTION – What You Need to Know**

CR 5780 will result in changes to Medicare systems to appropriately set the correct indicator in CLM08 based on the presence of or lack of a patient signature in box/item 13 of the Form CMS-1500.

**GO – What You Need to Do**

See the Background and Additional Information Sections of this article for further details regarding these changes and be sure billing personnel complete box/item 13 of the Form CMS-1500 in accordance with the revised instructions.

### Background

The basic claims form prescribed by the Centers for Medicare & Medicaid Services (CMS) for the Medicare program is the Form CMS-1500. It answers the needs of many health insurers, and 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 ([http://www.access.gpo.gov/nara/cfr/waisidx_02/42cfr424_02.html](http://www.access.gpo.gov/nara/cfr/waisidx_02/42cfr424_02.html)).

Coordination of Benefits (COB) trading partners requested that CMS change the current process of automatically setting a “Y” value in the CLM08 segment of the 837 Professional Coordination of Benefits (COB) claim crossover file. Trading partners may use the CLM08 value to determine where the claim reimbursement is to go and have, in some cases, reimbursed the provider instead of the beneficiary.

**NOTE** - CLM08 is the assignment of benefits indicator, and a “Y” value indicates insured or authorized person authorizes benefits to be assigned to the provider; an “N” value indicates benefits have not been assigned to the provider.

CR 5780 initiates system changes to appropriately set the correct indicator in CLM08 based on the presence of or lack of a signature in box/item 13 of the Form CMS-1500. In addition, CR5780 revises the Form CMS-1500 claim completion instructions in order to inform providers regarding how the presence or lack of a signature in box 13 will affect downstream patient assignment of benefits. Specifically, the Medicare Claims Processing Manual (Chapter 26, Section 10.3 – Items 11a-13 – Patient and Insured Information) is revised (changes are bolded and italicized) as follows:

"Item 13 - The patient's signature or the statement "signature on file" in this item authorizes payment of medical benefits to the physician or supplier. The patient or his/her authorized representative signs this item or the signature must be on file separately with the provider as an authorization."

The presence of or lack of a signature or "signature on file" in this field will be indicated as such to any downstream Coordination of Benefits trading partners (supplemental insurers) with whom we have a payer-to-payer coordination of benefits relationship. Medicare has no control over how supplemental claims are processed, so it is important that providers accurately address this field as it may or may not affect supplemental payments to providers and/or their patients.

In addition, the signature in this item authorizes payment of mandated Medigap benefits to the participating physician or supplier if required Medigap information is included in item 9 and its subdivisions. The patient or his/her authorized representative signs this item or the signature must be on file as a separate Medigap authorization. The Medigap assignment on file in the
participating provider of service/supplier’s office must be insurer specific. It may state that the authorization applies to all occasions of service until it is revoked."

NOTE: This can be “Signature on File” signature and/or a computer generated signature.”

The business requirements in CR 5780 do not affect inbound claims or current Medicare claims processing guidelines. They specifically address COB claims only which are sent to trading partners.

Additional Information

The official instruction, CR5680, issued to your carrier, DME MAC, and A/B MAC regarding this change may be viewed at:  http://www.cms.hhs.gov/Transmittals/downloads/R1369CP.pdf on the CMS Web site.

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

Remittance Advice Remark Code (RARC) and Claim Adjustment Reason Code (CARC) Update

MLN Matters Number: MM5800
Related Change Request (CR) #: 5800
Related CR Release Date: November 30, 2007
Effective Date: January 1, 2008
Related CR Transmittal #: R1384CP
Implementation Date: January 7, 2008

Provider Types Affected

Physicians, providers, and suppliers who submit claims to Medicare contractors (carriers, fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), Part A/B Medicare Administrative Contractors (A/B MACs), and Durable Medical Equipment Medicare Administrative Contractors (DME MACs)) for services.

Impact on Providers

CR 5800, from which this article is taken, announces the latest update of Remittance Advice Remark Codes used in electronic and paper remittance advice and Claim Adjustment Reason Codes used in electronic and paper remittance advice and coordination of benefits (COB) claim transactions. These changes will be effective January 1, 2008. Be sure billing staff are aware of these changes.

Background

Two code sets—the reason and remark code sets—must be used to report payment adjustments in remittance advice transactions. The reason codes are also used in some coordination-of-benefits transactions.

The remittance advice remark code list is maintained by the Centers for Medicare & Medicaid Service (CMS), and used by all payers; and additions, deactivations, and modifications to it may be initiated by both Medicare and non-Medicare entities. The health care claim adjustment reason code list is maintained by a national Code Maintenance committee that meets when X12 meets for their trimester meetings to make decisions about additions, modifications, and retirement of existing reason codes.

Both code lists are updated three times a year, and are posted at:  http://wpc-edi.com/codes on the Internet. The lists at the end of this article summarize the latest changes to the remark code lists, as announced in CR 5800, effective on January 1, 2008. As a reminder, CMS notes that the claim adjustment reason code of A2 (Contractual adjustment) is deactivated effective January 1, 2008.

CMS has developed a new Web site to help navigate the RARC database more easily. A tool is provided to help search if you are looking for a specific category of code. At this site, you can find some other information that is also available from the Washington Publishing Company (WPC) Web site. The new Web site address is:  http://www.cmsremarkcodes.info/ on the Internet.

Note that this Web site does not replace the Washington Publishing Company (WPC) site and, should there be any discrepancies between this site and the WPC site, consider the WPC site to be correct.

Additional Information

You may see the official instruction (CR5800) issued to your Medicare Carrier, A/B MAC, FI, DME MAC or RHHI by going to:  http://www.cms.hhs.gov/Transmittals/downloads/R1384CP.pdf on the CMS Web site.

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

### Remittance Advice Remark Code Changes

#### New Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Current Narrative</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>N388</td>
<td>Missing/incomplete/invalid prescription number. Note: (New Code 8/1/07)</td>
<td>Medicare initiated</td>
</tr>
<tr>
<td>N389</td>
<td>Duplicate prescription number submitted. Note: (New Code 8/1/07)</td>
<td>Medicare initiated</td>
</tr>
<tr>
<td>N390</td>
<td>This service cannot be billed separately. Note: (New Code 8/1/07)</td>
<td>Medicare initiated</td>
</tr>
<tr>
<td>N391</td>
<td>Missing emergency department records. Note: (New Code 8/1/07)</td>
<td>Not Medicare initiated</td>
</tr>
<tr>
<td>N392</td>
<td>Incomplete/invalid emergency department records. Note: (New Code 8/1/07)</td>
<td>Not Medicare initiated</td>
</tr>
<tr>
<td>N393</td>
<td>Missing progress notes or report. Note: (New Code 8/1/07)</td>
<td>Not Medicare initiated</td>
</tr>
<tr>
<td>N394</td>
<td>Incomplete/invalid progress notes or report. Note: (New Code 8/1/07)</td>
<td>Not Medicare initiated</td>
</tr>
<tr>
<td>N395</td>
<td>Missing laboratory report. Note: (New Code 8/1/07)</td>
<td>Not Medicare initiated</td>
</tr>
<tr>
<td>N396</td>
<td>Incomplete/invalid laboratory report. Note: (New Code 8/1/07)</td>
<td>Not Medicare initiated</td>
</tr>
<tr>
<td>N397</td>
<td>Benefits are not available for incomplete service(s)/undelivered item(s). Note: (New Code 8/1/07)</td>
<td>Not Medicare initiated</td>
</tr>
<tr>
<td>N398</td>
<td>Missing elective consent form. Note: (New Code 8/1/07)</td>
<td>Not Medicare initiated</td>
</tr>
<tr>
<td>N399</td>
<td>Incomplete/invalid elective consent form. Note: (New Code 8/1/07)</td>
<td>Not Medicare initiated</td>
</tr>
<tr>
<td>N400</td>
<td>Alert: Electronically enabled providers should submit claims electronically. Note: (New Code 8/1/07)</td>
<td>Not Medicare initiated</td>
</tr>
<tr>
<td>N401</td>
<td>Missing periodontal charting. Note: (New Code 8/1/07)</td>
<td>Not Medicare initiated</td>
</tr>
<tr>
<td>N402</td>
<td>Incomplete/invalid periodontal charting. Note: (New Code 8/1/07)</td>
<td>Not Medicare initiated</td>
</tr>
<tr>
<td>N403</td>
<td>Missing facility certification. Note: (New Code 8/1/07)</td>
<td>Not Medicare initiated</td>
</tr>
<tr>
<td>N404</td>
<td>Missing facility certification. Note: (New Code 8/1/07)</td>
<td>Not Medicare initiated</td>
</tr>
<tr>
<td>N405</td>
<td>This service is only covered when the donor’s insurer(s) do not provide coverage for the service. Note: (New Code 8/1/07)</td>
<td>Not Medicare initiated</td>
</tr>
<tr>
<td>N406</td>
<td>This service is only covered when the recipient’s insurer(s) do not provide coverage for the service. Note: (New Code 8/1/07)</td>
<td>Not Medicare initiated</td>
</tr>
<tr>
<td>N407</td>
<td>You are not an approved submitter for this transmission format. Note: (New Code 8/1/07)</td>
<td>Not Medicare initiated</td>
</tr>
<tr>
<td>N408</td>
<td>This payer does not cover deductibles assessed by a previous payer. Note: (New Code 8/1/07)</td>
<td>Not Medicare initiated</td>
</tr>
<tr>
<td>N409</td>
<td>This service is related to an accidental injury and is not covered unless provided within a specific time frame from the date of the accident. Note: (New Code 8/1/07)</td>
<td>Not Medicare initiated</td>
</tr>
<tr>
<td>N410</td>
<td>This is not covered unless the prescription changes. Note: (New Code 8/1/07)</td>
<td>Not Medicare initiated</td>
</tr>
<tr>
<td>N411</td>
<td>This service is allowed one time in a 6-month period. (This temporary code will be deactivated on 2/1/09. Must be used with Reason Code 119) Note: (New Code 8/1/07)</td>
<td>Not Medicare initiated</td>
</tr>
<tr>
<td>N412</td>
<td>This service is allowed 2 times in a 12-month period. (This temporary code will be deactivated on 2/1/09. Must be used with Reason Code 119) Note: (New Code 8/1/07)</td>
<td>Not Medicare initiated</td>
</tr>
<tr>
<td>N413</td>
<td>This service is allowed 2 times in a benefit year. (This temporary code will be deactivated on 2/1/09. Must be used with Reason Code 119) Note: (New Code 8/1/07)</td>
<td>Not Medicare initiated</td>
</tr>
<tr>
<td>N414</td>
<td>This service is allowed 4 times in a 12-month period. (This temporary code will be deactivated on 2/1/09. Must be used with Reason Code 119) Note: (New Code 8/1/07)</td>
<td>Not Medicare initiated</td>
</tr>
<tr>
<td>N415</td>
<td>This service is allowed 1 time in an 18-month period. (This temporary code will be deactivated on 2/1/09. Must be used with Reason Code 119) Note: (New Code 8/1/07)</td>
<td>Not Medicare initiated</td>
</tr>
<tr>
<td>N416</td>
<td>This service is allowed 1 time in a 3-year period. (This temporary code will be deactivated on 2/1/09. Must be used with Reason Code 119) Note: (New Code 8/1/07)</td>
<td>Not Medicare initiated</td>
</tr>
<tr>
<td>N417</td>
<td>This service is allowed 1 time in a 5-year period. (This temporary code will be deactivated on 2/1/09. Must be used with Reason Code 119) Note: (New Code 8/1/07)</td>
<td>Not Medicare initiated</td>
</tr>
<tr>
<td>N418</td>
<td>Misrouted claim. See the payer’s claim submission instructions. Note: (New Code 8/1/07)</td>
<td>Not Medicare initiated</td>
</tr>
<tr>
<td>N419</td>
<td>Claim payment was the result of a payer’s retroactive adjustment due to a retroactive rate change. Note: (New Code 8/1/07)</td>
<td>Not Medicare initiated</td>
</tr>
<tr>
<td>N420</td>
<td>Claim payment was the result of a payer’s retroactive adjustment due to a Coordination of Benefits or Third Party Liability Recovery. Note: (New Code 8/1/07)</td>
<td>Not Medicare initiated</td>
</tr>
<tr>
<td>N421</td>
<td>Claim payment was the result of a payer’s retroactive adjustment due to a Peer Review Organization decision. Note: (New Code 8/1/07)</td>
<td>Not Medicare initiated</td>
</tr>
<tr>
<td>N422</td>
<td>Claim payment was the result of a payer’s retroactive adjustment due to a payer’s contract incentive program. Note: (New Code 8/1/07)</td>
<td>Not Medicare initiated</td>
</tr>
</tbody>
</table>
New Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Current Narrative</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>N423</td>
<td>Claim payment was the result of a payer's retroactive adjustment due to a non standard program. <strong>Note:</strong> (New Code 8/1/07)</td>
<td>Not Medicare initiated</td>
</tr>
<tr>
<td>N424</td>
<td>Patient does not reside in the geographic area required for this type of payment. <strong>Note:</strong> (New Code 8/1/07)</td>
<td>Not Medicare initiated</td>
</tr>
<tr>
<td>N425</td>
<td>Statutorily excluded service(s). <strong>Note:</strong> (New Code 8/1/07)</td>
<td>Not Medicare initiated</td>
</tr>
<tr>
<td>N426</td>
<td>No coverage when self-administered. <strong>Note:</strong> (New Code 8/1/07)</td>
<td>Not Medicare initiated</td>
</tr>
<tr>
<td>N427</td>
<td>Payment for eyeglasses or contact lenses can be made only after cataract surgery. <strong>Note:</strong> (New Code 8/1/07)</td>
<td>Not Medicare initiated</td>
</tr>
<tr>
<td>N428</td>
<td>Service/procedure not covered when performed in this place of service. <strong>Note:</strong> (New Code 8/1/07)</td>
<td>Not Medicare initiated</td>
</tr>
<tr>
<td>N429</td>
<td>This is not covered since it is considered routine. <strong>Note:</strong> (New Code 8/1/07)</td>
<td>Not Medicare initiated</td>
</tr>
</tbody>
</table>

**NOTE** - Some remark codes may provide only information. They may not necessarily supplement the explanation provided through a reason code, or, in some cases another/other remark code(s), for an adjustment. Codes that are informational will have "Alert" in the text to identify them as informational rather than explanatory codes. For example, this informational code is sent per state regulation, but does not explain any adjustment:

N369 Alert: Although this claim has been processed, it is deficient according to state legislation/regulation.

These informational codes will be used only if specific information needs to be communicated but not as default codes.

Modified Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Current Narrative</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>M27</td>
<td><strong>Alert:</strong> The patient has been relieved of liability of payment of these items and services under the limitation of liability provision of the law. The provider is ultimately liable for the patient's waived charges, including any charges for coinsurance, since the items or services were not reasonable and necessary or constituted custodial care, and you knew or could reasonably have been expected to know, that they were not covered. You may appeal this determination. You may ask for an appeal regarding both the coverage determination and the issue of whether you exercised due care. The appeal request must be filed within 120 days of the date you receive this notice. You must make the request through this office.</td>
<td>Modified 10/1/02, 8/1/05, 4/1/07, 8/1/07</td>
</tr>
<tr>
<td>M70</td>
<td><strong>Alert:</strong> The patient is a member of an employer-sponsored prepaid health plan. Services from outside that health plan are not covered. However, as you were not previously notified of this, we are paying this time. In the future, we will not pay you for non-plan services.</td>
<td>Modified 4/1/07, 8/1/07</td>
</tr>
<tr>
<td>MA14</td>
<td><strong>Alert:</strong> The patient is a member of an employer-sponsored prepaid health plan. Services from outside that health plan are not covered. However, as you were not previously notified of this, we are paying this time. In the future, we will not pay you for non-plan services.</td>
<td>Modified 4/1/07, 8/1/07</td>
</tr>
<tr>
<td>M62</td>
<td><strong>Alert:</strong> This is a telephone review decision.</td>
<td>Modified 4/1/07, 8/1/07</td>
</tr>
<tr>
<td>N12</td>
<td>Policy provides coverage supplemental to Medicare. As the member does not appear to be enrolled in the applicable part of Medicare, the member is responsible for payment of the portion of the charge that would have been covered by Medicare.</td>
<td>Modified 8/1/07</td>
</tr>
<tr>
<td>N84</td>
<td><strong>Alert:</strong> Further installment payments are forthcoming.</td>
<td>Modified 4/1/07, 8/1/07</td>
</tr>
<tr>
<td>N85</td>
<td><strong>Alert:</strong> This is the final installment payment.</td>
<td>Modified 4/1/07, 8/1/07</td>
</tr>
<tr>
<td>N129</td>
<td>Not eligible due to the patient's age.</td>
<td>New Code 10/31/02, Modified 8/1/07</td>
</tr>
</tbody>
</table>

Fee Schedule Update for 2008 for Durable Medical Equipment, Prosthetics, Orthotics and Supplies

**MLN Matters Number:** MM5803  **Related Change Request (CR) #:** 5803
**Related CR Release Date:** December 7, 2007  **Effective Date:** January 1, 2008
**Related CR Transmittal #:** R1388CP  **Implementation Date:** January 7, 2008

**Provider Types Affected**

Providers and suppliers submitting claims to Medicare contractors (carriers, DME Medicare Administrative Contractors (DME MACs), Fiscal Intermediaries (FIs), Part A/B Medicare Administrative Contractors (A/B MACs), and/or Regional Home Health Intermediaries (RHHIs)) for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) provided to Medicare beneficiaries.
Provider Action Needed
This article is based on Change Request (CR) 5803, which provides the annual update to the 2008 DMEPOS fee schedules in order to implement fee schedule amounts for new codes and to revise any fee schedule amounts for existing codes that were calculated in error. Be sure your billing staff are aware of these changes.

