DME Happenings

• THIS IS WRITTEN NOTIFICATION OF MEDICARE CHANGES •

February 2012 | Issue No. 34

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

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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	1-866-243-7272	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 RAC Redeterminations	1-701-277-7886
Refunds to Medicare Immediate Offsets	1-701-277-7894
DME RAC 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 RAC Redeterminations Noridian Administrative Services PO Box 6728 Fargo ND 58108-6728	DME RAC 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: CIGNA Government Services	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 (1-866-243-7272) 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	February 10	8:30 a.m. – 12 p.m. CT
Off-the-Phone Training	February 24	8:30 a.m. – 12 p.m. CT
Off-the-Phone Training	March 9	8:30 a.m. – 12 p.m. CT
Off-the-Phone Training	March 23	8:30 a.m. – 12 p.m. CT
Good Friday	April 6	Entire Day Closed 8:30 a.m. – 6 p.m. CT
Off-the-Phone Training	April 13	8:30 a.m. – 12 p.m. CT
Off-the-Phone Training	April 27	8:30 a.m. – 12 p.m. CT
Off-the-Phone Training	May 11	8:30 a.m. – 12 p.m. CT
Off-the-Phone Training	May 25	8:30 a.m. – 12 p.m. CT
Memorial Day	May 28	Entire Day Closed 8:30 a.m. – 6 p.m. CT
Off-the-Phone Training	June 8	8:30 a.m. – 12 p.m. CT
Off-the-Phone Training	June 22	8:30 a.m. – 12 p.m. CT
Independence Day	July 4	Entire Day Closed 8:30 a.m. – 6 p.m. CT
Off-the-Phone Training	July 13	8:30 a.m. – 12 p.m. CT
Off-the-Phone Training	July 27	8:30 a.m. – 12 p.m. CT
Off-the-Phone Training	August 10	8:30 a.m. – 12 p.m. CT
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
Off-the-Phone T raining	March 7	8 a.m. – 12:30 p.m. CT
Off-the-Phone Training	April 4	8 a.m. – 12:30 p.m. CT
Good Friday	April 6	Entire Day Closed 8 a.m. – 4 p.m. CT
Off-the-Phone Training	May 2	8 a.m. – 12:30 p.m. CT
Memorial Day	May 28	Entire Day Closed 8 a.m. – 4 p.m. CT
Off-the-Phone Training	June 6	8 a.m. – 12:30 p.m. CT
Independence Day	July 4	Entire Day Closed 8 a.m. – 4 p.m. CT
Off-the-Phone Training	July 11	8 a.m. – 12:30 p.m. CT
Off-the-Phone Training	August 1	8 a.m. – 12:30 p.m. CT
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

Additional Documentation Request Submission - 60 day Time-frame Effective January 2012

Beginning January 2012, suppliers have 45 calendar days to reply to NAS Additional Documentation Request (ADR) letters for prepayment and post-payment review. The letters created by NAS DME MAC for Jurisdiction D include modified language that notifies suppliers they have 45 calendar days from the date of the ADR request to submit their documentation. This is a change from the prior 30 day response time-frame previously utilized per CMS requirements. NAS staff will deny claims for which the requested documentation was not received by day 60. During the transition to the new time-frame, suppliers are encouraged to review ADR letters to verify timeliness requirements for each claim.

The ADR letters generated by NAS contain specific fax numbers based on the department that needs the requested documentation. The NAS fax numbers for ADR receipts are similar and if the incorrect fax number is used for the documentation submission, this will delay claim processing. It is important that suppliers verify the fax number used matches the fax number on the ADR letter.

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 Online Information Just Got Better

We're always looking for ways to make your experience with the Medicare, Medicaid, Children's Health Insurance, and other healthcare programs better. On Monday, December 5, 2011, we expanded and enhanced our online presence at CMS: we're debuting a new look and feel for CMS.gov, and launching a brand-new site for the Medicaid program, Medicaid.gov.

