



## May 15, 2006 Newsletter

*In This Issue....*

	<b><u>Audit &amp; Reimbursement</u></b>	
A	Acceptance and Rejection of Cost Reports	3
S,C	DRA 2005 Section 5004 SNF Bad Debt Reduction	5
	<b><u>Claims</u></b>	
A	Clarification of Medicare Payment Policy When Inpatient Admission is Determined not to be Medically Necessary, Including the Use of Condition Code 44: "Inpatient Admission Changed to Outpatient"	6
A	Prospective Payment System (PPS) Payment for Blood Clotting Factors Administered to Hemophilia Inpatients	11
A	Cultural Competency: A National Health Concern	14
S	Access to the Part D Drug Benefit in Long Term Care Settings	16
A	MMA – The Centers for Medicare & Medicaid Services (CMS) Recovery Audit Contractor (RAC) Initiative	18
A	Announcing the Release of the Revised CMS-855 Medicare Enrollment Applications	20
A	Instructions for Provider Notification Regarding Streamlined Drug Coverage Materials for Health Care Professionals, a New Fact Sheet and Script for Recent Audio Conference	22
	<b><u>General Information</u></b>	
A	Drug Coverage Materials for Health Care Professionals	24
	<b><u>Systems</u></b>	
A	2006 Revised American National Standards Institute X12N 837 Institutional Health Care Claim Companion Document	24
A	Mutual of Omaha Medicare Companion Guide	26
A	Update to Chapter 24 (EDI Support Requirements) of the Medicare Claims	32
A	<b><u>MIP Tip</u></b> - Obtaining the CMS-855A Provider Enrollment Application	34

### **KEY**

- A** All Providers
- H** Hospital Providers
- S** Skilled Nursing Facility (SNF) Providers
- O** Comprehensive Outpatient Rehabilitation Facility (CORF) And Outpatient Physical Therapy (OPT) Providers
- C** Community Mental Health Center (CMHC) Providers
- R** Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Providers
- E** End-Stage Renal Disease (ESRD) Providers
- P** Hospice Providers
- M** Home Health Providers

If you have any questions regarding this newsletter, please contact your Customer Service Representative. However, some articles may contain a specific telephone number to contact for assistance.

Mutual of Omaha Insurance Company  
Medicare Area

**To stay informed of Medicare issues as they arise, please register for our Electronic Mail List at: [www.mutualmedicare.com/signup](http://www.mutualmedicare.com/signup)**

## Acceptance and Rejection of Cost Reports

Section 140 of the CMS Publication 15-II, Chapter 1 provides the list of items that a provider must submit before its cost report will be considered acceptable.

Specifically, a cost report submission to a providers' servicing fiscal intermediary (FI) must include the following seven (7) items:

1. A diskette of the ECR utilizing a CMS-approved vendor with the current specification date submitted. An ECR that passes all Level 1 edits. A print image file of the cost report except when using CMS free software.
2. The certification page (Worksheet S) of the ECR file with an **original** signature of an officer (administrator or chief financial officer). This must not be a faxed, stamped, or copied signature or the FI must reject the cost report. Blue ink is suggested to avoid confusion.
3. An exact match of the encryption code (fingerprint), date, and time for the ECR displayed on the certification page to that of the ECR file encryption code, date, and time.
4. An exact match of the encryption code (fingerprint), date, and time for the print image displayed on the certification page to that of the print image file encryption code, date, and time except when using CMS free software.
5. For teaching hospitals, a complete Intern and Resident Information System (IRIS) diskette that will pass all IRIS system edits.
6. The settlement summary on the electronic certification page agrees with the settlement summary on the Medicare cost report produced from the electronic file.
7. A completed, signed and submitted Form CMS-339 with an original signature.

From all other providers (not filing electronically):

1. A complete and legible cost report filed on the proper forms.
2. A general information and certification page which includes the original signature of an officer (administrator or chief financial officer).
3. A completed, signed and submitted Form CMS-339 with an original signature.

If the cost report submittal does not contain the above, then the cost report fails to meet the CMS cost report acceptability requirements. CMS has instructed FI's to **immediately** reject the cost report (CMS Pub. 15-II, Chp. 1, Sec. 140). For example, if a worksheet S comes to an Intermediary without a signature the FI must immediately reject the cost report, rather than delaying rejection, and having the provider submit the signed worksheet S.

There are only two exceptions where CMS has granted Intermediary's the authority to delay rejecting a cost report.

1.) Per CMS Pub. 15-II, Chp. 1, Sec. 140, if the sole cause of rejection is a faulty diskette (IRIS or cost report) then a notice will be sent out informing the provider that they have 15 days from the date of the letter to resubmit a good diskette. The resubmitted cost report must still be rejected or accepted within 30 days from the original

cost-reporting package receipt date. Due to this deadline, if the second diskette is faulty, you will not be given the chance to submit a third diskette if the 30-day filing deadline does not allow it.

Note that if you are permitted, for purposes of expediency, to e-mail an ECR file, that file must be a compressed or self-extracting file (i.e. using Win-zip or a similar program.) If the file is sent in its ASCII format without the benefit of compression or as a self-extraction the validity of the encryption verification is altered and therefore will be rejected. In addition, the date and time stamps will likely not match which would also cause rejection. Another important note is that the files that are sent the second time must be the same files that were originally sent on the diskette. In order to do this provider's should keep a backup of the files that they send on diskette. If you go back into your cost reporting software and re-export an ECR file to diskette this will create a brand new file with brand new date and time stamps along with new encryption codes. These will not match the signed worksheet S that was previously sent in, thus the cost report will be rejected at that point.

2.) Per CMS Pub. 100-06, Chp. 10, Sec. 3, prior to rejection, the Intermediary will determine that any settlement variances or edits are not caused by an error in the Intermediary's ADR cost reporting software. If such an error is the sole cause of the rejection then the Intermediary will work with their vendor to correct the problem in order to allow the Intermediary to accept the cost report. If it is the provider's software that is in error (e.g. it missed an edit that properly appears on the Intermediary's software,) then the cost report will still be rejected and the provider must work the issue out with their software vendor in order to submit a diskette free of valid errors.

In order to avoid the consequences of a rejected cost report, please be sure to doublecheck each cost report submission for all of the above listed requirements.

If you have any questions on the above article please contact the Audit Supervisor assigned to your team. The website below will lead you to the Home Office Contacts section of the Mutual Medicare website. From here you will be able to find contact information for your assigned team. The full test of acceptable cost report submittal requirements are contained in section 140 of CMS Pub. 15-2.

[http://www.mutualmedicare.com/audit\\_reimbursement/contacts/home\\_office/index](http://www.mutualmedicare.com/audit_reimbursement/contacts/home_office/index)

## **DRA 2005 Section 5004 SNF Bad Debt Reduction**

The Deficit Reduction Act of 2005 included a bad debt reduction for Skilled Nursing Facilities. This reduction is enacted in Transmittal 14 for the form-set 2540-96 (SNF) and is expected to be enacted in the near future for the Hospital based-SNF. This reduction takes place for cost reports beginning on or after 10/01/2005 and effectively reduces the bad debts by 30%. This reduction does not apply to bad debts for full-benefit dual eligible individuals. The revised instructions for the applicable lines of E part III are stated below.

### Line 10

Enter program reimbursable bad debts for deductibles and coinsurance (from your records,) excluding deductibles and coinsurance for physicians' professional services and net of bad debt recoveries.

### Line 10.01

Multiply the amount (including negative amounts) on line 10 by 100% for cost reporting periods beginning before 10/01/2005.

### Line 10.02

Enter the gross reimbursable bad debts for full-benefit dual eligible individuals. This amount must also be included in the amount on line 10.

### Line 10.03

DRA 2005 SNF Bad Debt- For cost report periods beginning on or after 10/01/2005, calculate as follows: [(Line 10 – line 10.02) times .7], PLUS the amount on line 10.02. This is the adjusted SNF allowable bad debt in accordance with DRA 2005, section 5004. (10/01/2005)

If you have any questions on this information, please contact the audit supervisor assigned to your facility.

# **Clarification of Medicare Payment Policy When Inpatient Admission is Determined not to be Medically Necessary, Including the Use of Condition Code 44: “Inpatient Admission Changed to Outpatient”**

**MLN Matters Number:** SE0622

**Related CR Release Date:** Sept. 10, 2004

**Related CR Transmittal #:** R299CP

**Related Change Request (CR) #:** 3444

**Effective Date:** N/A

**Implementation Date:** N/A

## **Introduction**

Following issuance of Transmittal 299 (Change Request 3444) on September 10, 2004, the Centers for Medicare & Medicaid Services (CMS) received numerous questions and requests for clarification. This Special Edition article and the Q&As that follow are intended to address those questions and provide clarification of Medicare policy related to inpatient admissions that are determined not to be medically necessary, as well as Medicare policy related to changing a beneficiary status from inpatient to outpatient, and how the two policies interface.

## **Provider Types Affected**

Hospitals, including those for which payment for Medicare Part B services is made under the hospital Outpatient Prospective Payment System (OPPS), as well as hospitals that are not subject to the OPPS for which payment for outpatient services is made under other payment methodologies

## **Provider Action Needed**

Be sure to understand Medicare rules and policy when utilization review (UR) determines that an inpatient admission is not medically necessary or when a hospital should report Condition Code 44 in Form Locator (FL) 24-30, or its electronic equivalent, on outpatient claims (type of bill 13X, 85X) to signal a change in patient status from inpatient to outpatient.