Background
This recurring update notification, CR5803, provides specific instructions regarding the 2008 annual update for the DMEPOS fee schedule. Payment on a fee schedule basis is required for durable medical equipment (DME), prosthetic devices, orthotics, prosthetics, and surgical dressings by §1834(a), (h), and (i) of the Social Security Act. Payment on a fee schedule basis is required for parenteral and enteral nutrition (PEN) by regulations contained at 42 CFR 414.102.

The update process for the DMEPOS fee schedule is located in the Medicare Claims Processing Manual (Publication 100-04, Chapter 23, Section 60; http://www.cms.hhs.gov/manuals/downloads/clm104c23.pdf) on the Centers for Medicare & Medicaid Services (CMS) Web site. Other information on the fee schedule, including access to the DMEPOS fee schedules is at: http://www.cms.hhs.gov/DMEPOSFeeSched/01_overview.asp on the CMS Web site.

Key Points
- The following codes are being deleted from the HCPCS effective January 1, 2008, and are therefore being removed from the DMEPOS and PEN fee schedule files:

<table>
<thead>
<tr>
<th>B4086</th>
<th>L1870</th>
<th>L3830</th>
<th>L3910</th>
<th>L3930</th>
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<td>E2618</td>
<td>L1880</td>
<td>L3835</td>
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</tbody>
</table>

- The payment category for code K0730 is revised to move the controlled dose inhalation drug delivery system from the DME payment category for capped rental items to the DME payment category for inexpensive and routinely purchased items, effective January 1, 2008. The total payment for inexpensive and/or routinely purchased items may not exceed the fee schedule amount for purchase of the equipment. In the case of controlled dose inhalation drug delivery systems furnished on a purchase basis on or after January 1, 2008, the allowed payment amount will be reduced by the total rental payments previously made for the item.
- The fee schedule amounts established for HCPCS codes K0553, K0554 and K0555 will directly crosswalk to new HCPCS codes A7027, A7028 and A7029, respectively.
- As of the July 2007 HCPCS Quarterly Update, the following composite dressing HCPCS codes are non-covered by Medicare, effective July 1, 2007: A6200, A6201 and A6202. To reflect this change, the fee schedule amounts for codes A6200, A6201 and A6202 will be removed from the fee schedule file as part of this update. Medicare Contractors will deny claims for A6200, A6201 and A6202 with dates of service July 1, 2007 through December 31, 2007.
- CMS will establish fee schedule amounts for the following HCPCS codes : B4087, B4088, E2312, E2312KC, E2373, E2313, L1846, L3808, L3923, L3764, L3763, L3925, L3929, and L3931. These fee schedule amounts will be added to the fee schedule file on January 1, 2008, and are effective for claims with dates of service on or after January 1, 2008. The existing fee schedule amounts for HCPCS code E2373 will become the full replacement E2373 KC fees, effective January 1, 2008.
- Suppliers are to submit the KC modifier when billing for the full replacement of HCPCS power wheelchair interface codes E2373 and E2312.
- Note that HCPCS codes E0328 and E0329 are rarely appropriate for Medicare billings; payment for pediatric beds represented by these codes will be based on individual Medicare contractor consideration.
- As part of this update, CMS is implementing the 2008 national monthly payment rates for stationary oxygen equipment, (HCPCS codes E0424, E0439, E1390 and E1391), effective for claims with dates of service on or after January 1, 2008. CMS is revising the fee schedule file to include the new 2008 monthly payment rate of $199.28 for stationary oxygen equipment. As required by statute, these payment rates are adjusted annually to assure budget neutrality on the addition of the new oxygen generating portable equipment class. Accordingly, a reduction to the national monthly payment amount for stationary oxygen equipment for 2008 that is necessary to offset payments under the new class will be slightly lower ($0.56) (from $199.84 to $199.28) than previously announced.
- As a result of the above adjustments, CMS is also revising the fee schedule amounts for HCPCS codes E1405 and E1406 as part of this update. Since 1989, the fees for codes E1405 and E1406 have been
established based on a combination of the Medicare payment amounts for stationary oxygen equipment and nebulizer codes E0585 and E0570, respectively.

The following are the new HCPCS codes, effective January 1, 2008:

<table>
<thead>
<tr>
<th>Code 1</th>
<th>Code 2</th>
<th>Code 3</th>
<th>Code 4</th>
<th>Code 5</th>
<th>Code 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>A2452</td>
<td>A9274</td>
<td>B4088</td>
<td>E2312</td>
<td>L3931</td>
<td>L7622</td>
</tr>
<tr>
<td>A5083</td>
<td>A9276</td>
<td>E0328</td>
<td>E2313</td>
<td>L7611</td>
<td>V2787</td>
</tr>
<tr>
<td>A6413</td>
<td>A9277</td>
<td>E0329</td>
<td>E2397</td>
<td>L7612</td>
<td></td>
</tr>
<tr>
<td>A7027</td>
<td>A9278</td>
<td>E0856</td>
<td>L3925</td>
<td>L7613</td>
<td></td>
</tr>
<tr>
<td>A7028</td>
<td>A9283</td>
<td>E2227</td>
<td>L3927</td>
<td>L7614</td>
<td></td>
</tr>
<tr>
<td>A7029</td>
<td>B4087</td>
<td>E2228</td>
<td>L3929</td>
<td>L7621</td>
<td></td>
</tr>
</tbody>
</table>

**Additional Information**

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

You may see the official instruction (CR5803) issued to your Medicare A/B MAC, FI, DMERC, DME/MAC, RHHI or carrier by going to: http://www.cms.hhs.gov/Transmittals/downloads/R1388CP.pdf on the CMS Web site.

**Nebulized Beta Adrenergic Agonist Therapy for Lung Diseases**

**MLN Matters Number:** MM5820  
**Related Change Request (CR) #:** 5820  
**Related CR Release Date:** December 21, 2007  
**Effective Date:** September 10, 2007  
**Related CR Transmittal #:** R79NCD  
**Implementation Date:** January 22, 2008

**Provider Types Affected**

Providers and suppliers who bill Medicare contractors (fiscal intermediaries (FI), regional home health intermediaries (RHHI), carriers, Medicare Administrative Contractors (A/B MAC), and Durable Medical Equipment Contractors (DME MAC) for nebulized beta adrenergic agonist therapy services for lung diseases.

**What You Need to Know**

CR 5820, from which this article is taken, provides that (effective September 10, 2007) no National Coverage Determination (NCD) for nebulized beta adrenergic agonist therapy for lung diseases is appropriate. Therefore, you should make sure that your billing staffs are aware that local contractors will continue to make Section 1862(a)(1)(A) reasonable and necessary decisions through a local coverage determination process or case-by-case adjudication.

**Note:** No changes to process or policy are being made with CR5820.

**Background**

Lung diseases such as chronic obstructive pulmonary disease (COPD) and asthma are characterized by airflow limitation that may be partially or completely reversible. Pharmacologic treatment with bronchodilators (intended to improve the movement of air into and from the lungs by relaxing and dilating the bronchial passageways) is used to prevent and/or control daily symptoms that may cause disability for persons with these diseases.

Beta adrenergic agonists (which can be administered via nebulizer, metered dose inhaler, orally, or dry powdered inhaler) are a commonly prescribed class of bronchodilator drug. For example, nebulized beta adrenergic agonist with racemic albuterol has been used for many years, and more recently, levalbuterol, the (R) enantiomer of racemic albuterol, has been used in some patient populations.

Because of concerns regarding the appropriate use of nebulized beta adrenergic agonist therapy for lung disease, the Centers for Medicare & Medicaid Services (CMS) internally generated a formal request for a national coverage determination (NCD) to determine when treatment with a nebulized beta adrenergic agonist is reasonable and necessary for Medicare beneficiaries with COPD.

The examination of the published medical evidence did not provide sufficient information that would enable CMS to define, at this time, specific populations of patients who would benefit from a particular treatment with particular medications. Moreover, because an NCD is defined, in part, as including “whether or not a particular item or service is covered nationally” under title XVIII, sections 1862(l), 1869(f)(1)(B); CMS does not believe a national policy is possible or prudent at this time.

Therefore, effective with dates of service on and after September 10, 2007, Medicare contractors will continue to make 1862(a)(1)(A) reasonable and necessary decisions and process claims for nebulized beta adrenergic agonist therapy for lung disease through their local coverage determination process or case-by-case adjudication.

**Note:** No changes to process or policy are being made with CR5820.

**Additional Information**

You can find the official instruction, CR 5820, issued to your FI, RHHI, Carrier, A/B MAC, or DME MAC by visiting http://www.cms.hhs.gov/Transmittals/downloads/R79NCD.pdf on the CMS Web site. You will find the Medicare National
Annual Update of Healthcare Common Procedure Codes System (HCPCS) Codes Used for Home Health Consolidated Billing Enforcement

MLN Matters Number: MMS829
Related Change Request (CR) #: 5829
Related CR Release Date: December 14, 2007
Effective Date: January 1, 2008
Related CR Transmittal #: R1391CP
Implementation Date: January 7, 2008

Provider Types Affected
Physicians, suppliers, and providers who bill Medicare contractors (Fiscal Intermediaries (FIs), carriers, regional home health intermediaries (RHHIs), and DME Medicare Administrative Contractors (DME MACs) and Part A/B Medicare Administrative Contractors (A/B MACs)) for medical supply or therapy services.

What Providers Need to Know
The Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of Healthcare Common Procedure Codes System (HCPCS) codes subject to the consolidated billing provision of the Home Health Prospective Payment System (HH PPS). This article provides the annual HH consolidated billing update effective January 1, 2008. Affected providers may note the changes in the table listed within this article or consult the instruction issued to the Medicare contractors as listed in the Additional information section of this article.

Background
Section 1842(b)(6) of the Social Security Act (SSA) requires that payment for home health services provided under a home health plan of care be made to the home health agency (HHA). As a result, billing for all such items and services is to be done by a single HHA overseeing that plan. This HHA is known as the primary agency for HH PPS for billing purposes. Services appearing on this list that are submitted on claims to Medicare contractors will not be paid separately on dates when a beneficiary for whom such a service is being billed is in a home health episode (i.e., under a home health plan of care administered by an HHA). Exceptions include the following:

- Therapies performed by physicians;
- Supplies incidental to physician services; and
- Supplies used in institutional settings.

Medicare has issued a Recurring Update Notification, which provides the annual HH consolidated billing updates for non-routine supplies and therapies effective January 1, 2008. These lists are updated annually, effective each January 1, to reflect the annual changes to the HCPCS code set. The lists may also be updated as frequently as quarterly if required by the creation of temporary HCPCS codes during the year.

CR5829 provides the annual HH consolidated billing update effective January 1, 2008. The following tables describe the HCPCS codes and the specific changes to each that this notification is implementing for claims with dates of service on or after January 1, 2008.

<table>
<thead>
<tr>
<th>Table 1: Non Routine Supplies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Code</td>
</tr>
<tr>
<td>------</td>
</tr>
<tr>
<td>A5083</td>
</tr>
<tr>
<td>A5105</td>
</tr>
<tr>
<td>A6200</td>
</tr>
<tr>
<td>A6201</td>
</tr>
<tr>
<td>A6202</td>
</tr>
<tr>
<td>A6413</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Table 2: Therapies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Code</td>
</tr>
<tr>
<td>------</td>
</tr>
<tr>
<td>96125</td>
</tr>
</tbody>
</table>

Additional Information
For details regarding this CR, please see the official instruction issued to your Medicare FI, carrier, A/B MAC, RHHI, or DME MAC. This may be viewed at: [http://www.cms.hhs.gov/Transmittals/downloads/R1391CPpdf](http://www.cms.hhs.gov/Transmittals/downloads/R1391CPpdf) on the CMS Web site.
If you have questions, please contact your Medicare FI, carrier, A/B MAC, RHHI, or DME MAC at their toll-free number, which may be found at: [http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip](http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip) on the CMS Web site.

A complete historical listing of codes subject to HH consolidated billing can be found at: [http://www.cms.hhs.gov/HomeHealthPPS/03_coding&billing.asp](http://www.cms.hhs.gov/HomeHealthPPS/03_coding&billing.asp) on the CMS Web site.


### Update to Medicare Deductible, Coinsurance and Premium Rates for 2008

**MLN Matters Number:** MM5830  
**Related Change Request (CR) #:** 5830  
**Related CR Release Date:** December 14, 2007  
**Effective Date:** January 1, 2008  
**Related CR Transmittal #:** R49GI  
**Implementation Date:** January 7, 2008

#### Provider Types Affected

Providers who bill Medicare contractors (fiscal intermediaries (FI), regional home health intermediaries (RHHI), Medicare Administrative Contractors (A/B MAC), durable medical equipment Medicare Administrative Contractors (DME MAC) and carriers) for care rendered to Medicare beneficiaries.

#### What You Need to Know

CR5830, from which this article is taken, instructs Medicare contractors to update the claims processing system with new Medicare rates for deductible, coinsurance and premium payment amounts for CY 2008, as published in the Federal Register, CMS-8033-N, on October 2, 2007.

Most individuals age 65 and older (and many disabled individuals under age 65) are insured for Health Insurance (HI) benefits without a premium payment. In addition, the Social Security Act provides that certain aged and disabled persons who are not insured may voluntarily enroll, but are subject to the payment of a monthly Part A premium.

Since 1994, voluntary enrollees may qualify for a reduced Part A premium if they have 30-39 quarters of covered employment. When voluntary enrollment takes place more than 12 months after a person’s initial enrollment period, a 2-year 10% penalty is assessed for every year they had the opportunity to (but failed to) enroll in Part A.

#### Background

The details of CR5830 follow:

### 2008 Part A – Hospital Insurance (HI)

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

#### Hospital

- A beneficiary is responsible for an inpatient hospital deductible amount, which is deducted from the amount that the Medicare program pays the hospital for inpatient hospital services it furnishes in an illness episode.
- When a beneficiary receives such services for more than 60 days during an illness encounter, he or she is responsible for a coinsurance amount that is equal to one-fourth of the inpatient hospital deductible per day for the 61st-90th day spent in the hospital.

Please note that an individual has 60 lifetime reserve days of coverage, which they may elect to use after the 90th day in a spell of illness. The coinsurance amount for these days is equal to one-half of the inpatient hospital deductible.

#### Skilled Nursing Facility

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

These details are summarized in table 1A, below.

#### Table 1A: 2008 Part A – Hospital Insurance (HI)

<table>
<thead>
<tr>
<th>Deductible</th>
<th>$1,024.00</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coinurance</td>
<td></td>
</tr>
<tr>
<td>Hospital</td>
<td>Days 61-90</td>
</tr>
<tr>
<td></td>
<td>Days 91-150</td>
</tr>
<tr>
<td></td>
<td>(Lifetime Reserve Days)</td>
</tr>
<tr>
<td></td>
<td>$256.00</td>
</tr>
<tr>
<td></td>
<td>$512.00</td>
</tr>
<tr>
<td></td>
<td>$128.00</td>
</tr>
<tr>
<td>SKNF</td>
<td>Days 21-100</td>
</tr>
<tr>
<td></td>
<td>$512.00</td>
</tr>
<tr>
<td></td>
<td>$128.00</td>
</tr>
</tbody>
</table>

#### Table 1B: Voluntary Enrollees Part A Premium Schedule

<table>
<thead>
<tr>
<th>Base Premium (BP)</th>
<th>$423.00 per month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Base Premium with 10% Surcharge</td>
<td>$465.30 per month</td>
</tr>
<tr>
<td>Base premium with 45% Reduction</td>
<td>$233.00 per month (for those who have 30-39 quarters of coverage)</td>
</tr>
<tr>
<td>Base premium with 45% Reduction and 10% surcharge</td>
<td>$256.30 per month</td>
</tr>
</tbody>
</table>

Details of this coverage are summarized in table 1B, below.
2008 Part B - Supplementary Medical Insurance (SMI)

Under Part B, the Supplementary Medical Insurance (SMI) program, all enrollees are subject to a monthly premium. In addition, most SMI services are subject to an annual deductible and coinsurance (percent of costs that the enrollee must pay), which are set by statute. Further, when Part B enrollment takes place more than 12 months after a person’s initial enrollment period, there is a permanent 10% increase in the premium for each year the beneficiary had the opportunity to (but failed to) enroll.

For 2008, the standard premium for SMI services is $96.40 a month; the deductible is $135.00 a year; and the coinsurance is 20%.

You should be aware that the Part B premium is influenced by the beneficiary’s income. This influence is summarized in Table 2.