These changes reflect what we've heard from you – our users – and respond to what you've said you want to be able to do on our site. Here's what you'll find on the new CMS and Medicaid sites:

- A significantly improved search engine that gets you to the information you're looking for, fast.
- More in-depth information about what we're doing to implement the Affordable Care Act and other new initiatives, and details about how you can apply for new programs.
- Up-to-date, real-time updates that reflect important developments and initiatives happening with CMS programs.
- Medicaid program information that's readily available, easy to find, and easy to use - and we'll be continually looking for ways to enhance your experience on this site.
- Easy-to-access links to Healthcare.gov, which will continue to be the primary site for consumer information.

While we've moved content around to make it easier to find, don't worry that you'll lose access to any of the current Medicare and Medicaid information you rely on now. We're launching an archive version of each of our websites too, so that historic information can remain online without adding clutter to our primary sites.

We think these changes are a good first step to improving our online presence and making information more accessible for all the patients, partners, providers, States, advocates and others who interact with our programs. However, this is just the first step - we have plans for continuous, ongoing improvements.

Take a look around at our www.CMS.gov and www.Medicaid.gov, and let us know what you think. We'd like to use your feedback to help drive the direction of future website improvements.

HHS Adopts HIPAA Standard for Electronic Funds Transfers/Remittance Advice

Action

The Centers for Medicare & Medicaid Services (CMS) today announced an interim final rule with comment period (IFC) (CMS-0024-IFC) under which the Department of Health and Human Services (HHS) adopts standards for the Health Care Electronic Funds Transfers (EFT) and Remittance Advice transaction (RA) under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Section 1104 of the Patient Protection and Affordable Care Act of 2010 requires CMS to issue a series of regulations over the next five years that are designed to streamline health care administrative transactions, encourage greater use of standards by providers, and make existing standards work more efficiently. On July 8, 2011, CMS published the first regulation, an IFC that puts in place operating rules for two electronic health care transactions that make it easier for providers to determine whether a patient is eligible for coverage and the status of a health care claim submitted to a health insurer.

The regulation announced today is the second in the series and establishes EFT standards that, when implemented by health plans, will save physician practices and hospitals between of $3 billion to $4.5 billion over the next ten years. Further environmental benefits from the use of an electronic payment in contrast to payments made by paper checks will result in an estimated 800,000 pounds of paper saved and 2.2 million pounds of greenhouse gases avoided over ten years.

Future administrative simplification rules will address adoption of:

- A standard unique identifier for health plans;
- A standard for claims attachments; and
- Requirements that health plans certify compliance with all HIPAA standards and operating rules.

Background
Congress addressed the need for a consistent framework for electronic health care transactions and other administrative simplification issues through the Health Insurance Portability and Accountability Act of 1996 (HIPAA), enacted on August 21, 1996. HIPAA amended the Social Security Act (the Act) by adding Part C—Administrative Simplification—to Title XI of the Act, requiring the Secretary of the Department of Health and Human Services (DHHS) to adopt standards for certain transactions to enable health information to be exchanged more efficiently and to achieve greater uniformity in the transmission of health information.

Section 1104(b)(2)(A) of the Patient Protection and Affordable Care Act (Pub. L. 111-148) amended section 1173(a)(2) of the Act by adding the electronic funds transfers (EFT) transaction to the list of electronic health care transactions for which the Secretary must adopt a standard under HIPAA.

In general, the savings and benefits related to use of EFT for business and consumer payments are well established. The most common savings are in paper, printing, and postage costs, as well as savings in staff time to manually process and deposit paper checks. Yet adoption and use of EFT by the health care industry has been low, resulting in administrative savings that go unrealized. The obstacles to greater use of EFT by the health care industry can be lessened by standardization of the EFT transaction. Beyond the material and administrative time savings for health care providers and health plans, the time and resources that physician practices and hospitals spend on billing and related tasks will be better spent on delivering health care to patients.

On December 3, 2010, the National Committee on Vital and Health Statistics (NCVHS) Subcommittee on Standards held a hearing and from it gathered a comprehensive review of the health care payment and remittance advice transaction for purposes of making a recommendation to the Secretary. Participants represented a cross section of the health care industry. On February 17, 2011, the NCVHS sent a letter to the Secretary that contained recommendations for adoption of a "health care EFT" standard.

Based on that recommendation, HHS is adopting two standards for the health care EFT that a health plan must comply with in order to transmit health care claim payments to providers via EFT. The first is a standard format for when a health plan orders, authorizes, or initiates an EFT with its financial institution. The second standard specifies the data content to be contained within the EFT.

