DME Happenings

• THIS IS WRITTEN NOTIFICATION OF MEDICARE CHANGES •

August 2012 | Issue No. 36

This Bulletin should be shared with all health care practitioners and managerial members of the provider/ supplier staff. Bulletins are available at no cost from our website at: http://www.noridianmedicare.com

Join the NAS DME email list to receive updates every Tuesday and Friday that contain the latest Medicare news, workshop announcements, and more. To subscribe, visit the NAS DME website and select "E-mail Newsletter Signup" in the left column.

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Jurisdiction D DME MAC Supplier Contacts and Resources

Phone Numbers		
Interactive Voice Response System	1-877-320-0390	24 hours a day, 7 days a week for Eligibility and general information 6 a.m. – 8 p.m. CT Menu options requiring system access: Same and Similar HCPCS Lookup, Claim Status, Payment Floor, Checks, Duplicate Remittance Advice, Overpayments, Provider Enrollment and CMN Status
Supplier Contact Center	1-877-320-0390	8:30am-6pm CT Monday-Friday
Beneficiary Customer Service	1-800-633-4227	24 hours a day/7 days a week
Telephone Reopenings	1-888-826-5708	8am-4pm CT
Website: www.noridianmedicare.com/dme		

Fax	
Reopenings and Redeterminations MSP Inquiries and Refunds DME Recovery Auditor Redeterminations	1-701-277-7886
Refunds to Medicare Immediate Offsets	1-701-277-7894
DME Recovery Auditor Offsets	1-701-277-7896
Medical Review Medical Documentation	1-701-277-7888
CERT Medical Documentation	1-701-277-7890

NAS Email Addresses	
NAS DME Customer Service	dme@noridian.com
Reopenings and Redeterminations	dmeredeterminations@noridian.com
NAS DME Endeavor	dmeendeavor@noridian.com

Mailing Addresses	
Claims, Redetermination Requests, Correspondence, ADMC Requests and Medical Review Documentation Noridian Administrative Services PO Box 6727 Fargo ND 58108-6727	**Benefit Protection** Noridian Administrative Services Benefit Protection-DME PO Box 6736 Fargo ND 58108-6736
Administrative Simplification Compliance Act Exception Requests Noridian Administrative Services PO Box 6737 Fargo ND 58108-6737	**Qualified Independent Contractor** C2C Solutions, Inc. Attn: DME QIC PO Box 44013 Jacksonville FL 32202-4013
Electronic Funds Transfer Forms/Overpayment Redeterminations/DME Recovery Auditor Redeterminations Noridian Administrative Services PO Box 6728 Fargo ND 58108-6728	**DME Recovery Auditor Overpayments** Noridian Administrative Services PO Box 6759 Fargo ND 58108-6759

Other DME MACs		
Jurisdiction A: NHIC, Corp	1-866-419-9458	www.medicarenhic.com
Jurisdiction B: National Government Services	1-877-299-7900	www.ngsmedicare.com
Jurisdiction C: CGS	1-866-270-4909	www.cgsmedicare.com

Other Resources		
Pricing, Data Analysis and Coding	1-877-735-1326	www.dmepdac.com
National Supplier Clearinghouse	1-866-238-9652	www.palmettogba.com/nsc
Common Electronic Data Interchange Help Desk	1-866-311-9184	www.ngscedi.com
Centers for Medicare & Medicaid Services		www.cms.gov

2012 Supplier Contact Center and Telephone Reopenings Holiday and Training Closures

Supplier Contact Center

The NAS Customer Service team (1-877-320-0390) will be closed for the entire day (8:30 a.m. through 6 p.m. CT) in recognition of holidays. Additionally, the Customer Service team will be closed two days each month to receive training from 8:30 a.m. – 12 p.m. CT. The holiday and training closures are provided below. The Interactive Voice Recognition (IVR) [PDF] system (1-877-320-0390) and Endeavor, the NAS DME Jurisdiction D supplier portal, will each continue to be available on these dates to assist suppliers with their claim status, eligibility, remittance advice, same and/or similar inquiries.

Event	Date	Closure Timeframe
Off-the-Phone Training	August 24	8:30 a.m. – 12 p.m. CT
Labor Day	September 3	Entire Day Closed 8:30 a.m. – 6 p.m. CT
Off-the-Phone Training	September 14	8:30 a.m. – 12 p.m. CT
Off-the-Phone Training	September 28	8:30 a.m. – 12 p.m. CT
Off-the-Phone Training	October 12	8:30 a.m. – 12 p.m. CT
Off-the-Phone Training	October 26	8:30 a.m. – 12 p.m. CT
Off-the-Phone Training	November 16	8:30 a.m. – 12 p.m. CT
Thanksgiving	November 22 and 23	Entire Day Closed 8:30 a.m. – 6 p.m. CT
Off-the-Phone Training	November 30	8:30 a.m. – 12 p.m. CT
Off-the-Phone Training	December 14	8:30 a.m. – 12 p.m. CT
Christmas	December 24 and 25	Entire Day Closed 8:30 a.m. – 6 p.m. CT

Telephone Reopenings

The NAS Telephone Reopening Team will be closed for the entire day (8 a.m. through 4:00 pm CT) in recognition of holidays. Additionally, the Telephone Reopening team will be closed one day each month between 8 a.m. and 12:30 p.m. CT to receive training. The holiday and training closures are provided below.

Event	Date	Closure Timeframe
Labor Day	September 3	Entire Day Closed 8 a.m. – 4 p.m. CT
Off-the-Phone Training	September 5	8 a.m. – 12:30 p.m. CT
Off-the-Phone Training	October 3	8 a.m. – 12:30 p.m. CT
Off-the-Phone Training	November 7	8 a.m. – 12:30 p.m. CT
Thanksgiving	November 22 and 23	Entire Day Closed 8 a.m. – 4 p.m. CT
Off-the-Phone Training	December 5	8 a.m. – 12:30 p.m. CT
Christmas	December 24 and 25	Entire Day Closed 8 a.m. – 4 p.m. CT

Automatic Mailing/Delivery of DMEPOS Reminder

Suppliers may not automatically deliver DMEPOS to beneficiaries unless the beneficiary, physician, or designated representative has requested additional supplies/equipment. The reason is to assure that the beneficiary actually needs the DMEPOS.

A beneficiary or their caregiver must specifically request refills of repetitive services and/or supplies before a supplier dispenses them. The supplier must not automatically dispense a quantity of supplies on a predetermined regular basis.

A request for refill is different than a request for a renewal of a prescription. Generally, the beneficiary or caregiver will rarely keep track of the end date of a prescription. Furthermore, the physician is not likely to keep track of this. The supplier is the one who will need to have the order on file and will know when the prescription will run out and a new order is needed. It is reasonable to expect the supplier to contact the physician and ask for a renewal of the order. Again, the supplier must not automatically mail or deliver the DMEPOS to the beneficiary until specifically requested.

Source: Internet Only Manual (IOM), Publication 100-4, *Medicare Claims Processing Manual*, Chapter 20, Section 200

Beneficiaries Call 1-800-MEDICARE

Suppliers are reminded that when beneficiaries need assistance with Medicare questions or claims that they should be referred to call 1-800-MEDICARE (1-800-633-4227) for assistance. The supplier contact center only handles inquiries from suppliers.

The table below provides an overview of the types of questions that are handled by 1-800-MEDICARE, along with other entities that assist beneficiaries with certain types of inquiries.

Organization	Phone Number	Types of Inquiries
1-800-MEDICARE	1-800-633-4227	General Medicare questions, ordering Medicare publications or taking a fraud and abuse complaint from a beneficiary
Social Security Administration	1-800-772-1213	Changing address, replacement Medicare card and Social Security Benefits
RRB - Railroad Retirement Board	1-800-808-0772	For Railroad Retirement beneficiaries only - RRB benefits, lost RRB card, address change, enrolling in Medicare
Coordination of Benefits	1-800-999-1118	Reporting changes in primary insurance information

Another great resource for beneficiaries is the website, http://www.medicare.gov/, where they can:

- Compare hospitals, nursing homes, home health agencies, and dialysis facilities
- Compare Medicare prescription drug plans
- Compare health plans and Medigap policies
- Complete an online request for a replacement Medicare card
- Find general information about Medicare policies and coverage
- Find doctors or suppliers in their area
- Find Medicare publications
- Register for and access MyMedicare.gov

As a registered user of MyMedicare.gov, beneficiaries can:

- View claim status (excluding Part D claims)
- Order a duplicate Medicare Summary Notice (MSN) or replacement Medicare card
- View eligibility, entitlement and preventive services information
- View enrollment information including prescription drug plans
- View or modify their drug list and pharmacy information
- View address of record with Medicare and Part B deductible status
- Access online forms, publications and messages sent to them by CMS

CMS e-News - August 1, 2012 Edition

In accordance with CMS TDL 12438, effective through September 30, 2012, Contractors will be publishing a brief article containing a link to the CMS publication e-News – a Medicare Learning Network® product. This link will contain a week's worth of Medicare-related topics for Medicare Fee-for-Service (FFS) providers/suppliers.

Articles in this edition relating to DME suppliers include "Prior Authorization of Power Mobility Devices Demonstration to Begin September 1", "Effective August 1, Medicare to Automatically Convert Format 4010A1 Electronic Remittance Advice (835) to X12 Version 5010", "CMS Announces Provider Compliance Interactive Map" and the MLN educational products update.

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- Special Open Door Forum: Manual Medical Review of Therapy Claims

Announcements and Reminders

- Effective Today August 1, Medicare to Automatically Convert Format 4010A1 Electronic Remittance Advice (835) to X12 Version 5010
- CMS Issues Final Inpatient Payment Rule
- Prior Authorization of Power Mobility Devices Demonstration to Begin September 1
- CMS Announces Provider Compliance Interactive Map
- August is National Immunization Awareness Month
- Obama Administration Announces Ground-Breaking Public-Private Partnership to Prevent Health Care Fraud
- Tips for Small Provider Practices to Plan for the ICD-10 Transition
- Assembling an ICD-10 Project Team
- Get Ready for DMEPOS Competitive Bidding

Claims, Pricer, and Code Updates

- Corrections to the Skilled Nursing Facility Consolidated Billing File for Healthcare Common Procedure Coding System Code J9033
- CY 2012 Outpatient Prospective Payment System Pricer File Update

MLN Educational Products Update

- "The Basics of Internet-based Provider Enrollment, Chain and Ownership System (PECOS) for Provider and Supplier Organizations" Fact Sheet – Revised
- Medicare Learning Network® Exhibit Schedule

Select the following link to access the entire e-News publication: http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2012-08-01Enews.pdf

Medicare Learning Network Matters Disclaimer Statement

Below is the Centers for Medicare & Medicaid (CMS) Medicare Learning Network (MLN) Matters Disclaimer statement that applies to all MLN Matters articles in this bulletin.

"This article was prepared as a service to the public and is not intended to grant rights or impose obligations. MLN Matters articles may contain references or links to statutes, regulations or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents."

NPPES Issues Resolved, NPI Registry Tip

The latency and performance issues experienced with the National Plan and Provider Enumeration System (NPPES) have been resolved. The National Provider Identifier (NPI) Registry is fully operational again.

NPI Registry Tip: Users of the NPI Registry are encouraged to exit the NPI Registry search and search results pages once they have completed their searches. Users who do not exit off of the NPI Registry search pages will get a "servlet error message" as a result of the timed out session (if session is idle). Please be advised that a user can access the NPI Registry again after being timed out and receiving the servlet error message. If users receive the servlet error message, they will need to click on the "Home" or "Logoff" link at the top right-hand corner of the webpage in order to get back to the NPPES homepage and access the NPI Registry again to conduct additional NPI Registry searches. Again, users should exit out of the NPI Registry once they have completed their searches in order to avoid the timed out session and servlet error messages.

Physician Documentation Responsibilities

Suppliers are encouraged to remind physicians of their responsibility in completing and signing the Certificate of Medical Necessity (CMN). It is the physician's and supplier's responsibility to determine the medical need for, and the utilization of, all health care services. The physician and supplier should ensure that information relating to the beneficiary's condition is correct. Suppliers are also encouraged to include language in their cover letters to physicians reminding them of their responsibilities.

Source: Internet Only Manual, Publication 100-8, Medicare Program Integrity Manual, Chapter 5, Section 5.3.2

Quarterly Provider Updates

The Quarterly Provider Update is a listing of non-regulatory changes to Medicare including Program Memoranda, manual changes, and any other instructions that could affect providers or suppliers. This comprehensive resource is published by CMS on the first business day of each quarter. Regulations and instructions published in the previous quarter are also included in the Update. The purpose of the Quarterly Provider Update is to:

- Inform providers about new developments in the Medicare program;
- Assist providers in understanding CMS programs ad complying with Medicare regulations and instructions;
- Ensure that providers have time to react and prepare for new requirements;
- Announce new or changing Medicare requirements on a predictable schedule; and
- Communicate the specific days that CMS business will be published in the Federal Register.

The Quarterly Provider Update can be accessed at http://www.cms.gov/Regulations-and-Guidance/Regulations-and-Policies/QuarterlyProviderUpdates/index.html. Suppliers may also sign up to receive notification when regulations and program instructions are added throughout the quarter on this page.

Reviews Section Added to NAS DME Website June 1, 2012

NAS has created a 'Reviews / CERT / Audits' category on our website to help suppliers access information regarding the various entities who are authorized by CMS to conduct pre-payment and post-payment Medicare claim reviews. This new section of our website includes information regarding the Comprehensive Error Rate Testing (CERT) as well as the Recovery Auditor, previously known as the Recovery Audit Contractor (RAC).

We suggest suppliers who previously had this website content bookmarked from the LCD / Coverage / MR and the Claims section of our website create new favorites or bookmarks.

Suppliers are encouraged to share this information regarding website changes with their staff. Recommendations regarding the website content and functionality are reviewed and changed are made based on data analysis and supplier feedback collected through various surveys CMS administers.

Sources for "Jurisdiction D Happenings" Articles

The purpose of "Jurisdiction D Happenings" is to educate NAS' Durable Medical Equipment supplier community. The educational articles can be advice written by NAS staff or directives from CMS. Whenever NAS publishes material from CMS, we will do our best to retain the wording given to us; however, due to limited space in our bulletins, we will occasionally edit this material. NAS includes "Source" following CMS derived articles to allow for those interested in the original material to research it at CMS's website, http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/index.html. CMS Change Requests and the date issued will be referenced within the "Source" portion of applicable articles.

CMS has implemented a series of educational articles within the Medicare Leaning Network (MLN), titled "MLN Matters", which will continue to be published in NAS bulletins. The Medicare Learning Network is a brand name for official CMS national provider education products designed to promote national consistency of Medicare provider information developed for CMS initiatives.

Supplier Manual Updates

The following table outlines updates to the DME MAC Jurisdiction D Online Supplier Manual. The content is ordered with the most current changes appearing on top.

Chapter	Subheading	Supplier Manual Update	Change Date
Chapter 1	NAS' Role as a DME MAC	Updated CMS link	07/20/12
Chapter 8	Introduction	Updated CMS link	07/20/12
Appendix	Resources	Updated CMS link	07/20/12
Appendix	Acronyms/Abbreviations	Added PECOS	06/22/12
Appendix	Resources	Updated Supplier Contact Center hours	06/22/12
Appendix	Contacting NAS and Inquiries	Added Appeals to IVR functionality and added information to Endeavor	06/22/12
1	NAS' Role as a DME MAC	Updated states	06/22/12
2	Supplier Enrollment	Updated CMS links	06/22/12
3	Dispensing Orders, Detailed Written Orders, Medical Record Information, Proof of Delivery	Updated according to Internet Only Manual changes and updated CMS links	06/22/12
4	Acceptable DIFs	Changed "CMN" to "DIF" and updated CMS links throughout the chapter	06/22/12
5	Oxygen Equipment and Contents Billing Chart	Removed and updated CMS links throughout the chapter	06/22/12
6	Definition of a Claim for Payment	Updated definition	06/22/12
6	Assignment Agreement	Removed one CMS reference	06/22/12
6	Guidelines for Filing Paper Claims	Updated CMS link	06/22/12
7	Medigap Procedures	Updated CMS link	06/22/12
9	DMEPOS Coverage, Benefit Categories, and Medical Policy	Updated CMS links	06/22/12
9	Advanced Determination of Medicare Coverage	Updated HCPCS codes	06/22/12
10	Indian Health Services	Updated CMS links	06/22/12
11	End Stage Renal Disease	Removed first line of table	06/22/12
11	Coordination of Benefits	Updated CMS links	06/22/12
13	Reopenings and Appeals	Added Endeavor as a filing option for reopenings and redeterminations	06/22/12
13	Reopenings	Added Endeavor as a filing option	06/22/12

Chapter	Subheading	Supplier Manual Update	Change Date
13	Redeterminations	Added Endeavor as a filing option; Updated CMS links; Added description of MA130	06/22/12
13	Appointment of Representative	Updated CMS links	06/22/12
14	Fraud and Abuse	Updated CMS link	06/22/12
15	Recoupment Process	Added Recovery Auditor and CERT and added Change Request 7167 information	06/22/12
15	Overpayments and Refunds	Updated reference	06/22/12
15	Refund of Excess Recoupments	Updated reference	06/22/12
15	Extended Repayment Schedule	Updated CMS link	06/22/12
16	Modifiers	Removed AX modifier; Added AY modifier	06/22/12
17	System Outputs	Updated CMS links	06/22/12

Website Navigation Changes to "Expand/Collapse" Menu Functionality

Based on supplier feedback, NAS changed the navigation menu functionality on July 26, 2012. Suppliers are now able to view the most frequently accessed categories and subcategories of website topics from the navigation menu by selecting the (+) symbol to expand the view or the (–) symbol to collapse the view of each website category.

Suppliers may select the category title to view all content and subcategories available. The most commonly viewed content is listed as a subcategory and may be selected directly from the expanded navigation menu.

Suppliers are encouraged to continue providing comments and suggestions regarding our website by completing the Website Satisfaction survey that randomly displays while navigating our website, www.noridianmedicare.com/dme. We value and appreciate your comments.

ABN Form CMS-R-131, Updated Manual Instructions

MLN Matters® Number: MM7821
Related Change Request (CR) #: CR 7821
Related CR Release Date: June 1, 2012
Related CR Transmittal #: R2480CP
Effective Date: September 4, 2012
Implementation Date: September 4, 2012

Provider Types Affected
This MLN Matters® Article is intended for physicians, providers and suppliers that submit claims to Medicare Contractors (carriers, Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), Durable Medical Equipment Medicare Administrative Contractors (DME MACs), and Part A/B Medicare Administrative Contractors (A/B MACs)) for services provided to beneficiaries enrolled in Original Medicare.

What You Need to Know
This article is based on Change Request (CR) 7821 which clarifies the currently published instructions on Advance Beneficiary Notice of Noncoverage (ABN) use in the "Medicare Claims Processing Manual" (Chapter 30, Section 50). Make sure that your billing staff is aware of these ABN policy updates and clarifications that are summarized in this article.

Background
ABNs are issued by providers and suppliers to inform beneficiaries in Original Medicare about possible charges for items or services that are not covered by Medicare. Issuance of the ABN is required in certain situations when limitation of liability (LOL) applies. You may review that information in the Social Security Act (Section 1879; see http://www.ssa.gov/OP_Home/ssact/title18/1879.htm). In 2008 CMS revised the notice and its instructions to streamline and simplify the notice process.

Change Request (CR) 7821 revises the current manual instructions on ABN use in the "Medicare Claims Processing Manual", Chapter 30 (Financial Liability Protections), Section 50 (Form CMS-R-131 Advance Beneficiary Notice of Noncoverage (ABN)). The revised Chapter 30, Section 50 is included as an attachment to CR7821. The last page of this article contains a "Quick Glance Guide" from the revised manual section, that may help you and your staff comply with ABN issuance requirements.

Key Points from the Updated Chapter 30 Section 50

General Information
Section 50 of the "Medicare Claims Processing Manual" establishes the standards for use by providers and suppliers (including laboratories) in implementing the Advance Beneficiary Notice of Noncoverage (ABN), Form CMS-R-131, formerly the "Advance Beneficiary Notice."

Since March 1, 2009, the ABN-G (general) and ABN-L (laboratory) are no longer valid notices and have been replaced with the ABN.

ABN Scope
The ABN is an Office of Management and Budget (OMB) approved written notice issued by providers and suppliers for items and services provided under Medicare Part B, including hospital outpatient services, and certain care provided under Part A (hospice and religious non-medical healthcare institutes only).

The ABN is given to beneficiaries enrolled in the Medicare Fee-For-Service (FFS) program. It is not used for items or services provided under the Medicare Advantage (MA) Program or for prescription drugs provided under the Medicare Prescription Drug Program (Part D). The ABN is used to fulfill both mandatory and voluntary notice functions.

Skilled Nursing Facilities (SNFs) issue the ABN for Part B services only. The Skilled Nursing Facility Advance Beneficiary Notice of Noncoverage (SNFABN), Form 10055, is issued for Part A SNF items and services.

Home Health Agencies (HHAs) do not issue the ABN. HHAs issue the Home Health Advance Beneficiary Notice of Noncoverage (HHABN), Form CMS-R-296.

Mandatory ABN Uses
The following provisions of the Social Security Act **necessitate** delivery of the ABN:

- Section1862(a)(1) of the Social Security Act (not reasonable and necessary); http://www.ssa.gov/OP_Home/ssact/title18/1862.htm;

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- Section 1834(a)(17)(B) of the Social Security Act (violation of the prohibition on unsolicited telephone contacts); http://www.ssa.gov/OP_Home/ssact/title18/1834.htm;
- Section 1834(j)(1) of the Social Security Act (medical equipment and supplies supplier number requirements not met)
- Section 1834(a)(15) of the Social Security Act (medical equipment and/or supplies denied in advance),
- Section 1862(a)(9) of the Social Security Act (custodial care); (http://www.ssa.gov/OP_Home/ssact/title18/1862.htm),
- Section 1879(g)(2) of the Social Security Act (hospice patient who is not terminally ill); see http://www.ssa.gov/OP_Home/ssact/title18/1879.htm on the Internet.

Expanded Mandatory ABN use in 2011
In addition, delivery of an ABN is mandatory under 42 CFR §414.408(e)(3)(ii) (http://ecfr.gpoaccess.gov/cgi/t/text/textidx?c=ecfr&tpl=/ecfrbrowse/Title42/42cfr414_main_02.tpl t) when a noncontract supplier furnishes an item included in the Durable Medical Equipment, Prosthetic, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program (CBP) for a Competitive Bidding Area (CBA) unless the beneficiary has signed an ABN. Although all other denial reasons triggering mandatory use of the ABN are found in Section 1879 of the Social Security Act, in this situation, Section 1847(b)(5)(D) (http://www.ssa.gov/OP_Home/ssact/title18/1847.htm) of the Social Security Act permits use of the ABN with respect to these items and services.

The Affordable Care Act, P.L. 111-148, section 4103(d)(1)(C) added a new subparagraph (P) to 1862(a)(1) of the Act. Per section 1862(a)(1)(P), Medicare covered personalized prevention plan services (as defined in section 1861(hhh)(1)) that are performed more frequently than covered are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member. The limitation of liability (LOL) provisions of section1879 apply to this new subparagraph; thus, providers must issue an ABN prior to providing a preventative service that is usually covered by Medicare but will not be covered in this instance because frequency limitations have been exceeded.

Voluntary ABN Uses
ABN issuance is not required for care that is either statutorily excluded from coverage under Medicare (i.e. care that is never covered) or most care that fails to meet a technical benefit requirement (i.e. lacks required certification). However, the ABN can be issued voluntarily.

The voluntary ABN serves as a courtesy to the beneficiary in forewarning him/her of impending financial obligation. When an ABN is used as a voluntary notice, the beneficiary should not be asked to choose an option box or sign the notice. The provider or supplier is not required to adhere to the issuance guidelines for the mandatory notice (as set forth below) when using the ABN for voluntary notification.

Note: Certain DME items/services that fail to meet a technical requirement may require an ABN as outlined in the mandatory use section above.

ABN Triggering Events
Notifiers are required to issue the ABN when an item or service is expected to be denied based on one of the provisions in the Mandatory Use section above. This may occur at any one of three points during a course of treatment which are initiation, reduction, and termination, also known as "triggering events."

a. **Initiations**
An initiation is the beginning of a new patient encounter, start of a plan of care, or beginning of treatment. If a notifier believes that certain otherwise covered items or services will be noncovered (e.g. not reasonable and necessary) at initiation, an ABN must be issued prior to the beneficiary receiving the non-covered care.

Example: Mrs. S. asks her physician for an EKG because her sister was recently diagnosed with atrial fibrillation. Mrs. S. has no diagnosis that warrants medical necessity of an EKG but insists on having an EKG even if she has to pay out of pocket for it. The physician's office personnel issue an ABN to Mrs. S. before the EKG is done.

b. **Reductions**
A reduction occurs when there is a decrease in a component of care (i.e. frequency, duration, etc.). The ABN is not issued every time an item or service is reduced. But, if a reduction occurs and the beneficiary wants to receive care that is no longer considered medically reasonable and necessary, the ABN must be issued prior to delivery of this noncovered care.

Example: Mr. T is receiving outpatient physical therapy five days a week, and after meeting several goals, therapy is reduced to three days per week. Mr. T wants to achieve a higher level of proficiency in performing goal related activities and wants to continue with therapy 5 days a week. He is willing to take financial responsibility for the costs of the 2 days of therapy per week that are no longer medically reasonable and necessary. An ABN would be issued prior to providing the additional days of therapy weekly.

c. **Terminations**
A termination is the discontinuation of certain items or services. The ABN is only issued at termination if the beneficiary wants to continue receiving care that is no longer medically reasonable and necessary.

Example: Ms. X has been receiving covered outpatient speech therapy services, has met her treatment goals, and has been given speech exercises to do at home that do not require therapist intervention. Ms. X wants her speech therapist to continue to work with her even though continued therapy is not medically reasonable or necessary. Ms. X is issued an ABN prior to her speech therapist resuming therapy that is no longer considered medically reasonable and necessary.

Completing the ABN
The ABN and step by step instructions for notice completion are posted on the CMS website at *http://www.cms.gov/Medicare/Medicare-General-Information/BNI/index.html* on the CMS website. Notifiers must follow the instructions posted on the CMS website to construct a valid notice.

Retention Requirements
Retention periods for the ABN are five years from discharge/completion of delivery of care when there are no other applicable requirements under State law. Retention is required in all cases, including those cases in which the beneficiary declined the care, refused to choose an option, or refused to sign the notice. Electronic retention of the signed paper document is acceptable. Notifiers may scan the signed paper or "wet" version of the ABN for electronic medical record retention and if desired, give the paper copy to the beneficiary.

Clarification of Period of Effectiveness/ Repetitive or Continuous Noncovered Care
An ABN can remain effective for up to one year. Notifiers may give a beneficiary a single ABN describing an extended or repetitive course of noncovered treatment provided that the ABN lists all items and services that the notifier believes Medicare will not cover. If applicable, the ABN must also specify the duration of the period of treatment. If there is any change in care from what is described on the ABN within the 1-year period, a new ABN must be given. If during the course of treatment additional noncovered items or services are needed, the notifier must give the beneficiary another ABN. The limit for use of a single ABN for an extended course of treatment is one year. A new ABN is required when the specified treatment extends beyond one year.

If a beneficiary is receiving repetitive non-covered care, but the provider or supplier failed to issue an ABN before the first or the first few episodes of care were provided, the ABN may be issued at any time during the course of treatment. However, if the ABN is issued after repetitive treatment has been initiated; the ABN cannot be retroactively dated or used to shift liability to the beneficiary for care that had been provided before ABN issuance.

Electronic Issuance of the ABN
Electronic issuance of ABNs is not prohibited. If a provider elects to issue an ABN that is viewed on an electronic screen before signing, the beneficiary must be given the option of requesting paper issuance over electronic if that is what s/he prefers. Also, regardless of whether a paper or electronic version is issued and regardless of whether the signature is digitally captured or manually penned, the beneficiary must be given a paper copy of the signed ABN to keep for his/her own records. Electronic retention of the signed ABN is permitted.

ABN Standards for Upgraded Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)
Notifiers must give an ABN before a beneficiary receives a Medicare covered item containing upgrade components that are not medically reasonable and necessary and not paid for by the supplier. For example, an ABN must be issued when a notifier expects that Medicare will not pay for additional parts or features of a usually covered item because those parts and/or features are not medically reasonable and necessary.

ABNs for Items Listed in a DMEPOS Competitive Bidding Program
The Social Security Act (Section 1862 (a)(17)(http://www.ssa.gov/OP_Home/ssact/title18/1862.htm) excludes Medicare payment for Competitive Bidding Program (CBP) items/ services that are provided by a non-contract supplier in a Competitive Bidding Area (CBA) except in special circumstances. A non-contracted supplier is permitted to provide a beneficiary with an item or service listed in the CBP when the supplier properly issues an ABN prior to delivery of the item or service per 42 CFR 414.408(e)(3)(ii)

(http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&tpl=/ecfrbrowse/Title42/42cfr414_main_02.tpl). In order for the ABN to be considered valid when issued under these circumstances, the reason that Medicare may not pay must be clearly and fully explained on the ABN that is signed by the beneficiary.

Sample wording for the "Reason Medicare May Not Pay" blank of the ABN:

Since we are not a contracted supplier, Medicare will not pay for this item. If you get this item from a contracted supplier such as ABC Medical Supplies, Medicare will pay for it.

To be a valid ABN, the beneficiary must understand the meaning of the notice. Suppliers must explain to the beneficiary that Medicare will pay for the item if it is obtained from a different supplier in the area. While some suppliers may be reluctant to direct beneficiaries to a specific contracted supplier, the non-contracted supplier should at least direct the beneficiary to 1-800-MEDICARE to find a local contracted supplier at the beneficiary's request.

Emergencies or Urgent Situations/ Ambulance Transport
In general, a notifier may not issue an ABN to a beneficiary who has a medical emergency or is under similar duress. Forcing delivery of an ABN during an emergency may be considered coercive. ABN usage in the Emergency Room (ER) may be appropriate in some cases where the beneficiary is medically stable with no emergent health issues.

Issuance of the ABN is mandatory if all of the following 3 criteria are met:

1. The service being provided is a Medicare covered ambulance benefit under Section1861(s)(7) of the Social Security Act (http://www.ssa.gov/OP_Home/ssact/title18/1861.htm) and regulations under this section as stipulated in 42 CFR 410.40 -.41 (http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&tpl=/ecfrbrowse/Title42/42cfr414_main_02.tpl);
2. The provider believes that the service may be denied, in part or in full, as "not reasonable and necessary" under Section 1862(a)(1)(A) for the beneficiary on that particular occasion; and
3. The ambulance service is being provided in a non-emergency situation. (The patient is not under duress.)

Simplified, there are three questions to ask when determining if an ABN is required for an ambulance transport. If the answer to all of the following 3 questions is "yes", an ABN must be issued:

1. Is this service a covered ambulance benefit? AND
2. Will payment for part or all of this service be denied because it is not reasonable and necessary? AND
3. Is the patient stable and the transport non-emergent?

Example: A beneficiary requires ambulance transportation from her Skilled Nursing Facility (SNF) to dialysis but insists on being transported to a new dialysis center 10 miles beyond the nearest dialysis facility. Medicare covers this type of transport; however, since this particular transport is not to the nearest facility, it is not considered a covered Medicare benefit. Therefore, NO ABN is required. As a courtesy to the beneficiary, an ABN could be issued as a voluntary notice alerting her to the financial responsibility.

Example: A beneficiary requires non-emergent ground transport from a local hospital to the nearest tertiary hospital facility; however, his family wants him taken by air ambulance. The ambulance service is a covered benefit, but the level of service (air transport) is not reasonable and necessary for this patient's condition. Therefore, an ABN MUST be issued prior to providing the service in order for the provider to shift liability to the beneficiary.

ABN issuance is mandatory only when a beneficiary's covered ambulance transport is modified to a level that is not medically reasonable and necessary and will incur additional costs. If an ambulance transport is statutorily excluded from coverage because it fails to meet Medicare's definition of the ambulance benefit, a voluntary ABN may be issued to notify the beneficiary of his/her financial liability as a courtesy.

Special Issues Associated with the ABN for Hospice Providers

General Use – Hospice
Mandatory use of the ABN is very limited for hospices. Hospice providers are responsible for providing the ABN when required as listed below for items and services billable to hospice. Hospices are not responsible for issuing an ABN when a hospice patient seeks care outside of the hospice's jurisdiction. The three situations that would require issuance of the ABN by a hospice are:

- Ineligibility because the beneficiary is not determined to be "terminally ill" as defined in Section1879(g)(2) of the Act;

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- Specific items or services that are billed separately from the hospice payment, such as physician services, are not reasonable and necessary as defined in either Section1862(a)(1)(A) or 1862(a)(1)(C); or
- The level of hospice care is determined to be not reasonable or medically necessary as defined in Section1862(a)(1)(A) or 1862(a)(1)(C), specifically for the management of the terminal illness and/or related conditions.

End of All Medicare Covered Hospice Care
When it is determined that a beneficiary who has been receiving hospice care is no longer terminally ill and the patient is discharged from hospice, the hospice must issue the Notice of Medicare Noncoverage (NOMNC), CMS 10123 (see the "FFS ED Notices" link on the CMS website at http://www.cms.gov/Medicare/Medicare-General-Information/BNI/index.html?redirect=/BNI/ for details). If upon discharge the patient wants to continue receiving hospice care that will not be covered by Medicare, the hospice would issue an ABN to the beneficiary in order to transfer liability for the noncovered care to the beneficiary. If no further hospice services are provided after discharge, ABN issuance would not be required.

Hospice Care Delivered by Non-Hospice Providers
It is the hospice's responsibility to issue an ABN when a beneficiary who has elected the hospice benefit chooses to receive inpatient hospice care in a hospital that is not under contract with the hospice. The hospice may delegate delivery of the ABN to the hospital in these cases.

The ABN must not be issued when the face to face requirement for hospice recertification is not met within the required timeframe. Failure to meet the face to face requirement for recertification should not be misrepresented as a determination that the beneficiary is no longer terminally ill. However, in this situation, the hospice would be required to issue a Notice of Medicare Noncoverage (NOMNC), CMS 10123, before the end of all covered care. (See the "FFS ED Notices" link on the CMS website at http://www.cms.gov/Medicare/Medicare-General-Information/BNI/index.html?redirect=/BNI/ for details.)

Since room and board are not part of the hospice benefit, an ABN would not be required when the patient elects hospice and continues to pay out of pocket for long term care room and board.

Special Issues Associated with the ABN for CORFs
Since Comprehensive Outpatient Rehabilitation Facility (CORF) services are billed under Part B, CORF providers must issue the ABN according to the instructions given in this section. The ABN is issued by CORFs before providing a service that is usually covered by Medicare but may not be paid for in a specific case because it is not medically reasonable and necessary.

When all Medicare covered CORF services end, CORF's are required to issue a notice regarding the beneficiary's right to an expedited determination called a Notice of Medicare Noncoverage (NOMNC), CMS 10123. Please see the "FFS ED Notices" link on the CMS website at http://www.cms.gov/Medicare/Medicare-General-Information/BNI/index.html?redirect=/BNI/ for these notification requirements. Upon termination of all CORF care, the ABN would be issued only if the beneficiary wants to continue receiving some or all services that will not be covered by Medicare because they are no longer considered medically reasonable and necessary. An ABN would not be issued if no further CORF services are provided.

Additional Information
The official instruction, CR 7821, issued to your Medicare Carrier, FI, RHHI, DME MAC, or A/B MAC regarding this change may be viewed at http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2480CP.pdf on the CMS website.

The ABN and instructions can be downloaded from http://www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN.html on the CMS website.

Telephone Reopenings: What Can and Cannot be Requested

Reopenings are separate and distinct from the appeals process. Reopenings are a discretionary action on the part of the contractor to correct a clerical error or omission. A contractor's decision to reopen a claim is not an initial determination and is therefore not appealable.

A telephone reopening must be requested within 12 months after the date of the initial determination. A written reopening can be submitted for claims being requested for a reopening after such 12-month period, but within four years after the date of the initial determination, for good cause. All requests for good cause must be submitted in writing.

How do I request a telephone reopening?	Requesting a telephone reopening is simple, call 1-888-826-5708.
What are the hours of operation for the telephone reopenings?	Monday through Friday 8 a.m. until 4 p.m. CT (Closed 11:45 a.m. – 12:30 p.m. CT) Additional closing information can be found at https://www.noridianmedicare.com/dme/contact/holiday.html.
What do I need to have before I can initiate a telephone reopening?	**Before a reopening can be completed, all of the following information must be readily available by the caller and will be verified by the telephone reopening representative.** • Supplier Number (Provider Transaction Access Number (PTAN)) • National Provider Identifier (NPI) • The last five digits of the Tax ID Number (TIN) • Supplier name • Beneficiary Health Insurance Claim Number (HICN) • Beneficiary last name and first initial • Beneficiary date of birth • Date of service • Claim Control Number (CCN) of claim • Billed amount • Healthcare Common Procedure Coding System (HCPCS) code in question • Corrective action to be taken **NOTE:** If at any time the information does not match the information housed in the claims processing Medicare System, the telephone reopening cannot be completed.

What may I request as a telephone reopening?	• The following is a list of clerical errors and omissions that may be completed as a telephone reopening. This list is not all-inclusive:
	• Diagnosis changes/additions
	• Date of service changes
	• HCPCS code changes
	• Certificate of Medical Necessity (CMN)/DME Information Form (DIF) updates (*with the exception of parenteral and enteral nutrition and oxygen Break In Service (BIS) which must be sent in as a written reopening or redetermination*)
	• Certain modifier changes/additions (not all inclusive list):
	  • KH – DMEPOS item, initial claim, purchase or first month
	  • KI – DMEPOS item, second or third month rental
	  • KJ – DMEPOS item, parenteral enteral nutrition (PEN) pump or capped rental, months four to fifteen
	  • RR – Rental
	• Surgical dressing (when number of services are within the policy – if the request is to allow over the policy amount, these must go to written redeterminations)
	• Wheelchairs – HCPCS K0004 and lower
	NOTE: If any of the above changes, upon research, are determined to be too complex, the requester will be notified that the request needs to be sent in writing, with the appropriate documentation, as a redetermination.

What is not accepted as a telephone reopening?	The following will not be accepted as a telephone reopening. These items must be submitted along with all supporting documentation as a redetermination. • Any item billed over the allowance listed in the medical policy – documentation is required to support amount billed • Parenteral and enteral DIF issues • Oxygen BIS • Wheelchairs/power mobility devices – HCPCS K0005 and higher • Recoupment/reduction of payment – complete Refunds to Medicare form • Medicare Secondary Payer (MSP) – send inquiry to MSP department • Timely denials – claims submitted within appropriate time frame • Late files – reopening and/or redetermination requests submitted within the appropriate time frame • Requests that require documentation • Advance Beneficiary Notice of Noncoverage (ABN) issues • A1–A9 modifiers • GA modifier • GY modifier • GZ modifier • KX modifier • HCPCS codes J1559, J1561, J1562 • Liability issues • Repairs to equipment • Miscellaneous codes • Labor codes **NOTE:** Claims with remittance message MA130 can never be submitted as a reopening. Claims with message MA130 are considered unprocessable and do not have reopening or redetermination rights. The claim is missing information that is needed for processing the claim or the claim information is invalid. These claims must be resubmitted with a new corrected claim.
What do I do when I have a large amount of the same correction?	In the event that a supplier has more than 50 of the same correction, that is able to completed as a reopening, NAS encourages the supplier to notify the telephone representative. The telephone representative will gather the required information and provide the supplier with direction on what is needed and how to submit the request.
Where can I find more information on telephone reopenings?	• Suppliers can utilize NAS website at https://www.noridianmedicare.com/dme, specifically • Supplier Manual, Chapter 13: https://www.noridianmedicare.com/dme/news/manual/chapter13.html • Appeals page: https://www.noridianmedicare.com/dme/appeals/
Additional Assistance Available	**Suppliers can email questions and concerns regarding reopenings and redeterminations to** dmeredeterminations@noridian.com, excluding any Protected Health Information (PHI) information.

Clarification of Medicare Conditional Payment Policy and Billing Procedures for Liability, No-Fault and Workers' Compensation MSP Claims

MLN Matters® Number: MM7355
Related Change Request (CR) #: 7355
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Related CR Transmittal #: R84MSP
Effective Date: October 1, 2011 for Professional Claims and DME Supplier Claims; January 1, 2013 for Institutional Claims
Implementation Date: October 1, 2012 for Professional and DME Supplier Claims; January 7, 2013 for Institutional Claims

Provider Types Affected
This MLN Matters® article is intended for physicians, hospitals, Home Health Agencies, and other providers who bill Medicare Carriers, Fiscal Intermediaries (FIs) or Medicare Administrative Contractors (A/B/MACs); and suppliers who bill Durable Medical Equipment MACs (DME MACs) for Medicare beneficiary liability insurance (including self insurance), no-fault insurance, and WC Medicare Second Payer (MSP) claims.

Provider Action Needed
This article provides clarifications in the procedures for processing liability insurance (including self-insurance), no-fault insurance and WC Medicare Secondary Payer (MSP) claims. Not following the procedures identified in this article may impact your reimbursement. Change Request (CR) 7355, from which this article is taken, clarifies the procedures you are to follow when billing Medicare for liability insurance (including self-insurance), no-fault insurance, or WC claims, when the liability insurance (including self-insurance), no-fault insurance, or WC carrier does not make prompt payment. It also includes definitions of the promptly payment rules and how contractors will identify conditional payment requests on MSP claims received from you. You should make sure that your billing staffs are aware of these Medicare instructions.

Background
CR7355, from which this article is taken: 1) Clarifies the procedures to follow when submitting liability insurance (including self-insurance), no-fault insurance and WC claims when the liability insurer (including self-insurance), no-fault insurer and WC carrier does not make prompt payment or cannot reasonably be expected to make prompt payment; 2) Defines the promptly payment rules; and 3) Instructs you how to submit liability insurance (including self-insurance), no-fault insurance and WC claims to your Medicare contractors when requesting Medicare conditional payments on these types of MSP claims.

The term Group Health Plan (GHP) as related to this MLN article means health insurance coverage that is provided by an employer to a Medicare beneficiary based on a beneficiary's own, or family member's, current employment status. The term Non-GHP means coverage provided by a liability insurer (including self-insurance), no-fault insurer and WC carrier where the insurer covers for services related to the applicable accident or injury.

Key Points

Conditional Medicare Payment Procedures
Medicare may not make payment on a MSP claim where payment has been made or can reasonably be expected to be made by GHPs, a WC law or plan, liability insurance (including self-insurance), or no-fault insurance.

Medicare can make conditional payments for both Part A and Part B WC, or no-fault, or liability insurance (including self insurance) claims if payment has not been made or cannot be reasonably expected to be made by the WC, or no-fault, or liability insurance claims (including self insurance) and the promptly period has expired. Note: If there is a primary GHP, Medicare may not pay conditionally on the liability, no-fault, or WC claim if the claim is not billed to the GHP first. The GHP insurer must be billed first and the primary payer payment information must appear on the claim submitted to Medicare.

These payments are made "on condition" that the trust fund will be reimbursed if it is demonstrated that WC, no-fault, or liability insurance is (or was) responsible for making primary payment (as demonstrated by a judgment; a payment conditioned upon the recipient's compromise, waiver, or release [whether or not there is a determination or admission of liability for payment for items or services included in a claim against the primary payer or the primary payer's insured]; or by other means).

"Promptly" Definition

No-fault Insurance and WC "Promptly" Definition
For no-fault insurance and WC, promptly means payment within 120 days after receipt of the claim (for specific items and services) by the no-fault insurance or WC carrier. In the absence of evidence to the contrary, the date of service for specific items and service must be treated as the claim date when determining the promptly period. Further with respect to inpatient services, in the absence of evidence to the contrary, the date of discharge must be treated as the date of service when determining the promptly period.

Liability Insurance "Promptly" Definition
For liability insurance (including self-insurance), promptly means payment within 120 days after the earlier of the following:

- The date a general liability claim is filed with an insurer or a lien is filed against a potential liability settlement; or
- The date the service was furnished or, in the case of inpatient hospital services, the date of discharge.

The "Medicare Secondary Payer (MSP) Manual" (http://www.cms.gov/manuals/downloads/msp105c01.pdf), Chapter 1 (Background and Overview), Section 20 (Definitions), provides the definition of promptly (with respect to liability, no-fault, and WC) which all Medicare contractors must follow.

Note: For the liability situation, the MSP auxiliary record is usually posted to the Medicare's Common Working File (CWF) after the beneficiary files a claim against the alleged tortfeasor (the one who committed the tort (civil wrong)) and the associated liability insurance (including self-insurance). In the absence of evidence to the contrary, the date the general liability claim is filed against the liability insurance (including self-insurance) is no later than the date that the record was posted on Medicare's CWF. Therefore, for the purposes of determining the promptly period, Medicare contractors consider the date the Liability record was created on Medicare's CWF to be the date the general liability claim was filed.

How to Request a Conditional Payment
The following summarizes the technical procedures that Part A, and Part B and supplier contractors will use to identify providers' conditional payment requests on MSP claims.

Part A Conditional Payment Requests
Providers of **Part A** services can request conditional non-GHP payments from Part A contractors on the hardcopy Form CMS-1450, if you have permission from Medicare to bill hardcopy claims, or the 837 Institutional Electronic Claim, using the appropriate insurance value code (i.e., value code 14, 15or 47) and zero as the value amount. Again, you must bill the non-GHP insurer, and the GHP insurer, if the beneficiary belongs to an employer group health plan, first before billing Medicare.

For hardcopy (CMS-1450) claims, Providers must identify the other payer's identity on line A of Form Locator (FL) 50, the identifying information about the insured is shown on line A of FL 58-65, and the address of the insured is shown in FL38 or Remarks (FL 80). All primary payer amounts and appropriate codes must appear on your claim submitted to Medicare.

For 837 Institutional Claims, Providers must provide the primary payer's zero value code paid amount and occurrence code in the 2300 HI. (The appropriate Occurrence code (2300 HI), coupled with the zeroed paid amount and MSP value code (2300 HI), must be used in billing situations where you attempted to bill a primary payer in non-GHP (i.e., Liability, no-fault and Workers' Compensation) situations, but the primary payer did not make a payment in the promptly period). Note: Beginning July 1, 2012 Medicare contractors will no longer be accepting 4010 claims; Providers must submit claims in the 5010 format beginning on this date.

Table 1 displays the required information of the electronic claim in which a Part A provider is requesting conditional payments.

Table 1
Data Requirements for Conditional Payment for Part A Electronic Claims

Type of Insurance	CAS	Part A Value Code (2300 HI)	Value Amount (2300 HI)	Occurrence Code (2300 HI)	Condition Code (2300 HI)
No-Fault/Liability	2320 – valid information why NGHP or GHP did not make payment	14 or 47	$0	01-Auto Accident & Date 02-No-fault Insurance Involved & Date 24-Date Insurance Denied	
WC	2320 – valid information why NGHP or GHP did not make payment	15	$0	04-Accident/Tort Liability & Date 24-Date Insurance Denied	02-Condition is Employment Related

Part B Conditional Payment Requests (Table 2)
Since the electronic Part B claim (837 4010 professional claim) does not contain Value Codes or Condition Codes, the physician or supplier must complete the: 1) 2320AMT02 = $0 if the entire claim is a non-GHP claim and conditional payment is being requested for the entire claim; or 2) 2430 SVD02 for line level conditional payment requests if the claim also contains other service line activity not related to the accident or injury, so that the contractor can determine if conditional payment should be granted for Part B services related to the accident or injury.

