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

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From the Medical Director

Local Coverage Determinations (LCD) Update

In the coming months be on the lookout for several updated LCDs. New and revised healthcare common procedure coding system (HCPCS) codes for 2012 will be incorporated into LCDs in the coming weeks. The new codes are effective for dates of service (DOS) on or after January 1, 2012.

The Durable Medical Equipment Medicare Administrative Contractor (DME MAC) medical directors continue to review comments from the draft LCDs – Pneumatic Compression Devices, Suction Pumps, and Automatic External Defibrillators. No final implementation date is available at this time.

Suppliers should watch the CGS website and ListServ for information about the release of updated LCDs.

Robert D. Hoover, Jr., MD, MPH, FACP
Medical Director
DME MAC Jurisdiction C

Coverage & Billing

Reminder: Ultrasonic/Electronic Aerosol Generator with Small Volume Nebulizer – Coding Verification Review Requirement

Recently it was brought to the attention of the Durable Medical Equipment Medicare Administrative Contractors (DME MAC) that suppliers and pharmacies are billing code E0574 (ULTRASONIC/ELECTRONIC AEROSOL GENERATOR WITH SMALL VOLUME NEBULIZER). The article published by the DME MACs on November 4, 2010, titled “Ultrasonic/Electronic Aerosol Generator with Small Volume Nebulizer – Coding Verification Review Requirement” (see https://www.dmepdac.com/resources/articles/2010/11_04_10.html) required:

Effective for claims with dates of service on or after April 1, 2011, the only products which may be billed to Medicare using code E0574 (Ultrasonic/Electronic Aerosol Generator With Small Volume Nebulizer) are those for which a written coding verification has been made by the Pricing, Data Analysis, and Coding (PDAC) contractor and that are listed in the Product Classification Matrix of the DME Coding System (DMECS) maintained on the PDAC website, https://www.dmepdac.com/dmecsapp/do/search.

Code E0574 and related accessories are reasonable and necessary to administer treprostinil inhalation solution (J7686) only. To date only one ultrasonic nebulizer has been approved to
use code E0574 – Optineb-ir Model ON-100/7 (NebuTec, GmbH). There are no other nebulizers that are authorized to bill the DME MACs using code E0574. Suppliers billing for ultrasonic nebulizers not listed in the Product Classification Matrix of the DME Coding System (DMECS) must contact the PDAC for proper coding instructions.

With the exception of the Optineb-ir®, no other ultrasonic nebulizers have received approval to use code E0574 through the coding verification review process. Suppliers of ultrasonic nebulizers other than the Optineb-ir® who have incorrectly coded these items and had paid claims for E0574 with dates of service on or after April 1, 2011, should submit a voluntary refund. In addition, voluntary refunds should be submitted for paid claims for inhalation medications used in conjunction with an E0574 nebulizer.

The PDAC coding verification application required for these products is the DME and Supplies application. This application is located on the PDAC website here: https://www.dmepdac.com/review/apps_check.html. If you have questions please contact the PDAC Contact Center at 1.877.735.1326 during the hours of 8:30 a.m. to 4:00 p.m. CT, Monday through Friday, or e-mail the PDAC by completing the DME PDAC Contact Form located on the PDAC website here: http://www.dmepdac.com. Once products are coded by the PDAC, they will be listed in the Product Classification Matrix on DMECS.

DME Stop Gap Project – Medicare Part B and D Drug Billing

On September 1, 2010, CMS awarded AdvanceMed the Durable Medical Equipment, Prostheses, Orthotics, and Supplies (DMEPOS) Stop Gap Project for North Carolina. CMS developed this plan to enhance DMEPOS fraud, waste and abuse detection, and prevention activities. The Stop Gap Project was developed in response to the continued escalation in DME payments and the growth in numbers of DMEPOS suppliers.

As part of the DME Stop Gap Project, the top billed beneficiaries in North Carolina for dates of service January 1, 2008, through March 25, 2011, were analyzed. The data analysis included a comparison of Medicare Part A and B (includes DME) drug billing. Based on the drug data analysis, the DME Stop Gap Project team wants to make providers/suppliers aware of the below information.

The Medicare Prescription Drug Benefit Manual, Chapter 6, Appendix C, Summary of Coverage Policy, Attachment 1 Part B and Part D Coverage Chart states the following:

It would not be appropriate for Part D sponsors to routinely require a rejection of a claim under Part B before processing a Part D claim. Such a policy would be disruptive to beneficiaries and pharmacies and would unnecessarily increase Part B contractor costs.


It is not necessary to submit claims to the DMAC for denial if the beneficiary’s drug(s) are primarily covered under Medicare Part D. Demand billing is not necessary since Medicare is the primary insurance depending on a beneficiary’s coverage under Medicare Part B or Part D.

The Medicare Prescription Drug Benefit Manual, Chapter 9, Section 70.2.4 summarizes suspect provider/supplier billing schemes between Medicare Part B and Part D:

- Beneficiaries or providers may “game the system” by submitting the drug claim to the inappropriate payer to lower the beneficiary’s cost sharing obligations (differential co-pays) if a crossover drug is paid under Medicare Part B versus Medicare Part D, or vice versa.
- Home infusion pharmacies may inappropriately bill Medicare Part B or Part D for delivery and dispensing fees for injectable medications (e.g., Epogen, Procrit) even if the beneficiary self-administers the medication(s).
- Providers may engage in duplicate billing by submitting drug claims to both Medicare Part B (medical) and D (pharmacy).

Furthermore, the Code of Federal Regulations defines covered Medicare Part D drugs as well as what is excluded as a covered drug. As defined by the 42 C.F.R. § 423.100, Medicare Part D excluded drugs are described as:

Drugs for which payment as so prescribed and dispensed or administered to an individual is available for that individual under Part A or Part B (even though a deductible may apply, or even though the individual is eligible for coverage under Part A or Part B but has declined to enroll in Part A or Part B).

Expansion of the Current Scope of Editing for Ordering/Referring Providers for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Suppliers’ Claims Processed by Durable Medical Equipment Medicare Administrative Contractors (DME MACs)

MLN Matters Number: MM6421 Revised
Related Change Request (CR) #: 6421
Related CR Release Date: October 14, 2011
Effective Dates: Phase 1 – October 1, 2009
Related CR Transmittal #: R963OTN
Implementation Date: Phase 1 – October 5, 2009
Phase 2 – To be announced

The providers who can order/refer are:
- Doctor of Medicine or Osteopathy;
- Dental Medicine;
- Dental Surgery;
- Podiatric Medicine;
- Optometry;
- Physician Assistant;
- Certified Clinical Nurse Specialist;
- Nurse Practitioner;
- Clinical Psychologist;
- Certified Nurse Midwife; and
- Clinical Social Worker.

Claims that are the result of an order or a referral must contain the National Provider Identifier (NPI) and the name of the ordering/referring provider and the ordering/referring provider must be in PECOS with one of the above specialties.

Key Points
- During Phase 1 (October 5, 2009- until further notice): When a claim is received, Medicare will determine if the ordering/referring provider is required for the billed service. If the ordering/referring provider is not on the claim, the claim will continue to process. If the ordering/referring provider is on the claim, Medicare will verify that the ordering/referring provider is in PECOS and is eligible to order/refer. If the ordering/referring provider is not in PECOS or is not of the type/specialty to order or refer, the claim will also continue to process.
  1. If the DMEPOS supplier claim is an ANSI X12N 837P standard electronic claim, the DMEPOS supplier will receive a warning message on the Common Electronic Data Interchange (CEDI) GenResponse Report.
  2. If the DMEPOS supplier claim is a paper CMS-1500 claim, the DMEPOS supplier will not receive a warning and will not know that the claim did not pass these edits.
- During Phase 2 (Start Date to Be Announced): If the ordering/referring provider is not on the claim, the claim will not be paid. If the ordering/referring provider is on the claim, Medicare will verify that the ordering/referring provider is in PECOS and eligible to order and refer. If the ordering/ referring provider is not in PECOS or is not of the specialty to order or refer, the claim will not be paid. It will be rejected.
  1. If the DMEPOS supplier claim is an ANSI X12N 837P standard electronic claim, the DMEPOS supplier will receive a rejection message on the CEDI GenResponse Report.
  2. If the DMEPOS supplier claim is a paper CMS-1500 claim, the DMEPOS supplier will see the rejection indicated on the Remittance Advice.
- In both phases, Medicare will verify the NPI and the name of the ordering/referring provider reported on the ANSI X12N 837P standard electronic claim against PECOS.

Provider Types Affected
Suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) submitting claims to Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for items or services provided to Medicare beneficiaries.

Provider Action Needed
This article is based on change request (CR) 6421, which requires Medicare implementation of system edits to assure that DMEPOS suppliers bill for items or services only when those items or services are ordered or referred by physician and non-physician practitioners who are eligible to order/refer such services. Physician and non-physician practitioners must be enrolled in the Medicare Provider Enrollment, Chain and Ownership System (PECOS) and of the type/specialty eligible to order/refer services for Medicare beneficiaries. Be sure billing staff are aware of these changes that will impact DMEPOS claims received and processed on or after October 5, 2009.

Background
CMS is expanding claim editing to meet the Social Security Act requirements for ordering and referring providers. Section 1833(q) of the Social Security Act requires that all ordering and referring physicians and non-physician practitioners meet the definitions at Section 1861(r) and 1842(b)(18)(C) and be uniquely identified in all claims for items and services that are the results of orders or referrals. Effective January 1, 1992, a provider or supplier who bills Medicare for an item or service that was ordered or referred must show the name and unique identifier of the ordering/referring provider on the claim.
What You Should Know

This article is based on Change Request (CR) 7397, which clarifies policy with respect to restrictions on pharmacy billing for drugs provided “incident to” a physician service. The CR also clarifies policy for the local determination of payment limits for drugs that are not nationally determined.

This article notes that CR 7397 rescinds and fully replaces CR 7109. Please be sure your staffs are aware of this update.

Background

Pharmacies billing drugs

Pharmacies may bill Medicare Part B for certain classes of drugs, including immunosuppressive drugs, oral anti-emetic drugs, oral anti-cancer drugs, and drugs self-administered through any piece of durable medical equipment.

- Claims for these drugs are generally submitted to the Durable Medical Equipment Medicare Administrative Contractor (DME MAC). The carrier or A/B MAC will reject these claims as they need to be sent to the DME MAC.
- In the rare situation where a pharmacy dispenses a drug that will be administered through implanted DME and a physician’s service will not be utilized to fill the pump with the drug, the claim is submitted to the A/B MAC or carrier.

The DME MAC, A/B MAC, or carrier will make payment to the pharmacy for these drugs, when deemed to be covered and reasonable and necessary. All bills submitted to the DME MAC, A/B MAC, or carrier must be submitted on an assigned basis by the pharmacy.

When drugs may not be billed by pharmacies to Medicare Part B

Pharmacies, suppliers and providers may not bill Medicare Part B for drugs dispensed directly to a beneficiary for administration “incident to” a physician service, such as refilling an implanted drug pump. These claims will be denied.

Pharmacies may not bill Medicare Part B for drugs furnished to a physician for administration to a Medicare beneficiary. When these drugs are administered in the physician’s office to a Medicare beneficiary, the only way these drugs can be billed to Medicare is if the physician purchases the drugs from the pharmacy. In this case, the drugs are being administered “incident to” a physician’s service and pharmacies may not bill Medicare Part B under the “incident to” provision.

Payment limits

The payment limits for drugs and biologicals that are not included in the average sales price (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 the Outpatient Prospective Payment System (OPPS) where the payment allowance limit is 95 percent of the published average wholesale price (AWP). In determining the payment limit based on WAC, the payment limit is 106 percent of the lesser of the lowest-priced brand or median generic WAC.

Additional Information

If you have questions, please contact your Medicare DME MAC at its toll-free number, which may be found at http://www.cms.gov/MedicareProviderSupEnroll/Downloads/CallCenterTollNumDirectory.zip on the CMS website.

The official instruction, CR6421, issued to your Medicare DME MAC regarding this change, may be viewed at http://www.cms.gov/MedicareProviderSupEnroll/Downloads/R963OTN.pdf on the CMS website.
Medicare contractors will not search their files to either retract payment for claims already paid or to retroactively pay claims, but will adjust claims brought to their attention.

Addtional Information

The official instruction, CR 7397 issued to your Medicare contractor regarding this issue may be viewed at http://www.cms.gov/Transmittals/downloads/R2312CP.pdf on the Centers for Medicare & Medicaid Services (CMS) website. If you have any questions, please contact your Medicare contractor at their toll-free number, which may be found at http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip on the CMS website. The following manual sections regarding billing drugs and biological and “incident to” services may be helpful:


Medicare Fee-For-Service (FFS) Claims Processing Guidance for Implementing International Classification of Diseases, 10th Edition (ICD-10)

MLN Matters® Number: MM7492
Related Change Request (CR) #: 7492
Related CR Release Date: August 19, 2011
Effective Date: October 1, 2013
Related CR Transmittal #: R9500TN
Implementation Date: January 1, 2012

Provider Types Affected

This article is for all physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs) and/or Part A/B Medicare Administrative Contractors (MACs), Regional Home Health Intermediaries (RHHIs), and Durable Medical Equipment MACs (DME MACs)) for services provided to Medicare beneficiaries.

Provider Action Needed

For dates of service on and after October 1, 2013, entities covered under the Health Insurance Portability and Accountability Act (HIPAA) are required to use the ICD-10 code sets in standard transactions adopted under HIPAA. The HIPAA standard health care claim transactions are among those for which ICD-10 codes must be used for dates of service on and after October 1, 2013. Make sure your billing and coding staffs are aware of these changes.