<table>
<thead>
<tr>
<th>Premium per month</th>
<th>Individual Income*</th>
<th>Joint Income (Married)^</th>
<th>Married but file Separate#</th>
</tr>
</thead>
<tbody>
<tr>
<td>$ 96.40</td>
<td>$ 82,000.00 or less</td>
<td>$ 164,000.00 or less</td>
<td>$ 82,000.00 or less</td>
</tr>
<tr>
<td>$122.20</td>
<td>$ 82,000.01 - $102,000.00</td>
<td>$ 164,000.01 - $204,000.00</td>
<td></td>
</tr>
<tr>
<td>$160.90</td>
<td>$102,000.01 - $153,000.00</td>
<td>$204,000.01 - $306,000.00</td>
<td></td>
</tr>
<tr>
<td>$199.70</td>
<td>$153,000.01 - $205,000.00</td>
<td>$306,000.01 - $410,000.00</td>
<td>$82,000.01 - $123,000.00</td>
</tr>
<tr>
<td>$238.40</td>
<td>$205,000.01 or more</td>
<td>$410,000.01 or more</td>
<td>$123,000.01 or more</td>
</tr>
</tbody>
</table>

* Individual Income = Beneficiaries who file an individual tax return (including those who are single, head of household, qualifying widow(er) with dependent child, or married filing separately who lived apart from their spouse for the entire taxable year)

^ Joint Income = Beneficiaries who are married and lived with their spouse at any time during the taxable year, and also filed a joint tax return.

# Married but file Separate = Beneficiaries who are married and lived with their spouse at any time during the taxable year, but file a separate tax return from their spouse.

Additional Information

You can find the official instruction, CR 5830, issued to your Medicare contractor by visiting http://www.cms.hhs.gov/Transmittals/downloads/R49GI.pdf 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.

January 2008 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files

MLN Matters Number: MM5852
Related Change Request (CR) #: 5852
Related CR Release Date: January 8, 2008
Effective Date: January 1, 2008
Related CR Transmittal #: R1406CP
Implementation Date: January 7, 2008

Provider Types Affected

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

What You Need to Know

CR 5852, from which this article is taken, instructs Medicare contractors to download and implement the January 2008 Average Sales Price (ASP) drug pricing file for Medicare Part B drugs; and if released by CMS, also the revised January 2007, April 2007, July 2007, October 2007, April 2006, July 2006, and October 2006 files.

Background

Section 303(c) of the Medicare Modernization Act of 2003 revised the payment methodology for Part B covered drugs and biologicals that are not paid on a cost or prospective payment basis. Beginning January 1, 2005, the vast majority of drugs and biologicals not paid on a cost or prospective payment basis are paid based on the average sales price (ASP) methodology, and pricing for compounded drugs has been performed by the local contractor.

Additionally, beginning in 2006, all end-stage renal disease (ESRD) drugs (that both independent and hospital-based ESRD facilities furnish), as well as specified covered outpatient drugs, and drugs and biologicals with pass-through status under the Outpatient Prospective Payment System (OPPS), are paid based on the ASP methodology. The ASP methodology is based on quarterly data that drug manufacturers submit to the Centers for Medicare & Medicaid Services (CMS), which CMS then provides (quarterly) to Medicare contractors (carriers, DME MACs, FIs, A/B MACs, and/or RHHIs) through the ASP drug pricing files for Medicare Part B drugs.
As announced in late 2006, CMS has been working further to ensure that accurate and separate payment is made for single source drugs and biologicals as required by Section 1847A of the Social Security Act. As part of the effort to ensure compliance with this requirement, CMS has also reviewed how the terms “single source drug,” “multiple source drug,” and “biological product” have been operationalized in the context of payment under section 1847A.

For the purpose of identifying “single source drugs” and “biological products” subject to payment under section 1847A, CMS (and its contractors) will generally utilize a multi-step process that will consider:

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

The payment limit for the following will be based on the pricing information for products marketed or sold under the applicable FDA approval:

- A biological product (as evidenced by a new FDA Biologic License Application or other relevant FDA approval), first sold in the United States after October 1, 2003; or
- A single source drug (a drug for which there are not two or more drug products that are rated as therapeutically equivalent in the most recent FDA Orange Book), first sold in the United States after October 1, 2003.

As appropriate, a unique HCPCS code will be assigned to facilitate separate payment. Separate payment may be operationalized through use of “not otherwise classified, (NOC)” HCPCS codes.

**ASP Methodology**

In general, 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% of the ASP. Beginning January 1, 2006, payment allowance limits are paid based on the ASP methodology for the following:

- ESRD drugs (when separately billed by freestanding and hospital-based ESRD facilities), and
- Specified covered outpatient drugs, and drugs and biologicals with pass-through status under the OPPS.

**Summary of Exceptions to this General Rule**

1. Except for blood clotting factors, the payment allowance limits for blood and blood products (that are not paid on a prospective payment basis) are determined in the same manner they were determined on October 1, 2003. Specifically, the payment allowance limits for blood and blood products are 95% of the average wholesale price (AWP) as reflected in the published compendia; and will be updated on a quarterly basis. Blood and blood products furnished in the hospital outpatient department are paid under OPPS at the amount specified for the APC to which the product is assigned.

**Note:** For 2006, the blood clotting furnishing factor of $0.146 per I.U. is added to the payment amount for the blood clotting factor when the blood clotting factor is not included on the ASP file. For 2007, the blood clotting furnishing factor of $0.152 per I.U. is added to the payment amount for a new blood clotting factor when a new blood clotting factor is not included on the ASP file. For 2008, a separate fee of $0.158 per I.U. of blood clotting factor furnished is payable when separate payment for the blood clotting factor is made. The furnishing fee will be included in the payment amounts on the quarterly ASP pricing files.

2. Payment allowance limits for infusion drugs furnished through a covered item of durable medical equipment (DME) on or after January 1, 2005, will continue to be 95% of the AWP as reflected in the published compendia as of October 1, 2003, unless the drug is compounded or incident to a professional service. The payment allowance limits will not be updated in 2008.

Similarly, payment allowance limits for infusion drugs furnished through a covered item of DME that were not listed in the published compendia as of October 1, 2003, (i.e., new drugs) are 95 percent (95%) of the first published AWP unless the drug is compounded or furnished incident to a professional service.

3. The payment allowance limits for influenza, Pneumococcal and Hepatitis B vaccines are 95% of the AWP as reflected in the published compendia except, when administered in a hospital outpatient department, the vaccines are paid at reasonable cost.

4. Except for new drugs and biologicals that are produced, or distributed, under a new drug application (or other application) approved by the Food and Drug Administration (FDA), the payment allowance limits for drugs and biologicals that are not included in the ASP Medicare Part B Drug Pricing File or Not Otherwise Classified (NOC) Pricing File, are based on the published wholesale acquisition cost (WAC) or invoice pricing (except under OPPS in which the payment allowance limit is 95% of the published AWP).

In determining the payment limit based on WAC,
contractors will follow the methodology specified in the Medicare Claims Processing Manual, Chapter 17, Drugs and Biologicals, for calculating the AWP but will substitute WAC for AWP. The payment limit is 100% of the lesser of the lowest-priced brand or median generic WAC.

5. The payment allowance limits for new drugs and biologicals that were first sold on or after January 1, 2005; and are: 1) Produced or distributed under a new drug application (or other new application) approved by the Food and Drug Administration, and 2) Not included in the ASP Medicare Part B Drug Pricing File or Not Otherwise Classified (NOC) Pricing File; are based on 106% of the WAC (or invoice pricing if the WAC is not published) except under OPPS in which the payment allowance limit is 95% of the published AWP.

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

7. The payment methodology for drugs furnished incident to the filling or refilling of an implantable pump or reservoir is determined under the ASP methodology (as described above) unless the drug furnished incident to the filling or refilling of an implantable pump or reservoir is a compounded drug, then pricing is performed by the local contractor.

Physicians (or a practitioner described in Section 1842(b) (18) (C)) may be paid for filling or refilling an implantable pump or reservoir when it is medically necessary that they perform the service. Contractors must find the use of the implantable pump or reservoir medically reasonable and necessary in order to allow payment for the professional service to fill or refill the implantable pump or reservoir and to allow payment for drugs furnished incident to the professional service.

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

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

On or after December 18, 2007, the January 2008 ASP file and ASP NOC files will be available for retrieval from the CMS ASP webpage. If CMS determines that revisions to the January 2007, April 2007, July 2007, October 2007, April 2006, July 2006 and October 2006 ASP payment files are necessary, the revised files will also be available for retrieval from the CMS webpage on or after December 18, 2007. The revised payment files will be applied to claims processed or reprocessed on or after this CR’s (5852) effective date.

Table 1 below displays the payment allowance limit revision dates, and the applicable dates of service.

<table>
<thead>
<tr>
<th>Payment Allowance Limit Revision Date</th>
<th>Applicable Dates of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Revised April 2007*</td>
<td>April 1, 2007 through June 30, 2007</td>
</tr>
<tr>
<td>Revised October 2007*</td>
<td>October 1, 2007 through December 31, 2007</td>
</tr>
<tr>
<td>Revised April 2006*</td>
<td>April 1, 2006 through June 30, 2006</td>
</tr>
<tr>
<td>Revised July 2006*</td>
<td>July 1, 2006, through September 30, 2006</td>
</tr>
<tr>
<td>Revised October 2006*</td>
<td>October 1, 2006, through December 31, 2006</td>
</tr>
</tbody>
</table>

*If made available by CMS

Note: The payment limits included in revised ASP and NOC payment files supersede the payment limits for these codes in any publication published prior to this document.

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

Contractors (at their discretion) may contact CMS to obtain payment limits for drugs and biologicals not included in the quarterly ASP or NOC files, or that CMS has not otherwise made available on its Web site. If the payment limit is available from CMS, contractors will substitute CMS-provided payment limits for pricing based on WAC or invoice pricing.

Contractors will not search for, and adjust, a claim that has already been processed unless you bring it to their attention.
Implementation
The implementation date is January 7, 2008.

Additional Information
For complete details, please see the official instruction (CR 5852) issued to your carriers, DME MACs, FIs, A/B MACs, and/or RHIs regarding this change, by visiting http://www.cms.hhs.gov/Transmittals/downloads/R1406CP.pdf on the CMS Web site.

If you have any questions, please contact your 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.

Skilled Nursing Facility Consolidated Billing and Preventive/Screening Services
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Implementation Date: N/A

Note: This article was revised on November 28, 2007 to clarify that services covered under the Part D benefit are not subject to SNF consolidated billing. The clarification is at the bottom of page 4 in bold. All other information remains unchanged.

Provider Types Affected
Skilled Nursing Facilities (SNFs), physicians, suppliers, and providers.

Provider Action Needed
This Special Edition is an informational article that describes SNF Consolidated Billing (CB) as it applies to preventive and screening services provided to SNF residents.

Clarification:
The SNF CB requirement makes the SNF itself responsible for including on the Part A bill that it submits to its Medicare intermediary almost all of the services that a resident receives during the course of a Medicare-covered stay, except for a small number of services that are specifically excluded from this provision. These “excluded” services can be separately furnished to the resident and billed under Medicare Part B by a variety of outside sources. These sources can include other providers of service (such as hospitals), which would submit the bill for Part B services to their Medicare intermediary, as well as practitioners and suppliers who would generally submit their bills to a Medicare Part B carrier. (Bills for certain types of items or equipment would be submitted by the supplier to their Durable Medical Equipment Medicare Administrative Contractor (DME MAC).

Background
When the Skilled Nursing Facility (SNF) prospective payment system (PPS) was introduced in the Balanced Budget Act of 1997 (BBA, P.L. 105-33, Section 4432), it changed the way SNFs are paid, and the way SNFs must work with suppliers, physicians, and other practitioners. CB assigns to the SNF itself the Medicare billing responsibility for virtually all of the services that the SNF’s residents receive during the course of a covered Part A stay. See MLN Matters article SE0431 for a detailed overview of SNF CB, including a section on services excluded from SNF CB. This article can be found at: http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0431.pdf on the CMS Web site.

Preventive and Screening Services
The BBA identified a list of services that are excluded from SNF CB. These services are primarily those provided by physicians and certain other types of medical practitioners, and they can be separately billed to Medicare Part B carriers directly by the outside entity that furnishes them to the SNF’s resident (Social Security Act, Section 1888(e)(2)(A)(ii)). Since the BBA did not list preventive and screening services among the services identified for exclusion, these services are included within the scope of the CB provision.

However, reimbursement for covered preventive and screening services, such as vaccines and mammographies, is subject to special billing procedures. As discussed in the May 12, 1998 Federal Register (63 FR 26296), since preventive services (such as vaccinations) and screening services (such as screening mammographies) do not appear on the exclusion list, they are subject to CB. Accordingly, if an SNF resident receives, for example, a flu vaccine during a covered Part A stay, the SNF itself is responsible for billing Medicare for the vaccine, even if it is furnished to the resident by an outside entity.

Billing for Preventive and Screening Services
Nevertheless, even though the CB requirement makes the SNF itself responsible for billing Medicare for a preventive or screening service furnished to its Part A resident, the SNF would not include the service on its Part A bill, but would instead submit a separate bill for the service. This is because the Part A SNF benefit is limited to coverage of “diagnostic or therapeutic” services (i.e., services that are reasonable and necessary to diagnose or treat a condition that has already manifested itself). (See Sections 1861(h) following (7), 1861(b)(3), and 1862(a)(1) of the Social Security Act.)
Accordingly, the Part A SNF benefit does not encompass screening services (which serve to check for the possible presence of a specific condition while it is still in an early, asymptomatic stage) or preventive services (which serve to ward off the occurrence of a condition altogether). As discussed below, such services are always covered under the applicable Part B benefit (or, in certain circumstances, under the Part D drug benefit), even when furnished to a beneficiary during the course of a covered Part A SNF stay.

**Priority of Payments**

Priority of payment between the various parts of the Medicare law (title XVIII of the Social Security Act) basically proceeds in alphabetical order: Part A is primary to Part B (see Section 1833(d) of the Social Security Act), and both Parts A and B are primary to Part D (see Section 1860D-2(e)(2)(B) of the Social Security Act). In the case of a vaccine, for example, this means that Part B can cover the vaccine only to the extent that it is not already coverable under Part A; similarly, the Part D drug benefit can cover such a vaccine only to the extent that it is not already coverable under either Part A or Part B.

Thus, when an SNF’s Part A resident receives a preventive vaccine for which a specific Part B benefit category exists (i.e., pneumococcal pneumonia, hepatitis B, or influenza), the vaccine would be covered under Part B. It would not be covered under Part A (because, as explained above, the scope of the Part A SNF benefit does not encompass preventive services), and it would also not be covered under Part D (because Part B already includes a specific benefit category that covers each of these three types of vaccines and, as discussed above, Part B is primary to Part D). Similarly, a preventive vaccine (such as poliomyelitis) for which no Part B benefit category exists would be coverable under the Part D drug benefit when administered to the SNF’s Part A resident, rather than being covered under the Part A SNF benefit.

**Example of Special Circumstance**

However, there are certain limited circumstances in which a vaccine would no longer be considered preventive in nature, and this can affect how the vaccine is covered. For example, while a booster shot of tetanus vaccine would be considered preventive if administered routinely in accordance with a recommended schedule, it would not be considered preventive when administered in response to an actual exposure to the disease (such as an animal bite, or a scratch on a rusty nail). In the latter situation, such a vaccine furnished to an SNF’s Part A resident would be considered reasonable and necessary to treat an existing condition and, accordingly, would be included within the SNF’s global Part A per diem payment for the resident’s Medicare-covered stay.

In terms of billing for an SNF’s Part A resident, a vaccine that is administered for therapeutic rather than preventive purposes (such as a tetanus booster shot given in response to an actual exposure to the disease) would be included on the SNF’s global Part A bill for the resident’s covered stay. Alternatively, if a vaccine is preventive in nature and is one of the three types of vaccines for which a Part B benefit category exists (i.e., pneumococcal pneumonia, hepatitis B, or influenza), then the SNF would submit a separate Part B bill to its fiscal intermediary for the vaccine. (Under Section 1886(e)(9) of the Social Security Act, payment for an SNF’s Part B services is made in accordance with the applicable fee schedule for the type of service being billed.) Finally, if the resident receives a type of preventive vaccine for which no Part B benefit category exists (e.g., poliomyelitis), then the vaccine would not be coverable under either Parts A or B, and so would be coverable under the Part D drug benefit.

Further, it is worth noting that unlike preventive services covered under Part B, those services covered under Part D are not subject to CB, even when furnished to an SNF’s Part A resident. This is because Section 1862(a)(18) of the Social Security Act specifies that CB applies to “...covered skilled nursing facility services described in section 1888(e)(2)(A)(i)....” Section 1888(e)(2)(A)(i), in turn, defines “covered skilled nursing facility services” specifically in terms of (I) Part A SNF services, along with (II) those non-excluded services that (if not for the enactment of CB) would be covered under Parts A or B...”

**Additional Information**

See MLN Matters Special Edition SE0431 for a detailed overview of SNF CB. This article lists services excluded from SNF CB and can be found at: [http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0431.pdf](http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0431.pdf) on the CMS Web site.


It includes the following relevant information:

- General SNF consolidated billing information;
- HCPCS codes that can be separately paid by the Medicare carrier (i.e., services not included in consolidated billing);
- Therapy codes that must be consolidated in a non-covered stay; and
- All code lists that are subject to quarterly and annual updates and should be reviewed periodically for the latest revisions.
The SNF PPS Consolidated Billing Web site can be found at: [http://www.cms.hhs.gov/SNFPPS/05_ConsolidatedBilling.asp](http://www.cms.hhs.gov/SNFPPS/05_ConsolidatedBilling.asp) on the CMS Web site. It includes the following relevant information:

- Background;
- Historical questions and answers;
- Links to related articles; and
- Links to publication (including transmittals and Federal Register notices).