For Version 4010, Physicians and other suppliers may include CP- Medicare Conditionally Primary, AP-auto insurance policy, or OT- other in the 2320 SBR05 field. The 2320 SBR09 may contain the claim filing indicator code of AM - automobile medical, LI - Liability, LM - Liability Medical or WC - Workers' Compensation Health Claim. Any one of these claim filing indicators are acceptable for the non-GHP MSP claim types.

The 2300 DTP identifies the date of the accident with appropriate value. The "accident related causes code" is found in 2300 CLM 11-1 through CLM 11-3. Note: Beginning July 1, 2012 Medicare contractors will no longer accept 4010 claims; Providers must submit claims in the 5010 format beginning on this date.

Table 2 displays the required information for a MSP 4010 Professional in which a physician/supplier is requesting conditional payments.

Table 2
Data Requirements for Conditional Payments for MSP 4010 Professional Claims

Type of Insurance	CAS	Insurance Type Code (2320 SBR05)	Claim Filing Indicator (2320 SBR09)	Paid Amount (2320 AMT or 2430 SVD02)	Insurance Type Code (2000B SBR05)	Date of Accident
No-Fault/Liability	2320 or 2430 valid information why NGHP or GHP did not make payment	AP or CP	AM, LI, or LM	$0.00	14	2300 DTP 01 through 03 and 2300 CLM 11-1 through 11-3 with value AA, AP or OA
WC	2320 or 2430 valid information why NGHP or GHP did not make payment	OT	WC	$0.00	15	2300 DTP 01 through 03 and 2300 CLM 11-1 through or 11-3 value EM

Please note that for 837 5010 Professional claims, the insurance codes changed and the acceptable information for Medicare conditional payment request is modified as displayed in Table 3.

Table 3
Data Requirements for Conditional Payment for 837 5010 Professional Claims

Type of Insurance	CAS	Insurance Type Code 2320 SBR05 from previous payer(s)	Claim Filing Indicator (2320 SBR09)	Paid Amount (2320 AMT or 2430 SVD02)	Condition Code (2300 HI)	Date of Accident
No-Fault/Liability	2320 or 2430 - valid information why NGHP or GHP did not make payment	14/47	AM or LM	$0.00		2300 DTP 01 through 03 and 2300 CLM 11-1 through 11-3 with value AA or OA
WC	2320 or 2430 – valid information why NGHP or GHP did not make payment	15	WC	$0.00	02-Condition is Employment Related	2300 DTP 01 through 03 and 2300 CLM 11-1 through or 11-3 with value EM

Note: Medicare beneficiaries are not required to file a claim with a liability insurer or required to cooperate with a provider in filing such a claim, but they are required to cooperate in the filing of no-fault claims. If the beneficiary refuses to cooperate in filing of no-fault claims Medicare does not pay.

Situations Where a Conditional Payment Can be Made for No-Fault and WC Claims
Conditional payments for claims for specific items and service may be paid by Medicare where the following conditions are met:

- There is information on the claim or information on Medicare's CWF that indicates the no-fault insurance or WC is involved for that specific item or service;
- There is/was no open GHP record on the Medicare CWF MSP file as of the date of service;
- There is information on the claim that indicates the physician, provider or other supplier sent the claim to the no-fault insurer or WC entity first; and
- There is information on the claim that indicates the no-fault insurer or WC entity did not pay the claim during the promptly period.

Note: When a conditional payment is made to you, Medicare contractors will use Remittance Advice Remark Code M32 to indicate a conditional payment is being made.

Situations Where a Conditional Payment Can be Made for Liability (including Self Insurance) Claims
Conditional payments for claims for specific items and service may be paid by Medicare where the following conditions are met:

- There is information on the claim or information on Medicare's CWF that indicates liability insurance (including self-insurance) is involved for that specific item or service;
- There is/was no open GHP record on the Medicare's CWF MSP file as of the date of service;
- There is information on the claim that indicates the physician, provider or other supplier sent the claim to the liability insurer (including the self-insurer) first, and
- There is information on the claim that indicates the liability insurer (including the self insurer) did not make payment on the claim during the promptly period.

Conditional Primary Medicare Benefits Paid When a GHP is a Primary Payer to Medicare
Conditional primary Medicare benefits may be paid if the beneficiary has GHP coverage primary to Medicare and the following conditions are NOT present:

- It is alleged that the GHP is secondary to Medicare;
- The GHP limits its payment when the individual is entitled to Medicare;

- The services are covered by the GHP for younger employees and spouses but not for employees and spouses age 65 or over; • If the GHP asserts it is secondary to the liability (including self insurance), no-fault or workers' compensation insurer.
- If the GHP asserts it is secondary to the liability (including self insurance), no-fault or workers' compensation insurer.

Situations Where Conditional Payment is Denied

Liability, No-Fault, or WC Claims Denied

1. Medicare will deny claims when:
   - There is an employer GHP that is primary to Medicare; and
   - You did not send the claim to the employer GHP first; and
   - You sent the claim to the liability insurer (including the self-insurer), no-fault, or WC entity, but the insurer entity did not pay the claim.
2. Medicare will deny claims when:
   - There is an employer GHP that is primary to Medicare; and
   - The employer GHP denied the claim because the GHP asserted that the liability insurer (including the self-insurer), no-fault insurer or WC entity should pay first; and
   - You sent the claim to the liability insurer (including the self-insurer), no-fault, insurer or WC entity, but the insurer entity did not pay the claim.

Denial Codes

To indicate that claims were denied by Medicare because the claim was not submitted to the appropriate primary GHP for payment, Medicare contractors will use the following codes on the remittance advice sent to you:

- Claim Adjustment Reason Code 22 - "This care may be covered by another payer per coordination of benefits" and
- Remittance Advice Remark Code MA04 -Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible."

Additional Information

You can find official instruction, CR7355, issued to your carrier, FI, RHHI, A/B MAC, or DME MAC by visiting (http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R84MSP.pdf on the CMS website.

You will find the following revised Chapters of the "Medicare Secondary Payer Manual," as an attachment to that CR:

Chapter 1 (Background and Overview):

- Section 10.7 (Conditional Primary Medicare Benefits),
- Section 10.7.1 (When Conditional Primary Medicare Benefits May Be Paid When a GHP is a Primary Payer to Medicare), and
- Section 10.7.2 (When Conditional Primary Medicare Benefits May Not Be Paid When a GHP is a Primary Payer to Medicare).

Chapter 3 (MSP Provider, Physician, and Other Supplier Billing Requirements):

- Section 30.2.1.1 (No-Fault Insurance Does Not Pay), and
- Section 30.2.2 (Responsibility of Provider Where Benefits May Be Payable Under Workers' Compensation).

Chapter 5 (Contractor Prepayment Processing Requirements):

- Section 40.6 (Conditional Primary Medicare Benefits),
- Section 40.6.1 (Conditional Medicare Payment), and
- Section 40.6.2 (When Primary Benefits and Conditional Primary Medicare Benefits Are Not Payable).

Examining the Difference between NPI and PTAN

MLN Matters® Number: SE1216 Revised

Note: This article was revised on May 30, 2012, to remove a sentence from the last paragraph on page 2. All other information is the same.

Provider Types Affected
This MLN Matters® Special Edition Article is intended for physicians, providers, and suppliers who are enrolled in Medicare.

What You Need to Know
This article explains the difference between a National Provider Identifier (NPI) and a Provider Transaction Access Number (PTAN). There are no policy changes in this article.

Background

New Enrollees
All providers and suppliers who provide services and bill Medicare for services provided to Medicare beneficiaries must have an NPI. Upon application to a Medicare contractor, the provider or supplier will also be issued a Provider Transaction Access Number (PTAN). While only the NPI can be submitted on claims, the PTAN is a critical number directly linked to the provider or supplier's NPI.

Revalidation
Section 6401(a) of the Affordable Care Act established a requirement for all enrolled physicians, providers, and suppliers to revalidate their enrollment information under new enrollment screening criteria.

Providers and suppliers receiving requests to revalidate their enrollment information have asked the Centers for Medicare & Medicaid Services (CMS) to clarify the differences between the NPI and the PTAN.

National Provider Identifier (NPI)
The NPI is a national standard under the Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification provisions.

- The NPI is a unique identification number for covered health care providers.
- The NPI is issued by the National Plan and Provider Enumeration System (NPPES).
- Covered health care providers and all health plans and health care clearinghouses must use the NPI in the administrative and financial transactions (for example, insurance claims) adopted under HIPAA.
- The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). The NPI does not carry information about healthcare providers, such as the state in which they live or their medical specialty. This reduces the chances of insurance fraud.
- Covered providers and suppliers must share their NPI with other suppliers and providers, health plans, clearinghouses, and any entity that may need it for billing purposes.

Since May 23, 2008, Medicare has required that the NPI be used in place of all legacy provider identifiers, including the Unique Physician Identification Number (UPIN), as the unique identifier for all providers, and suppliers in HIPAA standard transactions.

You should note that individual health care providers (including physicians who are sole proprietors) may obtain only one NPI for themselves (Entity Type 1 Individual). Incorporated individuals should obtain one NPI for themselves (Entity Type 1 Individual) if they are health care providers and an additional NPI(s) for their corporation(s) (Entity Type 2 Organization). Organizations that render healthcare or furnish health care supplies may obtain NPIs (Entity Type 2 Organization) for their organizations and their subparts (if applicable).

For more information about the NPI, visit the NPPES website at https://nppes.cms.hhs.gov/NPPES/Welcome.do on the CMS website.

Provider Transaction Access Number (PTAN)
A PTAN is a Medicare-only number issued to providers by Medicare contractors upon enrollment to Medicare. When a Medicare contractor approves enrollment and issues an approval letter, the letter will contain the PTAN assigned to the provider.

- The approval letter will note that the NPI must be used to bill the Medicare program and that the PTAN will be used to authenticate the provider when using Medicare contractor self-help tools such as the Interactive Voice Response (IVR) phone system, internet portal, on-line application status, etc..
- The PTAN's use should generally be limited to the provider's contacts with Medicare contractors.

Relationship of the NPI to the PTAN
The NPI and the PTAN are related to each other for Medicare purposes. A provider must have one NPI and will have one, or more, PTAN(s) related to it in the Medicare system, representing the provider's enrollment. If the provider has relationships with one or more medical groups or practices or with multiple Medicare contractors, separate PTANS are generally assigned.

Together, the NPI and PTAN identify the provider, or supplier in the Medicare program. CMS maintains both the NPI and PTAN in the Provider Enrollment Chain & Ownership System (PECOS), the master provider and supplier enrollment system.

Protect Your Information in PECOS
All providers and suppliers should carefully review their PECOS records in order to protect themselves and their practices from identity theft. PECOS should only contain active enrollment records that reflect current practice and group affiliations. You can review and update your PECOS records in the following ways:

- Use internet-based PECOS: Log on to internet-based PECOS at https://pecos.cms.hhs.gov/pecos/login.do on the CMS website.
- Use the Paper CMS 855 enrollment application (i.e., 855A, 855B, 855I, 855O, 855R, or 855S).
- **Note:** The Medicare contractor may not release provider specific information to anyone other than the individual provider, authorized/delegated official of the provider organization, or the contact person. The request must be submitted in writing on the provider's letterhead and signed by the individual provider, authorized/delegated official of the organization or the contact person.

The MLN fact sheet titled "How to Protect Your Identity Using the Provider Enrollment, Chain and Ownership System (PECOS)," provides guidelines and steps you can take to protect your identity while using Internet-based PECOS. This fact sheet is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MedEnroll_ProtID_FactSheet_ICN905103.pdf on the CMS website.

Additional Information
MLN Matters® Special Edition Article SE1126 titled "Further Details on the Revalidation of Provider Enrollment Information," is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1126.pdf on the CMS website.

"Medicare Provider–Supplier Enrollment National Educational Products," contains a list of products designed to educate Medicare Fee-For-Service (FFS) providers about important Medicare enrollment information, including how to use Internet-based PECOS to enroll in the Medicare Program and maintain their enrollment information. This resource is available at http://www.cms.gov/MedicareProviderSupEnroll/downloads/Medicare_Provider-Supplier_Enrollment_National_Education_Products.pdf on the CMS website.

Handling Misdirected Claims for Part B Items and Services

MLN Matters® Number: MM7629
Related Change Request (CR) #: CR 7629
Related CR Release Date: May 18, 2012
Related CR Transmittal #: R2474CP
Effective Date: July 20, 2012
Implementation Date: July 20, 2012

Provider Types Affected
This MLN Matters® Article is intended for physicians, other providers, and suppliers who bill Medicare carriers, Part A/B Medicare Administrative Contractors (A/B MACs) and Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for services provided to Medicare beneficiaries.

Provider Action Needed
Your misdirected claims for Part B items and services (those that you send to the wrong Medicare contractor) will be returned as unprocessable.

Change Request (CR) 7629, from which this article is taken, announces that effective July 20, 2012, your carrier or A/B MAC will return all misdirected claims as unprocessable; and your DME MAC will similarly return claims that should have been sent to a carrier or B MAC, as well as paper claims as that are sent to the wrong DME MAC.

You should make sure that claims are submitted to the correct carrier, A/B MAC, or DME MAC. See the Background section for details.

Background
A "misdirected claim" is a claim that you submit to the wrong carrier, A/B MAC, or DME MAC. As each Fee-For-Service (FFS) claims administration contractor is assigned a specific geographic and subject matter jurisdiction for claims processing, you must submit your claims to the one having the appropriate jurisdiction.

Carriers and A/B MACs previously returned as unprocessible assigned claims for Part B items and services that were sent to the wrong carrier or A/B MAC, and denied such claims that were unassigned; and DME MACs denied paper claims if sent to the wrong DME MAC.

CR7629, from which this article is taken, implements new instructions on handling misdirected claims.

Misdirected Carrier and A/B MAC Claims
With implementation of CR7629, carriers and A/B MACs will return all misdirected claims as unprocessable, **regardless of their unassigned/assigned status**. This includes: Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) claims that are appropriately billable to a A/B MAC or carrier, but are billed to the wrong one; and Misfiled claims for United Mine Workers of America (UMWA) and Railroad Beneficiaries (RRB) beneficiaries.

- Specifically, when it receives a claim for Medicare payment for items/services that have been furnished outside of its payment jurisdiction (other than for RRB and UMWA beneficiaries), your Part A/B MAC or carrier will return it as unprocessable; using the following messages:
- Claim Adjustment Reason Code (CARC) 109 – Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.
- Remittance Advice Remark Code (RARC) N104 - This claim/service is not payable under our claims jurisdiction area. You can identify the correct Medicare contractor to process this claim/service through the CMS website at www.cms.gov.
- RARC MA130 - Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.

Note: These remittance and remark code messages remain the same, and Medicare Summary Notice messages have been removed.

Similarly, effective for claims received on and after July 20, 2012, when it receives a claim for Medicare payment for items or services that are in a DME MAC's payment jurisdiction (other than for RRB and UMWA beneficiaries), your A/B MAC or carrier will return it as unprocessable, using the same messages.

Additionally, while DME MACs will continue to follow existing procedures for misdirected beneficiary-submitted claims (CMS Form 1490S) and electronic claims; effective with implementation of CR7629, a paper claim (Form CMS -1500), sent to the wrong DME MAC will be returned as unprocessable, using the same messages.

Misdirected Railroad Beneficiaries (RRB) Beneficiary Claims
Effective July 20, 2012, when it receives a claim for an RRB beneficiary (and therefore should be processed by the RRB contractor), your carrier, A/B MAC, or DME MAC will return it as unprocessable using the following messages:

- RA - Claim Adjustment Reason Code 109 – Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.
- Remark code N105 - This is a misdirected claim/service for a RRB beneficiary. Submit paper claims to the RRB carrier: Palmetto GBA, P.O. Box 10066, Augusta, GA 30999. Call 866-749-4301 for RRB EDI information for electronic claims processing.
- RARC MA130 - Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.

United Mine Workers of America (UMWA) Beneficiary Claims
Effective July 20, 2012, when it receives a claim for Medicare payment that should be processed by the UMWA, your carrier, A/B MAC, or DME MAC will return it as unprocessable using the following messages:

- RA - Claim Adjustment Reason Code 109 - Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.
- Remark code N127 – This is a misdirected claim/service for a United Mine Workers of America (UMWA) beneficiary. Please submit claims to them.
- RARC MA130 - Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.

Please note that this new guidance does not apply to:

- Misdirected beneficiary-submitted claims (please refer to the "Medicare Claims Processing Manual," Chapter 1 (General Billing Requirements), Section 80.3.2 (Handling Incomplete or Invalid Claims) regarding the handling of such claims);
- Electronic claims for DMEPOS that are submitted to the incorrect DME MAC (misdirected DMEPOS claims are automatically routed to the appropriate DME MAC jurisdiction for processing); or
- A claim submitted to the wrong Part A MAC or Fiscal Intermediary (FI), including a Regional Home Health Intermediary (RHHI).

Additional Information
You can find the official instruction, CR7629, issued to your carrier, A/ B MAC, or DME MAC by visiting http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2474CP.pdf on the CMS website.

Modifying the Timely Filing Exceptions on Retroactive Medicare Entitlement and Retroactive Medicare Entitlement Involving State Medicaid Agencies

MLN Matters® Number: MM7834
Related Change Request (CR) #: 7834
Related CR Release Date: May 25, 2012
Related CR Transmittal #: R2477CP
Effective Date: August 27, 2012
Implementation Date: August 27, 2012

Provider Types Affected
This MLN Matters® Article is intended for physicians, providers, and suppliers submitting claims to Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), carriers, A/B Medicare Administrative Contractors (MACs), and Durable Medical Equipment MACs for services provided to Medicare beneficiaries.

What You Need to Know
This article is based on Change Request (CR) 7834, which advises you that the Centers for Medicare & Medicaid Services (CMS) is revising the "Medicare Claims Processing Manual" to specify that, if a provider, supplier, or beneficiary is unable to provide the Medicare contractor with an official Social Security Administration (SSA) letter, the contractor must check the Common Working File (CWF) database in order to verify a beneficiary's retroactive Medicare entitlement date. Be sure that your staffs are aware of this change.

Background
The Medicare regulations at 42 Code of Federal Regulations (CFR), Section 424.44, specify the time limits for filing Part A and Part B Fee-For-Service claims. Section 424.44 also identifies certain exceptions to the claims filing time limit. If the requirements for satisfying a timely filing exception are met, an extension to file the claims may be granted. Section 6404 of the Affordable Care Act reduced the maximum period for the submission of all Medicare Fee-For-Service claims to no more than 12 months, or one calendar year, after the date a service is furnished.

Section 6404 also gave the Secretary of Health and Human Services the authority to create exceptions to the 12 month timely filing limit. As a result of this legislation, revisions were made to the timely filing regulations at 42 CFR, Section 424.44, and the relevant internet-only manual sections. (See Transmittal 2140/Change Request 7270, published on January 21, 2011, available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads//R2140CP.pdf, on the CMS website.)

The "Medicare Claims Processing Manual" currently requires that, in order to be granted a timely filing extension, the provider, supplier, or beneficiary must furnish an official letter from the SSA to the beneficiary in order to meet one of the conditions that the beneficiary was retroactively entitled to Medicare on or before the date of the furnished service.

BILLING CONT'D

The purpose of CR 7834 is to revise sections 70.7, 70.7.2, and 70.7.3 of the manual to specify that, if an official SSA letter to the beneficiary is not submitted, Medicare contractors must check the CWF database and may interpret the CWF data in order to verify that the beneficiary was retroactively entitled to Medicare on or before the date of the furnished service.

Consequently, CR 7834 requires the Medicare contractors to accept the SSA letter or, in the absence of such letter, to check the CWF database for a beneficiary's date of Medicare entitlement. Contractors may interpret the CWF data in order to verify retroactive Medicare entitlement that may permit a claim to be processed after the 12 month timely filing limit.

Additional Information
The official instruction, CR7834, issued to your FI, RHHI, carrier, A/B MAC, and DME MAC regarding this change, may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2477CP.pdf on the CMS website.

CEDI

Top 10 CEDI Edits for April 2012

National Government Services Common Electronic Data Interchange (CEDI) has identified the following as the top ten edits that were received during April on the 277CA for 5010A1 formatted claims. The edit, its description, the edit logic, and the TR3 edit reference are provided below.

For questions regarding the edits, please contact the CEDI Help Desk by e-mail at ngs.cedihelpdesk@wellpoint.com.

Top Ten Edits Received on the 277CA for 5010A1 claim files	
1	**CSCC A7: Acknowledgement /Rejected for Invalid Information…** **CSC 507: HCPCS** When Product or Service ID Qualifier = "HC", the Procedure Code must be a valid HCPCS Code for the Service Date (DTP01 = "472"). This can also be caused by sending an invalid HCPCS and modifier combination. For more information on the valid combination, please contact the Jurisdiction where the claim will be processed. Logic: When 2400.SV101-1 = "HC", 2400.SV101-2 must be a valid HCPCS Code on the date in 2400.DTP03 when DTP01 = "472". Edit Reference: X222.351.2400.SV101-2.020
2	**CSCC A7: Acknowledgement /Rejected for Invalid Information…** **CSC 164: Entity's contract/member number** **EIC IL: Subscriber** The subscriber HICN is invalid. Verify the HICN is entered exactly as it appears on the beneficiary's red, white, and blue Medicare card. If Medicare ID: Subscriber Primary Identifier must be 10 - 11 positions in the format of NNNNNNNNNA or NNNNNNNNNAA or NNNNNNNNNAN where "A" represents an alpha character and "N" represents a numeric digit. -OR- If Railroad ID: Subscriber Primary Identifier must be 7 - 12 positions in the format of ANNNNNN or AANNNNNN or ANNNNNNNNN or AANNNNNNNNN or AAANNNNNN or AAANNNNNNNNN where "A" represents an alpha character and "N" represents a numeric digit. Logic: If Medicare IDs: 2010BA.NM109 must be 10 - 11 positions in the format of NNNNNNNNNA or NNNNNNNNNAA or NNNNNNNNNAN where "A" represents an alpha character and "N" represents a numeric digit. OR If Railroad IDs: 2010BA.NM109 must be 7 - 12 positions in the format of ANNNNNN, AANNNNNN, ANNNNNNNNN, AANNNNNNNNN, AAANNNNNN, or AAANNNNNNNNN where "A" represents an alpha character and "N" represents a numeric digit. Edit Reference: X222.121.2010BA.NM109.020

Top Ten Edits Received on the 277CA for 5010A1 claim files	
3	**CSCC A8: Acknowledgement / Rejected for relational field in error** **CSC 562: Entity's National Provider Identifier (NPI)** **CSC 128: Entity's tax id** **EIC 85: Billing Provider** Billing Provider Tax Identification Number must be associated with the billing provider's NPI. Verify that the information you are submitting matches the information on file with the NPPES and NSC. Logic: 2010AA.REF must be associated with the provider identified in 2010AA.NM109. Edit Reference: X222.094.2010AA.REF02.050
4	**CSCC A7: Acknowledgement /Rejected for Invalid Information…** **CSC 562: Entity's National Provider Identifier (NPI)** **EIC 85: Billing Provider** Billing Provider Identifier must be a valid NPI on the Crosswalk. Verify that the NPI and DME PTAN are linked together. To establish a crosswalk, verify the supplier's information listed on the NPPES web site matches the information at the NSC. If you have questions about these matches please contact NPPES at 800-465-3203 or the NSC at 866-238-9652. Note: PECOS can also affect your crosswalk. PECOS is the system used by the NSC for DME suppliers to enroll in Medicare. Suppliers can log in to and verify that their NPI is listed correctly. For assistance with PECOS, call 866-484-8049. Logic: 2010AA.NM109 must be a valid NPI on the Crosswalk when evaluated with 1000B.NM109. Edit Reference: X222.087.2010AA.NM109.030
5	**CSCC A8: Acknowledgement / Rejected for relational field in error** **CSC 496: Submitter not approved for electronic claim submissions on behalf of this entity.** **EIC 85: Billing Provider** The Billing Provider NPI not associated with submitter. The Trading Partner/Submitter ID is not authorized to submit claims for the supplier. If this error is received, the supplier must complete and sign the appropriate form on the CEDI Web site (www.ngscedi.com) and return to CEDI for processing. Suppliers who use a third party (e.g. a clearinghouse or billing service) must complete the Supplier Authorization Form. Suppliers who submit their own claims and do not use a third party biller must complete the CMS EDI Enrollment Agreement. Logic: 2010AA.NM109 billing provider must be "associated" to the submitter (from a trading partner management perspective) in 1000A.NM109. Edit Reference: X222.087.2010AA.NM109.050

Top Ten Edits Received on the 277CA for 5010A1 claim files	
6	**CSCC A8: Acknowledgement / Rejected for relational field in error** **CSC 306: Detailed description of service** Description must be present when Procedure Code requires a description/additional information. CMS has released a NOC Code List to help providers identify procedure codes that will require the SV101-7 field to be sent. The NOC Code list is available through a link on the CEDI Web site www.ngscedi.com under the 5010 and D.0 Implementation Information page. Logic: 2400.SV101-7 must be present when 2400.SV101-2 is present on the table of procedure codes that require a description. Edit Reference: X222.351.2400.SV101-7.020Edit Reference: X222.157.2300.CLM02.070
7	**CSCC A7: Acknowledgement /Rejected for Invalid Information…** **CSC 187: "Date(s) of service"** The procedure code submitted for this line does not allow for spanned dates of service. Verify the start/from and end/to dates for this line are equal. Logic: Reject the claim if 2400.DTP02 = "RD8" and the first date is not = the second date and SV101-2 is not "E0935" or "E0936", & the proc option "GL" or "IS" does NOT exist, & the proc option "DF", "DI", "DR", "LP", "OC", "OG", "OL" or "OP does exist. Edit Reference: X222.380.2400.DTP03.090
8	**CSCC A7: Acknowledgement /Rejected for Invalid Information…** **CSC 254: "Primary diagnosis code"** The diagnosis code pointed to by diagnosis code pointer 1 (SV107□1, SV107-2, SV107-3, or SV107-4) is invalid for the claim line date of service. Questions regarding the effective dates of a diagnosis code should be directed to the DME MAC where the claim would be processed based on the patient's state code in the address provided on the claim. Logic: If 2400.SV107-1, SV107-2, SV107-3, or SV107-4 is "1" and 2300.HI01-1 is "BK" then 2300.HI01-2 must be a valid ICD-9-CM Diagnosis code on the date in 2400.DTP03 when DTP01 = "472", based on the ICD-9-CM Diagnosis Code list.
9	**CSCC A7: Acknowledgement /Rejected for Invalid Information…** **CSC 562: Entity's National Provider Identifier (NPI)** **EIC 82: Rendering Provider** Rendering Provider Identifier must be a valid NPI on the Crosswalk when evaluated with Receiver Primary Identifier. Medicare DME claims do not require the Rendering Provider information to be sent. It is recommended that the information is removed from the claim. For more information on how to remove the information, please contact your software vendor, billing service, or clearinghouse. Logic: 2310B.NM109 must be a valid NPI on the Crosswalk when evaluated with 1000B.NM109. Edit Reference: X222.262.2310B.NM109.030

Top Ten Edits Received on the 277CA for 5010A1 claim files	
	CSCC A7: Acknowledgement /Rejected for Invalid Information…
	CSC 510: Future date
	CSC 187: Date(s) of service
	The service end/to date is greater than the date this claim was received. Questions regarding proper billing policy should be directed to the DME MAC where the claim would be processed based on the patient's state code in the address provided on the claim.
	Logic: When 2400.DTP02 = RD8 and the second date is a future date, one of the following proc options must exist for the procedure: "IS", "PA", "PE", "PI", "PK", "PL", "PP", "PS" or "PX".
10	Edit Reference: X222.380.2400.DTP03.080

5010A1 edits are not specific to the definitions provided above. Edit codes received can apply to multiple Edit References. CEDI has included only the top edits being received. If you have received one of the above edit codes but the explanation does not fit your situation, please review the CMS Edit Spreadsheet for other possibilities causing your rejection.

CEDI has posted a Top 15 5010A1 Edits document on the CEDI Web site http://www.ngscedi.com/ under the 5010 and D.0 Implementation Information page. This document provides a list of the top 15 edits received on the 277CA acknowledgement file as well as all possibilities that could cause the same edit combination to be returned. A link to the CMS Edit Spreadsheet which contains all edit combinations is also provided in this document.

For more information regarding the 5010A1 Front-end edits, please send an e-mail to the CEDI Help Desk at ngs.cedihelpdesk@wellpoint.com.

CERT

CERT Documentation

This article is to remind suppliers they must comply with requests from the CERT Documentation Contractor for medical records needed for the Comprehensive Error Rate Testing program. An analysis of the CERT related appeals workload indicates the reason for the appeal is due to "no submission of documentation" and "submitting incorrect documentation."

Suppliers are reminded the CERT program produces national, contractor-specific and service-specific paid claim error rates, as well as a supplier compliance error rate. The paid claim error rate is a measure of the extent to which the Medicare program is paying claims correctly. The supplier compliance error rate is a measure of the extent to which suppliers are submitting claims correctly.

The CERT Documentation Contractor sends written requests for medical records to suppliers that include a checklist of the types of documentation required. The CERT Documentation Contractor will mail these letters to suppliers individually. Suppliers must submit documentation to the CERT Operations Center via fax, the preferred method, or mail at the number/address specified below.

The secure fax number for submitting documentation to the CERT Documentation Contractor is (240) 568-6222.

Mail all requested documentation to:

CERT Documentation Office
Attn: CID #:xxxxxx
9090 Junction Drive, Suite 9
Annapolis Junction, MD 20701

The CID number is the CERT reference number contained in the documentation request letter.

Suppliers may call the CERT Documentation Contractor at (301) 957-2380 with questions regarding specific documentation to submit.

Suppliers must submit medical records within 75 days from the receipt date of the initial letter or claims will be denied. The supplier agreement to participate in the Medicare program requires suppliers to submit all information necessary to support the services billed on claims.

Also, Medicare patients have already given authorization to release necessary medical information in order to process claims. Therefore, Medicare suppliers do not need to obtain a patient's authorization to release medical information to the CERT Documentation Contractor.

Suppliers who fail to submit medical documentation will receive claim adjustment denials from NAS as the services for which there is no documentation are interpreted as services not rendered.

2011 DME CERT Taskforce Documentation Webinar Q&A

Meeting Summary

On December 14, 2011 the Comprehensive Error Rate Testing (CERT) Task Force conducted two webinars over documentation for the supplier community. The purpose of these sessions is for the CERT Task Force to provide the supplier community education regarding the documentation requirements and CERT additional documentation requests (ADR).

Question and Answer Summary

Previously Submitted Questions

CERT:

Q1. Is it cost effective to have both Livanta and Advance Med involved in the collection and review of CERT request? Why not have one unit collect and review?

Answer: This is a Centers for Medicare & Medicaid (CMS) directive and the workload is currently contracted by CMS as two separate contracts. The CERT Documentation contractor is responsible for tracking CERT documentation requests and receipts, while the CERT Review contractor is responsible for review of the incoming documentation against existing Medicare guidelines.

Q2. What is the address to mail CERT requests to? Why is the National Supplier Clearinghouse (NSC) address on file for the PTAN/NPI not used? Can this address be changed by anyone who calls and requests that it be changed even if they are not authorized to do so?

Answer: Suppliers have the ability to designate an address to which all CERT requests should be sent. These updates may be made online at: https://www.certprovider.com/ProviderDirectory.aspx. The request will give suppliers the information; however, the preferred method for receipt of medical records or documentation is via fax: 240-568-6222.

The updates or corrections made through the CERT Documentation Contractor (CDC) only change CDC's records and are mainly for obtaining medical record documentation to support claims review. All revisions involving contacts and/or addresses and phone numbers, will not affect the information on record with the CMS provider enrollment office or the DME MAC contractors' provider files.

Q3. Some suppliers have not been receiving the CERT requests in a timely manner. The letter is dated two weeks later than the date it was mailed out, what can be done to correct this?

Answer: This is not a known issue. Please report these instances immediately to your durable medical equipment Medicare administrative contractor (DME MAC) and the CERT contractor as they occur so the issue can be tracked and resolved.

Q4. What are the phone number suppliers should call in order to receive an extension on a CERT review?

Answer: Extension requests are accepted by phone only at: 1.888.779.7477 or 1.301.957.2380.

Q5. How strongly is CMS/CERT explaining to physicians that their medical records/progress notes must be legible and signed & dated?

Answer: The CERT program is national in scope, and all Medicare contractors are tasked with reducing the error rate in their respective jurisdictions. Education based on CERT findings is a primary component of all contractors' educational programs, extending to physician education conducted by the A/B MACs.

Q6. Can one obtain their provider specific error rate?

Answer: Suppliers are encouraged to work with their Medicare contractor for supplier-specific errors. In general, contractors are able to provide the number of times a supplier has been audited and the results of each.

Q7. This is a general question regarding CERT. Why did we get such a large volume of CERT withdrawal requests? Are there a certain number of requests that each supplier is required to respond to?

Answer: Suppliers should respond to all CERT requests timely to avoid unnecessary and costly errors. Occasionally, a withdrawal request may be issued, but these instances are rare.

Q8. What is the maximum number of CERT requests a supplier should receive in a given month?

Answer: Because the CERT audit process is random, there are no thresholds for minimum or maximum number of requests in a designated period of time.

Q9. If the majority of items requested in the CERT letter are submitted to Medicare prior to the deadline date, what are the repercussions of submitting additional docs after the deadline, even if it is 1-2 days after the deadline?

Answer: If any required piece of documentation is missing, it could cause the entire claim to deny. If you are unable to gather all required documentation prior to the deadline, you may consider requesting an extension.

Q10. If CERT denies a claim how does a supplier know the exact reason for denial? Can the supplier speak with the CERT reviewer? If yes, what is the phone number?

Answer: Suppliers will be notified of their CERT denials through the overpayment recovery process. You will receive a letter requesting a repayment of the dollars paid in error from your Medicare contractor. This letter will provide a brief explanation of the reason for the denial. If you require additional information, your Medicare contractor will be able to provide more detail.

Q11. We are getting tons of CO-50 denials as result of us not responding to audit letters. However, we are not receiving the letters in many cases. We checked and our address of record is correct. Is anyone else having this problem?

Answer: This is not a known issue. Suppliers would be advised to work with the NSC and the CERT contractor to ensure all mailing addresses are current and accurately noted.

Q12. When suppliers respond to CERT requests via fax will they receive immediate confirmation the documentation was received?

Answer: Yes, you should receive a confirmation when you fax documentation for a CERT audit.

Q13. What percentages of the Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) claims are audited?

Answer: Approximately 50,000 Medicare claims are randomly audited through the CERT program each year. This sample of claims is evenly distributed among all Medicare contractors who process claims for the Medicare Program.

Detailed Written Orders:

Q1. Are digitally signed electronic prescriptions (sure script) allowed by Medicare?

Answer: Yes

Q2. Can a physician who works as a hospitalist write an order for DME?

Answer: Yes.

Q3. If the physician assistant (PA) sees a patient but the physician does not the day the order was placed, can the physician sign the certificate of medical necessity (CMN) or does it have to be the PA?

Answer: The CMN should be signed by the person listed in Section A. Someone different can complete the questions as long as their name is noted at the bottom of section B.

Q4. Physician assistants also have NPI numbers however billing is under the physician name. In the case of a nurse practitioner must we still bill under the physician name if we do not know if they bill for their services to Medicare?

Answer: Nurse Practitioners and Clinical Nurse Specialists must be practicing independently of physicians and claims should be billed under the NP's or CNS' name.

Q5. Does a detailed written order have to include the HCPCS code?

Answer: The written order must be sufficiently detailed, including all options or additional features that will be separately billed or that will require an upgraded code. The description can be either a narrative description (e.g., lightweight wheelchair base) or a brand name/model number. Regardless of the form of the description, there must be sufficient detail to identify the item(s) in order to determine that the item(s) dispensed is properly coded.

Q6. Under acceptable formats, please define "electronically maintained" as it pertains to e-scripts?

Answer: Medicare reviewers shall accept as a valid order any drugs incident to durable medical equipment (DME), other than controlled substances, ordered through a qualified E-Prescribing system. For the purpose of conducting Medicare medical review of drugs incident to DME, a qualified E-Prescribing system is one that meets all 42 CFR 423.160 requirements. To review the official standards for electronic prescribing, *42 CFR 423.160 Standards for Electronic Prescribing,* you may go to ***http://edocket.access.gpo.gov/cfr_2008/octqtr/pdf/42cfr423.160.pdf*** on the Internet.

Q7. Does a walker or commode billed as a sale need a length of need?

Answer: No.

Q8. We often fax over a detailed prescriptions for prosthetics to the ordering physician. These will be on our prescription pads, not the physicians. Would we need a Signature Attestation for the prescribing physician when sending in a CERT audit?

Answer: With the exception of Power Mobility Devices, someone other than the physician may complete the detailed written order; however, the treating physician must review the details and personally sign and date (handwritten or electronic only—stamped signatures and dates signature and date stamps are not acceptable) the order to indicate agreement.

Q9. Is frequency only necessary on Detailed Written Orders if the local coverage determination (LCD) specifically requires it to be documented?

Answer: In addition to LCD specifications, if the written order is for supplies that will be provided on a periodic basis, the written order should include appropriate information on the quantity used, frequency of change, and duration of need (for example, an order for surgical dressings might specify one 4 x 4 hydrocolloid dressing that is changed 1-2 times per week for one month or until the ulcer heals).

Q10. If a supplier has oxygen CMN, change of physician from the original order from hospitalist, is the CMN good for one year? The recertification comes from the PCD at one

year; do suppliers need to get a new initial from the primary care physician (PCP) prior to the one year?

Answer: A revised CMN is needed when there is a change in the treating physician but the original oxygen order stayed the same.

Q11. We require a new prescription every 6 months. Does this adequately cover the documentation requirements for continued need?

Answer: The new documentation language that is being incorporated into each of the policies provides direction on what can be used for continued need.

For ongoing supplies and rental durable medical equipment (DME) items, in addition to information described above that justifies the initial provision of the item(s) and/or supplies, there must be information in the beneficiary's medical record to support that the item continues to be used by the beneficiary and remains reasonable and necessary. Information used to justify continued medical need must be timely for the DOS under review. Any of the following may serve as documentation justifying continued medical need:

- A recent order by the treating physician for refills
- A recent change in prescription
- A properly completed CMN or DME Information Form (DIF) with an appropriate length of need specified
- Timely documentation in the beneficiary's medical record showing usage of the item.

Timely documentation is defined as a record in the preceding 12 months unless otherwise specified elsewhere in the policy

Q12. If physician completes an electronic prescription but attaches a pen and ink signature to the prescription, can we accept even though the date was electronically attached to the prescription? To clarify, physician signs but date signed is assigned by electronic prescription protocol. Can we accept as a valid detailed written order?

Answer: Yes.

Q13. Can a pharmacist place an order for the patient?

Answer: No. A treating physician must complete an order for a patient. Per the CMS IOM 100-01, chapter 5, section 70 "Physician means doctor of medicine, doctor of osteopathy (including osteopathic practitioner), doctor of dental surgery or dental medicine (within the limitations in subsection §70.2), doctor of podiatric medicine (within the limitations in subsection §70.3), or doctor of optometry (within the limitations of subsection §70.5), and, with respect to certain specified treatment, a doctor of chiropractic legally authorized to practice by a State in which he/she performs this function."

Q14. If length of need or physician changes for an Enteral patient, do we need a revised DIF in addition to the new refill order?

Answer: Yes.

Q15. Regarding Orders: Does the physician have to date the order himself/herself or can it be dated by the health care team?

Answer: The signature date of the physician must be dated by the physician. Other dates included on the order may be completed by other individuals.

Q16. If we are getting clinic soap notes and the physician signs it electronically is that ok or do they need to physically sign it?

Answer: Electronic signatures are acceptable as long as there is an indication the documents are being electronically signed, the name of the person executing the signature, and the date of the electronic signature.

Q17. If the physician writes an order and dates it at the top of the order, does he need to date the order again when he signs at the bottom?

Answer: Yes.

Q18. How can we obtain a signature log?

Answer: Medicare does not have a required format for signature logs. Signature logs can be created by the supplier. CMS has provided some suggested language for attestation statements.

Should a provider choose to submit an attestation statement, they may choose to use the following statement:

"I, _____[print full name of the physician/practitioner]___, hereby attest that the medical record entry for _____[date of service]___ accurately reflects signatures/notations that I made in my capacity as _____[insert provider credentials, e.g., M.D.]___ when I treated/diagnosed the above listed Medicare beneficiary. I do hereby attest that this information is true, accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to administrative, civil, or criminal liability."

If the physician's signature is missing from the order, the order is considered invalid. Signature logs and attestation statements can only be used for orders when the physician's signature is illegible and the printed physician name is missing from the order.

Q19. Must the "verbal" order pertain to specific item being dispensed such as immunosuppresives?

Answer: Yes.

Q20. If the initial order comes from the PCP and the beneficiary change comes to a different physician in same group, do we need a revised DME information form (DIF)?

Answer: Yes.

Q21. If company A purchases/acquires company B, can company A use company B's written order to send subsequent orders?

Answer: No. This would be a change in suppliers and a new order is required.

Q22. What do we do if we receive a dispensing order from a Home Health and there is no physician signature or medical documentation from physician?

Answer: An order from the treating physician is necessary to dispense and bill items to Medicare. If a detailed written order is not obtained before Medicare is billed, the EY modifier should be added to all HCPCS codes for which an order was not received.

Q23. How do we handle Physical Therapist orders for a patient who is being discharged from the hospital but there is no physician signature or no clear documentation the physician ordered the item?

Answer: An order from the treating physician is necessary to dispense and bill items to Medicare. If a detailed written order is not obtained before Medicare is billed, the EY modifier should be added to all healthcare common procedure coding system (HCPCS) codes for which an order was not received.

Q24. For a 5-year reasonable useful lifetime (RUL) for Oxygen, do we need to get a new order and follow up with a CMN? Or does CMN take place of an order?

Answer: When the 5-year RUL is reached and the beneficiary requests new equipment, only a new Initial oxygen CMN is required unless the treating physician changes the original order.

Q25. If a patient comes in with a prescription for a back brace for post-op use 3 weeks prior to surgery, who is responsible for payment, the hospital or Medicare?

Answer: In order to be billed to the DME MAC, the brace must be for home use. If the brace is being delivered to the patient or hospital for use at home after the surgery, it may be used only for fitting and training purposes and delivered no sooner than 2 days prior to the beneficiary being discharged to home. If the brace is being provided to the beneficiary for use immediately post-operatively or during the inpatient stay to stabilize the spine in the post-surgical period, the brace must be billed to the hospital, not the DME MAC.

Q26. Is a signed verbal order not a qualified medical record?

Answer: Orders, preliminary and/or detailed written, are not considered medical records.

Q27. When billing Medicare for a denial, is the supplier required to complete all the documentation requirements of a payable service? E.g., prepare a DIF and detailed written order?

Answer: Yes. All Medicare billing rules must be met for all claims billed.

Q28. If a company was purchased by another company but is still operating under the original company name/NPI, do we need to obtain a new order for the date that the new company purchased the other company?

Answer: No.

Q29. For PMD, on the DWO does it have to have make, model and charge?

Answer: No. A PMD requires a 7-element order and detailed product description (DPD). The DPD has the same requirements as a detailed written order. While make, model and charge are not required on the DPD, suppliers should put as much details as possible on the DPD so that contractor review staff can determine that the item(s) dispensed is properly coded.

Q30. For enteral feeding, when a resident has an increase or decrease in nutrition administration rate only, does the entire detailed written order (all supplies listed) need to be re-written, or is the administration rate and nutrition being used enough?

Answer: A completely new detailed written order is needed.

Q31. Is a detailed written order a prescription?

Answer: Yes. The detailed written order may serve as a dispensing order – or prescription -- as long as it obtained prior to dispensing/delivery of the item. However, a dispensing order may not necessarily contain sufficient information to satisfy the requirements of a DWO.

Q32. Can we complete a written order in full and send it to the prescribing practitioner for review and signature?

Answer: Yes. If the item was dispensed based on a verbal order then the supplier can complete the order and send to the physician to review, sign, and date. The exception to this rule is the requirement that the treating physician complete all elements of the 7-element order for a Power Mobility Device.

Q33. Is a written order for equipment only good for 30 days?

Answer: An order is valid based on the length of need determined by the treating physician. If the physician indicates a length of need for 30 days then the order is only valid for 30 days unless one of the other new order requirements have been met.

Q34. Do we need a new prescription if the chart notes to support the prescription are after the date on the prescription but before the date of service?

Answer: For all DMEPOS items, the initial medical need or justification is established at the time the item(s) is first ordered; therefore, beneficiary medical records demonstrating that the

item is reasonable and necessary are formed prior to the creation of the initial order. For a purchased item, the initial months of a rental item, or for ongoing supplies or drugs, information justifying reimbursement will come from this initial time period. Information from the beneficiary's medical record must have been created prior to the initial date of service (DOS) to establish whether reimbursement was justified based upon the applicable coverage policy**.**

Q35. What level of detail is needed on a Detailed Written Order for diabetic shoes & inserts?

Answer: The written order must be sufficiently detailed, including all options or additional features that will be separately billed or that will require an upgraded code. The description can be either a narrative description or a brand name/model number. Regardless of the form of the description, there must be sufficient detail to identify the item(s) in order to determine that the item(s) dispensed is properly coded.

An order must be obtained prior to claim submission and must contain the following:

- Beneficiary name
- Prescribing physician's name
- Detailed description of the item(s) to be provided
    - If custom item is provided, the order must state "custom"
    - Modifications
- Quantity dispensed
- Prescribing physician's signature and date order signed
    - Signature and date stamps are not acceptable
- Start date of order (*if the start date is different than the signature date*)

Note: The detailed written order must be signed on or after the date of the visit with the prescribing physician.
A detailed written order for some durable medical equipment prosthetics, orthotics, and supplies (DMEPOS) items may indicate "lifetime" and a new order is not routinely (i.e., quarterly, annually, etc.) required. However, when billing therapeutic shoes for persons with diabetes a new order is required if:

- A shoe needs to be replaced
- A modification or insert needs to be replaced more than one year from the most recent order on file

Q36. Is there a separate form other than the prescribing physician's prescription where the physician states that patient needs diabetic extra depth shoes & inserts?

Answer: No. However, if the prescribing physician is the supplier, a separate order is not required, but the items provided must be clearly noted in the patient's record.

Q37. Do we need both a dispensing and a written order?

Answer: No. A dispensing order is needed only when items are dispensed prior to a detailed written order being obtained. A detailed written order is needed prior to billing Medicare for the

items provided. However, some items do require a detailed written order prior to delivery. Refer to the CMS Manual System, Pub. 100-08, Medicare Program Integrity Manual, Chapter 5, 5.2.3.1 for a complete list of items that require a detailed written order prior to delivery.

Q38. Is a verbal order sufficient to dispense medical equipment along with a CMN or detailed written order?

Answer: Most items may be dispensed based on a verbal order. However, certain items require a DWO prior to delivery/dispensing. A detailed written order prior to delivery is required for the following:

- Pressure reducing support surfaces (group 1, 2, and 3), including mattress overlays, air-fluidized beds, and mattresses
- Seat lift mechanisms
- Transcutaneous electrical nerve stimulation (TENS) units
- Power operated vehicles
- Power wheelchairs
- Wheelchair seating
- Negative pressure wound therapy pumps

Suppliers may utilize the completed and physician-signed CMN to serve as the detailed written order for items which require a CMN and detailed written order prior to delivery (i.e., TENS, seat lift mechanisms). However, the CMN must be signed and dated prior to delivery of the item. Otherwise, a separate detailed written order in addition to a subsequently completed and signed CMN would be necessary.