## **Background**

### **Hospital Conditions of Participation**

The hospital Conditions of Participation (CoPs) require all hospitals to have a utilization review (UR) plan. A hospital must ensure that all the UR requirements of 42 CFR 482.30 are fulfilled. These requirements can be fulfilled by the hospital directly through its policies, procedures, and UR committee. Alternatively, the hospital may fulfill these UR requirements (including the UR committee’s functions and responsibilities) through a quality improvement organization (QIO) that has assumed binding review. However, in either case the hospital is responsible to ensure that all the UR activities, including the review of medical necessity of hospital admissions and continued stay are fulfilled as described in 42 CFR 482.30. Specifically:

- A UR committee consisting of two or more practitioners must carry out the UR function. At least two members of a hospital’s UR committee must be doctors of medicine or osteopathy, and the other members may be any of the other types of practitioners specified in regulation.
- The determination that an admission or continued stay is not medically necessary must either be made by (i) one member of the UR committee if the practitioner(s) responsible for the care of the patient either concurs with the determination or fails to

present their views when afforded the opportunity, or (ii) two members of the UR committee in all other cases.

- The UR committee must consult with the practitioner(s) responsible for the care of the patient and allow them to present their views **before** making the determination.
- If the UR committee determines that the admission is not medically necessary, the committee must give written notification, no later than 2 days after the determination, to the hospital, the patient, and the practitioner responsible for the care of the patient.

Review of admissions may be performed before, at, or after hospital admission.

**Note:** Patients are admitted to the hospital only on the recommendation of a licensed practitioner permitted by the State to admit patients to a hospital. “Outpatient” means a person who has not been admitted as an inpatient but who is registered on the hospital records as an outpatient and receives services (rather than supplies alone) directly from the hospital.

#### **The Use of Condition Code 44**

In some instances, a physician may order a beneficiary to be admitted to an inpatient bed, but upon subsequent review, it is determined that an inpatient level of care does not meet the hospital’s admission criteria. The National Uniform Billing Committee (NUBC) issued Condition Code 44, effective April 1, 2004, to identify cases when this occurs. The definition of Condition Code 44 is as follows:

- Condition Code 44 Inpatient admission changed to outpatient
- For use on outpatient claims only, when the physician ordered inpatient services, but upon internal utilization review performed before the claim was initially submitted, the hospital determined the services did not meet its inpatient criteria. CMS issued Transmittal 299 (Change Request 3444) on September 10, 2004, to implement new section 50.3 in Chapter 1 of the *Medicare Claims Processing Manual*. Section 50.3 describes when and how a hospital may change a patient’s status from inpatient to outpatient as well as the appropriate use of Condition Code 44.

In cases where a beneficiary’s status is changed from inpatient to outpatient subsequent to UR determination that the inpatient admission does not meet the hospital’s inpatient criteria, the hospital may submit an outpatient claim (Type of Bills 13x, 85x) to receive payment for medically necessary Medicare Part B services that were furnished to the beneficiary, provided all of the following conditions are met:

- The change in patient status from inpatient to outpatient is made prior to discharge or release, while the beneficiary is still a patient of the hospital;
- The hospital has not submitted a claim to Medicare for the inpatient admission;
- A physician concurs with the utilization review committee’s decision; and
- The physician’s concurrence is documented in the patient’s medical record.

#### **Questions and Answers (Q&As)**

***Q1. Isn’t there a conflict between the Condition Code 44 policy and the standards included in the hospital Condition of Participation related to review of admissions for medical necessity?***

**A1.** No. The CoP standards in section 482.30 of the regulations are comprehensive and broadly applicable with regard to the medical necessity of admissions to the hospital. CMS set the policy for the use of Condition Code 44 to address those relatively infrequent occasions, such as a late-night weekend admission when no case manager is

on duty to offer guidance, when internal review subsequently determines that an inpatient admission does not meet hospital criteria and that the patient would have been registered as an outpatient under ordinary circumstances. For such cases, prior to implementation of Condition Code 44, a hospital could only receive payment for certain nonphysician medical and other health services payable under Part B that were furnished either directly or indirectly to an inpatient for which payment could not be made under Part A. Condition Code 44 allows hospitals to treat the entire episode of care as an outpatient encounter, to report as outpatient services whatever services are furnished, and to receive payment under the outpatient prospective payment system as though the patient had been registered as an outpatient.

***Q2. If the hospital complies with the requirement for written notification within two days of the determination, can it still bill for the encounter as an outpatient episode of care and use Condition Code 44?***

**A2.** Yes, as long as the patient has not yet been released from the hospital, and provided that the other prerequisites for use of Condition Code 44 are met.

***Q3. Can a case manager or utilization management staff member change a patient's status from inpatient to outpatient after determining that the hospital's admission criteria were not met?***

**A3.** CMS has received many questions regarding who may make the status change, and requests for clarification as to whether utilization management staff or a case manager may implement the change. The CoP in §482.30 of the regulations requires that the utilization review committee be comprised of at least two doctors of medicine or doctors of osteopathy, although it may include other specified practitioners. The CoP provides that the determination concerning the medical necessity of an admission or continued stay must be made by members of the UR committee (or QIO) in consultation with the practitioner(s) responsible for the care of the patient. The CoP in §482.12(c) provides that patients are admitted to the hospital only on the recommendation of a licensed practitioner permitted by the State to admit patients to a hospital. If a Medicare patient is admitted by a practitioner not specified in Medicare regulations, the patient must be under the care of a doctor of medicine or osteopathy. Therefore, a case manager or other utilization management staff person who is not a licensed practitioner permitted by the state to admit patients to a hospital or a doctor of medicine or osteopathy would not have the authority to change a patient's status from inpatient to outpatient. However, we encourage and expect hospitals to employ case management staff to facilitate the application of hospital admission protocols and criteria, to facilitate communication between practitioners and the UR committee or QIO, and to assist the UR committee in the decision making process. Use of Condition Code 44 is not intended to serve as a substitute for adequate staffing of utilization management personnel or for continued education of physicians and hospital staff about each hospital's existing policies and admission protocols. As education and staffing efforts continue to progress, the need for hospitals to correct inappropriate admissions and to report condition code 44 should become increasingly rare.

***Q4. Is the concurrence of any physician or practitioner acceptable when a hospital has determined that a patient's status should be changed from inpatient to outpatient?***

**A4.** One of the requirements for the use of Condition Code 44 is physician concurrence with the determination that an inpatient admission does not meet the hospital's admission criteria and that the patient should have been registered as an outpatient. The

practitioner(s) responsible for the care of the patient must concur with the hospital's finding that inpatient admission criteria are not met. This prerequisite for use of condition code 44 is consistent with the requirements in the CoP at §482.30 (d) of the regulations. This paragraph provides that the practitioner or practitioners responsible for the care of the patient must be consulted and allowed to present their views before the UR committee or QIO makes its determination that an admission is not medically necessary. It may also be appropriate to include the practitioner who admitted the patient if this is a different person than the practitioner responsible for the care of the patient.

***Q5. How does a hospital bill using Condition Code 44?***

**A5.** When the hospital has determined that it may submit an outpatient claim according to the conditions applicable to the use of Condition Code 44, the hospital should report the entire episode of care as an outpatient encounter, as though the inpatient admission never occurred.

When a hospital submits a 13X or 85X type of bill for services furnished to a beneficiary whose status was changed from inpatient to outpatient, the hospital must report Condition Code 44 in one of Form Locators 24-30, or in the ANSI X12N 837 I in Loop 2300, HI segment, with qualifier BG, on the outpatient claim. Condition Code 44 will be used by CMS and QIOs to track and monitor these occurrences.

***Q6. How should the hospital bill Medicare if the criteria for using Condition Code 44 are not met, but all requirements in the condition of participation in §482.30 have been complied with?***

**A6.** If the conditions for use of Condition Code 44 are not met, the hospital should submit a bill using Type of Bill 12x for covered Part B Only services that were furnished to the inpatient. Medicare may still make payment for certain Part B services furnished to an inpatient of a hospital when payment cannot be made under Part A because an inpatient admission is determined not to be medically necessary. Information about Part B only services is located in the *Medicare Benefit Policy Manual* (Chapter 6, Section 10). Examples of such services include, but are not limited to, diagnostic x-ray tests, diagnostic laboratory tests, surgical dressings and splints, prosthetic devices, and other services. The *Medicare Benefit Policy Manual* includes a complete list of the payable Part B Only services.

***Q7. How should the change in patient status from inpatient to outpatient be reported in the patient's medical record? Can the hospital just discard the inpatient record?***

**A7.** Entries in the medical record cannot be expunged or deleted and must be retained in their original form. Therefore, all orders and all entries related to the inpatient admission must be retained in the record in their original form. If a patient's status changes in accordance with the requirements for use of Condition Code 44, the change must be fully documented in the medical record, complete with orders and notes that indicate why the change was made, the care that was furnished to the beneficiary, and the participants in making the decision to change the patient's status.