Key Points of CR7492

- General Reporting of ICD-10
  - As with ICD-9 codes today, providers and suppliers are still required to report all characters of a valid ICD-10 code on claims. ICD-10 diagnosis codes have different rules regarding specificity and providers/suppliers are required to submit the most specific diagnosis codes based upon the information that is available at the time. Please refer to http://www.cms.hhs.gov/ICD10 for more information on the format of ICD-10 codes. In addition, ICD-10 Procedure Codes (PCs) will only be utilized by inpatient hospital claims as is currently the case with ICD-9 procedure codes.
- General Claims Submissions Information
  - ICD-9 codes will no longer be accepted on claims (including electronic and paper) with FROM dates of service (on professional and supplier claims) or dates of discharge/through dates (on institutional claims) on or after October 1, 2013. Institutional claims containing ICD-9 codes for services on or after October 1, 2013, will be Returned to Provider (RTP). Likewise, professional and supplier claims containing ICD-9 codes for dates of services on or after October 1, 2013, will also be returned as unprocessable. You will be required to re-submit these claims with the appropriate ICD-10 code. A claim cannot contain both ICD-9 codes and ICD-10 codes. Medicare will RTP/return as unprocessable all claims that are billed with both ICD-9 and ICD-10 diagnosis codes on the same claim. For dates of service prior to October 1, 2013, submit claims with the appropriate ICD-9 diagnosis code. For dates of service on or after October 1, 2013, submit with the appropriate ICD-10 diagnosis code. Likewise, Medicare will also RTP/return as unprocessable all claims that are billed with both ICD-9 and ICD-10 procedure codes on the same claim. For claims with dates of service prior to October 1, 2013, submit with the appropriate ICD-9 procedure code. For claims with dates of service on or after October 1, 2013, submit with the appropriate ICD-10 procedure code. Remember that ICD-10 codes may only be used for services provided on or after October 1, 2013. Institutional claims containing ICD-10 codes for services prior to October 1, 2013, will be Returned to Provider (RTP). Likewise, professional and supplier claims containing ICD-10 codes for services prior to October 1, 2013, will be returned as unprocessable. Please submit these claims with the appropriate ICD-9 code.
- Claims that Span the ICD-10 Implementation Date
  - The Centers for Medicare & Medicaid Services (CMS) has identified potential claims processing issues for institutional, professional, and supplier claims that span the implementation date; that is, where ICD-9 codes are effective for the portion of the services that were rendered on September 30, 2013, and earlier and where ICD-10 codes are effective for the portion of the services that were rendered October 1, 2013, and later. In some cases, depending upon the policies associated with those services, there cannot be a break in service or time (i.e., anesthesia) although the new ICD-10 code set must be used effective October 1, 2013. The following tables provide further guidance to providers for claims that span the periods where ICD-9 and ICD-10 codes may both be applicable.

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### Table A – Institutional Providers

<table>
<thead>
<tr>
<th>Bill Type(s)</th>
<th>Facility Type/Services</th>
<th>Claims Processing Requirement</th>
<th>Use FROM or THROUGH Date</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>11X</strong></td>
<td>Inpatient Hospitals (incl. TERFHA hospitals, Prospective Payment System (PPS) hospitals, Long Term Care Hospitals (LTCHs), Critical Access Hospitals (CAHs))</td>
<td>If the hospital claim has a discharge and/or through date on or after 10/1/13, then the entire claim is billed using ICD-10.</td>
<td>THROUGH</td>
</tr>
<tr>
<td><strong>12X</strong></td>
<td>Inpatient Part B Hospital Services</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.</td>
<td>FROM</td>
</tr>
<tr>
<td><strong>13X</strong></td>
<td>Outpatient Hospital</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.</td>
<td>FROM</td>
</tr>
<tr>
<td><strong>14X</strong></td>
<td>Non-patient Laboratory Services</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.</td>
<td>FROM</td>
</tr>
<tr>
<td><strong>18X</strong></td>
<td>Swing Beds</td>
<td>If the [Swing bed or SNF] claim has a discharge and/or through date on or after 10/1/13, then the entire claim is billed using ICD-10.</td>
<td>THROUGH</td>
</tr>
<tr>
<td><strong>21X</strong></td>
<td>Skilled Nursing (Inpatient Part A)</td>
<td>If the [Swing bed or SNF] claim has a discharge and/or through date on or after 10/1/13, then the entire claim is billed using ICD-10.</td>
<td>THROUGH</td>
</tr>
<tr>
<td><strong>22X</strong></td>
<td>Skilled Nursing Facilities (Inpatient Part B)</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.</td>
<td>FROM</td>
</tr>
<tr>
<td><strong>23X</strong></td>
<td>Skilled Nursing Facilities (Outpatient)</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.</td>
<td>FROM</td>
</tr>
<tr>
<td><strong>32X</strong></td>
<td>Home Health (Inpatient Part B)</td>
<td>Allow HHAs to use the payment group code derived from ICD-9 codes on claims which span 10/1/2013, but require those claims to be submitted using ICD-10 codes.</td>
<td>THROUGH</td>
</tr>
</tbody>
</table>

### Table A – Institutional Providers

<table>
<thead>
<tr>
<th>Bill Type(s)</th>
<th>Facility Type/Services</th>
<th>Claims Processing Requirement</th>
<th>Use FROM or THROUGH Date</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>3X2</strong></td>
<td>Home Health – Request for Anticipated Payment (RAPs)*</td>
<td>* NOTE - RAPs can report either an ICD-9 code or an ICD-10 code based on the one (1) date reported. Since these dates will be equal to each other, there is no requirement needed. The corresponding final claim, however, will need to use an ICD-10 code if the HH episode spans beyond 10/1/2013.</td>
<td>*See Note</td>
</tr>
<tr>
<td><strong>34X</strong></td>
<td>Home Health – (Outpatient)</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.</td>
<td>FROM</td>
</tr>
<tr>
<td><strong>71X</strong></td>
<td>Rural Health Clinics</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.</td>
<td>FROM</td>
</tr>
<tr>
<td><strong>72X</strong></td>
<td>End Stage Renal Disease (ESRD)</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.</td>
<td>FROM</td>
</tr>
<tr>
<td><strong>73X</strong></td>
<td>Federally Qualified Health Clinics (prior to 4/1/10)</td>
<td>N/A – Always ICD-9 code set.</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>74X</strong></td>
<td>Outpatient Therapy</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.</td>
<td>FROM</td>
</tr>
<tr>
<td><strong>75X</strong></td>
<td>Comprehensive Outpatient Rehab facilities</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.</td>
<td>FROM</td>
</tr>
<tr>
<td><strong>76X</strong></td>
<td>Community Mental Health Clinics</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.</td>
<td>FROM</td>
</tr>
<tr>
<td><strong>77X</strong></td>
<td>Federally Qualified Health Clinics (effective 4/4/10)</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.</td>
<td>FROM</td>
</tr>
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</table>
Table A – Institutional Providers

<table>
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<th>Claims Processing Requirement</th>
<th>Use FROM or THROUGH Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>81X</td>
<td>Hospice - Hospital</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.</td>
<td>FROM</td>
</tr>
<tr>
<td>82X</td>
<td>Hospice – Non hospital</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.</td>
<td>FROM</td>
</tr>
<tr>
<td>83X</td>
<td>Hospice – Hospital Based</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>85X</td>
<td>Critical Access Hospital</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.</td>
<td>FROM</td>
</tr>
</tbody>
</table>

Table B - Special Outpatient Claims Processing Circumstances

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Claims Processing Requirement</th>
<th>Use FROM or THROUGH Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>3-day/1-day Payment Window</td>
<td>Since all outpatient services (with a few exceptions) are required to be bundled on the inpatient bill if rendered within three (3) days of an inpatient stay; if the inpatient hospital discharge is on or after 10/1/2013, the claim must be billed with ICD-10 for those bundled outpatient services.</td>
<td>THROUGH</td>
</tr>
</tbody>
</table>

Table C – Professional Claims

<table>
<thead>
<tr>
<th>Type of Claim</th>
<th>Claims Processing Requirement</th>
<th>Use FROM or THROUGH Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>All anesthesia claims</td>
<td>Anesthesia procedures that begin on 9/30/13 but end on 10/1/13 are to be billed with ICD-9 diagnosis codes and use 9/30/13 as both the FROM and THROUGH date.</td>
<td>FROM</td>
</tr>
</tbody>
</table>

Table D – Supplier Claims

<table>
<thead>
<tr>
<th>Supplier Type</th>
<th>Claims Processing Requirement</th>
<th>Use FROM or THROUGH Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>DMEPOS</td>
<td>Billing for certain items or supplies (such as capped rentals or monthly supplies) may span the ICD-10 compliance date of 10/1/13 (i.e., the FROM date of service occurs prior to 10/1/13 and the TO date of service occurs after 10/1/13).</td>
<td>FROM</td>
</tr>
</tbody>
</table>

Additional Information

The official instruction, CR7492 issued to your carrier, FI, RHHI, or MAC regarding this change may be viewed at [http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip](http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip) on the CMS website.

If you have any questions, please contact your carrier, FI, RHHI, or MAC at their toll-free number, which may be found at [http://www.cms.gov/Transmittals/downloads/R950OTN.pdf](http://www.cms.gov/Transmittals/downloads/R950OTN.pdf) on the CMS website.

Claim Status Category and Claim Status Codes Update

MLN Matters® Number: MM7585  
Related Change Request (CR) #: 7585  
Related CR Release Date: September 30, 2011  
Effective Date: January 1, 2012  
Related CR Transmittal #: R2314CP  
Implementation Date: January 3, 2012

Provider Types Affected

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

Provider Action Needed

This article, based on Change Request (CR) 7585, explains that the Claim Status and Claim Status Category Codes for use by Medicare contractors with the Health Care Claim Status Request and Response ASC X12N 276/277 and the Health Care Claim Acknowledgement ASC X12N 277 are updated three times per year at the Committee meeting. These meetings are held in the January/February time frame, again in June and finally in late September or early October, in conjunction with the Accredited Standards Committee (ASC) X12 meetings.

The Committee has decided to allow the industry 6 months for implementation of newly added or changed codes. Medicare contractors will begin using the current codes posted at [http://www.wpc-edi.com/codes](http://www.wpc-edi.com/codes) on the Internet, on or about November 1, 2011. Included in the code lists are specific details, including the date when a code was added, changed, or deleted. All providers are reminded to ensure that their billing staffs are aware of the updated codes and the timeframe for implementations.

Background

The Health Insurance Portability and Accountability Act (HIPAA) requires all health care benefit payers to use only Claim Status Category Codes and Claim Status Codes approved by the national Code Maintenance Committee in the X12 276/277 Health Care Claim Status Request and Response format adopted as the standard for national use (004010X093A1). These codes explain the status of submitted claims. Proprietary codes may not be used in the X12 276/277 to report claim status.
Additional Information

The official instruction, CR7585, issued to your Medicare contractors (FI, RHHI, A/B MAC, DME MAC and carrier) regarding this change, may be viewed at http://www.cms.gov/Transmittals/downloads/R2314CP.pdf on the CMS website.

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

Medical Policy

LCD and Policy Article Revisions Summary for October 14, 2011

Outline below are the principal changes to DME MAC Local Coverage Determinations (LCDs) and Policy Articles (PAs) that have been revised and posted. Please review the entire LCD and each related PA for complete information.

Enteral Nutrition

LCD
Revision Effective Date: 08/02/2011
INDICATIONS AND LIMITATIONS OF COVERAGE:
Revised: Refills information
DOCUMENTATION SECTION:
Added: Refills documentation information

Policy Article
Revision Effective Date: 08/02/2011
NONMEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: Preamble Language
Removed: Documentation Language

Positive Airway Pressure (PAP) Devices for the Treatment of Obstructive Sleep Apnea

LCD
Revision Effective Date: 10/01/2011
INDICATIONS AND LIMITATIONS OF COVERAGE:
Added: ACHC as approved accreditation body for sleep labs

Electronic Data Interchange (EDI)

Populating REF Segment - Other Claim Related Adjustment - for Healthcare Claim Payment/Advice or Transaction 835 Version 5010A1

MLN Matters® Number: MM7484 Revised
Related Change Request (CR) #: CR 7484
Related CR Release Date: September 2, 2011
Effective Date: January 1, 2012
Related CR Transmittal #: R959OTN
Implementation Date: January 3, 2012

Note: This article was revised on September 6, 2011, due to changes in CR7484. The CR was revised to add qualifier “F1” in Loop 2100 NM1 – Service Provider Name under special situations where the NPI is not available - enabling Medicare to report the Federal Taxpayer’s Identification Number instead of NPI if NPI is not available for the Rendering Provider and the Rendering provider is different from the Payee. The CR release date, transmittal number, and the Web address for accessing the CR were also revised. All other information remains the same.

Provider Types Affected

This article is for physicians, other providers, and suppliers who bill Medicare Carriers, Fiscal Intermediaries (FIs), Medicare Administrative Contractors (A/B MACs), Regional Home Health Intermediaries (RHHIs), or Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for Part B services provided to Medicare beneficiaries.

Provider Action Needed

STOP – Impact to You
The Centers for Medicare and Medicaid Services (CMS) has decided that populating the Healthcare Claim Payment/Advice or Transaction 835 version 5010A1 REF segment (Other Claim Related Adjustment) at Loop 2100 (for Part B) would provide useful information to providers and suppliers, and starting in January 2012, this segment will be populated for the Part B remittance advice.

CAUTION – What You Need to Know
CR7484, from which this article is taken, instructs Medicare systems, effective January 1, 2012, to populate the REF segment (Other Claim Related Adjustment) at Loop 2100 with qualifiers designated in the updated Flat File attached to CR7484. Note that CR also updates the 835 flat file by adding:

- PLB Code 90;
- Qualifier “PQ” to be used in Loop 1000B REF – Payee Additional Information under some special situations where the National Provider Identifier (NPI) is not available; and
- Qualifier “F1” to be used in Loop 2100 NM1 – service payable under some special situations where NPI is not available.

A webinar to enhance your understanding will be coming soon.
GO – What You Need to Do
You should make sure that your billing staffs are aware of this change.

Background
Currently the Healthcare Claim Payment/Advice or Transaction 835 REF segment (Other Claim Related Adjustment) at Loop 2100 is not being populated for the Part B remittance advice, and the 835 Flat File identifies this with a note: “N/U by Part B.”

CMS has decided that using this segment would provide useful information to providers and suppliers. Therefore, CR7484, from which this article is taken, instructs the VIPS Medicare System (VMS) and the Multi Carrier System (MCS) to populate this segment, effective January 1, 2012, under specific situations (e.g., for cost avoid claims) using one of the qualifiers included in the updated Flat File that is an attachment to CR7484.