Q39. Can a nurse practitioner sign & date the written order?

Answer: Yes.

Q40. If we have a prescription and order detail form signed by the physician, can progress notes be provided by the physician to the supplier after the delivery date?

Answer: Yes.

Q41. For diabetic shoes and custom inserts, when an order is started and the patient ends up in the hospital and/or skilled nursing facility can we use the start date to bill or do we have to start the order over?

Answer: The date of service on the claim will be the date the items are delivered to the beneficiary. If there has been an extended period of time between the original order date and the delivery timeframe, it might be necessary to get a new order if the original order no longer meets the beneficiary's medical need.

Also, a new order is required for the replacement of any shoe. A new order is also required for the replacement of an insert or modification more than one year from the most recent order on file.

Q42. If we receive an order for a walking boot, do we also need to have progress notes from the physician in order to provide the item or is the prescription with the diagnosis enough?

Answer: At a minimum, a dispensing order is required prior to delivery and a detailed written order is required prior to billing Medicare. Medical records, such as progress notes, must be available to Medicare upon request and should be obtained from the physician.

Q43. With electronic medical records becoming the standard, what is the ruling about signatures on records, or should they be electronically signed?

Answer: Both handwritten and electronic signatures are acceptable on medical records.

Q44. If we receive a verbal modification to the initial physician's order for urological supplies, do we need to obtain an updated written order prior to dispensing the supplies?

Answer: An updated detailed written order must be obtained prior to billing Medicare; however, urological supplies may be dispensed based on the revised verbal order.

Q45. We are a home infusion provider. If we get an order to provide IV antibiotics to a patient for 6 weeks, do we need to call them every time we ship their drug/supplies or are we covered with the 6 week prescription?

Answer: Items may not be shipped on a pre-determined basis, even at the request of the beneficiary. Please refer to the "*Items Provided on a Recurring Basis and Request for Refill Requirements*," article posted by each Jurisdiction in August 2011.

Q46. Is the prescribing physician required to sign off and confirm a preliminary verbal order in addition to signing the detailed written order?

Answer: For Medicare purposes, verbal preliminary orders do not require a physician's signature.

Q47. Do detailed written orders require a start date?

Answer: All orders must clearly specify the start date of the order (if the start date is different from the date of the order).

Q48. Is a detailed written order prior to delivery required for Group I, Group II, and Group III support surfaces used with hospital beds?

Answer: Yes.

Q49. If suppliers are providing a three month supply of an item, does the detailed written order need to specify that?

Answer: In addition to all other detailed written order requirements, it should include information on the quantity to be used, the frequency of use, and duration of need. The supplier may provide a three month supply of a supply, if the LCD allows for delivery of a three month supply.

Q50. If the verbal dispensing order indicates a specific manufacturer (i.e., One Touch) but the detailed written order doesn't specify a manufacturer, are suppliers required to follow the verbal order and provide the specific manufacturer?

Answer: The supplier must accurately transcribe the information provided by the physician in the verbal order to the detailed written order. If the physician specifies a particular make or model of a device to be dispensed in the verbal order, that same specific make or model of device must be included on the detailed written order. If the supplier does not have that specific make or model in their inventory, the supplier must contact the physician's office to determine if another a specific brand/manufacturer will meet the beneficiary's need. If the physician agrees to the substitution, this new brand or model would be included in the detailed written order. The supplier should also document in detail the interaction with the physician's office and the change in product dispensed.

Q51. If suppliers have a signed and dated detailed written order prior to dispensing, is a separate dispensing order required?

Answer: No.

Q52. Does the detailed written order need to specify a manufacturer, brand name, etc.?

Answer: The specific manufacturer and/or brand name assists Medicare in determining if the appropriate HCPCS code has been billed. The detailed written order does not need to specify the manufacturer or brand name; however, the description must be specific enough for Medicare to determine if the appropriate HCPCS code was billed.

Q53. If a supplier obtains a signature log from the physician and the signature is still illegible, what do suppliers need to do?

Answer: The purpose of the signature log is to associate the physician's printed name with their signature. The signature may still be illegible; however, the printed name must be legible.

Q54. Are signature logs required for every order or for each physician?

Answer: No, signature logs are not a requirement. Signature logs are a suggestion to associate an illegible signature on an order with the physician's printed name.

Q55. Is an International Classification of Diseases (ICD-9) code required on orders? If so, can suppliers enter the ICD-9 code on the order?

Answer: ICD-9 codes are not required on orders. Suppliers are to obtain the appropriate diagnosis or ICD-9 from the physician.

Q56. How often are suppliers required to obtain an order for Continuous Positive Airway Pressure (CPAP) supplies?

Answer: A new prescription is needed when:

- There is a change of supplier
- There is a change in the item(s), frequency of use, or amount prescribed
- There is a change in the length of need or a previously established length of need expires
- State law requires periodic prescription renewal

Q57. On the detailed written order, what is required to satisfy the "detailed description of the item"? For example, hospital bed or semi-electric hospital bed with side rails and mattress.

Answer: The description of the items must be specific enough for Medicare contractors to determine if the appropriate HCPCS codes have been billed.

Q58. If an order is received advising CPAP and supplies, can a supplier list CPAP, humidifier, tubing, and mask and resend to the ordering physician for a signature?

Answer: Yes.

Q59. Where are the requirements for electronic signatures published as regulation or policy by CMS?

Answer: CMS has not published formal regulations regarding electronic signatures. However, Medicare contractors strongly recommend that an electronic signature include a notation such as one of the following (not all-inclusive):

- Electronically signed by
- Authenticated by
- Approved by
- Completed by
- Finalized by
- Signed by
- Validated by
- Sealed by

Q60. Can a claim be denied if the electronic signature on the supporting medical record or the Detailed Written Order doesn't contain one of the prefix statements above?

Answer: Claims can be denied and/ or payments recovered if it is not clear the records have been authenticated by the treating physician. When records are electronically signed, there should be something to differentiate the physician's typed name versus the physician's electronic signature. The examples mentioned in the presentation are not all inclusive, however they are examples of signature tags that can be used to differentiate the signature from the printed name.

Medical Records:

Q1. What is meant by "electronically maintained"?

Answer: Electronically maintained generally means that the supplier utilizes computerized documentation retention system (i.e. electronic patient files stored on a hard drive or secured network within an organization). In the event a billed claim has been pulled for an audit the supplier would still be able to print and/or submit the documentation requested.

Q2. Following a patient evaluation does the physician need to sign and approve the forms?

Answer: If the physician completes the patient evaluation, the evaluation should be in their normal narrative format. The documentation should at a minimum have the patient's name, date of the evaluation, contain pertinent information regarding the visit, and be signed by the physician. If the evaluation is completed by another clinician, the treating physician should review and sign the evaluation if the physician concurs with the findings.

Q3. Does medical record documentation from other entities need to be signed off by the ordering physician?

Answer: As a general rule, No. Records from other healthcare providers not in the employ of the supplier are considered medical records as noted in the PIM Chapter 5.7. There are exceptions to this general rule such as the specific requirement in the power mobility device (PMD) LCD for face-to-face examinations referred to a physical or occupational therapist. There is also the scenario in the Therapeutic Shoes local coverage determination and related policy article that allows the certifying physician to "sign off" on records from the prescribing physician documenting a qualifying foot condition. (See Q37 in this document).

Q4. For diabetic shoes, the Statement of Certifying Physician form is required in place of Certificate of Medical Necessity (CMN). Currently this form requires a MD or DO signature. If this form is similar to a CMN, why can't a nurse practitioner (NP) sign this form but can sign a CMN?

Answer: The Statement of Certifying Physician form is not a substitution for a CMN nor it is review under the same guidelines as a CMS approved CMN. The Medicare Benefit Policy Manual chapter 15, Section 140 *Therapeutic Shoes for Individuals with* Diabetes states that the need for diabetic shoes must be certified by a physician who is a doctor of medicine or a doctor of osteopathy and who is responsible for diagnosing and treating the patient's diabetic systemic condition through a comprehensive plan of care. Therefore, a nurse practitioner is not authorized under Medicare guideline to order therapeutic shoes for individuals with diabetes. Note that the Statement of Certifying Physician form is a suggested form and is not mandated by CMS or the DME MACs. The information captured on the Statement of Ordering Physician form must be corroborated in the patient medical records.

Q5. What is an attestation statement signed by physician?

Answer: In the event a piece of documentation (such as a physician progress note) is missing a physician signature, the beneficiary's supplier may submit a signature attestation statement authored by the physician whom failed to sign the medical record entry. In order for an attestation statement to be considered valid for Medicare medical review purposes, the statement must be signed and dated by the author of the medical record entry and contain the appropriate beneficiary information. Claims reviewers will not consider attestation statements where there is no associated medical record entry or from someone other than the author of the medical record entry in question. Even in cases where two individuals are in the same group, one may not sign for the other in medical record entries or attestation statements.

Q6. Medicare does not allow "after-the-fact" letters from the physician however the physician is not required to provide us with documentation until "after-the-fact" audit. How is a supplier to ensure that the physician has the medical records?

Answer: It is expected that suppliers work closely with the physicians and help them understand the policies and documentation requirements. It is a supplier's business decision as when and how medical record information is secured to determine if the patient qualifies for the item being ordered.

Q7. Can progress notes/medical record documentation be electronically signed?

Answer: Yes. Medical records may be electronically signed and must be authenticated by the author making the medical record entry.

Q8. Although physicians have improved with documenting oxygen use in the chart notes, physicians have not always documented oxygen use at each visit with beneficiary. Why would a letter written by the physician after the fact which documents that the patient has needed and used the oxygen since set-up not be sufficient for Medicare?

Answer: The CMS Internet Only Manual (IOM) 100-08, Chapter 5 the *Program Integrity Manual*, section 5.7 states, "However, neither a physician's order nor a CMN nor a DIF nor a supplier prepared statement nor a physician attestation by itself provides sufficient documentation of medical necessity, even though it is signed by the treating physician or supplier. There must be information in the patient's medical record that supports the medical necessity for the item and substantiates the answers on the CMN (if applicable) or DIF (if applicable) or information on a supplier prepared statement or physician attestation (if applicable)." Physicians/practitioners should not add late signatures to the medical record (beyond the short delay that occurs during the transcription process), but instead may make use of the attestation process. In order to be considered valid for Medicare medical review purposes, an attestation statement must be signed and dated by the author of the medical record entry and must contain sufficient information to identify the beneficiary.

Q9. On the continued need/use, what if the patient is not seeing their treating physician on a regular basis?

Answer: It is expected that for items ordered/billed documentation will be available to support the need. The CMS Internet Only Manual (IOM) 100-08, Chapter 5 the Program Integrity Manual, section 5.7 states, "For any DMEPOS item to be covered by Medicare, the patient's medical record must contain sufficient documentation of the patient's medical condition to substantiate the necessity for the type and quantity of items ordered and for the frequency of use or replacement (if applicable)."

Q10. How often are you looking for ongoing need to be documented in physician charting?

Answer: For all DMEPOS items, the initial justification for medical need is established at the time the item(s) is first ordered; therefore, beneficiary medical records demonstrating that the item is reasonable and necessary are created just prior to, or at the time of, the creation of the initial prescription. For purchased items, initial months of a rental item or for initial months of ongoing supplies or drugs, information justifying reimbursement will come from this initial time period. Entries in the beneficiary's medical record must have been created prior to, or at the time of, the initial DOS to establish whether the initial reimbursement was justified based upon the applicable coverage policy.

For ongoing supplies and rental DME items, in addition to information described above that justifies the initial provision of the item(s) and/or supplies, there must be information in the beneficiary's medical record to support that the item continues to be used by the beneficiary and remains reasonable and necessary. Information used to justify continued medical need must be timely for the DOS under review.
Any of the following may serve as documentation justifying continued medical need:
1. A recent order by the treating physician for refills
2. A recent change in prescription
3. A properly completed CMN or DIF with an appropriate length of need specified
4. Timely documentation in the beneficiary's medical record showing usage of the item.
Timely documentation is defined as a record in the preceding 12 months unless otherwise specified elsewhere in the policy.

Q11. Would a nebulizer need recertification after purchased or only the drugs and supplies?

Answer: Nebulizers and nebulizer drugs do not require a certificate of medical necessity (CMN) and therefore does not have any recertification requirements.

Q12. If a physical therapist evaluates for a hand splint and the therapist signs the documentation, is the ordering physician also required to sign the documentation in order for it to be valid?

Answer: No.

Q13. For complex rehab wheelchairs is documentation of continued medical necessity required? Such as someone who is a quad, and has been for 10 years, do suppliers need the patient to go to their physician to verify continued medical necessity?

Answer: No. It would not be expected that the physician would continue to document the need for a PMD.

Q14. May a physician sign the last page of a visit note and this be considered acceptable?

Answer: Yes. If there are 4 pages of physician progress notes it is acceptable for the physician to sign the 4th page. Suppliers should be careful though because many times during an audit it is obvious there were 4 pages but only page 1-2 are submitted and not the page with the physician signature in this case. Suppliers may utilize the physician attestation if an entry is missing a physician signature.

Q15. Does CERT allow supplier created logbooks where the patient hand writes in the data and signs it?

Answer: CERT is looking for the beneficiary logs to have the patient name that the beneficiary is actually testing at the frequency ordered and patient signature to verify that the patient did in fact complete the log.

Q16. How are suppliers supposed to educate the physicians?

Answer: The medical directors have created several "*Dear Physician*" letters to help assist suppliers regarding the documentation required. Suppliers are also encouraged to attach the corresponding documentation checklist to the *Dear Physician* letters to assist in guiding the physician in providing the documentation required for the DMEPOS item(s) ordered.

Q17. What is considered stage III or IV decubitus ulcer (measurements)?

Answer: Stage III is a full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss which may include undermining and tunneling. Stage IV is a full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunneling.

Q18. Is there a difference between documentation scanned into a document-imaging system or the hard-copy documentation as far as which would need to be kept for the 7-year period?

Answer: Suppliers are expected to maintain documentation for up to 7 years. This documentation may be electronically maintained but in some cases the original documentation may be requested in order to authenticate what was provided. In all cases of additional documentation request copies are acceptable unless originals are specifically requested by the reviewing entity.

Q19. On the slide titled "What is NOT a Medical Record" it was mentioned that addendums after the fact are not allowed. What about addendums to records made prior to delivery? For instance in a PMD exam if the MD fails to cover one of the required topics and we notice it, can the MD go back and create an addendum as long as it is prior to our dispensing the chair?

Answer: Physicians/practitioners should not add late signatures to the medical record (beyond the short delay that occurs during the transcription process), but instead may make use of the attestation process. In order to be considered valid for Medicare medical review purposes, an attestation statement must be signed and dated by the author of the medical record entry and must contain sufficient information to identify the beneficiary.

Q20. In the case of oxygen equipment, if the physician does not document the required documentation, how do you suggest it is handled? Should the patient revisit the office for the proper documentation?

Answer: It is the supplier's responsibility, as the entity billing Medicare, to ensure that all medical necessity requirements have been met. Once a supplier determines that they have been paid incorrectly, an overpayment refund is in order. Continued billing for oxygen, knowing that required coverage criteria are not met would be a false claim.

Q21. Does a physician's attestation statement verify authenticity of a physician's signature or must the physician go back to the medical record sign and date with current date and if there is confusion as to reading of a signature, then an attestation would be filled out?

Answer: If the signature is missing from the medical records, the physician/practitioner may provide an attestation to verify the entry. Physicians/practitioners should not add late signatures to the medical record (beyond the short delay that occurs during the transcription process), but instead may make use of the attestation process. In order to be considered valid for Medicare medical review purposes, an attestation statement must be signed and dated by the author of the medical record entry and must contain sufficient information to identify the beneficiary.

Q22. Why are suppliers held responsible for physician's illegible medical records?

Answer: Suppliers are the entity billing Medicare and receiving payment for the item(s); therefore, it is the supplier's responsibility to ensure that the item(s) billed are reasonable and necessary.

Q23. If a physician indicates the patient is non-compliant in monitoring blood sugar or taking insulin, would that patient still qualify for therapeutic shoes & inserts?

Answer: The local medical policy and Medicare Benefit Policy manual, chapter 15, *Therapeutic Shoes for Individuals with Diabetes,* states that the need for diabetic shoes must be certified by a physician who is a doctor of medicine or a doctor of osteopathy and who is responsible for diagnosing and treating the patient's diabetic systemic condition through a comprehensive plan of care. This managing physician must:

- Document in the patient's medical record that the patient has diabetes;
- Certify that the patient is being treated under a comprehensive plan of care for diabetes, and that the patient needs diabetic shoes; and
- Document in the patient's record that the patient has one or more of the following conditions:
    - Peripheral neuropathy with evidence of callus formation;
    - History of pre-ulcerative calluses;

- History of previous ulceration;
- Foot deformity;
- Previous amputation of the foot or part of the foot; or Poor circulation.

If the patient fails to meet any portion of this criterion, the shoes, inserts and/or modifications will be denied as noncovered.

Q24. What are suppliers to tell physicians who call and request a form for them to fill out for a power mobility face-to-face evaluation?

Answer: Suppliers are encouraged to work with their referring physicians and ensure they are familiar with the medical policies. Suppliers should utilize the "Dear Physician" letters created by the DME MAC medical directors and corresponding documentation checklist to help assist with guiding the physicians in documenting the need for the power mobility device**.**

Q25. For diabetic shoes, what is considered a comprehensive care of plan for diabetes?

Answer: A comprehensive plan of care for diabetes would be the direction and plan the treating physician has determined in order to address the patient's condition**.** This could include but is not limited to: history, prognosis, medications, treatments, and directives to be used to help stabilize and maintain the patient's health.

Q26. For enteral nutrition specifically for diabetics, when asking for specific documentation regarding the trial on another formula what exactly is Medicare looking for?

Answer: There are no specific detailed documentation requirements in this situation but the medical record should provide an overall picture of that particular patient's condition, previous treatments, prognosis, and need for the item ordered**.**

Q27. How can suppliers obtain an attestation form/signature attestation form?

Answer: Should a physician/practitioner choose to submit an attestation statement, they may choose to use the following statement:

"I _____ [full name of the physician/practitioner] _____, hereby attest that the medical record entry for _____ [Date of Service] _____ accurately reflects signatures notations that I made in my capacity as _____ [insert provider credentials, e.g., M.D.] _____ when I treated/diagnosed the above listed Medicare beneficiary. I do hereby attest that this information is true, accurate and complete to the best of my knowledge and I understand that any falsification, omission or concealment of material fact may subject me to administrative, civil or criminal liability."

Q28. Would a form created by the physician that includes all the required details per the medical policy for diabetic supplies be sufficient for medical record documentation?

Answer: A form can be used to provide medical record documentation but in most cases the documentation is limited and does not provide enough information to substantiate the need for the item or that particular patient's medical condition necessitating the need for the item ordered.

Q29. If a beneficiary resides in a skilled nursing facility (SNF) and daily nurse notes or progress notes/dietary records are used with the nurse signature only would this be sufficient for medical records or does the ordering physician need to sign off?

Answer: Please see the response to question #3 in medical record section.

Q30. Can an Advance Beneficiary Notice of Noncoverage (ABN) be provided if the beneficiary's physician is not providing proper documentation to support medical necessity?

Answer: If the supplier exhaust every avenue to obtain medical documentation to support the need for the DMEPOS items ordered, and is unsuccessful, it is acceptable for the supplier to issue an ABN. The ABN must document the specific reason for why the patient does not meet medical necessity.

Q31. Who can perform a swallowing evaluation for enteral nutrition a primary care physician (PCP) or speech therapist?

Answer: Either one; however, speech-language pathologists who specialize in swallowing disorders are often consulted to perform a swallowing evaluation.

Q32. What is the allowed frequency for HCPCS L0456 when replacing the item for wear and tear, and what are the documentation requirements?

Answer: The reasonable useful lifetime (RUL) for a Thoracic-lumbar-sacral orthoses, L0456 is 5 years. Therefore Medicare would not cover replacement prior to this timeframe due to wear and tear. Replacement for a L0456 prior to the 5 year RUL would only be covered if the item was lost, stolen, or irreparably damaged but does not include normal wear and tear.

Q33. Is the continued medical need documentation required if CERT pulls a claim for review?

Answer: CERT would look for continued need documentation for items that are provided on a reoccurring periodic basis.

Q34. When proving continued use of oxygen for the contemporaneous notes, is it sufficient if the chart notes simply list the oxygen use in the medication portion of the chart when patient is in for another routine visit?

Answer: There should be some sort of documentation in the patient's medical records indicating the physician's over site for continued use and need of the oxygen.

Q35. If the certifying physician does not indicate the qualifying foot condition for diabetic shoes but indicates they referred the beneficiary to a podiatrist is this valid medical record documentation to support coverage criteria has been met?

Answer: The certifying physician may choose to refer the beneficiary to a podiatrist regarding the foot condition but in order for this documentation to be considered as part of the certifying physicians medical records he/she must sign off and date concurrence prior to or the same day as completing the Statement of Certifying Physician**.**

Q36. It was indicated that supplier created forms (even completed by a physician and included in the chart) are not considered as part of the comprehensive medical record. So if a physician signs and dates a written confirmation of a verbal order is it not acceptable if they are signing a form (of any kind) generated by the supplier?

Answer: If a physician completes a supplier created form, these forms are not considered part of the beneficiary's comprehensive medical records even if the physician signs, dates, and includes the form within their charts. During pre or post payment audits, supplier created forms will not stand alone in order to support medical necessity for the ordered DMEPOS item.

Q37. Is there any way for suppliers to obtain more specific information regarding their CERT denials?

Answer: Suppliers should contact the appropriate Provider Contact Center in order to obtain additional information on their denials. Suppliers will need to have the following information prior to calling:

- CERT identification (CID) number assigned to the claim
- The beneficiary's name
- Health Insurance Claim Number (HICN)
- Provider Transaction Number (PTAN)
- National Provider Identifier (NPI)
- Last five digits of the supplier's tax identification number

Suppliers should refer to the DME MACs Web sites to determine the appropriate Provider Contact Center:
Jurisdiction A, NHIC, Corp – http://www.medicarenhic.com
Jurisdiction B, National Government Services – http://www.ngsmedicare.com
Jurisdiction C, CGS Administrators, LLC – http://www.cgsadmin.com
Jurisdiction D, Noridian Administrative Services, LLC – http://www.noridianmedicare.com

Q38. How are suppliers to handle when a physician refuses to correct medical notes that are illegible or incomplete?

Answer: If a supplier is unable to obtain supporting legible medical record documentation from the physician prior to dispensing the item(s), then the supplier has a business decision to make. If from the documentation received indicates the patient does not meet coverage criteria as outlined in the policy, suppliers must make a business decision whether or not to supply the product. If suppliers choose to supply the product to the beneficiary, suppliers must make the decision

whether to provide a properly executed Advance Beneficiary Notice of Noncoverage (ABN) with details for the specific reason the beneficiary does not meet coverage criteria or provide for the items for free.

Q39. How often do suppliers need to get diabetic logs for patients over-utilizing?

Answer: Per the LCD, if the beneficiary is regularly using quantities of supplies that exceed the utilization guidelines, new documentation must be present at least every six months.

Q40. For an oxygen claim if denied during an audit as not medically necessary because information was not sent what can suppliers do to start getting claims paid again?

Answer: The Medicare program offers suppliers the right to appeal audit findings that they are not in agreement with. In fact, CMS encourages suppliers to appeal audit findings when documentation is available and supports the items or services provided as the purpose of the appeals process is to ensure the correct adjudication of claims.

Suppliers should refer to the DME MACs Web sites to determine the appropriate forms, addresses, and or faxes to utilize when submitting their appeals request:
Jurisdiction A, NHIC, Corp – http://www.medicarenhic.com
Jurisdiction B, National Government Services – http://www.ngsmedicare.com
Jurisdiction C, CGS Administrators, LLC – http://www.cgsadmin.com
Jurisdiction D, Noridian Administrative Services, LLC – http://www.noridianmedicare.com

Q41. What type of documentation is required for HCPCS A6261 and A6262 (unspecified wound filler) when medical policy does not state what is specifically required as far as amount of exudate, stage of wound or depth of wound?

Answer: Surgical dressings are covered when either they are required for the treatment of a wound caused by, or treated by, a surgical procedure; or they are required after debridement of a wound. Furthermore, use of more than one type of wound filler or more than one type of wound cover in a single wound is rarely medically necessary and the reasons must be well documented. It may not be appropriate to use some combinations of a hydrating dressing on the same wound at the same time as an absorptive dressing (e.g., hydrogel and alginate). The quantity and type of dressings dispensed at any one time must take into account the current status of the wound(s), the likelihood of change and the recent use of dressings, and surgical dressings must be tailored to the specific needs of the patient.

Please note there are unique codes for other wound fillers, e.g. A6024 (collagen, A6199), A6215 (foam), etc.

Not Otherwise Classified (NOC) coded wound fillers are covered under the same rules as specifically- coded wound fillers, i.e., when a qualifying wound is large (deep) enough to require a filler to close the space and the material of the filler is appropriate to the wound type (e.g. hydrogel on a dry wound or collagen on an exudative wound). The filler chosen must be compatible with the primary dressing as well.

Q42. Do the referring doctor's medical records need to have the functional level of the patient for prosthesis? The policy states "and or" the referring doctor - prosthetist.

Answer: A determination of the medical necessity for certain components/additions to the prosthesis is based on the patient's potential functional abilities. Potential functional ability is based on the reasonable expectations of the prosthetist, and treating physician. This expectation of functional ability information must be clearly documented and retained in the prosthetist's records. There must be information in the treating physician's records about the patient's history and current condition which supports the designation of the functional level by the prosthetist.

Q43. It was stated on the call that CERT is looking for the beneficiary signature on test logs?

Answer: There is no requirement for the beneficiary to sign and date their testing logs.

Q44. For oxygen recertification the patient needs to have a documented office visit with the physician who is going to sign the CMN. What exactly should the progress notes completed during this visit include?

Answer: The progress notes should include, at minimum, compliance with current oxygen treatment, continued need for oxygen, any new issues with usage of oxygen, etc.

Q45. If a physician determines that a piece of equipment is needed for their patient while the patient is in their office and they send the patient to our office with a prescription in hand for that equipment, generally speaking, the SOAP notes or chart notes VERY rarely ever have the supporting documentation that is required by Medicare. Is it okay for the physician to type or write up a "letter of medical necessity" on their letterhead with all supporting documentation of medical necessity that pertains to that patient for that piece of equipment, to go along with the chart notes from that day? Will this suffice to prove medical necessity as long as it is obtained prior to dispensing the product?

Answer: No. For any DMEPOS item to be covered by Medicare, the patient's medical record must contain sufficient documentation of the patient's medical condition to substantiate the necessity for the type and quantity of items ordered and for the frequency of use or replacement (if applicable). The information should include the patient's diagnosis and other pertinent information including, but not limited to, duration of the patient's condition, clinical course (worsening or improvement), prognosis, nature and extent of functional limitation, other therapeutic interventions and results, past experience with related items, etc. However, neither a physician's order, nor a supplier-prepared statement, nor a physician attestation by itself provides sufficient documentation of medical necessity, even though it is signed by the treating physician. There must be clinical information in the patient's medical record which supports the medical necessity for the item and substantiates the information on a supplier-prepared statement or physician attestation (if applicable).

Q46. What are suppliers to do when an amputee has a broken or deteriorated component and needs to be seen immediately to avoid further damage to prosthesis or residual limb, or potential injury?

Answer: Repairs to prosthesis are covered when necessary to make the prosthesis functional. If the expense for repairs exceeds the estimated expense of purchasing another entire prosthesis, no payments can be made for the amount of the excess. Maintenance which may be necessitated by manufacturer's recommendations or the construction of the prosthesis and must be performed by the prosthetist is covered as a repair.

Replacement of a prosthesis or prosthetic component is covered if the treating physician orders a replacement device or part because of any of the following:

- A change in the physiological condition of the patient; or
- Irreparable wear of the device or a part of the device; or
- The condition of the device, or part of the device, requires repairs and the cost of such repairs would be more than 60% of the cost of a replacement device, or of the part being replaced.

Replacement of a prosthesis or prosthetic components required because of loss or irreparable damage may be reimbursed without a physician's order when it is determined that the prosthesis as originally ordered still fills the patient's medical needs.

Q47. Is a revised DIF required for enteral nutrition?

Answer: A revised DIF for enteral nutrients is required when:

- The number of calories per day is changed, or
- The number of days per week administered is changed, or
- The method of administration (syringe, gravity, pump) changes, or
- The route of administration is changed from tube feedings to oral feedings (if billing for denial).

Q48. Can handwritten oxygen saturations from the facility, prior to discharge, be acceptable if written by a registered nurse (RN) or Physician?

Answer: Testing done in hospital needs to be recorded and reported in the standard way that the particular hospital records and reports lab test results. That record of the test must then be made available upon request. Alternatively physicians may make note of the test result after reviewing the report. The progress not with the included test result would also be an acceptable source.

Q49. Medicare policy states you only need a revised CMN if the liter flow changes to over 4lpm not if it changes from 2-3lpm, is this correct?

Answer: A revised CMN is required:

- When the prescribed maximum flow rate changes from one of the following categories to another:
    - less than 1 LPM,

  - 1–4 LPM,
  - greater than 4 LPM
- When the length of need expires – if the physician specified less than lifetime length of need on the most recent CMN.
- When a portable oxygen system is added subsequent to Initial Certification of a stationary system.
- When a stationary system is added subsequent to Initial Certification of a portable system
- When there is a new treating physician but the oxygen order is the same.
- If there is a new supplier and that supplier does not have the prior CMN.

Q50. Are physicians being trained on the continued need documentation for medical necessity of equipment and legible signatures?

Answer: CMS and contractors have provided information to the Medicare physician and hospital community in regards to the requirements for the supplier community to provide continued services for Medicare beneficiaries.

Q51. We have a CMN from the hospitalist for oxygen. Patient is discharged from the hospital. Patient follows up with primary care physician. No change in liter flow. No revised CMN necessary, correct?

Answer: A revised CMN would be required since there is a change in the treating physician.

Q52. We provide custom wheelchair seating, what information is required in the doctor's notes?

Answer: Documentation should contain at minimum:

- Patient meets all of the criteria for a prefabricated skin protection seat cushion or positioning seat cushion outlined in the LCD;
- Patient meets all of the criteria for a prefabricated positioning back cushion outline in the LCD;
- There is a comprehensive written evaluation by a licensed/certified medical professional, such as a physical therapist (PT) or occupational therapist (OT), which clearly explains why a prefabricated seating system is not sufficient to meet the patient's seating and positioning needs. The PT or OT may have no financial relationship with the supplier.

Q53. If doctor "A" performs a face-to-face assessment and orders a PT/OT evaluation and the PT/OT evaluation is sent back to doctor "A" for concurrence but doctor "A" is on vacation for two weeks, must we wait for doctor "A" to return, or may another physician within the practice sign for the prescribing physician?

Answer: Dr. B merely needs to be filling in for Dr. A and it needs to be clear that his is what is occurring.

Q54. Is medical necessity documentation required for canes?

Answer: Please refer to the Canes and Crutches medical policy and policy article for coverage criteria requirements.

Q55. Do medical records have to document specific need for anti-tippers, general back/seat cushions or is medical necessity justified by diagnosis and prognosis and can the suppliers detailed written order justifying the accessories?

Answer: The medical necessity for all options and accessories must be documented in the patient's medical record and be available on request. This documentation might include information on why the patient needs the item, the patient's diagnosis, the patient's abilities and limitations as they relate to the equipment (e.g., degree of independence/dependence, frequency and nature of the activities the patient performs, etc.), the duration of the condition, the expected prognosis, and past experience using similar equipment.

Q56. Is it acceptable if a supplier has an order from one physician but medical records from another physician if they work in the same hospital?

Answer: Yes it is acceptable. The patient's medical record is not limited to the physician's office records, and may include hospital, nursing home, or home health agency records. Patient medical records also include medical documentation from other professionals including, nurses, and physical or occupational therapists as long as those individuals have no financial relationship with the supplier.

Q57. Is it acceptable for a doctor to write that he concurs with the OT/PT evaluation on the bottom of their evaluation?

Answer: There is no requirement for the physician to concur with the OT/PT evaluation unless a portion of the exam is being considered as a part of the face-to-face examination.

Q58. If after Physician "A" does the face to face and the beneficiary changes physicians and Physician "B" is not within the same practice may Physician "B" still sign the PT/OT evaluation? Or does the beneficiary need to start over with the new physician?

Answer: "No. The LCD/NCD/and statute requires that the physician who performs the face-to-face (both components) must be the one to write the seven-element order. A change in treating physician would require a new visit to request a PMD, and a new evaluation by the new physician.

Q59. Can suppliers keep a copy of the signed attestation statements on file in order to submit at any time or a later date?

Answer: Suppliers are encouraged to keep all records associated with the item that they have billed for. The approved physician attestation statements may be used for a medical entry that was not signed by the physician or illegible signature. One attestation statement is not valid for the entire medical record. It is only valid for the date of service attested to.

Q60. Are physician's notified of these webinars and how is it expected for suppliers to education medical professionals on how to document in their charts?

Answer: The DME MACs are funded to provide education to DMEPOS suppliers. However, the DME MACs do try and assist in educating ordering physicians. We have developed "Dear Physician" letters and "Documentation Checklists" to assist suppliers in obtaining the required documentation. Each jurisdiction has their own listserve articles to help keep supplier up to date with Medicare. These publications are open to anyone, including physician's and are a good way to keep them abreast of any educational offerings.

Q61. Regarding fluctuating blood sugars, is there a definition used by Medicare?

Answer: No. The patient's medical records should document whether the ordering physician believes the patient has fluctuating blood glucose levels including any signs and symptoms associated with fluctuating blood sugar levels.

Q62. What are some specific examples of patient conditions or documentation that would support special enteral nutrients?

Answer: The documentation should provide evidence for the need of the specialty nutrient over one of the basic nutrients. This documentation may include but is not limited to, physician progress notes, labs, hospital records, and the products packaging. The diagnosis alone does not support the need for a specialty nutrient. For example, a diabetic patient does not necessarily need to be placed on glucerna. The documentation should be tailored to each patient and their current condition.

Q63. What time frame is acceptable regarding testing logs for a patient over-utilizing glucose supplies?

Answer: The log provided should be within an approximate time frame to the claim in question.

Q64. Is medical necessity documentation required for diabetic supplies?

Answer: Yes. The Glucose Monitors Local Coverage Determination outlines the documentation requirements for diabetic testing supplies.

Q65. Can you provide an example of medical notes for an over-utilization diabetic patient that you find acceptable to justify the testing frequency?

Answer: The documentation should provide evidence for the need to test at a higher frequency. This documentation may include but is not limited to, physician progress notes, labs, and hospital records. The documentation should be tailored to each patient and their current condition.

Q66. Relevant medical records verifying the beneficiary has severe lung disease/hypoxia-related symptoms that might be expected to improve with oxygen therapy and that

alternative treatment measures have been tried or considered and deemed clinically ineffective. Please give detail as to what alternative treatment measures Medicare is referring too?

Answer: Many disease conditions have standard treatment regimens associated with them. This criterion, together with the requirement that testing be done while the patient is in their chronic, stable state means that the usual treatment modalities need to be optimized before oxygen becomes eligible for reimbursement.

Q67. The Glucose Monitor LCD indicates that a supplier is required to get progress notes or a diabetic testing log every 6 months for beneficiary orders that exceed utilization guidelines. We have heard that documentation to validate these requirements must be relative to the DOS and needs to be dated within 3 months of the DOS to be valid. Is this the case?

Answer: The progress notes or testing log should be within six months prior to the date of service on the claim.

Q68. If a supplier creates an intake form that contains the beneficiary's information, the ordering physician information and a listing of equipment/supplies that the ordering physician can check for the medical need of the beneficiary, is this acceptable?

Answer: Many suppliers create "intake forms" to record beneficiary eligibility information and other information necessary for the supplier. Documentation regarding the medical necessity for the item being billed will need to come from the patient's comprehensive medical record per the applicable medical policy.

Q69. What recourse do suppliers have when ordering physicians refer their beneficiaries to suppliers that do not require documentation up front?

Answer: Beneficiaries have the right to choose where and from whom they receive DMEPOS items. Physicians can provide the names of DMEPOS suppliers in the area but ultimately it is up to the beneficiary to make the choice.

Q70. Do repairs require physician medical records?

Answer: Documentation for a repair does not have to be documented in the medical record. The item being repaired and the repair itself do need to be considered medically necessary per Medicare guidelines. The supplier should have complete and detailed records about the repair.

Q71. If a patient has an HMO and qualifies for Medicare is a new CMN required?

Answer: It depends on whether the item was initially started in FFS or was started in the HMO. For items started in the HMO, all FFS requirement for a new initial item must be met unless otherwise stated in the medical policy.

Q72. If a consumer receives a wheelchair from one physician and 3 years later requires repairs to this wheelchair and is no longer seeing the physician that originally ordered the wheelchair, do suppliers use the original physician as the physician for the repairs or is the physician who is currently following the consumer's care eligible to document the need for the repair?

Answer: A new CMN and or physician order is not needed for repairs unless specifically indicated in the LCD. However, if you are looking for documentation of continued use and need you should contact the physician that is currently treating the patient.

Q73. Physicians do not typically understand function levels for amputees regarding prosthetic devices. We have been trying to educate our physicians on function levels and how to document them, but we don't usually get detailed information from the physician regarding function level. What should suppliers do in this case?

Answer: Potential functional ability is based on the reasonable expectations of the prosthetist and treating physician. The records must document the patient's current functional capabilities and his/her expected functional potential, including an explanation for the difference, if that is the case. The expectation of functional ability information must be clearly documented and retained in the prosthetist's records. There must be information about the patient's history and current condition which supports the designation of the functional level by the prosthetist.

Q74. As a pedorthist, can a physician sign off on a foot exam and the patient needing diabetic shoes and inserts that the pedorthists completes?

Answer: No. Pedorthists are not recognized as medical provider for Medicare documentation purposes. A pedorthic exam would not be an acceptable substitute for a medical exam, even if co-signed by a physician (PIM 5.7 exclusion of supplier records as a substitute for medical records.

Q75. If a supplier has several locations with different NPI numbers but is the same company and a patient goes from one location to another, is new documentation required?

Answer: Suppliers are identified to the DME MAC by the NPI/PTAN combination. If a claim is received and processed for NPI 1234567890, the documentation must correlate to the billing NPI of 1234567890. If a different NPI of 0987654321 is billed, the documentation must correlate to the billing NPI of 0987654321.

Per Medicare requirements, if there is a change in the supplier or treating physician, new documentation is required. Examples of new documentation include, but not limited to, detailed written order, Certificate of Medical Necessity, DME Information Form, and Proof of Delivery.

Q76. Should a signature attestation be routinely sent with medical records if legibility of the signature is in question?

Answer: Yes.

Q77. A lot of our enteral patients have been on service for a number of years. As an example a patient has been on service for 10+years. At that time CMNs were used in lieu of medical records. CMNs are no longer valid in an audit so we have to go to the physician and/or hospital for medical records. Old medical records may not be available showing that a formula other than Glucerna was tried first. How does that affect a CERT audit? I have a patient who has been on enteral for approximately 14 years. The previous physician is now deceased and saw the patient in the hospital. We have the old CMN but are unable to obtain medical records indicating the patient was tried on a formula other than Glucerna first.

Answer: The CMS Internet-Only Manual (IOM) Publication 100-08, Medicare Program Integrity Manual, Chapter 5, Section 5.7 (251 KB) states:

"However, neither a physician's order nor a Certificate of Medical Necessity (CMN) nor a Durable Medical Equipment Regional Carrier Information Form (DIF) nor a supplier prepared statement nor a physician attestation by itself provides sufficient documentation of medical necessity, even though it is signed by the treating physician or supplier. There must be information in the patient's medical record that supports the medical necessity for the item and substantiates the answers on the CMN (if applicable) or DIF (if applicable) or information on a supplier prepared statement or physician attestation (if applicable)." CMNs and DIFs have never been sufficient to support medical necessity. There has always been an expectation that medical records would support the responses to questions on the CMN or DIF.

Q78. On the slide titled "What is NOT a Medical Record" it was mentioned that addendums and after-the-fact letters are not acceptable. What about addendums to records made prior to delivery?

Answer: Physicians/practitioners should not add late signatures to the medical record (beyond the short delay that occurs during the transcription process), but instead may make use of the attestation process. In order to be considered valid for Medicare medical review purposes, an attestation statement must be signed and dated by the author of the medical record entry and must contain sufficient information to identify the beneficiary.

Q79. If the patient owns their DME equipment and the doctor that they currently see, didn't provide the equipment and it needs to be repaired, will the new doctor need to provide updated medical necessity for continued use?

Answer: Medicare does provide reimbursement for repairs made to medically necessary, beneficiary-owned equipment when necessary to make the equipment serviceable. It is expected that the beneficiary has visited his/her treating physician with 1-year of the date of service under review, and that documentation within the beneficiary's medical record (i.e., notes within the current treating physician's records) reflects the ongoing need and continued use of the item.

Q80. If we call the IVR to check on an E0143 HCPCS code, would that be same or similar to a K0001 or/and a manual wheelchair (MWC)?

Answer: If you use the same/similar option on the IVR to check for HCPCS code E0143, the system will not check to see if the beneficiary owns/rents a manual wheelchair (K0001). In order to determine if the beneficiary already owns or rents a K0001, you must enter that code as well.

Q81. What are the credentials of the persons reviewing the claims for medical necessity? Is there someone familiar with Orthotics and Prosthetics reviewing for claims of this nature?

Answer: The medical professional staff at AdvanceMed, the CERT review contractor consists of board certified physicians, nurses, physical therapists, occupational therapists, speech-language therapists, and other allied health professionals.

Q82. When follow-up visit documentation is requested but it is not within the timeframe for the patient to see the physician, will we be held accountable for providing said documentation when it's due?

Answer: Yes. It is the supplier's responsibility to provide all requested documentation to support the medical necessity of the item for which they are billing. All requested documentation must be provided so the reviewer can make an accurate determination. If the supplier does not provide all requested documentation, the reviewer will make a determination based upon the documentation the supplier provided.

Q83. What about when new technology comes available that could significantly benefit a patient and the reasonable useful lifetime (RUL) has not passed? Is it possible to get a new suspension method socket covered? What documentation is required?

Answer: Medicare will provide reimbursement for replacement of a prosthetic when the item has reached its RUL, has sustained irreparable damage, or when the physician has ordered a replacement due to a medically necessary reason (i.e., it is recognized that there are situations where the reason for replacement includes but is not limited to: changes in the residual limb; functional need changes; or irreparable damage or wear/tear due to excessive patient weight or prosthetic demands of very active amputees.)

Claims involving the replacement of a prosthesis or major component (foot, ankle, knee, and socket) must be supported by a new physician's order. The prosthetist must retain documentation of the prosthesis or prosthetic component replaced, the reason for replacement, and a description of the labor involved irrespective of the time since the prosthesis was provided to the beneficiary. This information must be available upon request.

Q84. If during an audit it is discovered that the documentation is inadequate and a denial is given, are suppliers able to file a redetermination acknowledging that we are unable to obtain records from the physician?

Answer: Yes. Suppliers may file a request for redetermination acknowledging that they are unable to obtain records from the physician; however, unless additional documentation is provided that supports medical necessity, the CERT contractor's decision may be upheld.

Q85. If during an audit the documentation is inadequate and a denial is given, can suppliers contact the ordering physician for a pick-up order since the ordering physician will not provide additional documentation?

Answer: If Medicare denies payment for a DMEPOS item and the beneficiary is relieved of liability for payment for that rental item (supplier is held liable), this effectively cancels the contract for the sale or rental of the item and, if the item is re-sellable or re-rentable, the supplier may repossess that item (unless state law prevents the supplier from doing so) for resale or re-rental if the supplier refunds amounts collected. In regards to consumable items that may not be fit for resale, suppliers are strongly discouraged from recovery of those.

The supplier may enter into a new sale or rental regardless of whether or not the supplier physically repossesses the re-sellable or re-rentable item, as long as the beneficiary has been informed of their liability. The supplier can establish the beneficiary's liability for payment for the denied resold or re-rented item by giving the beneficiary an ABN notifying the beneficiary that Medicare will not pay for the item and obtaining the beneficiary's signed agreement to pay for the item. The resale or re-rental does not change the fact that the beneficiary is relieved of liability in connection with the original transaction.

Q86. Are testing logs required for diabetic beneficiaries that are obtaining therapeutic shoes?

Answer: Testing logs are not required documentation to support a claim for therapeutic shoes. Diabetic shoes and inserts are eligible for coverage if the patient has documented diabetes mellitus and meet one or more of the conditions as outlined in the local coverage determination (LCD) and policy article documented in the medical records by the certifying physician. Documentation requirements for Diabetic Shoes are available in the Therapeutic Shoes for Diabetics LCD (L11525) and Policy Article located on the DME MACs Web sites.

Q87. If a supplier cannot determine medical necessity of the item, should the item be dispensed and billed to Medicare?

Answer: Suppliers must refer to the Local Coverage Determination and related Policy Article to determine whether an item meets Medicare coverage guidelines and medical necessity criteria. The medical policies are located on the DME MACs Web sites.

The DME MACs suggest that suppliers obtain supporting documentation up-front in order to determine if the documentation supports medical necessity criteria have been met. If documentation does not support medical necessity, the supplier may execute an Advance Beneficiary Notice of Noncoverage, citing the specific reason Medicare does not consider the item medically necessary for the beneficiary. If the beneficiary does not accept financial responsibility for the item by signing the ABN, the supplier should consider not providing the item. If the supplier provides an item to the beneficiary that is not medically necessary and does not obtain a signed ABN, the supplier must append modifier GZ to the claim line. Use of this modifier will result in a denial holding the supplier liable.

Q88. If a supplier has a letter of medical necessity from the physician documenting the need for blood glucose testing supplies, is a 30-day blood glucose testing log also required?

Answer: Attestation letters of medical necessity are not considered part of the medical record and are not sufficient to support the medical necessity of an item, even though they may be signed by the physician.

Q89. Do signed and dated statement of medical necessity forms serve as medical record documentation if they are obtained prior to claim submission?

Answer: No. The documentation should be in the physician's normal narrative format and be signed and dated by the treating physician. Addendums and after-the-fact letters, even though they may be signed by the physician, are not considered part of the medical record and are not sufficient to support the medical necessity of an item. As it is stated in the PIM 100-8 Chapter 5 Section 5.7 "However, neither a physician's order nor a CMN nor a DIF nor a supplier prepared statement nor a physician attestation by itself provides sufficient documentation of medical necessity, even though it is signed by the treating physician or supplier. There must be information in the patient's medical record that supports the medical necessity for the item and substantiates the answers on the CMN (if applicable) or DIF (if applicable) or information on a supplier prepared statement or physician attestation (if applicable)."

Q90. Does Medicare only cover accessories if they are paid for the base equipment (i.e., wheelchair accessories, hospital bed accessories, etc.? If the answer is yes, where can I find that information in writing?

Answer: Medicare will cover supplies but not necessarily accessories for beneficiary-owned equipment that was not paid for by Medicare fee-for-service (FFS)—i.e., only equipment that was paid by other insurance or by the beneficiary. For supplies and accessories used with that equipment, all of the following information must be submitted with the initial claim in Item 19 on the CMS-1500 claim form or in the 2400.NTE segment for electronic claims:

- HCPCS code of base equipment
- A notation that this equipment is beneficiary-owned
- Date the patient obtained the equipment

Claims for supplies and accessories must include all three pieces of information listed above. Claims lacking any one of the above elements will be rejected with ANSI code PR-16. When PR-16 is received for this reason, the supplier must resubmit the claim with the correct information in the NTE segment.