### An Overview of Medicare Covered Diabetes Supplies and Services

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**Note:** This article was revised on December 12, 2007, to remove a bullet point on page 3 which indicated an initial prescription needed to specify how many lancets and test strips were needed for a month and to remove a second bullet from the same page that stated a new prescription is needed every 12 months for lancets and test strips. Both of these requirements were eliminated from local policy.

**Provider Types Affected**

Physicians, providers, suppliers, and other health care professionals who furnish or provide referrals for and/or file claims to Medicare contractors (carriers, DME Medicare Administrative Contractors (DME MACs), Fiscal Intermediaries (FIs), and/or Part A/B Medicare Administrative Contractors (A/B MACs)) for Medicare-covered diabetes benefits.

**Provider Action Needed**

This article is informational only and represents no Medicare policy changes.

### Background

Diabetes is the sixth leading cause of death in the United States, and approximately 20 million Americans have diabetes with an estimated 20.9 percent of the senior population age 60 and older being affected. Millions of people have diabetes and do not know it. Left undiagnosed, diabetes can lead to severe complications such as heart disease, stroke, blindness, kidney failure, leg and foot amputations, and death related to pneumonia and flu. Scientific evidence now shows that early detection and treatment of diabetes with diet, physical activity, and new medicines can prevent or delay much of the illness and complications associated with diabetes.

This special edition article presents an overview of the diabetes services and supplies covered by Medicare (Part B and Part D) to assist physicians, providers, suppliers, and other health care professionals who provide diabetic supplies and services to Medicare beneficiaries.

### Medicare Part B Covered Diabetic Supplies

Medical covers certain supplies if a beneficiary has Medicare Part B and has diabetes. These supplies include:

- Blood glucose self-testing equipment and supplies;
- Therapeutic shoes and inserts; and
- Insulin pumps and the insulin used in the pumps

### Blood Glucose Self-testing Equipment and Supplies

Blood glucose self-testing equipment and supplies are covered for all people with Medicare Part B who have diabetes. This includes those who use insulin and those who do not use insulin. These supplies include:

- Blood glucose monitors;
- Blood glucose test strips;
- Lancet devices and lancets; and
- Glucose control solutions for checking the accuracy of testing equipment and test strips.

Medicare Part B covers the same type of blood glucose testing supplies for people with diabetes whether or not they use insulin. However, the amount of supplies that are covered varies.

If the beneficiary:

- Uses insulin, they may be able to get up to 100 test strips and lancets every month, and 1 lancet device every 6 months.
- Does not use insulin, they may be able to get 100 test strips and lancets every 3 months, and 1 lancet device every 6 months.

If a beneficiary’s doctor documents why it is medically necessary, Medicare will cover additional test strips and lancets for the beneficiary.

Medicare will only cover a beneficiary’s blood glucose self-testing equipment and supplies if they get a prescription from their doctor.

Their prescription should include the following information:

- That they have diabetes;
- What kind of blood glucose monitor they need and why they need it (i.e., if they need a special monitor because of vision problems, their doctor must explain that);
- Whether they use insulin; and
- How often they should test their blood glucose.
- A beneficiary needing blood glucose testing equipment and/or supplies:
- Can order and pick up their supplies at their pharmacy;
Can order their supplies from a medical equipment supplier, but they will need a prescription from their doctor to place their order; and

Must ask for refills for their supplies.

Note: Medicare will not pay for any supplies not asked for, or for any supplies that were sent to a beneficiary automatically from suppliers. This includes blood glucose monitors, test strips, and lancets. Also, if a beneficiary goes to a pharmacy or supplier that is not enrolled in Medicare, Medicare will not pay. The beneficiary will have to pay the entire bill for any supplies from non-enrolled pharmacies or non-enrolled suppliers.

All Medicare-enrolled pharmacies and suppliers must submit claims for blood glucose monitor test strips. A beneficiary cannot submit a claim for blood glucose monitor test strips themselves. The beneficiary should make sure that the pharmacy or supplier accepts assignment for Medicare-covered supplies. If the pharmacy or supplier accepts assignment, Medicare will pay the pharmacy or supplier directly. Beneficiaries should only pay their coinsurance amount when they get their supply from their pharmacy or supplier for assigned claims. If a beneficiary’s pharmacy or supplier does not accept assignment, charges may be higher, and the beneficiary may pay more. They may also have to pay the entire charge at the time of service and wait for Medicare to send them its share of the cost.

Before a beneficiary gets a supply, it is important for them to ask the supplier or pharmacy the following questions:

- Are you enrolled in Medicare?
- Do you accept assignment?

If the answer to either of these two (2) questions is “no,” they should call another supplier or pharmacy in their area who answers “yes” to be sure their purchase is covered by Medicare, and to save them money.

If a beneficiary can not find a supplier or pharmacy in their area that is enrolled in Medicare and accepts assignment, they may want to order their supplies through the mail, which may also save them money.

Therapeutic Shoes and Inserts
If a beneficiary has Medicare Part B, has diabetes, and meets certain conditions (see below), Medicare will cover therapeutic shoes if they need them. The types of shoes that are covered each year include one of the following:

- One pair of depth-inlay shoes and three pairs of inserts; or
- One pair of custom-molded shoes (including inserts) if the beneficiary cannot wear depth-inlay shoes because of a foot deformity and two additional pairs of inserts.

Note: In certain cases, Medicare may also cover shoe modifications instead of inserts.

In order for Medicare to pay for the beneficiary’s therapeutic shoes, the doctor treating their diabetes must certify that they meet all of the following three conditions:

- They have diabetes;
- They have at least 1 of the following conditions in one or both feet:
  - Partial or complete foot amputation;
  - Past foot ulcers;
  - Calluses that could lead to foot ulcers;
  - Nerve damage because of diabetes with signs of problems with calluses;
  - Poor circulation; or
  - Deformed foot;
- They are being treated under a comprehensive diabetes care plan and need therapeutic shoes and/or inserts because of diabetes.

Medicare also requires the following:

- A podiatrist or other qualified doctor must prescribe the shoes, and
- A doctor or other qualified individual like a pedorthist, orthotist, or prosthetist must fit and provide the shoes to the beneficiary.

Medicare helps pay for one pair of therapeutic shoes and inserts per calendar year, and the fitting of the shoes or inserts is covered in the Medicare payment for the shoes.

Insulin Pumps and the Insulin Used in the Pumps
Insulin pumps worn outside the body (external), including the insulin used with the pump, may be covered for some people with Medicare Part B who have diabetes and who meet certain conditions. If a beneficiary needs to use an insulin pump, their doctor will need to prescribe it. In the Original Medicare Plan, the beneficiary pays 20% of the Medicare-approved amount after the yearly Part B deductible. Medicare will pay 80% of the cost of the insulin pump. Medicare will also pay for the insulin that is used with the insulin pump.

Medicare Part B covers the cost of insulin pumps and the insulin used in the pumps. However, if the beneficiary injects their insulin with a needle (syringe), Medicare Part B does not cover the cost of the insulin, but the Medicare prescription drug benefit (Part D) covers the insulin and the supplies necessary to inject it. This includes syringes, needles, alcohol swabs and gauze. The Medicare Part D plan will cover the insulin and any other medications to treat diabetes at home as long as the beneficiary is on the Medicare Part D plan’s formulary.

Coverage for diabetes-related durable medical equipment (DME) is provided as a Medicare Part B benefit. The
Medicare Part B deductible and coinsurance or copayment applies after the yearly Medicare part B deductible has been met. In the Original Medicare Plan, Medicare covers 80% of the Medicare-approved amount (after the beneficiary meets their annual Medicare Part B deductible of $131 in 2007), and the beneficiary pays 20% of the total payment amount (after the annual Part B deductible of $131 in 2007). This amount can be higher if the beneficiary’s doctor does not accept assignment, and the beneficiary may have to pay the entire amount at the time of service. Medicare will then send the beneficiary its share of the charge.

Medicare Part D Covered Diabetic Supplies and Medications
This section provides information about Medicare prescription drug coverage (Part D) for beneficiaries with Medicare who have or are at risk for diabetes. If a beneficiary wants Medicare prescription drug coverage, they must join a Medicare drug plan. The following diabetic medications and supplies are covered under Medicare drug plans:
- Diabetes supplies;
- Insulin;
- Anti-diabetic drugs.

Medicare Part B Covered Diabetic Services
All of the diabetes services listed in this section are covered by Medicare Part B unless otherwise noted. For people with diabetes, Medicare covers certain services. A doctor must write an order or referral for the beneficiary to get these services. These services include the following:
- Diabetes screenings;
- Diabetes self-management training;
- Medical nutrition therapy services;
- Hemoglobin A1c tests; and
- Special eye exams.

Diabetes Screenings
Medicare pays for a beneficiary to get diabetes screening tests if they are at risk for diabetes. These tests are used to detect diabetes early, and some, but not all, of the conditions that may qualify a beneficiary as being at risk for diabetes include:
- High blood pressure;
- Dyslipidemia (history of abnormal cholesterol and triglyceride levels);
- Obesity (with certain conditions);
- Impaired blood glucose tolerance; and
- High fasting blood glucose.

Diabetes screening tests are also covered if a beneficiary answers “yes” to two or more of the following questions:
- Are you age 65 or older?
- Are you overweight?
- Do you have a family history of diabetes (parents, siblings)?
- Do you have a history of gestational diabetes (diabetes during pregnancy), or
- Did you deliver a baby weighing more than 9 pounds?

Based on the results of these tests, a beneficiary may be eligible for up to 2 diabetes screenings every year at no cost (no coinsurance, or copayment or Part B deductible). Medicare will pay for a beneficiary to get 2 diabetes screening tests in a 12-month period, but not less than 6 months apart. After the initial diabetes screening test, the beneficiary’s doctor will determine when to do the second test. Diabetes screening tests that are covered include the following:
- Fasting blood glucose tests; and
- Other tests approved by Medicare as appropriate.

Diabetes Self-management Training (DSMT)
Diabetes self-management training helps a beneficiary learn how to successfully manage their diabetes. Their doctor or qualified non-physician practitioner must prescribe this training for them for Medicare to cover it. A beneficiary can get diabetes self-management training if they met one (1) of the following conditions during the last twelve (12) months:
- They were diagnosed with diabetes;
Classroom training includes topics such as the following:

- How to prevent, recognize, and treat acute and chronic complications from ones diabetes;
- Foot, skin, and dental care;
- How diet, exercise, and medication affect blood glucose;
- How to adjust emotionally to having diabetes;
- Family involvement and support; and
- The use of the health care system and community resources.

A beneficiary must get this training from an accredited diabetes self-management education program as part of a plan of care prepared by their doctor or qualified non-physician practitioner. These programs are accredited by the American Diabetes Association or the Indian Health Service. Classes are taught by health care providers who have special training in diabetes education.

A beneficiary is covered by Medicare to get a total of 10 hours of initial training within a continuous 12-month period. One of the hours can be given on a one-on-one basis. The other 9 hours must be training in a group class. The initial training must be completed no more than 12 months from the time the beneficiary starts the training.

An initial nutrition and lifestyle assessment; Nutrition counseling (what foods to eat and how to follow an individualized diabetic meal plan); How to manage lifestyle factors that affect diabetics; and Follow-up visits to check on progress in managing diet.

Beneficiaries learn how to successfully manage their diabetes in DSMT classes, and the training includes information on self-care and making lifestyle changes. The first session consists of an individual assessment to help the instructors better understand the beneficiary’s needs. Classroom training includes topics such as the following:

- General information about diabetes, and the benefits and risks of blood glucose control;
- Nutrition and how to manage ones diet;
- Options to manage and improve blood glucose control;
- Exercise and why it is important to ones health;
- How to take ones medications properly;
- Blood glucose testing and how to use the information to improve ones diabetes control;
- How to prevent, recognize, and treat acute and chronic complications from ones diabetes;
- Foot, skin, and dental care;
- How diet, exercise, and medication affect blood glucose;
- How to adjust emotionally to having diabetes;
- Family involvement and support; and
- The use of the health care system and community resources.

Note: If a patient lives in a rural area, they may be eligible to get DSMT in a Federally Qualified Health Center (FQHC). For more information about FQHCs, visit http://www.cms.hhs.gov/center/fqhc.asp on the CMS Web site. FQHCs are special health centers, usually located in urban or rural areas, and they can give routine health care at a lower cost. Some FQHCs are Community Health Centers, Tribal FQHC Clinics, Certified Rural Health Clinics, Migrant Health Centers, and Health Care for the Homeless Programs.

Medical Nutrition Therapy (MNT) Services

In addition to DSMT, medical nutrition therapy services are also covered for beneficiaries with diabetes or renal disease. To be eligible for this service, a beneficiary’s fasting blood glucose has to meet certain criteria. Also, their doctor must prescribe these services for them. These services can be obtained from a registered dietitian or certain nutrition professionals. MNT services covered by Medicare include the following:

- An initial nutrition and lifestyle assessment;
- Nutrition counseling (what foods to eat and how to follow an individualized diabetic meal plan);
- How to manage lifestyle factors that affect diabetics; and
- Follow-up visits to check on progress in managing diet.

Medicare covers 3 hours of one-on-one medical nutrition therapy services the first year the service is provided, and 2 hours each year after that. Additional MNT hours of service may be obtained if the beneficiary’s doctor determines there is a change in their diagnosis, medical condition, or treatment regimen related to diabetes or renal disease and orders additional MNT hours during that episode of care.

Foot Exams and Treatment

If a beneficiary has diabetes-related nerve damage in either of their feet, Medicare will cover 1 foot exam every 6...
months by a podiatrist or other foot care specialist, unless they have seen a foot care specialist for some other foot problem during the past 6 months. Medicare may cover more frequent visits to a foot care specialist if a beneficiary has had a non-traumatic (not because of an injury) amputation of all or part of their foot or their feet have changed in appearance which may indicate they have serious foot disease.

Hemoglobin A1c Tests
A hemoglobin A1c test is a lab test ordered by the beneficiary’s doctor. It measures how well a beneficiary’s blood glucose has been controlled over the past 3 months. Anyone with diabetes is covered for this test if it is ordered by their doctor. Medicare may cover this test when a beneficiary’s doctor orders it.

Glaucoma Tests
Medicare will pay for a beneficiary to have their eyes checked for glaucoma once every 12 months. This test must be done or supervised by an eye doctor who is legally allowed to give this service in their state.

Special Eye Exam
People with Medicare who have diabetes can get special eye exams to check for eye disease (called a dilated eye exam). These exams must be done by an eye doctor who is legally allowed to provide this service in their state. The dilated eye exam is recommended once a year and must be performed by an eye doctor who is legally allowed to provide this service in the beneficiary’s state.

Supplies and Services Not Covered by Medicare
The Original Medicare Plan and Medicare drug plans (Part D) don’t cover everything. Diabetes supplies and services not covered by Medicare include:

- Eye exams for glasses (eye refraction);
- Orthopedic shoes;
- Routine or yearly physical exams (Medicare will cover a one-time initial preventive physical exam (the “Welcome to Medicare” physical exam) within the first 6 months of the beneficiary enrolling in Part B—coinsurance and Part B deductible applies); and
- Weight loss programs.

Additional Information
- The Centers for Medicare & Medicaid Services (CMS) has developed a variety of educational resources for use by health care professionals and their staff as part of a broad outreach campaign to promote awareness and increase utilization of preventive services covered by Medicare. For more information about coverage, coding, billing, and reimbursement of Medicare-covered preventive services and screenings, visit [http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp#TopOfPage](http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp#TopOfPage) on the CMS Web site.
- **Medicare Learning Network** - The Medicare Learning Network (MLN) is the brand name for official CMS educational products and information for Medicare fee-for-service providers. For additional information visit the Medicare Learning Network’s web page at: [http://www.cms.hhs.gov/MLNGenInfo](http://www.cms.hhs.gov/MLNGenInfo) on the CMS Web site.
- **Patient Resources** - For literature to share with Medicare patients, please visit [http://www.medicare.gov](http://www.medicare.gov) on the Internet.
- If you have any questions, please contact your Medicare contractor (carrier, DME MAC, FI, and/or A/B MACs) at their toll-free number, which may be found at: [http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip](http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip) on the CMS Web site.

Special “Skilled Nursing Facility” (SNF) Definition Used in Determining Durable Medical Equipment (DME) Coverage, and in Ending a Benefit Period or “Spell of Illness”

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**Provider Types Affected**
Skilled Nursing Facilities (SNFs), Durable Medical Equipment (DME) Suppliers billing Medicare fiscal intermediaries (FIs), Medicare Administrative Contractors (A/B MACs), or DME MACs.

**What You Need to Know**
This article is for informational purposes only and does not represent any change in policy. Instead, it reinforces existing policy by providing legal, regulatory, and Medicare manual references for:
The definitions of SNFs and NFs;
The policies applicable to restricting payment for DME coverage in SNFs; and
The definition of the benefit period and of how one benefit period ends and another begins, especially as it applies to residents of SNFs.

Skilled Nursing Facility (SNF) Restriction on Coverage of Durable Medical Equipment (DME)
Coverage of a beneficiary’s skilled nursing facility (SNF) stay under Part A (the Original Medicare Plan’s hospital insurance program) encompasses the overall package of institutional care that the SNF furnishes during the course of the beneficiary’s Medicare-covered stay. This comprehensive Part A coverage includes durable medical equipment (DME) under the heading of “. . . drugs, biologicals, supplies, appliances, and equipment . . .” as stated in Section 1861(h)(5) of the Social Security Act (the Act). (The Social Security Act is available at: http://www.ssa.gov/OPP_Home/ssact/ssact-toc.htm on the Internet.)