***Q8. Why has CMS required that the patient still be in the hospital when his or her status is changed from that of an inpatient to outpatient? Most hospitals have agreements with QIOs for UR, and determinations about medically unnecessary admissions can be decided days or weeks after the patient leaves the hospital.***

**A8.** The patient rights CoP in §482.13 of the regulations require a hospital to protect and promote each patient's rights. Medicare beneficiaries have the right to participate in

treatment decisions and to know their treatment choices. Beneficiaries are also entitled to receive information about co-insurance and deductibles. CMS has a duty to protect these rights. Requiring that the decision resulting in a change in patient status be made before the beneficiary is discharged is intended to ensure that the patient is fully informed about the change in status and its impact on the co-insurance and deductible for which the beneficiary would be responsible. For example, if a patient has already met her Part A deductible, informing the beneficiary a month after discharge that she will now be responsible for additional coinsurance as an outpatient could impose a financial hardship.

Additionally, the hospital is responsible to ensure that when there is a question regarding the medical necessity of an inpatient admission that the required UR review of that patient's status is conducted as stated in 42 CFR 482.30. The UR committee's responsibilities and functions may be conducted by the hospital's QIO that has assumed binding UR review. However, the hospital is responsible to have either a UR committee or have a QIO that carries out the UR activities as described in 42 CFR 482.30, including the review for medical necessity of an inpatient admission and continued stay.

***Q9: HIPAA establishes NUBC as the keeper of the UB-92 condition codes. How can CMS place extra requirements on the use of the code? Doesn't this violate HIPAA?***

**A9.** No, this does not violate HIPAA. CMS has established conditions when this code may be used for payment purposes under Medicare. The CMS policy neither modifies nor contradicts the code descriptor published by NUBC. Instead, it sets additional payment conditions under Medicare. The HIPAA implementation guide is unaffected by payment policy decisions and the other insurers who use the UB- 92 codes may continue to rely on the code as they otherwise would.

In another example, CMS and its contractors set payment policy related to CPT and HCPCS codes through national and local coverage determinations (NCDs and LCDs). These determinations include payment policy standards such as when, how, and by whom CPT and HCPCS codes may be used for a particular diagnosis or procedure. CMS pays only for services that meet the requirements of these coverage determinations.

### **Additional Information**

The instructions provided in CR3444 and the information in this article should be followed within the framework of an individual hospital's existing policies and procedures and do not override or supersede other CMS policies or procedures on observation services, beneficiary financial liability protections, or other related policies.

If you have questions regarding this issuance, please contact your fiscal intermediary (FI) for additional guidance with regard to CR3444.

For complete details, please see the official instruction issued to your FI regarding this change. That instruction for Condition Code 44 that affects the Medicare Claims Processing Manual may be found at:

**<http://www.cms.hhs.gov/transmittals/downloads/R299CP.pdf>** on the CMS web site.

For details concerning the "Part B Only" rule, see the Medicare Benefit Policy Manual, Chapter 6, Section 10, at:

**<http://www.cms.hhs.gov/manuals/Downloads/bp102c06.pdf>** on the CMS web site.

For a link to the Code of Federal Regulations, go to:  
[http://www.access.gpo.gov/nara/cfr/waisidx\\_04/42cfr482\\_04.html](http://www.access.gpo.gov/nara/cfr/waisidx_04/42cfr482_04.html)

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

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## Prospective Payment System (PPS) Payment for Blood Clotting Factors Administered to Hemophilia Inpatients

**Related Change Request (CR) #:** 4229  
**Related CR Release Date:** April 14, 2006  
**Related CR Transmittal #:** R903CP  
**Effective Date:** July 14, 2006  
**Implementation Date:** July 14, 2006

**MLN Matters Number:** MM4229

### Provider Types Affected

Providers billing fiscal intermediaries (FIs) for services related to blood clotting factors administered to hemophilia inpatients.

### Provider Action Needed

This article is based on Change Request (CR) 4229, which clarifies the pricing methodologies used for blood clotting factors. It is especially important to point out that the provider determines the dosage furnished to the patient and, using the definition of the appropriate HCPCS code, translates the dosage into Units of Services on the claim submitted to Medicare.

### Background

The Centers for Medicare & Medicaid Services (CMS) provided CR4229 to clarify billing practices for providers to ensure that units of service for blood clotting factor are reported accurately. Some Medicare providers have been billing units of drugs and biologicals incorrectly on outpatient bills as well as on inpatient claims for hemophilia clotting factors. The erroneous reporting of units of service has resulted in Medicare overpayments.



The provider must determine the actual dosage furnished to the patient and, using the long version of the description of the HCPCS code, translate the dosage into **UNITS OF SERVICE**. **Note:** Not all short version descriptions of HCPCS codes define units for the HCPCS code.

The examples below include the Healthcare Common Procedure Coding System (HCPCS) code, and indicate the dosage amount specified in the descriptor of that HCPCS code. Facilities are instructed to use the units field as a multiplier to arrive at the dosage amount.

### Example 1

HCPCS Code	Drug	Dosage
J9355	Trastuzumab	10 mg

**Actual dosage:** 140 mg

On the bill, the facility shows HCPCS Code J9355 and **14 in the units of service** field (140 mg divided by 10 mg equals 14).

When the dosage amount is **greater than** the amount indicated for the HCPCS code, the facility rounds up to determine units. When the dosage amount is **less than** the amount indicated for the HCPCS code, use one as the unit of measure.

### Example 2

HCPCS Code	Drug	Dosage
J3100	Tenecteplase	50 mg

**Actual Dosage:** 40 mg

The provider would bill for one unit, even though less than one full unit was furnished. (40 mg divided by 50 mg equals 0.8)

### Example 3

HCPCS Code	Drug	Dosage
J9255	Paclitaxel	30 mg

**Actual Dosage:** 175 mg

The provider would bill for six units, even though less than six full units were furnished. (175 mg divided by 30 mg equals 5.83).

At times, a facility provides less than the amount provided in a single use vial and there is waste, i.e., some drugs may be available only in packaged amounts that exceed the needs of an individual patient. Once the drug is reconstituted in the hospital's pharmacy, it may have a limited shelf life.

Since an individual patient may receive less than the fully reconstituted amount, CMS encourages hospitals to schedule patients in such a way that the hospital can use the drug most efficiently. However, if the hospital must discard the remainder of a vial after administering part of it to a Medicare patient, the provider may bill for the amount of drug discarded plus with the amount administered, as illustrated in Examples 4 and 5.

#### **Example 4**

Drug X is available only in a 100-unit size. A hospital schedules three Medicare patients to receive drug X on the same day within the designated shelf life of the product. An appropriate hospital staff member administers 30 units to each patient. The remaining 10 units are billed to Medicare on the account of the last patient. Therefore:

- **30 units** are billed on behalf of the first patient seen;
- **30 units** are billed on behalf of the second patient seen; and
- **40 units** are billed on behalf of the last patient seen because the hospital had to discard 10 units at that point.

#### **Example 5**

Drug X is available only in a 100-unit size. An appropriate hospital staff member must administer 30 units of drug X to a Medicare patient, and it is not practical to schedule another patient who requires the same drug.

For example, the hospital has only one patient who requires drug X, or the hospital sees the patient for the first time and did not know the patient's condition. The hospital bills for 100 units on behalf of the patient, and Medicare pays for 100 units.

#### **Additional Requirements**

CR4229 further instructs your intermediary to:

- Calculate the payment amount and subtract the charge from those submitted to Pricer so that the clotting factor charges are not included in cost outlier computations;
- Use the blood-clotting factors HCPCS codes from the Medicare Part B Drug Pricing File, which is made available on a quarterly basis;
- Use the Average Sales Price (ASP) plus six percent to make payment to facilities that are not paid on cost or Prospective Payment System (PPS);
- Pay for hemophilia clotting factors during a covered part A stay in a PPS hospital at ASP plus six percent in addition to the Diagnosis Related Group (DRG) payment;
- Pay the Ambulatory Patient Classification (APC) rate to Outpatient Prospective Payment System (OPPS) hospitals for hemophilia clotting factors administered in inpatient Part B and outpatient settings;
- Pay for hemophilia clotting factors to beneficiaries based on cost for Part B skilled nursing facility (SNF) services, including inpatient Part B, and all such factors administered by critical access hospitals (CAHs);
- Pay for hemophilia clotting factors based on cost for non-PPS swing bed services; and

- **Not** pay a separate add-on under SNF PPS for SNF or swing bed services. **Providers should no longer divide the number of units by 100 when billing for clotting factors.**

### **Implementation**

The implementation date for the instruction is July 14, 2006.

### **Additional Information**

For complete details, please see the official instruction issued to your intermediary regarding this change. That instruction may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R903CP.pdf> on the CMS web site.

If you have any questions, please contact your intermediary at their toll-free number, which may be found at <http://www.cms.hhs.gov/apps/contacts/> on the CMS web site.

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## **Cultural Competency: A National Health Concern**

**MLN Matters Number:** SE0621  
**Related CR Release Date:** N/A  
**Related CR Transmittal #:** N/A

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

### **Provider Types Affected**

This article is for informational purposes only and does not affect Medicare billing processes.