Medicare requires that supplies and accessories only be provided for equipment that meets the existing coverage criteria for the base item. In addition, if the supply or accessory has additional, separate criteria, these must also be met. In the event of a documentation request from the contractor or a redetermination request, suppliers should provide information justifying the medical necessity for the base item and the supplies and/or accessories. Refer to the applicable local coverage determination(s) and related policy article(s) for information on the relevant coverage, documentation and coding requirements.

Q91. Why is the durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) supplier responsible for determining what is reasonable and necessary for the beneficiary? For example, if the treating physician prescribes a specific surgical dressing to treat a beneficiary's wound, how should the supplier determine if it is medically necessary even though it was ordered?

Answer: Section 1833(e) of the Social Security Act precludes payment to any provider of services unless "there has been furnished such information as may be necessary in order to determine the amounts due such provider." It is expected that the patient's medical records will reflect the need for the care provided. The patient's medical records include the physician's office records, hospital records, nursing home records, home health agency records, records from other healthcare professionals and test reports. This documentation must be available upon request. It is the responsibility of the entity billing Medicare to ensure the items they provide and for which they are seeking Medicare reimbursement, meet medical necessity criteria indicated out the in the Local Coverage Determination and Policy Article. Therefore, suppliers must refer to the LCD and Policy Article for the items they provide. The indications of coverage and medical necessity criteria, as well as documentation requirements are spelled out in the medical policies which are available on the DME MACs Web sites.

Q92. If a new beneficiary comes in with a prescription for diabetic testing supplies and the treating physician has indicated the beneficiary tests more often than allowed by medical policy (over utilization), do suppliers obtain medical records and beneficiary testing logs to justify the need for overutilization for that claim?

Answer: Yes. The documentation that should be provided if requested in an audit for a diabetic beneficiary testing above the typical allowed amount would include; written order, physician progress notes regarding the patient's condition and need for testing above the allowed amount, patient's testing log showing they are in fact testing the prescribed amount of times, request for refill, and proof of delivery.

Q93. What documentation should be in the medical records for mobility assistive equipment (MAE)? Do the mobility related activities of daily living (MRADLs) that are affected need to be specific?

Answer: The medical record must contain information showing that the applicable policy coverage criteria are met. The Indications and Limitations of Coverage and/or Medical Necessity differ according to the MAE; therefore, for medical necessity criteria and documentation requirements, suppliers should refer to the medical policy specifically for the item they are providing.

Documentation of MRADLs should be objective and as specific as possible.

Q94. As an Occupational Therapy practice who provides splints to beneficiaries, do the requirements apply to this type of practice?

Answer: All Medicare providers and suppliers are subject to CERT audits and must be prepared to provide supporting documentation upon request.

Q95. If the item that is being provided is customized, does the person doing the measuring have to be employed by the DMEPOS supplier or can someone at the hospital where the beneficiary is being discharged from, actually take the measurements?

Answer: There is no Medicare policy requirement that the person completing the customized measurements be employed by the supplier**.**

Q96. What information can a supplier provide to instruct the ordering physician on how to complete a CMN?

Answer: Instructions regarding completion of the CMN are indicated on the back of the CMN. Suppliers are prohibited from completing Section B on the CMS forms 484, 846, 847, 848, and 849. Section B must be completed by the physician, the physician's employee, or another clinician involved in the care of the patient (e.g., nurse, physical or occupational therapist, etc.) as long as that person is not the supplier. Suppliers may assist the physician by answering the physician's questions or providing instructions, but may in no way lead the physician to provide a specific answer.

Q97. What documentation is required in order to dispense therapeutic shoes for a person with diabetes? What constitutes a physical examination of the patient's feet before and at the time of dispensing the shoes?

Answer: Suppliers of diabetic shoes are not required to obtain supporting documentation at the time the service(s) is provided. Per the Therapeutic shoes for Persons with Diabetes medical policy, suppliers must add a KX modifier to codes for shoes, inserts, and modification only if criteria 1-5 in the Non-Medical Necessity Coverage and Payment Rules section of the related Policy Article have been met. If the documentation requirements have not been met, suppliers must append the GY modifier. In order to determine which modifier is required for claim submission, the supplier must determine whether the criteria have been met; thus, the supplier would have to obtain documentation from the treating physician prior to claim submission. Documentation requirements for diabetic shoes are available in the Therapeutic Shoes for Diabetics LCD (L11525) and Policy Article located on the DME MACs Web sites.

Per the Therapeutic shoes for Persons with Diabetes Policy Article, prior to selecting the specific items that will be provided; the supplier must conduct and document an in-person evaluation of the patient. Additionally, at the time of delivery of the items selected, the supplier must conduct and document an in-person visit with the patient.

The in-person evaluation of the patient by the supplier at the time of selecting the items that will be provided must include at least the following:

1. An examination of the patient's feet with a description of the abnormalities that will need to be accommodated by the shoes/inserts/modifications.
2. For all shoes, taking measurements of the patient's feet.

3. For custom molded shoes (A5501) and inserts (A5513), taking impressions, making casts, or obtaining CAD-CAM images of the patient's fee that will be used in creating positive models of the feet.

The in-person evaluation of the patient by the supplier at the time of delivery must be conducted with the patient wearing the shoes and inserts and must document that the shoes/inserts/ modifications fit properly.

Q98. If suppliers are providing an amount of blood glucose testing supplies above what is normally allowed by Medicare and the beneficiary can only provide a two week testing log, would a statement from the treating physician be sufficient to support medical necessity?

Answer: Attestation letters or after-the-fact letters signed by the physician are not considered part of the beneficiary's medical record. The patient's medical records must reflect the need for the item being ordered. The documentation should be in the physician's normal narrative format and be signed and dated by the treating physician.

Request for Refill:

Q1. "Quantity of each item that the beneficiary still has remaining," would this requirement pertain more to enteral and diabetic supplies, rather than cpap/bipap or nebulizer supplies?

Answer: The refill requirements apply to all DMEPOS (Durable Medical Equipment, Prosthetics, Orthotics, and Supplies) items that are refilled on a recurring basis.

Q2. When you are asking for a quantity of all items the patient still has remaining - for items that are billed with a "kit code" such as enteral feeding kits (B4034, B4035, B4036), do we need to know the quantity of each and every item - such as gauze, tape, needles, etc. - when these items are not billed separately? Is it necessary to list them out on the refill request OR can we ask "how many kits do you have left?"

Answer: Documentation of approximately how many kits the beneficiary has on hand will allow the supplier to calculate when they may ship new supplies no sooner than 10 days prior to the previous kit's end of usage. The use of individual items within a kit may differ from patient to patient and day to day. Individual items do not need to be counted.

Q3. Is it possible that a supplier's billing department vs. the shipping department vs. the customer service department is off by one day in calling for refill, billing, or shipping or is that not allowed? Can you appreciate the fact that if the billing department billed for the claim today, but the shipping department was backed up so it didn't go out until the next day, our shipping and billing dates would be off by one day?

Answer: Per the CMS Internet Only Manual 100-08 Chapter 4 Section 4.26.1, if a supplier utilizes a shipping service or mail order, suppliers shall use the shipping date as the date of service on the claim.

Q4. In regards to the Diabetic Supplies LCD, when refilling a 90 day supply for a beneficiary that exceeds the utilization guidelines, after the supplier receives the progress notes to show the need for the additional materials when supplying the original order, would it be appropriate for the supplier to only get a Diabetic Testing Log showing the testing frequency from the beneficiary every 6 months in order to supply the continued refills of the ordered supplies?

Answer: The refill request must occur and be documented before shipment. The refill record must include:

- Beneficiary's name or authorized representative if different than the beneficiary
- A description of each item that is being requested
- Date of refill request
- Quantity of each item that the beneficiary still has remaining

Q5. How do you recommend we document the quantity remaining for cpap supplies, such as a mask refill? The beneficiary might have the one they are currently using, but not an extra one.

Answer: In the case of the mask, it may not be the quantity is exhausted but it is reasonable and necessary to replace the supply. Replacement of CPAP supplies is not automatic. Items should only be replaced when the current one is no longer serviceable. Documentation of contacting the beneficiary prior to dispensing refills ensures the refilled item remains reasonable and necessary, existing supplies are approaching exhaustion, and to confirm any changes/modifications to the order. The supplier may document the date and quantity of the previous supply dispensed.

Q6. Regarding the request for refill, if the beneficiary resides in a SNF and is not able to determine needs, can a call to the nursing facility nurse be sufficient for determining refill requirements? Can our company representative sign the request for refill for documentation?

Answer: Contact may be made to the beneficiary or a designee. Documentation may take the form of a written request received from the beneficiary or designee or a supplier written record of a phone conversation/contact between the supplier and beneficiary or designee.

Q7. For a CPAP supply, the beneficiary has the supply they are currently using, but will discard when they return home with the replacement supply. What quantity on hand is documented as what the beneficiary still has?

Answer: Please see response to question #5 in request for refill section.

Q8. Is a DME supplier of diabetic testing supplies required to get the patient's prior three months of logs before dispensing the next three months of supplies?

Answer: If refills of quantities of supplies exceed the utilization guidelines, there must be documentation in the physician's records (specific narrative statement that adequately documents

the frequency at which the patient is actually testing or a copy of the beneficiary's log) or in the supplier's records (e.g., a copy of the beneficiary's log) that the patient is actually testing at a frequency that corroborates the quantity of supplies that have been dispensed. If the beneficiary is not exceeding the utilization guidelines, the supplier must document how many days supplies the beneficiary has remaining to determine the delivery of the refills no sooner than 10 days prior to the expected end of usage of the previously dispensed supplies.

Q9. Should we automatically request diabetic testing logs from patients prior to dispensing refills?

Answer: Only if refills of quantities of supplies exceed the utilization guidelines, there must be documentation in the physician's records (specific narrative statement that adequately documents the frequency at which the patient is actually testing or a copy of the beneficiary's log) or in the supplier's records (e.g., a copy of the beneficiary's log) that the patient is actually testing at a frequency that corroborates the quantity of supplies that have been dispensed.

Q10. When ordering refills, example 2 asks how many supplies does the patient have left? Is this question concerning how many the patient currently has left?

Answer: Correct, in the example provided, the question was asking the amount of supplies the beneficiary has remaining. This could be how many days of supplies the beneficiary has on hand from the previous supplies dispensed.

Q11. If a beneficiary tells you they have 15 days of supplies left, do you need to re-contact them since it is greater than 14 days?

Answer: You do not need to re-contact the beneficiary. The supplier would document how many days of supplies the beneficiary has left and then deliver the next amount of supplies no sooner than 10 days before the end of usage on the supplies.

Q12. If a patient comes into the store for a refill of diabetic supplies, are we required to ask what is on hand and the frequency of utilization?

Answer: For items that the beneficiary obtains in-person at a retail store, the signed delivery slip or a copy of the itemized sales receipt is sufficient documentation of a request for refill.

Q13. I'm trying to get a complete picture of items that need to be addressed when contacting a patient for a reorder of diabetes testing supplies. The LCD list more items than were addressed on the slides in his webinar.

Answer: For items that the beneficiary obtains in-person at a retail store, the signed delivery slip or a copy of the itemized sales receipt is sufficient documentation of a request for refill.

For items that are delivered to the beneficiary, documentation of a request for refill must be either a written document received from the beneficiary or a contemporaneous written record of a phone conversation/contact between the supplier and beneficiary. The refill request must occur

and be documented before shipment. A retrospective attestation statement by the supplier or beneficiary is not sufficient. The refill record must include:

- Beneficiary's name or authorized representative if different than the beneficiary
- A description of each item that is being requested
- Date of refill request
- Information documenting that the beneficiary's remaining supply is approaching exhaustion by the expected delivery date.

Q14. Question regarding refill documentation for enteral nutrition therapy. I would like to clarify the statement that it would be acceptable to state "xx days' supply left" for this type of therapy - or do we need to list out the individual items such as Enteral Formula, Enteral syringe, Enteral bags with the quantity remaining for all the specific items.

Answer: The supplier must document the amount of days of formula and the amount of days of supply kits remaining.

Q15. For request for refills, we must document the quantity of supplies remaining. How exactly should this be stated? Are we required to say the exact number of units that the beneficiary has remaining, or can we state a more general reference (e.g. "beneficiary has two weeks' worth of supplies remaining")?

Answer: Suppliers should state how many days of supplies the beneficiary has remaining to ensure that new supplies are shipped no sooner than 10 days prior to the end of usage of the previously dispensed supplies.

Q16. In regards to urological supply request for refill, it stated we can dispense up to 3 month supply at a time?

Answer: For urological supplies, suppliers may dispense no more than a three-month supply at any one time.

Q17. Page 50 of the presentation discusses refills. On our initial order for prosthetic filling socks we state that they need to be replaced every 5-6 months. If the patient contacts us 7 months later and says all their socks are worn out -- does this 14 day "refill" rule apply to prosthetic socks? If so, does it mean that I cannot deliver the needed socks until 14 days after they contacted us saying they needed them?

Answer: If the beneficiary is contacting the supplier for refills, this indicates the supplies are at or near the end of usage and refills may be dispensed.

Q18. Can we dispense a 3 month supply of catheters as long as the amount does not exceed quantity of 200 dispensed?

Answer: For urological supplies, suppliers may dispense no more than a three-month supply at any one time.

Q19. Does the request for refill documentation apply to beneficiaries who pick items up directly from the pharmacy?

Answer: Please see answer to question #12 in request for refill section.

Q20: What documentation is required to show the beneficiary requested a refill of positive airway pressure (PAP) supplies? Are suppliers required to document the number of supplies the beneficiary has remaining?

Answer: The refill request must occur and be documented before shipment. The refill record must include:

- Beneficiary's name or authorized representative if different than the beneficiary
- A description of each item that is being requested
- Date of refill request
- Quantity of each item that the beneficiary still has remaining

Q21. When providing a refill for items required on a reoccurring basis suppliers cannot deliver the refill sooner than ten calendar days prior to the end of usage for the beneficiary's current supply?

Answer: Correct.

Q22. If billing Medicare for refills, what documentation is required?

Answer: The refill request must occur and be documented before shipment. The refill record must include:

- Beneficiary's name or authorized representative if different than the beneficiary
- A description of each item that is being requested
- Date of refill request
- Quantity of each item that the beneficiary still has remaining

Proof of Delivery:

Q1. What if the patient is unable to sign a delivery ticket- physically or in a setting such as the operating room- for an item required (brace, orthosis, etc.)?

Answer: A designee of the beneficiary may sign on their behalf. Be sure to indicate the relationship to the beneficiary on the delivery slip.

Q2. On the proof of delivery slip is a prescription RX number sufficient for the item dispensed along with the date of service and subscriber signature or must there be a detailed description of the item dispensed to be a valid proof of delivery?

Answer: No, that would not be sufficient. It must have a detailed description of the items so the beneficiary can understand what they have received.

Q3. Can we use the date on the delivery ticket as the date of service verses the shipment date?

Answer: No, it must be the shipping date for items delivered via mail order.

Q4. We have billed date of discharge and received denial still part A? Why is that?

Answer: The patient may have not been discharged timely or the file has not been updated. Please contact your DME MAC with an example for further clarification.

Q5. If a drug is delivered to a Hospital for use after discharge but the discharge is delayed one day, does this fall under the Date of Service exception?

Answer: You may only deliver directly to a hospital for fitting or training purposes. However, you may deliver the drugs to the patient's home within two days prior to discharge for their availability.

Q6. Can we deliver a 90 supply of CPAP supplies and how do we bill the items? Do we just include a narrative note that the item is for a 3 month supply or bill monthly?

Answer: Yes. It is acceptable to bill a 90 day supply of CPAP supplies. Be sure to include a note in the NTE field indicating "3 month supply" or "90 day supply".

Q7. Why is the shipping date used as the date of service and not the date the patient receives the supplies?

Answer: The instruction to use the shipping date as the date of service if the supplier utilizes a shipping service or mail order is a CMS requirement per the Medicare Program Integrity Manual Chapter 4 located at: http://www.cms.gov/manuals/downloads/pim83c04.pdf
"If the supplies are delivered directly by the supplier, the date the beneficiary received the DMEPOS supply shall be the date of service on the claim."

Q8. Does the patient need to date the delivery slip?

Answer: Yes, the patient or their designee should sign and date the delivery slip for items that are delivered directly to the beneficiary or picked up.

Q9. A proof of delivery question, we send a postcard with our orders of diabetic supplies which has their name, signature and amount of quantity sent, why would we still be denied as no proof of delivery?

Answer: Suppliers are to follow the proof of delivery requirements as outlined in the standard documentation language for local coverage determinations.

Q10. If Medicare can audit up to ten years, should we keep the proof of delivery for ten years instead of seven?

Answer: Medicare requires suppliers to maintain proof of delivery documentation in their files and that documentation must be maintained in the supplier's files for 7 years per the Program Integrity Manual. However, if you are still billing rentals or maintenance and service on an item older than 7 years, it is recommended to retain the documentation longer.

Q11. If you are missing a proof of delivery and discover this before an audit request is received and are in the process of picking up the equipment, what should you do?

Answer: Proof of delivery is required in order to verify that the beneficiary received the DMEPOS. Therefore, the claim will be subject to an overpayment via or a voluntary refund would be encouraged.

Q12. It was mentioned earlier in call that DOS is date beneficiary actually receives item, then it was stated if a shipping service is used the DOS is date of shipment. Please clarify?

Answer: In instances where the supplies are delivered directly by the supplier, the date the beneficiary received the DMEPOS supply shall be the date of service on the claim. If the supplier utilizes a shipping service or mail order, suppliers shall use the shipping date as the date of service on the claim.

Q13. When delivering a bone stimulator and patient is in hospital/SNF what is the correct date of service (date of delivery or date of discharge)?

Answer: A supplier may deliver a DMEPOS item to a patient in a hospital or nursing facility for the purpose of fitting or training the patient in the proper use of the item. This may be done up to two (2) days prior to the patient's anticipated discharge to their home. The supplier should bill the date of service on the claim as the date of discharge and shall use the place of service (POS) as 12 (patient's home). The item **must** be for subsequent use in the patient's home. No billing may be made for the item on those days the patient was receiving training or fitting in the hospital or nursing facility.

Q14. Is pricing information required on the delivery tickets for each item being supplied?

Answer: No. Pricing information is not required on the delivery ticket.

Q15. If we utilize a delivery service such as FedEx, does the patient/designee have to sign for the package or is the service stating delivered considered a valid proof of delivery?

Answer: If the supplier utilizes a shipping service or mail order, the POD documentation must be a complete record tracking the item(s) from the DMEPOS supplier to the beneficiary. An example of acceptable proof of delivery would include both the supplier's own detailed shipping invoice and the delivery service's tracking information. The supplier's record must be linked to the delivery service record by some clear method like the delivery service's package identification number or supplier's invoice number for the package sent to the beneficiary. The POD record must include:

- Beneficiary's name

- Delivery address
- Delivery service's package identification number, supplier invoice number or alternative method that links the supplier's delivery documents with the delivery service's records.
- Sufficiently detailed description to identify the item(s) being delivered (e.g., brand name, serial number, narrative description)
- Quantity delivered
- Date delivered
- Evidence of delivery

If a supplier utilizes a shipping service or mail order, suppliers must use the shipping date as the date of service on the claim. Suppliers may also utilize a return postage-paid delivery invoice from the beneficiary or designee as a POD. This type of POD record must contain the information specified above.

Q16. We are contacting the patient 14 days in advance and shipping out prior to end date of the prior shipment so the patient does not run out of supplies. We were advised to bill the delivery date or date of shipment however that is prior to the end date of the prior bill and we are receiving denials, what is the correct date to bill, shipping date or next date needed?

Answer: For delivery via mail, you must use the shipping date as your date of service. You have a 10 day window to deliver supplies prior to the end of usage. However, keep in mind you should not be billing 10 days earlier each month, you should remain within a 10 day window from your original shipment date. (Example: If you shipped the initial supply on the 10th of the month, any shipment thereafter should fall between the 1st and 10th of the month.) The DME MACs are required to allow for processing of claims within this time frame. If you have received incorrect denials, please contact your DME MAC with an example.

Q17. Is a call from the recipient that is documented by the office sufficient proof of delivery?

Answer: No.

Q18. If we deliver to a facility / hospital (48 hours prior to discharge) and the patient is out of his/her room and hospital staff signs the delivery ticket. Is this sufficient?

Answer: Yes, this is acceptable. It is suggested that you document who signed on behalf of the patient. The relationship of the designee to the beneficiary should be noted on the delivery slip obtained by the supplier (i.e., spouse, neighbor, etc.). The signature of the designee should be legible. If the signature of the designee is not legible, the supplier should note the name of the designee on the delivery slip. However, the supplier must ensure that the beneficiary takes the item home, or you must pick up the item at the facility and deliver it to the beneficiary's home on the date of discharge. For additional requirements, please refer to Chapter 20 of the Medicare Claims Processing Manual Section 110.3.1.

Q19. If the post office goes through with its proposed changes next year of eliminating Saturday delivery and reducing service for first class mail so that it will take 3 days for letters now, will the beneficiary contact requirements change? If not, then beneficiaries will not have time to process their re-orders without running out of supplies which could be dangerous.

Answer: The DME MACs do not have any information regarding changes to the requirements based upon possible changes in USPS delivery schedules.

Q20. The proof of delivery via shipping service example shows only the city, state on the delivery service tracking slip. Is this acceptable as long as the provider delivery slip shows the full street delivery address? Or, does the delivery service tracking slip need to show the full street delivery address? We have been told in the past that the delivery service tracking slip must show the full street address.

Answer: Please see the response to question #15 in the proof of delivery section.

Q21. Does the proof of delivery slip need to have the beneficiary name typed on the form or is just the beneficiary signature alone sufficient?

Answer: The beneficiary's name and address should be provided on the form.

Q22. I thought if the patient had to stay past the 48 hours, you would need to get a letter from the facility stating why the patient required further stay and then it would extend the discharge date and the date of service vs. discharge date. Please clarify.

Answer: Per Chapter 4 of the CMS Program Integrity Manual: " supplier may deliver a DMEPOS item to a patient in a hospital or nursing facility for the purpose of fitting or training the patient in the proper use of the item. This may be done up to 2 days prior to the patient's anticipated discharge to their home." The PIM only allows for delivery up to two days prior to discharge. If there is an unexpected delay in discharge they may have to pick up and re deliver if the delay is prolonged (Undefined). A short delay would merely need a clear explanation in the record.

Q23. If there is equipment that is provided in anticipation of discharge, and the beneficiary was not released, there was mention of a pick-up and redelivery of the equipment on paper only. When this process is followed, will the redelivered piece of equipment be allowed to be billed as New, or will this now be used equipment, even though the beneficiary received a new piece of equipment initially.

Answer: Yes, the equipment is still considered new in this circumstance and can be billed with the NU modifier.

Q24. This is for a delivery of enteral feedings. At one time we were told that we could bill for a 2 month supply on one billing claim. In this webinar there was a slide that stated we

could only bill a month at a time. Please clarify which it is can we bill for 45 days on one claim.

Answer: For refills of surgical dressings, enteral and parenteral nutrients and supplies, immunosuppressive drugs, oral anti-cancer drugs, intravenous immune globulin, external infusion pump drugs and supplies, and oral antiemetic drugs, no more than a one-month quantity of supplies may be dispensed.
For all other refills that are provided on a recurring basis, including but not limited to DME accessories or supplies, nebulizer drugs, urological and ostomy supplies, suppliers may dispense no more than a three-month supply at any one time.

Q25. We are having issues with proof of delivery for patients in nursing homes. We submit a usage report with patient names and detailed information regarding the products, signed and dated by a representative from the facility that the products have been delivered. Can you please give more detailed information regarding the requirements to meet proof of delivery for patients in a nursing home?

Answer: Regardless of the method of delivery used, for those beneficiaries that are residents of a nursing facility, information from the nursing facility showing that the item(s) delivered for the beneficiary's use were actually provided to and used by the beneficiary must be available upon request.

Q26. When a patient is discharged from hospice to the home, do we need a new delivery ticket to continue billing for equipment that was previously in the patient's home prior to their stay in Hospice?

Answer: Please refer to the break in service rules found in your Jurisdictions Supplier Manual.

Q27. When a beneficiary picks up diabetic testing supplies at a retail location, the receipt is considered consent and proof of delivery. If the beneficiary does not have to provide testing frequency and supplies on hand, how is the retail location documenting they are not dispensing on a predetermined basis?
Answer: The supplier must still have access to documentation to support the beneficiary had less than a 10 day supply remaining upon delivery. The receipt acts as proof of refill request but it does not document the amount of supplies remaining. Suppliers can create their own form or means of documenting this information.

Q28. If a supplier provides a high strength lightweight wheelchair (K0004), does the delivery ticket need to include all of the items included in the base equipment package (i.e., swingaway footrests (K0045), since these items are not separately billed to Medicare?

Answer: No, it only needs to include items which are separately billable to Medicare.

Q29. If hospice reports a date of death for the beneficiary, the beneficiary did not die but was simply discharged from hospice, how can a supplier have this corrected?

Answer: The beneficiary must contact Social Security to have the records updated.

Q30. If DMEPOS items are shipped to a beneficiary and they advise the shipment was not received, a new shipment of replacement items are sent, do suppliers have Medicare recoup the payments from the original shipment and submit a new claim for the replacement shipment?

Answer: The supplier should refund the initial date of service and rebill with the new shipping date as the date of service.

Q31. When is it appropriate to send a self-addressed envelope to obtain a beneficiary's signature on shipped items?

Answer: Only if you are using return postage paid to meet proof of delivery requirements would this be required.

Q32. If a beneficiary cannot pick up their medications, can a minor come in to the pharmacy to pick-up?

Answer: No.

Q33. If a beneficiary is unable to sign proof of delivery must the individual who is signing advise why the beneficiary cannot sign?

Answer: It is not necessary to document why the patient is not signing but you must document the relationship.

Q34. What advice does Medicare have for a supplier that cannot obtain the pick-up slip from a previous supplier for a piece of rental equipment?

Answer: A pick-up slip is not required to begin billing the rental. Suppliers can contact the IVR to obtain the date last billed.

COMPETITIVE BIDDING

Get Ready for DMEPOS Competitive Bidding

The Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program Round 1 Recompete is coming soon.

Summer 2012:

- CMS announces bidding schedule
- CMS begins bidder education program
- Bidder registration period to obtain user ID and password begins

Fall 2012:

- Bidding begins

If you are a supplier interested in bidding, prepare now – don't wait.

Update Your Contact Information: The following contact information in your enrollment file at the National Supplier Clearinghouse (NSC) must be up-to-date before you register to bid. If your file is not current, you may experience delays and/or be unable to register and bid. If you want to bid, you will need to register even if you registered for a previous round. DMEPOS suppliers should review and update:

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

DMEPOS suppliers can update their enrollment file via the internet-based Provider Enrollment, Chain and Ownership System (PECOS) or by using the July 11, 2011 version of the CMS-855S enrollment form. Suppliers not currently using PECOS can learn more about this system by accessing the PECOS website or reviewing the PECOS fact sheet. Information and instructions on how to submit a change of information via the hardcopy CMS-855S enrollment form may be found in the Change of Information Guide on the NSC website.

Get Licensed: Contracts are only awarded to suppliers that have all required state licenses at the time of bidding. Therefore, if you are bidding for a product category in a competitive bidding area (CBA), you must ensure that all required state licenses for that product category are either on file with the NSC or received by the NSC by the close of bidding. Every location must be licensed in each state in which it provides services. If you have only one location and are bidding in a CBA that includes more than one state, you must have all required licenses for every state in that CBA. If you have more than one location and are bidding in a CBA that includes more than one state, your company must have all required licenses for the product category for every state in that CBA. Make sure that current versions of all required licenses are with the NSC before you bid. If any required licenses are expired or missing from your enrollment file, your bid(s) may be rejected.

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

More information about the DMEPOS accreditation requirements may be found on the CMS website.

The Competitive Bidding Implementation Contractor (CBIC) is the official information source for bidders. Stay informed – visit the CBIC website to subscribe to email updates and for the latest information about the DMEPOS Competitive Bidding Program.

October 2012 Quarterly Update for DMEPOS Competitive Bidding Program

MLN Matters® Number: MM7768
Related Change Request (CR) #: 7768
Related CR Release Date: May 18, 2012
Related CR Transmittal #: R2470CP
Effective Date: October 1, 2012
Implementation Date: October 1, 2012

Provider Types Affected
This MLN Matters® Article is intended for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) providers and suppliers submitting claims to Medicare Durable Medical Equipment Medicare Administrative Contractors (DME MACs) or Medicare Regional Home Health Intermediaries (RHHIs) for DMEPOS provided to Medicare beneficiaries.

What You Need to Know
This article is based on Change Request (CR) 7768, which provides the DMEPOS October 2012 quarterly update. Change Request (CR) 7768 provides specific instructions for implementing updates to the DMEPOS Round One Rebid CBP Healthcare Common Procedure Coding System (HCPCS), ZIP code, and Single Payment Amount files.

Background
Section 302 of the Medicare Modernization Act of 2003 (MMA) established requirements for a new competitive bidding program for certain DMEPOS. Under the program, DMEPOS suppliers compete to become Medicare contract suppliers by submitting bids to furnish certain items in competitive bidding areas, and the Centers for Medicare & Medicaid Services (CMS) awards contracts to enough suppliers to meet beneficiary demand for the bid items. The new, lower payment amounts resulting from the competition replace the Medicare DMEPOS fee schedule amounts for the bid items in these areas. All contract suppliers must comply with Medicare enrollment rules, be licensed and accredited, and meet financial standards. The program sets more appropriate payment amounts for DMEPOS items while ensuring continued access to quality items and services, which will result in reduced beneficiary out-of-pocket expenses and savings to taxpayers and the Medicare program.

Under the MMA, the DMEPOS Competitive Bidding Program was to be phased in so that competition under the program would first occur in 10 areas in 2007. As required by law, CMS conducted the Round One competition in 10 areas and for 10 DMEPOS product categories, and successfully implemented the program on July 1, 2008, for two weeks before the contracts were terminated by subsequent law.

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) temporarily delayed the program in 2008, terminated the Round One contracts that were in effect, and made other limited changes. As required by MIPPA, CMS conducted the supplier competition again in 2009, referring to it as the Round One Rebid.

The Round One Rebid Competitive Bidding Program was implemented on January 1, 2011, in Competitive Bidding Areas (CBA) defined by ZIP codes within nine of the largest Metropolitan Statistical Areas (MSAs). The CBAs in the Round One Rebid include: Charlotte-Gastonia-Concord, NC-SC; Cincinnati-Middletown, OH-KY-IN; Cleveland-Elyria-Mentor, OH; Dallas-Fort Worth-Arlington, TX; Kansas City, MO-KS; Miami-Fort Lauderdale-Pompano Beach, FL; Orlando- Kissimmee, FL; Pittsburgh, PA; and Riverside-San Bernardino-Ontario, CA.

The Round One Rebid competitive bidding product categories are: Oxygen Supplies and Equipment; Standard Power Wheelchairs, Scooters, and Related Accessories; Group 2 Complex Rehabilitative Power Wheelchairs and Related Accessories; Mail-Order Diabetic Supplies; Enteral Nutrients, Equipment and Supplies; Continuous Positive Airway Pressure (CPAP) Devices, Respiratory Assist Devices, and Related Supplies and Accessories; Hospital Beds and Related Accessories; Walkers and Related Accessories; and, in the Miami-Fort Lauderdale-Pompano Beach CBA only, Support Surfaces (Group 2 Mattresses and Overlays). A list of the Healthcare Common Procedure Coding System (HCPCS) codes that are included in each of the Round One Rebid product categories can be accessed by visiting the Competitive Bidding Implementation Contractor's (CBIC) website at http://www.dmecompetitivebid.com/palmetto/cbic.nsf on the Internet.

MIPPA required the competition for Round Two to occur in 2011 in 70 additional Metropolitan Statistical Areas (MSAs) and authorizes competition for national mail order items and services after 2010. The Affordable Care Act expands the number of Round Two MSAs from 70 to 91 areas and mandates that all areas of the country are subject either to DMEPOS competitive bidding or payment rate adjustments using competitively bid rates by 2016. You can find additional information on the DMEPOS Competitive Bidding Program at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSCompetitiveBid/index.html on the CMS website.

COMPETITIVE BIDDING CONT'D

Additional Information
The official instruction, CR7768, issued to your DME MAC and RHHI regarding this change, may be viewed at http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2470CP.pdf on the CMS website.

CONSOLIDATED BILLING

Correction to Skilled Nursing Facility Consolidated Billing File

When the 2012 Annual Update of Healthcare Common Procedure Code System (HCPCS) Codes for Skilled Nursing Facility Consolidated Billing was implemented in January 2012, the code J9033 was not included in file # 1-Physician Services. The Medicare claims processing system will update the edit associated with this file on October 1, 2012. The updated edit will be effective for services provided in 2012.

Providers may choose to refrain from billing for 2012 services with this code until the update is effective on October 1. However, if the service is billed and denied prior to October 1, contact your Medicare Administrative Contractor or carrier to have the claim reopened and reprocessed. If you have any additional questions, please contact your Medicare Administrative Contractor or carrier.

October Quarterly Update to 2012 Annual Update of HCPCS Codes Used for SNF Consolidated Billing Enforcement

MLN Matters® Number: MM7856 Revised
Related Change Request (CR) #: CR 7856
Related CR Release Date: June 27, 2012
Related CR Transmittal #: R2492CP
Effective Date: January 1, 2012
Implementation Date: October 1, 2012

Note: This article was revised on June 29, 2012, to reflect the revised CR7856, issued on June 27. The CR was revised to show that it also applied to providers/suppliers submitting claims to DME MACs. Also, the CR release date, transmittal number, and the Web address for accessing the CR have been revised. All other information remains the same.

Provider Types Affected
This MLN Matters® Article is intended for physicians, providers, and suppliers submitting claims to Medicare contractors (carriers and/or A/B Medicare Administrative Contractors (A/B MACs) and Durable Medical Equipment (DME) MACs) for Skilled Nursing Facility (SNF) services provided to Medicare beneficiaries.

Provider Action Needed
The changes noted in Change Request (CR) 7856, which apply to the "Medicare Claims Processing Manual," Chapter 6 (SNF Inpatient Part A Billing and SNF Consolidated Billing), Section 10.1 (Consolidated Billing Requirement for SNFs), allow for correct processing of claims under the Skilled Nursing Facility Consolidated Billing provisions. For the October 2012 update, the only change is the addition of Healthcare Common Procedure Coding System (HCPCS) code J9033 (Injection, bendamustine hcl, 1 mg) to the File 1 Coding List for SNF Consolidated Billing (CB) for dates of service on or after January 1, 2012. Please note that, when brought to their attention, your Medicare contractor will re-open and re-process claims for J9033 with dates of service on or after January 1, 2012, that have been previously denied prior to the implementation of CR7856.

Background
Section 1888 of the Social Security Act (see http://www.ssa.gov/OP_Home/ssact/title18/1888.htm) codifies the Skilled Nursing Facility Prospective Payment System (SNF PPS) and Consolidated Billing (CB); and the Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of HCPCS codes that are subject to the CB provision of the SNF PPS. These updates (which do not add any additional services) are required by changes to the coding system, not because the services subject to SNF CB are being redefined. Other regulatory changes beyond code list updates will be noted when, and if, they occur.

To assure proper payment in all settings, Medicare systems must edit for services provided to SNF beneficiaries that are both included and excluded from SNF CB. You should be aware that Medicare will not pay any providers (other than SNFs) for services included in SNF CB that appear on claims submitted to Medicare Carriers, A/B MACs, and Durable Medical Equipment MACs (DME MACs). However services excluded from SNF PPS and CB may be paid to providers

CONSOLIDATED BILLING CONT'D

(other than SNFs) for beneficiaries, even when in a SNF stay.

SNF CB applies to physical and occupational therapies and speech-language pathology services whenever they are furnished to a SNF resident, regardless of whether Part A covers the stay; but applies to non-therapy services only when the services are furnished to a SNF resident during a covered Part A stay.

Additional Information
The official instruction, CR7856 issued to your carrier, DME MAC, or A/B MAC regarding this change may be viewed at http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2492CP.pdf on the CMS website.

COVERAGE

LCD and Policy Article Revisions Summary for August 2012

Outlined below are the principal changes to the DME MAC Local Coverage Determination (LCD) and Policy Article (PA) that has been revised and posted. Please review the entire LCD and related PA for complete information.

Tracheostomy Care Supplies
LCD
Revision Effective Date: 08/01/2012
INDICATIONS AND LIMITATIONS OF COVERAGE:
Revised: Order requirements language to specify a "detailed written order"
Added: Usual maximum quantities of supplies
Added: Refill Requirements (effective 08/02/2011)
HCPCS CODES AND MODIFIERS:
Added: A4364, A4402, A4456, A4481, A4623, A5120, A7501–A7509, A7520–A7524, A7526 and A7527
DOCUMENTATION REQUIREMENTS:
(Note: The effective date above is not applicable to this section. These revised and added requirements are existing Medicare requirements which are now included in the LCD for easy reference)
Added: Prescription (Order) Requirements, Medical Record Information and Policy Specific Documentation Requirements

POLICY ARTICLE
Revision Effective Date: 08/01/2012
NONMEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: Preamble and SSA reference
Added: Benefit category statement
Clarified: Tracheostomy care kits language
CODING GUIDELINES:
Added: A7526 and Heat/Moisture Exchangers

Note: The information contained in this article is only a summary of revisions to the LCD and Policy Article. For complete information on any topic, you must review the LCD and/or Policy Article.

LCD and Policy Article Revisions Summary for July 6, 2012

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

Ankle-Foot/Knee-Ankle-Foot Orthoses
Policy Article
Revision Effective Date: 07/01/2012 (July Publication)
CODING GUIDELINES:
Deleted: Coding verification for codes L1930, L1932, L1940, L1960, L1970 and L1971

Ostomy Supplies
LCD
Revision History Effective Date: 01/01/2012 (July Publication)
INDICATIONS AND LIMITATIONS OF COVERAGE AND MEDICAL NECESSITY:

COVERAGE CONT'D

Revised: Order requirements language to specify a "detailed written order" (omitted in error from the last revision)
Added: Reference to Policy Article for information about the statutory coverage requirements for ostomy supplies
Added: Refill requirements per PIM 5.2.6 (effective 08/02/2011 per CR7452)
Added: Reference to information in Tracheostomy Care Supplies LCD
Added: POLICY SPECIFIC DOCUMENTATION REQUIREMENTS

Oral Appliances for Obstructive Sleep Apnea
LCD
Revision Effective Date: 07/01/2012
INDICATIONS AND LIMITATIONS OF COVERAGE:
Revised: Denial Statement for tongue-retaining devices
Clarified: Projection of AHI/RDI calculations based upon less than 2 hours of testing time
Added: ACHC as accreditation entity for personnel interpreting sleep testing
DOCUMENTATION REQUIREMENTS:
(Note: The effective date above is not applicable to this section. These revised and added requirements are existing Medicare requirements which are now included in the LCD for easy reference)
Revised: Prescription requirements
Added: General medical record information requirements and proof of delivery requirements

Policy Article

Revision Effective Date: 07/01/2012
NONMEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Revised: Section describing the general dental exclusion
CODING GUIDELINES
Revised: Coding for tongue retaining devices
Revised: Coding for E0486

Note: The information contained in this article is only a summary of revisions to LCDs and Policy Articles. For complete information on any topic, you must review the LCD and/or Policy Article.

DRUGS/BIOLOGICALS

Widespread Prepayment Review for Immunosuppressive Drugs – Edit Effectiveness for 3rd Quarter

The Jurisdiction D DME MAC Medical Review Department is conducting a widespread complex review of HCPCS codes J7507, J7517, J7518 and J7520 and the third quarter edit effectiveness results from March 2012 through June 2012 are as follows:

The results of the review, for item J7507, identified 2,648 claims of which 2,186 were denied. A total of 1,398 claims were denied for no response to the additional documentation request. This resulted in an overall error rate of 85%.

The result of the review, for item J7517, identified 1,707 claims of which 1,383 were denied. A total of 916 claims were denied for no response to the additional documentation request. This resulted in an overall error rate of 81%.

The result of the review, for item J7518, identified 666 claims of which 564 were denied. A total of 364 claims were denied for no response to the additional documentation request. This resulted in an overall error rate of 85%.

The result of the review, for item J7520, identified 240 claims of which 194 were denied. A total of 120 claims were denied for no response to the additional documentation request. This resulted in an overall error rate of 79%.

The following are the top reasons for denial:

a. Requested documentation was not provided within the allotted time frame as referenced in the Medicare guidelines
b. No refill request documentation provided
c. No valid written order
    a. No written order submitted with the documentation
    b Insufficient or incomplete order

d. No proof of delivery

a. No proof of delivery submitted with the documentation

b. Invalid proof of delivery

An in-depth explanation of the denial reasons are as follows:

A. A large number of suppliers failed to respond to our request for records.

Suppliers are in violation of Supplier Standard #28 when, upon request, they fail to provide requested documentation to a Medicare contractor. Medicare regulations (42 C.F.R §424.516[f]) stipulate that a supplier is required to maintain documentation for seven years from the date of service and, upon the request of CMS or a Medicare contractor, provide access to that documentation. Therefore, the consequences of failure to provide records may not only be a claim denial but also referral to the NSC.

B. For items that the beneficiary obtains in-person at a retail store, the signed delivery slip or a copy of the itemized sales receipt is sufficient documentation of a request for refill. For items that are delivered to the beneficiary, documentation of a request for refill must be either a written document received from the beneficiary or a contemporaneous written record of a phone conversation/contact between the supplier and beneficiary. The refill request must occur and be documented before shipment. A retrospective attestation statement by the supplier or beneficiary is not sufficient. The refill record must include:

a. Beneficiary's name or authorized representative if different than the beneficiary

b. A description of each item that is being requested

c. Date of refill request

d. Information documenting that the beneficiary's remaining supply is approaching exhaustion by the expected delivery date

C. An order for the drug(s) must be signed and dated by the treating physician, kept on file by the supplier, and made available upon request. Items billed before a signed and dated order has been received by the supplier must be submitted with an EY modifier added to each affected HCPCS code.

Suppliers are required to maintain proof of delivery documentation in their files. Documentation must be maintained in the supplier's files for seven years.

Proof of delivery is required in order to verify that the beneficiary received the DMEPOS. Proof of delivery is one of the supplier standards as noted in 42 CFR, 424.57(12). Proof of delivery documentation must be made available to the DME MAC, DME PSC, and ZPIC upon request.

The date of signature on the delivery slip must be the date that the DMEPOS item was received by the beneficiary or designee. In instances where the supplies are delivered directly by the supplier, the date the beneficiary received the DMEPOS supply shall be the date of service on the claim.

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Immunosuppressive Drugs Local Coverage Determination (LCD) L68 and Policy Article A25366. Suppliers can also review the Immunosuppressive Drugs documentation checklist on the NAS website at https://www.noridianmedicare.com/dme/coverage/checklists.html.

Information about probe/error validation reviews may be found in CMS Publication 100-8, Program Integrity Manual (PIM), Chapter 3 located at: http://www.cms.gov/manuals/downloads/pim83c03.pdf

EDUCATIONAL

2012 Ask the Contractor Teleconferences

If you have a question on your mind and are not sure who to ask, the Ask the Contractor Teleconferences (ACTs) are your opportunity to speak directly to NAS DME. Knowledgeable NAS staff representing a variety of functions will be available to answer your questions. If we cannot answer your question during the teleconference, we will research the issue and include the answer in the posted minutes.

Upcoming 2012 ACT: 3 p.m. CT

Date	Topic	Call Information	Confirmation Number
10/25/12	General	(800) 288-8976	231729

After placing the call for the ACT, suppliers need to provide the following:

- Conference Name: DME Jurisdiction D Ask the Contractor Teleconference
- Name
- Name of the organization represented
- State

MLN Updates

- **"Negative Pressure Wound Therapy Interpretive Guidelines" MLN Matters® Article Released**
  MLN Matters® Special Edition Article #SE1222, "Negative Pressure Wound Therapy Interpretive Guidelines" has been released and is now available in downloadable format. This article is designed to provide education on CMS-approved guidelines that accrediting organizations can use to accredit suppliers that provide Negative Pressure Wound Therapy (NPWT) equipment to Medicare beneficiaries. It includes a list of relevant local coverage determinations and standards to help DMEPOS suppliers comply with standards and guidelines for NPWT equipment.
- "**Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Quality Standards" Booklet Revised**
  Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Quality Standards Booklet (ICN 905700) has been revised and is now available in downloadable and hard copy format. This booklet is designed to provide education on durable medical equipment, prosthetics, orthotics and supplies (DMEPOS). It includes DMEPOS quality standards as well as information on Medicare deemed Accreditation Organizations (AOs) for DMEPOS suppliers.
- **"Medicare Fraud & Abuse: Prevention, Detection, and Reporting" Web-Based Training — New**
  This Web-Based Training (WBT) course is designed to provide education on how to identify Medicare fraud and abuse and understand the related laws and penalties. It includes information on what entities and safeguards protect against and detect fraud and abuse, as well as how you can help prevent and report it. Continuing education credit is available for this course. To access a new or revised WBT course, visit the MLN Products webpage and click on "Web-Based Training (WBT) Courses" under "Related Links" at the bottom of the webpage.
- **"MLN Products Catalog" Revised**
  The MLN has revised the MLN Products Catalog. The May 2012 MLN Products Catalog is a free interactive downloadable document that links you to online versions of MLN products or the product ordering page for hardcopy materials. Once you have opened the catalog, you may either click on the title of an individual product or on "Formats Available."
- **"Publications for Medicare Beneficiaries" Fact Sheet Revised**
  The Publications for Medicare Beneficiaries Fact Sheet (ICN905183) has been revised and is now available in downloadable format. This fact sheet is designed to provide education on the variety of beneficiary-related publications available to assist providers in answering patients' questions. It includes a list of products with information you can print out and provide to your Medicare beneficiaries.
- **"Medicare Fee-For-Service (FFS) Physicians and Non-Physician Practitioners: Protecting Your Privacy – Protecting Your Medicare Enrollment Record" Fact Sheet — Revised**
  The Medicare Fee-For-Service (FFS) Physicians and Non-Physician Practitioners: Protecting Your Privacy - Protecting Your Medicare Enrollment Record Fact Sheet (ICN 903765) has been revised and is now available in downloadable format. This fact sheet is designed to provide education on how to ensure Medicare enrollment records

are up-to-date and secure. It includes information on the actions physicians and non-physician practitioners should take to protect their Medicare enrollment information.