The goal for adopting these standards is to ensure that a trace number that connects the payment to the electronic remittance advice is inputted into a standard EFT format and that is received without error by the health care provider. This can be best achieved by requiring that a single electronic file format (CCD+Addenda) be used by all health plans that transmit health care EFT to their financial institutions and by requiring that data elements are consistent and ordered according to clear implementation specifications.

Provisions of the IFC Announced Today
HHS is adopting two standards for the health care EFT: the CCD+Addenda implementation specifications in the 2011 National Automated Clearing House Association (NACHA) Operating Rules & Guidelines, and the TRN Segment implementation specifications in the X12 835 TR3 for the data content of the Addenda Record of the CCD+Addenda.

Costs/Benefits
Although all covered entities are required to comply with the adopted standards of HIPAA transactions, the health care EFT standards are expected to have the most substantial cost and benefit impacts on physician practices, hospitals, and commercial and government health plans.

We estimate that many health plans will have direct costs associated with implementing and using the health care EFT standards. However, those costs are expected to be comparably small software investments, approximately $18 million to $28 million overall for all commercial health plans, and $400,000 to $600,000 for Medicaid, the Children's' Health Insurance Program (CHIP), and the Indian Health Service (IHS). The savings for commercial health plans could be as much as $40 million over ten years, $31 million for Medicaid, CHIP, and IHS.

For physician practices and hospitals, there is little to no cost to implement the health care EFT standards, as providers are the receivers of the standardized transaction and not the senders. Overall, physician practices and hospitals should see savings of $3 billion to $4.5 billion over the next ten years as health plans implement the health care EFT standards.

We can also expect a modest environmental benefit from the use of an electronic payment in contrast to payments made by paper checks, including an estimated 800,000 pounds of paper saved and 2.2 million pounds of greenhouse gases avoided over ten years.

Regulation Effective Date/Standards Compliance Date
The effective date of this regulation is January 1, 2012. Under the Affordable Care Act, HIPAA-covered entities must be in compliance with the standards (in other words, use the health care EFT standards) on January 1, 2014.

The rule (CMS-0024-IFC) is on display today and may be viewed at www.ofr.gov/inspection.aspx. A news release on the rule may be viewed at http://www.hhs.gov/news.

Hours Extended for Customer Service Representatives Effective January 23, 2012

Effective January 23, 2012, the hours of availability for the NAS DME MAC Jurisdiction D Supplier Contact Center will be extended 30 minutes to better accommodate suppliers serving beneficiaries located in the Pacific, Alaskan and Hawaiian Time Zones. Customer Service Representatives will be accessible between 8:30 a.m. and 6 p.m. CT Monday through Friday.

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."

Patient Account Numbers Now Display on NAS Additional Documentation Request Letters

All outgoing Additional Documentation Request (ADR) letters sent by NAS Jurisdiction D display the contents entered in Item 26 of the CMS 1500 claim form (electronic equivalent 2300 CLM 01). The internal supplier patient account number, prescription number, or other identifying narrative entered in that field is printed directly underneath the beneficiary's name on the first page of the ADR letter. If no contents were entered within the patient account number field on the claim, this portion of the ADR letter is blank.

NAS implemented this enhancement as a result of supplier feedback. We hope you find this helpful in the event you have a claim selected for review.

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/QuarterlyProviderUpdates. Suppliers may also sign up to receive notification when regulations and program instructions are added throughout the quarter on this page.

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/manuals. 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
3	Proof of Delivery	Updated IOM Chapter	01/09/12
Appendix	Contacting NAS and Inquiries	Changed Supplier Contact Center hours to 8:30 a.m. - 6 p.m. CT	01/03/12
1	What is Medicare?	Updated deductible amount for 2012 to $140.00	12/22/11
2	Supplier Standards	Removed implementation dates	12/22/11
3	Orders	Added "The treating physician must sign and date the detailed written order."	12/22/11
8	Billing software	Changed ANSI 837 4010a1 to 5010	12/22/11
11	Miscellaneous Issues	Changed "poser" to "power"	12/22/11
13	Redeterminations	Updated MA130 link	12/22/11
13	Reconsiderations	Added link to "Forms"	12/22/11
13	Parties to an appeal	Under appt of representative, last paragraph, changed "his" to "his/her"	12/22/11