When a beneficiary’s SNF stay does not qualify for Part A coverage (no qualifying 3-day hospital stay, SNF level of care not met, etc.), Part B (the supplementary medical insurance program) generally can still provide limited coverage for certain individual “medical and other health services” described in Section 1861(s) of the Act. However, as explained below, the scope of coverage under the Part B benefit for DME (Section 1861(s)(6) of the Act) specifically excludes items that are furnished for use in the SNF setting.

Section 1861(n) of the Act limits Part B coverage under the DME benefit to those items that are furnished for use in a patient’s home. This provision further specifies that any institution meeting the basic definition of a hospital in Section 1861(e)(1) of the Act, or of an SNF in Section 1819(a)(1) of the Act, cannot be considered a patient’s “home” for this purpose. Section 1819(a)(1) (formerly Section 1861(j)(1)) of the Act, in turn, defines an “SNF” broadly as any institution that is primarily engaged in providing skilled nursing (clause (A)) or rehabilitation services (clause (B)) to its residents.

This expansive SNF definition omits the specific, more restrictive elements contained in the remainder of Sections 1819(a)-(d) of the Act, which list the detailed requirements that an institution must meet in order to participate in the Medicare program as a certified SNF. Thus, in excluding Part B coverage for DME furnished in “SNFs” as defined broadly in Section 1819(a)(1) of the Act, Congress intended for this exclusion to encompass not only all Medicare-participating SNFs, but also any other institutions which, though not participating in Medicare, do provide the type of care described in that section of the law. This policy is also reflected in the regulations in title 42 of the Code of Federal Regulations (42 CFR) at §410.38(b), and in Chapter 15, Section 110.1.D of the Medicare Benefit Policy Manual, which is available at: http://www.cms.hhs.gov/manuals/iom/list.asp on the CMS Web site.

The blanket prohibition that Congress imposed on any separate Part B payment for DME furnished in this setting (See §144(d) of the Social Security Amendments of 1967, Public Law 90-248) would appear to reflect the view that any institution whose primary function is to provide skilled care to its residents would have an payment for such items is already an integral part of the skilled facility’s basic inpatient rate. Accordingly, any separate, additional DME payment under Part B in this situation would be redundant. Modifying or eliminating the statutory prohibition on Part B payment for DME furnished in this setting would require legislation to amend the law itself.

Additional Considerations for DME Furnished in Medicaid-Only Nursing Facilities (NFs)
Additional considerations apply in determining whether a Medicaid-only nursing facility (NF) would meet the basic SNF definition in this context. Medicaid NFs were created when the Omnibus Budget Reconciliation Act of 1987 (OBRA 1987, Public Law 100-203) enacted nursing home reform legislation that combined the previously separate Medicaid categories of SNFs and intermediate care facilities (ICFs) into a single category. Prior to the OBRA 1987 changes, Medicaid SNFs were always considered to meet the law’s basic definition of an SNF, while pursuant to a U.S. District Court decision in Kron v. Heckler (E.D. La., October 17, 1983), those facilities licensed or certified solely as ICFs were never considered to meet the basic SNF definition.

The parallel Medicare SNF and Medicaid NF definitions that OBRA 1987 established in Sections 1819(a)(1) and 1919(a)(1) of the Act, respectively, both turn on the type of care that the facility is primarily engaged in furnishing. However, while the NF definition in Section 1919(a)(1) of the Act contains a clause (A) for skilled nursing and a clause (B) for rehabilitation services that are identical to their SNF counterparts in Section 1819(a)(1) of the Act, it also contains an additional clause (C) for health-related institutional care above the level of room and board (comparable to the type of care furnished by ICFs prior to OBRA 1987), which is not found in the SNF definition.

Thus, if a Medicaid NF is primarily engaged in furnishing skilled care under either clauses (A) or (B) of Section 1919(a)(1) of the Act, it would meet the basic SNF definition and cannot be considered a “home” for purposes of DME coverage under Part B. Alternatively, if the NF is primarily engaged in furnishing essentially ICF-level care...
under clause (C) of this provision, it would not meet the basic SNF definition and can be considered a home for DME coverage purposes. Thus, because some NFs meet the basic SNF definition while others do not, NFs cannot as a class automatically be regarded as either qualifying or not qualifying as a “home” for DME coverage purposes and, therefore, must be evaluated individually under the administrative criteria discussed below.

Administrative Criteria
Administrative criteria to identify those institutions that meet the basic SNF definition are used by each of the State agencies that survey the individual institutions within their jurisdictions, and appear in Chapter 2, Section 2166 of the State Operations Manual. This manual is also available at: http://www.cms.hhs.gov/manuals/iom/list.asp on the CMS Web site. These criteria also were published in the Federal Register as HCFA Rulings 83-2 (47 FR 54551, December 3, 1982) and 83-3 (49 FR 10710, March 22, 1984). Historically, it has been the State survey agency’s responsibility to evaluate an institution in terms of these criteria. This evaluation reflects the type of care that the institution provides to its residents generally (rather than the type of care that an individual resident may be receiving at a given point in time), because the requirements of the law relate to the type of care that an institution is primarily engaged in providing to its overall resident population.

Further, as indicated in Chapter 2, Section 2164 of the State Operations Manual, States can choose to incorporate the requirements of Section 1819(a)(1) of the Act directly into their own facility licensure standards. In a State that elects to adopt this approach, simply ascertaining that a particular nursing home is licensed under the applicable facility category of State law can also serve to confirm that the facility meets the basic SNF definition in Section 1819(a)(1) of the Act.

Applying the Criteria in Institutions That Contain a Participating “Distinct Part”
Generally, the determination of whether an institution meets the basic SNF definition is made by evaluating it as a single unit rather than by separately evaluating and classifying individual areas within the institution. In order to categorize a particular portion of an institution separately from the remainder of that institution, it is necessary for that portion to constitute a “distinct part,” i.e., a separate, physically identifiable unit consisting of all the beds in a particular building, floor, wing, or ward (see the regulations at 42 CFR 483.5(b)).

In this situation, if the participating distinct part of an institution meets the basic SNF definition and the remainder of the institution does not, DME payment would be available under Part B only in the portion of the institution that qualifies as a “home” for DME coverage purposes. Part B payment would not be available for DME furnished in any part of the institution that is identified as meeting the basic SNF definition, regardless of the type of care that a particular resident may be receiving there.

A more detailed discussion of situations in which part of an institution meets the basic SNF definition and part of it does not appears in Chapter 5, Section 1 of the Medicare Program Integrity Manual, also available at: http://www.cms.hhs.gov/manuals/iom/list.asp on the CMS Web site. This is the same material that originally appeared in Section 4105.1 of the Medicare Carriers Manual, Part 3 (CMS Publication 14-3).

The Basic SNF Definition and the Medicare Policy on Ending a Benefit Period, or “Spell of Illness”
The special, broad definition of an SNF discussed above in connection with the DME coverage exclusion also figures in another aspect of Medicare policy, regarding the ending of a benefit period in an SNF. The law (at Section 1812(a) (2)(A) of the Act) provides for a maximum of 100 days of SNF benefits in a benefit period, or “spell of illness” (see Section 1861(a) of the Act). Medicare uses the benefit period concept to keep track of how many of these 100 days of SNF coverage a beneficiary has used, and how many are still available. A benefit period begins on the day that a beneficiary begins receiving Part A hospital or SNF benefits. Once the 100 days of SNF benefits available in the benefit period have been exhausted, they cannot be renewed until the current benefit period ends. Under Section 1861(a)(2) of the Act, this occurs when a period of 60 consecutive days has elapsed throughout which the beneficiary has not been an inpatient of a hospital or an SNF.

There is no limit to the number of benefit periods that a beneficiary can have. However, after a given benefit period ends, the beneficiary must once again meet all of the requirements for SNF coverage (3-day qualifying hospital stay, timely transfer to a Medicare-participating SNF, etc.) in order to begin utilizing the 100 days of renewed SNF benefits. The law’s reference to a benefit period as a “spell of illness” sometimes leads to the mistaken belief that a benefit period is linked to a particular medical episode or type of condition, so that the onset of a new and unrelated condition could serve to end the benefit period. In fact, however, this does not end the benefit period, which can occur in an SNF only under the circumstances described below.

As noted previously, Section 1861(a)(2) of the Act provides, in part, that a benefit period ends after a beneficiary has not been an inpatient of an SNF for 60 consecutive days.
In defining an “SNF” for this purpose, this provision uses the same broad SNF definition described in the preceding discussion on the DME coverage exclusion. This is reflected in the benefit period regulations at 42 CFR 409.60(b)(1)(iii), and in Chapter 3, Section 10.4.3.2 of the Medicare General Information, Eligibility and Entitlement Manual. This manual is available at [http://www.cms.hhs.gov/manuals/iom/list.asp](http://www.cms.hhs.gov/manuals/iom/list.asp) on the CMS Web site.

**Special “Inpatient” Definition for Ending a Benefit Period in an SNF**

However, unlike in the DME context, the benefit period policy additionally uses a special definition of the term “inpatient” as well. The instructions in Chapter 3, Section 10.4.4 of the Medicare General Information, Eligibility and Entitlement Manual indicate that a beneficiary in an institution that meets the basic SNF definition would be considered an “inpatient,” for benefit period purposes, only while actually receiving a skilled level of care there. These instructions also contain a set of administrative presumptions that simplify the process for determining whether the beneficiary is, in fact, receiving this level of care. This means that a beneficiary who remains in an SNF can nonetheless end a benefit period, after 60 consecutive days elapse during which the beneficiary does not receive a skilled level of care there (and, thus, is not considered an “inpatient” of the SNF for benefit period purposes).

This special “inpatient” definition, which reflects regulations at 42 CFR 409.60(b)(2), (c), and (d), and the Federal circuit court decision in Mayburg v. Heckler (740 F.2d 100 (1st Cir. 1984)), is intended to address situations in which a beneficiary essentially uses the SNF as a place of residence rather than as a provider of ongoing medical care. It is important to note as well that, under this policy, a beneficiary would still be considered an SNF “inpatient” (and his or her current benefit period would continue) for as long as the beneficiary keeps receiving a skilled level of care in the SNF—even if Medicare has stopped paying for the SNF stay due to the beneficiary’s exhaustion of Part A benefits.

Thus, if a particular nursing home does not meet the basic SNF definition, a beneficiary’s stay in that nursing home would not serve to prolong the current benefit period, regardless of the type of care being received there. Further, even when a beneficiary is in a nursing home that does meet the basic SNF definition, the beneficiary can nonetheless end a benefit period there after 60 consecutive days elapse during which he or she is not an “inpatient” of the SNF for benefit period purposes (that is, does not receive a skilled level of care). Accordingly, a nursing home stay would serve to prolong a benefit period only if both of the following two conditions are met:

- The nursing home meets the basic SNF definition; and
- The beneficiary remains an “inpatient,” for benefit period purposes, by continuing to receive a skilled level of care there.

**Additional Information**

If you have any questions regarding this issue, contact your Medicare FI, A/B MAC, or DME MAC at their toll free number, which is available at: [http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip](http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip) on the CMS Web site.

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**Individuals Authorized Access to CMS Computer Services - Provider Community (IACS-PC): THE FIRST IN A SERIES OF ARTICLES**

**MLN Matters Number:** SE0747  
**Related Change Request (CR) #:** N/A  
**Related CR Release Date:** N/A  
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**Related CR Transmittal #:** N/A  
**Implementation Date:** N/A

These articles will help providers to register for future access to CMS online computer services. This article contains:

- 10 questions and answers to get you started and
- Overview of the registration process for IACS-PC defined provider organization users.

**Provider Types Affected**

Physicians, providers, and suppliers who submit fee-for-service claims to Medicare contractors (carriers, fiscal intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), and Medicare Administrative Contractors (A/B MACs)).

**Special Note:** Durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers should not register for IACS-PC at this time. DMEPOS suppliers may want to review question #10 below.

**What Providers Need to Know**

In the near future, the Centers for Medicare & Medicaid Services (CMS) will be announcing new online enterprise applications that will allow Medicare fee-for-service providers to access, update, and submit information over the Internet. Details of these provider applications will be announced as they become available.

**Provider Action Needed**

Even though these new internet applications are not yet available, CMS recommends that providers take the time now to set up their online account so they can access...
these applications as soon as they are available. The first step is for the provider or appropriate staff to register for access through a new CMS security system known as the Individuals Authorized Access to CMS Computer Services - Provider Community (IACS-PC). See the following section for key questions and answers about the registration process.

10 Questions and Answers to Get You Started

1. What is IACS-PC?
   IACS-PC is a security system CMS uses to control issuance of electronic identities and access to new CMS provider web-based applications. Through IACS-PC, provider organizations, as defined by IACS-PC (see question #7 below), and their staff, as well as individual practitioners, will be able to access new CMS applications. Provider organizations will also be able to manage users who they authorize to conduct transactions on their behalf, which may include staff and contractors.

2. Who can use this system?
   Medicare providers and their designated representatives (e.g. clearinghouses, credentialing departments) may request access to CMS enterprise applications. At this time, the soon-to-be-announced online applications under IACS-PC do not include services to DMEPOS suppliers. (See question #10 below.)

3. Why register NOW?
   Since the new applications have not been announced at the time of this notice, it may be hard to decide if you should register to use the system. However, because IACS-PC registration must precede use, we recommend that individual practitioners and provider organizations (with the exception of DMEPOS suppliers) register now. Even if the IACS-PC registration process goes well and all documentation is in order, it can still take several weeks to finalize registration. Since the system is new, registering now gives you a “cushion” so that if there are delays in processing your registration, you will have the registration process complete in time to request access to the various CMS provider related computer services as soon as they are available early next year.

4. If I register now, how long is my password valid?
   Passwords expire in 60 days. After that point, when you log into IACS-PC, you will be prompted to create a new password to re-activate your account. Therefore, we recommend that once registered, you sign on periodically to IACS-PC to keep your current password active.

5. How do I register as an IACS-PC user?
   IACS-PC uses a self-registration process. The self-registration process that you will follow will depend on the type of IACS-PC user you are. There are two categories of user types: individual practitioners and provider organizations. There are step-by-step registration instructions to help you through this process.

   Note: The CMS Web site contains links to IACS user guides for other communities of users. Only use instruction links for the IACS-PC community as directed by CMS.

   The External User Services (EUS) Help Desk will support this process for IACS-PC. It may be reached by email at: EUSSupport@cgi.com or by phone on 1.866.484.8049 or TTY/TDD on 1.866.523.4759.

6. When would I register as an individual practitioner?
   An individual practitioner is defined by IACS-PC as a physician or non-physician practitioner. This is intended for practitioners who will be conducting transactions with online applications personally and have no staff who will be accessing the applications.


7. When would I register as an IACS-PC provider organization?
   The term “organization”, as defined by IACS-PC, should not be confused with the term organization as it applies to provider enrollment or the NPI. For IACS-PC registration purposes, “organization” includes providers and suppliers such as hospitals, home health agencies, skilled nursing facilities, independent diagnostic testing facilities, ambulance companies, ambulatory surgical centers and physician group practices.

   It also includes individual physicians and non-physician practitioners who want to delegate staff to conduct transactions on their behalf. In this case, for IACS-PC registration purposes, registration must be as an organization.

   IACS-PC provider organizations require Security Officials (see question #9 below) that establish the provider organization in IACS-PC. All users will then be grouped together within IACS-PC under the
provider organization Security Official.

8. What should I have in hand before I register?
For an individual practitioner (who will be conducting transactions with online applications personally and have no additional staff that will be accessing the applications) they will need to know their:
- Social Security Number and
- Correspondence Information.
For an IACS-PC provider organization, the Security Official (SO) of that organization will be the first person to register within IACS and create their organization. The SO should have the following organizational information available before they sign on to register:
- Taxpayer Identification Number (TIN);
- Legal Business Name;
- Corporate Address; and
- Internal Revenue Service (IRS) Issued CP-575 hard copy form.

9. How do I register my IACS-PC provider organization?
IACS-PC is based on a delegated authority model. Each organization must designate an SO who will register the organization via IACS-PC and then be accountable for users in the organization. Using information supplied via the IACS-PC registration as well as a mailed-in copy of the organization’s CP-575 form, CMS will verify the SO’s role in the organization, the TIN and the Legal Business Name of the organization. This can take several weeks. Once approved, the SO then has the ability to approve other registrants under the provider organization. For more detail, please read the Overview section, which follows question #10.


The next MLN article in this series of articles will provide instructions for additional users to register in IACS-PC.

10. Why are you excluding DMEPOS suppliers from IACS-PC?
DMEPOS suppliers should not register in IACS-PC at this time because we do not expect any new online services will be available to them in 2008. DMEPOS suppliers interested in the second round of DMEPOS competitive bidding should follow CMS DMEPOS Competitive Bid instructions which will be released closer to the 2008 bid window.

OVERVIEW: Registering in IACS-PC as a Provider Organization or a Provider Organization User
For IACS-PC registration purposes, “organization” includes providers and suppliers such as hospitals, home health agencies, skilled nursing facilities, independent diagnostic testing facilities, ambulance companies, ambulatory surgical centers, and physician group practices. It also includes individual physicians and non-physician practitioners who want to delegate employees to conduct transactions on their behalf.

I. The Registration Process
IACS-PC is based on a delegated authority model. Each user self-registers and is approved as shown below. The system is designed for flexibility to meet provider needs while assuring security of computer systems and privileged information. At able to access IACS-PC applications.