- **"Internet-based Provider Enrollment, Chain and Ownership System (PECOS) Contact Information" Fact Sheet — Revised**
  The Internet-based Provider Enrollment, Chain and Ownership System (PECOS) Contact Information Fact Sheet (ICN 903766) has been revised and is now available in downloadable format. This fact sheet is designed to provide contact information for technical assistance with Internet-based PECOS. It includes a list of contacts and other resources.
- **"MLN Guided Pathways to Medicare Resources" - Revised**
  The MLN Guided Pathways to Medicare Resources have been revised and are now available in downloadable format. The MLN Guided Pathways curricula contain brief descriptions and links to many CMS resources. These products are designed to allow users to quickly and easily scan or search the resources and click on topics of interest. They are also designed so you can move directly to a specific section by using bookmarks or the Table of Contents.
- **"How to Protect Your Identify Using the Provider Enrollment, Chain and Ownership System (PECOS)" Fact Sheet - Revised**
  The "How to Protect Your Identify Using the Provider Enrollment, Chain and Ownership System (PECOS)" Fact Sheet (ICN 905103) has been revised and is now available in downloadable format. This fact sheet is designed to provide education on identity protection when using Internet-based PECOS. It includes step-by-step instructions on how providers can protect their identity while using Internet-based PECOS.
- **"Medicare Secondary Payer for Provider, Physician, and Other Supplier Billing Staff" Fact Sheet - Revised**
  The "Medicare Secondary Payer for Provider, Physician, and Other Supplier Billing Staff" Fact Sheet, (ICN 006903) was revised and is now available in downloadable format. This fact sheet is designed to provide education on the Medicare Secondary Payer provisions. It includes information on Medicare Secondary Payer (MSP) basics, common situations when Medicare may pay first or second, Medicare conditional payments, and the role of the Coordination of Benefits Contractor.
- **"Medicare Quarterly Provider Compliance Newsletter [Volume 2, Issue 4]" Educational Tool - New**
  The "Medicare Quarterly Provider Compliance Newsletter [Volume 2, Issue 4]" Educational Tool (ICN 908064) was released and is now available in downloadable format. This educational tool is designed to provide education on how to avoid common billing errors and other erroneous activities when dealing with the Medicare Program. It highlights the top issues of the particular Quarter. Visit the Medicare Quarterly Provider Compliance Newsletter Archive to download, print, and search an index of previously-issued newsletters.
- **New MLN Provider Compliance Fast Fact**
  A new fast fact is now available on the MLN Provider Compliance page. This web page provides the latest Medicare Learning Network® (MLN) products designed to help Medicare Fee-For-Service providers understand – and avoid – common billing errors and other improper activities. A list of previous fast facts is available on the MLN Provider Compliance Fast Fact Archive page. Please bookmark this page and check back often as a new fast fact is added each month.
- **"Advance Beneficiary Notice of Noncoverage (ABN) Part A and Part B" – Revised**
  The "Advance Beneficiary Notice of Noncoverage (ABN) Part a and Part B" booklet has been revised and is now available in downloadable format. This booklet is designed to provide education on the Advanced Beneficiary Notice (ABN). It includes information on when an ABN should be used and how it should be completed.
- **"The Basics of Internet-based Provider Enrollment, Chain and Ownership System (PECOS) for Physicians and Non-Physician Practitioners" Fact Sheet – Revised**
  "The Basics of Internet-based Provider Enrollment, Chain and Ownership System (PECOS) for Physicians and Non-Physician Practitioners" Fact Sheet (ICN 903764) has been revised and is now available in downloadable format. This fact sheet is designed to provide education on how physician and non-physician practitioners should enroll in the Medicare Program and maintain their enrollment information using Internet-based PECOS. It includes information on how to complete an enrollment application using Internet-based PECOS and a list of frequently asked questions and resources.
- **MLN Matters® Search Tips**
  Looking for the latest new and revised MLN Matters® articles? The Medicare Learning Network® offers several ways to search and quickly find articles of interest to you:

- MLN Matters® Index: a list of common keywords and phrases contained within MLN Matters® articles. Each index is organized by year with the ability to search by specific keywords and topics. Most indices link directly to the related article(s). For a list of available indices, visit the MLN Matters® Articles web page and scroll down to the "Downloads" section.
- MLN Matters® Dynamic Lists: an archive of previous and current articles organized by year with the ability to search by keyword, transmittal number, subject, article number, and release date. To view and search articles, select the desired year from the left column on the MLN Matters® Articles web page.
- MLN Matters® *Electronic Mailing List*: This free electronic notification service sends an email message when new and revised MLN Matters® articles are released. For more information, including how to subscribe to the service, view the How to Sign Up for MLN Matters® document. You can also view and search an archive of previous messages here.

- **Submit Feedback on MLN Products and Services**
  The Medicare Learning Network® (MLN) is interested in what you have to say! Visit the MLN Opinion web page to submit an anonymous evaluation about specific MLN products and resources. Your feedback is important in developing and improving future MLN products and services.
- **Get Connected with the Medicare Learning Network!**
  Want to stay informed about the latest new and revised Medicare Learning Network® (MLN) products and services? Subscribe to the MLN Educational Products electronic mailing list! For more information about the MLN and how to register for this service, view the "The Medicare Learning Network® -- Get Connected!" document to learn how to start receiving updates immediately!

New Continuing Education Associations Now Accepting Medicare Learning Network® Courses

The Medicare Learning Network (MLN) is happy to announce that the latest continuing education associations to accept MLN courses are the National Academy of Ambulance Coders (NAAC) and the American Association of Medical Assistants (AAMA). NAAC and AAMA join the American Association of Professional Coders (AAPC), the American Medical Billing Association (AMBA), and the Medical Association of Billers (MAB).

For more information about continuing education associations that accept MLN courses, visit the MLN Educational Web Guides website.

If the association you belong to accepts outside credit sources and is not on the list, you should contact them to see if they are interested in working with the MLN. If they are interested, the association should e-mail CE_Issues@cms.hhs.gov.

ENDEAVOR

Overpayment Inquiries – Tips for Successful Endeavor Supplier Portal Inquiries

The NAS supplier portal, Endeavor, allows overpayment inquiries by collecting the National Provider Identifier (NPI) and Financial Control Number (FCN). NAS identified that approximately 29 percent of Endeavor overpayment inquiries have resulted in error messages due to two data entry reasons. First, the NPI being selected does not match the NPI associated with the FCN. The second reason for an error is due to the FCN that was entered was invalid (missing a digit, transposed, not issued by NAS). Suppliers should ensure each 14-digit FCN being entered is valid per the remittance advice and/or overpayment letter.

Additional information regarding the overpayment inquiry feature and the anticipated results from Endeavor is accessible in a previously published article, https://www.noridianmedicare.com/dme/news/docs/2012/05_may/overpayment_information_available_in_endeavor.html.

ENTERAL NUTRITION

HCPCS B4035 and B9002 – Notification of Prepayment Review

NAS Jurisdiction D DME MAC Medical Review will be initiating a widespread prepayment review of claims for HCPCS codes B4035 (Enteral feeding supply kit; pump fed, per day), and B9002 (Enteral nutrition infusion pump with alarm). This review is being initiated based on the results of Comprehensive Error Rate Testing (CERT) analysis.

In order to evaluate compliance with Medicare coverage and coding rules, all suppliers billing Jurisdiction D for HCPCS codes B4035 and B9002 are subject to this review. Suppliers of the selected claims will receive an *Additional Documentation Request* (ADR) letter asking for specific information to determine if the item billed complies with the existing reasonable and necessary criteria. Failure to supply the requested information within 45 days of the date on the letter will result in the claim being denied as not medically necessary. The ADR letter will provide instruction for submitting documentation.

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Enteral Nutrition Local Coverage Determination (LCD) L11568 and Policy Article A25361. Suppliers can find additional Enteral Nutrition resources on the NAS website at: https://www.noridianmedicare.com/dme/news/enteral_nutrition.html

Information about prepay reviews may be found in CMS Publication 100-8, Program Integrity Manual (PIM), Chapter 3 located at: http://www.cms.hhs.gov/manuals/downloads/pim83c03.pdf

HCPCS B4154 – Notification of Prepayment Review

NAS Jurisdiction D DME MAC Medical Review will be initiating a widespread prepayment probe review of claims for HCPCS codes B4154 (Enteral formula, nutritionally complete, for special metabolic needs, exludes inherited disease of metabolism, includes altered composition of proteins, fats, carbohydrates, vitamins, and/or minerals, may include fiber, administered through an enteral feeding tube, 100 calories=1 unit). Widespread reviews are used to determine the extent of potential problem areas across multiple suppliers.

In order to evaluate compliance with Medicare coverage and coding rules, all suppliers billing Jurisdiction D for HCPCS code B4154 are subject to this review. Suppliers of the selected claims will receive an Additional Documentation Request (ADR) letter asking for specific information to determine if the item billed complies with the existing reasonable and necessary criteria. Failure to supply the requested information within 45 days of the date on the letter will result in the claim being denied as not medically necessary. The ADR letter will provide instruction for submitting documentation.

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Enteral Nutrition Local Coverage Determination (LCD) L11568 and Policy Article A25361. Suppliers can find additional Enteral Nutrition resources on the NAS website at: https://www.noridianmedicare.com/dme/news/enteral_nutrition.html

Information about prepay reviews may be found in CMS Publication 100-8, Program Integrity Manual (PIM), Chapter 3 located at: http://www.cms.hhs.gov/manuals/downloads/pim83c03.pdf

FRAUD AND ABUSE

Obama Administration Announces Ground-Breaking Public-Private Partnership to Prevent Health Care Fraud

On July 26, HHS Secretary Kathleen Sebelius and Attorney General Eric Holder announced the launch of a ground-breaking partnership among the federal government, State officials, several leading private health insurance organizations, and other health care anti-fraud groups to prevent health care fraud. This voluntary, collaborative arrangement uniting public and private organizations is the next step in the Obama administration's efforts to combat health care fraud and safeguard health care dollars to better protect taxpayers and consumers.

The new partnership is designed to share information and best practices in order to improve detection and prevent payment of fraudulent health care billings. Its goal is to reveal and halt scams that cut across a number of public and private payers. The partnership will enable those on the front lines of industry anti-fraud efforts to share their insights more easily with investigators, prosecutors, policymakers and other stakeholders. It will help law enforcement officials to more effectively identify and prevent suspicious activities, better protect patients' confidential information and use the full range of tools and authorities provided by the Affordable Care Act and other essential statutes to combat and prosecute illegal actions.

One innovative objective of the partnership is to share information on specific schemes, utilized billing codes and geographical fraud hotspots so that action can be taken to prevent losses to both government and private health plans before they occur. Another potential goal of the partnership is the ability to spot and stop payments billed to different insurers for care delivered to the same patient on the same day in two different cities. A potential long-range goal of the partnership is to use sophisticated technology and analytics on industry-wide healthcare data to predict and detect health care fraud schemes.

The Executive Board, the Data Analysis and Review Committee, and the Information Sharing Committee will hold their first meeting in September. Until then, several public-private working groups will continue to meet to finalize the operational structure of the partnership and develop its draft initial work plan.

- The partnership builds on existing tools provided by the Affordable Care Act, resulting in:
- Tougher sentences for people convicted of health care fraud. Criminals will receive 20 to 50 percent longer sentences for crimes that involve more than $1 million in losses
- Enhanced screenings of Medicare and Medicaid providers and suppliers to keep fraudsters out of the program
- Suspended payments to providers and suppliers engaged in suspected fraudulent activity

The administration's efforts to date have already resulted in a record-breaking $10.7 billion in recoveries of health care fraud over the last three years. For more information on this partnership and the Obama administration's work to combat health care fraud, please visit the Stop Medicare Fraud web page.

Full text of this excerpted CMS press release (issued July 26).

Two New Fraud and Abuse CME Modules Posted on Medscape

In early June, Medscape posted two new CME modules entitled, "Reducing Medicare and Medicaid Fraud and Abuse: Protecting Practices and Patients" and "How CMS Is Fighting Fraud: Major Program Integrity Initiatives." These modules highlight efforts by CMS to fight fraud and abuse and how health care professionals can be part of those efforts.

GLUCOSE MONITORS

Glucose Monitors LCD – Retracted

The Glucose Monitors local coverage determination (LCD), with an effective date for dates of service on or after July 1, 2012, is being withdrawn. The existing Glucose Monitors LCD will remain in effect.

Widespread Prepayment Target Review for Diabetic Supplies – Edit Effectiveness for 1st Quarter

The Jurisdiction D DME MAC Medical Review Department is conducting a widespread complex review of HCPCS code A4253KS (Blood glucose test or reagent strips for home blood glucose monitor, per 50 strips) and the first quarter edit effectiveness results from April 2012 through June 2012 are as follows:

This review identified 1938 claims of which 1903 were denied. A total of 551 claims were denied for no response to the additional documentation requested. This resulted in an overall error rate of 95%. Due to this high error rate, NAS will continue with the widespread target review.

The following are the top reasons for denial:

- Requested documentation was not provided within the allotted time frame as referenced in the Medicare guidelines
- Invalid or no beneficiary evidence of exhaustion
- Documentation submitted did not support testing frequency above utilization guidelines
- Claims were submitted with incorrect modifier

An in-depth explanation of the denial reasons are as follows:

a. A large number of suppliers failed to respond to our request for records. Suppliers are in violation of Supplier Standard #28 when, upon request, they fail to provide requested documentation to a Medicare contractor. Medicare regulations (42 C.F.R §424.516[f]) stipulate that a supplier is required to maintain documentation for seven years from the date of service and, upon the request of CMS or a Medicare contractor, provide access to that documentation. Therefore, the consequences of failure to provide records may not only be a claim denial but also referral to the NSC.

b. For items that the beneficiary obtains in-person at a retail store, the signed delivery slip or a copy of the itemized sales receipt is sufficient documentation of a request for refill per PIM 5.2.5-6. For items that are delivered to the beneficiary, documentation of a request for refill must be either a written document received from the beneficiary or a contemporaneous written record of a phone conversation/contact between the supplier and beneficiary. The refill request must occur and be documented before shipment. A retrospective attestation statement by the supplier or beneficiary is not sufficient. The refill record must include:

    a. Beneficiary's name or authorized representative if different than the beneficiary

    b. A description of each item that is being requested

    c. Date of refill request

    d. Information documentation that the beneficiary's remaining supply is approaching exhaustion by the expected delivery date.

c. There must be documentation from the treating physician in the medical record the specific reason for the additional materials when ordering a frequency of testing that exceeds the utilization guidelines. The treating physician must see the patient and evaluate their diabetes control within 6 months prior to ordering quantities that exceed the utilization guidelines. Also, there must be documentation that adequately supports that the patient is actually testing at a frequency that corroborates with the quantity of supplies that have been dispensed. If the patient is regularly using quantities of supplies that exceed the utilization guidelines, new documentation must be present at least every six months.

d. If the patient is being treated with insulin injections, the KX modifier must be added to the code for the monitor and each related supply on every claim submitted. The KX modifier must not be used for a patient who is not treated with insulin injections, and then the KS modifier is to be used.

To be eligible for coverage of home blood glucose monitor and related accessories and supplies, the patient must meet the criteria as noted in LCD L196 and Policy Article A33673, which can be found on our website: https://www.noridianmedicare.com/dme/coverage/lcd.html.

GLUCOSE MONITORS CONT'D

It is important for suppliers to be familiar with the documentation requirements outlined in the Glucose Monitor LCD and Policy Article. Please ensure when submitting additional documentation, that all supporting medical necessity documentation is provided. Supplier responses should also be submitted timely.

The following references were used in the medical review of these claims and can be accessed on our NAS DME website at https://www.noridianmedicare.com/dme/:

- Glucose Monitors LCD (L196)
- Glucose Monitors Policy Article (A33673)
- Home Blood Glucose Monitors (National Coverage Determination 40.20)
- Supplier Manual
- Program Integrity Manual: http://www.cms.gov/manuals/downloads/pim83c04.pdf

In addition, there are other educational resources that can be found on our website: https://www.noridianmedicare.com/dme/news/glucose_monitors_testing_supplies.html

ICD-10

2013 ICD-10 CM Codes and Mapping Files Now Available

The 2013 ICD-10-CM codes and mapping files are now posted on the 2013 ICD-10-CM and GEMs web page. The files contain information on the new diagnosis coding system, ICD-10-CM, that is being developed as a replacement for ICD-9-CM, Volumes 1 and 2. This posting includes the following 2013 files:

- Tabular and index of ICD-10-CM
- Addenda (changes since the 2012 version)
- Complete list of ICD-10-CM code titles – long and abbreviated
- General Equivalence Mappings
- Reimbursement Mappings
- Duplicate ICD-9-CM and ICD-10-CM codes

As a reminder, CMS recently posted the 2013 ICD-10-PCS files to the 2013 ICD-10-PCS and GEMs web page. CMS also posted the ICD-10 Medicare Code Editor v 29 (MCE v29 to be used with v29 Definitions Manual) on the ICD-10 MS-DRG Conversion Project web page, along with additional files for the ICD-10 MS-DRG conversion project.

How to Prepare for Documentation Changes and Improvements with ICD-10

Although the final rule on the proposed ICD-10 deadline change has not been published yet, it is important to continue planning for the transition. ICD-10 will require an increased granularity and specificity in documentation of patient encounters. This change will mean that providers and payers need to adjust how they document patient visits but will create more detailed data that can be used to improve patient care. More specific code sets can also assist providers avoid delays in reimbursement payments by identifying why certain claims are being rejected or denied by payers.

You will need to prepare for these changes in clinical documentation by taking certain steps:

1. **Inventory Systems and Identify Discrepancies**: You should review your systems that currently use ICD-9 in order to identify areas in your revenue cycle, reimbursement rates, health information management, electronic medical records, and clinical systems that will eventually use ICD-10. These systems will be affected by the increased specificity of documentation as well as the increase in number of codes used in ICD-10. Your systems inventory will need to evaluate any potential gaps in clinical conditions or work flow processes that could be affected by increased documentation. Once you have identified any discrepancies, you can update and modify your systems and processes prior to transitioning to the new code sets. This will save your organization time by finding incomplete or non-specific data and ensuring that they do not cause a delay with coding and billing when you finalize implementing ICD-10.
2. **Evaluate Current Software Systems**: As you conduct your systems inventory, you may realize that some of your systems have become out-of-date or are redundant. You will need to determine if it is more cost-effective and efficient to upgrade these systems or centralize and replace them before ICD-10 implementation.

3. **Train and Educate Staff**: Your organization should identify staff members, from providers to coders, who currently use ICD-9 codes. Staff who will now be using ICD-10 will need training to become familiar with the increased documentation standards necessary with the new code sets. Training will help staff members become comfortable with both the heightened specificity and increased number of code sets that they will be using frequently.
4. **Test the Documentation Process**: Finally, your organization will need to test each stage of the new documentation process in a trial setting. Staff members should simulate a typical patient encounter in its entirety to ensure that data is being documented thoroughly and consistently. This will also help identify any areas that still require improvement in the coding process.

Keep Up to Date on ICD-10
Please visit the ICD-10 website for the latest news and resources to help you prepare.

Medscape ICD-10 Video Lectures Have Launched

In June, three CME modules regarding ICD-10 implementation were posted to Medscape:

- "ICD-10: A Guide for Small and Medium Practices"
- "ICD-10: A Guide for Large Practices"
- "Transition to ICD-10: Getting Started"

Steps to Assess How ICD-10 Transition will Affect your Organization

Although the final rule on the proposed ICD-10 deadline change has yet to be published, it is important to continue planning for the transition to ICD-10. The switch to the new code set will affect every aspect of how your organization provides care, from registration and referrals, to software/hardware upgrades and clinical documentation.

A critical step in planning for the transition is to conduct an impact assessment of how the new code sets will affect your organization. Your impact assessment should include:

- **Documentation Changes:** You will need to consider the increased specificity of ICD-10 codes compared to ICD-9 codes, and ensure that patient encounters are documented with appropriately comprehensive clinical descriptions. You should:
  - Train staff to accommodate the substantial increase and specificity in code sets
  - Consider physician workflow and patient volume changes
  - Revise forms, documents, and encounter forms to reflect ICD-10 codes
  - Evaluate processes for ordering and reporting lab/diagnostic services to health plans
- **Reimbursement Structures:** You should coordinate with payers on contract negotiations and new policies that reflect the expanded code sets, since they can affect reimbursement schedules.
- **Systems and Vendor Contracts:** Ensure your vendors can accommodate your ICD-10 needs. Find out how and when your vendor plans to update your existing systems. You will need to review existing and new vendor contracts and to evaluate vendor offerings and capabilities against your organization's expectations. Work with your vendors to draft a schedule for needed tasks.
- **Business Practices:** Once you have implemented ICD-10, you will need to determine how the new codes affect your processes for referrals, authorizations/pre-certifications, patient intake, physician orders, and patient encounters.
- **Testing:** Work with your vendors to determine the amount of time needed for testing and schedule accordingly.

ICD-10 will affect nearly all areas of your practice, but with a thorough impact assessment, you can keep your day-to-day activities running smoothly while you transition to ICD-10.

Keep Up to Date on ICD-10
Please visit the ICD-10 website for the latest news and resources to help you prepare.

NAS DME Jurisdiction D

Interactive Voice Response (IVR) At-A-Glance

1-877-320-0390 NPI _____ PTAN_____ Last 5 Digits of TIN____

NORIDIAN® Administrative Services LLC

Hours of Operation

CSR Monday-Friday: 8:30 a.m. to 6 p.m. CT for complex inquiries that cannot be addressed through the IVR or the online supplier portal, Endeavor.
IVR Monday-Friday: 6 a.m. to 8 p.m. CT for inquiries described in the menu options below. Eligibility inquiries available 24/7 with some exceptions due to CMS scheduled maintenance.

Main Menu: Options: Say or Press
Claim Status (1) Eligibility (2) Pricing (3) Same/Similar (4) Duplicate Remittance (5) Provider Enrollment (6)
Financial (7) Appeals (8) Questions (9) Customer Service Rep. (0) **Note: ◯ Indicates the key that can be used on the touch pad.**

1 Claim Status

Information needed:
- NPI, PTAN, last 5 digits of TIN
- Patient Medicare number
- Patient first name, last name
- Date of service (DOS)

Claim Status provides:
- Claim status, allowed and payment amount for a paid claim, date of payment/denial, check number, submitted amount for the denied claim.
- Deductible information for the DOS given

Detailed Information Provides:
- Paid Claim: CCN and number of line items, DOS, submitted amount, allowed amount, HCPCS, and diagnosis code
- Denied Claim: CCN, DOS and reason for denial

Overlapping Claim Denial provides:
- To and from DOS on the overlapping line items, allowed amount, number of units billed, supplier name, and phone number

2 Eligibility

Information needed:
- NPI, PTAN, last 5 of TIN
- Patient Medicare number
- Patient first name, last name
- Patient Date of Birth
- DOS

Eligibility provides:
- Part A & B effective dates, if the Part B deductible has been met or if not the amount remaining, the new Medicare number if applicable, deceased notification, HMO, Home Health, and Hospice information.

Note: After 6 p.m. the first initial of the patient's first name and first six letters of the last name are required with a 3 key combination.

3 Pricing

Information needed:
- NPI, PTAN, last 5 digits of TIN
- HCPCS
- Modifier
- DOS
- State
- If no modifer, state "No modifier" or press (1)

Pricing provides:
Fee schedule allowed amount for the quarter requested

4 Same or Similar

Information needed:
- NPI, PTAN, last 5 digits of TIN
- Patient Medicare Number
- Patient First Name, Last Name
- Patient Date of Birth
- HCPCS & modifier used, if any

Oxygen provides:
Number of rental months paid on HCPCS entered or any similar HCPCS

Same or Similar provides:
- Any same or similar HCPCS code and the modifier
- Initial date on file
- Recertification or revision date (if applicable)
- Last day the item was billed
- Name of the supplier
- Supplier's phone number

5 Duplicate Remittance

Information needed:
- NPI, PTAN, last 5 digits of TIN
- Press (1) to order by check number and date
- Press (2) to order by claim control number and date

The IVR will advise whether the request was successful or not.

6 PECOS Lookup (Provider Enrollment)

Information needed:
- Referring/Ordering Physician NPI
- Referring/Ordering Physician Name (as licensed; no nicknames)

Provider Enrollment provides:
- Referring physician is enrolled in the Medicare program (and is able to order DMEPOS)
- Referring physician is unable to refer Medicare services (unable to order DMEPOS)

Touch-tone Combination

*See IVR Instructions to determine which touch-tone combination is appropriate.

Three Key		Single Key	
A	*21	A	2
B	*22	B	2
C	*23	C	2
D	*31	D	3
E	*32	E	3
F	*33	F	3
G	*41	G	4
H	*42	H	4
I	*43	I	4
J	*51	J	5
K	*52	K	5
L	*53	L	5
M	*61	M	6
N	*62	N	6
O	*63	O	6
P	*71	P	7
Q	*11	Q	1
R	*72	R	7
S	*73	S	7
T	*81	T	8
U	*82	U	8
V	*83	V	8
W	*91	W	9
X	*92	X	9
Y	*93	Y	9
Z	*12	Z	1

7 Financial

Checks Information needed:
- NPI, PTAN, last 5 digits of TIN
- (1) for check status by check date
- (2) to review last 3 checks

Check Status provides:
- Issue date, check amount, and check number

Payment Floor (2) Information needed:
- NPI, PTAN, last 5 digits of TIN

Payment Floor provides:
- Number and dollar amount of pending claims
- Number and dollar amount of claims on the payment floor

Overpayments (3) Information needed:
- NPI, PTAN, last 5 digits of TIN, and Financial Control Number (FCN)

Overpayments provides:
- To and from dates of services
- Amount overpaid
- Beneficiary name

8 Appeals

Information Needed:
- NPI, PTAN, last 5 digits of TIN
- Patient Medicare Number
- Patient First Name, Last Name
- CCN

Appeals provides:
The Document Control Number (DCN) assigned to all supplier appeals attached to the CCN provided. For open appeals it provides additional information regarding its' current status. For closed appeals it states the appeal is closed and provides additional information such as fully/partially favorable or unfavorable.

9 Questions

- Phone Numbers
- Addresses
- Claims
- Redetermination Request
- Correspondence
- Electronic Funds Transfer (EFT) Form
- Common Electronic Data Interchange (CEDI) Supplier Enrollment
- Supporting Documentation
- Administrative Law Judge (ALJ) Request
- Hours of Operation
- Comprehensive Error Rate Testing (CERT)
- Redeterminations

0 Customer Service Rep.

Information Needed:
- NPI, PTAN, TIN
- In the NPI, PTAN, and TIN are not available, indicate "Representative" or "Agent" to skip the provider authentication.

29314028 (4271) 7-12

IVR Same or Similar Feature Improved June 15

Effective June 15, the NAS Interactive Voice Response (IVR) system, 1-877-320-0390, was improved. The Same or Similar Durable Medical Equipment inquiry feature now distinguishes between the statuses of a Certificate of Medical Necessity (CMN) or DME Information Form (DIF), restricts modifier entry to the only applicable options, researches patient's history in excess of five years, and notifies the supplier when HCPCS are not eligible for a same or similar inquiry. Additional details of each enhancement are provided within this article. Use of the IVR is mandatory for all Same or Similar inquiries. Customer Service Representatives will be able to help redirect and train callers to successfully use the IVR for all Same or Similar inquiries.

The IVR can now tell the difference between an Initial, Revised, and Recertification CMN and/or DIF. For example, if a supplier is checking Same or Similar for an E1390 and there is an initial, revised, and recertification on file, the IVR will indicate how many HCPCS are on file. Then, the IVR will provide the status of the CMN or DIF; options include Initial, Revised, or Recertification. The IVR also provides the CMN or DIF date, number of rentals, supplier on file, and that supplier's contact information. The supplier will then need to speak "Next HCPCS" and the IVR will continue with the details of each HCPCS' CMN or DIF on file.

The Same or Similar IVR feature will now collect modifier information by having the telephone keypad option "1" to represent modifier NU, the keypad option "2" for modifier RR, and the keypad option "3" to indicate when there is not a modifier. This keypad entry is an option in addition to the existing voice command of speaking the modifier following the pronunciation of the HCPCS.

The IVR is now able to provide DME on file for dates of service greater than five years. When the IVR asks for a date of service as part of the Same or Similar function, a supplier can enter the current date of service or enter a prior calendar date. With each entry, the IVR will search five years at a time. An example is provided below. Suppliers may choose to conduct multiple date of service inquiries per beneficiary.

Date of Service Entered	IVR Searches Dates of Services
01/01/2012	01/01/2007 through 01/01/2012
01/01/2010	01/01/2005 through 01/01/2010
01/01/2008	01/01/2003 through 01/01/2008

There are times when a supplier attempts to conduct a Same or Similar inquiry for a HCPCS in which NAS is unable to provide information on that supply. For example, HCPCS that begin with an A, G, J, L, Q or V are not made available by NAS Customer Service Representatives, the IVR, or the Endeavor supplier portal. The only exception would be HCPCS A4600. The IVR will communicate to the supplier that "Codes beginning with "G" are not tracked for same or similar purposes."

NAS appreciates the feedback received from our supplier community regarding the self-service functionality offered. We will continue to be responsive to recommendations received and communicate those changes through our website and e-mail list.

NAS IVR Enforcement Effective July 9 for Authentication, Same or Similar, and Basic Inquiries

Effective July 9, 2012, suppliers will be redirected to the NAS Interactive Voice Response (IVR) system, 1-877-320-0390 for basic questions. This also requires suppliers to authenticate themselves by providing their National Provider Identifier, Provider Transaction Authorization Number, and the last five digits of their Tax Identification Number. NAS classifies basic inquiries to include eligibility, claim status, same or similar, duplicate remittance advice order requests, and the number of oxygen rental months. NAS Customer Service Representatives will provide training on the proper use of the IVR as well as provide guidance on where IVR educational resources may be obtained.

NAS appreciates our supplier support to ensure self-service tools are used as required by the Centers for Medicare & Medicaid Services. By diverting the basic inquiries to either the IVR and/or Endeavor, NAS' free supplier portal, the CSRs will be available to assist with complex inquiries.

MOBILITY DEVICES

Notification of Prepayment Review for Power Mobility Devices

NAS Jurisdiction D DME MAC Medical Review will be initiating a widespread prepayment review of claims for the following HCPCS codes and related options/accessories;

- K0813 (Power wheelchair, group 1 standard, portable, sling/solid seat and back, patient weight capacity up to and including 300 pounds).
- K0821 (Power wheelchair, group 2 standard, portable, captain's chair, patient weight capacity up to and including 300 pounds).
- K0822 (Power wheelchair, group 2 standard, sling/solid seat/back, patient weight capacity up to and including 300 pounds).
- K0823 (Power wheelchair, group 2 standard, captain's chair, patient weight capacity up to and including 300 pounds).
- K0824 (Power wheelchair, group 2 heavy-duty, sling/solid seat/back, patient weight capacity 301 to 450 pounds).
- K0825 (Power wheelchair, group 2 heavy-duty, captain's chair, patient weight capacity 301 to 450 pounds).
- K0850 (Power wheelchair, group 3 heavy-duty, sling/solid seat/back, patient weight capacity 301 to 450 pounds).
- K0861 (Power wheelchair, group 3 standard, multiple power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds).

This review is being initiated based on the results of Comprehensive Error Rate Testing (CERT) review analysis.

In order to evaluate compliance with Medicare coverage and coding rules, all suppliers billing Jurisdiction D for HCPCS codes listed above and related options/accessories are subject to this review. Suppliers of the selected claims will receive an *Additional Documentation Request* (ADR) letter asking for specific information to determine if the item billed complies with the existing reasonable and necessary criteria. Failure to supply the requested information within 45 days of the date on the letter will result in the claim being denied. The ADR letter will provide instruction for submitting documentation.

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Local Coverage Determination (LCD) and related Policy Articles:

- Power Mobility Devices L23598 & A41127
- Wheelchair Seating L15670 & A17265
- Wheelchair Options/Accessories L11462 & A19846

Information about probe/error validation reviews may be found in CMS Publication 100-8, Program Integrity Manual (PIM), Chapter 3 located at: http://www.cms.hhs.gov/manuals/downloads/pim83c03.pdf

Prior Authorization of Power Mobility Devices Demonstration to Begin September 1

On August 1, CMS displayed a Federal Register Notice announcing a **September 1, 2012 start date** of the **Power Mobility Devices (PMD) demonstration**. The start date of the demonstration is based on the date of the written order. CMS believes this demonstration will lead to reductions in improper payments for power mobility devices, which will help ensure the sustainability of the Medicare Trust Funds and protect beneficiaries who depend upon the Medicare program. In addition, this demonstration is designed to develop and demonstrate improved methods for the investigation and prosecution of fraud in the provision of care or services under the health programs established by the Social Security Act.

Demonstration Description
CMS will implement a Prior Authorization process for scooters and power wheelchairs for people with Fee-For-Service Medicare who reside in seven states with high populations of fraud- and error-prone providers (CA, IL, MI, NY, NC, FL and TX). In addition to the benefits mentioned above, this demonstration will help ensure that a beneficiary's medical condition warrants their medical equipment under existing coverage guidelines. Moreover, the program will assist in preserving a Medicare beneficiary's ability to receive quality products from accredited suppliers. Additional information is available on the Prior Authorization of Power Mobility Devices Demonstration web page.

NAS will provide additional information as released by CMS on the What's New section of our website and in the bi-weekly email updates.

Widespread Prepayment Review for K0001, K0003, and K0004 Manual Wheelchairs – Edit Effectiveness for 2nd Quarter

The Jurisdiction D DME MAC Medical Review Department is conducting a widespread complex review of HCPCS codes K0001, K0003, K0004 and the 2nd quarter edit effectiveness results from April 2012 through July 2012 are as follows:

The results of the review, for item K0001, identified 626 claims of which 577 were denied. A total of 92 claims were denied for no response to the additional documentation request. This resulted in an overall error rate of 94%. Total dollars allowed were $2,438.73. Total dollars denied were $35,768.54.

The results of the review, for item K0003, identified 665 claims of which 637 were denied. A total of 89 claims were denied for no response to the additional documentation request. This resulted in an overall error rate of 97%. Total dollars allowed were $1537.56. Total dollars denied were $56,919.46.

The results of the review, for item K0004, identified 372 claims of which 347 were denied. A total of 99 claims were denied for no response to the additional documentation request. This resulted in an overall error rate of 95%. Total dollars allowed were $2,665.08. Total dollars denied were $48,913.23.

Due to this high error rate, NAS will continue with the widespread complex review for all 3 codes.

The following are the top reasons for denial:

a. Criteria B of LCD L11454 was not met.

b. Criteria A of LCD L11454 was not met.

c. Criteria D of LCD L11454 was not met.

d. Criteria C of LCD L11454 was not met.

An in-depth explanation of the denial reasons are as follows:

A. Per Criteria B of LCD L11454, a manual wheelchair is not covered if there is no documentation provided to indicate that the patient's mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker.

B. Per Criteria A of LCD L11454, a manual wheelchair is not covered if there is no documentation that supports that the patient has a mobility limitation that significantly impairs his/her ability to participate in one or more mobility-related activities of daily living (MRADLs) such as toileting, feeding, dressing, grooming, and bathing in customary locations in the home.

A mobility limitation is one that:

a. Prevents the patient from accomplishing an MRADL entirely, or

b. Places the patient at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to perform an MRADL; or

c. Prevents the patient from completing an MRADL within a reasonable time frame.

C. Per Criteria D of LCD L11454, a manual wheelchair is not covered if there is no documentation to justify that the use of a manual wheelchair will significantly improve the patient's ability to participate in MRADLs and the patient will use it on a regular basis in the home.

D. Per LCD L11454, a manual wheelchair must be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member. Coverage criteria must be submitted in the form of a medical record. Coverage criteria for K0003 and K0004 must be submitted in the medical record also.

a. Documentation that the coverage criteria have been met must be present in the patient's medical record. The exception is information about whether the patient's home can accommodate the wheelchair (Criterion C) which may be documented by the supplier. For manual wheelchairs, the assessment does not need to be conducted in the patient's home. Information from the patient's medical record and the supplier must be available upon request. The patient's medical record is not limited to the physician's office records. It may include hospital, nursing home, or home health agency records and records from other professionals including, but not limited to, nurses, physical and occupational therapists, prosthetists, and orthotists.

b. A lightweight wheelchair (K0003) is covered when a patient:

a. Cannot self-propel in a standard wheelchair in the home; and

b. The patient can and does self-propel in a lightweight wheelchair.

c. A high strength lightweight wheelchair (K0004) is covered when a patient meets the criteria in (1) and/or (2):

1. The patient self-propels the wheelchair while engaging in frequent activities in the home that cannot be performed in a standard or lightweight wheelchair.
2. The patient requires a seat width, depth, or height that cannot be accommodated in a standard, lightweight or hemi-wheelchair, and spends at least two hours per day in the wheelchair.

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Manual Wheelchair Bases Local Coverage Determination L11454 and Policy Article A25378, Wheelchair Options/ Accessories LCD L11462 and Policy Article A19846 and Wheelchair Seating LCD L15670 and Policy ArticleA17265 and Supplier Manual Chapter 3: https://www.noridianmedicare.com/dme/news/manual/chapter3.html.

Information about probe/error validation reviews may be found in CMS Publication 100-8, Program Integrity Manual (PIM), Chapter 3 located at: http://www.cms.gov/manuals/downloads/pim83c03.pdf

Widespread Prepayment Review for K0823 Power Wheelchair – Edit Effectiveness for 4th Quarter

The Jurisdiction D DME MAC Medical Review Department is conducting a widespread complex review of HCPCS code K0823 (power wheelchair, group 2 standard, captain's chair, patient weight capacity up to and including 300 pounds) and related accessories. The 4th quarter edit effectiveness results from April 8, 2012 to July 7, 2012 are as follows:

The results of the review identified 1030 total claims of which 898 were denied. This resulted in an overall error rate of 87%. Forty-four (44) claims were denied for no response to the additional documentation request. NAS will continue with this review due to the high error rate.

The following are the top reasons for denial:

- LCD L23598 Criteria C not met.
- LCD L23598 Criteria B not met.
- LCD L23598 Criteria A not met.
- No/invalid detailed product description received.

As a reminder, the Local Coverage Determination (LCD) for Power Mobility Devices (L23598) states in part:

BASIC COVERAGE CRITERIA
All of the following basic criteria (A–C) must be met for a power mobility device (K0800-K0898) or a push-rim activated power assist device (E0986) to be covered.

a. The patient has a mobility limitation that significantly impairs his/her ability to participate in one or more mobility-related activities of daily living (MRADLs) such as toileting, feeding, dressing, grooming, and bathing in customary locations in the home. A mobility limitation is one that:

- Prevents the patient from accomplishing an MRADL entirely, or
- Places the patient at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to perform an MRADL; or
- Prevents the patient from completing an MRADL within a reasonable time frame.

b. The patient's mobility limitation cannot be sufficiently and safely resolved by the use of an appropriately fitted cane or walker.

c. The patient does not have sufficient upper extremity function to self-propel an optimally-configured manual wheelchair in the home to perform MRADLs during a typical day.

- Limitations of strength, endurance, range of motion, or coordination, presence of pain, or deformity or

absence of one or both upper extremities are relevant to the assessment of upper extremity function.

- An optimally-configured manual wheelchair is one with an appropriate wheelbase, device weight, seating options, and other appropriate non-powered accessories.

DETAILED PRODUCT DESCRIPTION
LCD L23598 states, "Once the supplier has determined the specific power mobility device that is appropriate for the patient based on the physician's 7-element order, the supplier must prepare a written document (termed a detailed product description). This detailed product description (DPD) must comply with the requirements for a detailed written order as outlined in the Supplier Manual and CMS' Program Integrity Manual (Internet-Only Manual, Pub. 100-08) Chapter 5. Regardless of the form of the description, there must be sufficient detail to identify the item(s) in order to determine that the item(s) dispensed is properly coded.

The physician must sign and date the detailed product description and the supplier must receive it prior to delivery of the PWC or POV. A date stamp or equivalent must be used to document the supplier receipt date. The detailed product description must be available on request."

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in Power Mobility Devices Local Coverage Determination (LCD) L23598 and Policy Article A41127. Suppliers can review the Group 2 Power wheelchairs (K0820-K0829) documentation checklist on the NAS website at https://www.noridianmedicare.com/dme/news/power_mobility_devices.htm.

NEBULIZERS

Widespread Prepayment Review for Nebulizer Drugs – Edit Effectiveness for 3rd Quarter

The Jurisdiction D DME MAC Medical Review Department is conducting a widespread complex review of nebulizer drugs with HCPCS codes J7626 and J7605 and the third quarter edit effectiveness results from March 2012 through June 2012 are as follows:

The results of the review, for item J7626, identified 2480 claims of which 1338 were denied. A total of 696 claims were denied for no response to the additional documentation request. This resulted in an overall error rate of 54%.

The results of the review, for item J7605, identified 1022 claims of which 511 were denied. A total of 239 claims were denied for no response to the additional documentation request. This resulted in an overall error rate of 51%.

Due to the error rate remaining high, NAS will continue with the widespread complex review for the above mentioned nebulizer drugs.

The following are the top reasons for denial:

a. Requested documentation was not provided within the allotted time frame as referenced in the Medicare guidelines

b. There was no medical documentation provided to support the medical necessity for the billed items.

c. There was no beneficiary evidence of exhaustion submitted regarding refills.

d. There was no Proof of Delivery for the billed items provided and/or the proof of delivery provide was invalid as it did not meet Medicare guidelines.

An in-depth explanation of the denial reasons are as follows:

a. A large number of suppliers failed to respond to our request for records. Suppliers are in violation of Supplier Standard #28 when, upon request, they fail to provide requested documentation to a Medicare contractor. Medicare regulations (42 C.F.R §424.516[f]) stipulate that a supplier is required to maintain documentation for seven years from the date of service and, upon the request of CMS or a Medicare contractor, provide access to that documentation. Therefore, the consequences of failure to provide records may not only be a claim denial but also referral to the NSC.

b. Section 1833(e) of the Social Security Act precludes payment to any provider of services unless "there has been furnished such information as may be necessary in order to determine the amounts due such provider." It is expected that the patient's medical records will reflect the need for the care provided. The patient's medical records include the physician's office records, hospital records, nursing home records, home health agency records, records from other healthcare professionals and test reports. This documentation must be available upon request.

c. The Program Integrity Manual chapter 5 section 5.2.6 states, "For DMEPOS products that are supplied as refills to the original order, suppliers must contact the beneficiary prior to dispensing the refill and not automatically ship on a pre-determined basis, even if authorized by the beneficiary. This shall be done to ensure that the refilled item remains reasonable and necessary, existing supplies are approaching exhaustion, and to confirm any changes/modifications to the order. Contact with the beneficiary or designee regarding refills must take place no sooner than 14 calendar days prior to the delivery/shipping date. For delivery of refills, the supplier must deliver the DMEPOS product no sooner than 10 calendar days prior to the end of usage for the current product. This is regardless of which delivery method is utilized. DME MACs shall allow for the processing of claims for refills delivered/shipped prior to the beneficiary exhausting his/her supply."

d. Suppliers are required to maintain proof of delivery documentation in their files. Documentation must be maintained in the supplier's files for seven years. Proof of delivery is required in order to verify that the beneficiary received the DMEPOS. Proof of delivery is one of the supplier standards as noted in 42 CFR, 424.57(12). Proof of delivery documentation must be made available to the DME MAC, DME PSC, and ZPIC upon request. The date of signature on the delivery slip must be the date that the DMEPOS item was received by the beneficiary or designee. In instances where the supplies are delivered directly by the supplier, the date the beneficiary received the DMEPOS supply shall be the date of service on the claim.

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Nebulizers Local Coverage Determination (LCD) L11488 and Policy Article A24942. Suppliers can also review the Nebulizer documentation checklist on the NAS website at https://www.noridianmedicare.com/dme/coverage/checklists.html.

Information about probe/error validation reviews may be found in CMS Publication 100-8, Program Integrity Manual (PIM), Chapter 3 located at: http://www.cms.gov/manuals/downloads/pim83c03.pdf

NEGATIVE PRESSURE WOUND THERAPY

Negative Pressure Wound Therapy Interpretive Guidelines

MLN Matters® Number: SE1222

Provider Types Affected
This MLN Matters® Special Edition Article is intended for suppliers who submit claims to Medicare contractors (carriers, Durable Medical Equipment Medicare Administrative Contractors (DME MACs), Fiscal Intermediaries (FIs), A/B Medicare Administrative Contractors (A/B MACs), and/or Regional Home Health Intermediaries (RHHIs)) for negative pressure wound therapy services provided to Medicare beneficiaries.

What You Need to Know
This article is intended to provide interpretive guidance to Centers for Medicare & Medicaid Services (CMS) approved accrediting organizations to use in their accreditation of suppliers that provide Negative Pressure Wound Therapy (NPWT) equipment to Medicare beneficiaries. These guidelines also apply to suppliers that are furnishing NPWT equipment to Medicare beneficiaries. SE1222 is also intended to assist the supplier in understanding their responsibilities related to this equipment in order to be in compliance with CMS Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) quality standards.

Background
(NPWT is defined as the application of sub-atmospheric pressure to a wound to remove exudate and debris from the wound(s). NPWT is delivered to a qualified wound through an integrated system that includes:

- A Suction Pump;
- A Separate Exudate Collection Chamber; and
- Dressing Sets.

In these systems, the exudate is completely removed from the wound site to the collection chamber.

This Special Edition article, while assisting the supplier of NPWT to fulfill all Centers for Medicare & Medicaid Services (CMS) Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) quality standards, does not contain a detailed discussion of all coverage and documentation requirements pertinent to this subject. Please consult the appropriate Local Coverage Determination (LCD) (or Local Coverage Article) more complete information using the Medicare Coverage Database Quick Search at http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx on the CMS website. Some of the more pertinent LCDs, per DME MAC Jurisdiction, are as follows:

NEGATIVE PRESSURE WOUND THERAPY CONT'D

Jurisdiction A:
L11500 (Local Coverage Determination (LCD) for Negative Pressure Wound Therapy Pumps)
See http://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=11500&ContrId=137&ver=35&ContrVer=1&Date=&DocID=L11500&bc=iAAAAAgAAAAA& on the CMS website.

A35347 (Local Coverage Article for Negative Pressure Wound Therapy Pumps - Policy Article - Effective October 2011)
See http://www.cms.gov/medicare-coverage-database/details/article-details.aspx?articleId=35347&ver=17&ContrId=137&ContrVer=1&LCDId=11500&Date=&DocID=L11500&IsPopup=y& on the CMS website.

Jurisdiction B:
L27025 (Local Coverage Determination (LCD) for Negative Pressure Wound Therapy Pumps)
See http://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=27025&ContrId=138&ver=12&ContrVer=1&Date=&DocID=L27025&bc=iAAAAAgAAAAA& on the CMS website.

A47111 (Local Coverage Article for Negative Pressure Wound Therapy Pumps - Policy Article - Effective October 2011)
See http://www.cms.gov/medicare-coverage-database/details/article-details.aspx?articleId=47111&ver=8&ContrId=138&ContrVer=1&CntrctrSelected=138*1&Date=&DocID=A47111&bc=hAAAAAgAAAAA& on the CMS website.

Jurisdiction C:
L5008 (Local Coverage Determination (LCD) for Negative Pressure Wound Therapy Pumps)
See http://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=5008&ContrId=140&ver=46&ContrVer=2&CntrctrSelected=140*2&Cntrctr=140&name=CGS+Administrators%2c+LLC+(18003%2c+DME+MAC)&LCntrctr=140*2&bc=AgACAAIAAAAA& on the CMS website.

A35363 (Local Coverage Article for Negative Pressure Wound Therapy Pumps - Policy Article - Effective October 2011)
See http://www.cms.gov/medicare-coverage-database/details/article-details.aspx?articleId=35363&ver=19&ContrId=140&ContrVer=2&CntrctrSelected=140*2&Date=&DocID=A35363&bc=hAAAAAgAAAAA& on the CMS website.

Jurisdiction D:
L11489 (Local Coverage Determination (LCD) for Negative Pressure Wound Therapy Pumps)
See http://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=11489&ContrId=139&ver=39&ContrVer=1&Date=&DocID=L11489&bc=iAAAAAgAAAAA& on the CMS website.

A35425 (Local Coverage Article for Negative Pressure Wound Therapy Pumps - Policy Article)
See http://www.cms.gov/medicare-coverage-database/details/article-details.aspx?articleId=35425&ver=17&ContrId=139&ContrVer=1&LCDId=11489&Date=&DocID=L11489&IsPopup=y& on the CMS website.

