CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 356	Date: June 20, 2008
	Change Request 6069

SUBJECT: National Competitive Bidding (NCB) for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) - Phase VIIB of Implementation

I. SUMMARY OF CHANGES: This instruction establishes additional reason codes to use when processing NCB claims.

NEW/REVISED MATERIAL
EFFECTIVE DATE: JULY 1, 2008
IMPLEMENTATION DATE: JULY 7, 2008

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	

III. FUNDING:

SECTION A: For Fiscal Intermediaries and Carriers:
Not Applicable.

SECTION B: For Medicare Administrative Contractors (MACs):
The Medicare administrative contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the contracting officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the contracting officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

One-Time Notification

Unless otherwise specified, the effective date is the date of service.

Attachment – One Time Notification

Pub. 100-20	Transmittal: 356	Date: June 20, 2008	Change Request: 6069

SUBJECT: National Competitive Bidding (NCB) for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) — Phase VIIB of Implementation

Effective Date: July 1, 2008

Implementation Date: July 7, 2008

I. GENERAL INFORMATION

A. Background: On February 1, 2008, The Centers for Medicare and Medicaid Services (CMS) published Change Request (CR) 5887, Transmittal 1428, Pub. 100-04, NCB Medicare Summary Notice (MSN) and Remittance Advice (RA) Messages. That CR established the messages that the Durable Medical Equipment Medicare Administrative Contractors (DME MACs) must use when processing claims under the NCB program. However, CMS has discovered that additional reason codes are needed for some of the scenarios identified in CR 5887.

This instruction establishes additional reason codes to use when processing NCB claims.

B. Policy: The DME MACs shall use the appropriate reason codes when processing NCB claims as indicated in the business requirements below.

II. BUSINESS REQUIREMENTS TABLE

Use"Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6069.1	Contractors shall use the following reason code when paying claims under NCB where the submitted charge on the claim is higher than the allowed charge: 45: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.		X								
6069.2	Contractors shall use the following reason code when denying claims for a beneficiary who resides in a CBA who obtains an item from a non-contract supplier that has not obtained a signed Advanced Beneficiary Notice (ABN): 96: Non-covered charge(s).		X								
6069.3	Contractors shall use the following remark and reason codes when denying claims under NCB where a contract		X								

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	supplier submits a claim for oxygen equipment after the payment cap (maximum of 45 total payments for the beneficiary) has been reached: B7: This provider was not certified/eligible to be paid for this procedure/service on this date of service. N211: Alert: You may not appeal this decision. N370: Billing exceeds the rental months covered/approved by the payer.										
6069.4	Contractors shall use the following remark and reason codes when denying claims under NCB where a contract supplier submits a claim for a capped rental item after the payment cap (maximum of 25 total payments for the beneficiary) has been reached: B7: This provider was not certified/eligible to be paid for this procedure/service on this date of service. N211: Alert: You may not appeal this decision. N370: Billing exceeds the rental months covered/approved by the payer.		X								
6069.5	Contractors shall use the following remark and reason codes when denying a claim for an NCB item obtained from a non-contract supplier when the supplier has obtained an ABN: 96: Non-covered charge(s) N211: Alert: You may not appeal this decision. M38: The patient is liable for the charges for this service as you informed the patient in writing before the service was furnished that we would not pay for it, and the patient agreed to pay.		X								
6069.5.1	Contractors shall suppress the following messages when denying a claim for an NCB item obtained from a non-contract supplier when the supplier has obtained an ABN: A1: Claim/Service Denied		X								

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	50: These are non-covered services because this is not deemed a "medical necessity" by the payer. MSN 8.52: You signed an Advanced Beneficiary Notice (ABN). You are responsible for the difference between the upgrade amount and the Medicare payment.										
6069.6	Contractors shall use the following remark code when a supplier has collected more than 20% co-pay and any remaining deductible for an NCB claim: N211: Alert: You may not appeal this decision.		X								
6069.7	Contractors shall use the following remark code when denying beneficiary-submitted claims that are subject to NCB: N211: Alert: You may not appeal this decision.		X								
6069.8	Contractors shall use the following remark code when denying paper claims subject to NCB: N211: Alert: You may not appeal this decision.		X								

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	None.										

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below:
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
All Requirements	For more information on NCB implementation, see the following CRs: 4327, 4337, 5487, 5686, 5779, 5804, 5887, and 5918.

X-Ref Requirement Number	Recommendations or other supporting information:
6069.1	The contractors shall use this reason code in conjunction with the messages specified in the following requirements from CR 5887: 5887.1, 5887.3, 5887.5-5887.8, 5887.13, and 5887.15.
6069.2	The contractors shall use this reason code in conjunction with the messages specified in requirement 5887.2 of CR 5887.
6069.3	The contractors shall use these remark and reason codes in conjunction with the messages specified in requirement 5887.14 of CR 5887.
6069.4	The contractors shall use these remark and reason codes in conjunction with the messages specified in requirement 5887.16 of CR 5887.
6069.5	The contractor shall use these remark and reason codes in conjunction with the messages specified in requirement 5887.4 of CR 5887, except as noted below.
6069.5.1	This requirement supersedes any conflicting requirements in 5887.4 of CR 5887.
6069.6	The contractor shall use this remark code in conjunction with the messages specified in requirement 5887.3 of CR 5887.
6069.7	The contractor shall use this remark code in conjunction with the messages specified in requirement 5887.10 of CR 5887.
6069.8	The contractor shall use this remark code in conjunction with the messages specified in requirement 5887.11 of CR 5887.

Section B: For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

Pre-Implementation Contact(s): Renée Hildt at renee.hildt@cms.hhs.gov or (410) 786-1446.
Post-Implementation Contact(s): Renée Hildt at renee.hildt@cms.hhs.gov or (410) 786-1446.

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs) and Carrier*:

N/A

Section B: *For Medicare Administrative Contractors (MACs)*:

The Medicare administrative contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the contracting officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the contracting officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.