Chapter	Subheading	Supplier Manual Update	Change Date
15	RAC Overpayments	Changed RAC to Recovery Auditor	12/22/11
Appendix	Acronyms	Removed RAC-Recovery Audit Contractor	12/22/11
Appendix	Resources	Changed Recovery Audit Contractor to Recovery Auditor	12/22/11
13	Overview	Updated Amount in Controvery for Federal Court Review to $1,350 for 2012	12/22/11
13	Reconsiderations	Changed zip code	12/13/11
5	Place of Service	Updated link to CMS website	12/05/11
13	Reconsiderations	Changed contractor to C2C Solutions, Inc.	11/10/11
Appendix	Resources	Added Additional Documentation Request Letters fax number	11/02/11

Update to Medicare Deductible, Coinsurance and Premium Rates for 2012

MLN Matters® Number: MM7567 Revised
Related Change Request (CR) #: CR 7567
Related CR Release Date: December 16, 2011
Related CR Transmittal #: R74GI
Effective Date: January 1, 2012
Implementation Date: January 3, 2012

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

Provider Action Needed
This article is based on Change Request (CR) 7567, which provides the Medicare rates for deductible, coinsurance, and premium payment amounts for Calendar Year (CY) 2012. Be sure billing staffs are aware of these updates.

Background
2012 Part A - Hospital Insurance (HI)
Beneficiaries who use covered Part A services may be subject to deductible and coinsurance requirements. A beneficiary is responsible for an inpatient hospital deductible amount, which is deducted from the amount payable by the Medicare program to the hospital, for inpatient hospital services furnished in a spell of illness. When a beneficiary receives such services for more than 60 days during a spell of illness, he or she is responsible for a coinsurance amount equal to one-fourth of the inpatient hospital deductible per-day for the 61st-90th day spent in the hospital.

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

In addition, a beneficiary is responsible for a coinsurance amount equal to one-eighth of the inpatient hospital deductible per day for the 21st through the 100th day of Skilled Nursing Facility (SNF) services furnished during a spell of illness. The 2012 inpatient deductible is $1,156.00. The coinsurance amounts are shown below in the following table:

Hospital Coinsurance		Skilled Nursing Facility Coinsurance
Days 61-90	**Days 91-150 (Lifetime Reserve Days)**	**Days 21-100**
$289.00	$578.00	$144.50

Most individuals age 65 and older, and many disabled individuals under age 65, are insured for Health Insurance (HI) benefits without a premium payment. The Social Security Act provides that certain aged and disabled persons who are not insured may voluntarily enroll, but are subject to the payment of a monthly premium. Since 1994, voluntary enrollees may qualify for a reduced premium if they have 30-39 quarters of covered employment. When voluntary enrollment takes place more than 12 months after a person's initial enrollment period, a 2-year 10% penalty is assessed for every year they had the opportunity to (but failed to) enroll in Part A. The 2012 Part A premiums are as follows:

Voluntary Enrollees Part A Premium Schedule for 2012	
Base Premium (BP)	$451.00 per month
Base Premium with 10% Surcharge	$496.10 per month
Base Premium with 45% Reduction	$248.00 per month (for those who have 30-39 quarters of coverage)
Base Premium with 45% Reduction and 10% Surcharge	$272. 80 per month

2012 Part B - Supplementary Medical Insurance (SMI)
Under Part B of the Supplementary Medical Insurance (SMI) program, all enrollees are subject to a monthly premium. Most SMI services are subject to an annual deductible and coinsurance (percent of costs that the enrollee must pay), which are set by statute. When Part B enrollment takes place more than 12 months after a person's initial enrollment period, there is a permanent 10 percent increase in the premium for each year the beneficiary could have enrolled and failed to enroll.

- Standard Premium: $99.90 a month
- Deductible: $140.00 a year
- Coinsurance: 20 percent

In addition, some beneficiaries may pay higher premiums based on their incomes. These amounts change each year. There may be a late-enrollment penalty.

Additional Information
The official instruction, CR7567, issued to your carriers, FIs, A/B MACs, and RHHIs regarding this change may be viewed at http://www.cms.gov/Transmittals/downloads/R74GI.pdf on the CMS website.