The “delegated authority model” previously described is below. The EUS Help Desk will be responsible for approving the organization’s Security Official. Then the Security Official may approve the Backup Security Official(s) etc.

![Diagram showing the registration process]

II. Registration Roles
1. The first person to register must be the Security Official.
The Security Official is the person who registers their organization in IACS-PC and updates the organization profile information in IACS-PC. There can be only one Security Official for an organization. The Security Official is trusted to approve the access request of Backup Security

The next MLN article in this series of articles will provide instructions for additional users to register in IACS-PC.
Official(s) and can approve the access requests of User Group Administrators and End Users. The Security Official will be approved by CMS through its EUS Help Desk. The Security Official is held accountable by CMS for the behavior of those they approve including the End Users for the organization.


Note: Additional employee and contractor users cannot be approved until the security official has been approved by the EUS Help Desk.

2. An organization may choose to have one or more Backup Security Officials. (Optional).
This is an optional role. You need not have a Backup Security Official. The Backup Security Official is approved by the Security Official. A Backup Security Official performs the same functions as a Security Official in an organization, with the exception of approving other Backup Security Officials. There can be one or more Backup Security Officials in an organization. The Backup Security Official can approve the access requests of User Group Administrators and End Users and may aid the Security Official with the administration of User Groups and User Group Administrators’ accounts.

3. The next registrant must be a User Group Administrator (UGA).
The UGA is approved by the Security Official or Backup Security Official. The UGA is trusted to approve the access requests of End Users for that User Group.
Organizations with 2-9 IACS-PC users must, at a minimum, have a Security Official and one or more UGAs. If there will be only one user in a group, that user must register as a UGA. A UGA registers the User Group within an organization in IACS-PC and updates the User Group profile information in IACS-PC. There can be multiple UGAs for the same User Group within an organization.

4. Organizations with 10 or more IACS-PC users must also have End Users.
An End User is a staff member who is trusted to perform Medicare business and conduct transactions for the provider organization. An End User may be an employee of a provider/supplier/practitioner or a contractor working on the behalf of one of these entities. An End User may belong to multiple groups in one or more organizations. The End User is approved by the UGA.

Note: End User requests cannot be approved until after the User Group Administrator has been approved.

III. Surrogate User Groups
This applies to provider organizations that want to delegate online work to individuals or a company outside of the provider organization. Under this scenario, those working on behalf of the provider organization register as a Surrogate User Group. Examples include clearinghouses, credentialing departments, independent contractors. A Surrogate User Group has a direct contractual business relationship with the Medicare provider/supplier, but not with CMS. A Surrogate User Group may be associated with multiple provider organizations.

1. The first contractor employee to register in a Surrogate User Group must be the UGA.
If there will be only one user in a Surrogate Group, that user must register as a UGA. The UGA for the Surrogate User Group will register the Surrogate User Group and update the User Group profile information in IACS-PC. There can be multiple UGAs within the same Surrogate User Group. The UGA is trusted to approve the access requests of End Users for their user group.

The UGA of the Surrogate User Group must be approved by the Security Official or Backup Security Official in the provider organization on whose behalf it performs work. Once approved, the UGA of a Surrogate Group may request to associate with other provider organizations for which it performs work without registering again.

2. A contractor employee may also register as an End User.
An End User is approved to perform Medicare business for a surrogate or provider User Group by their UGA. An End User may belong to multiple groups in one or more organizations.

III. Additional Help
The EUS Help Desk will support this process for IACS-PC. It may be reached by email at EUSSupport@cgi.com or by phone on 1.866.484.8049 or TTY/TDD on 1.866.523.4759.
2007 - 2008 Influenza (Flu) Season Resources for Health Care Professionals

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Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

Provider Types Affected
All Medicare fee-for-service (FFS) physicians, non-physician practitioners, providers, suppliers, and other health care professionals who bill Medicare for flu vaccines and vaccine administration provided to Medicare beneficiaries

Provider Action Needed
★ Keep this Special Edition MLN Matters article and refer to it throughout the 2007 - 2008 flu season.
★ Talk with your patients about their risk of contracting the flu virus and complications arising from the virus and encourage them to get the flu shot. (Medicare provides coverage of the flu vaccine and its administration without any out-of-pocket costs to the Medicare beneficiaries, i.e., no deductible or copayment/coinsurance.)
★ Stay abreast of the latest flu information and inform your patients.
★ Order appropriate provider resources for yourself and your staff.
★ Have appropriate literature on hand about seasonal flu that can be handed out to your patients during the flu season.
★ Don’t forget to immunize yourself and your staff – Get the Flu Shot – Not the Flu!

Introduction
Historically the flu vaccine has been an under-utilized benefit by Medicare beneficiaries. Yet, of the nearly 36,000 people who, on average, die every year in the United States from seasonal flu and complications arising from the flu, the majority of deaths occur in persons 65 years of age and older. People with chronic medical conditions such as diabetes and heart disease are considered to be at high risk for serious complications from the flu, as are people in nursing homes and other long-term care facilities. Complications of flu can include bacterial pneumonia, ear infections, sinus infections, dehydration, and worsening of chronic medical conditions, such as congestive heart failure, asthma, or diabetes.

Prevention is Key to Public Health!
★ While flu season can begin as early as October and last as late as May the optimal time to get a flu vaccine is in October or November. However, protection can still be obtained if the flu vaccine is given in December or later. The flu vaccine continues to be the most effective method for preventing flu virus infection and its potentially severe complications. You can help your Medicare patients reduce their risk for contracting seasonal flu and serious complications by recommending that they take advantage of the annual flu shot covered by Medicare.
★ Medicare Part B reimburses health care professionals who accept the Medicare-approved payment amount for the flu vaccine and its administration. There is no beneficiary coinsurance or copayment and beneficiaries do not have to meet their deductible to receive the flu shot.
★ Health care providers and their staff are also at risk for contracting the flu, so do not forget to immunize yourself and your staff. Protect yourself, your patients, your staff, and your family and friends. Get Your Flu Shot – Not the Flu!

Helping You Stay Informed
★ CMS has developed a variety of educational resources to help promote increased awareness and utilization of the flu vaccine among beneficiaries, providers, and their staff and to ensure that Medicare FFS health care professionals have the information they need to bill Medicare correctly for the flu vaccines and their administration.

Note: The following educational products have been developed by CMS to be used by Medicare FFS health care professionals and are not intended for distribution to Medicare beneficiaries.

Products
1. MLN Matters Articles
   - MM5744: Payment Allowances for the Influenza Virus Vaccine and the Pneumococcal Vaccine When Payment is Based on 95 Percent of the Average Wholesale Price (AWP) located at: http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5744.pdf on the CMS Web site.
   - MM5037: Reporting of Diagnosis Code V06.6 on Influenza Virus and/or Pneumococcal Pneumonia...

2. MLN Influenza Related Products for Health Care Professionals


- Medicare Preventive Services Series: Part 1 Adult Immunizations Web-based Training (WBT) Course: This WBT course contains four modules that include information about Medicare's coverage of influenza, pneumococcal, and hepatitis B vaccines. Module Four includes lessons on mass immunizers, roster billing, and centralized billing. This course was updated September 2007 and has been approved for .1 IACET* CEU for successful completion. This course can be accessed through the MLN Product Ordering web page located at: http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5 on the CMS Web site.

- An Overview of Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals video program: This educational video program provides health care professionals with an overview of Medicare-covered preventive services. The program includes a segment on Medicare's coverage of influenza, pneumococcal, and hepatitis B vaccines. Included in the segment are strategies that providers may use to increase the use of these vaccines in their practices and tips for setting up a flu clinic. This educational video has been approved for .1 IACET* CEU for successful completion. This video program can be ordered through the MLN Product Ordering web page located at: http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5 on the CMS Web site.

- Quick Reference Information: Medicare Preventive Services: This two-sided laminated chart gives Medicare FFS physicians, providers, suppliers, and other health care professionals a quick reference to Medicare's preventive services and screenings, identifying coding requirements, eligibility, frequency parameters, and copayment/coinsurance and deductible information for each benefit. This chart includes influenza, pneumococcal, and hepatitis B. Available in print or as a downloadable PDF file at: http://www.cms.hhs.gov/MLNPredictiveServices/downloads/MPS_QuickReferenceChart_1.pdf on the CMS Web site.

- Medicare Preventive Services Bookmark: This bookmark lists the preventive services and screenings covered by Medicare (including influenza) and serves as a handy reminder to health care professionals about the many preventive benefits covered by Medicare. Appropriate for use as a give away at conferences and other provider related gatherings. Available in print or as a downloadable PDF file at: http://www.cms.hhs.gov/MLNPredictiveServices/downloads/medprevsrvcesbkmrk.pdf on the CMS Web site.

- MLN Preventive Services Educational Products Web Page: This Medicare Learning Network (MLN) web page provides descriptions of all MLN preventive services related educational products and resources designed specifically...
for use by Medicare FFS providers. PDF files provide product ordering information and links to all downloadable products, including those related to the influenza vaccine and its administration. This web page is updated as new product information becomes available. Bookmark this page (http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp#TopOfPage) for easy access.

3. **Other CMS Resources**


4. **Other Resources**

   The following non-CMS resources are just a few of the many available in which clinicians may find useful information and tools to help increase flu vaccine awareness and utilization during the 2007 – 2008 flu season:
   - American Lung Association's Influenza (Flu) Center located at: http://www.lungusa.org on the Internet - This site provides a flu clinic locator at: http://www.flucliniclocator.org on the Internet. Individuals can enter their zip code to find a flu clinic in their area. Providers can also obtain information on how to add their flu clinic to this site.
   - Centers for Disease Control and Prevention http://www.cdc.gov/flu
   - Immunization Action Coalition http://www.immunize.org
   - Medicare Quality Improvement Community http://www.medicqic.org
   - National Alliance for Hispanic Health http://www.hispanichealth.org/
   - The National Center for Immunization and Respiratory Diseases (NCIRD) (established spring 2007) replaces the name National Immunization Program (NIP) http://www.cdc.gov/vaccines/about/
   - National Foundation For Infectious Diseases http://www.nfid.org/influenza
   - National Network for Immunization Information http://www.immunizationinfo.org
   - National Vaccine Program http://www.hhs.gov/nvpo
   - Partnership for Prevention http://www.prevent.org

**Additional Information**

For information to share with your Medicare patients, please visit: http://www.medicare.gov on the Web.

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### Centers for Medicare & Medicaid Services (CMS) Seeks Provider Input on Satisfaction with Medicare Fee-for-Service Contractor Services

**MLN Matters Number:** SE0750

**Related Change Request (CR) #:** N/A

**Related CR Release Date:** N/A

**Effective Date:** January 1, 2008

**Related CR Transmittal #:** N/A

**Implementation Date:** January 7, 2008

#### Provider Types Affected

Sample of 35,000 Medicare providers served by Medicare Fee-for-Service (FFS) Contractors, including Medicare Administrative Contractors (A/B MACs), carriers, fiscal intermediaries (FIs), durable medical equipment Medicare Administrative Contractors (DME/MACs) and regional home health intermediaries (RHHIs)

#### Provider Action Needed

**STOP – Impact to You**

CMS offers providers the opportunity to voice your opinions about the services you receive from your FFS contractors. CMS announced it has begun its third annual provider satisfaction survey of Medicare FFS contractors who process and pay more than $280 billion in Medicare claims each year. The Medicare Contractor Provider Satisfaction Survey (MCPS) is designed to gather quantifiable data on provider satisfaction with
the performance of FFS contractors as well as aid future process improvement efforts at the contractor level. The survey is used by CMS as an additional measure to evaluate contractor performance. In fact, all MACs will be required to achieve performance targets on the MCPSS as part of their contract requirements by 2009.

CAUTION – What You Need to Know
CMS is sending the 2008 survey to about 35,000 randomly selected providers, including physicians and other health care practitioners, suppliers and institutional facilities that serve Medicare beneficiaries across the country. Those providers selected to participate in the survey will be notified by December 2007. The survey is designed so that it can be completed in about 15 minutes. Providers can submit their responses via a secure Web site, mail, fax, or over the telephone. CMS is urging all Medicare providers selected to participate in the survey by completing and returning their surveys upon receipt.

GO – What You Need to Do
Be alert for a notification via e-mail, phone or mail by the survey contractor, Westat. If you are selected to participate in the survey, please take the time to complete and submit your survey responses upon receipt.

Background
The 2008 MCPSS is designed to gather quantifiable data on provider satisfaction levels with the key services that comprise the provider-contractor relationship. The survey focuses on seven major parts of the relationship:

- Provider inquiries;
- Provider outreach and education;
- Claims processing;
- Appeals;
- Provider enrollment;
- Medical review; and
- Provider audit and reimbursement.

Respondents are asked to rate their experience working with contractors using a scale of 1 to 6 with “1” representing “not at all satisfied” and “6” representing “completely satisfied.” The results of the second MCPSS -- which are available to health care providers and contractors on at: http://www.cms.hhs.gov/MCPSS on the CMS Web site. Last year’s findings showed that 85 percent of respondents rated their contractors between 4 and 6.

Further, the 2007 MCPSS results indicate that the provider inquiry function has the greatest influence on whether providers are satisfied with their contractors. This indicated a shift from 2006, when the claims processing function was the strongest predictor of a provider’s overall satisfaction.

Additional Information
CMS plans to make the survey results publicly available in July 2008. For questions or additional information about the MCPSS please visit: http://www.cms.hhs.gov/MCPSS on the CMS Web site.

Clarification on the National Provider Identifier (NPI) Enumerator’s Responsibilities
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Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

Provider Types Affected
All physicians, providers, and suppliers who submit claims to Medicare Contractors (Fiscal Intermediaries (FIs), Carriers, and Medicare Administrative Contractors (A/B MACs))

Provider Action Needed
STOP – Impact to You
The Centers for Medicare & Medicaid Services (CMS) is issuing this Special Edition (SE) 0751 article to clarify the type of assistance that the NPI Enumerator can and cannot provide to health care providers.

CAUTION – What You Need to Know
CMS is providing this information so you and your staff will know what issues should be referred to the NPI Enumerator and to identify issues on which the NPI Enumerator will not be able to help you. This will save you valuable time in resolving your Medicare questions.

GO – What You Need to Do
Please share this information with your office staff.

Background
The NPI Enumerator is responsible for assisting health care providers in applying for their NPIs and updating their information in the National Plan and Provider Enumeration System (NPPES). The NPI Enumerator’s responsibilities include:

- Processing NPI applications/updates/deactivations;
- Providing blank NPI application forms to health care providers upon request;
- Assisting health care providers with questions or problems regarding the processing of their NPI applications, updates, or deactivations (web-based or
Health care providers needing the above types of assistance may contact the NPI Enumerator at 1-800-465-3203, TTY 1-800-692-2326 or email the request to the NPI Enumerator at CustomerService@NPIEnumerator.com on the Internet. Please note that application processing times may vary based on current inventories. Please allow 15 working days to process your application/updates before contacting the NPI Enumerator.

Health care providers should NOT contact the NPI Enumerator for the following issues:

- The NPI Enumerator cannot provide assistance with the Medicare NPI Crosswalk and Medicare claims processing issues.
  » The NPI Enumerator does not generate, maintain or have access to the Medicare NPI Crosswalk.
  » The NPI Enumerator does not have the means/authority to alter/add/remove any information on the Medicare NPI Crosswalk.
  » The NPI Enumerator cannot report problems to CMS or to the Medicare Fee-for-Service contractors concerning the Medicare NPI Crosswalk or claims processing problems.
  » The NPI Enumerator does not send updates to the Medicare NPI Crosswalk.
  » The NPI Enumerator does not know how/when the Medicare NPI Crosswalk will be updated.
  » The NPI Enumerator cannot advise a provider as to how to complete the paper or electronic claim.
  » The NPI Enumerator cannot tell a provider how many legacy numbers to report on the NPPES record in order to assist in populating information on the Medicare NPI Crosswalk.
- The NPI Enumerator cannot provide assistance with information disseminated or not disseminated via the NPI Registry or the NPPES downloadable file:
  » The NPI Enumerator cannot assist providers with questions regarding “temporarily suppressed” information found on the NPI Registry or downloadable file.
- Although the NPI Enumerator can confirm whether or not the information still exists in the provider’s active NPPES record; this confirmation is limited to the health care provider or contact person on the provider’s NPPES record. Third party sources, including Medicare contractors, cannot call the NPI Enumerator for confirmation of information in a health care provider’s NPPES record. If this type of confirmation is needed, the third party should request the information from the provider directly.
- The NPI Enumerator cannot provide assistance with Medicare-related provider enrollment information:
  » The NPI Enumerator cannot determine how providers are enrolled with Medicare (e.g., as an individual or as a group).
  » The NPI Enumerator cannot determine which identifiers (Unique Physician Identification Number (UPIN), Provider Identification Number (PIN), Online Survey Certification and Reporting System (OSCAR), or National Supplier Clearinghouse (NSC)) should be included on health care providers’ NPPES records.
  » The NPI Enumerator has no way of knowing which type(s) of legacy number(s) were assigned to a provider by the Medicare contractor(s).
- The NPI Enumerator cannot determine which subparts should receive NPIs;
- Where NPIs or legacy identifiers are to be placed in claims transactions;
- Health Insurance Portability and Accountability Action (HIPAA) regulations or regulatory policies;
- Proper use of NPIs in transactions with health plans; and
- Determining if the provider is a sole proprietor or an incorporated individual.