Specifically, VMS and MCS will use one of the following Reference Identification Qualifiers in REF01 as appropriate:
- 28: Employee Identification Number
- 6P: Group Number
  (When they use this 6P qualifier, they will also populate NM1 – Corrected Priority Payer Name segment at Loop 2100 and REF02 with the Other Insured Group Number for the payer identified in NM1, and use Claim Status Code 2 in CLP02 in CLP – Claim Payment Information segment at Loop 2100);
- EA: Medical Record Identification Number
- F8: Original Reference

Note: Medicare will update Medicare Remit Easy Print (MREP) software to include this additional REF segment in the MREP Remittance Advice for version 5010A1.

Claim Adjustment Reason Code (CARC), Remittance Advice Remark Code (RARC), and Medicare Remit Easy Print (MREP) and PC Print Update

MLN Matters® Number: MM7514
Related Change Request (CR) #: 7514
Related CR Release Date: September 15, 2011
Effective Date: October 1, 2011
Related CR Transmittal #: R2304CP
Implementation Date: October 3, 2011

Provider Types Affected
Physicians, providers and suppliers who bill Medicare contractors (Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), Medicare Carriers, A/B Medicare Administrative Contractors (A/B MACs) and Durable Medical Equipment Medicare Administrative Contractors (DME MACs)) for services provided to Medicare beneficiaries are affected.

Provider Action Needed
Change Request (CR) 7514, from which this article is taken, announces the latest update of Claim Adjustment Reason Codes (CARC) and Remittance Advice Remark Codes (RARCs) that are effective on October 1, 2011, for Medicare. It also instructs certain Medicare contractors to update Medicare Remit Easy Print (MREP) and PC Print software. Be sure your billing staffs are aware of these changes.

Background
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 (COB) transactions. A national code maintenance committee maintains the Healthcare Claim Adjustment Reason Codes (CARCs). The CARC list is updated three times a year in early March, July, and November. The Centers for Medicare & Medicaid Services (CMS) maintains the Remittance Advice Remark Code (RARC) list, which is also updated three times a year in early March, July, and November.


The lists at the end of this article summarize the latest changes to these code lists, as announced in CR7514.

Additional Information
You can find the official instruction, CR7484, issued to your FI, carrier, A/B MAC, RHHI, or DME MAC by visiting http://www.cms.gov/Transmittals/downloads/R959OTN.pdf on the CMS website. You will find the updated 835 T 5010A1 flat file containing the qualifiers as an attachment to that CR.

Additionally, you can learn more about CMS’s implementation activities to convert from Health Insurance Portability and Accountability Act (HIPAA) Accredited Standards Committee (ASC) X12 version 4010A1 to ASC X12 version 5010A1 and National Council for Prescription Drug Programs (NCPDP) version 5.1 to NCPDP version D.0, by going to http://www.cms.gov/MFFS5010D0/01_Overview.asp#TopOfPage on the CMS website.

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

Additional Information
If you use the MREP and/or PC Print software, be sure to obtain an updated copy once it is available.

The official instruction, CR7514, issued to your FI, RHHI, carrier, A/B MAC, and DME MAC regarding this change, may be viewed at http://www.cms.gov/Transmittals/downloads/R2304CP.pdf on the CMS website.
If you have any questions, please contact your FI, RHHI, carrier, A/B MAC, or DME MAC, at their toll-free number, which may be found at http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip on the CMS website.

CR 7514 Changes

<table>
<thead>
<tr>
<th>Code</th>
<th>Current Narrative</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>237</td>
<td>Legislated/Regulatory Penalty. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)</td>
<td>6/5/2011</td>
</tr>
</tbody>
</table>

Modified Codes – CARC

<table>
<thead>
<tr>
<th>Code</th>
<th>Current Narrative</th>
<th>Effective Date</th>
</tr>
</thead>
</table>

Deactivated Codes – CARC

<table>
<thead>
<tr>
<th>Code</th>
<th>Current Narrative</th>
<th>Effective Date</th>
</tr>
</thead>
</table>

New Codes – RARC

<table>
<thead>
<tr>
<th>Code</th>
<th>Current Narrative</th>
<th>Medicare Initiated</th>
</tr>
</thead>
<tbody>
<tr>
<td>N544</td>
<td>Alert: Although this was paid, you have billed with a referring/ordering provider that does not match our system record. Unless corrected, this will not be paid in the future.</td>
<td>Yes</td>
</tr>
<tr>
<td>N545</td>
<td>Payment reduced based on status as an unsuccessful e-prescriber per the Electronic Prescribing (eRx) Incentive Program.</td>
<td>Yes</td>
</tr>
<tr>
<td>N546</td>
<td>Payment represents a previous reduction based on the Electronic Prescribing (eRx) Incentive Program.</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Modified Codes – RARC

<table>
<thead>
<tr>
<th>Code</th>
<th>Current Narrative</th>
<th>Effective Date</th>
</tr>
</thead>
</table>

Deactivated Codes – RARC

<table>
<thead>
<tr>
<th>Code</th>
<th>Current Narrative</th>
<th>Effective Date</th>
</tr>
</thead>
</table>

Medicare Pilot Project for Electronic Submission of Medical Documentation (esMD)

MLN Matters® Number: SE1110 Revised
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

**Note:** This article was revised on October 14, 2011, to correct the contractor for DME MAC C on page 5. It had incorrectly listed Palmetto GBA. The correct contractor is CGS Administrators, LLC. All other information remains the same.

Provider Types Affected

This Special Edition (SE) affects all Medicare Fee-For-Service (FFS) providers who submit medical documentation to Medicare review contractors.

Provider Action Needed

**STOP – Impact to You**

Each year, the Medicare Fee-For-Service (FFS) Program makes billions of dollars in estimated improper payments. The Centers for Medicare & Medicaid Services (CMS) employs several types of Medicare review contractors to measure, prevent, identify, and correct these improper payments. Review contractors find the improper payments by requesting medical documentation from each provider who submitted a questionable claim. The review contractor then manually reviews the claims against the submitted medical documentation to verify the providers’ compliance with Medicare’s rules.

Currently, review contractors request medical documentation by sending a paper letter to the provider. The provider has two options for submitting the requested records: 1) mail paper, or 2) send a fax.

**CAUTION – What You Need to Know**

Medicare’s Electronic Submission of Medical Documentation (esMD) pilot project gives some providers a new mechanism for submitting medical documentation to review contractors. A list of review contractors that will accept esMD transactions can be found at http://go.usa.gov/kr4 on the Internet.

The esMD pilot will begin in September of 2011.

The primary intent of esMD is to reduce provider costs and cycle time by minimizing and eventually eliminating paper processing and mailing of medical documentation to review contractors. A secondary goal of esMD is to reduce costs and time at review contractors.

In order to send medical documentation electronically to review contractors, Medicare providers, including physicians, hospitals, and suppliers, must obtain access to a CONNECT-compatible gateway.
Certain larger providers, such as hospital chains, may choose to build their own gateway.

Many providers may choose to obtain gateway services by entering into a contract or other arrangement with a Health Information Handler (HIH) that offers esMD gateway services.

A list of HIHs that offer esMD services as of September 2011 can be found in the “Key Points” section of this article. An updated listing of the HIHs that have been approved by CMS to offer esMD services can also be found at http://go.usa.gov/krg on the Internet.

CMS does not set the price that an HIH may charge a provider for esMD services. Providers who believe it may be more efficient to respond to documentation requests electronically are encouraged to contact one or more of the HIHs to determine if esMD services are available at a reasonable price.

GO – What You Need to Do
You should know that esMD is completely voluntary. You may continue to mail or fax documentation to your review contractor.

The initial esMD system accepts Portable Document Format (PDF) files, which means that even those providers who have paper records may utilize esMD services as long as there is a mechanism to scan the paper records into PDF files. Some HIHs may offer scanning services in addition to their esMD services.

Key Points
The following are tentative schedules of when HIHs will be ready to offer esMD services and when Review Contractors will be ready to accept esMD:

<table>
<thead>
<tr>
<th>HIH/Web Address</th>
<th>Scheduled Readiness*</th>
</tr>
</thead>
<tbody>
<tr>
<td>HealthPort (<a href="http://www.healthport.com">http://www.healthport.com</a>)</td>
<td>September 2011</td>
</tr>
<tr>
<td>IVANS (<a href="http://www.ivans.com">http://www.ivans.com</a>)</td>
<td>September 2011</td>
</tr>
<tr>
<td>MRO (<a href="http://www.mrocorp.com">http://www.mrocorp.com</a>)</td>
<td>September 2011</td>
</tr>
<tr>
<td>NaviNet (<a href="http://www.navinet.net">http://www.navinet.net</a>)</td>
<td>September 2011</td>
</tr>
<tr>
<td>RISARC (<a href="http://www.risarc.com">http://www.risarc.com</a>)</td>
<td>September 2011</td>
</tr>
<tr>
<td>eSolutions (<a href="http://www.ecorpnet.com">http://www.ecorpnet.com</a>)</td>
<td>November 2011</td>
</tr>
<tr>
<td>Cobius (<a href="http://www.cobius.com">http://www.cobius.com</a>)</td>
<td>November 2011</td>
</tr>
<tr>
<td>IOD, Inc. (<a href="http://www.iodincorporated.com">http://www.iodincorporated.com</a>)</td>
<td>November 2011</td>
</tr>
<tr>
<td>Proficient Health (<a href="http://www.proficienthealth.com">http://www.proficienthealth.com</a>)</td>
<td>November 2011</td>
</tr>
<tr>
<td>Craneware (<a href="http://www.craneware.com">http://www.craneware.com</a>)</td>
<td>November 2011</td>
</tr>
<tr>
<td>MDClick (<a href="http://www.mdclick.com">http://www.mdclick.com</a>)</td>
<td>November 2011</td>
</tr>
<tr>
<td>Medical Electronic Attachment (<a href="http://www.mea-fast.com">http://www.mea-fast.com</a>)</td>
<td>November 2011</td>
</tr>
<tr>
<td>EHR Doctors (<a href="http://www.ehrdoctors.com">http://www.ehrdoctors.com</a>)</td>
<td>November 2011</td>
</tr>
<tr>
<td>ApeniMED (<a href="http://www.Apenimed.com">http://www.Apenimed.com</a>)</td>
<td>November 2011</td>
</tr>
<tr>
<td>HealthIT+ (<a href="http://www.healthitplus.com">http://www.healthitplus.com</a>)</td>
<td>November 2011</td>
</tr>
<tr>
<td>ECC Technologies (<a href="http://www.ecc">http://www.ecc</a> tec.com)</td>
<td>January 2012</td>
</tr>
<tr>
<td>Stratiche Healthcare (<a href="http://stratichehealthcare.com/">http://stratichehealthcare.com/</a>)</td>
<td>January 2012</td>
</tr>
<tr>
<td>AT&amp;T (<a href="http://www.att.com/healthcare">http://www.att.com/healthcare</a>)</td>
<td>January 2012</td>
</tr>
<tr>
<td>CureMD (<a href="http://www.curemd.com">http://www.curemd.com</a>)</td>
<td>January 2012</td>
</tr>
</tbody>
</table>

Medicare review contractors include the Recovery Auditors (RACs), Medicare Administrative Contractors (MACs), the Comprehensive Error Rate Testing (CERT) contractor, the Program Error Rate Measurement (PERM) contractor, and Zone Program Integrity (ZPIC) contractors.

The following shows when some of these contractors will be accepting esMD transactions:

<table>
<thead>
<tr>
<th>Review Contractors</th>
<th>Scheduled Readiness*</th>
</tr>
</thead>
<tbody>
<tr>
<td>RAC A - Diversified Collection Services (DCS)</td>
<td>September 2011</td>
</tr>
<tr>
<td>RAC B - CGI Technologies and Solutions</td>
<td>September 2011</td>
</tr>
<tr>
<td>MAC J1 and J11 - Palmetto GBA</td>
<td>September 2011</td>
</tr>
<tr>
<td>MAC J3 - Noridian Administrative Services</td>
<td>September 2011</td>
</tr>
<tr>
<td>MAC J4 - Trailblazer Health Enterprises</td>
<td>September 2011</td>
</tr>
<tr>
<td>MAC J5 - Wisconsin Physicians Services Health Insurance Corporation</td>
<td>September 2011</td>
</tr>
<tr>
<td>MAC J9 - First Coast Service Options</td>
<td>September 2011</td>
</tr>
<tr>
<td>MAC J12 - Highmark Medicare Services</td>
<td>September 2011</td>
</tr>
<tr>
<td>MAC J14 - NHIC</td>
<td>September 2011</td>
</tr>
<tr>
<td>DME MAC A - NHIC</td>
<td>September 2011</td>
</tr>
<tr>
<td>DME MAC D - Noridian Administrative Services, LLC</td>
<td>September 2011</td>
</tr>
<tr>
<td>CERT - Livanta</td>
<td>September 2011</td>
</tr>
<tr>
<td>PERM - A+ Government Solutions</td>
<td>September 2011</td>
</tr>
<tr>
<td>MAC J10 - Cahaba Government Benefit Administrators</td>
<td>September 2011</td>
</tr>
<tr>
<td>MAC J13 - National Government Services</td>
<td>September 2011</td>
</tr>
<tr>
<td>DME MAC B - NGS</td>
<td>September 2011</td>
</tr>
<tr>
<td>ZPIC 1 - Safeguard Services LLC</td>
<td>September 2011</td>
</tr>
<tr>
<td>ZPIC 7 - Safeguard Services LLC</td>
<td>September 2011</td>
</tr>
<tr>
<td>RAC D - HealthDataInsights</td>
<td>September 2011</td>
</tr>
<tr>
<td>MAC J15 - CGS Administrators, LLC</td>
<td>January 2012</td>
</tr>
<tr>
<td>DME MAC C - CGS Administrators, LLC</td>
<td>January 2012</td>
</tr>
</tbody>
</table>

* These are anticipated dates and subject to change. Please check the esMD website (http://www.cms.gov/ESMD) for more information.

Note: CMS expects that the Region C and D Recovery Auditors and remaining MACs will begin accepting esMD transactions within the next 12 months.

Additional Information
If you have any questions, please contact the review contractor to which you wish to send esMD transactions. MAC toll-free
Important Update Regarding 5010/D.0 Implementation – Action Needed Now

MLN Matters® Number: SE1131
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
This MLN Matters® Special Edition Article is intended for all physicians, providers, and suppliers who bill Medicare contractors (carriers, Fiscal Intermediaries (FIs), Medicare Administrative Contractors (A/B MACs), Home Health and Hospice MACs (HH+H MACs), and Durable Medical Equipment MACs (DME MACs)) for services provided to Medicare beneficiaries.