Updates to Ordering/Referring Report

In response to concerns raised by the provider community, CMS will no longer post the complete NPI on the ordering & referring reports found in the "Downloads" on http://www.CMS.gov/MedicareProviderSupEnroll/06_MedicareOrderingandReferring.asp#TopOfPage. The following reports will be updated shortly to only contain the last 4 digits of the NPI:

- Ordering/Referring Report
- Initial Physician Applications Pending Contractor Review
- Initial Non Physician Applications Pending Contractor Review

APPEALS

New Qualified Independent Contractor – C2C Solutions, Inc. – Revised

Reconsideration requests, the second level in the Medicare appeals process, are processed by the Qualified Independent Contractor (QIC), who is currently RiverTrust Solutions. Effective November 15, 2011, C2C Solutions, Inc. will take over the QIC contract and begin processing reconsideration requests for all four of the Durable Medical Equipment Medicare Administrative Contractors (DME MACs).

All requests for reconsideration received by RiverTrust Solutions, on or after November 15, 2011 will be forwarded to the new Qualified Independent Contract (QIC). All requests for reconsideration received on or before November 14, 2011 will continue to be processed by RiverTrust Solutions.

Effective, November 15, 2011 DMEPOS suppliers should send all requests for reconsideration to C2C Solutions, Inc. Below is the address and contact information for C2C Solutions, Inc.

C2C Solutions, Inc.
ATTN: DME QIC
P.O. Box 44013
Jacksonville, Florida 32231-4013
Website: www.C2Cinc.com

C2C Solutions, Inc. also holds the QIC contract for Medicare Part B Reconsiderations in the Northern Jurisdiction. The DME MACs and C2C Solutions, Inc. will strive to make this transition as seamless as possible for DMEPOS suppliers.

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.

Timeline for Appeals Processing

The following is a timeline for appeals processing. The process is explained from the first level of appeals (Redeterminations) through the fifth level of appeals (Federal Court). The timeline explained below is the basic timeline for processing.

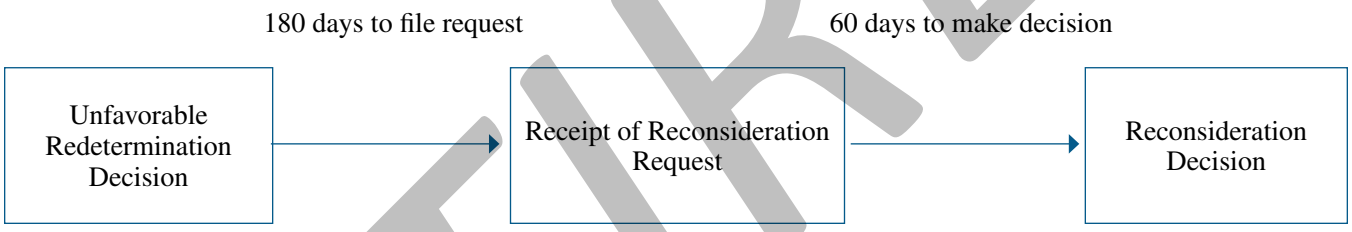
Redeterminations
A party must file a request for redetermination within 120 days of the date of receipt of the notice of initial determination, Medicare Summary Notice (MSN) or Remittance Advice (RA) with the contractor indicated on the notice of initial determination.

The contractor must complete and mail a redetermination notice within 60 days of receipt of the request.

Reconsiderations
Any individual dissatisfied with the contactor's redetermination may file a request for a reconsideration within 180 days of receipt of the redetermination. Reconsiderations are processed within 60 days of receipt by entities called qualified independent contractors (QICs).

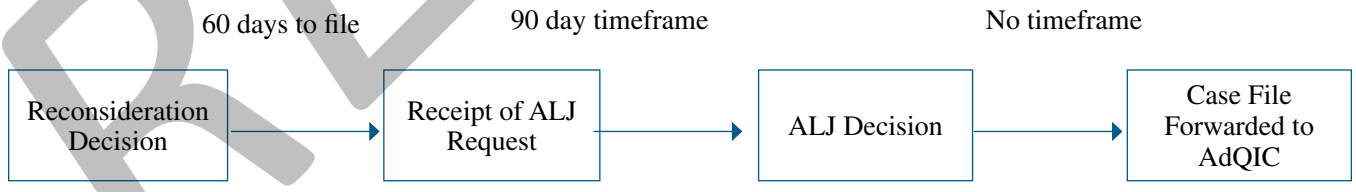
A party to a contractor's dismissal of a request for redetermination has a right to have the dismissal reviewed by a QIC, if the party files a written request for review of the dismissal with the QIC within 60 calendar days after receipt of the contractor's notice of dismissal.