Additional Information

CMS advises providers to read the information available at: http://www.cms.hhs.gov/NationalProvIdentStand/ on the CMS NPI Web site. Included on this site are NPI Frequently Asked Questions and Answers that can assist you with issues for which the NPI Enumerator is not responsible.

In addition, the NPI Application/Update form itself is also...
a good source of information. Providers should refer to the instructions (they are part of the form) for clarification on information to be submitted in order to obtain NPIs or update their records. You can also refer to the “Application Help” tab located at: https://nppes.cms.hhs.gov on the NPPES Web site for additional assistance when you are online.

If you have questions related to Medicare issues, please contact your Medicare Carrier, FI, or A/B MAC at their toll-free number, which may be found at: http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip on the CMS Web site.

Medicare Provides Coverage for Many Preventive Services and Screenings

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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 Medicare fee-for-service (FFS) physicians, providers, suppliers, and other health care professionals, who furnish or provide referrals for and/or file claims for Medicare-covered preventive services and screenings provided to Medicare beneficiaries

Provider Action Needed
This article conveys no new Medicare policy but serves as a reminder of the many preventive services and screenings now covered by Medicare and provides a list of related provider educational resources developed by the Centers for Medicare & Medicaid Services (CMS) to inform FFS health care professionals and their staff about the preventive services and screenings now covered by Medicare. CMS needs your help in spreading the word about preventive health care and ensuring that people with Medicare take full advantage of preventive benefits covered by Medicare that are appropriate for them.

Keep this Special Edition MLN Matters article and refer to it often.
* Order appropriate provider resources for yourself and your staff.
* Talk with your Medicare patients about their risk factors for disease and benefits of preventive health care, and encourage utilization of appropriate preventive services covered by Medicare for which they may be eligible.

Introduction
Heart disease, stroke, cancer, diabetes, osteoporosis, influenza, pneumonia, and other chronic diseases have a significant impact on the health and well-being of seniors in the United States. Yet the reality is, many of these diseases can be prevented and complications can be reduced. Medicare now provides coverage for a full range of preventive services and screenings that can help seniors and other people with Medicare stay healthy, detect disease early, and manage conditions to reduce complications. Preventive services and screenings now covered by Medicare include:

Medicare Provides Coverage for the Following Preventive Services and Screenings (subject to certain eligibility and other limitations)

- Adult Immunizations
  - Influenza (Flu)
  - Pneumococcal
  - Hepatitis B
- Bone Mass Measurements
- Cancer Screenings
  - Breast (mammogram and clinical breast exam)
  - Cervical & Vaginal (Pap test & pelvic exam)
  - Colorectal
  - Prostate
- Cardiovascular Disease Screening
- Diabetes Screening
- Diabetes Self-Management Training
- Diabetes Supplies
- Medical Nutrition Therapy (beneficiaries diagnosed with diabetes or renal disease)
- Glaucoma Screening
- Initial Preventive Physical Exam (IPPE) (“Welcome to Medicare” Physical Exam)
- Smoking and Tobacco-Use Cessation Counseling Services
- Ultrasound Screening for Abdominal Aortic Aneurysms (AAA)

Help in Spreading the Word
CMS recognizes the crucial role that health care professionals play in promoting, providing, and educating Medicare patients about potentially life saving preventive services and screenings. While Medicare now helps to pay for more preventive benefits than ever before, many Medicare beneficiaries are not yet taking full advantage of them, leaving significant gaps in their preventive health program. Statistics show that while Medicare beneficiaries visit their physician on an average of six or more times a year, many of them are not aware of their risk for disease
or even that they may already have a condition that preventive services are intended to detect. As a health care professional, you can help your patients with Medicare understand the importance of disease prevention, early detection, and lifestyle modifications that support a healthier life.

CMS hopes that you will join with us in spreading the word about preventive health care by educating your patients about their risk for disease. Talk with them about the importance of preventive health care, early detection, and the preventive services covered by Medicare that are right for them, and encourage utilization of these benefits when appropriate. As people with Medicare increase their knowledge of their risk for disease and understand the benefits of early detection and disease prevention, they will be better prepared to take full advantage of the preventive benefits covered by Medicare.

Educational Products and Informational Resources for Health Care Professionals

As a trusted source, a physician's recommendation is one of the most important factors in increasing the use of preventive services and screenings by people with Medicare. However, we know the discussion can be complicated. Therefore, CMS has developed a variety of educational products to:

1. Help increase your awareness of Medicare's coverage of disease prevention and early detection;
2. Provide you with information and tools to help you communicate with your Medicare patients about these potentially life saving benefits for which they may be eligible; and
3. Give you resources to help you effectively file claims for these services.

These provider education products may be ordered, free of charge, from the CMS Medicare Learning Network (MLN). All print products are available as downloadable PDF files and may be viewed online, reprinted, and redistributed as needed. Some print products may only be available as a downloadable PDF file. To order MLN products, visit the MLN Product Ordering (http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5) page at: http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5 on the CMS Web site.

**ATTENTION:** The following educational products have been developed by CMS to be used by Medicare FFS health care professionals and their staff and are not intended for distribution to Medicare beneficiaries.

** Bookmark**

Medicare Preventive Services Bookmark - This bookmark, available at: [http://www.cms.hhs.gov/MLNProducts/downloads/medprevsrvcsebkrmk.pdf](http://www.cms.hhs.gov/MLNProducts/downloads/medprevsrvcsebkrmk.pdf) on the CMS Web site, lists the preventive services and screenings covered by Medicare and serves as a handy reminder to health care professionals and their staff about the many preventive benefits covered by Medicare. Appropriate for use as a give away at conferences and other provider/supplier related education and outreach events. Available in print or as a downloadable PDF file.

### Brochures

The Medicare Preventive Services Brochure Series for Physicians, Providers, Suppliers, and Other Health Care Professionals - This series of seven tri-fold brochures provides an overview of Medicare's coverage of preventive services and screenings. Available in print and as downloadable PDF files.


### Guide

- **The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals, 2nd Edition** - This updated comprehensive guide, available at: [http://www.cms.hhs.gov/MLNProducts/downloads/expanded_benefits.pdf](http://www.cms.hhs.gov/MLNProducts/downloads/expanded_benefits.pdf), for Medicare FFS providers/suppliers and their staff provides information on coverage, coding, billing, and reimbursement guidelines for preventive...
services and screenings covered by Medicare. Available as a downloadable PDF file.

Quick Reference Information Charts

- **Medicare Preventive Services**: This two-sided laminated chart, available at: [http://www.cms.hhs.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf](http://www.cms.hhs.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf), provides Medicare FFS physicians, providers, suppliers, and other health care professionals a quick reference to Medicare’s preventive services and screenings, identifies coding requirements, eligibility, frequency parameters, and copayment/coinsurance and deductible information for each benefit. Available in print or as a downloadable PDF file.
- **The ABCs of Providing the Initial Preventive Physical Examination**: This two-sided laminated chart at: [http://www.cms.hhs.gov/MLNProducts/downloads/MPS_QRI_IPPE001a.pdf](http://www.cms.hhs.gov/MLNProducts/downloads/MPS_QRI_IPPE001a.pdf) can be used by Medicare FFS physicians and qualified non-physician practitioners as a guide when providing the initial preventive physical examination (IPPE). This handy tool identifies the components and elements of the IPPE, and provides eligibility requirements, procedure codes to use when filing claims, FAQs, suggestions for preparing patients for the IPPE, and lists references for additional information. Available in print and as a downloadable PDF file.

Video Program

An Overview of Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals - This educational video program provides health care professionals and their staff with an overview of preventive services and screenings covered by Medicare. This educational video has been approved for .1 IACET* CEU for successful completion. This video program can be ordered, free of charge, through the MLN Product Ordering web page at: [http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5](http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5) on the CMS Web site.

Web-Based Training Courses

- **Medicare Preventive Services Series Web-Based Training (WBT) Course**: This series of three WBT courses has been designed to help fee-for-services providers/suppliers and their staff understand Medicare’s coverage and billing guidelines for preventive services and screenings covered by Medicare. (To register, to take these WBT courses, free of charge, visit the MLN Product Ordering Page - [http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5](http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5).
  - **Medicare Preventive Services Series: Part 1 Adult Immunizations Web-Based Training (WBT) Course**: This WBT course contains four learning modules that provide information about Medicare’s coverage of influenza, pneumococcal, and hepatitis B vaccines and their administration. Information is also included about mass immunizers, roster billing, and centralized billing. This course was updated September 2007 and has been approved for .1 IACET* CEU for successful completion.
  - **Medicare Preventive Services Series: Part 2 Women’s Health Web-Based Training (WBT) Course**: This WBT course contains five learning modules that provide information about Medicare’s coverage of mammography services, pap tests, pelvic exams, colorectal cancer screenings, and bone mass measurements. This course was updated October 2007 and has been approved for .2 IACET* CEUs for successful completion.
  - **Medicare Preventive Services Series: Part 3 Expanded Benefits Web-Based Training (WBT) Course**: This WBT course contains seven learning modules that provide information about Medicare’s coverage of preventive services related educational products and resources designed specifically for use by Medicare FFS providers/suppliers. PDF files provide product ordering information and links to all downloadable products. This web page is updated as new product information becomes available. Bookmark this page for easy access. [http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp#TopOfPage](http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp#TopOfPage) on the CMS Web site.

Other Useful Provider Resources:

- **The Medicare Learning Network (MLN)** is the brand name for official CMS educational products and information for Medicare fee-for-service providers. For additional information, visit the Medicare Learning Network’s web page at: [http://www.cms.hhs.gov/MLNGenInfo](http://www.cms.hhs.gov/MLNGenInfo) on the CMS Web site.
- **CMS Prevention Web Pages**: CMS has created preventive services web pages. For additional information, visit: [http://www.cms.hhs.gov/home/medicare.asp](http://www.cms.hhs.gov/home/medicare.asp) and scroll down to the “Prevention” section.
Preventive Benefit Information for Medicare Beneficiaries: For literature to share with your Medicare patients, please visit: http://www.medicare.gov. Medicare beneficiaries can also obtain information about Medicare preventive benefits at this Web site or they may call 1.800.MEDICARE (1.800.633.4227). TTY users should call 1.877.486.2048.

*The Centers for Medicare & Medicaid Services (CMS) has been reviewed and approved as an Authorized provider by the International Association for Continuing Education and Training (IACET), 8405 Greensboro Drive, Suite 800, McLean, VA 22102. The authors of the video program and web-based training course have no conflicts of interest to disclose. The video program and web-based training course were developed without any commercial support.

Individuals Authorized Access to CMS Computer Services - Provider Community (IACS-PC): THE SECOND IN A SERIES OF ARTICLES ON THE IACS

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Related CR Release Date: N/A
Effective Date: N/A
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Implementation Date: N/A

This article contains:

- 3 questions and answers about the registration process for provider organizations. (See NOTE below.)
- Information on the Guides available for completing the registration process for provider organizations. (See NOTE below.)

NOTE: For purposes of the IACS-PC, “Provider Organizations” include individual practitioners who will delegate IACS-PC work to staff as well as their staff using IACS-PC.

Provider Types Affected

Physicians, providers, and suppliers (collectively referred to as providers) who submit fee-for-service claims to Medicare contractors (carriers, fiscal intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), and Medicare Administrative Contractors (A/B MACs)).

Special Note for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) suppliers. Do not register for IACS-PC at this time. DMEPOS suppliers may want to review the first MLN Matters article in this new series on IACS-PC, which can be found at: http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0747.pdf on the Centers for Medicare & Medicaid Services (CMS) Web site.

Provider Action Needed

Even though these new Internet applications are not yet available, CMS recommends that providers take the time now to set up their online account so they can access these applications as soon as they are available. The first step is for the provider and/or appropriate staff to register for access through a new CMS security system known as the Individuals Authorized Access to CMS Computer Services - Provider Community (IACS-PC).

What Providers Need to Know

In the near future, the CMS will be announcing new online enterprise applications that will allow Medicare fee-for-service providers to access, update, and submit information over the Internet. CMS enterprise applications are those hosted and managed by CMS and do not include FI/Carrier/MAC Internet applications. Details of these provider applications will be announced as they become available.

Registering in IACS-PC

The provider community is the first in a series of IACS communities which are the front-door to protecting and allowing access to CMS enterprise applications. Communities are comprised of groups of users who provide a similar service to CMS and who need access to similar applications (ex. Providers need access to provider-related CMS applications). The next community which will become available in early 2008 is the FI/Carrier/MAC community. It will be comprised of users who work within Medicare contracting organizations (FIs, Carriers and MACs). Since many IACS communities will be added in the future, the IACS community’s user instructions are generic to allow use by multiple communities. The rules and concepts across communities are very similar.

When given a choice in IACS to select your community, please select the “Provider Community.”

The first MLN Matters article in this series provided an overview of the IACS-PC registration process as well as registration instructions for Security Officials (SOs) and individual practitioners using IACS-PC personally. This article can be found at: http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0747.pdf on the CMS Web site.

Three Questions and Answers about the Provider Organization Registration Process

1. How can I get registered in IACS-PC? Can I just figure it out by myself?

   We recommend that you use the reference guides as they contain detailed explanations of the role responsibilities, acceptable data formats and
interpretations of error messages. To directly access IACS-PC go to https://applications.cms.hhs.gov, then click on Enter CMS Applications Portal.

2. I want to register as an SO. I do not have my organization’s IRS CP-575. What else can I send? In addition to the CP-575, SOs may also submit copies of other official IRS documentation. An official IRS document should have the following information:

Required:
- IRS letterhead;
- Legal Business Name (not handwritten); and
- TIN/EIN (not handwritten).

Optional:
- Form Number in upper right; and
- Reference to a letter or form number in body of text.

Examples of acceptable IRS documents include, but are not limited to:
- Copy of IRS CP-575;
- Copy of IRS 147C Letter; or
- Copy of Federal Tax Deposit Coupon.

All documents received must be legible.

3. My organization is too small to fill all these roles. What should I do? As few as 2 staff can be registered in IACS-PC for a provider organization to access CMS enterprise applications. The first person must register as a Security Official (SO), the second registers as a User Group Administrator (UGA). The UGA may access CMS applications as approved by the SO.

The Backup Security Official is an optional role. End users are only required for provider organizations with 10 or more IACS-PC users.

If you are an individual practitioner who will be using IACS-PC personally, please refer to the first MLN article which may be found at: http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0747.pdf on the CMS Web site.

Quick Reference Guides for Completing the Provider Organization Registration Process


2. User Group Administrator (UGA) Guide
UGAs are the first user type able to request access to CMS web-based applications. Their task, during the registration process, is to create a provider or surrogate user group, or associate with an existing provider or surrogate user group. A provider user group is a group that can be created by a UGA within an existing provider organization.

Once the user group is created and approved by the SO/BSO, end users can then submit a request to register in IACS and join that user group. The UGA will either approve or deny their request to join their user group. This is a way for users within an organization to form groups that align with business needs or any other logical grouping that is appropriate for that organization and ensure that the UGA appropriately approves each end user into their user group. The important thing to keep in mind is that the UGA will need to approve the end users in the user group for which s/he is responsible, so they should know everyone in their user group.

The UGA Registration Quick Reference Guide may be found at: http://www.cms.hhs.gov/MMAHelp/downloads/iacs_user_group_administrator_registration_qrg_12_06_07.pdf on the CMS Web site.

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Edition Four • Spring 2008
A surrogate user group is established by individuals or a company outside of the provider organization which performs Medicare work on behalf of the provider organization (a contractor for a provider organization, billing company, etc.). If you will be creating a surrogate user group, the UGA of the surrogate user group must be approved by the SO or BSO in the provider organization on whose behalf it performs work. For example: Surrogate Billing Company ABC will work on behalf of Provider Organization XYZ. Once the Provider Organization XYZ is approved in IACS, the Surrogate Billing Company ABC can register in IACS and request to create a surrogate user group under the Provider Organization XYZ. Once approved, the UGA of a surrogate user group is issued an IACS user ID that enables the UGA to associate with other provider organizations for which it performs work without registering again.

At this time, a new surrogate user group must be created for each provider organization with which a UGA wishes to associate. If a surrogate user group performs work on behalf of 3 different provider organizations, the UGA for the surrogate user group will need to make 3 different requests to create 3 different surrogate user groups, one for each provider with which the UGA needs to associate. If a provider organization does not appear in IACS-PC, they have not yet registered/been approved and you should contact them. You will not be able to associate with them until the provider appears in IACS-PC.

If the provider organization does appear in IACS-PC, each provider’s SO or BSO must approve the request to associate that surrogate user group with their organization. Remember, as a surrogate user group, you will only be able to associate with provider organizations after those respective provider organizations and SOs have been approved in IACS-PC.

In the future, CMS will explore options for simplifying this process for contractors which perform work on behalf of more than one provider organization and also to allow surrogate user groups to associate to Individual Practitioners within IACS.


4. Approver Quick Reference Guide

Next Steps in Accessing a CMS Enterprise Application
A third MLN article discussing the final steps in accessing CMS enterprise applications has been released on this issue, and may be found at: [http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0754.pdf](http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0754.pdf) on the CMS Web site.

Additional Help
The CMS has established an end user support (EUS) Help Desk to assist with your access to IACS-PC. The EUS Help Desk may be reached by E-mail at: EUSSupport@cgi.com or by phone on 1.866.484.8049 or TTY/TDD on 1.866.523.4759.