Provider Action Needed

STOP – Impact to You
You and your billing and software vendors must be ready to begin processing the Health Insurance Portability and Accountability Act (HIPAA), Versions 5010 & D.0 production transactions by December 31, 2011. Beginning January 1, 2012, all electronic claims, eligibility and claim status inquiries, must use Versions 5010 or D.0. Version 4010/5.1 claims and related transactions will no longer be accepted. The electronic remittance advice will only be available in the 5010 version.

CAUTION – What You Need to Know
You must comply with this important deadline to avoid delays in payments for Medicare Fee-For-Service (FFS) claims after December 31, 2011. The implementation requires changes to the software, systems, and perhaps procedures that you use for billing Medicare and other payers.

GO – What You Need to Do
Contact your MACs to receive the free Version 5010 software (PC-Ace Pro32) and begin testing now. Consider contracting with a Version 5010 compliant clearinghouse who can translate the non-compliant transactions into compliant 5010 transactions. For Part B and DME providers, download the free Medicare Remit Easy Print (MREP) software to view and print compliant HIPAA 5010 835 remittance advices, which are available at http://www.cms.gov/AccessDataApplication/02_MedicareRemitEasyPrint.asp on the CMS website. Part A providers may download the free PC-Print software to view and print compliance HIPAA 5010 835 remittance advices, which is available on your A/B MACs website. Contact your respective professional associations and other payers for guidance and resources in order to meet their deadlines.

Background
HIPAA requires the Secretary of the Department of Health and Human Services (HHS) to adopt standards that covered entities (health plans, health care clearinghouses, and certain health care providers) must use when they electronically conduct certain health care administrative transactions, such as claims, remittance, eligibility, claims status requests and responses, and others.

The implementation of HIPAA 5010 and the National Council for Prescription Drug Programs (NCPDP) Version D.0 presents substantial changes in the content of the data that you submit with your claims, as well as the data available to you in response to your electronic inquiries. The implementation requires changes to the software, systems, and perhaps procedures that you use for billing Medicare and other payers.

Version 5010 refers to the revised set of HIPAA transaction standards adopted to replace the current Version 4010/4010A standards. Every standard has been updated, from claims to eligibility to referral authorizations.

All HIPAA covered entities must transition to Version 5010 by January 1, 2012. Any electronic transaction for which a standard has been adopted must be submitted using Version 5010 on or after January 1, 2012. Electronic transactions that do not use Version 5010 are not compliant with HIPAA and will be rejected.

To allow time for testing, CMS began accepting electronic transactions using either Version 4010/4010A or Version 5010 standards on January 1, 2011, and will continue to do so through December 31, 2011. This process allows a provider and its vendors to complete end-to-end testing with Medicare contractors and demonstrate that they are able to operate in production mode with Versions 5010 and D.0.

Note: HIPAA standards, including the ASC X12 Version 5010 and Version D.0 standards are national standards and apply to your transactions with all payers, not just with FFS Medicare. Therefore, you must be prepared to implement these transactions for your non-FFS Medicare business as well.

Are You at Risk of Missing the Deadline?
If you can answer NO to any of the following questions, you are at risk of not being able to meet the January 1, 2012, deadline and not being able to submit claims:

1. Have you contacted your software vendor (if applicable) to ensure that they are on track to meet the deadline or contacted your MAC to get the free Version 5010 software (PC-Ace Pro32)?
2. Alternatively, have you contacted clearinghouses or billing services to have them translate your Version 4010 transactions to Version 5010 (if not converting your older software)?

3. Have you identified changes to data reporting requirements?

4. Have you started to test with your trading partners, which began on January 1, 2011?

5. Have you started testing with your MAC, which is required before being able to submit bills with the Version 5010?

6. Have you updated MREP software to view and print compliant HIPAA 5010 835 remittance advices?

Additional Information


Additional educational resources about HIPAA 5010 & D.0 are available at http://www.cms.gov/versions5010andD0/40Educational_Resources.asp on the CMS website.

If you have any questions, please contact your Medicare contractor (carrier, FI, A/B MAC, HH+H MAC, and DME MACs) at their toll-free number, which may be found at http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip on the CMS website.

Appeals

New Qualified Independent Contractor (QIC) - C2C Solutions, Inc.

Reconsideration requests, the second level in the Medicare appeals process, are processed by the Qualified Independent Contractor (QIC). Beginning November 15, 2011, C2C Solutions, Inc. became the new QIC contractor and began processing reconsideration requests for all four of the Durable Medical Equipment Medicare Administrative Contractors (DME MACs).

DMEPOS suppliers should send all requests for reconsideration to C2C Solutions, Inc. at the following address:

C2C Solutions, Inc.
Attn: DME QIC
PO Box 44013
Jacksonville FL 32231-4013

Website: http://www.C2Cinc.com

Any request for reconsideration received by the previous contractor, RiverTrust Solutions, on or after November 15, 2011, will be forwarded to C2C Solutions, Inc.

Miscellaneous

Voluntary Refunds

As you know, suppliers may at times receive incorrect payment (e.g., for services/items not covered, erroneously billed, etc.). When this happens, the overpayment is a debt due to the Medicare program.

Medicare expects suppliers to exercise care when billing and accepting payment and also expects that suppliers will promptly bring incorrect payments to the contractor’s attention. You are to be commended for any voluntary refund(s) made during the year. These submissions acknowledge your awareness of this expectation and confirm a measure of compliance. However, please be aware that the CMS Manual System, Publication 100-08, Medicare Program Integrity Manual, Chapter 4, §4.16 states:

The acceptance of a voluntary refund in no way affects or limits the rights of the Federal Government or any of its agencies or agents to pursue any appropriate criminal, civil, or administrative remedies arising from or relating to these or any other claims.

Thank you for your efforts to work in cooperation with CGS to ensure proper and appropriate delivery of Medicare benefits.
Additional Fields for Additional Documentation Request (ADR) Letters

MLN Matters® Number: MM7254 Revised
Related Change Request (CR) #: 7254
Related CR Release Date: September 15, 2011
Effective Date: January 1, 2012, except April 1, 2012 for suppliers billing DME MACs
Related CR Transmittal #: R958OTN
Implementation Date: January 3, 2012, except April 2, 2012 for DME MACs

Note: This article was revised on September 30, 2011, to clarify the description of the content in the ADR. All other information remains the same.

Provider Types Affected

This article is for physicians, providers, and suppliers who must respond to ADRs from Medicare Administrative Contractors (A/B MACs) or Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for services provided to Medicare beneficiaries.

What You Need to Know

CR 7254, from which this article is taken, makes changes to the Medicare systems that allow A/B MACs and DME MACs to include, on Additional Documentation Request (ADR) letters, information about the Electronic Submission of Medical Documentation (esMD) pilot.

Background

CR7254, from which this article is taken, announces several changes to the Medicare systems that enable Medicare Review Contractors, participating in the esMD pilot, to include on ADR letters additional information necessary for Electronic Submission of Medical Documentation (esMD).

Specifically, these will allow MACs to include in each ADR:

- A statement about how providers can get more information about submitting medical documentation via the esMD mechanism
- A documentation case ID number that may facilitate tracking of submitted documents.

Additional Information

You can find the official instruction, CR7254, issued to your A/B MAC or DME MAC by visiting http://www.cms.gov/Transmittals/downloads/R958OTN.pdf on the Centers for Medicare & Medicaid Services (CMS) website.

You can learn more about the esMD pilot by going to http://www.cms.gov/ESMD/ on the CMS website. In addition, MLN Matters® article SE1110 provides more details on the esMD initiative. That article is at http://www.cms.gov/MLNMattersArticles/downloads/SE1110.pdf on the CMS website.

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

Proof of Delivery and Delivery Methods

MLN Matters® Number: MM7410 Revised
Related Change Request (CR) #: 7410
Related CR Release Date: September 30, 2011
Effective Date: October 31, 2011
Related CR Transmittal #: R389PI
Implementation Date: October 31, 2011

Note: This article was revised on November 8, 2011, to add a reference to MM7452 (http://www.cms.gov/MLNMattersArticles/downloads/MM7452.pdf) that provides information regarding the prospective billing requirement for refills provided on a recurring basis. It was previously revised on November 1, 2011, to clarify the language in the “What You Need to Know” section. All other information is the same.

Provider Types Affected

Suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) submitting claims to Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for items or services provided to Medicare beneficiaries are affected by this article.

What You Need to Know

CR 7410 modifies the number of days for a supplier to contact the beneficiary prior to dispensing a refill as well as the number of days to deliver a DMEPOS product prior to the end of usage for the current product. For DMEPOS products that are supplied as refills to the original order, suppliers must contact the beneficiary prior to dispensing the refill. This must be done to ensure that the refilled item is necessary and to confirm any changes or modifications to the order. CR7410 mandates that contact with the beneficiary or designee regarding refills shall take place no sooner than 14 calendar days prior to the delivery/shipping date. For subsequent deliveries of refills, the supplier shall deliver the DMEPOS product no sooner than 10 calendar days prior to the end of usage for the current product.

Additional Information

The official instruction, CR 7410 issued to your DME MAC regarding this change may be viewed at http://www.cms.gov/Transmittals/downloads/R389PI.pdf on the CMS website. If you have any questions, please contact your DME MAC at their toll-free number, which may be found at http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip on the CMS website.
Recovery Audit Program:
Medicare Administrative Contractor (MAC)-issued Demand Letters

MLN Matters® Number: MM7436
Related Change Request (CR) #: 7436
Related CR Release Date: July 29, 2011
Effective Date: January 3, 2012
Related CR Transmittal #: R192FM
Implementation Date: January 3, 2012

Provider Types Affected
This article is for all physicians, providers, and suppliers who bill Medicare claims processing contractors (Carriers, Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), and Medicare Administrative Contractors (MACs)).

Provider Action Needed
STOP – Impact to You
This article is based on Change Request (CR) 7436 which announces that Medicare’s Recovery Auditors will no longer issue demand letters to you as of January 3, 2012.

CAUTION – What You Need to Know
Recovery Auditors will, however, submit claim adjustments to your Medicare contractor, who will perform the adjustments based on the Recovery Auditor’s review, and issue an automated demand letter to you.

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

Background
As of January 3, 2012, the Centers for Medicare & Medicaid Services (CMS) is transferring the responsibility for issuing demand letters to providers from its Recovery Auditors to its claims processing contractors. This change was made to avoid any delays in demand letter issuance. As a result, when a Recovery Auditor finds that improper payments have been made to you, they will submit claim adjustments to your Medicare (claims processing) contractor. Your Medicare contractor will then establish receivables and issue automated demand letters for any Recovery Auditor identified overpayment. The Medicare contractor will follow the same process as is used to recover any other overpayment from you.

The Medicare contractor will then be responsible for fielding any administrative concerns you may have such as timeframes for payment recovery and the appeals process. However, the Medicare contractor will include the name of the initiating Recovery Auditor and his/her contact information in the related demand letter. You should contact that Recovery Auditor for any audit specific questions, such as their rationale for identifying the potential improper payment.

Additional Information
If you have questions, please contact your Medicare contractor at their toll-free number, which may be found at http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip on the Centers for Medicare & Medicaid Services (CMS) website.

To see the official instruction (CR7436) issued to your Medicare contractor, see http://www.cms.gov/Transmittals/downloads/R192FM.pdf on the CMS website.

Contractor Entities at a Glance:
Who May Contact You About Specific Centers for Medicare & Medicaid Services (CMS) Activities

MLN Matters® Number: SE1123
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 physicians, providers, and suppliers who submit claims to Medicare contractors (as defined in this article) for services and supplies provided to Medicare beneficiaries are affected.

What You Need to Know
The Centers for Medicare & Medicaid Services (CMS) has received calls from providers about the various entities that may contact them with questions and requests for medical records, documentation, or other information. CMS recognizes that shifts in contracting entities due to recent Medicare Contracting Reform may be confusing. CMS has prepared this Special Edition article to describe the current Medicare contracting environment. In addition, this article will list the entities responsible for activities in the Medicare Program, as well as with some Medicaid claims, and explain the reasons why they may contact you. CMS has also prepared a quick reference table titled, “Contractor Entities at a Glance: Who May Contact You about Specific Centers for Medicare & Medicaid Services (CMS) Activities,” that you may provide to your office staff for easy reference. The table is available at http://www.cms.gov/MLNProducts/downloads/ContractorEntityGuide_ICN906983.pdf on the CMS website.

CMS understands that several of these entities may contact you concurrently. You may question whether the efforts of these entities are coordinated and whether the burden placed upon providers can be reduced. CMS constantly strives to reduce the burden on providers. However, as this article explains, certain functions are performed by different entities by design. Sometimes different entities are involved because different skill sets are needed. For example, reviewing a provider enrollment application for correctness requires different skills than reviewing medical records to determine correct diagnosis and procedure...
coding. Also, sometimes certain functions must be performed by different entities to protect providers and the Medicare Program. For example, appeals of claims decisions should be heard, at least at certain levels, by an entity that is separate and distinct from the entity that made the claims decision. Therefore, while CMS strives to coordinate efforts of these entities, there may be times when providers are contacted by several of the entities concurrently.

Background

Listed below are general categories of the current entities that CMS uses under the Medicare and Medicaid programs to handle claims processing and other functions. Some of the entities are new to these programs as part of Medicare Contracting Reform. This article and the table mentioned above display the new entities in bold type. The table also provides websites that are available should you need further information. Finally, we explain how CMS coordinates the work of these entities so that phone calls and letters requesting medical records, documentation, or other information related to a beneficiary’s claims are minimized.

Claims Processing Contractors

CMS contracts with entities to process claims submitted by physicians, hospitals, and other health care providers/suppliers, and to make payment in accordance with Medicare regulations and policies. These entities, called carriers, Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), and Medicare Administrative Contractors (MACs), are also referred to as Medicare claims processing contractors. These entities are the entry point for participating in the Medicare program as they process provider enrollment applications.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) mandated that the Secretary of the Department of Health and Human Services (DHHS) replace the current contracting authority under Title XVIII of the Social Security Act (SSA) with the new MAC authority.