If the QIC's decision is favorable to the appellant and gives a specific amount to be paid, the contractor effectuates the claim within 30 calendar days of the date of the QIC's decision.



Administrative Law Judge (ALJ)
A party to a QIC reconsideration may request a hearing before an ALJ if the party files a written request for an ALJ hearing within 60 days after receipt of the notice of the QIC's reconsideration.

To receive an ALJ hearing, a party to the QIC's reconsideration must file a written request for an ALJ hearing with the entity specified in the QIC's reconsideration. The appellant must also send a copy of the request for hearing to the other involved parties. Failure to do so will suspend the ALJ's 90-day adjudication deadline until all parties to the QIC reconsideration receive notice of the requested ALJ hearing.



AdQIC: The Administrative Qualified Independent Contractor (AdQIC) will receive all case files and decisions from the Office of Medicare Hearings and Appeals (OMHA) field offices as well as any decisions and case files from the Departmental Appeals Board (DAB). Once an ALJ rules favorably on an appeal, the OMHA forwards the decision and case file to the AdQIC.

Favorable rulings by an ALJ hearing do not result in immediate payment of claims. The AdQIC's review cannot begin until it receives the case file. Regulations do not require the OMHA to forward case files within a given amount of time.

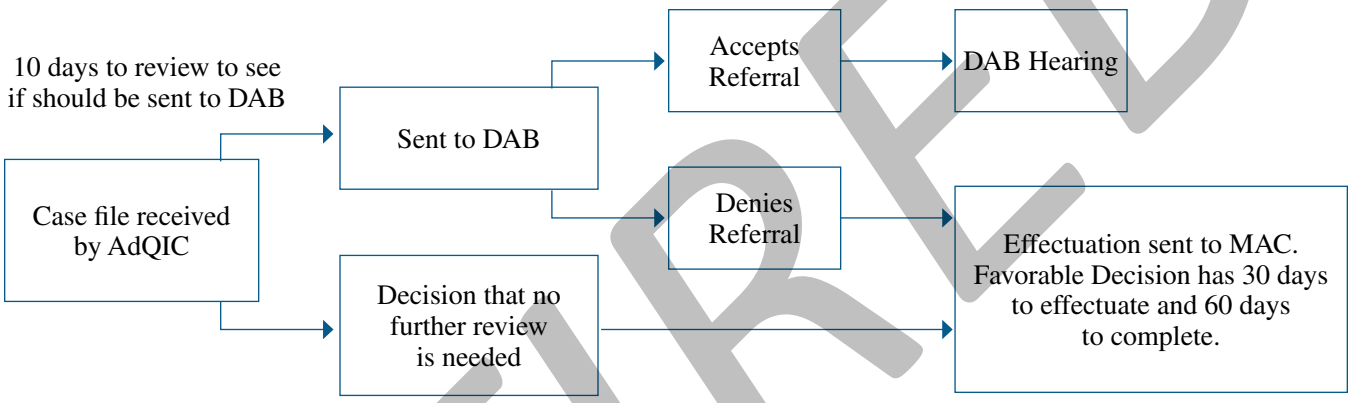
APPEALS CONT'D

Once the AdQIC receives the case file, they subsequently have 10 days to update the appeals tracking system and to decide whether the case requires further review by the Medicare Appeal Council (referred to interchangeably as the Departmental Appeals Board, or DAB) or the effectuation notice is sent to the Medicare Administrative Contractor (MAC) for payment.

If the AdQIC refers the case to the DAB, the MAC that processed the original claim is notified to not process any previous effectuations. Effectuations made by the contractor are then contingent upon the DAB's decision.