In addition, you can find an informative reference chart outlining the steps for accessing CMS enterprise applications at: [http://www.cms.hhs.gov/MLNProducts/downloads/IACSchart.pdf](http://www.cms.hhs.gov/MLNProducts/downloads/IACSchart.pdf) on the CMS Web site.

Individuals Authorized Access to CMS Computer Services - Provider Community (IACS-PC): THE THIRD IN A SERIES OF ARTICLES ON THE IACS-PC

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Implementation Date: N/A

This article contains 3 steps to accessing a CMS Enterprise Provider Application including how to request a provider application role in IACS-PC (See step 2).

Provider Types Affected
Physicians, providers, and suppliers (collectively referred to as providers) who submit fee-for-service claims to Medicare contractors (carriers, fiscal intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), and Medicare Administrative Contractors (A/B MACs)).
Special Note for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) suppliers: Do not register for IACS-PC at this time. DMEPOS suppliers may want to review the first MLN Matters article in a new series on IACS-PC which can be found at: http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0747.pdf on the Centers for Medicare & Medicaid Services (CMS) Web site.

Provider Action Needed
CMS enterprise applications to be made available via the web soon include the Provider Enrollment, Chain and Ownership System (PECOS) and the Provider Statistical and Reimbursement Report (PS&R) System. Even though these new Internet applications are not yet available, CMS recommends that providers take the time now to set up their online account so they can access these applications as soon as they are available. The first step is for the provider or appropriate staff to register for access through a new CMS security system known as the Individuals Authorized Access to CMS Computer Services - Provider Community (IACS-PC).

What Providers Need to Know
In the near future, the CMS will be formally announcing new online enterprise applications that will allow Medicare Fee-For-Service (FFS) providers to access, update, and submit information over the Internet.

CMS enterprise applications are those hosted and managed by CMS and for the most part do not include internet applications offered by FI/carrier/MAC. Details of these provider applications will be announced as they become available.

The first article in this series provided an overview of the IACS-PC registration process as well as registration instructions for Security Officials (SOs) and individual practitioners. This article can be found at: http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0747.pdf on the CMS Web site.

The second article addressed questions and gave remaining instructions for registering provider organizations including registering as a Backup Security Official (BSO), User Group Administrator (UGA), and End User (EU). It also discussed approving user requests. This article can be found at: http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0753.pdf on the CMS Web site.

The 3 Steps to Access a CMS Enterprise Application
Provider IACS-PC users must take 3 steps to access a CMS enterprise application:

Step 1: Be Approved for an IACS-PC Role.
The first two MLN Matters Articles in this series discussed how to register in IACS-PC.

The purpose of the IACS-PC registration process is to:
- Confirm the identity of the person requesting registration;
- Assure registrants have a legitimate business need to access CMS provider systems;
- Provide the registrant an IACS-PC role (e.g., SO, BSO, UGA, or end User) that defines their responsibilities (if any) for approving the registration requests of others in their organization; and
- Provide the registrant a User ID and Password for IACS-PC.

Step 2: Be Approved for an Application Role
After receiving approval for an IACS-PC role, a registered user in a Provider Organization may then request to be an "Application Approver" or an "End User." (Note: Because Individual Practitioners do work in the application themselves, they do not designate "Application Approver" roles).

Users who received approval in IACS-PC in Step 1, may now request access to specific CMS enterprise applications using their IACS-PC account.

This role determines:
- Their responsibilities (if any) to approve application access requests from others in their organization;
- What CMS enterprise applications (if any) they have a legitimate need to access, and
- The appropriate level of access to each application for their job function (which application "role" they require).

Users registered in IACS-PC can now request access to specific CMS enterprise applications using their IACS-PC account.

This can be done by requesting either an "Application Approver" or an application "User" role for each application needed to perform Medicare related job functions. For provider applications, there are specific roles within the application that define what the user can do. For example,
some application users may be limited to viewing information and printing reports, while others can enter, edit and submit information to CMS. These roles will be specific to each application.

Each user must request a specific application role in IACS-PC for each CMS enterprise provider application they wish to use.


**Application Approvers**

Organizations must have designated persons that approve each end user’s request for an application role. The person who performs this task is an “Application Approver” and as such cannot personally access applications for which they serve in this role.

Though the UGA may frequently be the appropriate persons to have this role, organizations have discretion in how they designate the Application Approvers so that it is appropriate for their particular organization. For example, the UGA may be designated by the SO or BSO to serve in this role for their user group, or an end User may be approved for this role by the SO or BSO for the user group with which they are associated.

**Application Approver Key Points**

An Application Approver must be a member of the user group(s) for which they serve as an Application Approver (this does not apply if the SOs/BSOs is the Application Approver).

- Providers have flexibility in assigning the Application Approver role:
- The UGA does not have to be the Application Approver within the user group.
- An end User within a user group may serve in the role of the Application Approver.
- A different person may serve as an Application Approver in a user group for each application.
- The same person can be the Application Approver for multiple applications in a user group.
- The same person can be the Application Approver for multiple user groups (though they must be a member of each group.)
- There can be multiple Application Approvers for the same application within the same user group. In this situation, the first approver who approves or denies the request will serve as the decision authority. All of the application approvers within the user group do not need to act on each request.
- A person can be an Application Approver for one application, and an application user for a different application, just not for the same one.
- If an Application Approver does not exist for an application in a user group, the user group requests for that application will go to the SO and BSO for a decision.
- Organizations with a large number of IACS-PC users are encouraged to have Application Approvers in each user group for each application (can be the same person) so that all of the application requests are not routed to the SO and BSO as the default application approvers.

**Note:** System security requires a “separation of duties” – which means that those who approve user requests for CMS enterprise application roles will not have access to the applications for which they have, an approver role. Therefore those in Application Approver roles will not have access to the application for which they are an approver. Security Officials and Backup Security Officials, by definition, can never access any applications as they serve as the default Application Approvers as noted above.

Instructions for approving Application Approver and application user role requests are the same as for approving IACS-PC registration requests. The Approver Quick Reference Guide may be found at:  http://www.cms.hhs.gov/MMAHelp/downloads/iacs_approver_qrg_12_07_07.pdf on the CMS Web site.

**Step 3: Enter the application when it becomes available.**

You will be notified as CMS enterprise applications become available. After you have been approved in steps 1 and 2, you will be able to access available CMS enterprise applications using your approved application specific roles via the CMS Web site.

**Additional CMS Partner and Customer Communities will use IACS**

The provider community is the first in a series of IACS communities which are the front-door to protecting and allowing access to CMS enterprise applications. Communities are comprised of groups of users who provide a similar service to CMS and who need access to similar applications (ex. Providers need access to provider-related CMS applications). The next community which will become available in early 2008 is the FI/Carrier/MAC community. It will be comprised of users who work within Medicare contracting organizations (FIs, Carriers and MACs). Since many IACS communities will be added in the future, the IACS community’s user instructions are generic to allow use by multiple communities. The rules and concepts across communities are very similar.
When given a choice in IACS to select your community, please select the “Provider Community.”

**Additional Help**
CMS has established the End User Services (EUS) Help Desk to support access to IACS-PC. The EUS Help Desk may be reached by e-mail at: EUSSupport@cgi.com or by phone on 1.866.484.8049 or TTY/TDD on 1.866.523.4759.

**COMING SOON**
- CMS enterprise applications to be made available via the web include the Provider Enrollment, Chain and Ownership System (PECOS) and the Provider Statistical and Reimbursement Report (PS&R)
- IACS Web site
- Instructions for modifying your user profile
- What to do if you forget your user ID or password
- Tools for SOs, BSOs and UGAs to manage user accounts

## DME MAC Jurisdiction C Contact Information

<table>
<thead>
<tr>
<th>Contact for:</th>
<th>Contact Information:</th>
</tr>
</thead>
<tbody>
<tr>
<td>EDI – Electronic Claim Submission;</td>
<td>Jurisdiction C EDI Technology Support Center (toll-free): 1.888.613.9271</td>
</tr>
<tr>
<td>Electronic Remittance Notices</td>
<td>Support hours: 8:00 a.m. – 5:00 p.m. EST, Monday – Friday</td>
</tr>
<tr>
<td></td>
<td>Address: Jurisdiction C EDI Operations</td>
</tr>
<tr>
<td></td>
<td>PO Box 100170, Columbia, SC 29202</td>
</tr>
<tr>
<td>Paper Claim Submission</td>
<td>Address: CIGNA Government Services</td>
</tr>
<tr>
<td></td>
<td>PO Box 20010, Nashville, TN 37202</td>
</tr>
<tr>
<td>Provider Customer Service Calls</td>
<td>IVR (Interactive Voice Response): 1.866.238.9650</td>
</tr>
<tr>
<td></td>
<td>Hours: 24/7 (with allowances for normal IVR and system maintenance)</td>
</tr>
<tr>
<td></td>
<td>Customer Service: 1.866.270.4909 (Hours: 8:00 a.m. to 6:00 p.m. EST)</td>
</tr>
<tr>
<td></td>
<td>Hearing Impaired: 1.888.204.3771 (Hours: 8:00 a.m. to 6:00 p.m. EST)</td>
</tr>
<tr>
<td>Beneficiary Customer Service Calls</td>
<td>Phone: 1.800.Medicare</td>
</tr>
<tr>
<td>Written Inquiries</td>
<td>Address: CIGNA Government Services</td>
</tr>
<tr>
<td></td>
<td>PO Box 20010, Nashville, TN 37202</td>
</tr>
<tr>
<td>Claim Reopenings (Adjustments)</td>
<td>Address: CIGNA Government Services</td>
</tr>
<tr>
<td></td>
<td>PO Box 20010, Nashville, TN 37202</td>
</tr>
<tr>
<td></td>
<td>Fax: 1.615.782.4649</td>
</tr>
<tr>
<td></td>
<td>Telephone requests for Reopenings: 1.866.813.7878</td>
</tr>
<tr>
<td></td>
<td>Hours: 8:00 a.m. – 11:00 a.m. and 12:00 p.m. – 4:00 p.m. CST</td>
</tr>
<tr>
<td>Appeals – Redetermination Requests</td>
<td>Address: CIGNA Government Services</td>
</tr>
<tr>
<td></td>
<td>PO Box 20010, Nashville, TN 37202</td>
</tr>
<tr>
<td>Electronic Funds Transfer</td>
<td>Address: CIGNA Government Services</td>
</tr>
<tr>
<td></td>
<td>Attn: EFT-DME</td>
</tr>
<tr>
<td></td>
<td>PO Box 20010, Nashville, TN 37202</td>
</tr>
<tr>
<td>Refunds</td>
<td>Address: CIGNA Government Services</td>
</tr>
<tr>
<td></td>
<td>Jurisdiction C DME MAC</td>
</tr>
<tr>
<td></td>
<td>PO Box 30629, New York, NY 10087-0629</td>
</tr>
<tr>
<td>Overnight or Special Shipping</td>
<td>Address: CIGNA Government Services</td>
</tr>
<tr>
<td></td>
<td>DME MAC Jurisdiction C</td>
</tr>
<tr>
<td></td>
<td>Two Vantage Way, Nashville, TN 37228</td>
</tr>
<tr>
<td>DME MAC Jurisdiction C Web site</td>
<td>Web site: <a href="http://www.cignagovernmentservices.com">http://www.cignagovernmentservices.com</a></td>
</tr>
</tbody>
</table>
Mark Your Calendars and Plan to Participate in the Upcoming Maximizing Your Reimbursement - Medicare Workshop-

<table>
<thead>
<tr>
<th>Contact for:</th>
<th>Contact Information:</th>
</tr>
</thead>
</table>
| Advance Determination of Medicare Coverage (ADMC) - Requests | Address: CIGNA Government Services  
Attn: ADMC  
PO Box 20010, Nashville, TN 37202  
Fax: 1.615.782.4647 |
| Requests for Additional Information from TrustSolutions, LLC | Address: TrustSolutions, LLC  
PO Box 50218, Indianapolis, IN 46250  
Fax: 1.317.863.0054 |
| Supplier Enrollment                                | Address: National Supplier Clearinghouse  
Palmetto GBA * AG-495  
PO Box 100142, Columbia, SC 29202-3142  
Phone: 1.866.238.9652 |

What? The Provider Outreach and Education (POE) team at CIGNA Government Services is pleased to present a full-day Medicare workshop, “Maximizing Your Reimbursement.” Participants will have the opportunity to choose your own breakout sessions on various Medicare topics offered throughout the day. A help desk staffed with CIGNA Government Services representatives will also be available for specific questions from participants.

Who? This workshop is tailored to both North Carolina Part B Medicare Providers and Jurisdiction C DME Suppliers.

Why? The goals of this workshop are for providers and suppliers to be able to:
- Understand key changes to the Medicare Program and how they will impact you.
- Share relevant information with staff members.
- Recognize which changes and updates will require action.
- Understand key processes to minimize re-work and ultimately maximize reimbursement by “getting it right the first time”.

When? Mark your calendars now to participate in this important workshop! The “Maximizing your Reimbursement” Medicare Workshop will begin with registration and breakfast starting at 7am (ET), and will conclude with breakout sessions ending at 4pm (ET).

Where? This workshop will take place in the Charlotte Convention Center in Charlotte, North Carolina, located at:
Charlotte Convention Center  
501 S. College Street, Charlotte, NC 28202

Additional Details: Additional event details and registration are available at the following links to the CIGNA Government Services Web site:
- Jurisdiction C DME Suppliers: [http://www.cignagovernmentservices.com/jc/education/Events.html](http://www.cignagovernmentservices.com/jc/education/Events.html)

Space is limited for this workshop! Register today!
DME MAC Jurisdiction C Interactive Voice Response (IVR) System

USER GUIDE

Information you may need:

PTAN - Same number as your NSC Supplier Number

HICN - Press 1 if begins with Letter, Press 2 if begins with number

Beneficiary’s First Initial

Beneficiary’s Last Name - First 6 letters plus # sign

Beneficiary Date of Birth

Date of Service

HCPCS Code / Modifiers

FCN - Located on your remittance notice

Payment Date

Standard Functions

7 = Repeat

8 = Main Menu

9 = New PTAN

Additional Feature:

May inquire on Multiple PTANs within the same phone transaction

To Access a full script of the IVR system go to

http://www.cignagovernment.
services.com/jc/pubs/news/articles/0507/051107a.html

To access the IVR, call 1.866.238.9650

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

Press 1 for PTAN which contains a letter. Press 2 for PTAN without a letter

<table>
<thead>
<tr>
<th>Press</th>
<th>Available Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Claim Status - Press Enter HICN, Beneficiary Name, and date of service</td>
</tr>
<tr>
<td>2</td>
<td>Available Information • Line-by-Line Information • Payment Floor (Claim Level) • Explanation of the Denial • Appeal Rights</td>
</tr>
<tr>
<td>3</td>
<td>Surety Information • Surety Name and Address</td>
</tr>
<tr>
<td>4</td>
<td>Pending Claim Information • Claims currently on the Payment Floor • Pending Claims at the Common Working File • Other Pending Claims</td>
</tr>
</tbody>
</table>

Press 1 for PTAN which contains a letter. Press 2 for PTAN without a letter

<table>
<thead>
<tr>
<th>Press</th>
<th>Available Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Beneficiary Eligibility Enter HICN, Beneficiary name, and date of birth</td>
</tr>
<tr>
<td>2</td>
<td>Available Information • Part A entitlement date • Part B entitlement date • Medicare Advantage Plan information • Home Health information • Medicare Secondary Payer information</td>
</tr>
<tr>
<td>3</td>
<td>Offset Information Enter FCN</td>
</tr>
<tr>
<td>4</td>
<td>General Information press</td>
</tr>
</tbody>
</table>

Press 1 for PTAN which contains a letter. Press 2 for PTAN without a letter

<table>
<thead>
<tr>
<th>Press</th>
<th>Available Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Beneficiary Part B Deductible Enter HICN, Beneficiary name, and date of birth</td>
</tr>
<tr>
<td>2</td>
<td>Available Information • Amount of deductible applied for the current calendar year</td>
</tr>
<tr>
<td>3</td>
<td>Outstanding Check Information • Outstanding checks within last 30 days • Check date • Check amount</td>
</tr>
<tr>
<td>4</td>
<td>Information on your Appeal Right</td>
</tr>
</tbody>
</table>

Press 1 for PTAN which contains a letter. Press 2 for PTAN without a letter

<table>
<thead>
<tr>
<th>Press</th>
<th>Available Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Pricing Enter State, HCPCS, and Modifier</td>
</tr>
<tr>
<td>2</td>
<td>Available Information • Medicare allowed amount</td>
</tr>
<tr>
<td>3</td>
<td>General Information press</td>
</tr>
</tbody>
</table>

Press 1 for PTAN which contains a letter. Press 2 for PTAN without a letter

<table>
<thead>
<tr>
<th>Press</th>
<th>Available Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Information on your Appeal Right</td>
</tr>
<tr>
<td>4</td>
<td>Customer Service hours of operation</td>
</tr>
</tbody>
</table>

Press 1 for PTAN which contains a letter. Press 2 for PTAN without a letter

<table>
<thead>
<tr>
<th>Press</th>
<th>Available Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>General Information press</td>
</tr>
</tbody>
</table>

Press 1 for PTAN which contains a letter. Press 2 for PTAN without a letter

<table>
<thead>
<tr>
<th>Press</th>
<th>Available Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>Offset Information Enter FCN</td>
</tr>
<tr>
<td>4</td>
<td>General Information press</td>
</tr>
</tbody>
</table>