MACs will be the central point in CMS’ national Fee-For-Service (FFS) program.

- Carrier and FI workloads have or will be transitioned to 10 Part A/B MAC jurisdictions.
- Regional Home Health Intermediaries (RHHI) workloads are being transitioned to 4 HH MAC jurisdictions.
- Durable Medical Equipment (DME) workloads have been transitioned to 4 DME MAC jurisdictions.

You may access the most current Medicare Contracting Reform information to determine the effect of these changes on your practice and to view the list of current MACs for each jurisdiction at http://www.cms.gov/MedicareContractingReform on the CMS website. MACs may contact you for a variety of reasons, such as:

- Resolving issues regarding your initial and renewal enrollment applications;
- Providing education and guidance on procedures for billing Medicare;
- Resolving issues regarding claims you submit;
- Requesting medical records related to the claims you submit for medical review;
- Paying you for approved claims and/or explaining why some claims are not processed or are denied; and
- Recovering overpayments on claims previously processed.

Program Integrity Contractors

CMS contracts with Program Safeguard Contractors (PSCs) and Zone Program Integrity Contractors (ZPICs), who are responsible for identifying cases of suspected fraud and taking appropriate actions.

As a result of Medicare Contracting Reform, seven ZPICs were created based on the MAC jurisdictions. Eventually, PSCs will no longer exist and ZPICs will perform all benefit integrity work. ZPICs were created to perform program integrity for Medicare Parts A, B, C (Medicare Advantage or MA), D (Prescription Drugs, including MA-Drug Plans), Durable Medical Equipment (DME), Home Health and Hospice, and Medicare-Medicaid data matches, also referred to as Medi-Medi. Since these seven ZPICs focus on these different aspects of the Medicare Program, it is possible that providers could hear from more than one ZPIC, depending on the aspects of that ZPIC’s review and/or the nature of the services for which the provider bills Medicare.

CMS also contracts with Recovery Auditors to identify and correct underpayments and overpayments. There are 4 Recovery Auditors. Recovery Auditors improper payments. Recovery Auditors conduct reviews of claims in the following ways:

- Automated (no medical records are needed);
- Semi-Automated (medical records are supplied at the discretion of the provider to support a claim identified by data analysis as an improper payment); and
- Complex (medical record is required).

FFS Recovery Auditors contact providers to request additional documentation in support of potential improper payments. If an improper payment is determined, the FFS Recovery Auditor will send a review results letter, providing the decision and the accompanying reviewer rationale. A Demand letter is issued to you by the FFS Recovery Auditor or the MAC once the claim is adjusted. The FFS Recovery Auditor will offer you an opportunity to discuss the improper payment determination with the FFS Recovery Auditor (this is outside the normal appeal process).

The Tax Relief and Health Care Act of 2006 (TRHCA) authorizes the Recovery Audit program for Part A and Part B Medicare services.

The Affordable Care Act expands the Recovery Audit program to Medicaid and Medicare Part C (Medicare Advantage or MA) and Part D (prescription drugs).

- Medicaid Recovery Auditors are responsible for identifying and recovering Medicaid overpayments and identifying underpayments.
- MA Recovery Auditors will ensure that MA plans have an anti-fraud plan in effect and review the effectiveness of each anti-fraud plan.
Prescription Drug Plan (PDP) Recovery Auditors will ensure that each PDP under part D has an anti-fraud plan in effect and review the effectiveness of each anti-fraud plan.

CMS also reviews Medicare FFS claims nationally to identify improper payments, as required by the Improper Payment Information Act (IPIA) and the Improper Payments Elimination and Recovery Act (IPERA). This is accomplished through the Comprehensive Error Rate Testing (CERT) program. If a provider’s claim is randomly chosen, the CERT program will contact the provider to obtain medical records that support the claim and will conduct a review of the medical records to determine if the claim was paid correctly. If an improper payment is identified by the CERT program, your MAC will notify you and make the appropriate payment adjustment. Normal appeal rights apply to CERT-initiated denials and are handled through the routine appeal process.

CMS also reviews Medicaid and Children’s Health Insurance Program (CHIP) claims to identify improper payments, as required by the IPIA and the IPERA. This is accomplished through the Payment Error Rate Measurement (PERM) program.

CMS reviews a sample of claims in one-third of the states each year to develop a national estimate of improper payments. PERM conducts two types of reviews on these claims:
- Medical review (medical record is required)
- Data processing reviews (this is a validation that the payment was processed correctly in a state’s system)

If a provider’s claim is randomly chosen, the PERM program will contact the provider to obtain medical records that support the claim and will conduct a review of the medical records to determine if the claim was paid correctly.

Medicaid Integrity Contractors (MICs) are entities that contract with CMS to conduct audit-related activities for the Medicaid programs. There will be five MIC jurisdictions performing three primary functions:
- Review MICs, which analyze Medicaid claims data to investigate suspected/potential provider fraud, waste, or abuse;
- Audit MICs, which audit provider claims and identify overpayments; and
- Education MICs, which provide education to providers and others on payment integrity and quality-of-care issues.

Program Integrity contractors may contact you to resolve problems they identify in your claims or to request medical records for claims under review.

Specialty Medical Review Contractors
In an effort to continue the prevention and reduction of improper payments, CMS has contracted with a Specialty Medical Review Contractor to conduct medical review studies of Part A and B claims. Studies are conducted as fact-finding undertakings to allow CMS to better understand trends in billing behavior that may lead to improper payments. These studies occur on a quarterly basis and vary in topic. Claims chosen for review are selected randomly.

The Specialty Medical Review Contractor may contact you to request medical records for claims under review.

Also, CMS contracts with the Medicare Coordination of Benefits Contractor (COBC), a single entity, to provide a centralized COB operation. Responsibilities of the COBC include all activities that support the collection, management, and reporting of other insurance coverage of Medicare beneficiaries. The COBC may contact you to identify Medicare Secondary Payer (MSP) situations quickly and accurately.

There is also a Medicare Secondary Payer Recovery Contractor (MSPRC) that performs post-payment recovery of funds paid where Medicare should not have been the primary payer. The MSPRC may contact you for information related to MSP recoveries and can issue demand letters to require payment recovery.

BE THE FIRST
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By joining the CGS electronic mailing list, you can get immediate updates on all Medicare information, including:
- Medicare publications
- Important updates
- Workshops
- Medical review information

It is easy to enroll, and best of all it is free. To join:
- Go to: http://www.cgsmedicare.com/
- Then click on “Join ListServ.”
The last specialty contractor is the National Supplier Clearinghouse (NSC), which handles enrollment activities related to Durable Medical Equipment suppliers. The NSC may contact you about your enrollment information.

**Appeals Contractors and Entities**

CMS contracts with entities to conduct appeals of claims determinations. These include FIs, carriers, RHHIs, and MACs, who conduct first level appeals. **Qualified Independent Contractors (QICs)** conduct reconsiderations, the second level of appeals. There are:

- Two Part A QICs,
- Two Part B QICs,
- One DME QIC,
- One Part C QIC for MA, and
- One Part D QIC for Medicare Prescriptions Drug Plans (PDPs) and MA Drug Plans.

Other appeals-related entities include the Administrative Law Judges (ALJs) within the HHS Office of Medicare Hearings and Appeals and the Medicare Appeals Council within the HHS Departmental Appeals Board conduct the next two levels of appeal. The ALJ will send you a notice of hearing to all parties to the appeal, indicating the time and place of the hearing. The ALJ will generally issue a decision or dismissal within 90 days of receipt of a valid appeal request. The Medicare Appeals Council will generally issue a decision or dismissal within 90 days of receipt of a valid appeals request.

ALJs in the Civil Remedies Division within the HHS Departmental Appeals Board also conduct hearings on provider and supplier enrollment issues, and hearings on civil money penalties and sanctions imposed against providers and suppliers by CMS and the HHS Office of the Inspector General. For appeals of enrollment issues, the ALJ will generally issue a decision within 180 days of receipt of your request. For other types of appeals, the ALJ will issue a decision as soon as practical after the close of the hearing.

The Provider Reimbursement Review Board (PRRB) is an independent panel to which a certified Medicare provider of services may appeal if it is dissatisfied with a final determination of its fiscal intermediary or the Centers for Medicare & Medicaid Services (CMS). The Medicare Geographic Classification Review Board (MGCRB) decides on requests of Prospective Payment System (PPS) hospitals for reclassification to another area (Urban or in some cases Rural) for the purposes of receiving a higher wage index.

The PRRB and the MGCRB provide appeals avenues for providers on specific matters, including cost report disputes.

When you, or a beneficiary (or an appointed representative), appeal claims decisions, any of these appeals entities may request more information from you (or your representative).

**Quality Improvement Contractors**

Quality Improvement Organizations (QIOs) provide quality of care review services and conduct quality improvement projects. CMS contracts with one QIO in each state, as well as the District of Columbia, Puerto Rico, and the U.S. Virgin Islands. QIOs are private, mostly not-for-profit organizations, staffed by professionals, mostly doctors and other health care professionals, responsible for the review of services provided to beneficiaries enrolled in MA plans and in FFS Medicare, including:

- Conducting expedited Medicare coverage determinations of inpatient hospital discharges and provider service terminations;
- Reviewing beneficiary complaints about quality of care, including working with the provider and reviewing medical records as part of the complaint-resolution process;
- Working with providers to accomplish national quality improvement goals;
- Implementing improvements in the quality of care;
- Contacting providers to provide technical assistance and encouraging partnerships to achieve quality goals;
- Providing technical assistance with many of the CMS Value-Based Purchasing Programs; and
- Performing provider-requested higher-weighted Diagnosis Related Group reviews.

**Additional Information**

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

**Prohibition on Balance Billing Qualified Medicare Beneficiaries (QMBs)**

- **MLN Matters® Number:** SE1128
- **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 physicians, providers and suppliers who submit claims to Medicare for services and supplies provided to Qualified Medicare Beneficiaries (QMBs) are affected. This includes providers of services to enrollees of Medicare Advantage plans.

**What You Need to Know**

**STOP – Impact to You**

This Special Edition MLN Matters® Article provides guidance from the Centers for Medicare & Medicaid Services (CMS) to Medicare providers serving QMBs. **All Medicare providers are reminded that they may not bill QMBs for Medicare cost-sharing.**

**CAUTION – What You Need to Know**

All Medicare physicians, providers, and suppliers who offer services and supplies to QMBs must be aware that they may not bill QMBs for Medicare cost-sharing. This includes deductible, coinsurance, and copayments, known as “balance billing.” Section
1902(n)(3)(B) 4714 of the Social Security Act prohibits Medicare providers from balance billing QMBs for Medicare cost-sharing. QMBs have no legal obligation to make further payment to a provider or Medicare managed care plan for Part A or Part B cost sharing. Providers who inappropriately bill QMBs for Medicare cost-sharing are subject to sanctions.

**GO – What You Need to Do**

Refer to the Background and Additional Information Sections of this article for further details and resources about this guidance. Please ensure that you and your staffs are aware of the current balance billing law and policies regarding QMBs. Visit the State Medicaid Agency websites of the states in which you practice to learn how to submit claims if you are not currently submitting claims to a state.

**Background**

This article provides CMS guidance to Medicare providers to help them avoid inappropriately billing QMBs for Medicare cost-sharing, including deductible, coinsurance, and copayments. This is known as “balance billing.”

**Balance Billing of QMBs Is Prohibited by Federal Law**

Under current law, Medicare providers cannot balance bill a QMB. Section 1902(n)(3)(B) 4714 of the Social Security Act prohibits Medicare providers from balance billing QMBs for Medicare cost-sharing. (Please note, this section of the Act is available at [http://www.ssa.gov/OP_Home/ssact/title19/1902.htm](http://www.ssa.gov/OP_Home/ssact/title19/1902.htm) on the Internet.)

Specifically, the statute provides that the Medicare payment and any Medicaid payment are considered payment in full to the provider for services rendered to a QMB.

QMBs have no legal obligation to make further payment to a provider or Medicare managed care plan for Part A or Part B cost sharing. Providers who balance bill QMB patients may be subject to sanctions based on Medicare provider requirements established in Sections 1902(n)(3)(C) and 1905(p)(3) of the Social Security Act. Medicare providers who violate these billing restrictions are violating their Medicare provider agreement.

Please note that the statute referenced above supersedes Section 3490.14 of the “State Medicaid Manual,” which is no longer in effect, and therefore, may be causing confusion about QMB billing.

**QMBs and Benefits**

QMBs are persons who are entitled to Medicare Part A and are eligible for Medicare Part B; have incomes below 100 percent of the Federal Poverty Level; and have been determined to be eligible for QMB status by their State Medicaid Agency.

- Medicaid pays the Medicare Part A and B premiums, deductibles, co-insurance and co-payments for QMBs.
- At the State’s discretion, Medicaid may also pay Part C Medicare Advantage premiums for joining a Medicare Advantage plan that covers Medicare Part A and B benefits and Mandatory Supplemental Benefits.
- Regardless of whether the State Medicaid Agency opts to pay the Part C premium, the QMB is not liable for any co-insurance or deductibles for Part C benefits.

**Ways to Improve the Claims Process**

Effective communications between you and State Medicaid Agencies can improve the claims process for all parties involved. Therefore, CMS suggests that you take the following four actions to improve communications with State Medicaid Agencies and better understand the billing process for services provided to QMB beneficiaries:

1. **Determine if the State in which you operate has electronic crossover processes with the Medicare Coordination of Benefits Contractor (COBC) in place or if direct submission to the State Medicaid Agency is required or available.** Nearly all States participate in the Medicare crossover process. It may just be that particular QMBs need to be added to the eligibility exchange between given States and Medicare. If a claim is automatically crossed over to another payer, such as Medicaid, it is customarily noted on the Medicare remittance advice.