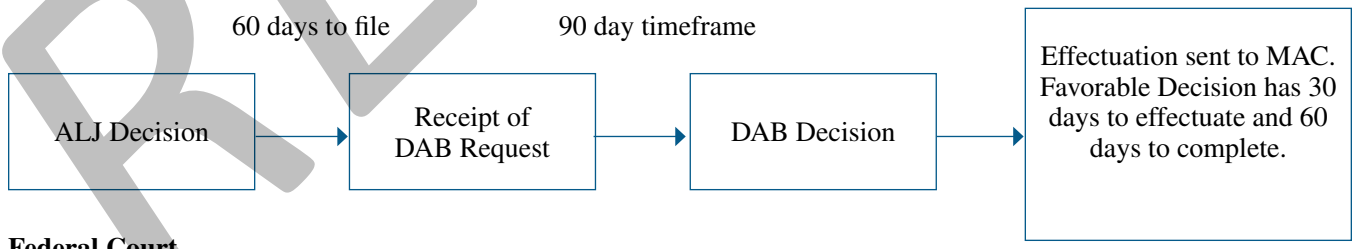
For ALJ decisions that require no further review, the AdQIC sends an effectuation notice to the contractor, who must then pay specified claim amounts within 30 days. Effectuations in which the contractor must calculate the amount may take up to 60 days.

The contractor does not effectuate based on correspondence from any party to the ALJ hearing. It takes an effectuation action only in response to a formal effectuation notice from the AdQIC.



Departmental Appeals Board (DAB)
The DAB is the level of administrative review available to parties after the ALJ hearing decision or dismissal order has been issued but before judicial review is available. As noted above, the AdQIC may send a case for DAB review, however, a party to the ALJ hearing may also request a DAB review if the party files a written request within 60 calendar days after receipt of the ALJ's decision or dismissal.

The DAB issues a final decision or dismissal order or remands the case back to the ALJ within 90 calendar days of receipt of the appellant's request for review. When a contractor receives an effectuation notice from the AdQIC regarding a DAB decision that requires effectuation, it initiates effectuation within 30 days of its receipt of the effectuation notice, and completes effectuation within 60 days.



Federal Court
Following issuance of a decision by the DAB, a party may request court review of the DAB's decision. A contractor cannot accept requests for court review. The appellant must file the complaint with the U.S. District Court. The request must be filed with the Federal District Court within 60 days of receiving the DAB's decision.

AUTOMTIC EXTERNAL DEFIBRILLATORS

Automatic External Defibrillators Draft Local Coverage Determination – Update

The Durable Medical Equipment Medicare Administrative Contractors (DME MACs) released a draft revision of the Automatic External Defibrillators (AED) LCD for comment on August 4, 2011, with the comment period ending on September 23, 2011. The DME MAC medical directors appreciate the feedback from all commenters on the draft policy. Based upon the comments received, the DME MAC medical directors will make no changes to the current policy at this time.

CEDI

Rendering Provider Information

The Common Electronic Data Interchange (CEDI) Help Desk has seen an increase in 5010A1 claim rejections and calls due to the rendering provider information being submitted in Medicare DME claims. CEDI would like to provide the following information as clarification on why the Rendering Provider Loop **should not** be submitted in Medicare DME claims.

- The rendering provider information will be verified in the 5010A1 format where it was not being verified in the 4010A1 format. Sending this information can cause a front-end rejection.
- The NPI of the rendering provider must be on the DME supplier crosswalk. Since the rendering provider is typically an individual provider and not listed on the DME supplier crosswalk, this can cause a front-end rejection if sent.
- The rendering provider information is a sub-set of the billing provider information which is only used in Medicare Part B claims to indicate the physician that saw the patient. Medicare DME does not use sub-sets making the rendering provider information identical to the billing provider information. When the billing provider and rendering provider are the same, the rendering provider should not be sent.
- The rendering provider information is not used by Medicare to process the Medicare DME claims. The rendering provider information is also not forwarded by Medicare to secondary payers for use in processing.

The CEDI Help Desk recommends not sending the Rendering Provider Loop(s) 2310B or 2420A in the Medicare DME claims to avoid unnecessary front-end rejections. CEDI only requires NPIs in the Billing Provider Loop 2010AA and the Ordering Provider Loop 2420E.

If you have any questions, please contact 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.

CERT CONT'D

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.