### **Background**

The increasing diversity of the racial, ethnic, and linguistic composition of the U.S. challenges providers as they strive to deliver health care services. Cultural and language differences between patients and providers may generate miscommunication of critical health care information, a lack of compliance with prescribed treatment or medication, or other factors that negatively influence clinical situations and health outcomes. The existence of racial and ethnic disparities in health has been well documented by organizations such as the Institute of Medicine and the Agency for Healthcare Research and Quality. Cultural competency, or the ability of health care providers to work effectively with colleagues and patients in cross-cultural situations, is a vital component of professional competence. Culturally competent practice can offer a variety of benefits to health care providers and their organizations, including:

- Improved patient care and satisfaction
- Decreased malpractice risk
- Enhanced operational efficiency
- Increased compliance with State and Federal regulations
- Reduction in health disparities

### **Highlights of the Centers for Medicare & Medicaid Services' (CMS) Activities to Address Health Disparities**

To ensure that providers are prepared for the challenges they face to deliver the right care to every person every time, CMS's Quality Improvement Organizations (QIOs) are working with healthcare providers to become more effective and culturally aware of how they provide care to diverse populations. As part of a national initiative, QIOs are recruiting health providers to participate in a FREE online (web-based) program *A Family Physician's Practical Guide to Culturally Competent Care* to ensure that Medicare providers are prepared to effectively serve the increasingly diverse patient population. QIOs have adopted the Guide as the "Program of Choice" for health care provider cultural competency education. The Guide is an innovative educational product designed to equip health care providers with the cultural and linguistic competencies required to improve the quality of care for minority, immigrant, and ethnically diverse communities.

*A Family Physician's Practical Guide to Culturally Competent Care* is anchored in the three themes of the National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS) and serves a key initiative in helping the Department of Health and Human Services' Office of Minority Health to achieve its mission of "improving the health of racial and ethnic minority populations' through the development of effective health policies and programs that help to eliminate disparities in health care."

*A Family Physician's Practical Guide to Culturally Competent Care* is a case study based curriculum, featuring video vignettes and a diverse group of providers and clinic staff at a fictional practice setting that reinforce learning points throughout the modules. Participants can also share their reactions to the case studies in an online bulletin-board feature. This program was designed with the busy health care provider in mind, offering "anytime, anywhere" continuing education credit in an engaging and innovative format.

This curriculum is available to all health care providers at <http://www.thinkculturalhealth.org>. The program is accredited for Continuing Medical Education (CME) credits for physicians and Continuing Education Units (CEUs) for nurses and pharmacists.

Please visit <http://www.thinkculturalhealth.org> to access the free accredited continuing education program, *A Family Physician's Practical Guide to Culturally Competent Care*, and to view updates about the nursing program.

#### **Additional Information**

To access the free program, *A Family Physician's Practical Guide to Culturally Competent Care*, please visit <http://www.thinkculturalhealth.org>.

The National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care are available at:  
<http://www.omhrc.gov/templates/browse.aspx?lvl=2&lvlID=15>.

For more information about the QIO cultural competency initiative, please visit <http://www.qsource.org/uqiosc/>.

Additional information about the Office of Minority Health is available at <http://www.omhrc.gov/>.

## Access to the Part D Drug Benefit in Long Term Care Settings

**MLN Matters Number:** SE0614  
**Related CR Release Date:** N/A  
**Related CR Transmittal #:** N/A

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

**Note:** This article was revised to contain web addresses that conform to the new CMS web site and to show they are now MLN Matters articles. All other information remains the same.

### Provider Types Affected

Skilled nursing facilities (SNFs) and nursing homes with Medicare residents

### Impact on Providers

To simplify access to the Part D drug benefit in the long term care (LTC) setting, the Centers for Medicare & Medicaid Services (CMS) recommends that providers take steps to clearly differentiate those drugs which may qualify as Part B drugs and those which may qualify as Part D drugs.

### Important Points to Remember

CMS released the following information via the Minimum Data Set (MDS) submission system's Welcome Page on March 14, 2006:

### Drugs Administered Through a Part B Covered Item of Durable Medical Equipment (DME) Such as a Nebulizer or Pump

Medicare Part B only covers the above categories of drugs when used in conjunction with Part B covered DME in the patient's home. For those LTC facilities that do not qualify as a patient's home, CMS recommends for the above categories of drugs that the following be **included in the written order**:

- The diagnosis and indication for the drug, **and**
- A statement of status such as "Nursing Home Part D"

**Note:** See the web site listed at the end of this document for more information regarding the definition of a home.

### Certain Infusion and Injectable Drugs

Medicare Part B covers injectible and infusible drugs that are not usually selfadministered and that are furnished incident to a physician's service. If a LTC facility, rather than a physician, furnishes and administers these drugs to a patient who is not in a Medicare Part A stay, **CMS recommends including a statement of status such as "Administered by Facility, Nursing Home Part D."**

### Certain Oral and Immunosuppressive Drugs

At this time, Part B covers three categories of drugs: oral anti-cancer, oral antiemetic, and immunosuppressive drugs listed below under certain circumstances. This does not represent an exhaustive list of Part B covered drugs. It is possible for the list of drugs covered by Part B to change over time.

The following are immunosuppressive drugs for transplants paid for by Medicare:

<b>Cyclophosphamide – Oral</b>	<b>Cyclosporine – Oral</b>
<b>Cyclosporine – Parenteral</b>	<b>Daclizumab – Parenteral</b>
<b>Lymphocyte Immune Globulin, Antithymocyte Globulin – Parenteral</b>	<b>Methotrexate – Oral</b>
<b>Methylprednisolone – Oral</b>	<b>Methylprednisolone Sodium Succinate – Injection</b>
<b>Muromonab-Cd3 – Parenteral</b>	<b>Mycophenolate Acid – Oral</b>
<b>Mycophenolate Mofetil – Oral</b>	<b>Oral Azathioprine</b>
<b>Parenteral Azathioprine</b>	<b>Prednisolone – Oral</b>
<b>Prednisone – Oral</b>	<b>Sirolimus – Oral</b>
<b>Tacrolimus – Oral</b>	<b>Tacrolimus – Parenteral</b>

The following are the oral anti-cancer drugs paid for by Medicare Part B:

<b>Busulfan Capecitabine</b>	<b>Cyclophosphamide</b>
<b>Etoposide</b>	<b>Melphalan</b>
<b>Methotrexate</b>	<b>Temozolomide</b>

The following are oral anti-emetics paid for by Medicare when prescribed for use within 48 hours of chemotherapy except as noted below:

<b>3 Oral Drug Combination of: (1) Aprepitant; (2) A 5-HT3 Antagonist (Q0166, Q0179, Q0180); and (3) Dexamethasone</b>	<b>Chlorpromazine Hydrochloride</b>
<b>Diphenhydramine Hydrochloride</b>	<b>Dolasetron Mesylate (Q0180) (Within 24 Hours)</b>
<b>Dronabinol</b>	<b>Granisetron Hydrochloride (Q0166) (Within 24 Hours)</b>
<b>Hydroxyzine Pamoate</b>	<b>Ondansetron Hydrochloride (Q0179)</b>
<b>Perphenazine</b>	<b>Prochlorperazine Maleate – Oral</b>
<b>Promethazine Hydrochloride</b>	<b>Thiethylperazine Maleate</b>
<b>Trimethobenzamide Hydrochloride</b>	

For these categories of drugs, CMS recommends including in the written prescription the diagnosis and the indication as well as the statement of status as “Part B” (for above indications) or for “Part D” (for all other indications).

For example, Methotrexate for rheumatoid arthritis should have the diagnosis specified, and the designation “Part D” added to the prescription.

While this guidance does not guarantee payment or coverage, following the process may help pharmacists respond more readily to additional information to support Part D or Part B coverage, and facilitate processing by the appropriate plan.

**Note:** This Special Edition information does not supersede any existing guidance concerning documentation for Part B prescriptions.

### **Additional Information**

For more detailed information on Part B versus Part D coverage, see [http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/Downloads/PartBandPartDdoc\\_07.27.05.pdf](http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/Downloads/PartBandPartDdoc_07.27.05.pdf) on the CMS web site.

A comprehensive list of links to agency-wide Part D resources for physicians is available at <http://www.cms.hhs.gov/center/provider.asp>, scroll to “Part D Tools for Health Care Professionals”.

As always, the source for Part D information for Fee-For-Service (FFS) providers is located on the Medicare Learning Network’s drug coverage page at [http://www.cms.hhs.gov/MLNProducts/23\\_DrugCoverage.asp](http://www.cms.hhs.gov/MLNProducts/23_DrugCoverage.asp) on the CMS web site.

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## **MMA – The Centers for Medicare & Medicaid Services (CMS) Recovery Audit Contractor (RAC) Initiative**

**MLN Matters Number:** SE0617  
**Related CR Release Date:** N/A  
**Related CR Transmittal #:** N/A

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

### **Provider Types Affected**

Physicians, providers, and suppliers, especially in California, Florida, and New York

### **Provider Action Needed**

Based on comments received during provider open door forums and community meetings, CMS has amended the payment methodology for the Recovery Audit Contractors to include payment for the identification of Medicare underpayments.

### **Background**

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), Section 306, directs the Secretary of the U.S. Department of Health and Human Services (HHS) to demonstrate the use of RACs under the Medicare Integrity Program in: 1) identifying underpayments and overpayments; and 2) recouping overpayments under the Medicare program (for services for which payment is made under Part A or Part B of Title XVIII of the Social Security Act).