2. **Recognize that you must meet any state-imposed requirements and may need to complete the provider registration process to be entered into the State payment system.**

3. **Understand the specific requirements for provider registration for the State(s) in which you work.**

4. **Contact the State Medicaid Agency directly to determine the process you need to follow to begin submitting claims and receiving payment.**

<table>
<thead>
<tr>
<th>QMB Eligibility and Benefits</th>
<th>Eligibility Criteria</th>
<th>Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified Medicare Beneficiary</td>
<td>Income cannot exceed 100% of the Federal Poverty Level (FPL)</td>
<td>Entitled to Medicare Part A</td>
</tr>
<tr>
<td>(QMB only)</td>
<td>Resources cannot exceed $6,600 for a single individual or $9,910 for an individual living with a spouse and no other dependents.</td>
<td>Eligible for Medicaid payment of Medicare Part B premiums, deductibles, co-insurance and co-pays (except for Part D)</td>
</tr>
<tr>
<td>QMB Plus</td>
<td>Meets all of the standards for QMB eligibility as described above, but also meets the financial criteria for full Medicaid coverage.</td>
<td>Entitle to all benefits available to QMB, as well as all benefits available under the State Plan to a fully eligible Medicaid recipient.</td>
</tr>
</tbody>
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For more information about dual eligible categories and benefits, please visit [http://www.medicare.gov/Publications/Pubs/pdf/10126.pdf](http://www.medicare.gov/Publications/Pubs/pdf/10126.pdf) on the Internet.

**Additional Information**

For more information about QMBs and other individuals who are dually eligible to receive Medicare and Medicaid benefits,
please refer to the Medicare Learning Network® publication titled “Medicaid Coverage of Medicare Beneficiaries (Dual Eligibles),” which is available at [http://www.cms.gov/MLNMattersArticles/downloads/medicare_beneficiaries_dual_eligibles_at_a_glance.pdf](http://www.cms.gov/MLNMattersArticles/downloads/medicare_beneficiaries_dual_eligibles_at_a_glance.pdf) on the CMS website.


### Implementation of Pay.gov Application Fee Collection Process through PECOS

**MLN Matters® Number**: SE1130  
**Related Change Request (CR) #**: N/A  
**Related CR Release Date**: N/A  
**Effective Date**: October 3, 2011  
**Related CR Transmittal #**: N/A  
**Implementation Date**: N/A

#### Provider Types Affected

This Medicare Learning Network (MLN) Matters® Special Edition Article is intended for all providers and suppliers, (except physicians and non-physician practitioners who are not required to pay an application fee), who are initially enrolling in Medicare, adding a practice location, or revalidating their enrollment information, and do so by submitting one of the following paper Medicare enrollment applications or the associated Internet-based Provider Enrollment, Chain and Ownership System (PECOS) enrollment applications:

- CMS 855A—Medicare Enrollment Application for Institutional Providers;
- CMS 855B—Medicare Enrollment Application for Clinics, Group Practices; and Certain Other Suppliers; and
- CMS 855S—Medicare Enrollment Application for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Suppliers.

#### Provider Action Needed

**STOP — Impact to You**

Currently, providers or suppliers use [http://www.Pay.gov](http://www.Pay.gov) to make Medicare application fee payments electronically. This article announces a change to this website address to submit your application fee.

**CAUTION — What You Need to Know**

The changes outlined below have no effect on the [http://www.Pay.gov](http://www.Pay.gov) payment collection process. CMS is simply revising the way providers submit their application fee to improve the efficiency of the payment, collection, and accounting process.

**GO — What You Need to Do**

Use the following address to make your application fee payments: [https://pecos.cms.hhs.gov/pecos/feePaymentWelcome.do](https://pecos.cms.hhs.gov/pecos/feePaymentWelcome.do) on the CMS website. Please update any bookmarks you may have in place to the new address.

### Background

In February 2011, CMS published a final rule, CMS-6028-FC, with provisions related to the submission of application fees as part of the provider enrollment process. An application fee and/or hardship exception must be submitted with any application received from institutional providers initially enrolling in Medicare, adding a practice location, or revalidating their enrollment on or after March 25, 2011.

### Changes for Making Medicare Application Payments

#### Internet based PECOS On-Line Application Submitters:

For those who submit applications online via the PECOS website (also referred to as PECOS Provider Interface (or PECOS PI)), you will no longer have to separately access [http://www.Pay.gov](http://www.Pay.gov) to make your application fee payments. Instead, as you proceed through the Internet based PECOS application process, if a fee is required, you will be prompted to submit your payment by credit card or ACH debit card. Once your payment transaction is complete, you will be automatically returned to the PECOS website to complete the remaining part of your application. PECOS will track the collection transaction and will update payment status, allowing your application to be processed.

#### 855 Paper Application Submitters:

For providers who continue to use the 855 paper enrollment application, you will now submit your application fee using the following URL: [https://pecos.cms.hhs.gov/ pecos/feePaymentWelcome.do](https://pecos.cms.hhs.gov/pecos/feePaymentWelcome.do) on the CMS website.

Complete the Medicare Application Fee form and click the ‘PAY NOW’ button. You will be redirected to enter and submit payment collection information. At the conclusion of the collection process, you will receive a receipt indicating the status of your payment. Please print a copy for your records. We strongly recommend that you attach this receipt to the completed CMS-855 application submitted to your Medicare contractor.

#### Paper Application Submitters-Interim Procedures

Through December 31, 2011, if you go to Pay.gov directly, you will be redirected to the correct URL: [https://pecos.cms.hhs.gov/ pecos/feePaymentWelcome.do](https://pecos.cms.hhs.gov/pecos/feePaymentWelcome.do) on the CMS website. Please update any bookmarks you may have in place.

After December 31, 2011, you will be required to use the URL [https://pecos.cms.hhs.gov/ pecos/feePaymentWelcome.do](https://pecos.cms.hhs.gov/pecos/feePaymentWelcome.do) on the CMS website to submit your application fee.

### Additional Information


More information on revalidation can be found in SE1126, which is available at [http://www.cms.gov/MLNMattersArticles/downloads/SE1126.pdf](http://www.cms.gov/MLNMattersArticles/downloads/SE1126.pdf) on the CMS website.
If you have any questions, please contact your Medicare contractor at their toll-free number, which may be found at http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip on the CMS website.

**Predictive Modeling Analysis of Medicare Claims**

**MLN Matters® Number:** SE1133  
**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**

This MLN Matters® Special Edition Article is intended for all physicians, providers, and suppliers who submit Fee-For-Service (FFS) claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs), A/B Medicare Administrative Contractors (A/B MACs), Durable Medical Equipment (DME) MACs, and Home Health and Hospice MACs (HH+H MACs)).

**What Providers Need to Know**

**STOP — Impact to You**

As of June 30, 2011, the Centers for Medicare & Medicaid Services (CMS), has implemented a predictive analytics system that will analyze all Medicare FFS claims to detect potentially fraudulent activity.

**CAUTION — What You Need to Know**

The predictive analytics system uses algorithms and models to examine Medicare claims in real time to flag suspicious billing. This article briefly explains the predictive modeling system, its purpose, and how CMS is incorporating the system into its claims payment process.

**GO — What You Need to Do**

See the Background and Additional Information sections of this article for more information about this change.

**Background**

Section 4241 of the Small Business Jobs Act of 2010 (SBJA) mandated that the CMS implement a predictive analytics system to analyze Medicare claims to detect patterns that present a high risk of fraudulent activity. Signed by the President in Fall 2010, the SBJA enables CMS to employ real-time, pre-payment claims analysis to identify emerging trends of potentially fraudulent activity. This new process is similar to the pre-payment analysis that was already done by the financial and credit card industries. The SBJA enables CMS to employ real-time, pre-payment claims analysis to identify emerging trends of potentially fraudulent activity. Signed by the President in Fall 2010, the SBJA enables CMS to employ real-time, pre-payment claims analysis to identify emerging trends of potentially fraudulent activity. Signed by the President in Fall 2010, the SBJA enables CMS to employ real-time, pre-payment claims analysis to identify emerging trends of potentially fraudulent activity.

**Real Time Claims Streaming to Build Profiles and Create Risk Scores**

As of June 30, 2011, CMS is streaming all Medicare FFS claims through its predictive modeling technology. As each claim streams through the predictive modeling system, the system builds profiles of providers, networks, billing patterns, and beneficiary utilization. These profiles enable CMS to create risk scores to estimate the likelihood of fraud and flag potentially fraudulent claims and billing patterns.

Risk scores enable CMS to quickly identify unusual billing activity and flag claims for more thorough review prior to releasing payment. The system automatically prioritizes claims, providers, beneficiaries, and networks that are generating the most alerts and highest risk scores. CMS is leveraging the benefits of its new high-tech system to complement, not replace, the expertise of its experienced analysts:

- Analysts review prioritized cases by closely reviewing claims histories, conducting interviews, and performing site visits as necessary.
- If an analyst finds only innocuous billing, the outcome is recorded directly into the predictive modeling system and the payment is released as usual. This feedback loop refines the predictive models and algorithms to better target truly fraudulent behavior.
- Analysts who find evidence or indicators of fraud will work with the CMS Center for Program Integrity, MACs, and Zone Program Integrity Contractors to enact targeted payment denials, and in cases of egregious fraud, revoke Medicare billing privileges. Program integrity entities may also, as appropriate, coordinate with law enforcement officials to investigate cases for criminal or civil penalties.

**Effect of Risk Scores on Claims Payment**

Risk scores alone do not initiate administrative action and serve only to alert CMS to the necessity of more careful review of claims activity. While providers will be unable to appeal risk scores, CMS’s new technology will in no way alter a provider or supplier’s existing rights to appeal administrative actions or overpayment recovery efforts.

Currently, CMS is not denying claims solely based on the alerts generated by predictive models. CMS is focused on developing and refining models that identify unusual behavior without disrupting its claims processing for Medicare providers.

Working closely with clinical experts across the country and of every provider specialty, CMS is developing and refining algorithms that reflect the complexities of medical treatment and billing. The new technology will ultimately benefit the program’s many honest providers and suppliers by enabling the agency to prioritize the highest-risk cases for investigation and review. Prioritizing the alerts will minimize the disruption to providers who may occasionally exhibit unusual but honest billing.

CMS’s predictive modeling technology also enables automated cross-checks of provider, beneficiary, and claim information against historical trends and external databases. Automating checks that were previously performed manually will help CMS to more quickly identify and resolve any issues that may delay payment to providers and suppliers. Even as CMS implements a more thorough claims screening process, the Agency remains
dedicated to ensuring prompt payment for the providers. Prompt payment of claims is a statutory requirement; only in exceptional and urgent circumstances will CMS leverage its authority to waive prompt payment to conduct further investigation or review.

Additional Information
If you have any questions, please contact your Medicare contractor (carrier, FI, A/B MAC, HH+H MAC, or DME MAC) at their toll-free number, which may be found at http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip on the CMS website.

Fees & Pricing

January 2012 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files
MLN Matters® Number: MM7624
Related Change Request (CR) #: CR 7624
Related CR Release Date: October 27, 2011
Effective Date: January 1, 2012
Related CR Transmittal #: R2331CP
Implementation Date: January 3, 2012

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

Provider Action Needed
This article is based on Change Request (CR) 7624 which instructs your Medicare contractors to download and implement the January 2012 Average Sales Price (ASP) Medicare Part B drug pricing file for Medicare Part B drugs and, if released by the Centers for Medicare & Medicaid Services (CMS), also to download and implement the revised October 2011, July 2011, April 2011, and January 2011 files. Medicare will use these files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after January 3, 2012, with dates of service January 1, 2012, through March 31, 2012.

Background
The Medicare Modernization Act of 2003 (MMA; Section 303(c); see http://www.cms.gov/MMAUpdate/downloads/PL108-173summary.pdf on the Centers for Medicare & Medicaid Services (CMS) website) revised the payment methodology for Part B covered drugs and biologicals that are not priced on a cost or prospective payment basis. The Average Sales Price (ASP) methodology is based on quarterly data submitted to CMS by manufacturers. CMS will supply contractors with the ASP and Not Otherwise Classified (NOC) drug pricing files for Medicare Part B drugs on a quarterly basis. Payment allowance limits under the OPPS are incorporated into the Outpatient Code Editor (OCE) through separate instructions that can be located in the “Medicare Claims Processing Manual” (Chapter 4, Section 50; see http://www.cms.gov/manuals/downloads/clm104c04.pdf on the CMS website.

The following table shows how the quarterly payment files will be applied:

<table>
<thead>
<tr>
<th>Files</th>
<th>Effective for Dates of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>October 2011 ASP and ASP NOC</td>
<td>October 1, 2011, through December 31, 2011</td>
</tr>
<tr>
<td>July 2011 ASP and ASP NOC</td>
<td>July 1, 2011, through September 30, 2011</td>
</tr>
<tr>
<td>April 2011 ASP and ASP NOC</td>
<td>April 1, 2011, through June 30, 2011</td>
</tr>
<tr>
<td>January 2011 ASP and ASP NOC</td>
<td>January 1, 2011, through March 31, 2011</td>
</tr>
</tbody>
</table>

Additional Information
The official instruction, CR7624, issued to your carriers, DME MACs, FIs, A/B MACs, and RHHIs regarding this change may be viewed at http://www.cms.gov/Transmittals/downloads/R2331CP.pdf on the CMS website.

If you have any questions, please contact your carriers, DME MACs, FIs, A/B MACs, or RHHIs at their toll-free number, which may be found at http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip on the CMS website.

HCPCS Updates

The 2012 HCPCS Code Update – New, Discontinued, and Verbiage Changes

The following lists are categorized by the changes that will become effective January 1, 2012. Each list identifies specific changes to Level II Healthcare Common Procedure Coding System (HCPCS) codes for 2012.

The first listing contains the new HCPCS codes that will be effective for dates of service on or after January 1, 2012. If billed before January 1, 2012, the code will be returned as unprocessable or denied as an invalid code. In addition, the appearance of a HCPCS code in the following list does not necessarily indicate coverage.

<table>
<thead>
<tr>
<th>HCPCS/Mod</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A5056</td>
<td>OSTOMY POUCH, DRAINABLE, WITH EXTENDED WEAR BARRIER ATTACHED, WITH FILTER, (1 PIECE), EACH</td>
</tr>
</tbody>
</table>
This list contains a new modifier that becomes effective on January 1, 2012.