Note: These interpretive guidelines do not address clinical aspects of NPWT, nor do they intend to assign clinical responsibilities to DMEPOS suppliers that provide the NPWT equipment to Medicare beneficiaries.

In addition to the LCDs and Articles, following are some guidelines for the CMS DMEPOS Quality Standards that CMS uses to ascertain compliance with standards:

I. Supplier Business Services Requirements

Consumer Services

CMS DMEPOS Quality Standard: Suppliers shall provide information and telephone number(s) for customer service, regular business hours, after-hours access, equipment and/or item(s) repair, and emergency coverage.

Interpretive Guidelines: Suppliers shall demonstrate that they have provided the beneficiary/caregiver with the following information:

1. How to contact the supplier for equipment problems both during business hours and after hours through a 24/7 support function provided by the manufacturer or supplier;
2. How to access supplier staff for 24/7 technical product consultation; and
3. That they shall call their physician or 911 if a medical emergency arises.

Product Safety

CMS DMEPOS Quality Standards: Suppliers shall implement a program that promotes the safe use of equipment and item(s) and minimizes safety risks, infections, and hazards both for its staff and for beneficiaries:

Suppliers shall implement and maintain a plan for identifying, monitoring and reporting equipment and item(s) failure, repair and preventive maintenance provided to beneficiaries.

Interpretive Guideline: Suppliers shall demonstrate that they have ensured the equipment is cleaned between uses by different beneficiaries per the manufacturers' recommendations.

II. Supplier Product-Specific Service Requirements

CMS DMEPOS Quality Standard: The supplier shall consult with the prescribing physician as needed to confirm the order and to recommend any necessary changes, refinements, or additional evaluations to the prescribed equipment, item(s), and/or service(s).

Interpretive Guidelines: The supplier shall:

- Ensure the physician order contains all of the documentation requirements in the LCD, including the pump type and necessary supplies.
- If there is a home health agency involved in the patient's care, identify and document in the patient's record the home health care provider by contacting the physician.

CMS DMEPOS Quality Standard: The supplier shall review the beneficiary's record as appropriate and incorporate any pertinent information, related to the beneficiary's condition(s) which affect the provision of the DMEPOS and collaboration with the prescribing physician.

Interpretative Guidelines: The supplier shall:

1. Confirm that the wound type or risk factors in the patient record are not among those listed in the most recent public health notification of the U.S Food and Drug Administration. Refer to the FDA's link for all of the specific clinical information at http://www.fda.gov/Safety/MedWatch/SafetyInformation/SafetyAlertsforHumanMedicalProducts/ucm190704.htm on the Internet.
2. Confirm that if the wound type or any of the risk factors included in the patient's record are also in the most recent guidance issued by the FDA, there is a written approval from the patient's physician that the NPWT equipment is appropriate for this patient.
3. Not supply the NPWT equipment to a beneficiary without the physician's written approval.

Delivery & Set-up

CMS DMEPOS Quality Standard: Suppliers shall deliver and set-up, or coordinate set-up with another supplier, all equipment and item(s) in a timely manner as agreed upon by the beneficiary and/or caregiver, supplier, and prescribing physician.

Interpretive Guidelines: Suppliers shall:

1. Coordinate the delivery of the equipment with the home health care providers' home visit, if there is a Home Health Agency (HHA) involved in the patient's care.
2. Deliver the NPWT pump, dressings, and supplies prior to a beneficiary's discharge from the hospital, if the patient is being discharged from an acute care facility.

CMS DMEPOS Quality Standard: Suppliers shall provide all equipment and item(s) that are necessary to operate the equipment or item(s) and perform any further adjustments as applicable.

Interpretive Guidelines: The supplier shall demonstrate that they have (prior to home delivery):

1. Performed quality checks on pumps, tubing, dressings, drapes, containers, and canisters per the manufacturer maintenance schedule, before delivery;
2. Confirmed that each NPWT component is operational and that equipment and supplies are available and complete prior to setup or at the time of setup;
3. Confirmed that all of the supplies are within expiration date;
4. Confirmed that the number and sizes of dressings are correct and the packaging is sterile;
5. Confirmed that the correct pump, containers/canisters, dressing, tubing is used for the specific brand of equipment according to manufacturer requirements;
6. Confirmed that clamps are available if required;
7. Confirmed that the exudate collection containers or canister are specific to the NPWT system being used;

8. Confirmed that the beneficiary has sufficient number of exudate collection containers to meet his/her wound needs based on the patient's history of drainage amount;
9. Confirmed that the alarms are setup and working properly, capable of sounding an audible alarm and/or visual alarm, dependent upon the pump type when desired pressures are not being achieved (that is, where there is a leak in the dressing seal) or the wound drainage container/canister is full or the battery is low;
10. Confirmed that the pump and the wound system (stationary or portable) are operational during use.

CMS DMEPOS Quality Standard: Suppliers shall provide, or arrange for, loaner equipment equivalent to the original equipment during any repair period except for orthotics and prosthetics.

Interpretive Guidelines: The supplier shall demonstrate that they have:

1. Performed or arranged maintenance and repairs or replacement of the pump and supplies;
2. Given information to the beneficiary and/or caregiver(s) on how to obtain service for purchased equipment.

Training/Instruction to Beneficiary and/or Caregiver(s)

CMS DMEPOS Quality Standards: Suppliers shall provide or coordinate the provision of, appropriate information related to the set-up, features, routine use, troubleshooting, cleaning, infection control practices and maintenance of all equipment and item(s) provided.

Suppliers shall provide relevant information and/or instructions about infection control issues related to the use of all equipment and item(s) provided.

Interpretive Guidelines: Suppliers shall demonstrate that they have provided training to the beneficiary/caregiver:

- That is specific to the system being used; and
- At a minimum it includes:

1. Verification that new packages are not torn, damaged or opened prior to use;
2. Operation of the pump and its settings;
3. Written instructions that are left with the beneficiary/caregiver on the safety section of the manufacturer's manual after they have been reviewed by the supplier at a comprehension level applicable for the beneficiary/caregiver needs;
4. Instructions on not servicing any of the equipment without calling the supplier first;
5. What to do in case of equipment-related complications, including power failure, dislodged tube, accidental disconnection from pump and low battery;
6. Equipment troubleshooting in case of equipment-related complications, including situations where tube replacement may be required; or alarm will not turn off or other failure of the pump or its supplies;
7. How to contact the supplier if the physician changes settings, or the pump stops working or any review is necessary of the initial instruction;
8. Contacting the supplier if the system shuts off;
9. How to disconnect the system to take a shower or bath;
10. How to disconnect the system when toileting, if the system is not portable;
11. How to respond when the pump is turned off and the alarm sounds after a period of time;
12. Review of the physician's order for the length of time per day that the pump has to be used;
13. What to do if there is a sudden or rapid increase of blood under the drape, in the tubes or container;
14. When to immediately turn off the pump;
15. When to call the physician or other treating practitioner;
16. Contacting the supplier if the NPWT is being discontinued or if the beneficiary is being transferred to another setting;

17. How to arrange with the supplier for pickup or shipment of the system;
18. The function of the clamps on the tubing both open and closed;
19. How to attach, remove, and change the exudates collection container;
20. Importance of infection control procedures such as good hand washing techniques when working with the pump and its supplies;
21. How to keep the pump clean, the importance of not spilling liquids or food on the pump and wipe off spills immediately;
22. Instruction on the frequency of canister changes. No canisters are to be re-used;
23. Disposal procedure of the tubing, dressings and canister according to local waste policy requirements.
24. The beneficiary/caregiver is given written warranty information for purchased equipment.

Follow-up

CMS DMEPOS Quality Standard: Suppliers shall provide follow-up services to the beneficiary and/or caregiver(s), consistent with the type(s) of equipment, item(s) and service(s) provided, and recommendations from the prescribing physician or healthcare team member(s).

Interpretive Guidelines: The supplier shall have an on-going individualized service plan with a defined frequency that addresses, defines or confirms;

1. The ongoing operation and maintenance of the equipment, operation and maintenance of the equipment;
2. The frequency for scheduled/planned delivery or supply of additional supplies
3. That the beneficiary is using the equipment per the physicians order
4. The supplier picks up the equipment when it is no longer needed per the physicians orders.

ORAL APPLIANCES

Correct Coding for Oral Appliances for the Treatment of Obstructive Sleep Apnea (E0486)

Recently questions have arisen about reimbursement for custom fabricated oral appliances coded as E0486 (ORAL DEVICE/APPLIANCE USED TO REDUCE UPPER AIRWAY COLLAPSIBILITY, ADJUSTABLE OR NON-ADJUSTABLE, CUSTOM FABRICATED, INCLUDES FITTING AND ADJUSTMENT). Only oral appliances used for the treatment of obstructive sleep apnea (OAOSA) that meet the durable medical equipment (DME) statutory benefit category requirements are eligible for Medicare reimbursement by the Durable Medical Equipment Medicare Administrative Contractors (DME MACs). All requirements of the definition must be met before an item can be considered to be DME (CMS IOM 100-2, Ch. 15, §100). Oral devices that do not meet the DME benefit criteria are classified as dental appliances and are not eligible for reimbursement under the DME benefit by the DME MACs.

Since the OAOSA Local Coverage Determination first became effective in January 2011, numerous devices have been submitted to the Pricing, Data Analysis and Coding (PDAC) contractor for inclusion into HCPCS code E0486. Many of these items vary significantly from the characteristics of the predicate product upon which the initial benefit category determination and subsequent HCPCS code were developed. The coding guidelines for OAOSA contained in the Oral Appliances for Obstructive Sleep Apnea Local Coverage Determination related Policy Article describe the requirements that must be met for an OAOSA to be classified as DME and coded as E0486. Based on the wide variety of products that have been submitted for review, the DME MACs are revising the coding guidelines to provide more detailed and specific information to assist with product classification.

Effective July 1, 2012 the coding guidelines for OAOSA items coded as E0486 are revised to state:

> A custom fabricated oral appliance (E0486) is one which is individually and uniquely made for a specific patient. It involves taking an impression of the patient's teeth and making a positive model of plaster or equivalent material. Basic materials are used with the positive model to produce the final product. Custom fabrication requires more than trimming, bending, or making other modifications to a substantially prefabricated item. A custom fabricated oral appliance may include a prefabricated component (e.g., the joint mechanism).

Code E0486 may only be used for custom fabricated mandibular advancement devices. To be coded as E0486, custom fabricated mandibular advancement devices must meet all of the criteria below:

- Have a fixed mechanical hinge (see below) at the sides, front or palate; and,
- Be able to protrude the individual beneficiary's mandible beyond the front teeth when adjusted to maximum protrusion; and,
- Incorporate a mechanism that allows the mandible to be easily advanced by the beneficiary in increments of one millimeter or less; and,
- Retain the adjustment setting when removed from the mouth; and,
- Maintain the adjusted mouth position during sleep; and,
- Remain fixed in place during sleep so as to prevent dislodging the device; and,
- Require no return dental visits beyond the initial 90-day fitting and adjustment period to perform ongoing modification and adjustments in order to maintain effectiveness (see below)

A fixed hinge is defined as a mechanical joint containing an inseparable pivot point. Interlocking flanges, tongue and groove mechanisms, hook and loop or hook and eye clasps, elastic straps or bands, etc. (not all-inclusive) do not meet this requirement.

Items that require repeated adjustments and modification beyond the initial 90-day fitting and adjustment period in order to maintain fit and/or effectiveness are not eligible for classification as DME. These items are considered as dental therapies, which are not eligible for reimbursement, by Medicare under the DME benefit. They must not be coded using E0486.

Custom fabricated mandibular advancement devices that do not incorporate all of the criteria above must be coded as A9720.

Effective July 1, 2012 all product submissions will be reviewed using these coding guidelines. All products currently listed on DMECS must be re-reviewed and will be evaluated based on these requirements by the PDAC. The PDAC will not require a resubmission of applications for products that have already been coded and listed on DMECS. Current file information will be used for this re-review. Effective November 1, 2012, only those products that have been re-reviewed through the PDAC coding verification review process and listed as code E0486 on the PDAC Durable Medical Equipment Coding System (DMECS) web site may use this code. All unlisted devices must use HCPCS code A9270 (NON-COVERED ITEM OR SERVICE).

The PDAC DME and Supplies coding verification application required for these products is located on the PDAC website at: https://www.dmepdac.com/review/apps_check.html. Coding decisions are updated frequently. Suppliers should refer to the Product Classification List often to ensure that items billed have been coded by the PDAC. The Product Classification List in DMECS is located on the PDAC web site at: https://www.dmepdac.com/dmecs/index.html

For questions about correct coding, contact the PDAC Contact Center at (877) 735-1326 during the hours of 8:30 a.m. to 4:00 p.m. CT, Monday through Friday, or e-mail the PDAC by completing the DME PDAC Contact Form located on the PDAC website: https://www.dmepdac.com.

Refer to the Local Coverage Determination, related Policy Article and Supplier Manual for additional information.

E0486 Fee Schedule Amount

NAS has established a fee schedule amount for HCPCS code E0486 (Oral device/appliance used to reduce upper airway collapsibility, adjustable or non-adjustable, custom fabricated, includes fitting and adjustment).

This fee was created using historical billing data. The fees for E0486 are listed below:

ORAL APPLIANCES CONT'D

E0486	2012		2011		2010
State	Fee		Fee		Fee
AK	$1321.61		$1290.63		$1175.39
AZ	$1321.61		$1290.63		$1175.39
CA	$1321.61		$1290.63		$1175.39
HI	$1321.61		$1290.63		$1175.39
IA	$1321.61		$1290.63		$1175.39
ID	$1321.61		$1290.63		$1175.39
KS	$1321.61		$1290.63		$1175.39
MO	$1367.41		$1335.36		$1220.16
MT	$1321.61		$1290.63		$1175.39
ND	$1321.61		$1290.63		$1175.39
NE	$1321.61		$1290.63		$1175.39
NV	$1321.61		$1290.63		$1175.39
OR	$1321.61		$1290.63		$1175.39
SD	$1321.61		$1290.63		$1175.39
UT	$1383.88		$1351.45		$1236.27
WA	$1538.27		$1502.22		$1387.19
WY	$1321.61		$1290.63		$1175.39

Suppliers may call the Supplier Contact Center at 1-877-320-0390 for any questions regarding HCPCS code pricing.

ORTHOTICS AND PROSTHETICS

Notification of Prepayment Review for Orthotic and Prosthetic HCPCS codes

NAS Jurisdiction D DME MAC Medical Review will be initiating a widespread prepayment probe review of claims for each of the following HCPCS codes:

- L0631 – Lumbar-sacral orthosis (LSO), sagittal control, with rigid anterior and posterior panels, posterior extends from sacrococcygeal junction to T-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, prefabricated, includes fitting and adjustment
- L0637 – Lumbar-sacral orthosis (LSO), sagittal-coronal control, with rigid anterior and posterior frame/panels, posterior extends from sacrococcygeal junction to T-9 vertebra, lateral strength provided by rigid lateral frame/panels, produces intracavitary pressure to reduce load on intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, prefabricated, includes fitting & adjustment
- L8030 – Breast prosthesis, silicone or equal, without integral adhesive
- L4360 – Walking boot, pneumatic and/or vacuum, with or without joints, with or without interface material, prefabricated, includes fitting & adjustment
- L1960 – Ankle-foot orthosis (AFO), posterior solid ankle, plastic, custom fabricated
- L1970 – Ankle-foot orthosis (AFO), plastic with ankle joint, custom fabricated

This review is being initiated based on the results of Comprehensive Error Rate Testing (CERT) analysis and previous review results.

In order to evaluate compliance with Medicare coverage and coding rules, all suppliers billing Jurisdiction D for HCPCS codes listed above are subject to this review. Suppliers of the selected claims will receive an Additional Documentation Request (ADR) letter asking for specific information to determine if the item billed complies with the existing reasonable and necessary criteria. Failure to supply the requested information within 45 days of the date on the

letter will result in the claim being denied. The ADR letter will provide instruction for submitting documentation.

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Local Coverage Determination (LCD) and related Policy Articles for the HCPCS listed in this notification article:

- Spinal Orthoses: TLSO and LSO L11459 & A23846
- External Breast Prosthesis L11569 & A19833
- Ankle-Foot/Knee-Ankle-Foot Orthosis L142 & A19800

Information about prepay reviews may be found in CMS Publication 100-8, *Program Integrity Manual* (PIM), Chapter 3 located at: http://www.cms.hhs.gov/manuals/downloads/pim83c03.pdf

Questionable Billing By Suppliers of Lower Limb Prostheses

MLN Matters® Number: SE1213 Revised

Note: This article was revised on June 7, 2012, to include the full OIG recommendations, to make several minor clarifications, and to delete a reference to recent legislation requiring face-to-face encounters for certain DMEPOS. All other information is the same.

Provider Types Affected
This MLN Matters® Special Edition Article is intended for providers who bill Medicare for lower limb prostheses. No new policies are contained in this article.

What You Need to Know
This article highlights the August 2011 report from the Department of Health and Human Services (DHHS), Office of Inspector General (OIG) study titled "Questionable Billing By Suppliers of Lower Limb Prostheses." It also discusses Medicare policy regarding the coverage of lower limb prostheses under its Part B Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) benefit.

The study was designed to meet the following objectives:

1. Identify payments for lower limb prostheses in 2009 that did not meet certain Medicare requirements;
2. Identify Medicare payments for lower limb prostheses in 2009 for beneficiaries with no claims from their referring physicians;
3. Identify suppliers of lower limb prostheses that had questionable billing in 2009; and
4. Describe the program safeguards in place in 2009 and the first half of 2010 to prevent inappropriate payments for lower limb prostheses.

Background
Between 2005 and 2009, Medicare spending for lower prostheses increased 27 percent, from $517 million to $655 million. The number of Medicare beneficiaries receiving lower limb prostheses decreased by 2.5 percent, from almost 76,000 to about 74,000.

Medicare policy requires that a supplier have an order from the referring physician before providing prostheses to the beneficiary. Upon receipt of the referring physician's order, the supplier can move forward with the prostheses fitting for the beneficiary with the applicable prostheses. Medicare policy also requires that suppliers follow local coverage determination policies. These policies provide guidelines for determining the beneficiary's potential functional level and specify how suppliers must submit claims for certain types and combinations of prostheses.

The study completed by the OIG was based on an analysis of Medicare Part B claims for lower limb prostheses from 2009 and Part A and Part B claims from 2004 to 2009 for beneficiaries who received lower limb prostheses in 2009. OIG staff also completed interviews with the four DME Medicare Administrative Contractors (MACs), three Zone Program Integrity Contractors (ZPICs), and two DME Program Safeguard Contractors (PSCs). The OIG considered a paid claim did not meet the requirements if the supplier:

- Did not indicate whether the prosthesis was for the right or left limb;
- Billed for a prosthesis for both limbs on the same date using two claims;
- Did not meet potential functional level requirements;
- Billed for a higher number of units of a prosthesis than allowed on a claim;

- Billed for combinations of prostheses that were not allowed; or
- Billed for prostheses that were not covered.

Claims data was an additional component of the OIG's analysis to determine the number of claims for beneficiaries with no claims from their referring physicians during the last 5 years and the Medicare payments for these claims. The following elements were analyzed to identify suppliers that had questionable billing:

- Suppliers that had at least 10 beneficiaries, and
- Suppliers that were paid at least $100,000 for lower limb prostheses in 2009.

This sample included 1,632 of the 4,575 Medicare suppliers who had a paid claim for lower limb prostheses in 2009, which accounted for 92 percent of the $655 million who billed for lower limb prostheses.

Findings
In 2009, the study found that:

1. In 2009, Medicare inappropriately paid $43 million for lower limb prostheses that did not meet certain requirements. These payments could have been prevented by using claims processing edits.
2. Medicare paid an additional $61 million for beneficiaries with no claims from their referring physicians.
3. In 2009, 267 suppliers of lower limb prostheses had questionable billing. Approximately 136 suppliers frequently submitted claims that did not meet certain Medicare requirements or were for beneficiaries with no claims from their referring physicians. An additional 131 suppliers had other questionable billing. This included billing for a high percentage of beneficiaries with no history of an amputation or missing limb or a high percentage of beneficiaries with unusual combinations of prostheses.
4. Medicare contractors conducted varying degrees of program safeguard activities related to lower limb prostheses.
   - The four DME MACs had varying claims processing edits in place, but none had edits for all requirements.
   - None of the DME MACs conducted medical reviews, and not all had conducted data analyses or provided education related to lower limb prostheses.
   - All ZPICs and DME PSCs conducted data analyses and opened investigations related to lower limb prostheses.

Recommendations
The OIG made six recommendations based upon their findings. The Centers for Medicare & Medicaid Services (CMS) concurred with five of the six recommendations made by the OIG. The recommendations and CMS actions are as follows:

OIG Recommendation 1: Implement additional claims processing edits to prevent inappropriate payments. CMS should instruct the four DME MACs to implement claims processing edits based on all of the local coverage determination requirements.
CMS Response: CMS concurred and stated it would instruct the DME MACs to implement consistent claims processing edits based on local coverage determination requirements.

OIG Recommendation 2: Strengthen monitoring of billing for lower limb prostheses. CMS should instruct the DME MACs, ZPICs, and DME PSCs to monitor billing for lower limb prostheses using the measures discussed in this report. CMS should develop thresholds for these measures and instruct its contractors to conduct additional reviews of suppliers that exceed the thresholds.
CMS Response: CMS concurred and stated it would issue guidance to the DME MACs and instruct them to consider the measures used in the OIG report as supplemental criteria for detecting high-risk suppliers.

OIG Recommendation 3: Implement requirements for a face-to-face encounter to establish the beneficiary's need for prostheses. We recommend that CMS implement requirements that the referring physician document that a face-to-face encounter occurred. This would help ensure that lower limb prostheses provided to beneficiaries are medically necessary.
CMS Response: CMS concurred and stated it is exploring its current authorities to implement such requirements. CMS also stated that it would issue an educational article to further explain policy requirements for lower limb prostheses and to providers and suppliers.

OIG Recommendation 4: Revise the requirements in the local coverage determination. CMS should work with the DME MACs to clarify several aspects of the local coverage determination. First, CMS should clarify the definitions

of beneficiaries' functional levels. Second, CMS should revise the local coverage determination or take other steps to require that licensed/certified medical professionals, such as physical therapists, evaluate beneficiaries to determine their potential functional levels. Finally, CMS should consider denying as medically unnecessary certain combinations of prostheses.
CMS Response: CMS concurred and stated it would review the definitions for the functional levels and develop refinements as appropriate. CMS also stated it would consider adapting an algorithm to guide determination of the functional status of the beneficiary.

OIG Recommendation 5: Enhance screening for currently enrolled suppliers of lower limb prostheses. Federal regulations place new DMEPOS suppliers at the high-risk level and currently enrolled DMEPOS suppliers at the moderate-risk level. CMS should consider placing current suppliers of lower limb prostheses at the high-risk level, thus subjecting them to the more rigorous screening procedures.
CMS Response: CMS did not concur and stated that it has in place sufficient tools that allow for increased scrutiny of existing DMEPOS suppliers. CMS noted that if an existing supplier meets one of several triggering events, that supplier automatically is elevated to the high-risk level.

OIG Recommendation 6: Take appropriate action on suppliers with questionable billing. In a separate memorandum, we will refer the suppliers that we identified to CMS for appropriate action.
CMS Response: CMS concurred and stated it would share the information with the DME MACs and the Recovery Audit Contractors. Recovery Audit Contractors review Medicare claims on a post payment basis to identify inappropriate payments.

The following section reviews Medicare policy for coverage of lower limb prostheses.

Key Points

Medicare Requirements for Lower Limb Prostheses
Provisions of the Social Security Act (the Act) govern Medicare payment for all items or services, including lower limb prostheses. The Act states that Medicare will cover only services and items considered reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body part.

In addition, Medicare requires that a supplier have an order from a physician before providing prostheses to the beneficiary. This physician is known as the referring physician. Upon receiving the order, the supplier consults with the referring physician, as needed, to confirm the order and recommend any necessary changes and evaluates the beneficiary. The supplier fits the beneficiary with the most appropriate prostheses. The supplier then determines the group of codes that best describes the prostheses provided, choosing from 178 Healthcare Common Procedure Coding System (HCPCS) codes that are specific to lower limb prostheses.

Note: If a supplier is replacing an old prosthesis and there is no upgrade in the model, the supplier does not need a physician order. Also, the "ordering" physician need not be a surgeon and may be the beneficiary's primary care physician.

Further, local coverage determination policies provide additional Medicare requirements for lower limb prostheses. These policies, consistent with policies for other DMEPOS, are identical across the country. The local coverage determination specifies how suppliers must submit claims for certain types and combinations of prostheses. In particular, it states that each claim must include a modifier to indicate whether the prosthesis is for the right or left limb. When a supplier provides prosthesis for each limb on the same date, the supplier must submit only one claim and include both the right and left modifiers on the claim.

The local coverage determination also has guidelines for determining the beneficiary's potential functional level. Specifically, it states that a beneficiary is placed at one of five potential functional levels based on the reasonable expectations of the supplier and the referring physician. When determining the potential functional level, suppliers and the referring physicians must take into account the beneficiary's history, current overall medical condition, and desire to walk. The supplier then uses a modifier on the claim to indicate the beneficiary's potential functional level (K0 to K4). Prostheses are not considered medically necessary if the beneficiary has the lowest potential functional level (K0), which indicates that he or she does not have the ability or the potential to walk. In addition, for some prostheses, the local coverage determination specifies the minimum potential functional level that the beneficiary must have for the prosthesis to be considered medically necessary.

Further, the local coverage determination limits the number of certain items that can be billed on a claim. If the number of units of these prostheses exceeds the limit, the additional items will be denied as not medically necessary. The local coverage determination also considers certain combinations of prostheses to be medically unnecessary. For example,

certain sockets are not allowed for use with temporary base prostheses. Finally, the local coverage determination states that HCPCS L5990, a specific type of foot addition, will be denied as not medically necessary.

In addition, CMS recently established new screening procedures for provider enrollment. For example, screening may include licensure and criminal background checks. CMS created three levels of screening – limited, moderate, and high – based on the risk of fraud, waste, and abuse. New DMEPOS suppliers were placed at the high risk level, while currently-enrolled DMEPOS suppliers were placed at the moderate risk level.

Note: You should ensure that any items or services submitted on Medicare claims are referred or ordered by Medicare-enrolled providers of a specialty type authorized to order or refer the same. You must also place the ordering or referring provider or supplier's NPI on the claim you submit to Medicare for the service or item you provide. You may want to review MLN Matters® Article SE1201 at http://www.cms.gov/MLNMattersArticles/downloads/SE1201.pdf for important reminders on the requirements for Ordering and Referring Physicians.

Additional Information
The entire OIG report titled "Questionable Billing By Suppliers of Lower Limb Prostheses" is available at http://oig.hhs.gov/oei/reports/oei-02-10-00170.pdf on the OIG website.

OVERPAYMENTS/REFUNDS

Immediate Recoupment for Claims Overpayments – Definition of Process Suppliers May Use

Suppliers may elect to have overpayment(s) repaid through the "immediate recoupment" process and avoid paying by check or waiting the standard recoupment process that begins on day 41 from the date of the demand letter.

This process is voluntary and for supplier's convenience. If used, the request must contain the following seven elements:

1. Provider/Supplier Name
2. Contact phone number
3. Supplier's PTAN and/or Suppliers' National Provider Identification (NPI)
4. Signature of the supplier or the Chief Financial Officer (CFO)
5. Letter number to identify the debt (i.e., the Document Control Number)
6. Indication of which type of immediate recoupment is being requested:
7. Suppliers must specify the type of request being submitted; however, request for immediate recoupment must be received in writing no later than 16 days from the date of initial demand letter.
    a. A request for the current overpayment address in this demand letter only, or
    b. A one-time request for the current overpayment and all future overpayments
8. The supplier's request must specifically state he/she understand potential receipt of interest payment pursuant to Section 1893(f)(2) for overpayments is begin waived.
    a. Note: Such interest may be payable for certain overpayments reversed at the Administrative Law Judge (ALJ).

The request can be submitted using either one of the following mechanisms:

- Fax: 701-277-7894
- Email: dmemsprecoupment@noridian.com
- Postal: NAS DME Recoupment, PO Box 6727, Fargo ND, 58108-6727

If there is a remaining principal balance after the initial immediate recoupment contractors' shall continue recoupment and other collection activities.

In the event the supplier elects to modify their current immediate recoupment arrangement, they must notify NAS with a new request. This would include the seven elements identified above.

Source: Change Request 7688; MLN Matters 7688

Overpayment Indicator on Redetermination Request Form: What Does It Mean?

NAS has seen an increase of suppliers inappropriately checking the Overpayment Appeal box on the Redetermination Request Form. This should only be checked if the supplier has received an overpayment demand letter specifying the cause of the overpayment with the DME MAC, Medical Review, Zone Program Integrity Contractor (ZPIC), Comprehensive Error Rate Testing (CERT) or the Recovery Auditor.

Delays in processing occur when the form is not completed correctly.

Refunding Medicare – Questions, Answers, and Benefits Regarding New Immediate Offset Process

Would you like to avoid having to initiate a check and send paperwork to NAS in response to an overpayment request letter? By using the process outlined in CMS Change Request 7688 and the Request for Immediate Offset Form, suppliers can have their Medicare account set to immediately offset/withhold payment for debt from a current Medicare payment. This does not impact a supplier's ability to appeal an overpayment. Common questions and answers have been prepared to help suppliers determine if initiating an immediate offset indicator for their future debt would be beneficial for their business practice.

Q1. What may cause a Medicare overpayment that is not initiated by a supplier?
A1. There are a variety of situations that may cause a supplier to owe Medicare money on previously paid claims. Debt may be the result of a NAS initiated claim edit correction, the Recover Auditor findings, a Comprehensive Error Rate Testing (CERT) contractor finding, or as a result of an Office of Inspector General claim review. Part A and B providers and DME suppliers have one year to file a claim which may cause situations in which a claim was paid that would normally have been denied if all of the patient's services were filed in a sequential order. This may include Skilled Nursing Facility or Hospital admissions. Other situations that may cause debt include changes to the beneficiary's eligibility as maintained by the Social Security Administration (i.e., date of death, cancelled policy, election of a Managed Care Plan).

Q2. How are suppliers notified when they have debt owed to Medicare?
A2. Suppliers receive overpayment request letters that contain the detail of the Medicare claims that were processed which led to an overpayment. This initial overpayment notification letter includes the process a supplier may use to appeal the debt.

Q3. Why would a supplier want to elect to have all of their future debt automatically offset?
A3. Depending on the claim payment activity a supplier has with NAS, this Change Request 7688 standard "immediate recoupment" process gives suppliers the option to avoid interest from accruing on claims overpayments when the debt is recouped in full prior to or by the 30th day from the initial demand letter date. If the supplier does not appeal the identified overpayment, and the supplier has claim payment activity that would satisfy the debt, suppliers can avoid the administrative activity of creating the paperwork and sending NAS a check.

Q4. If a supplier who has elected to have their account set to automatically offset when debt is identified, can they change that decision?
A4. Yes, a supplier may change their election by providing the following information via fax (701-277-7894), e-mail (dmemsprecoupment@noridian.com), or postal mail (NAS DME Recoupment, PO Box 6727, Fargo ND, 58108-6727).

- Provider/Supplier Name
- Contact phone number
- Supplier's PTAN and/or Suppliers' National Provider Identification (NPI)
- Signature of the supplier or the Chief Financial Officer (CFO)
- Indication that the supplier requests that an existing immediate offset indicator be removed from their file.

Q5. If a supplier who has elected to have their account set to automatically offset when debt is identified, can they still appeal the overpayment identified?
A5. Yes. Suppliers will continue to receive overpayment letters with the details that were used to determine the debt. The letter defines the steps necessary to appeal the debt. If the debt is successfully appealed and the supplier has proven the claim was paid correctly, any debt and interest collected will be provided to the supplier and/or applied to any outstanding debt the supplier may have on file.

Q6. How can a supplier learn the status of existing overpayments?
A6. NAS offers suppliers three tools to determine the status of repayment for debt. First, the suppliers receive their overpayment request letter which contains the detail of the debt in addition to the Financial Control Number (FCN). Second, suppliers may use the FCN in the NAS IVR (1-877-320-0390) to gain specific details about the debt and collection activity. Third, suppliers can use the free online supplier portal, Endeavor, to enter the FCN to gain details regarding what claim(s) caused the debt as well as what checks, offsets, and interest have been collected to satisfy the debt.

Q7. Is a supplier who bills multiple DME MACs required to have their account set to Immediate Offset for every DME MAC or is the setting on a contractor-by-contractor basis?
A7. If a supplier bills multiple DME MACs, the supplier would need to initiate the immediate offset process with each DME MAC. Ensure the claim number used in the submission is specific to the claim processed by that DME MAC.

Additional resources regarding the Immediate Offset can be accessed from the NAS website:

- DME Request for Immediate Recoupment Form
- https://www.noridianmedicare.com/dme/news/docs/2012/02_feb/mm7688_revised.pdf
- https://www.noridianmedicare.com/dme/news/docs/2012/07_jul/immediate_recoupment_for_claims_overpayments_definition_of_process_suppliers_may_use.html

Refunds to Medicare

When submitting a voluntary refund to Medicare, please include the Refunds to Medicare form found on the Forms page of the NAS DME website. This form provides Medicare with the necessary information to process the refund properly. This is an interactive form, which NAS has created to make it easy for you to type and print out. We've included a highlight button to ensure you don't miss required fields. When filling out the form, be sure to refer to the Refunds to Medicare form instructions.

A separate interactive form has been created for MSP Inquiries & Refunds. Please use the MSP form for MSP issues.

Processing of the refund will be delayed if adequate information is not included. Medicare may contact the supplier directly to find out this information before processing the refund. If the specific patient name, HIC or claim number information is not provided, no appeal rights can be afforded.

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

Source: Transmittal 50, Change Request 3274, dated July 30, 2004

Reporting of Recoupment for Overpayment on the Remittance Advice (RA) with Patient Control Number

MLN Matters® Number: MM7499 Revised
Related Change Request (CR) #: CR 7499
Related CR Release Date: July 19, 2012
Related CR Transmittal #: R1101OTN
Effective Date: January 1, 2012
Implementation Date: January 3, 2012 for professional claims billed to carriers or B MACs; April 2, 2012 for institutional claims billed to Fiscal intermediaries or A MACs; October 1, 2012 for supplier claims submitted to DME MACs

Note: This article was revised on July 25, 2012, to reflect a revised CR7499 issued on July 19, 2012. The article was revised to show a revised transmittal number, CR release date, and Web address for accessing CR7499. All other information is the same.

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

Provider Action Needed
This article is based on Change Request (CR) 7499 which instructs Medicare's claims processing systems maintainers to replace the Health Insurance Claim (HIC) number being sent on the ASC X12 Transaction 835) with the Patient Control Number received on the original claim, whenever the electronic remittance advice (ERA) is reporting the recovery of an overpayment.

Background
The Centers for Medicare & Medicaid Services (CMS) generates Health Insurance Portability and Accountability Act (HIPAA) compliant remittance advice that includes enough information to providers so that manual intervention is not needed on a regular basis. CMS changed reporting of recoupment for overpayment on the ERA) as a response to provider request per CR6870 and CR7068. The MLN Matters article corresponding to CR6870 can be reviewed at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6870.pdf and CR7068 can be reviewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R812OTN.pdf on the CMS website.

It has been brought to the attention of CMS that providing the Patient Control Number as received on the original claim rather than the Health Insurance Claim (HIC) number would:

- Enhance provider ability to automate payment posting, and
- Reduce the need for additional communication (via telephone calls, etc.) that would subsequently reduce the costs for providers as well as Medicare.

CR7499 instructs the shared systems to replace the HIC number being sent on the ERA with the Patient Control Number, received on the original claim. The ERA will continue to report the HIC number if the Patient Control Number is not available. This would appear in positions 20-39 of PLB 03-2. A demand letter is also sent to the provider when the Accounts Receivable (A/R) is created. This document contains a claim control number for tracking purposes that is also reported in positions 1-19 of PLB 03-2 on the ERA. (DME ERAs (835's) will show a Financial Control Number in positions 1-14 of PLB 03-2 and the Adjustment Claim Control Number in positions 15-29 of PLB 03-2.)

Note: Instructions in CR7499 apply to the 005010A1 version of ASC X12 Transaction 835 only and do not apply to the Standard Paper Remit or the 004010A1 version of ASC X12 Transaction 835.

Additional Information
The official instruction, CR7499, issued to your carrier, FI, A/B MAC, DME MAC, or RHHI regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1101OTN.pdf on the CMS website.

OXYGEN

Assigned Codes for Home Oxygen Use for Cluster Headache in Clinical Trial (ICD-10)

MLN Matters® Number: MM7820
Related Change Request (CR) #: CR 7820
Related CR Release Date: May 11, 2012
Related CR Transmittal #: R2465CP
Effective Date: October 1, 2012
Implementation Date: October 1, 2012

Provider Types Affected
This MLN Matters® Article is intended for providers and suppliers who bill Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for providing home use of oxygen services to Medicare beneficiaries.

Provider Action Needed
Effective for claims with dates of service on or after October 1, 2012, your DME MAC will pay for home use of oxygen for the treatment of Cluster Headaches (CH) during the 36 month rental period, if the claims contain all of the codes and modifiers described in the Background Section below.

Change Request (CR) 7820, from which this article is taken, provides the oxygen codes and modifiers that will be used, effective October 1, 2012, to identify home use of oxygen for CH provided in a Medicare approved clinical study under Coverage with Evidence Development (CED) pursuant to the "National Coverage Determinations Manual," Chapter 1, Part 4 (Sections 200 – 310.1) Coverage Determinations, Section 240.22 (Home Oxygen Use to Treat Cluster Headache (CH) – (Effective January 4, 2011)).

Background

On January 14, 2011, the Centers for Medicare & Medicaid Services (CMS) released CR7235, "Home Use of Oxygen to Treat Cluster Headache (CH)," effective January 4, 2011, to be implemented February 14, 2011. (You can find the associated MLN Matters® Article at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads//MM7235.pdf on the CMS website).

CR7235 explained that effective for claims with dates of service on or after January 4, 2011, Medicare will allow for coverage of home use of oxygen to treat Medicare beneficiaries diagnosed with CH when those beneficiaries are enrolled in CMS approved clinical studies, for the purpose of gaining further evidence. The clinical studies must: 1) Compare normobaric 100% oxygen with at least one clinically appropriate comparator for the treatment of CH, and 2) Address whether the home use of oxygen improves Medicare beneficiaries' health outcomes in compliance with the criteria in the "Medicare National Coverage Determinations Manual," Chapter 1, Part 4 (Sections 200 – 310.1) Coverage Determinations, Section 240.2.2 (Home Oxygen Use to Treat Cluster Headache (CH) (Effective January 4, 2011)) which you can find at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads//ncd103c1_Part4.pdf on the CMS website.

The following oxygen codes and modifiers will be used, effective October 1, 2012, to identify home use of oxygen for CH, provided pursuant to a Medicare-approved clinical study under Coverage with Evidence Development (CED):

Code	Description
E0424	Stationary Compressed Gaseous Oxygen System, Rental; Includes Container, Contents, Regulator, Flowmeter, Humidifier, Nebulizer, Cannula or Mask, and Tubing
E0441	Stationary Oxygen Contents, Gaseous, 1 Month's Supply = 1 Unit
E0443	Portable Oxygen Contents, Gaseous, 1 Month's Supply = 1 Unit
Modifier	Description
QF	Prescribed Amount of Oxygen Exceeds 4 Liters Per minute (LPM) and Portable Oxygen is Prescribed
QG	Prescribed Amount of Oxygen is Greater than 4 Liters Per Minute (LPM).

Please note that for the treatment of CH, this policy refers to the use of gaseous oxygen equipment and contents only. Further, the usual dosage of oxygen for the treatment of CH is between 6-12 liters per minute. Modifiers "QG" or "QF" will be used with E0424 to adjust the monthly stationary oxygen payment amount to recognize that oxygen is prescribed for CH at a rate that exceeds 4 liters per minute. Therefore, during the 36 month rental period:

- If the beneficiary is prescribed stationary gaseous oxygen at a rate that exceeds 4 LPM, suppliers use the modifier "QG" with Healthcare Common Procedure Coding System (HCPCS) code E0424 to increase the monthly stationary oxygen payment amount by 50 percent.
- If the beneficiary is prescribed both stationary and portable gaseous oxygen at a rate that exceeds 4 LPM, suppliers use the modifier "QF" with HCPCS code E0424 to increase the monthly stationary oxygen payment amount by 50 percent in accordance with the payment rules found in the "Medicare Claims Processing Manual," Chapter 20 (Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)), Section 130.6 (Billing for Oxygen and Oxygen Equipment), which you can find at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads//clm104c20.pdf on the CMS website. A separate monthly payment is not allowed for the portable gaseous oxygen equipment described under HCPCS code E0431.

Payment for Oxygen Contents

Beginning with dates of service on or after the end date of service for the month representing the 36th payment for code E0424, suppliers may bill on a monthly basis for furnishing oxygen contents (stationary and/or portable). If only stationary gaseous oxygen equipment was furnished in month 36 and billed with code E0424, suppliers may bill on a monthly basis for stationary oxygen contents using HCPCS code E0441. However, if both gaseous stationary and portable oxygen equipment were furnished in month 36 and billed using code E0424 "QF", suppliers may bill on a monthly basis for both stationary and portable oxygen contents using HCPCS codes E0441 and E0443.

Additional Billing Information
Specifically, DME MACs will pay claims with dates of service on or after October 1, 2012, for home use of oxygen for the treatment of Cluster Headaches (CH) duringthe 36 month rental period, if they contain all of the following:

- HCPCS code E0424; and Modifier "QF" or "QG" andmodifier Q0 (clinical trial); and
- ICD-9 diagnosis code 339.00, 339.01, or 339.02; and
- ICD-9 diagnosis code V70.7; and
- POS 12 (home)

Adding the 8-digit clinical trial number is optional.

DME MACs will pay claims with dates of service on or after October 1, 2012, for home use of oxygen for the treatment of Cluster Headaches (CH) afterthe 36 month rental period, if they contain all of the following:

- HCPCS code E0441 and/or E0443; and
- Modifier modifier Q0 (clinical trial); and
- ICD-9 diagnosis code 339.00, 339.01, or 339.02; and
- ICD-9 diagnosis code V70.7; and
- POS 12 (home).

Again, adding the 8-digit clinical trial number is optional.

Effective October 1, 2012, DME MACs will deny claims received with HCPCS code E1399 when billed with ICD-9 diagnosis code(s) 339.00, 339.01, or 339.02. When denying such claims, they will use the following codes:

- Claim Adjustment Reason Code (CARC) 167 – This (these) diagnosis (es) are not covered. Note: Refer to the 835 Healthcare Policy Identification segment (loop 2110 Service Payment Information REF), if present.
- Remittance Advice Remark Code (RARC) N386 - This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at http://www.cms.gov/mcd/search.asp on the CMS website. If you do not have web access, you may contact the contractor to request a copy of the NCD.
- MSN 14.9- "Medicare cannot pay for this servi ce for the diagnosis shown on the claim."
- Group Code CO (Contractual Obligation)

CR7820 also relates the appropriate ICD-10 codes for CH are as follows:

- Cluster Headache ICD-10 diagnosis code(s): G44.001, G44.009, G44.011, G44.019, G44.021, or G44.029; and
- Clinical Trial ICD-10 diagnosis code Z00.6

Additional Information
The official instruction, CR7820, is located at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2465CP.pdf on the CMS website.

Widespread Prepayment Review for Liquid Oxygen and Oxygen Equipment Edit Effectiveness for 1st Quarter

The Jurisdiction D DME MAC Medical Review Department is conducting a widespread complex review of HCPCS codes E0439 and E0434. The first quarter edit effectiveness results from April 2012 through July 2012 are as follows:

The E0439 review identified 206 claims of which 109 were denied. This resulted in an overall error rate of 55%. A total of 11 claims were denied for no response to the additional documentation request. The E0434 review identified 89 claims of which 47 were denied. This resulted in an overall error rate of 54%. A total of 13 claims were denied for no response to the additional documentation request. Because the error rate remains high, NAS will continue with the widespread complex review.

The following are the top reasons for denial:

a. No medical records to support that the patient was seen and evaluated by the treating physician within 30 days prior to the date of initial certification

b. No documentation to support that alternative treatment measures have been tried or considered and deemed clinically ineffective prior to initiating home oxygen therapy

c. Requested documentation was not provided within the allotted time frame as referenced in the Medicare guidelines

d. No qualifying blood gas study submitted

e. When the qualifying blood gas study was not performed during an inpatient hospital stay, the documentation does not support that the reported test was performed while the patient was in a chronic stable state

f. The medical documentation does not support that the treating physician has determined that the patient has a severe lung disease or hypoxia-related symptoms that might be expected to improve with oxygen therapy

As a reminder, the Local Coverage Determination (LCD) for Oxygen and Oxygen Equipment (L11457) states in part:

Home oxygen therapy is covered only if all of the following conditions are met:

1. The treating physician has determined that the patient has a severe lung disease or hypoxia-related symptoms that might be expected to improve with oxygen therapy, and
2. The patient's blood gas study meets the criteria, and
3. The qualifying blood gas study was performed by a physician or by a qualified provider or supplier of laboratory services, and
4. The qualifying blood gas study was obtained under the following conditions:
   - If the qualifying blood gas study is performed during an inpatient hospital stay, the reported test must be the one obtained closest to, but no earlier than 2 days prior to the hospital discharge date, or
   - If the qualifying blood gas study is not performed during an inpatient hospital stay, the reported test must be performed while the patient is in a chronic stable state – i.e., not during a period of acute illness or an exacerbation of their underlying disease, and
5. Alternative treatment measures have been tried or considered and deemed clinically ineffective.

An in-depth explanation of the denial reasons are as follows:

a. The patient must be seen and evaluated by the treating physician within 30 days prior to the date of Initial Certification.

b. Alternative treatment measures have been tried or considered and deemed clinically ineffective.

c. A large number of suppliers failed to respond to our request for records.
Suppliers are in violation of Supplier Standard #28 when, upon request, they fail to provide requested documentation to a Medicare contractor. Medicare regulations (42 C.F.R §424.516[f]) stipulate that a supplier is required to maintain documentation for seven years from the date of service and, upon the request of CMS or a Medicare contractor, provide access to that documentation. Therefore, the consequences of failure to provide records may not only be a claim denial but also referral to the NSC.

d. In this policy, the term blood gas study includes both an oximetry test and an arterial blood gas test. Group I criteria include any of the following:

1. An arterial PO 2 at or below 55 mm Hg or an arterial oxygen saturation at or below 88 percent taken at rest (awake), or

2. An arterial PO 2 at or below 55 mm Hg, or an arterial oxygen saturation at or below 88 percent, for at least 5 minutes taken during sleep for a patient who demonstrates an arterial PO 2 at or above 56 mm Hg or an arterial oxygen saturation at or above 89 percent while awake, or

3. A decrease in arterial PO 2more than 10 mm Hg, or a decrease in arterial oxygen saturation more than 5 percent, for at least 5 minutes taken during sleep associated with symptoms (e.g., impairment of cognitive processes and [nocturnal restlessness or insomnia]) or signs (e.g., cor pulmonale, "P" pulmonale on EKG, documented pulmonary hypertension and erythrocytosis) reasonably attributable to hypoxemia, or

4. An arterial PO 2 at or below 55 mm Hg or an arterial oxygen saturation at or below 88 percent, taken during exercise for a patient who demonstrates an arterial PO 2 at or above 56 mm Hg or an arterial oxygen saturation at or above 89

percent during the day while at rest. In this case, oxygen is provided for during exercise if it is documented that the use of oxygen improves the hypoxemia that was demonstrated during exercise when the patient was breathing room air.