### **Update**

The RACs are paid on a contingency basis; that is, the RACs receive a portion of what they identify and collect. Beginning with underpayments identified on or after March 1, 2006, the RACs will receive an equivalent percentage for all underpayment and overpayment identifications.

The RACs will use the same methodologies of automated and complex reviews to identify potential Medicare underpayments.

### **Important Things Providers Need to Know about the Underpayment Identification Portion of the Recovery Audit Contractor Demonstration**

- The RAC may request a medical record for an underpayment determination. However, the medical record request letter will not indicate if the medical record is being requested for overpayment or underpayment review. When responding to a medical record request from the RAC, the provider may attach its own opinion regarding an underpayment. However, the findings from the RAC may differ from that of the provider.
- Upon identification of a potential underpayment, the RAC will forward the claim and all supporting documentation to the appropriate Medicare fiscal intermediary, carrier or durable medical equipment regional carrier (DMERC) for their review. An underpayment identification will not be final unless the fiscal intermediary, carrier or DMERC agrees with the identification. The RAC or the fiscal intermediary, carrier or DMERC will NOT ask the provider to correct and resubmit the claim. Under the RAC demonstration, the RAC contractors have no authority to make refunds. Therefore, once the underpayment has been validated by the appropriate fiscal intermediary, carrier or DMERC, the RAC will send the provider written notice of the underpayment determination. This notice will include claim and beneficiary details.
- The RACs do not have the authority to review unsolicited cases from providers where underpayment is thought to have occurred. Outside of the RAC program if a provider feels they have received an underpayment they may resubmit a corrected claim if the timely filing limit has not yet passed.
- The provider does not have any official appeals rights in relation to an underpayment determination. The provider may utilize the RAC rebuttal process and discuss the underpayment determination with the RAC. If the provider disagrees with the RAC that an underpayment exists, the RAC will defer to the billing provider's judgment.

### **Definition of an Underpayment**

For purposes of the RAC demonstration, a Medicare underpayment is defined as those lines or payment groups (APC, RUG) on a claim that were billed at a low level of payment but should have been billed at a higher level of payment. The RAC will review each claim line or payment group and consider all possible occurrences of an underpayment in that one line or payment group.

If changes to the diagnosis, procedure or order of diagnoses would change a line or payment group on the claim from a low level of payment to a higher level of payment (and the medical record supports such a change), an underpayment exists. Service lines or payment groups that a provider failed to include on a claim are **not** considered underpayments for the purposes of this demonstration.

Note: CMS has excluded the review of physician evaluation and management codes relevant to the level of an office visit or the medical necessity of the level of office visit from the RAC demonstration. This includes the review of overpayments and underpayments.

### **Examples of an Underpayment**

The following **are** considered underpayments:

- The provider billed for 15 minutes of therapy when the medical record clearly indicates 30 minutes of therapy was provided. (This provider type is paid based on a fee schedule that pays more for 30 minutes of therapy than for 15 minutes of therapy.)

- The provider billed for a particular service and the amount the provider was paid was lower than the amount on the CMS physician fee schedule.
- A diagnosis/condition was left off the MDS but appears in the medical record. Had this diagnosis or condition been listed on the MDS, a higher payment group would have been the result.
- The physician submitted a claim for a surgical procedure using a code for a simpler procedure when in fact the procedure was a more complex one such as in the case of skin repair which can be billed at a simple, intermediate, or complex level depending upon size and complexity. The following are **not** considered underpayments:
  - The medical record indicates that the provider performed additional services such as an EKG, but did not bill for the service.
  - The provider billed for 15 minutes of therapy when the medical record clearly indicates 30 minutes of therapy was provided; however, the additional minutes do not affect the grouper or the pricer. (This provider type is paid based on a prospective payment system that does not pay more for this much additional therapy.)
  - The medical record indicates that the provider implanted a particular device for which a device APC exists (and is separately payable over and above the service APC), but the provider did not bill for the device APC.

Questions concerning the recovery audit contractor demonstration may be directed to a special email address CMS has established specifically for the demonstration: **[cmsrecoveryauditdemo@cms.hhs.gov](mailto:cmsrecoveryauditdemo@cms.hhs.gov)**.

#### **Additional Information**

If you have any questions, please contact your carrier/intermediary at their toll-free number, which may be found at **<http://www.cms.hhs.gov/apps/contacts/>** on the CMS web site.

Find out more about the Medicare Prescription Drug and Modernization Act of 2003 (MMA) at **<http://www.cms.hhs.gov/MMAUpdate/>** on the CMS web site.

## **Announcing the Release of the Revised CMS-855 Medicare Enrollment Applications**

**MLN Matters Number:** SE0632  
**Related CR Release Date:** N/A  
**Related CR Transmittal #:** N/A

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

#### **Provider Types Affected**

All Medicare physicians, providers, and suppliers

#### **Background**

On **May 1, 2006**, the Centers for Medicare & Medicaid Services (CMS) issued the revised CMS-855 Medicare enrollment applications. **Providers and suppliers should begin to use the new Medicare enrollment applications immediately.** Initially, these

applications will be available only from the CMS provider enrollment web site. The link for that CMS web site is listed in the *Additional Information* section of this article.

Over the last year, CMS has received numerous comments and suggestions regarding the proposed revisions to the Medicare enrollment applications. CMS reviewed the comments and adopted many of the suggested revisions. Also, CMS incorporated a number of enhancements and changes (see *Key Points* below) to clarify the enrollment process and to reduce the burden imposed on the provider and supplier communities.

### **Key Points**

This Special Edition outlines the significant revisions to the Medicare enrollment applications and they are as follows:

#### **Enhancements**

- Improved the application's aesthetics via a more visually appealing format, larger font, clarified headings, and the use of plain language;
- Revised cover page to include instructions that help applicants submit the correct enrollment application, inform applicants where to mail the application, and provide information on the documents that must be furnished with the enrollment application;
- Added tips on how to avoid delays in the enrollment process; and
- Redesigned Section 17 (Supporting Documentation) to make it easier for providers and suppliers to know which documents must be submitted with an enrollment application.

#### **Significant Changes**

- Require the submission of the National Provider Identifier (NPI) and a copy of the NPI notification furnished by the National Plan and Provider Enumeration System with each enrollment application;
- Require that providers and suppliers complete the Authorization Agreement for Electronic Funds Transfer (CMS-588) when initially enrolling or – if they are currently not receiving payments via EFT - making a change to their enrollment information; and,
- Removed Sections 9 (Electronic Claims Submission Information), 10 (Staffing Companies), and 11 (Surety Bonds) from the application. In addition, information regarding overpayments no longer must be submitted.

#### **Application-Specific Changes for Physicians and Non-Physician Practitioners (CMS-855I)**

- A sole proprietor who incorporates (and who is the sole owner of that business) only needs to complete the CMS 855I form. In the past, such suppliers had to complete the CMS 855B, CMS 855I and CMS 855R. However, the person will still need to report information about the practice, such as the legal business name and adverse legal history.

#### **Application-Specific Changes for Clinics/Group Practices and Certain Other Suppliers (CMS-855B)**

- Removed the requirement to collect crew member and certain vehicle information from ambulance companies **in Attachment 1 of the application.**
- Revised the Independent Diagnostic Testing Facility information contained in Attachment 2 of the application.

### **Application-Specific Changes for Institutional Providers (CMS-855A)**

- Eliminated questions dealing with fiscal intermediary preferences. This change implements section 911(d) (2) (B) of the Medicare Modernization Act. See MLN Matters article SE0582 at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0582.pdf> for further information.

### **Additional Information**

For additional information regarding the Medicare enrollment process, including the mailing address and telephone number for the carrier or FI serving your area, visit <http://www.cms.hhs.gov/MedicareProviderSupEnroll> on the CMS web site.

Special Edition article SE0612 contains helpful information about the Medicare enrollment process. You may review the article on the CMS web site at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0612.pdf> on the CMS site.

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## **Instructions for Provider Notification Regarding Streamlined Drug Coverage Materials for Health Care Professionals, a New Fact Sheet and Script for Recent Audio Conference**

**MLN Matters Number:** SE0619 Revised  
**Related CR Release Date:** N/A  
**Related CR Transmittal #:** N/A

**Related Change Request (CR) #:** N/A  
**Effective Date:** March 3, 2006  
**Implementation Date:** N/A

**Note:** This article was revised to contain web addresses that conform to the new CMS web site and to show they are now MLN Matters articles. The web address on page 2 for the fact sheet was also changed. All other information remains the same.

### **Provider Types Affected**

Providers, physicians, and suppliers and their staff who prescribe medications for Medicare patients

### **Key Points**

The Centers for Medicare & Medicaid Services (CMS) has developed three new products as part of the Medicare Prescription Drug Coverage (Part D) campaign for health care professionals:

### **Consolidated List of Links**

A consolidated list of links to resources for prescribers is located at <http://www.cms.hhs.gov/center/provider.asp> on the CMS web site.

At this web page, offices can get access to direct telephone numbers to a Medicare drug plan's coverage determination staff, as well as to obtain model forms that will help speed this process.

Educational information for Fee-For-Service (FFS) providers is always available through our Medicare Learning Network drug coverage page at [http://www.cms.hhs.gov/MLNProducts/23\\_DrugCoverage.asp](http://www.cms.hhs.gov/MLNProducts/23_DrugCoverage.asp) on the CMS web site.