The list below contains the discontinued HCPCS codes with and without replacement codes. If the codes noted in this list are billed after January 1, 2012, they will be returned as unprocessable or denied as an invalid code. Descriptions of codes listed as replacements code should be reviewed carefully as these may be slightly different than the discontinued HCPCS code. Also, keep in mind some of the codes listed below do not have replacement codes.
The following list contains the HCPCS code verbiage changes. The changes include the following:

<table>
<thead>
<tr>
<th>HCPCS</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>E0638</td>
<td>STANDING FRAME/TABLE SYSTEM, ONE POSITION (E.G. UPRIGHT, SUPINE OR PRONE STANDER), ANY SIZE INCLUDING PEDIATRIC, WITH OR WITHOUT WHEELS</td>
</tr>
<tr>
<td>E0641</td>
<td>STANDING FRAME/TABLE SYSTEM, MULTI-POSITION (E.G. THREE-WAY STANDER), ANY SIZE INCLUDING PEDIATRIC, WITH OR WITHOUT WHEELS</td>
</tr>
<tr>
<td>E0642</td>
<td>STANDING FRAME/TABLE SYSTEM, MOBILE (DYNAMIC STANDER), ANY SIZE INCLUDING PEDIATRIC</td>
</tr>
<tr>
<td>E0691</td>
<td>ULTRAVIOLET LIGHT THERAPY SYSTEM, INCLUDES BULBS/LAMPS, TIMER AND EYE PROTECTION; TREATMENT AREA 2 SQUARE FEET OR LESS</td>
</tr>
<tr>
<td>J0129</td>
<td>INJECTION, ABATACEPT, 10 MG (CODE MAY BE USED FOR MEDICARE WHEN DRUG ADMINISTERED UNDER THE DIRECT SUPERVISION OF A PHYSICIAN, NOT FOR USE WHEN DRUG IS SELF ADMINISTERED)</td>
</tr>
<tr>
<td>J0220</td>
<td>INJECTION, ALGLUCOSIDASE ALFA, 10 MG, NOT OTHERWISE SPECIFIED</td>
</tr>
<tr>
<td>J0256</td>
<td>INJECTION, ALPHA 1 PROTEINASE INHIBITOR (HUMAN), NOT OTHERWISE SPECIFIED, 10 MG</td>
</tr>
<tr>
<td>J1561</td>
<td>INJECTION, IMMUNE GLOBULIN, (GAMUNEX/GAMUNEX-C/GAMMAKED), NON-LYOPHILIZED (E.G. LIQUID), 500 MG</td>
</tr>
<tr>
<td>L2005</td>
<td>KNEE ANKLE FOOT ORTHOSIS, ANY MATERIAL, SINGLE OR DOUBLE UPRIGHT, STANCE CONTROL, AUTOMATIC LOCK AND SWING PHASE RELEASE, ANY TYPE ACTIVATION, INCLUDES ANKLE JOINT, ANY TYPE, CUSTOM FABRICATED</td>
</tr>
<tr>
<td>L6000</td>
<td>PARTIAL HAND, THUMB REMAINING</td>
</tr>
<tr>
<td>L6010</td>
<td>PARTIAL HAND, LITTLE AND/OR RING FINGER REMAINING</td>
</tr>
<tr>
<td>L6020</td>
<td>PARTIAL HAND, NO FINGER REMAINING</td>
</tr>
<tr>
<td>L7368</td>
<td>LITHIUM ION BATTERY CHARGER, REPLACEMENT ONLY</td>
</tr>
</tbody>
</table>

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2012 Annual Update of Healthcare Common Procedure Coding System (HCPCS) Codes for Skilled Nursing Facility (SNF) Consolidated Billing (CB) Update

**MLN Matters® Number:** MM7552  
**Related Change Request (CR) #:** CR 7552  
**Related CR Release Date:** August 26, 2011  
**Effective Date:** January 1, 2012  
**Related CR Transmittal #:** R2286CP  
**Implementation Date:** January 3, 2012

**Provider Types Affected**

Physicians, other providers, and suppliers submitting claims to Medicare contractors (carriers), Durable Medical Equipment Medicare Administrative Contractors (DME MACs), Fiscal Intermediaries (FIs), and/or A/B Medicare Administrative Contractors (A/B MACs) for services provided to Medicare beneficiaries who are in a Part A covered Skilled Nursing Facility (SNF) stay.
What You Need to Know

This article is based on Change Request (CR) 7552 which provides the 2012 annual update of Healthcare Common Procedure Coding System (HCPCS) Codes for Skilled Nursing Facility Consolidated Billing (SNF CB) and how the updates affect edits in Medicare claims processing systems.

By the first week in December 2011:
- Physicians and other providers/suppliers who bill carriers, DME MACs, or A/B MACs are advised that new code files (entitled 2012 Carrier/A/B MAC Update) will be posted at http://www.cms.hhs.gov/SNFConsolidatedBilling/ on the Centers for Medicare & Medicaid Services (CMS) website; and
- Providers who bill Fiscal Intermediaries or A/B MACs are advised that new Excel and PDF files (entitled 2011 FI/A/B MAC Update) will be posted to http://www.cms.hhs.gov/SNFConsolidatedBilling/ on the CMS website.

It is important and necessary for the provider community to view the “General Explanation of the Major Categories” PDF file located at the bottom of each year’s FI/A/B MAC update in order to understand the Major Categories, including additional exclusions not driven by HCPCS codes.

Background

Medicare’s claims processing systems currently have edits in place for claims received for beneficiaries in a Part A covered SNF stay as well as for beneficiaries in a non-covered stay. Changes to HCPCS codes and Medicare Physician Fee Schedule designations are used to revise these edits to allow carriers, A/B MACs, DME MACs, and FIs to make appropriate payments in accordance with policy for Skilled Nursing Facility Consolidated Billing (SNF CB) contained in the “Medicare Claims Processing Manual” (Chapter 6, Section 110.4.1 for carriers and Chapter 6, Section 20.6 for FIs) which is available at http://www.cms.gov/manuals/downloads/clm104c06.pdf on the CMS website.

Please note that these edits only allow services that are excluded from CB to be separately paid by Medicare contractors.

Additional Information

You can find the official instruction, CR7552, issued to your carrier, FI, A/B MAC, or DME MAC by visiting http://www.cms.gov/Transmittals/downloads/R2286CP.pdf on the CMS website.

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

Competitive Bidding

Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program Expansion Announced

MLN Matters® Number: SE1127
Related Change Request (CR) #: NA
Related CR Release Date: NA
Effective Date: NA
Related CR Transmittal #: NA
Implementation Date: NA

Provider Types Affected

This article is for suppliers of DMEPOS that wish to participate in the upcoming Round 2 of the Medicare DMEPOS Competitive Bidding Program and/or the National Mail-Order Competition for Diabetic Testing Supplies that will occur at the same time as Round 2.

What You Need to Know

This article provides important information from the Centers for Medicare & Medicaid Services (CMS) regarding the next phase (Round 2 and National Mail-Order) of Medicare’s Competitive Bidding Program for DMEPOS. If you are interested in bidding, prepare now – don’t wait!

The Round 2 product categories are:
- Oxygen, oxygen equipment, and supplies;
- Standard (Power and Manual) wheelchairs, scooters, and related accessories;
- Enteral nutrients, equipment, and supplies;
- Continuous Positive Airway Pressure (CPAP) devices and Respiratory Assist Devices (RADs) and related supplies and accessories;
- Hospital beds and related accessories;
- Walkers and related accessories;
- Negative Pressure Wound Therapy pumps and related supplies and accessories; and
- Support surfaces (Group 2 mattresses and overlays).

CMS will also be conducting a national mail-order competition for diabetic testing supplies at the same time as the Round 2 competition. The national mail-order competition will include all parts of the United States, including the 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, and American Samoa.

A list of the specific items in each product category is available on the Competitive Bidding Implementation Contractor (CBIC) website, http://www.dmecompetitivebid.com, and the specific ZIP codes in each Round 2 competitive bidding area (CBA) are also available on the CBIC website.
UPDATE YOUR CONTACT INFORMATION: The following contact information in your enrollment file at the National Supplier Clearinghouse (NSC) must be up to date before you register to bid. If your file is not current, you may experience delays and/or be unable to register and bid. DMEPOS suppliers should review and update the following:

- The name, Social Security number, and date of birth for all authorized official(s) (if you have only one authorized official listed on your enrollment file, consider adding one or more authorized officials to help with registration and bidding) and
- The correspondence address.

DMEPOS suppliers can update their enrollment via the internet-based Provider Enrollment, Chain and Ownership System (PECOS) or by using the 7/11/2011 version of the CMS-855S enrollment form. Suppliers not currently using PECOS can learn more about this system by accessing the PECOS website at http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/Provider-Enrollment-and-Chain-of-Ownehip-System/Provider-Enrollment-and-Chain-and-Ownehip-System-PECOSPro.html or reviewing the PECOS fact sheet at http://www.cms.gov/MLNProducts/downloads/MedEnroll_PECOS_DMEPOS_FactSheet_ICN904283.pdf on the CMS website.

Information and instructions on how to submit a change of information via the hardcopy CMS-855S enrollment form may be found on the NSC website at http://www.palmettogba.com/nsc and by following this path: Supplier Enrollment/Change of Information/Change of Information Guide.

GET LICENSED: Contracts are only awarded to suppliers that have all required state licenses at the time the bid is submitted. Therefore, before you submit a bid for a product category in a CBA, you must have all required state licenses for that product category on file with the NSC. Every location must be licensed in each state in which it provides services. If you have only one location and are bidding in a CBA that includes more than one state, you must have all required licenses for every state in that CBA. If you have more than one location and are bidding in a CBA that includes more than one state, your company must have all required licenses for the product category for every state in that CBA. It is VERY IMPORTANT that current versions of all required licenses are in your enrollment file with the NSC BEFORE you bid. If any required licenses are expired or missing from your enrollment file, CMS can reject your bid. Suppliers bidding in the National Mail-Order Competition must have the applicable licenses for all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, and American Samoa.

GET ACCREDITED: Suppliers must be accredited for all items in a product category in order to submit a bid for that product category. If you are interested in bidding for a product category and are not currently accredited for that product category, take action NOW to get accredited for that product category. Your accreditation organization will need to report any accreditation updates to the NSC. CMS cannot contract with suppliers that are not accredited by a CMS-approved accreditation organization.

Current Round 2 and National Mail-Order Schedule
CMS has announced the following next steps for the program to ensure that suppliers have ample time to prepare for the competition:

**Summer 2011**
- CMS begins pre-bidding supplier awareness program;

**Fall 2011**
- CMS announces bidding schedule;
- CMS begins bidder education program; and
- Bidder registration period to obtain user ID and passwords begins.

**Winter 2012**
- Bidding begins.

Additional Information
The Competitive Bidding Implementation Contractor (CBIC) is the official information source for bidders. Stay informed - visit the CBIC website at http://www.dmecompetitivebid.com/ to subscribe to e-mail updates and for the latest information.

For more information on the DMEPOS competitive bidding program, visit http://www.cms.gov/dmeposcompetitivebid/ on the CMS website.

Information on the DMEPOS accreditation requirements along with a list of the accreditation organizations and those professionals and other persons exempted from accreditation may be found at http://www.cms.gov/MedicareProviderSupEnroll/01_Overview.asp on the CMS website.

The press release about the expanded competitive bidding program may be found at http://www.cms.gov/apps/media/press_releases.asp on the CMS website.

To view the Fact Sheet titled: Next Steps For Expansion Of The Medicare Durable Medical Equipment, Prosthetics, Orthotics, And Supplies go to http://www.cms.gov/apps/media/fact_sheets.asp on the CMS website.

News Flash Items

Looking for the latest Medicare Fee-For-Service (FFS) information? Then subscribe to a Medicare FFS Provider listserv that suits your needs! For information on how to register and start receiving the latest news, go to http://www.cms.gov/MLNProducts/downloads/MailingLists_FactSheet.pdf on the Centers for Medicare & Medicaid Services (CMS) website.

The publication titled “Evaluation and Management Services Guide” (revised December 2010), is now available in print format from the Medicare Learning Network®. This guide is designed to provide education on medical record documentation and evaluation and management billing and coding considerations.

**Vaccinate Early to Protect Against the Flu /2011-2012 Influenza Vaccine Prices Are Now Available**

CDC recommends a yearly flu vaccination as the most important step in protecting against flu viruses. Remind your patients that annual vaccination is recommended for optimal protection. Under Medicare Part B, Medicare pays for the flu vaccine and its administration for seniors and other Medicare beneficiaries with no co-pay or deductible. Take advantage of each office visit and start protecting your patients as soon as your 2011-2012 seasonal flu vaccine arrives. And don’t forget to immunize yourself and your staff. Get the Flu Vaccination – Not the Flu.


Influenza vaccine is NOT a Part D-covered drug. For information about Medicare’s coverage of the influenza vaccine, its administration, and educational resources for healthcare professionals and their staff, visit [http://www.CMS.gov/MLNProducts/35_PreventiveServices.asp](http://www.CMS.gov/MLNProducts/35_PreventiveServices.asp) on the CMS website.

**The new publication titled “Annual Wellness Visit” is now available** in downloadable format from the Medicare Learning Network® at [http://www.cms.gov/MLNProducts/downloads/Annual_Wellness_Visit.pdf](http://www.cms.gov/MLNProducts/downloads/Annual_Wellness_Visit.pdf) on the Centers for Medicare & Medicaid Services (CMS) website. This brochure is designed to provide education on the Annual Wellness Visit, providing Personalized Prevention Plan Services, at no cost to the beneficiary, so beneficiaries can work with their physicians to develop and update their personalized prevention plan.

**If you are a provider or supplier that furnishes the technical component of Advanced Diagnostic Imaging (ADI) services and bill Medicare under the Physician Fee Schedule for these services, you should know that you must be accredited by Sunday, January, 1, 2012.** Those not accredited by that deadline will not be able to bill Medicare until they become accredited. For more information about ADI Accreditation, including details of the accreditation process and the organizations approved by the Centers for Medicare & Medicaid Services (CMS) to grant accreditation, please visit [http://www.CMS.gov/MedicareProviderSupEnroll/03_AdvancedDiagnosticImagingAccreditation.asp](http://www.CMS.gov/MedicareProviderSupEnroll/03_AdvancedDiagnosticImagingAccreditation.asp) on the CMS website. A Medicare Learning Network (MLN) Special Edition Article (SE1122) – “Important Reminders about Advanced Diagnostic Imaging (ADI) Accreditation Requirements” – has also been published and is available at [http://www.CMS.gov/MLNMattersArticles/Downloads/SE1122.pdf](http://www.CMS.gov/MLNMattersArticles/Downloads/SE1122.pdf) on the CMS website.