Group II criteria include the presence of (a) an arterial PO 2 of 56–59 mm Hg or an arterial blood oxygen saturation of 89 percent at rest (awake), during sleep for at least 5 minutes, or during exercise (as described under Group I criteria) and (b) any of the following:

5. Dependent edema suggesting congestive heart failure, or
6. Pulmonary hypertension or cor pulmonale, determined by measurement of pulmonary artery pressure, gated blood pool scan, echocardiogram, or "P" pulmonale on EKG (P wave greater than 3 mm in standard leads II, III, or AVF), or
7. Erythrocythemia with a hematocrit greater than 56 percent.

Group III includes patients with arterial PO 2 levels at or above 60 mm Hg or arterial blood oxygen saturations at or above 90 percent. For these patients there is a rebuttable presumption of noncoverage.

e. The qualifying blood gas study must be obtained under one of the following conditions:

1. If the qualifying blood gas study is performed during an inpatient hospital stay, the reported test must be the one obtained closest to, but no earlier than 2 days prior to the hospital discharge date, or
2. If the qualifying blood gas study is not performed during an inpatient hospital stay, the reported test must be performed while the patient is in a chronic stable state – i.e., not during a period of acute illness or an exacerbation of their underlying disease.

f. The medical documentation must support that the treating physician has determined that the patient has a severe lung disease or hypoxia-related symptoms that might be expected to improve with oxygen therapy

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Oxygen and Oxygen Equipment Local Coverage Determination (LCD) L11457 and Policy Article A33677. Suppliers can also review the Oxygen and Oxygen Equipment documentation checklist on the NAS website at https://www.noridianmedicare.com/dme/coverage/docs/checklists/oxygen_and_oxygen_equipment.pdf.

Information about probe/error validation reviews may be found in CMS Publication 100-8, Program Integrity Manual (PIM), Chapter 3 located at: http://www.cms.gov/manuals/downloads/pim83c03.pdf

PAP DEVICES

PAP Devices – Supplier Frequently Asked Questions

Ordering/Treating Physician Issues

1. **Question: The LCD uses the term "treating physician" in various places. What is the definition of a treating physician?**
   Answer: Medicare statute defines treating physician as one "…who furnishes a consultation or treats the beneficiary for a specific medical problem and who uses the [diagnostic x-ray tests, diagnostic laboratory tests and other diagnostic tests] results in the management of the beneficiary's specific medical problem." In a scenario where the beneficiary visits their primary care provider (PCP) who then refers the beneficiary to a sleep specialist for a polysomnogram and subsequent treatment with PAP and follow-up, both the PCP and the sleep specialist would be considered a "treating physician" within the context of Medicare regulations. Both physicians are engaged in diagnosing and treating the beneficiary for sleep disordered breathing. This scenario is quite common in medical practice where the primary medical care for the patient is rendered by the PCP and subspecialty physician consultation is engaged for specific diagnostic and/or therapeutic treatment outside the scope of the PCP's area of medical expertise.
2. **Question: Are nurse practitioners, clinical nurse specialists and physician assistants allowed to conduct the initial clinical evaluation and/or follow-up evaluation since the LCD states this must be done by the treating physician?**
   Answer: Yes. Medicare regulations provide for the use of nurse practitioners, clinical nurse specialists and physician assistants in the care of Medicare beneficiaries. The Social Security Act §1861(s) addresses the provision of Medical and Other Services as follows:

Physician Assistants: (K)(i) services which would be physicians' services if furnished by a physician and which are performed by a physician assistant under the supervision of a physician and which the physician assistant is legally authorized to perform by the State in which the services are performed, and such services and supplies furnished as incident to such services as would be covered if furnished incident to a physician's professional service, but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services.

Nurse Practitioners and Clinical Nurse Specialists: (K)(ii) services which would be physicians' services if furnished by a physician and which are performed by a nurse practitioner or clinical nurse specialist working in collaboration with a physician which the nurse practitioner or clinical nurse specialist is legally authorized to perform by the State in which the services are performed, and such services and supplies furnished as an incident to such services as would be covered if furnished incident to a physician's professional service, but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services.

3. **Question: Can a registered nurse (RN) conduct the follow-up evaluation?**
   Answer: No, the treating physician must be directly involved in the follow-up evaluation.

4. **Question: The policy states that the data that the physician evaluates must be for a period of 30 consecutive days.** The policy is silent on a time frame in which the physician must see the patient in relationship to the data.
   Answer: The physician may see the patient and conduct the follow-up evaluation between the 31 st and 91 st day. Continued coverage of a PAP device requires that a determination be made by the treating physician that the patient is benefiting from the use of the selected device as evidenced by a face-to-face clinical follow-up evaluation and adherence to therapy. While the documentation of adherence may occur following the treating physician's follow-up evaluation, the adherence report must be provided to the treating physician for inclusion in the patient's medical record in order to fulfill the requirement to assess therapy benefit. Consider the following example:
   - 11/01/08 Patient set up with a PAP device
   - 12/05/08 Face-to-face re-evaluation indicates subjective improvement, but objective data is not available
   - 01/30/09 Supplier obtains data demonstrating adherent use; faxes to MD for review
   - 02/01/09 Add KX modifier to fourth month's claim

5. **Question: Does the treating physician who does the initial face-to-face examination have to write the order for the PAP therapy or can it be ordered by the interpreting physician from the sleep lab?**
   Answer: The treating physician that does the initial face to face exam does not have to be the same physician that orders the CPAP.

6. **Question: Is there a time limit from initial face-to-face evaluation to the sleep study?**
   Answer: No time limit is specified in the policy; however, one would anticipate that these two events occur reasonably close together in time, typically within 3 months.

Adherence Monitoring

7. **Question: Help us understand the term "visual inspection" as it relates to adherence monitoring. What does this mean and how can it be documented?**
   Answer: The LCD was revised to include allowance for visual inspection based on comments that not all suppliers use devices that allow downloading of adherence information. Visual inspection means determining adherence by looking at information on the PAP device's display screen and documenting the values in a written report. As noted in a prior FAQ, the supplier may contact the beneficiary via telephone and ask them to read values from their device (i.e., phone-in compliance) or the supplier or physician may read the values during a home/office visit. The values must document that the patient is using the device for 4 or more hours per night for 70% of the nights in a consecutive 30-day period.

8. **Question: Can we report hours used, for example with information from a device with an hour meter, and meet the requirement for documenting adherence? For example, "Spoke to patient and she states that as of 12/01/08, there are a total of 650 hours on her CPAP machine. She states that she uses the CPAP every night and it is very beneficial. On 11/01/08, the beginning reading was 500 hours. This calculates to 5 hours per night for 30 days."**
   Answer: No. Devices that simply report "device on" time or "blower on" time will not provide enough information

to determine that the PAP device was used ≥ 4 hours per night on 70% of nights during a consecutive thirty (30) day period anytime during the first three (3) months of initial usage.

9. **Question: Several manufacturers have devices that report "sessions" of use. Are these types of devices acceptable to meet the LCD requirement for adherence?**
Answer: Possibly, depending on the definition of "session" which can vary based on the manufacturer or the session definition if a user-defined option. For example, consider a device that measures a "session" as use greater than X hours and also reports number of days used. Assuming that a session was set up to measure use ≥ 4 hours, one could use the number of session in conjunction with total days of use over a 30 day period and determine whether or not the patient met the adherence requirement.

10. **Question: We use devices from a manufacturer that reports adherence information on a rolling 30 day basis. Information is displayed in a window on the device; however, adherence may vary depending on which 30 day period is examined. How can we use this device and still meet the adherence requirement?**
Answer: Devices that report information on a rolling 30 day interval can be problematic if using visual inspection as the reporting method. One solution is to engage the beneficiary in their care and emphasize the importance of monitoring their therapy, including the potential loss of Medicare reimbursement for their PAP device due to failure to meet the adherence requirements. In the scenario with this specific piece of equipment, the supplier should instruct the beneficiary to monitor their device after the initial 30 days of use and report back to the supplier the point at which they meet the adherence metric.

    Note that most devices that allow one to potentially determine adherence through visual inspection are designed to report adherence information in much greater detail via download. Suppliers are strongly encouraged to discuss the capabilities of devices being considered for purchase with each manufacturer to determine the capacity for reporting adherence as defined in the LCD.

11. **Question: Must suppliers continue to document adherence as defined in the LCD after the initial 3 month period?**
Answer: No. Following the initial 3 month trial and documentation of use ≥ 4 hrs. per night on 70% of nights in a 30 consecutive day period, suppliers should document continued use of the device. This may be accomplished via documentation of attestation by the beneficiary.

12. **Question: The PAP LCD states "Adherence to therapy is defined as use of PAP ≥ 4 hours per night on 70% of nights during a consecutive thirty (30) day period anytime during the first three (3) months of initial usage." Can you please clarify whether the ≥ 4 hours per night is continuous use or cumulative use in a 24 hour period? Would a patient who uses the device for 4 hours a night, but has a break in usage of 45 minutes still satisfy the requirements of the LCD?**
Answer: The ≥ 4 hours per night is based on continuous use, with allowances for short breaks (e.g., toileting).

13. **Question: A patient was placed on PAP therapy and during the course of their 12 week trial period they were hospitalized for two weeks. How does this impact the requirement for adherence monitoring and timing of the face-to-face follow-up evaluation?**
Answer: The 12 week trial period applies to PAP use in the home setting. If a patient is admitted to an inpatient hospital or skilled nursing facility (SNF), the trial period is suspended. The trial period, including the requirement for adherence monitoring and the timing of the face-to-face re-evaluation (i.e., between the 31st and 91st day) resumes when the patient returns home.

14. **Question: Can continued coverage of PAP therapy be extended to patients who come close to meeting the adherence metric requirements but don't quite achieve all of them in the 90 day timeframe?**
Answer: No. All of the requirements must be met within the 90 day time frame. CMS' national coverage determination contained specific language that benefit from PAP therapy must be demonstrated in the first 12 weeks in order to provide continued coverage beyond that time. Compliance is a major issue with CPAP; failure of therapy is often related to mask fit, humidification, ramp time, etc. Most of these issues arise in the first few days of treatment and must be aggressively addressed by the supplier and/or treating physician. Even if that takes 4–6 weeks there is still adequate time to achieve the liberal local coverage determination metric of ≥ 4 hours per night on 70% of the nights in a 30 day period.

Reimbursement Issues

15. **Question: A patient received a CPAP device paid for by fee for service (FFS) Medicare in 1998 and now needs to replace their device. Do they have to get a face-to-face evaluation, a new sleep study and meet the other requirements in the new LCD?**

Answer: According to the LCD:

If a PAP device is replaced during the 5 year reasonable useful lifetime (RUL) because of loss, theft, or irreparable damage due to a specific incident, there is no requirement for a new clinical evaluation, sleep test, or trial period.

If a PAP device is replaced following the 5 year RUL, there must be a face-to-face evaluation by their treating physician that documents that the beneficiary continues to use and benefit from the PAP device. There is no requirement for a new sleep test or trial period.

16. **Question: A patient was diagnosed with obstructive sleep apnea and received a PAP device paid for by private insurance. The patient is now enrolled in FFS Medicare and needs a replacement PAP device and/or accessories. What is required for coverage?**
Answer: For beneficiaries who received a PAP device prior to enrollment in FFS Medicare and are now seeking Medicare coverage of either a replacement PAP device and/or accessories, both of the following coverage requirements must be met:

    1. Sleep test – There must be documentation that the beneficiary had a sleep test, prior to FFS Medicare, that meets the FFS Medicare AHI/RDI coverage criteria in effect at the time that the beneficiary seeks a replacement PAP device and/or accessories; and,

    2. Clinical Evaluation – Following enrollment in FFS Medicare, the beneficiary must have a face-to-face evaluation by their treating physician who documents in the beneficiary's medical record that:

        1. The beneficiary has a diagnosis of obstructive sleep apnea; and,

        2. The beneficiary continues to use the PAP device.

If either criteria 1 or 2 above are not met, the claim will be denied as not medically necessary. The supplier may hold claims, pending confirmation that the above requirements are met, and then submit claims with the KX modifier beginning with the date of the beneficiary's enrollment in FFS Medicare.

17. **Question: DME company ABC conducts home sleep tests and then refers patients to DME company XYZ for PAP therapy after the physician makes the diagnosis of obstructive sleep apnea. Since the two companies are not related and DME company XYZ did not conduct the home sleep test, is DME company XYZ allowed to dispense the PAP device based on this test?**
Answer: No, a DME supplier is not a qualified provider of laboratory services; therefore, this is not a valid test for Medicare purposes. According to the PAP LCD, "No aspect of an HST [home sleep test], including but not limited to delivery and/or pickup of the device, may be performed by a DME supplier. This prohibition does not extend to the results of studies conducted by hospitals certified to do such tests."

18. **Question: If a patient is put on a RAD device with less than 30 day left in the initial 91 day period, the LCD indicates that the patient will be given to 120 days after the initiation of PAP therapy to document adherence. If the patient had a face to face exam in the 31 to 91 day period while on a CPAP device, must they have another face to face exam after they are on RAD? Certainly if they did not have a face to face exam in the 31 to 90 days we understand that one would need to be done before the 120th day.**
Answer: Yes, the patient would need to have a follow-up evaluation before the 120th day to determine benefit from the RAD device. This answer is based on the assumption that the reason the patient changed from a CPAP to RAD is the failure to show clinical benefit with the CPAP device. According to the NCD, continued coverage requires demonstration of therapy benefit within the first 90 days. The LCD recognizes that some patients may require a change in therapy to a RAD device and this transition may happen late in the first 90 day period such that an extension to 120 days is necessary.

19. **Question: If compliance is not documented in the first 90 days and the patient then has a new facility-based polysomnogram and face-to-face evaluation with a physician and a new trial period is begun, does a new capped rental period start?**
Answer: No. Standard break-in-need rules apply because there has been no change in the underlying condition that necessitates the PAP therapy. Consequently, a new capped rental period does not begin.

20. **Question: Would it be considered use of a blanket Advance Beneficiary Notice (ABN) to have all new PAP patients sign an ABN at the beginning of therapy stating that if they do not get a face-to-face evaluation or refuse to get the follow-up re-examination by their treating physician between the 31st and 91st day that Medicare will deny the claim?**

Answer: Yes, it would be considered a "blanket" ABN if the notice was presented at the beginning of therapy for the purpose of transferring financial liability to the beneficiary. However, the supplier may issue a voluntary ABN at the start of therapy, or at any time during therapy, to forewarn the beneficiary of the potential for Medicare noncoverage if certain clinical requirements are not met during the trial period. The beneficiary does not select an option box or sign a voluntary ABN, and the voluntary ABN does not transfer liability to the beneficiary.

Beginning on Day 61 of the trial period, if the supplier has knowledge that the beneficiary is not making efforts to meet policy criteria for continued coverage or there is other reason to anticipate that continued coverage will be denied, a mandatory ABN may be issued. The beneficiary should choose an option box, and sign and date the ABN when a mandatory ABN is issued.

This ABN should advise the beneficiary that if, by the 90th day of therapy, s/he does not meet the policy criteria for continue coverage (e.g., adherent to therapy and obtain a follow-up face-to-face evaluation), Medicare may deny subsequent claim(s) and the beneficiary will be liable for payment.

Additional information regarding issuance of voluntary and mandatory ABNs can be found in the Internet Only Manual (IOM) 100-04, Medicare Claims Processing Manual, Chapter 30, Section 50. This can be accessed via the CMS website: http://www.cms.gov/Manuals/IOM/.

21. **Question: What can a supplier do if the patient does not get in to see the treating physician within the 31st–91st day?**
Answer: If the patient received the re-evaluation at a later date and it was documented that the patient was benefiting from the use of the PAP device, the supplier may begin submitting claims with the KX modifier from the date of that re-evaluation. Claims for services in the interim between the 91st day and the date of the re-evaluation must be submitted with the KX omitted.

22. **Question: What can be done in a situation where an order is received for PAP therapy but the patient never had a face-to-face evaluation? Can the face-to-face evaluation be done after the sleep test or after initiation of PAP therapy and will that meet our documentation requirements?**
Answer: The NCD and LCD require that prior to initiating PAP therapy; the patient has a clinical evaluation and sleep test. There is a sound clinical rationale for this specific sequence of events; therefore, a face-to-face evaluation performed after the sleep test or after the initiation of PAP therapy would not meet the coverage requirements and a KX modifier must not be added to the claim. Suppliers may obtain an ABN to inform the beneficiary that the PAP device will not be covered since the coverage requirements were not met.

For more information, please refer to the Local Coverage Decision Policies by clicking on the following link. http://www.CGSMedicare.com/jc/coverage/LCDinfo.html.Suppliers should contact the Pricing, Data Analysis, and Coding contractor (PDAC) for guidance on the correct coding of specific items.

PECOS

Edits on the Ordering/Referring Providers in Medicare Part B, DME and Part A HHA Claims (Change Requests 6417, 6421, 6696, and 6856)

MLN Matters® Number: SE1011 Revised

Note: This MLN Matters® Article was revised on June 20, 2012, to delete the first bullet point on page 3 and make several grammatical changes. All other information is the same.

Provider Types Affected
This Special Edition MLN Matters® Article is intended for physicians, non-physician practitioners (including interns, residents, fellows, and also those who are employed by the Department of Veterans Affairs (DVA) or the Public Health Service (PHS)) who order or refer items or services for Medicare beneficiaries, Part B providers and suppliers who submit claims to carriers, Part B Medicare Administrative Contractors (MACs), Part A Regional Home Health Intermediaries, Fiscal Intermediaries who still have a Home Health Agency (HHA) workload and DME MACs for items or services that they furnished as the result of an order or a referral should be aware of this information.

Provider Action Needed
If you order or refer items or services for Medicare beneficiaries and you do not have a Medicare enrollment record, you need to submit an enrollment application to Medicare. You can do this using Internet-based PECOS or by completing the paper enrollment application (CMS-855O). Review the background and additional information below and make sure that your billing staffs are aware of these updates.

What Providers Need to Know
Phase 1: Beginning October 5, 2009, if the billed Part B service requires an ordering/referring provider and the ordering/referring provider is not reported on the claim; the claim will not be paid. If the ordering/referring provider is reported on the claim, but does not have a current enrollment record in PECOS or is not of a specialty that is eligible to order and refer, the claim will be paid and the billing provider will receive an informational message in the remittance indicating that the claim failed the ordering/referring provider edits.

Phase 2: CMS has not announced a date when the edits for Phase 2 will become active. CMS will give the provider community at least 60 days notice prior to turning on these edits. During Phase 2, Medicare will deny Part B, DME and Part A HHA claims that fail the ordering/referring provider edits. Physicians and others who are eligible to order and refer items or services need to establish their Medicare enrollment record and must be of a specialty that is eligible to order and refer.

Enrollment applications must be processed in accordance with existing Medicare instructions. It is possible that it could take 45-60 days, sometimes longer, for Medicare enrollment contractors to process enrollment applications. All enrollment applications, including those submitted over the web, require verification of the information reported. Sometimes, Medicare enrollment contractors may request additional information in order to process the enrollment application.

Waiting too late to begin this process could mean that your enrollment application will not be able to be processed prior to the implementation date of Phase 2 of the ordering/referring provider edits.

Background
The Centers for Medicare & Medicaid Services (CMS) has implemented edits on ordering and referring providers when they are required to be identified in Part B, DME and Part A HHA claims from Medicare providers or suppliers who furnished items or services as a result of orders or referrals.

Below are examples of some of these types of claims:

- Claims from laboratories for ordered tests;
- Claims from imaging centers for ordered imaging procedures; and
- Claims from suppliers of durable medical equipment, prosthetics, orthotics and supplies
- (DMEPOS) for ordered DMEPOS.
- Only physicians and certain types of non-physician practitioners are eligible to order or refer items or services for Medicare beneficiaries. They are as follows:
    - Physician (doctor of medicine or osteopathy, doctor of dental medicine, doctor of dental surgery, doctor of podiatric medicine, doctor of optometry),
    - Physician Assistant,
    - Certified Clinical Nurse Specialist,
    - Nurse Practitioner,
    - Clinical Psychologist,
    - Interns, Residents, and Fellows,
    - Certified Nurse Midwife, and
    - Clinical Social Worker.

Questions and Answers Relating to the Edits

1. **What will the edits do?** The edits will determine if the Ordering/Referring Provider (when required to be identified in a Part B, DME, and Part A HHA claims) (1) has a current Medicare enrollment record and it contains a valid National Provider Identifier (NPI) (the name and NPI must match), and (2) is of a provider type that is eligible to order or refer for Medicare beneficiaries (see list above).

2. **Why did Medicare implement these edits?** These edits help protect Medicare beneficiaries and the integrity of the Medicare program.

3. **How and when will these edits be implemented?** These edits are being implemented in two phases:

- **Phase 1:** Beginning October 5, 2009, if the billed Part B service requires an ordering/referring provider and the ordering/referring provider is not reported on the claim, the claim is not paid. If the ordering/referring provider is reported on the claim, but does not have a current Medicare enrollment record or is not of a specialty that is eligible to order and refer, the claim was paid, but the billing provider received an informational message1 in the Medicare Remittance Advice2 indicating that the claim failed the ordering/referring provider edits.

1 The informational messages vary depending on the claims processing system.

2 DMEPOS suppliers who submit paper claims will not receive an informational message on the Remittance Advice.

The informational message will indicate that the identification of the ordering/referring provider is missing, incomplete, or invalid, or that the ordering/referring provider is not eligible to order or refer. The informational message on an adjustment claim that does not pass the edits will indicate that the claim/service lacks information that is needed for adjudication. The informational messages are identified below:

For Part B providers and suppliers who submit claims to carriers:

N264	Missing/incomplete/invalid ordering physician provider name
N265	Missing/incomplete/invalid ordering physician primary identifier

For adjusted claims CARC code 45 along with RARC codes N264 and N265 will be used. DME suppliers who submit claims to carriers (applicable to 5010 edits):

N544 Alert	Although this was paid, you have billed with a referring/ordering provider that does not match our system record. Unless, corrected, this will not be paid in the future

For Part A HHA providers who order and refer the claims system shall initially process the claim and add the following remark message:

N272	Missing/incomplete/invalid other payer attending provider identifier

For adjusted claims the CARC code 16 and/or the RARC code N272 shall be used.

Note: if the billed service requires an ordering/referring provider and the ordering/referring provider is not on the claim, the claim will not be paid.

- **Phase 2** CMS has not announced a date when the edits for Phase 2 will become active. CMS will give the provider community at least 60 days notice prior to turning on these edits. In Phase 2, if the Ordering/Referring Provider does not pass the edits, the claim will be denied. This means that the billing provider will not be paid for the items or services that were furnished based on the order or referral. The denial edits are identified below:

Below are the denial edits for Part B providers and suppliers who submit claims to carriers including DME:

254D	Referring/Ordering Provider Not Allowed To Refer
255D	Referring/Ordering Provider Mismatch
289D	Referring/Ordering Provider NPI Required

CARC code 16 and/or the RARC code N264 and N265 shall be used for denied or adjusted claims. Below are the denial edits for Part A HHA providers who submit claims:

37236 – This reason code will assign when	The statement "From" date on the claim is on or after the date the phase 2 edits are turned on. The type of bill is '32' or '33' Covered charges or provider reimbursement is greater than zero but the attending physician NPI on the claim is not present in the eligible attending physician file from PECOS or the attending physician NPI on the claim is present in the eligible attending physician files from PECOS but the name does not match the NPI record in the eligible attending physician files from PECOS or the specialty code is not a valid eligible code
37237 - This reason code will assign when	The statement "From" date on the claim is on or after the date the phase 2 edits are turned on. The type of bill is '32' or '33' The type of bill frequency code is '7' or 'F-P' Covered charges or provider reimbursement is greater than zero but the attending physician NPI on the claim is not present in the eligible attending physician file from PECOS or the attending physician NPI on the claims is present in the eligible attending physician files from PECOS but the name does not match the NPI record in the eligible attending physician files from PECOS or the specialty code is not a valid eligible code

CMS has taken actions to reduce the number of informational messages.
In December 2009, CMS added the NPIs to more than 200,000 PECOS enrollment records of physicians and non-physician practitioners who are eligible to order and refer but who had not updated their PECOS enrollment records with their NPIs.3

On January 28, 2010, CMS made available to the public, via the Downloads section of the "Ordering Referring Report" page on the Medicare provider/supplier enrollment website, a file containing the NPIs and the names of physicians and non-physician practitioners who have current enrollment records in PECOS and are of a type/specialty that is eligible to order and refer. The file, called the Ordering Referring Report, lists, in alphabetical order based on last name, the NPI and the name (last name, first name) of the physician or non-physician practitioner. To keep the available information up to date, CMS will replace the Report on a bi-weekly basis. At any given time, only one Report (the most current) will be available for downloading. To learn more about the Report, and to download it, go to http://www.cms.gov/Medicare/Provider-Enrollment-and- Certification/MedicareProviderSupEnroll/index.html; click on "Ordering Referring Report" (on the left). Information about the Report will be displayed.

3 NPIs were added only when the matching criteria verified the NPI.

Effect of Edits on Providers

a. **I order and refer. How will I know if I need to take any sort of action with respect to these two edits?**
In order for the claim from the billing provider (the provider who furnished the item or service) to be paid by Medicare for furnishing the item or service that you ordered or referred, you—the Ordering/Referring Provider—need to ensure that:

1. You have a current Medicare enrollment record.

- If you are not sure you are enrolled in Medicare, you may: (1) check the Ordering Referring Report mentioned above, and if you are on that report, you have a current enrollment record in Medicare and it contains your NPI; (2) contact your designated Medicare enrollment contractor and ask if you have an enrollment record in Medicare and it contains the NPI; or (3) use Internet-based PECOS to look for your Medicare enrollment record (if no record is displayed, you do not have an enrollment record in Medicare). If you choose (3), please read the

information on the Medicare provider/supplier enrollment web page about Internet-based PECOS before you begin.

- **If you do not have an enrollment record in Medicare:** You need to submit an enrollment application to Medicare in one of two ways:
  - **Use Internet-based PECOS** to submit your enrollment application over the Internet to your designated Medicare enrollment contractor. You will have to either e-sign the certification statement or mail a printed, signed, and dated Certification Statement and any required supporting paper documentation, to your designated Medicare enrollment contractor. The designated enrollment contractor cannot begin working on your application until it has received the signed and dated Certification Statement. If you will be using Internet-based PECOS, please visit the Medicare provider/supplier enrollment web page to learn more about the web-based system before you attempt to use it. Go to http://www.cms.gov/Medicare/Provider-Enrollment-and- Certification/MedicareProviderSupEnroll/index.html, click on "Internet-based PECOS" on the left-hand side, and read the information that has been posted there. Download and read the documents in the Downloads Section on that page that relate to physicians and non-physician practitioners. A link to Internet-based PECOS is included on that web page.
  - Submit an electronic application through the use of internet-based PECOS or obtain a paper enrollment application, fill it out, sign and date it, and mail it, along with any required supporting paper documentation, to your designated Medicare enrollment contractor. If you order or refer items or services for Medicare beneficiaries and you do not have a Medicare enrollment record, you need to submit an enrollment application to Medicare. You can do this using Internet-based PECOS or by completing the paper enrollment application (CMS-855O). Enrollment applications are available via internet-based PECOS or .pdf for downloading from the CMS forms page (http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/index.html).

NOTE about physicians/non-physician practitioners who have opted-out of Medicare but who order and refer: Physicians and non-physician practitioners who have opted out of Medicare may order items or services for Medicare beneficiaries. Their opt-out information must be current (an affidavit must be completed every 2 years, and the NPI is required on the affidavit).

2. **You are of a type/specialty that can order or refer items or services for Medicare beneficiaries**. When you enrolled in Medicare, you indicated your Medicare specialty. Any physician specialty (Chiropractors are excluded) and only the non-physician practitioner specialties listed above in this article are eligible to order or refer in the Medicare program.

b. **I bill Medicare for items and services that were ordered or referred. How can I be sure that my claims for these items and services will pass the Ordering/Referring Provider edits?**
As the Billing Provider, you need to ensure that your Medicare claims for items or services that you furnished based on orders or referrals will pass the edits on the Ordering/Referring Provider so that you will not receive informational messages in Phase 1 and so that your claims will be paid in Phase 2.

You need to use due diligence to ensure that the physicians and non-physician practitioners from whom you accept orders and referrals have current Medicare enrollment records (i.e., they have Medicare enrollment records that contain their NPIs) and are of a type/specialty that is eligible to order or refer in the Medicare program. If you are not sure that the physician or non-physician practitioner who is ordering or referring items or services meets those criteria, it is recommended that you check the Ordering Referring Report described earlier in this article. Ensure you are correctly spelling the Ordering/Referring Provider's name. If you furnished items or services from an order or referral from someone on the Ordering Referring Report, your claim should pass the Ordering/Referring Provider edits. Keep in mind that this Ordering Referring Report will be replaced bi-weekly to ensure it is current. It is possible, therefore, that you may receive an order or a referral from a physician or non-physician practitioner who is not listed in the Ordering Referring Report but who may be listed on the next Report. You may appeal a claim that did not initially pass the Ordering/Referring provider edits.

Make sure your claims are properly completed. Do not use "nicknames" on the claim, as their use could cause the claim to fail the edits. Do not enter a credential (e.g., "Dr.") in a name field. On paper claims (CMS-1500), in item 17, you should enter the Ordering/Referring Provider's first name first, and last name second (e.g., John Smith). Ensure that the name and the NPI you enter for the Ordering/Referring Provider belong to a physician or non-physician practitioner and not to an organization, such as a group practice that employs the physician or non-physician practitioner who generated the order or referral. Make sure that the qualifier in the electronic claim

(X12N 837P 4010A1) 2310A NM102 loop is a 1 (person). Organizations (qualifier 2) cannot order and refer. If there are additional questions about the informational messages, Billing Providers should contact their local carrier, A/B MAC, or DME MAC.

Billing Providers should be aware that claims that are denied because they failed the Ordering/Referring Provider would expose the Medicare beneficiary to liability. **Therefore, an Advance Beneficiary Notice is not appropriate.**

Additional Guidance

1. A note on terminology: Part B claims use the term "ordering/referring provider" to denote the person who ordered, referred or certified an item or service reported in that claim. CMS has used this term on its website and in educational products. The final rule uses technically correct terms: 1) a provider "orders" non physician items or services for the beneficiary, such as DMEPOS, clinical laboratory services, or imaging services and 2) a provider "certifies" home health services for a beneficiary. The terms "ordered" "referred" and "certified" are often used interchangeably within the health care industry. Since it would be cumbersome to be technically correct, CMS will continue to use the term "ordered/referred" in materials directed to a broad provider audience.
2. Orders or referrals by interns or residents. The IFC mandated that all interns and residents who order and refer specify the name and NPI of a teaching physician (i.e., the name and NPI of the teaching physician would have been required on the claim for service(s)). The final rule states that State-licensed residents may enroll to order and/or refer and may be listed on claims. Claims for covered items and services from un-licensed interns and residents must still specify the name and NPI of the teaching physician. However, if States provide provisional licenses or otherwise permit residents to order and refer services, CMS will allow interns and residents to enroll to order and refer, consistent with State law.
3. Orders or referrals by physicians and non-physician practitioners who are of a type/specialty that is eligible to order and refer who work for the Department of Veterans Affairs (DVA), the Public Health Service (PHS), or the Department of Defense(DoD)/Tricare. These physicians and non-physician practitioners will need to enroll in Medicare in order to continue to order or refer items or services for Medicare beneficiaries. They may do so by filling out the paper CMS-855O or they may use Internet-based PECOS. They will not be submitting claims to Medicare for services they furnish to Medicare beneficiaries.
4. Orders or referrals by dentists. Most dental services are not covered by Medicare; therefore, most dentists do not enroll in Medicare. Dentists are a specialty that is eligible to order and refer items or services for Medicare beneficiaries (e.g., to send specimens to a laboratory for testing). To do so, they must be enrolled in Medicare. They may enroll by filling out the paper CMS-855O or they may use Internet-based PECOS. They will not be submitting claims to Medicare for services they furnish to Medicare beneficiaries.

Additional Information

You may want to review MLN Matters® Article SE1201 (http://www.cms.gov/Outreach-and- Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1201.pdf) for important reminders on the requirements for Ordering and Referring Physicians.

Phase 2 of Ordering and Referring Requirement

MLN Matters® Number: SE1221

Provider Types Affected

This MLN Matters® Special Edition Article is intended for:

- Physicians and non-physician practitioners (including interns, residents, fellows, and those who are employed by the Department of Veterans Affairs (DVA) or the Public Health Service (PHS)) who order or refer items or services for Medicare beneficiaries,
- Part B providers (including Portable X-Ray services) and suppliers of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) who submit claims to carriers, Part A/B Medicare Administrative Contractors (MACs), and DME MACs for items or services that they furnished as the result of an order or a referral, and
- Part A Home Health Agency (HHA) services who submit claims to RHHIs, Fiscal Intermediaries (who still maintain an HHA workload), and Part A/B MACs.

PECOS CONT'D

CMS will soon begin denying Part B, DME, and Part A HHA claims that fail the Ordering/Referring Provider edits. These edits ensure that physicians and others who are eligible to order and refer items or services have established their Medicare enrollment records and are of a specialty that is eligible to order and refer. CMS will provide 60 day advanced notice prior to turning on the Ordering/Referring edits. CMS does not have a date at this time.

CMS shall authorize A/B MACs and DME MACs to begin editing Medicare claims with Phase 2 Ordering/Referring edits. This means that the Billing Provider will not be paid for the items or services that were furnished based on the order or referral from a provider who does not have a Medicare enrollment record.

If you order or refer items or services for Medicare beneficiaries and you do not have a Medicare enrollment record, you need to submit an enrollment application to Medicare. You can do this using Internet-based PECOS or by completing the paper enrollment application (CMS-855O).

Background
The Social Security Act (the Act) requires that all physicians and non-physician practitioners be uniquely identified for all claims for services that are ordered or referred. Effective January 1, 1992, a physician or supplier that bills Medicare for a service or item must show the name and unique identifier of the attending physician on the claim if that service or item was the result of an order or referral. Effective May 23, 2008, the unique identifier was determined to be the National Provider Identifier (NPI).

CMS began expanding the claims editing to meet the Act's requirements for ordering and referring providers as follows:

- **Phase 1**: Beginning October 5, 2009, if the billed Part B service requires an ordering/referring provider and the ordering/referring provider is not reported on the claim, the claim is not paid. If the ordering/referring provider is reported on the claim, but does not have a current Medicare enrollment record or is not of a specialty that is eligible to order and refer, the claim was paid, but the billing provider received an informational message in the remittance advice indicating that the claim failed the ordering/referring provider edits.

  Only physicians and certain types of non-physician practitioners are eligible to order or refer items or services for Medicare beneficiaries. They are as follows:

  - Physician (doctor of medicine or osteopathy, doctor of dental medicine, doctor of dental surgery, doctor of podiatric medicine, doctor of optometry),
  - Physician Assistant,
  - Certified Clinical Nurse Specialist,
  - Nurse Practitioner,
  - Clinical Psychologist,
  - Interns, Residents, and Fellows
  - Certified Nurse Midwife, and
  - Clinical Social Worker.

The informational message will indicate that the identification of the Ordering/Referring provider is missing, incomplete, or invalid, or that the Ordering/Referring Provider is not eligible to order or refer. The informational message on an adjustment claim that does not pass the edits will indicate that the claim/service lacks information that is needed for adjudication. The informational messages are identified below:

For Part B providers and suppliers who submit claims to carriers:

N264	Missing/incomplete/invalid ordering physician provider name
N265	Missing/incomplete/invalid ordering physician primary identifier

For adjusted claims CARC code 45 along with RARC codes N264 and N265 will be used. DME suppliers who submit claims to carriers (applicable to 5010 edits):

N544 Alert	Although this was paid, you have billed with a referring/ordering provider that does not match our system record. Unless, corrected, this will not be paid in the future

PECOS CONT'D

For Part A HHA providers who order and refer, the claims system shall initially process the claim and add the following remark message:

N272	Missing/incomplete/invalid other payer attending provider identifier

For adjusted claims the CARC code 16 and/or the RARC code N272 shall be used.

Note: if the billed service requires an ordering/referring provider and the ordering/referring provider is not on the claim, the claim will not be paid.

- **Phase 2:** CMS has not announced a date when the edits for Phase 2 will become active. CMS will give the provider community at least 60 days notice prior to turning on these edits. During Phase 2, Medicare will deny Part B, DME and Part A HHA claims that fail the ordering/referring provider edits. Physicians and others who are eligible to order and refer items or services need to be enrolled in Medicare and must be of a specialty that is eligible to order and refer. If the billed service requires an ordering/referring provider and the ordering/referring provider is not on the claim, the claim will not be paid. If the ordering/referring provider is on the claim, but is not enrolled in Medicare, the claim will not be paid. In addition, if the ordering/referring provider is on the claim, but is not of a specialty that is eligible to order and refer, the claim will not be paid. Below are the denial edits for Part B providers and suppliers who submit claims to carriers including DME:

254D	Referring/Ordering Provider Not Allowed To Refer
255D	Referring/Ordering Provider Mismatch
289D	Referring/Ordering Provider NPI Required

CARC code 16 and/or the RARC code N264 and N265 shall be used for denied or adjusted claims. Below are the denial edits for Part A HHA providers who submit claims:

37236 – This reason code will assign when:	• The statement "From" date on the claim is on or after the date the phase 2 edits are turned on. • The type of bill is '32' or '33' • Covered charges or provider reimbursement is greater than zero but the attending physician NPI on the claim is not present in the eligible attending physician file from PECOS or the attending physician NPI on the claim is present in the eligible attending physician files from PECOS but the name does not match the NPI record in the eligible attending physician files from PECOS or the specialty code is not a valid eligible code
37237 - This reason code will assign when	• The statement "From" date on the claim is on or after the date the phase 2 edits are turned on. • The type of bill is '32' or '33' • The type of bill frequency code is '7' or 'F-P' • Covered charges or provider reimbursement is greater than zero but the attending physician NPI on the claim is not present in the eligible attending physician file from PECOS or the attending physician NPI on the claims is present in the eligible attending physician files from PECOS but the name does not match the NPI record in the eligible attending physician files from PECOS or the specialty code is not a valid eligible code

CMS published the final rule, CMS-6010-F, RIN 0938-AQ01, "Medicare and Medicaid Programs; Changes in Provider and Supplier Enrollment, Ordering and Referring, and Documentation Requirements; and Changes in Provider Agreements," on April 24, 2012, permitting Phase 2 edits to be implemented.

CMS will announce the date via an updated article when it shall authorize Part A/B and DME MACs and Part A RHHIs to implement Phase 2 edits.

Additional Information

A note on terminology: Part B claims use the term "ordering/referring provider" to denote the person who ordered,

referred or certified an item or service reported in that claim. CMS has used this term on its website and in educational products. The final rule uses technically correct terms: 1) a provider "orders" non physician items or services for the beneficiary, such as DMEPOS, clinical laboratory services, or imaging services and 2) a provider "certifies" home health services for a beneficiary. The terms "ordered" "referred" and "certified" are often used interchangeably within the health care industry. Since it would be cumbersome to be technically correct, CMS will continue to use the term "ordered/referred" in materials directed to a broad provider audience.

For more information about the Medicare enrollment process, visit http://www.cms.gov/Medicare/Provider-Enrollment-and- Certification/MedicareProviderSupEnroll/index.html, or contact the designated Medicare contractor for your State. Medicare provider enrollment contact information for each State can be found at http://www.cms.gov/Medicare/Provider-Enrollment-and- Certification/MedicareProviderSupEnroll/downloads/Contact_list.pdf on the CMS website.

The Medicare Learning Network® fact sheet, "Medicare Enrollment Guidelines for Ordering/Referring Providers" provides information about the requirements for eligible ordering/referring providers and is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network- MLN/MLNProducts/downloads/MedEnroll_OrderReferProv_FactSheet_ICN906223.pdf on the CMS website.

You may find the following articles helpful in understanding this matter:

- MLN Matters® Article MM6417, "Expansion of the Current Scope of Editing for Ordering /Referring Providers for Claims Processed by Medicare Carriers and Part B Medicare Administrative Contractors (MACs)," is available at http://www.cms.gov/Outreach-and- Education/Medicare-Learning-Network- MLN/MLNMattersArticles/downloads/MM6417.pdf on the CMS website.
- MLN Matters® Article MM6421, "Expansion of the Current Scope of Editing for Ordering/Referring Providers for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Suppliers' Claims Processed by Durable Medical Equipment Medicare Administrative Contractors (DME MACs)," is available at http://www.cms.gov/Outreach- and-Education/Medicare-Learning-Network- MLN/MLNMattersArticles/downloads/MM6421.pdf on the CMS website.
- MLN Matters® Article MM6856, "Expansion of the Current Scope of Editing for Attending Physician Providers for free-standing and provider-based Home Health Agency (HHA) claims processed by Medicare Regional Home Health Intermediaries (RHHIs)", is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network- MLN/MLNMattersArticles/downloads/MM6856.pdf on the CMS website.
- MLN Matters® Article MM7097, "Eligible Physicians and Non-Physician Practitioners Who Need to Enroll in the Medicare Program for the Sole Purpose of Ordering and Referring Items and Services for Medicare Beneficiaries," is available at http://www.cms.gov/Outreach-and- Education/Medicare-Learning-Network- MLN/MLNMattersArticles/downloads/MM7097.pdf on the CMS website.
- MLN Matters® Article MM6129, "New Requirement for Ordering/Referring Information on Ambulatory Surgical Center (ASC) Claims for Diagnostic Services," is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network- MLN/MLNMattersArticles/downloads/MM6129.pdf on the CMS website.
- MLN Matters® Special Edition Article SE1011, "Edits on the Ordering/Referring Providers in Medicare Part B Claims (Change Requests 6417, 6421, and 6696)," is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network- MLN/MLNMattersArticles/downloads/SE1011.pdf on the CMS website.
- MLN Matters® Article Special Edition Article SE1201 "Important Reminder for Providers and Suppliers Who Provide Services and Items Ordered or Referred by Other Providers and Suppliers" is available at http://www.cms.gov/Outreach-and-Education/Medicare- Learning-Network-MLN/MLNMattersArticles/downloads/SE1201.pdf on the CMS website.
- MLN Matters® Special Edition Article SE1208, "855-O Medicare Enrollment Application Ordering and Referring Physicians or Other Eligible Professionals," is available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network- MLN/MLNMattersArticles/downloads/SE1208.pdf on the CMS website.

REFILLS

Items Provided on a Recurring Basis and Request for Refill Requirements – Revised – June 2012

For all DMEPOS items that are provided on a recurring basis, suppliers are required to have contact with the beneficiary or caregiver/designee prior to dispensing a new supply of items. CMS has revised the requirements for refills effective for dates of service on or after August 2, 2011.

June 2012 Revision
This revision updates the original article. Changes include;

- Revised refill documentation instructions regarding consumable and non-consumable supplies
- Addition of External Breast Prosthesis LCD to the list of included policies

Requirements
For all DMEPOS items and supplies provided on a recurring basis, billing must be based on prospective, not retrospective use.

For DMEPOS products that are supplied as refills to the original order, suppliers must contact the beneficiary prior to dispensing the refill and not automatically ship on a pre-determined basis, even if authorized by the beneficiary. This shall be done to ensure that the refilled item remains reasonable and necessary, existing supplies are approaching exhaustion, and to confirm any changes/modifications to the order. Contact with the beneficiary or designee regarding refills must take place no sooner than 14 calendar days prior to the delivery/shipping date. For delivery of refills, the supplier must deliver the DMEPOS product no sooner than 10 calendar days prior to the end of usage for the current product. This is regardless of which delivery method is utilized.

For all DMEPOS items that are provided on a recurring basis, suppliers are required to have contact with the beneficiary or caregiver/designee prior to dispensing a new supply of items. Suppliers must not deliver refills without a refill request from a beneficiary. Items delivered without a valid, documented refill request will be denied as not reasonable and necessary.

Suppliers must not dispense a quantity of supplies exceeding a beneficiary's expected utilization. Suppliers must stay attuned to changed or atypical utilization patterns on the part of their clients. Suppliers must verify with the ordering physicians that any changed or atypical utilization is warranted. Regardless of utilization, a supplier must not dispense more than a one- or three-month quantity at a time. See below for billing frequencies.

Documentation Requirements
A routine refill prescription is not needed. A new prescription is needed when:

- There is a change of supplier
- There is a change in the item(s), frequency of use, or amount prescribed
- There is a change in the length of need or a previously established length of need expires
- State law requires a prescription renewal

For items that the patient obtains in person at a retail store, the signed delivery slip or copy of itemized sales receipt is sufficient documentation of a request for refill.

For items that are delivered to the beneficiary, documentation of a request for refill must be either a written document received from the beneficiary or a contemporaneous written record of a phone conversation/contact between the supplier and beneficiary. The refill request must occur and be documented before shipment. A retrospective attestation statement by the supplier or beneficiary is not sufficient. The refill record must include:

- Beneficiary's name or authorized representative if different than the beneficiary
- A description of each item that is being requested
- Date of refill request
- For consumable supplies i.e., those that are used up (e.g., ostomy or urological supplies, surgical dressings, etc.) – The Supplier should assess the quantity of each item that the beneficiary still has remaining to document that the amount remaining will be nearly exhausted on or about the supply anniversary date.
- For non-consumable supplies i.e., those more durable items that are not used up but may need periodic replacement (e.g., Positive Airway Pressure and Respiratory Assist Device supplies) – The supplier should assess whether

the supplies remain functional, providing replacement (a refill) only when the supply item(s) is no longer able to function . Document the functional condition of the item(s) being refilled in sufficient detail to demonstrate the cause of the dysfunction that necessitates replacement (refill).

This information must be kept on file and be available upon request.

Billing Frequencies
For refills of surgical dressings, enteral and parenteral nutrients and supplies, immunosuppressive drugs, oral anti-cancer drugs, intravenous immune globulin, external infusion pump drugs and supplies, and oral antiemetic drugs, only a one-month quantity of supplies may be dispensed.

For all other refills that are provided on a recurring basis, including but not limited to DME accessories or supplies, nebulizer drugs, urological and ostomy supplies, suppliers may dispense no more than a three-month supply at any one time.

Miscellaneous
The Local Coverage Determinations affected by these requirements will be updated in a future revision. The following policies are subject to these requirements:

- Automatic External Defibrillators
- Enteral Nutrition
- External Breast Prosthesis
- External Infusion Pumps
- Glucose Monitors
- Immunosuppressive Drugs
- Intravenous Immune Globulin
- Nebulizers
- Negative Pressure Wound Therapy
- Oral Anticancer Drugs
- Oral Antiemetic Drugs
- Ostomy Supplies
- Oxygen (for billable contents)
- Parenteral Nutrition
- Positive Airway Pressure Devices
- Respiratory Assist Devices
- Suction Pumps
- Surgical Dressings
- Tracheostomy Supplies
- Transcutaneous Electrical Nerve Stimulator (TENS)
- Urologic Supplies

These requirements are not limited to DMEPOS refills for items addressed in LCDs only. All DMEPOS items that are refilled on a recurring basis are subject to these requirements.

The original article, published August 2011, replaces the articles "Request for Refill – Documentation Requirements," published in September 2010 and "Dispensing DMEPOS Items: Quantity Limits" published in June 2007.