### **Transition Policy Fact Sheet**

A new fact sheet regarding the new transition policy, as well as the exceptions and appeals process for Medicare Prescription Drug Coverage, is available for use in prescriber offices. This resource fact sheet provides ready links to tools that will streamline the prescribing process under the new coverage.

CMS continues to work with groups representing physicians, pharmacists, patients, and Part D plans to simplify and standardize the information that physicians need to provide to plans.

The fact sheet is at:

[http://www.cms.hhs.gov/MLNProducts/downloads/Part\\_D\\_Resource\\_Fact\\_sheet\\_revised.pdf](http://www.cms.hhs.gov/MLNProducts/downloads/Part_D_Resource_Fact_sheet_revised.pdf) on the CMS web site.

### **An Important Message for Providers Regarding Medicare Part D from CMS Administrator Dr. Mark McClellan**

Dr. McClellan's message to providers describes the steps CMS is taking to implement the new Medicare prescription drug coverage. Dr. McClellan also discusses helpful resources for providers. Streaming video of this message is available at <http://media.cms.hhs.gov/cms/McClellanPartDProvider.wmv> on the CMS web site.

### **Phone Conference Training Session**

A PowerPoint presentation and audio replay of a recent phone conference training session is available, entitled "*Working with Plan Formularies: Transition Supplies, Prior Authorization, Quantity Limits, Step Therapy, and Exceptions.*"

This training session is geared towards guiding office staff through the exceptions process. These materials are located at:

<http://media.cms.hhs.gov/cms/partner03022006.wma> on the CMS web site.

### **Other Special Edition Articles**

Other special edition articles regarding the prescription drug program include, but are not limited to, the following:

- SE0618 – “2006 Standard Medicare Prescription Drug Coverage: Understanding Costs to Beneficiaries,” available at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0618.pdf> on the CMS web site.
- SE0603 – “Medicare Prescription Drug Coverage: Essential Information and Resources for Prescribing Health Care Professionals – The Eleventh in the MLN Matters Series on the New Prescription Drug Plans,” available at: <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0603.pdf> on the CMS web site.
- SE0557 – “Clarification on Part D and Fee-for-Service (FFS) Providers,” available at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0557.pdf> on the CMS web site.

- SE0502 – “The Facts for Providers Regarding the Medicare Prescription Drug Program,” is available at:  
<http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0502.pdf> on the CMS web site.

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## Drug Coverage Materials for Health Care Professionals

NEW! Visit [www.cms.hhs.gov/center/provider.asp](http://www.cms.hhs.gov/center/provider.asp) and scroll down to “Part D Tools for Health Care Professionals” for a comprehensive list of links to agency-wide resources for providers on Medicare Rx coverage. These resources can help providers and office staff access direct phone numbers to a Medicare drug plan’s coverage determination staff, as well as obtain model forms that will help speed the process. Additionally, a new fact sheet, as well as other educational products for the FFS community, is now available at [www.cms.hhs.gov/medlearn/drugcoverage.asp](http://www.cms.hhs.gov/medlearn/drugcoverage.asp) on the CMS website.

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## 2006 Revised American National Standards Institute X12N 837 Institutional Health Care Claim Companion Document

**MLN Matters Number:** MM4379

**Related CR Release Date:** March 31, 2006

**Related CR Transmittal #:** R217OTN

**Related Change Request (CR) #:** 4379

**Effective Date:** June 29, 2006

**Implementation Date:** June 29, 2006

### Provider Types Affected

Providers and physicians who bill Medicare fiscal intermediaries (FIs), including regional home health intermediaries (RHHIs), for services

### Key Points

- The American National Standards Institute X12N 837 Institutional Health Care Claim Companion Document is being updated to add National Provider Identifier (NPI) and other information.
- This companion document is a set of statements that supplements the X12N 837 Institutional Implementation Guide, and clarifies Medicare contractor expectations regarding data submission, processing, and adjudication.
- It will be available through your Medicare FI or RHHI via their newsletter and web site. Information will also be provided via listserv communication for those who subscribe to their Medicare FI’s or RHHI’s listserv.
- The information contained in the companion document to the Health Insurance Portability and Accountability Act (HIPAA) X12N 837 institutional claim is intended solely for clarification. It describes specific requirements for processing data in your Medicare FI/RHHI’s system. The information in the companion document is subject

to change, and any changes will be communicated to you in your FI's or RHHI's provider news bulletin and on their web site.

- Please note that the companion document supplements, but does not contradict, any requirements in the X12N 837 Institutional Implementation Guide. The descriptions provided in the guide will also indicate whether the specific information is required, optional, or situational (e.g., relevant specifically for RHHIs).

### **Key Changes to X12N 837 Institutional Implementation Guide**

The key changes to the X12N 837 Institutional Implementation Guide described in CR4379 include the following:

- Addition of a new statement indicating “The National Provider Identifier (NPI) must be submitted in the NM109 segment (NM108 = XX)”;
- Revision to the code set statement providing an updated URL for Washington Publishing Company code sets (<http://www.wpc-edi.com>);
- Medicare conversion of all lower case characters submitted on an inbound 837 file to upper case and, consequently, only upper case characters will be sent for coordination of benefits purposes;
- A requirement that all 837 claim data submitted must use the basic character set as defined in the Appendix A of the 837 Institutional Implementation Guide;
- A reminder that Medicare does not require taxonomy codes in order to adjudicate claims, but taxonomy codes will be accepted. However, claims submitted with taxonomy codes that are not valid will be rejected. Valid codes are published at <http://www.wpc-edi.com/codes/taxonomy>.
- A requirement that all dates submitted on an incoming 837 must be valid calendar dates in the appropriate format based on the respective qualifier or the claim will be rejected;
- Negative values submitted in CLM02 (Total Submitted Charges may not be processed and may cause claim to be rejected); and
- Addition of a LIN03 statement “The format for National Drug Codes (NDC) is 5-4-2 [11 positions]. Claims that contain NDC codes in any other format will be rejected.”

### **Background**

HIPAA requires that Medicare, and all other health insurance payers in the United States, comply with the EDI standards for health care as established by the Secretary of Health and Human Services. The X12N 837 implementation guides were established as the standards of compliance for submission of claims for all services, supplies, equipment, and health care other than retail pharmacy prescription drug claims. The implementation guides for each X12 transaction adopted as a HIPAA standard are available electronically at <http://www.wpc-edi.com>. The information in the companion

guide may not contradict any other items in the companion document or X12N 837 institutional implementation guide.

### **Relevant Links**

Additional information about electronic transactions and code sets standards can be found at [http://www.cms.hhs.gov/TransactionCodeSetsStands/01\\_Overview.asp#TopOfPage](http://www.cms.hhs.gov/TransactionCodeSetsStands/01_Overview.asp#TopOfPage) on the CMS web site. CR4379 is the official instruction issued to your FI/RHHI regarding changes mentioned in this article. CR4379 may be found by going to <http://www.cms.hhs.gov/Transmittals/downloads/R2170TN.pdf> on the CMS web site. Please refer to your local FI/RHHI if you have questions about this issue. To find their toll-free phone number, go to <http://www.cms.hhs.gov/apps/contacts/> on the CMS web site.

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## **Mutual of Omaha Medicare Companion Guide**

Companion Document for ANSI ASC X12N 837 Institutional Version 4010A1

The Health Insurance Portability and Accountability Act (HIPAA) requires that Medicare, and all other health insurance payers in the United States, comply with the EDI standards for health care as established by the Secretary of Health and Human Services. The X12N 837 Implementation Guides have been established as the standards of compliance for submission of claims for all services, supplies, equipment, and health care other than retail pharmacy prescription drug claims. The implementation guides for each X12 transaction adopted as a HIPAA standard are available electronically at <http://www.wpc-edi.com>.

The following information is intended to serve only as a companion document to the HIPAA X12N 837 institutional claim implementation guide. The use of this document is solely for the purpose of clarification. The information describes specific requirements to be used for processing data in the FISS System of Mutual of Omaha Medicare Contractor number 52280.

The information in this document is subject to change. Changes will be communicated in the standard Medicare Newsletter, provider news bulletin and on Mutual of Omaha Medicare's Web site: [www.mutualmedicare.com](http://www.mutualmedicare.com).

This companion document supplements, but does not contradict any requirements in the X12N 837 Institutional Implementation Guide.

Please contact us at 866-734-6656 if you have any questions.