**The July 2011 issue of the “Medicare Quarterly Provider Compliance Newsletter” is now available in downloadable format from the Medicare Learning Network® at [http://www.CMS.gov/MLNProducts/downloads/MedQtrlyCompNewsletterICN903687.pdf](http://www.CMS.gov/MLNProducts/downloads/MedQtrlyCompNewsletterICN903687.pdf) on the Centers for Medicare & Medicaid Services (CMS) website.** This educational tool is issued on a quarterly basis and designed to provide education on how to avoid common billing errors and other erroneous activities when dealing with the Medicare Program. Please visit [http://www.CMS.gov/MLNProducts/downloads/MedQtrlyCompNL_Archive.pdf](http://www.CMS.gov/MLNProducts/downloads/MedQtrlyCompNL_Archive.pdf) to download, print, and search newsletters from previous quarters.

**A new fact was posted to the MLN Provider Compliance web page** ([http://www.cms.gov/MLNProducts/45ProviderCompliance.asp](http://www.cms.gov/MLNProducts/45ProviderCompliance.asp)), which contains educational Fee For Service (FFS) provider materials to help you understand – and avoid – common billing errors and other improper activities identified through claim review programs. You can review quick tips on relevant provider compliance issues and corrective actions directly from this web page. Please bookmark this page and check back often as a new “fast fact” is added each month!

**The Centers for Medicare & Medicaid Services (CMS) has released 4 podcasts and a video slideshow presentation of the May 18, 2011, national provider call on “CMS ICD-10 Conversion Activities, Including a Lab Case Study.”** The podcasts, slideshow presentation, and written transcripts are now available at [http://www.cms.gov/ICD10/Tel10/itemdetail.asp?itemID=CMS1246998](http://www.cms.gov/ICD10/Tel10/itemdetail.asp?itemID=CMS1246998) on the CMS website. The 4 audio podcasts with corresponding written transcripts, as well as the full written transcript of the call can be accessed by scrolling to the “Downloads” section at the bottom of the page. To access the video slideshow presentation, select the link in the “Related Links Outside CMS” section of the webpage.

**Are you short on time? The Centers for Medicare & Medicaid Services (CMS) has created podcasts from four popular ICD-10 National Provider Calls.** These podcasts are perfect for use in the office, on the go in your car, or your portable media player or smart phone. Listen to all of the podcasts from a call or just the ones that fit your needs. To access the podcasts, visit the CMS Sponsored ICD-10 Teleconferences webpage located at [http://www.cms.gov/ICD10/Tel10/list.asp](http://www.cms.gov/ICD10/Tel10/list.asp) on the Centers for Medicare & Medicaid Services (CMS) website.

**The “Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Quality Standards” fact sheet is now available in a hard copy format from the Medicare Learning Network.** This fact sheet is designed to provide education on DMEPOS quality standards for Medicare-deemed Accreditation Organizations (AOs) for DMEPOS suppliers. To place your order, visit the MLN Product Ordering Page at [http://CMS.meridianksi.com/kc/pfs/pfs_lnkfrm_fl.asp?lgfrm=reqprod&function=pfs](http://CMS.meridianksi.com/kc/pfs/pfs_lnkfrm_fl.asp?lgfrm=reqprod&function=pfs) on the Internet.

**The Centers for Medicare & Medicaid Services (CMS) is pleased to announce that two new educational resources on the 2011 Electronic Prescribing Incentive Program are now available on the CMS website.** One new resource is a fact sheet with step-by-step in protecting against flu viruses.
step advice for the 2011 program and the other is a simple quick reference chart. To access all available Electronic Prescribing Incentive Program educational resources, visit http://www.cms.gov/ERxIncentive on the CMS website and click on the Educational Resources tab. Once on the Educational Resources page, scroll down to the “Downloads” section select the publication title.

The Office of Management and Budget recently approved changes to the Medicare Provider-Supplier Enrollment Applications (CMS-855) in order to update them from the 2008 versions, as well as the new CMS-855O application form used for the sole purpose of enrolling to order and refer items and/or services to Medicare beneficiaries. The revised and new forms are now available at http://www.CMS.gov/CMSForms/CMSForms/list.asp?filtertype=dual&filtertype=keyword&keyword=855 on the Centers for Medicare & Medicaid Services (CMS) website. Providers and suppliers enrolling for the sole purpose to order and refer are required to begin using the new CMS-855O form immediately. Providers and suppliers using the other CMS-855 forms to enroll in Medicare are encouraged to begin using the revised forms, though the old forms may be used through October 2011.

Under the Affordable Care Act, Medicare beneficiaries may now receive coverage for an Annual Wellness Visit (AWV), which is a yearly office visit that focuses on preventive health. In addition, Medicare also provides coverage for the Initial Preventive Physical Examination (IPPE), commonly known as the “Welcome to Medicare” visit. To learn more about the AWV and the IPPE, please refer to the CMS Medicare Learning Network® publication at http://www.cms.gov/MLNProducts/downloads/mps_guide_web-061305.pdf on the Centers for Medicare & Medicaid Services (CMS) website.


The Medicare Quarterly Provider Compliance Newsletter is designed to provide education on how to avoid common billing errors and other erroneous activities when dealing with the Medicare Program. This publication is issued on a quarterly basis and highlights the “top” issues of that particular quarter. An archive and searchable index of current and previously-issued newsletters is available at http://cms.gov/MLNProducts/downloads/MedQtrlyCompNL_Archive.pdf on the Centers for Medicare & Medicaid website.

Beginning January 1, 2012, eligible professionals and group practices participating under the group practice reporting option (GPRO) that have not successfully met the requirements of the eRx incentive program (or, alternately, qualify for a significant hardship exemption) will be subject to the 2012 Medicare eRx payment adjustment. The adjustment will reduce Medicare payment rates by 1% of the provider’s allowable Medicare Part B charges. Individual eligible professionals must submit their hardship exemption requests through the Quality Communications Support Page (https://www.qualitynet.org/portal/server.pt/community/communications_support_system/234) and group practices participating under the group practice reporting option (GPRO) must submit hardship exemption requests via a letter to CMS. The deadline to submit a hardship exemption request is Tuesday November 1, 2011.

Vaccinate Early to Protect Against the Flu. The Centers for Disease Control and Prevention (CDC) recommends a yearly flu vaccination as the first and most important step in protecting against flu viruses. Remind your patients that annual vaccination is recommended for optimal protection. Medicare pays for the flu vaccine and its administration for seniors and other Medicare beneficiaries with no co-pay or deductible. Take advantage of each office visit and start protecting your patients as soon as your 2011-2012 seasonal flu vaccine arrives. And, don’t forget to immunize yourself and your staff. Get the Flu Vaccination -- Not the Flu. Remember – Influenza vaccine plus its administration are covered Part B benefits. Note that influenza vaccine is NOT a Part D covered drug. For information about Medicare’s coverage of the influenza vaccine and its administration, as well as related educational resources for health care professionals and their staff, please visit http://www.cms.gov/MLNProducts/35_PreventiveServices.asp on the Centers for Medicare & Medicaid Services (CMS) website.

Vaccination is the Best Protection Against the Flu. The Centers for Disease Control and Prevention (CDC) is encouraging everyone 6 months of age and older to get vaccinated against the seasonal flu. The risks for complications, hospitalizations, and deaths from the flu are higher among individuals aged 65 years and older. Medicare pays for the seasonal flu vaccine and its administration for seniors and others with Medicare with no co-pay or deductible. And remember, vaccination is particularly important for healthcare workers, who may spread the flu to high risk patients. Don’t forget to immunize yourself and your staff. Protect your patients. Protect your family. Get the Flu Vaccination -- Not the Flu. Remember – Influenza vaccine plus its administration are covered Part B benefits. CMS has posted the 2011-2012 seasonal influenza vaccine payment limits at http://www.CMS.gov/McrPartBDrugAvgSalesPrice/10_VaccinesPricing.asp. Note that influenza vaccine is NOT a Part D-covered drug. For information about Medicare’s coverage of the influenza vaccine and its administration, as well as related educational resources for healthcare professionals and their staff, visit http://www.CMS.gov/MLNProducts/35_PreventiveServices.asp.

CHECK IT OUT! Find us on Facebook®

The CGS DME MAC Jurisdiction C Provider Outreach & Education page on Facebook® offers you the latest in DME MAC provider education, news, and much more! Become a fan and get all of the latest DME MAC Provider Outreach & Education (POE) information and more on the CGS DME POE page on Facebook® at: http://www.facebook.com/cignagovernmentservices
## DME MAC Jurisdiction C Contact Information

<table>
<thead>
<tr>
<th>Contact for:</th>
<th>Contact Information:</th>
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<tbody>
<tr>
<td><strong>EDI – Electronic Claim Submission;</strong></td>
<td></td>
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<tr>
<td><strong>Electronic Remittance Notices</strong></td>
<td><strong>Jurisdiction C CEDI (toll-free):</strong> 1.866.311.9184 (8:00a - 6:00p CST, Mon. – Fri.)</td>
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<tr>
<td></td>
<td><strong>Jurisdiction C CEDI website:</strong> <a href="http://www.ngscedi.com">http://www.ngscedi.com</a></td>
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<tr>
<td></td>
<td><strong>E-mail:</strong> <a href="mailto:ngs.CEDIHelpdesk@wellpoint.com">ngs.CEDIHelpdesk@wellpoint.com</a></td>
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<tr>
<td><strong>Paper Claim Submission</strong></td>
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<tr>
<td><strong>Address:</strong></td>
<td><strong>CGS</strong> PO Box 20010, Nashville, TN 37202</td>
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<tr>
<td><strong>Provider Customer Service Calls</strong></td>
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<tr>
<td><strong>IVR (Interactive Voice Response):</strong></td>
<td><strong>1.866.238.9650</strong> (Mon.-Fri., 6:00a - 8:00p CST, Sat., 6:00a - 4:00p CST)</td>
</tr>
<tr>
<td><strong>Customer Service:</strong></td>
<td><strong>1.866.270.4909</strong> (Mon.-Fri., 7:00a - 5:00p CST)</td>
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<tr>
<td><strong>Hearing Impaired:</strong></td>
<td><strong>1.888.204.3771</strong> (Mon.-Fri., 7:00a - 5:00p CST)</td>
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<tr>
<td><strong>Beneficiary Customer Service Calls</strong></td>
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<tr>
<td><strong>Phone:</strong></td>
<td><strong>1.800.Medicare</strong></td>
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<tr>
<td><strong>Written Inquiries</strong></td>
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<tr>
<td><strong>Address:</strong></td>
<td><strong>CGS</strong> PO Box 20010, Nashville, TN 37202</td>
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<tr>
<td><strong>Claim Reopenings (Adjustments)</strong></td>
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<tr>
<td><strong>Address:</strong></td>
<td><strong>CGS</strong> PO Box 20010, Nashville, TN 37202</td>
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<tr>
<td><strong>Fax (for underpayments):</strong></td>
<td><strong>1.615.782.4649</strong></td>
</tr>
<tr>
<td><strong>Fax (for overpayments):</strong></td>
<td><strong>1.615.782.4477</strong></td>
</tr>
<tr>
<td><strong>Telephone requests for Reopenings:</strong></td>
<td><strong>1.866.813.7878</strong> (8:00a - 10:30a and 12:00p – 3:30p CST)</td>
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<tr>
<td><strong>Claim Status Inquiry</strong></td>
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<tr>
<td><strong>&amp; Beneficiary Eligibility</strong></td>
<td><strong>Security Access Issues/Password Reset, Email:</strong> <a href="mailto:MedicareOPID@cigna.com">MedicareOPID@cigna.com</a></td>
</tr>
<tr>
<td><strong>Enrollment Status:</strong></td>
<td><strong>1.866.270.4909</strong></td>
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<tr>
<td><strong>Appeals – Redetermination Requests</strong></td>
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<tr>
<td><strong>Address:</strong></td>
<td><strong>CGS</strong> PO Box 20009, Nashville, TN 37202</td>
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<tr>
<td><strong>Fax:</strong></td>
<td><strong>1.615.782.4630</strong></td>
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<tr>
<td><strong>Electronic Funds Transfer</strong></td>
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<tr>
<td><strong>Address:</strong></td>
<td><strong>CGS</strong> Attn: EFT-DME</td>
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<td><strong>PO Box 20010, Nashville, TN 37202</strong></td>
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<td><strong>Refunds</strong></td>
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<td><strong>Address:</strong></td>
<td><strong>CGS</strong> DME MAC Jurisdiction C</td>
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<tr>
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<td><strong>PO Box 955152, St. Louis, MO 63195-5152</strong></td>
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<td><strong>Phone:</strong> <strong>1.888.315.6930</strong></td>
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<td><strong>Overnight or Special Shipping</strong></td>
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<td><strong>Address:</strong></td>
<td><strong>CGS</strong> DME MAC Jurisdiction C</td>
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<tr>
<td></td>
<td><strong>Two Vantage Way, Nashville, TN 37228</strong></td>
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<tr>
<td><strong>DME MAC Jurisdiction C website</strong></td>
<td><strong>Website:</strong> <a href="http://www.cgsmedicare.com/jc/index.html">http://www.cgsmedicare.com/jc/index.html</a></td>
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<td><strong>Advance Determination of Medicare</strong></td>
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<td><strong>Coverage (ADMC) - Requests</strong></td>
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<tr>
<td><strong>Address:</strong></td>
<td><strong>CGS</strong> Attn: ADMC</td>
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<td><strong>PO Box 20010, Nashville, TN 37202</strong></td>
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<tr>
<td><strong>Fax:</strong></td>
<td><strong>1.615.782.4647</strong></td>
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<tr>
<td><strong>Supplier Enrollment</strong></td>
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<tr>
<td><strong>Address:</strong></td>
<td><strong>National Supplier Clearinghouse</strong></td>
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<tr>
<td></td>
<td><strong>Palmetto GBA * AG-495</strong></td>
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<tr>
<td></td>
<td><strong>PO Box 100142, Columbia, SC 29202-3142</strong></td>
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<tr>
<td><strong>Phone:</strong></td>
<td><strong>1.866.238.9652</strong></td>
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