The June 2012 revision replaces the version published in August 2011.

For additional information, refer to CMS' Program Integrity Manual, Internet-Only Manual, CMS Pub. 100-8, Chapter 5, Section 5.2.5 and 5.2.6, and the applicable Local Coverage Determination and the Supplier Manual.

July Quarterly Update for 2012 DMEPOS Fee Schedule

MLN Matters® Number: MM7822
Related Change Request (CR) #: CR 7822
Related CR Release Date: May 11, 2012
Related CR Transmittal #: R2467CP
Effective Date: January 1, 2012
Implementation Date: July 2, 2012

Provider Types Affected
This MLN Matters® Article is intended for physicians, other providers, and suppliers submitting claims to Medicare contractors (Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), carriers, A/B Medicare Administrative Contractors (MACs), and Durable Medical Equipment MACs (DME MACs) for Durable Medical Equipment, Prosthetics Orthotics, and Supplies (DMEPOS) items or services paid under the DMEPOS fee schedule.

Provider Action Needed
This article is based on Change Request (CR) 7822 and alerts providers and suppliers that the Centers for Medicare & Medicaid Services (CMS) issued instructions updating the DMEPOS fee schedule payment amounts. Be sure your billing staffs are aware of these changes.

Note: Claims for codes L6715 and L6880 with dates of service on or after January 1, 2012, that were previously processed, will be adjusted to reflect the newly established fees if you bring those claims to your contractor's attention.

Background
The DMEPOS fee schedules are updated on a quarterly basis, when necessary, in order to implement fee schedule amounts for new codes and to revise any fee schedule amounts for existing codes that were calculated in error. The quarterly update process for the DMEPOS fee schedule is documented in the "Medicare Claims Processing Manual," Chapter 23, Section 60 at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c23.pdf on CMS website.

Key Points of CR7822
Healthcare Common Procedure Coding System (HCPCS) codes L6715 and L6880 were added to the HCPCS file effective January 1, 2012. The fee schedule amounts for the aforementioned HCPCS codes are established as part of this update and are effective for claims with dates of service on or after January 1, 2012. These items were paid on a local fee schedule basis prior to implementation of the fee schedule amounts established in accordance with this update. Claims for codes L6715 and L6880 with dates of service on or after January 1, 2012, that have already been processed, may be adjusted to reflect the newly established fees if you bring those claims to your contractor's attention.

Per CR7679, the claims filling jurisdiction for the following HCPCS codes is changed from DME MAC to joint local carrier and DME MAC jurisdiction, effective January 1, 2012:

- L8511 Insert for Indwelling Tracheoesophageal Prosthesis, With or Without Valve, Replacement Only
- L8512 Gelatin Capsules or Equivalent, For Use with Tracheoesophageal Voice Prosthesis, Replacement Only, Per 10
- L8513 Cleaning Device Used with Tracheoesophageal Voice Prosthesis, Pipet, Brush, Or Equal, Replacement Only, Each
- L8514 Tracheoesophageal Puncture Dilator, Replacement Only, Each
- L8515 Gelatin Capsule, Application Device for Use with Tracheoesophageal Voice Prosthesis, Each

Additional Information
The official instruction, CR7822 issued to your FI, RHHI, A/B MAC, and DME/MAC regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2467CP.pdf on the CMS website.

Current and past DMEPOS Fee schedules can be viewed at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/DMEPOS-Fee-Schedule.html on the CMS website.

REMITTANCE ADVICE

MREP – Version 3.2.4

The latest Claim Adjustment Reason Codes and Remittance Advice Remark Codes are available in the Codes.ini file for the Medicare Remit Easy Print (MREP) software. You can access this file in the Zipped folder for "Medicare Remit Easy Print - Version 3.2.4" on the MREP web page of the CMS website.

REPAIR/REPLACEMENT

Supplier Replacement of Beneficiary-owned Capped Rental Equipment Based upon Accumulated Repair Costs

Recently, the Durable Medical Equipment Medicare Administrative Contractors (DME MAC) have received inquiries about the Centers for Medicare & Medicaid Services' (CMS) Fact Sheet, Power Mobility Devices (PMDs): Complying with Documentation & Coverage Requirements.

The Fact Sheet states:

> Under a special rule established for certain patient-owned equipment, such as a power wheelchair for which the title has been transferred to the patient after 13 continuous months of rental, the supplier must replace the equipment free of charge if it does not last the full 5-year period (i.e., is no longer serviceable or needs substantial repairs). This replacement equipment does not need to be 'new'. For more information, refer to 42 Code of Federal Regulations (CFR) Section 414.210(e)(4).

This passage references regulations that implemented the Deficit Reduction Act of 2005 (DRA). This regulation stipulates that the supplier is responsible for replacement of a capped rental item if it is determined to be incapable of lasting for the entire 5 year reasonable useful lifetime. Replacement is provided at no cost to the beneficiary or to the Medicare program. 42 Code of Federal Regulations (CFR) Section 414.210(e)(4) states:

> (4)*Supplier replacement of beneficiary-owned equipment based on accumulated repair costs.* A supplier that transfers title to a capped rental item to a beneficiary in accordance with §414.229(f)(2)* is responsible for furnishing replacement equipment at no cost to the beneficiary or to the Medicare program if the carrier determines that the item furnished by the supplier will not last for the entire reasonable useful lifetime established for the equipment in accordance with §414.210(f)(1)**. In making this determination, the carrier may consider whether the accumulated costs of repair exceed 60 percent of the cost to replace the item.

* §414.229(f)(2) describes requirements for providing a capped rental item
** §414.210(f)(1) describes reasonable useful lifetime requirements

The default reasonable useful lifetime (RUL) of durable medical equipment (DME) is five years unless otherwise specified. Therefore, DME dispensed to Medicare beneficiaries is expected to remain in proper working condition throughout the required five year RUL. If it is determined based upon accumulated repair costs that the item is unable to last for the entire 5 year RUL, the supplier must replace the equipment with properly working equipment at no charge to the beneficiary or the Medicare program.

"Accumulated repair costs" refer to all repair claims from all suppliers for a given item after the rental period ends. These repair costs represent the total of all repair costs after the beneficiary has assumed ownership of the item.

The DME MACs encourage suppliers to provide DME items of sufficient quality to last for the entire 5 year RUL.

Refer to the Supplier Manual and/or the applicable Local Coverage Determination and related Policy Article for additional information on repairs and replacement.

TENS

Conductive Garment for Delivery of TENS or NMES Prepayment Widespread Review - 1st Quarter Edit Effectiveness

The Jurisdiction D DME MAC Medical Review Department is conducting a widespread complex review of the TENS conductive garment with HCPCS code E0731. The first quarter edit effectiveness results from April 2012 through July 2012 are as follows:

The results of the review, for item E0731, identified 88 claims of which 73 were denied. A total of 8 claims were denied for no response to the additional documentation request. This resulted in an overall error rate of 87%.

Due to the high error rate, NAS will continue with this widespread complex review.

The following are the top reasons for denial:

A. Medical documentation was either not submitted or did not document why 2 leads are insufficient to meet the patient's needs.

B. Medical documentation was either not submitted or did not document trial criteria.

C. The medical documentation does not support coverage of the garment purchase.

D. Proof of delivery was not submitted.

An in-depth explanation of the denial reasons are as follows:

A. Per LCD L11495, a TENS unit may be used with either 2 leads or 4 leads, depending on the characteristics of the patient's pain. If it is ordered for use with 4 leads, the medical record must document why 2 leads are insufficient to meet the patient's needs.

B. Per LCD L11495, when used for the treatment of chronic, intractable pain, the TENS unit must be used by the patient on a trial basis for a minimum of one month (30 days), but not to exceed two months. The trial period will be paid as a rental. The trial period must be monitored by the physician to determine the effectiveness of the TENS unit in modulating the pain. For coverage of a purchase, the physician must determine that the patient is likely to derive significant therapeutic benefit from continuous use of the unit over a long period of time. The physician's records must document a reevaluation of the patient at the end of the trial period, must indicate how often the patient used the TENS unit, the typical duration of use each time, and the results.

C. Per LCD L11495, a conductive garment (E0731) used with a TENS unit is rarely reasonable and necessary, but may be covered if all of the following conditions are met:

1. It has been prescribed by a physician for use in delivering covered TENS treatment; and
2. One of the medical indications outlined below is met:

a. The patient cannot manage without the conductive garment because there is such a large area or so many sites to be stimulated and the stimulation would have to be delivered so frequently that it is not feasible to use conventional electrodes, adhesive tapes, and lead wires; or

b. The patient cannot manage without the conductive garment for the treatment of chronic intractable pain because the areas or sites to be stimulated are inaccessible with the use of conventional electrodes, adhesive tapes, and lead wires; or

c. The patient has a documented medical condition, such as skin problems, that preclude the application of conventional electrodes, adhesive tapes, and lead wires; or

D. The patient requires electrical stimulation beneath a cast to treat chronic intractable pain.

A conductive garment is not covered for use with a TENS device during the trial period unless:

1. The patient has a documented skin problem prior to the start of the trial period; and
2. The item is reasonable and necessary for the patient.

d. Per the Medicare Program Integrity Manual, suppliers are required to maintain proof of delivery documentation in their files. Please refer to the Internet Only Manual, publication 100-08, chapter 5.8.

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Transcutaneous Electrical Nerve Stimulators (TENS) Local Coverage Determination (LCD) L11495 and Policy Article A37074.

Information about probe/error validation reviews may be found in the CMS Publication 100-08, Program Integrity Manual (PIM), Chapter 3.

TENS Device, 4 or More Leads, Prepayment Widespread Review - 1st Quarter Edit Effectiveness

The Jurisdiction D DME MAC Medical Review Department is conducting a widespread complex review of TENS device, 4 or more leads, with HCPCS code E0730. The first quarter edit effectiveness results from April 2012 through July 2012 are as follows:

The results of the review, for item E0730, identified 155 claims of which 153 were denied. A total of 13 claims were denied for no response to the additional documentation request. This resulted in an overall error rate of 99%.

Due to the high error rate, NAS will continue with this widespread complex review.

The following are the top reasons for denial:

a. Medical documentation was not provided to support the medical necessity for the billed items.

b. Medical documentation was either not submitted or did not document why 2 leads are insufficient to meet the patient's needs.

c. Medical documentation was either not submitted or did not document trial criteria.

d. Medical documentation was either not submitted or did not document other appropriate treatment modalities that have been tried and failed.

An in-depth explanation of the denial reasons are as follows:

a. Suppliers are in violation of Supplier Standard #28 when, upon request, they fail to provide requested documentation to a Medicare contractor. Medicare regulations (42 C.F.R §424.516[f]) stipulate that a supplier is required to maintain documentation for seven years from the date of service and, upon the request of CMS or a Medicare contractor, provide access to that documentation. Therefore, the consequences of failure to provide records may not only be a claim denial but also referral to the NSC.

b. Per LCD L11495, a TENS unit may be used with either 2 leads or 4 leads, depending on the characteristics of the patient's pain. If it is ordered for use with 4 leads, the medical record must document why 2 leads are insufficient to meet the patient's needs.

c. Per LCD L11495, when used for the treatment of chronic, intractable pain, the TENS unit must be used by the patient on a trial basis for a minimum of one month (30 days), but not to exceed two months. The trial period will be paid as a rental. The trial period must be monitored by the physician to determine the effectiveness of the TENS unit in modulating the pain. For coverage of a purchase, the physician must determine that the patient is likely to derive significant therapeutic benefit from continuous use of the unit over a long period of time. The physician's records must document a reevaluation of the patient at the end of the trial period, must indicate how often the patient used the TENS unit, the typical duration of use each time, and the results.

d. Per LCD L11495, other appropriate treatment modalities must have been tried and failed, and the medical record must document what treatment modalities have been used.

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Transcutaneous Electrical Nerve Stimulators (TENS) Local Coverage Determination (LCD) L11495 and Policy Article A37074.

Information about probe/error validation reviews may be found in the CMS Publication 100-8, Program Integrity Manual (PIM), Chapter 3.

THERAPEUTIC SHOES

3rd Quarter Edit Effectiveness for Therapeutic Shoes Review

The Jurisdiction D DME MAC Medical Review Department is conducting a widespread complex review of HCPCS codes A5500. The first quarter edit effectiveness results from March 2012 through June 2012 are as follows:

This review identified 4442 claims of which 4205 were denied. A total of 517 claims were denied for no response to the additional documentation request. This resulted in an overall error rate of 93%. Due to this high error rate, NAS will continue with the widespread complex review.

The following are the top reasons for denial:

a. Criterion 2 was not met per Policy Article (PA) A37076

b. Criterion 3 was not met per PA A37076

c. There was no documentation from the supplier to support an in-person visit at the time of delivery per Local Coverage Determination (LCD) L157 and PA A37076

d. There was no documentation from the supplier to support an in-person visit prior to selection of the item billed per Local Coverage Determination (LCD) L157 and PA A37076

An in-depth explanation of the denial reasons are as follows:

a. There must be documentation to support that the certifying physician has documented in the patient's medical record one or more of the following conditions:

   a. Previous amputation of the other foot, or part of either foot, or

   b. History of previous foot ulceration of either foot, or

   c. History of pre-ulcerative calluses of either foot, or

   d. Peripheral neuropathy with evidence of callus formation of either foot, or

   e. Foot deformity of either foot, or

   f. Poor circulation in either foot;

In order to meet criterion 2, the certifying physician must either:

   g. Personally document one or more of criteria a – f in the medical record of an in-person visit within 6 months prior to delivery of the shoes/inserts and prior to or on the same day as signing the certification statement; or

   f. Obtain, initial/sign, date (prior to or on the same day as signing the certification statement), and indicate agreement with information from the medical records of an in-person visit with a podiatrist, other M.D or D.O., physician assistant, nurse practitioner, or clinical nurse specialist that is within 6 months prior to delivery of the shoes/inserts, and that documents one of more of criteria a – f.

Note: The certification statement is not sufficient to meet the requirement for documentation in the medical record.

b. There must be documentation to support that the certifying physician has certified that indications (1) and (2) are met and that he/she is treating the patient under a comprehensive plan of care for his/her diabetes and that the patient needs diabetic shoes. For claims with dates of service on or after 1/1/2011, the certifying physician must:

- Have an in-person visit with the patient during which diabetes management is addressed within 6 months prior to delivery of the shoes/inserts; and
- Sign the certification statement (refer to the Documentation Requirements section of the related Local Coverage Determination) on or after the date of the in-person visit and within 3 months prior to delivery of the shoes/inserts.

Note: Per Policy Article A37076 the Certifying Physician is defined as a doctor of medicine (M.D.) or a doctor of osteopathy (D.O.) who is responsible for diagnosing and treating the patient's diabetic systemic condition through a comprehensive plan of care. The certifying physician may not be a podiatrist, physician assistant, nurse practitioner, or clinical nurse specialist

c. There must be documentation from the supplier to support an in-person visit at the time of delivery. The supplier must conduct and document an in-person visit with the patient. The in-person evaluation of the patient by the supplier at the time of delivery (refer to related Policy Article, Non-Medical Necessity Coverage and Payment Rules, criterion 5) must be conducted with the patient wearing the shoes and inserts and must document that the shoes/inserts/modifications fit properly.

d. There must be documentation from the supplier to support an in-person visit prior to selection of the item billed. Prior to selecting the specific items that will be provided, the supplier must conduct and document an in-person evaluation of the patient. The in-person evaluation of the patient by the supplier at the time of selecting the items that will be provided must include at least the following:

1. An examination of the patient's feet with a description of the abnormalities that will need to be accommodated by the shoes/inserts/modifications.
2. For all shoes, taking measurements of the patient's feet.
3. For custom molded shoes (A5501) and inserts (A5513), taking impressions, making casts, or obtaining CAD-CAM images of the patient's fee that will be used in creating positive models of the feet.

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Therapeutic Shoes for Persons with Diabetes Local Coverage Determination (LCD) L157 and Policy Article A37076. Suppliers can also review the Therapeutic Shoes documentation checklist on the NAS website at https://www.noridianmedicare.com/dme/coverage/docs/checklists/therapeutic_shoes.pdf.

Information about probe/error validation reviews may be found in CMS Publication 100-8, Program Integrity Manual (PIM), Chapter 3 located at: http://www.cms.gov/manuals/downloads/pim83c03.pdf

Toe Fillers and Diabetic Shoe Inserts – Coding Clarification

Questions have arisen about the correct coding for shoe inserts used to accommodate missing digits (toes) on feet for beneficiaries with and without diabetes. These items fall under two separate benefit categories and use two distinct Healthcare Common Procedure Coding System (HCPCS) codes, L5000 and A5513.

Beneficiaries without Diabetes
Shoe inserts for beneficiaries with missing toes or partial foot amputations who are not diabetic are considered for coverage under the prosthetic benefit. Code L5000 is described by:

L5000 – PARTIAL FOOT, SHOE INSERT WITH LONGITUDINAL ARCH, TOE FILLER

As noted in the descriptor, code L5000 describes a shoe insert with a rigid longitudinal arch support that also incorporates material accommodating the void left by the missing digit(s) or forefoot. Additional soft material is added where contact is made with the residual limb/toes. For beneficiaries missing digits, particularly the hallux (great toe), or the forefoot, L5000 inserts are designed to provide standing balance and toe off support for improved gait. The biomechanical control required of L5000 differs from the foot-protective function provided by inserts used as part of diabetes management.

For beneficiaries who are non-diabetic and require accommodation of missing foot digit(s) or forefoot, suppliers must only bill code L5000. Codes A5512 and A5513 describe inserts used with therapeutic shoes provided to persons with diabetes (see below) and must not be billed for non-diabetic beneficiaries.

Beneficiaries with Diabetes
A separate benefit category allows Medicare coverage of therapeutic shoes and inserts for persons with diabetes. Shoe inserts for persons with diabetes are described by the codes below:

A5512 – FOR DIABETICS ONLY, MULTIPLE DENSITY INSERT, DIRECT FORMED, MOLDED TO FOOT AFTER EXTERNAL HEAT SOURCE OF 230 DEGREES FAHRENHEIT OR HIGHER, TOTAL CONTACT WITH PATIENT'S FOOT, INCLUDING ARCH, BASE LAYER MINIMUM OF 1/4 INCH MATERIAL OF SHORE A 35 DUROMETER OR 3/16 INCH MATERIAL OF SHORE A 40 DUROMETER (OR HIGHER), PREFABRICATED, EACH

A5513 – FOR DIABETICS ONLY, MULTIPLE DENSITY INSERT, CUSTOM MOLDED FROM MODEL OF PATIENT'S FOOT, TOTAL CONTACT WITH PATIENT'S FOOT, INCLUDING ARCH, BASE LAYER MINIMUM OF 3/16 INCH MATERIAL OF SHORE A 35 DUROMETER OR HIGHER), INCLUDES ARCH FILLER AND OTHER SHAPING MATERIAL, CUSTOM FABRICATED, EACH

For a beneficiary with diabetes missing digit(s) or a forefoot, suppliers have two options for billing inserts:

Option 1: For diabetic beneficiaries who do not require the rigidity and support afforded by code L5000 (e.g., beneficiaries missing digits excluding the hallux), suppliers must bill code A5513 for an insert appropriately custom-fabricated to accommodate the missing digit(s). Codes L5000 or A5512 may not be billed in addition to code A5513.

THERAPEUTIC SHOES CONT'D

Option 2: For beneficiaries missing the hallux or a forefoot that require rigidity and support for effective gait, suppliers must bill L5000 for an insert appropriately custom-fabricated to accommodate the missing digit(s) or forefoot as well as providing the foot-protective functions required for a person with diabetes. Codes A5512 or A5513 may not be billed in addition to code L5000.

Suppliers are encouraged to review both the Therapeutic Shoes for Persons with Diabetes Local Coverage Determination and related Policy Article and the Lower Limb Prostheses Local Coverage Determination and related Policy Article for additional information on the coverage, coding and documentation of these items.

VACUUM ERECTION SYSTEM

HCPCS L7900 - Notification of Prepayment Review

NAS Jurisdiction D DME MAC Medical Review will be initiating a widespread prepayment probe review of claims for HCPCS code L7900 (VACUUM ERECTION SYSTEM). Widespread reviews are used to determine the extent of potential problem areas across multiple suppliers. This review is being initiated based on data analysis identifying a concern with changes in billing patterns.

In order to evaluate compliance with Medicare coverage and coding rules, all suppliers billing Jurisdiction D for HCPCS code L7900 are subject to this review. Suppliers of the selected claims will receive an *Additional Documentation Request* (ADR) letter asking for specific information to determine if the item billed complies with the existing reasonable and necessary criteria. Failure to supply the requested information within 45 days of the date on the letter will result in the claim being denied as not medically necessary. The ADR letter will provide instruction for submitting documentation.

This product is not referenced in an LCD or Policy Article so it is important for suppliers to be familiar with the documentation requirements in the Supplier Manual, Chapter 3 located at: https://www.noridianmedicare.com/dme/news/manual/chapter3.html

Information about probe/error validation reviews as well as documentation requirements may be found in CMS Publication 100-8, Program Integrity Manual (PIM), Chapter 3 and 5 located at: http://www.cms.hhs.gov/manuals/downloads/pim83c03.pdf and http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads//pim83c05.pdf

VERSION 5010

Denise Buenning from CMS Answers Industry's Top Questions About Version 5010 Upgrade

Upgrading to Version 5010 involves significant planning and preparation. The Version 5010/4010A electronic standards upgrade deadline was January 1, 2012. However, CMS enacted an enforcement discretion period through June 30, 2012 for all HIPAA-covered entities. It you haven't upgraded to Version 5010, it is important to begin testing now.

Denise Buenning, MsM, Acting Deputy Director, Office of E-health Standards & Services (OESS) recently took time to answer some of the industry's top questions on the Version 5010 upgrade.

1. Is the industry up to date with the Version 5010 upgrade and taking steps to prepare for the ICD-10 transition?
   Yes, we are hearing that the industry is progressing with Version 5010 implementation. We also continue to see from the Medicare Fee-For-service (FFS) group consistent increases across the board for 5010 transaction volumes and number of 5010 submitters. We are also hearing that the industry is continuing to take steps to prepare for ICD-10. ICD-10 is a major undertaking for providers, payers, and vendors. It will drive business and systems changes throughout the health care industry, from large national health plans to smaller provider offices, laboratories, hospitals, and more. The updates will go much more smoothly for organizations that plan ahead and prepare now. A successful upgrade to Version 5010 now and transition to ICD-10 later will be vital to transforming our nation's health care system.
2. What steps should I take if I am behind in the upgrade to Version 5010?
   There are a number of things that HIPAA-covered entities should do now. Communication among plans, providers, clearinghouses, and vendors, as well as other trading partners, is critical. Below outlines three steps providers can take now:

- Reach out to clearinghouses for assistance and/or take advantage of any free or low cost software that may be available from payers.
- Check with payers now to see what plans they will have in place to handle incoming claims, and what interim alternatives are available.
- Consider contacting financial institutions to establish lines of credit to get through any possible temporary interruptions in claims reimbursement as a result of not being Version 5010 compliant.

CMS has developed a fact sheet for health care providers, which discusses the risk mitigation steps in more detail.

3. How is CMS helping the industry prepare?

- The Workgroup for Electronic Data Interchange (WEDI) and CMS are holding a webinar on ASCX12 5010 implementation and problem solving on May 23 from 1-2:30pm ET. Registration is free. These online presentations are designed to gather feedback, track challenges and provide guidance to correcting ASC X12 5010 implementation-related issues.
- WEDI and CMS previously held a webinar on ASCX12 5010 implementation, and a replay of the webinar with the slides presented is located online.
- Additionally, the CMS website has official resources to help the industry prepare for Version 5010 and ICD-10. CMS will continue to add new tools and information to the site throughout the course of the transition. Sign up for ICD-10 Email Updates and follow @CMSgov on Twitter for the latest news and resources.

Keep Up to Date on Version 5010 and ICD-10
Please visit the ICD-10 website for the latest news and resources to help you prepare.

How to Avoid Common Version 5010 Claims Rejections

The deadline for the Version 5010 upgrade was January 1, 2012, and the enforcement discretion period for all HIPAA-covered entities to complete their upgrade to the Version 5010 electronic standards ends on June 30, 2012. The Version 5010 transaction standards have different requirements than those of Version 4010 and 4010A. There are a few things to keep in mind for processing your Version 5010 claims, which should help avoid unnecessary rejections:

1. **ZIP Code:** You need to include a complete 9-digit ZIP code for the billing provider and service facility location. You should work with your vendor to make sure that your system captures the full 9-digit ZIP.
2. **Billing Provider Address:** You need to use a physical address for your Billing Provider Address. Version 5010 does not allow for use of a PO Box address for either professional or institutional claim formats. You can still use a PO Box, however, as your address for payments and correspondence from payers as long as you report this location as a pay-to address.
3. **National Provider Identifier (NPI):** You were previously allowed to report an Employer's Identification Number (Tax ID) or Social Security Number (SSN) as a primary identifier for the billing provider. For Version 5010 claims, however, you are only allowed to report an NPI as a primary identifier.

For additional help with your Version 5010 upgrade and Medicare claims, you can contact your Medicare Administrative Contractor (MAC). The MACs work closely with clearinghouses, billing vendors, and health care providers who require assistance in submitting and receiving Version 5010 compliant transactions. If you experience difficulty reaching a MAC, you should send a message describing your issue to ProviderFeedback@cms.hhs.gov with "5010 Extension" in the subject line.

The Medicare Fee-For-Service group has created a fact sheet that provides guidance to help providers troubleshoot some of the difficulties they may experience with Version 5010 claims processing and links to each of the MAC websites, including lists of the top 10 edits for Version 5010 claims.

Keep Up to Date on Version 5010 and ICD-10
Please visit the ICD-10 website for the latest news and resources to help you prepare.

Implementation of the Paperwork Segment within 5010 837 Professional and Institutional Electronic Transactions

CMS is rescheduling the implementation date of the Paperwork (PWK) segment within the 5010 837 Professional and Institutional electronic transactions to October 1, 2012. The PWK segment provides the "linkage" between electronic claims and additional documentation which is needed for claims adjudication. The PWK was originally due to be implemented on April 1, 2012, but was delayed in order to address system concerns. For additional information, please refer to MLN Matters® Articles #MM7041 and #MM7306.

Important Reminders about HIPAA 5010 & D.0 Implementation

MLN Matters® Number: SE1106 Revised

Note: This article was revised on June 15, 2012, to include this statement that enforcement of the HIPAA 5010/D.0 standards will begin on July 1, 2012. Also, remember that when claims use nonspecific procedure codes, a corresponding description of the service is now required. All other information remains the same.

Provider Types Affected
This Special Edition MLN Matters® Article is intended for all physicians, providers, and suppliers who bill Medicare contractors (carriers, Fiscal Intermediaries (FIs), Medicare Administrative Contractors (A/B MACs), and Durable Medical Equipment MACs (DME MACs)) for services provided to Medicare beneficiaries.

Provider Action Needed
The implementation of HIPAA 5010 and D.0 presents substantial changes in the content of the data that you submit with your claims as well as the data available to you in response to your electronic inquiries. The implementation requires changes to the software, systems, and perhaps procedures that you use for billing Medicare and other payers. It is important for new providers enrolling in Medicare to know that Electronic Data Interchange (EDI) transactions are the normal mode of business for Medicare claims, claim status, and remittance advice.

Medicare requires the use of electronic claims (except for certain rare exceptions) in order for providers to receive Medicare payment. Effective January 1, 2012, you must be ready to submit your claims electronically using the Accredited Standards Committee (ASC) X12 Version 5010 and National Council for Prescription Drug Programs (NCPDP) Version D.0 standards. This also is a prerequisite for implementing the new ICD-10 codes. This Special Edition MLN Matters® Article is being provided by the Centers for Medicare & Medicaid Services (CMS) to assist you and keep you apprised of progress on Medicare's implementation of the ASC X12 Version 5010 and NCPDP Version D.0 standards. Remember that the HIPAA standards, including the ASC X12 Version 5010 and Version D.0 standards are national standards and apply to your transactions with all payers, not just with Fee-for-Service (FFS) Medicare. Therefore, you must be prepared to implement these transactions with regard to your non-FFS Medicare business as well. Medicare began Level II transitioning to the new formats on January 1, 2011, and will be ending the exchange of current formats on January 1, 2012. While the new claim format accommodates the ICD-10 codes, ICD-10 codes will not be accepted as part of the 5010 project. Separate MLN Matters® articles will address the ICD-10 implementation.

In preparing for the implementation of these new ASC X12 and NCPDP standards, providers should also consider the requirements for implementing the ICD-10 code set as well. You are encouraged to prepare for the implementation of these standards or speak with your billing vendor, software vendor, or clearinghouse to inquire about their readiness plans for these standards.

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

It is important that new providers enrolling in Medicare know that EDI transactions are the normal mode of business for Medicare claims, claim status, and remittance advice. More information about Medicare's EDI requirements can be found in the "Medicare Claims Processing Manual," Chapter 24 – "General EDI and EDI Support Requirements, Electronic Claims and Coordination of Benefits Requirements, Mandatory Electronic Filing of Medicare Claims," at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c24.pdf on the CMS website. Electronic billing and EDI transaction information can be found at http://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/index.html on the CMS website. This section contains information on:

- EDI transaction and corresponding paper claims requirements;
- Links to those chapters of the "Medicare Claims Processing Manual" that contain further information on these types of transactions;
- The Administrative Simplification Compliance Act (ASCA) requirement that claims be sent to Medicare electronically as a condition for payment;
- How you can obtain access to Medicare systems to submit or receive claim or beneficiary eligibility data electronically; and
- EDI support furnished by Medicare contractors.

Current versions of the transaction standards (ASC X12 Version 4010/4010A1 for health care transactions, and the NCPDP Version 5.1 for pharmacy transactions) are widely recognized as lacking certain functionality that the health care industry needs. Therefore, on January 16, 2009, HHS announced a final rule that replaced the current Version 4010/4010A and NCPDP Version 5.1 with Version 5010 and Version D.0, respectively. The final rule (CMS-0009-F) titled, "Health Insurance Reform; Modifications to the Health Insurance Portability and Accountability Act (HIPAA) Electronic Transaction Standards," can be found at http://edocket.access.gpo.gov/2009/pdf/E9-740.pdf on the US Government Printing Office (GSP) website.

Subsequently, CMS is performing activities to convert from processing the ASC X12 Version 4010A1 to HIPAA ASC X12 Version 5010, and the NCPDP Version 5.1 to NCPDP Version D.0.

HHS is permitting the dual use of existing standards (4010A1 and 5.1) and the new standards (5010 and D.0) from the March 17, 2009, effective date of the regulation until January 1, 2012, the fully compliant (Level I and Level II Compliance) date to facilitate testing subject to trading partner agreement.

- **Level I** compliance means "that a covered entity can demonstrably create and receive compliant transactions, resulting from the compliance of all design/build activities and internal testing."
- **Level II** compliance means "that a covered entity has completed end-to-end testing with each of its trading partners, and is able to operate in production mode with the new versions of the standards."

The CMS Medicare Fee-for-Service implementation schedule is:

- **Level I** April 1, 2010, through December 31, 2010;
- **Level II** January 1, 2011, through December 31, 2011; and
- **Fully compliant** on January 1, 2012.

CMS has prepared a comparison of the current ASC X12 HIPAA EDI standards (Version 4010/4010A1) with Version 5010, and NCPDP EDI standards Version 5.1 with Version D.0. For more information see http://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/index.html on the CMS website.

CMS has made the side-by-side comparison documents available to interested parties without guarantee and without cost. The documents are available for download in both Microsoft Excel and PDF formats.

The comparisons were performed for Medicare Fee-for-Service business use and while they may serve other uses, CMS does not offer to maintain for purposes other than Medicare Fee-for-Service. Maintenance will be performed without notification, as needed to support Medicare Fee-for-Service.

Readiness Assessment 1– Have you done the following to be ready for 5010/D.0?
Are you ready for 5010/D.0? Testing with external trading partners began in January of 2011. Testing with version 5010A1 Errata will begin in April 2011. Please don't wait until April to begin testing because compliance with the Errata must be achieved by the original regulation compliance date of January 1, 2012.

Visit http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/Versions5010andD0/downloads/readiness_1.pdf to see a summary of information that is important for your readiness assessment.

Do not wait to begin testing with your MAC because the MACs may not be able to accommodate large volumes of trading partners seeking production status all at once.

Be sure to start testing Version 5010 and D.0 as early as possible in 2011. Be prepared.

To download readiness checklists and a resource card with helpful web links go to http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/Versions5010andD0/index.html on the CMS website.

Readiness Assessment 2 – What do you need to have in place to test with your MAC?
Providers/trading partners should make it a priority to test early during calendar year 2011 with their MACs for the implementation of Versions 5010 and D.0 transactions so as not to impact future Medicare claim processing.

- Trading partner testing for the 5010 base version began with MACs on January 1, 2011.
- Testing with the 5010 errata version (5010A1) will be available for testing in April 2011.
- Successful testing with your MAC is required prior to being placed into production.

Prior to testing, trading partners should ensure their billing service, clearinghouse, or software vendor:

- Has passed testing requirements for each transaction (testing with each Medicare contractor or a certification system that the Medicare contractor has accepted); and
- Is using the same program/software to generate the transaction for all of their clients.

Details about Medicare testing requirements and protocols and the 5010 National Call presentation on Provider Outreach and Education – Transition Year Activities can be found at http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/Versions5010andD0/downloads/OE_National_Presentation_12-8-10.pdf on the CMS website.

Trading partners are encouraged to review the following:

- Version 5010 and D.0. transaction resources can be found at http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/Versions5010andD0/index.html?redirect=/Versions5010andD0/ on the CMS website;
- Educational Resources (i.e., Medicare Learning Network® (MLN) articles, fact sheets, readiness checklists, brochures, quick reference charts and guides, frequently asked questions, and transcripts from previous national provider calls) can be found at http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/Versions5010andD0/index.html on the CMS website; and
- The dedicated HIPAA 5010/D.0 Project web page, which includes technical documents and communications at national conferences, can be found at http://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/index.html on the CMS website.

Errata Requirements and Testing Schedule
HIPAA Version 5010 has new Errata, which can be found at http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/Versions5010andD0/downloads/Errata_Req_and_Testing.pdf on the CMS website. According to the published regulation (Federal Register, Vol. 74, No. 11, 3296-3328, January 16, 2009; RIN 0938-AM50 of 45 CFR Part 162), testing with external trading partners must begin in January of 2011. Compliance with the Errata must be achieved by the original regulation compliance date of January 1, 2012.

Medicare FFS will implement the errata versions of the affected 5010 transactions to meet HIPAA compliance requirements, and Medicare FFS contractors will be ready to test the 5010 Errata versions in April 2011.

Transactions not impacted by the errata can be tested starting January 2011 without regard to the published errata schedule. Trading Partners should contact their local Medicare FFS contractor for specific testing schedules. To find a Medicare FFS contractor in your state, please refer to the "Downloads" section at http://www.cms.gov/ElectronicBillingEDITrans/ on the CMS website.

CMS 5010 Provider Outreach and Education Materials
CMS has developed extensive information and educational resources pertaining to the topics listed below. This information is available on the CMS website:

- Version 5010- the new version of the X12 standards for HIPAA transactions;
- Version D.0 – the new version of the National Council for Prescription Drug Program (NCPDP) standards for pharmacy and supplier transactions;
- Version 3.0 – a new NCPDP standard for Medicaid pharmacy subrogation.

The information posted at http://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/index.html on the CMS website may be applicable to the healthcare industry at large, or may be specifically Medicare-related information. The "Overview" web page is designed to distinguish the Medicare-related information from the industry related.

Please note there are separate resource pages for D.0 and 3.0 for tools and information specific to these pharmacy-

related standards. The highlights and overview of these pages are as follows:

- **Federal Regulation & Notices** (http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/Versions5010andD0/index.html) This web page contains general information related to federal regulations and notices and contains the following link to the Final Rule for X12 5010, D.0 and 3.0 document. See http://edocket.access.gpo.gov/2009/pdf/E9-740.pdf on the GPO website.
- **CMS Communications** (http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/Versions5010andD0/index.html) This CMS Communications web page includes Versions 5010 & D.0 implementation information and the following downloads:
  - 5010 Implementation Calendar [PDF, 325KB]; see http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/Versions5010andD0/downloads/5010ImplementationCalendar.pdf on the CMS website.
  - Readiness Assessment - What do you need to have in place to test with your MAC? [PDF, 241KB]; see http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/Versions5010andD0/downloads/Readiness_2.pdf on the CMS website.
- **Educational Resources** (http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/Versions5010andD0/index.html)The Educational Resources web page includes information designed to increase national awareness and assist in the implementation of Versions 5010, D.0 and 3.0. Products that target a specific population, such as Medicare FFS, are clearly identified. Otherwise, products and information may be appropriate for the healthcare industry at large. This Web page includes the following downloads:
  - **Version 5010 Resource Card** [PDF, 243KB] (see http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/5010EDI_RefCard_ICN904284.pdf);
  - **Preparing for Electronic Data Interchange (EDI) Standards: The Transition to Versions 5010 and D.0 Fact Sheet** [PDF, 1208KB] (see http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/Versions5010andD0/downloads/w5010TransitionFctSht.pdf);
  - **Checklist for Level I Testing Activities** [PDF, 324 KB] (see http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/Versions5010andD0/downloads//w5010PrepChklst.pdf);
  - **Provider Action Checklist for a Smooth Transition** [PDF, 333KB] (see http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/Versions5010andD0/downloads/w5010PvdrActionChklst.pdf); and
  - **Versions 5010 and D.0 MLN Matters® Articles** [PDF, 31KB] (see http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/Versions5010andD0/downloads/Versions_5010_and_D0_MLN_Matters_Articles.pdf on the CMS website).

5010 National Calls

Throughout the implementation of Version 5010, CMS has been hosting a variety of national education calls that inform the provider community of the steps that they need to take in order to be ready for implementation. These calls also give participants an opportunity to ask questions of CMS subject matter experts. The 5010 web page contains the list of past calls with links to Web pages where you can download the past call presentations, transcripts, and audio files.

Additional Information

A Special Edition MLN Matters® article on the ICD-10 code set can be found at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE0832.pdf on the CMS website.

You may want to review MLN Matters® article SE1131 (http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1131.pdf) that references the approaching deadline of January 1, 2012, for 5010 implementation. SE1131 urges providers to contact their MACS for the free Version 5010 software and begin testing to avoid delays in payment for Fee-For-Service claims.

CMS is also using the Open Door Forums and listservs to keep providers informed of its implementation progress and will also use these vehicles to assist providers in preparing for the new standards. Information on the Open Door Forums can be found at http://www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForums/index.html on the CMS website.

Important Update Regarding 5010/D.0 Implementation – Action Needed Now

MLN Matters® Number: SE1131 Revised

Note: This article was revised on June 15, 2012, to include this statement that enforcement of the HIPAA 5010/D.0 standards will begin on July 1, 2012. Also, remember that when claims use nonspecific procedure codes, a corresponding description of the service is now required. All other information remains the same.

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

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

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

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

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

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

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

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

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

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

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

1. Have you contacted your software vendor (if applicable) to ensure that they are on track to meet the deadline or contacted your MAC to get the free Version 5010 software (PC-Ace Pro32)?
2. Alternatively, have you contacted clearinghouses or billing services to have them translate your Version 4010 transactions to Version 5010 (if not converting your older software)?
3. Have you identified changes to data reporting requirements?
4. Have you started to test with your trading partners, which began on January 1, 2011?
5. Have you started testing with your MAC, which is required before being able to submit bills with the Version 5010?
6. Have you updated MREP software to view and print compliant HIPAA 5010 835 remittance advices?

Additional Information
MLN Matters® article MM7466, "Medicare Remit Easy Print (MREP) and PC Print User Guide Update for Implementation of Version 5010A1," is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7466.pdf on the CMS website.

The Medicare Learning Network® (MLN) fact sheet, "Preparing for Electronic Data Interchange (EDI) Standards: The Transition to Versions 5010 and D.0," is available at http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/Versions5010andD0/downloads/w5010TransitionFctSht.pdf on the CMS website.

MLN Matters® Special Edition article SE1106 titled "Important Reminders about HIPAA 5010 & D.0 Implementation," is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1106.pdf on the CMS website. MLN Matters® Special Edition article SE1138 is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1138.pdf on the CMS website.

Additional educational resources about HIPAA 5010 & D.0 are available at http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/Versions5010andD0/index.html on the CMS website.

Medicare Fee-For-Service Version 5010/D.0 Updates

In its continuing effort to help trading partners transition to the new versions of standards adopted under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) for electronically exchanging health care transactions, Medicare Fee-For-Service (FFS) has the following updates:

Week of June 11, 2012

Deadlines
Inbound Transactions: After close of business, June 29, 2012, you must submit only the following versions when sending Medicare FFS inbound transactions:

- Accredited Standards Committee (ASC) X12 Version 005010 (5010)
  - Health Care Claim: Professional (837P)
  - Health Care Claim: Institutional (837I)
  - Heath Care Claim Status Request (276)
- National Council for Prescription Drug Program (NCPDP) Version D.0 Claim

Any inbound Medicare FFS transaction received by Medicare Administrative Contractors (MACs) in either version 4010/A1 or NCPDP 5.1 formats after normal close of business on June 29 will be rejected back to the submitter. If a claim transaction is rejected, the specific message you will receive will depend on the specific MAC receiving your claim file(s). Please visit the CMS Important 4010 - 5.1 Rejection Information website for a detailed list of rejection error messages.

Outbound Transactions: In addition, beginning July 1, 2012, the Coordination of Benefits (outbound ASC X12 837) and Health Care Claim Status Response (ASC X12 277) transactions will be sent in version 5010 only.

Medicare FFS will be allowing an additional 30 days to complete the transition to the ASC X12 Health Care Claim Payment/Advice (835), also called the Remittance Advice. Therefore, as of August 1, 2012, Medicare FFS will be generating only the 5010 version of the 835 Remittance Advice for all trading partners.

Please ensure you have tested with your MAC to successfully receive and process a parallel version 5010 835 Remittance Advice transaction during this transition period.

Week of June 18, 2012

Version 5010/D.0 Only Accepted By Medicare FFS Effective July 1, 2012
Effective July 1, 2012 only ASC X12 Version 5010 (Version 5010) or NCPDP Telecom D.0 (NCPDP D.0) formats will be accepted by Medicare FFS. Providers that are still conducting one or more of the Version 4010 transactions electronically, such as submitting a claim or checking claim status, or rely on a software vendor, billing service, or clearinghouse to do this on their behalf, are affected by this change. Now is the time to contact your software vendor, billing service, or clearinghouse, when applicable, if you have not done so already to insure you are ready. Transactions conducted by Medicare Administrative Contractor (MAC), fiscal intermediary (FI) or carrier telephone interactive voice response (IVR) systems, Direct Data Entry (DDE) and Internet Portals, for those contractors with Internet Portals, are not impacted.

Version 5010/D.0 Transition Statistics
The Medicare FFS version 5010 transition statistics are available on the CMS website. These statistics represent the transition of transaction standards adopted under HIPAA from ASC X12 4010 to 5010 and from NCPDP 5.1 to D.0. The transition statistics cover the following:

- Part A claims and remittances
- Part B/DME claims and remittances
- NCPDP claims
- Eligibility inquiries and responses
- Claim status inquiries and responses

In addition, Medicare FFS has recently published information by provider specialty related to the transition to ASC X12 Version 5010.

Week of June 25

Remittance Advice (835)
Medicare FFS has stated in previous communications that trading partners would be allowed an additional 30 days to complete the 835 remittance advice transaction transition. Medicare FFS' internal processes related to closeout activities for the 835 remittance transaction include the generation of the last Accredited Standards Committee (ASC) X12 Version 4010A1 835 data on July 31, 2012. Remittance Advice files from the last processing cycle will be available for retrieval upon conclusion of the July 31, 2012 batch cycle. Beginning August 1, 2012, the Medicare FFS program shall only produce the 835 remittance advice transaction in the ASC X12 Version 5010.

Claims (837 I and P)
All claims received after normal close of business cutoff times on June 29th must be in the ASC X12 Version 5010 or NCPDP Version D.0. Any Medicare FFS claims received in ASC X12 Version 4010 or NCPDP Version 5.1 after normal close of business cutoff times on June 29th will be rejected back to the submitter. The specific message you receive if a claim is rejected will depend on your MAC. A detailed list of 4010 rejection error messages by MAC has been posted.

Claim Status (276/277)
The last Claim Status Inquiry will be accepted in version 4010 at the end of the business day on Friday, June 29th, 2012. Following that date, all Claim Status activity will be in ASC X12 Version 5010.

Coordination of Benefits (837)
CMS has directed its MACs, FIs and carriers to begin sending all claims to the Coordination of Benefits Contractor (COBC) in version 5010 as of June 29, 2012. This will ensure that all claims that the COBC will issue to COB payers as of its Monday July 2, 2012 evening crossover claims cycle will be properly transmitted in the version 5010 format. Therefore, all COB payers will have to be in version 5010 COB production by June 29, 2012.

Weeks of July 2 and July 9

Business Partner Confirmation for Version 5010
Have you confirmed that your business partner has converted to version 5010 on your behalf? By now all providers should have contacted their clearinghouses, billing services, or vendors that they use to electronically submit Medicare FFS claims to ensure that as of July 1, 2012 all of your claims will be submitted in version 5010. Please contact your

clearinghouse, billing service, or vendor before calling your MAC's EDI helpdesk to search for your claims and confirm your transition to version 5010.

Claim (837 I and P) Rejection Error Message
Since June 29, all Medicare FFS claims must be sent as Accredited Standards Committee (ASC) X12 Version 5010 or NCPDP D.0. Any Medicare FFS claims received in version 4010 format after normal close of business on June 29 are being rejected back to the submitter. The specific message received if a claim is rejected depends on your specific MAC. A detailed list of 4010 rejection error messages by MAC may be found on the Important 4010 - 5.1 Rejection Information web page.

Remittance Advice (835)
Medicare FFS has stated in previous communications that trading partners would be allowed an additional 30 days to complete the 835 remittance advice transaction transition. Medicare FFS' internal processes related to closeout activities for the 835 remittance transaction include the generation of the last ASC X12 Version 4010A1 835 data on July 31, 2012. Remittance Advice files from the last processing cycle will be available for retrieval upon conclusion of the July 31, 2012 batch cycle. Beginning August 1, 2012, the Medicare FFS program shall only produce the 835 remittance advice transaction in the ASC X12 Version 5010.

Medicare to Automatically Convert Format 4010A1 Electronic Remittance Advice (835) to X12 Version 5010 Effective August 1, 2012

Effective August 1, 2012, if you have not yet converted from the 4010A1 format of the electronic remittance advice, the Medicare Fee-For-Service (FFS) program will automatically convert your electronic remittance advice to the X12 Version 5010 format. If the computer software you use to open/translate the electronic remittance advice X12 Version 5010 format is not ready for this conversion, you may not be able to open and read the electronic remittance advice to review payments, adjustments, and denials, as well as post payments to patient accounts. If you use a vendor, clearinghouse, or billing service for receipt of your electronic remittance advice and your computer software is unable to open/translate the electronic remittance advice X12 Version 5010 format, please contact your vendor, clearinghouse, or billing service before contacting your Medicare contractor.

Providers should be advised that any billing staff or representatives that make inquiries related to Medicare payment on his/her behalf will need a copy of the remittance advice. Any issue with opening/translating the electronic remittance advice X12 Version 5010 format effective August 1, 2012 should be addressed with your vendor, clearinghouse, or billing service, if you use one of these entities for receipt of the electronic remittance advice, before contacting your Medicare contractor.

NOTES

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