S.No	Mutual of Omaha Medicare Specifications.
1	You must submit incoming 837 claim data using the basic character set as defined in Appendix A of the 837 Institutional Implementation Guide. In addition to the basic character set, you may choose to submit lower case characters and the '@' symbol from the extended character set. Any other characters submitted from the extended character set will cause the interchange (transmission) to be rejected at the intermediary's translator.
2	For Medicare, the subscriber is always the same as the patient (SBR02 = 18, SBR09 = MA). Claims containing data in the Patient Hierarchical Level (2000C loop) will not be processed.
3	The maximum size for the fields containing number of days information (covered, lifetime, reserve, etc.) in the Medicare system is four characters. Claims submitted with data that exceed will be returned to the provider (RTP'd) or will be errored back to the submitter by Mutual of Omaha – Medicare.
4	The maximum size for dollar amount fields in the Medicare system is 10 characters. Claims submitter with dollar amounts in excess of 99,999,999.99 will be RTP'd or will be errored back to the submitter by Mutual of Omaha – Medicare.
5	Claims submitter with attending, other, or operating physician UPIN data exceeding 6 positions will be RTP'd or will be errored back to the submitter by Mutual of Omaha – Medicare.
6	Claims with external code set data that does not conform to the format requirements of the external code set maintainer will be RTP'd or will be errored back to the submitter by Mutual of Omaha – Medicare. Data elements referencing external code sets are limited to the size of the data as defined by the code set maintainer. For example, the element in the Implementation Guide designated for HCPCS information may contain up to 30 positions but the HCPCS external code list allows only 5 positions (claims with more that 5 positions of HCPCS data in this element would be RTP'd or will be errored back to the submitter by Mutual of Omaha – Medicare.)
7	The maximum size for the service unit count field in the Medicare system is 7 characters. Claims submitted with data that exceeds this limit will be RTP'd or will be errored back to the submitter by Mutual of Omaha – Medicare. Claims submitted with decimal data will be rounded to the closest whole number before being processed.
8	The Medicare System does not process decimal points in diagnosis codes or ICD9 – CM procedure codes. Medicare will strip out decimal points submitted in valid diagnosis before processing. Medicare will strip out decimal points submitted in valid procedure codes before processing.
9	You may send as many diagnosis codes as allowed in the implementation guide. However, only the primary / principal and first 8 other diagnosis codes will be considered for adjudication and payment determination.
10	Hospital (14X) claims that lack diagnosis information when required for CMS adjudication (2300 HI Principal, Admitting, E-Code and Patient Reason for Visit Diagnosis Information) will be RTP'd or will be errored back to the submitter by Mutual of Omaha Medicare.
11	Do not use Credit/Debit card information to bill Medicare Credit/Debit card information will be ignored.
12	Claims that lack a patient status code when required for CMS adjudication will be

	RTP'd or will be errored back to the submitter by Mutual of Omaha – Medicare.
13	Claims that lack an admission source code when required for CMS adjudication will be RTP'd or will be errored back to the submitter by Mutual of Omaha – Medicare.
14	Inpatient claims that lack HCPCS when required for CMS adjudication will be RTP'd or will be errored back to the submitter by Mutual of Omaha – Medicare.
15	Medicare will process only HL structures as described in the implementation guide front matter (Billing Provider HL (parent) followed by appropriate Subscriber HL (child)).
16	Mutual of Omaha – Medicare will reject an interchange (transmission) that uses the following character as a delimiter: ‘ ‘.
17	Mutual of Omaha – Medicare will reject an interchange (transmission) that uses the following character as a delimiter: ‘\’.
18	Mutual of Omaha – Medicare will only process one transaction type (records group) per interchange (transmission). A submitter can submit more than one GS-GE (Functional Group) within an ISA – IEA (Interchange) when submitting claims to Mutual of Omaha – Medicare.
19	Mutual of Omaha – Medicare will validate individual identifiers submitted within the ISA and GS envelope segments in addition to the verifying the format requirements defined in the IG. Claims submitted with invalid Medicare identifiers will be RTP'd or will be errored back to the submitter by Mutual of Omaha – Medicare.
20	Mutual of Omaha – Medicare will not process an interchange (transmission) that is not submitted with a valid receiver/submitter code (each individual Contractor determines this code)).
21	Mutual of Omaha – Medicare will only accept claims for one line of business per transaction. Claims submitted for multiple lines of business within one ST-SE (Transaction Set) will cause the transaction to be rejected.
22	Mutual of Omaha – Medicare will process more than one (ST–SE) Transaction Set within a (GS–GE) Functional Group. A Submitter Cannot submit one ST–SE for each claim.
23	Mutual on Omaha – Medicare will accept and process transmissions with a Claim or Encounter Indicator (BHT06) of ‘CH’ (Chargeable).
24	Compression of files using a vendor’s software is supported for transmissions between the submitter and Mutual of Omaha – Medicare.
25	For all outpatient claims, all line items must contain a date or dates of service for each revenue code or it will be rejected.
26	Any outpatient claims containing Covered Days (QTY Segment) will be rejected.
27	All claims will be edited to ensure all Health Insurance Prospective Payment System (HIPPS) Rate Codes used with a “ZZ” qualifier are accepted (not just HIPPS SNF rate codes). A complete list of valid HIPPS codes may be found at <a href="http://www.cms.hhs.gov/providers/hippscodes">http://www.cms.hhs.gov/providers/hippscodes</a> .
28	All claims containing a NPP000 UPIN will be rejected.
29	All claims containing an invalid E-Code (an E-Code not listed in the external code source reference by the HIPAA 837 Institutional implementation guide) will be rejected. Note that Medicare does not require or use E codes, but if they are sent, they must be valid.
30	Medicare does not require taxonomy codes be submitted in order to adjudicate claims, but will accept the taxonomy code, if submitted. However, taxonomy codes that are submitted must be valid against the taxonomy code set published

	at <a href="http://www.wpc-edi.com/codes/taxonomy">http://www.wpc-edi.com/codes/taxonomy</a> . Claims submitted with invalid taxonomy codes will be rejected.
31	All HIPAA X12N 837 claims that contain revenue code 045X, 0516, or 0526 must also contain an HI02 – 1 code of ‘ZZ’ along with a HIPAA – compliant “Patient Reason for Visit” diagnosis code or it will be rejected.
32	All inpatient claims must contain the admission date, admitting diagnosis, admission type code, patient status code, and admission source code or the claim will be rejected. Medicare previously did not require these elements on 12X or 22X bill types, but now they will be required.
33	Mutual of Omaha – Medicare will convert all lower case characters submitted on an inbound 837 file to upper case when sending data to the Medicare processing system. Consequently, data later submitted for coordination of benefits will be submitted in upper case.
34	Only loops, segments and data elements valid for the HIPAA Institutional Implementation Guides will be translated. Submitting data not valid based on the Implementation Guide will cause files to be rejected.
35	The incoming 837 transactions utilize delimiters from the following list: >, *, ~, ^,  , and:. Submitting delimiters not supported within this list will cause an interchange (transmission) to be rejected.
36	When applicable, the National Provider Identifier (NPI) must be submitted in the NM109 segment (NM108 = XX).
37	All dates that are submitted on an incoming 837 claim transaction must be valid calendar dates in the appropriate format based on the respective qualifier. Failure to submit a valid calendar date will result in rejection of the claim or the applicable interchange (transmission).
38	Mutual of Omaha Medicare will reject an interchange (transmission) submitted with more than 9,999 loops.
39	Mutual of Omaha will reject an interchange (transmission) submitted with more than 9,999 segments per loop.
40	Mutual of Omaha Medicare will reject an interchange (transmission) with more than 5000 CLM segments (claims) submitted per transaction.
41	Only valid qualifiers for Medicare must be submitted on incoming 837 claim transactions. Any qualifiers submitted for Medicare processing which are not defined for use in Medicare billing will cause the claim or the transaction to be rejected.
42	We suggest retrieval of the ANSI 997 functional acknowledgement files on the first business day after the claim file is submitted, but no later than 5 days after the file submission.
43	Mutual of Omaha Medicare will return (X) as the version in GS08 (Version/Release/Industry Identifier Code) of the 997.
	Helpful Hints:
1	Please use your Tax Id number in ISA06 and GS02
2	GS03 should be Mutual of Omaha’s Fiscal Intermediary Number, which is 52280.
3	The file version in the REF02 segment should appear like this: 004010X096A1, not 004010X096DA1.
4	Do not include the discharge hour on the following TOB’s: 212, 23X, 24X, 71X, 72X, 74X, 75X, 76X, 83X as the translator will reject the claims. For all other

	TOB's, the system will accept the discharge hour; however it must be in the proper format (0000 is a valid time; however 00000000 is not a valid date)
5	Do not report covered days or DRG information on outpatient claims.
6	As of March 8, 2004, all AMT segments with a valid qualifier will be allowed to contain a zero dollar amount.
7	Patient Relation Code (from FL57 of the UB92) must be present on each claim and dependent to subscriber is amount.
8	Use the Employer's EIN number for the value in the NM109 segment of Loop 2310A of the Physician's SS# is unknown.
9	837 Transactions to Mutual of Omaha Medicare should contain no more than 5,000 claims per ISA / IEA.
10	Test files should only be submitted to designated HIPAA test mailboxes, not to production mailboxes. Please contact Medicare Systems at 866 – 734 – 6656.
11	Here's what CMS feels are Inpatient Vs. Outpatient bill types for HIPAA editing purposes. Inpatient: 11X , 12X , 18X , 21X , 22X , 41X. Outpatient: 13X , 14X , 23X , 24X , 32X , 33X , 34X , 71X , 72X , 73X , 74X , 75X , 76X , 81X , 82X , 83X , 85X.
12	Submitters sending file for multiple states in the same file should send on GS/ST – GE/SE for each provider number within each ISA / IEA segment in order to ensure all claims are successfully loaded into the FISS system. Failure to do so could cause claims for some providers not to get loaded into the FISS system. For example, if claims would get loaded but the Nebraska claims would not because the provider numbers are maintained in different claims processing regions.
13	<p>How our Translator Check for Duplicate Transmissions:</p> <p>Our duplicate program captures the key information below from the first and last claim in each ST/SE loop of every successful file in order to create a key. The key is then stored in a library of the program. All files that are transmitted to Mutual create this key, the key is then ran against the keys that are already stored in the library from previous files received from the same submitter. If a match is found, then the system duplicates the file out. If a match is not found the batch of claims continues in the claims processing job stream.</p> <p>Key Information:</p> <ul style="list-style-type: none"> <li>• APPL-SENDER-CD GS 02</li> <li>• CLAIM-CNT CALCULATED FIELD – NUMBER 500 RECORDS</li> <li>• SRVC-LN-CNT CALCULATED FIELD - NUMBER OF 600 RECORDS</li> <li>• REC-CNT CALCULATED FIELD - TOTAL RECORDS IN THE ST</li> <li>• TOTAL-CHG. 2400 SV2 03</li> <li>• FST-SBR-LST-NAME 2010BA NM1 03</li> <li>• FST-SBR-FST-NAME 2010BA NM1 04</li> <li>• FST-SBR-PAT-CTRL 2300 CLM 01</li> <li>• FST-SBR-TOT-CHG 2400 SV2 02</li> <li>• FST-SBR-STMT-FROM-DT 2300 DTP 03 QUAL 434</li> <li>• LST-SBR-LST-NAME 2010BA NM1 03</li> <li>• LST-SBR-FST-NAME 2010BA NM1 04</li> <li>• LST-SBR-PAT-CTRL 2300 CLM 01</li> <li>• LST-SBR-TOT-CHG 2400 SV2 03</li> </ul>

• LST-SBR-STMT-FROM-DT 2300 DTP 03 QUAL 434			
<b>Interchange Control Header</b>			
ISA05	Interchange Qualifier	Mutual of Omaha will reject an interchange (transmission) that does not contain a 29 in ISA05	
ISA06	Interchange Sender ID	Mutual of Omaha Medicare will reject an interchange (transmission) that does not contain a valid ID in ISA06.	
ISA07	Interchange ID Qualifier	Mutual of Omaha Medicare will reject an interchange (transmission) that does not contain 28 qualifier in ISA07	
ISA08	Interchange Receiver ID	Mutual of Omaha will reject an interchange (transmission) that does not contain 52280 in ISA08. Each individual contractor determines this code.	
<b>Loop Transaction Set</b>			
	BHT02	Transaction Set Purpose Code	Transaction Set Purpose Code(BHT) must equal '00' (ORIGINAL).
1000A	NM109	Submitter ID	Mutual of Omaha Medicare will reject an interchange (transmission) that is submitted with a submitter identification number that is not authorized for electronic claim submission.
1000B	NM109	Receiver Primary Identifier	Mutual of Omaha Medicare will reject an interchange (transmission) that is not submitted with a valid intermediary code (NM1). Each individual contractor determines this code
2000B	HL	Subscriber Hierarchical Level	The subscriber hierarchical level (HL segment) must be in order from one, by one(+1) and must be numeric.
2000B	SBR02, SBR09	Subscriber Information	For Medicare, the subscriber is always the same as the patient (SBR02=18, SBR09=MA). The Patient Hierarchical Level (2000C loop) is not used.
<b>Loop Claim information</b>			
2300	CLM02	Total Submitted Charges	Negative values submitted in CLM02 will not be processed and will result in the claim being rejected.
2300	CLM02	Total Submitted Charges	Total submitted charges (CLM02) must equal the sum of the line item charge amounts (SV203).
2300	CLM20	Delay Reason Code	Data submitted in CLM20 will not be used for processing.
2300	HI	Healthcare Diagnosis Code	Effective October 2004, all diagnosis codes submitted on a claim must be valid codes per the qualified code source. Claims that contain invalid diagnosis codes will be rejected.
2410	LIN03	Drug Identification	The format for National Drug Codes (NDC) is 5-4-2 (11 positions). Claims that contain NDC codes in any other format will be rejected.

## Update to Chapter 24 (EDI Support Requirements) of the Medicare Claims

MLN Matters Number: MM4398  
Related CR Release Date: April 7, 2006  
Related CR Transmittal #: R900CP

Related Change Request (CR) #: 4398  
Effective Date: May 8, 2006  
Implementation Date: July 7, 2006

### Processing Manual to Show New CMS Web Site URL References

#### Provider Types Affected

Physicians, providers, and suppliers who submit claims for services to the Centers for Medicare & Medicaid Services (CMS) Medicare contractors (carriers, fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), and durable medical equipment regional carriers (DMERCs))

#### Background

This article, based on CR4398, highlights the fact that the <http://www.cms.hhs.gov> web site has been completely redesigned. Currently, Chapter 24 of the *Medicare Claims Processing Manual* contains URLs that no longer direct the user to the new CMS web site. If used, the following message will appear. *'We're sorry. The page you requested cannot be found. CMS has recently launched a web site redesign and many addresses have changed.'* This instruction updates the URLs that are currently in Chapter 24, removes the URLs that no longer apply, and replaces them with the new URLs.

#### Key Points

The key new web addresses are as follows:

- [http://www.cms.hhs.gov/ElectronicBillingEDITrans/01\\_Overview.asp](http://www.cms.hhs.gov/ElectronicBillingEDITrans/01_Overview.asp) is the new address for accessing and downloading the CMS EDI instructions.
- The X12N 837 implementation guide (IG) version 4010A1 for Institutional (I) and Professional (P) claims is now at [http://www.cms.hhs.gov/ElectronicBillingEDITrans/08\\_HealthCareClaims.asp](http://www.cms.hhs.gov/ElectronicBillingEDITrans/08_HealthCareClaims.asp) on the CMS web site.
- The implementation guide for coordination of benefits (COB) with other payers is at [http://www.cms.hhs.gov/ElectronicBillingEDITrans/12\\_COB.asp](http://www.cms.hhs.gov/ElectronicBillingEDITrans/12_COB.asp) on the CMS web site.
- The NCPDP Telecommunications Standard Specifications and IG version 5.1 and Batch Standard 1.1 for retail prescription drug claims (Billed to Medicare DMERCs only) and COB are at [http://www.cms.hhs.gov/ElectronicBillingEDITrans/08\\_HealthCareClaims.asp](http://www.cms.hhs.gov/ElectronicBillingEDITrans/08_HealthCareClaims.asp) on the CMS web site.
- The X12 835 IG version 4010A1 for Remittance Advice is at [http://www.cms.hhs.gov/ElectronicBillingEDITrans/11\\_Remittance.asp](http://www.cms.hhs.gov/ElectronicBillingEDITrans/11_Remittance.asp) on the CMS web site.

- The X12 276/277 IG version 4010A1 for Claim Status Inquiry and Response is located at **[http://www.cms.hhs.gov/ElectronicBillingEDITrans/10\\_ClaimStatus.asp](http://www.cms.hhs.gov/ElectronicBillingEDITrans/10_ClaimStatus.asp)** on the CMS web site.
- Information on the X12 270/271 IG version 4010A1 transactions for Beneficiary Eligibility Inquiry and response are at **[http://www.cms.hhs.gov/ElectronicBillingEDITrans/09\\_Eligibility.asp](http://www.cms.hhs.gov/ElectronicBillingEDITrans/09_Eligibility.asp)** on the CMS web site.
- HIPAA IG “companion documents” are available at **<http://www.cms.hhs.gov/ElectronicBillingEDITrans>** on the CMS web site. Once at that site, select the specific transaction desired from the left side of the screen and you will then get a link to the companion document at the bottom of the page for that transaction.

#### **Additional Information**

The official instructions issued to your carrier or intermediary regarding this change can be found at **<http://www.cms.hhs.gov/Transmittals/downloads/R900CP.pdf>** on the CMS web site. If you have questions, please contact your Medicare FI/RHHI or carrier/DMERC at their toll-free number, which may be found at **<http://www.cms.hhs.gov/apps/contacts/>** on the CMS web site.

To our providers....keep informed of Medicare Integrity Program issues as they arise by reading the MIP Tip in every issue.

### "MIP Tip"

This tip is brought to you from our Audit and Reimbursement Department.

#### **Obtaining the CMS-855A Provider Enrollment Application**

Effective April 14, 2006, Medicare contractors must refer all providers seeking a copy of the CMS-855A Medicare provider enrollment application to the CMS provider enrollment web site. Mutual of Omaha will no longer mail out hard copy CMS-855A provider enrollment applications. The CMS-855A provider enrollment application must be downloaded from: <http://www.cms.hhs.gov/MedicareProviderSupEnroll/>

As before, the completed CMS-855A provider enrollment application may be sent to one of the following addresses:

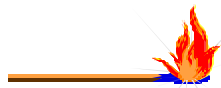
Delivery/Overnight Service:

Mutual of Omaha  
Medicare Audit & Reimbursement  
Attn: Provider Enrollment Area – LL2  
Mutual of Omaha Plaza  
Omaha, NE 67175

Regular Mail Service:

Mutual of Omaha  
Medicare Audit & Reimbursement  
Attn: Provider Enrollment Area – LL2  
P.O. Box 1604  
Omaha, NE 68101

For any questions, please call Nick Schuchardt at 1-866-734-9444 x 2178 or Krystal Wyatt at 1-866-734-9444 x 6238.



**Please stay tuned for more hot tips!**