CLAIM SUBMISSION

Electronic Claim Narratives – Reminder of Line Level Submission

When narratives are submitted on electronic claims to provide additional information related to the service line, they should be entered at the line level, the 2400 loop in the NTE segment. This is a free form text field with a limit of 80 characters. Claims that require a narrative will be denied as a return/reject if the narrative is not listed in this segment.

NAS has noticed that some suppliers are providing a description of the DMEPOS provided in the 2400 loop, SV101-7 segment, which is a description field, rather than the NTE segment. Doing so will result in the claim being denied as a return/reject.

HCPCS Code Set Update

The Centers for Medicare & Medicaid Services is pleased to announce the scheduled release of modifications to the Healthcare Common Procedure Coding System (HCPCS) code set. These changes have been posted to the HCPCS website at http://www.cms.gov/medhcpcsgeninfo. Changes are effective on the date indicated on the update.

HCPCS Code Update – 2012

The following list identifies changes to level II Healthcare Common Procedure Coding System (HCPCS) codes for 2012.

Added Codes/Added Modifiers: New codes and modifiers are effective for dates of service on or after January 1, 2012.

Discontinued Codes/Deleted Modifiers: Codes or modifiers that are discontinued/deleted will continue to be valid for claims with dates of service on or before December 31, 2011, regardless of the date of claim submission. If there is a direct crosswalk for a discontinued/deleted code or modifier, it is listed in the table. The crosswalked codes are also "added" codes effective for dates of service on or after January 1, 2012.

There is no grace period that would allow submission of the discontinued code for dates of service in 2012.

Narrative Changes/Revised Modifiers: A description change for an existing code or modifier is effective for dates of service on or after January 1, 2012.

The appearance of a code in this list does not necessarily indicate coverage.

Ankle-Foot/Knee-Ankle-Foot Orthosis

	Narrative Changes	
Code	**Old Narrative**	**New Narrative**
L2005	KNEE ANKLE FOOT ORTHOSIS, ANY MATERIAL, SINGLE OR DOUBLE UPRIGHT, STANCE CONTROL, AUTOMATIC LOCK AND SWING PHASE RELEASE, MECHANICAL ACTIVATION, INCLUDES ANKLE JOINT, ANY TYPE, CUSTOM FABRICATED	KNEE ANKLE FOOT ORTHOSIS, ANY MATERIAL, SINGLE OR DOUBLE UPRIGHT, STANCE CONTROL, AUTOMATIC LOCK AND SWING PHASE RELEASE, ANY TYPE ACTIVATION, INCLUDES ANKLE JOINT, ANY TYPE, CUSTOM FABRICATED

Immunosuppressive Drugs

	Added Code
Code	**Narrative**
J8561	EVEROLIMUS, ORAL, 0.25 MG

Intravenous Immune globulin

	Added Code
Code	**Narrative**
J1557	INJECTION, IMMUNE GLOBULIN, (GAMMAPLEX), INTRAVENOUS, NON-LYOPHILIZED (E.G. LIQUID), 500 MG

	Narrative Changes	
Code	**Old Narrative**	**New Narrative**
J1561	INJECTION, IMMUNE GLOBULIN, (GAMUNEX), INTRAVENOUS, NON-LYOPHILIZED (E.G.LIQUID), 500 MG	INJECTION, IMMUNE GLOBULIN, (GAMUNEX/ GAMUNEX-C/GAMMAKED), NON-LYOPHILIZED (E.G. LIQUID), 500 MG

Lower Limb Prostheses

	Added Code
Code	**Narrative**
L5312	KNEE DISARTICULATION (OR THROUGH KNEE), MOLDED SOCKET, SINGLE AXIS KNEE, PYLON, SACH FOOT, ENDOSKELETAL SYSTEM

	Discontinued Code	
Code	**Narrative**	**Crosswalk to Code**
L5311	KNEE DISARTICULATION (OR THROUGH KNEE), MOLDED SOCKET, EXTERNAL KNEE JOINTS, SHIN, SACH FOOT, ENDOSKELETAL SYSTEM	L5312

Miscellaneous

	Added Code
Code	**Narrative**
A9272	MECHANICAL WOUND SUCTION, DISPOSABLE, INCLUDES DRESSING, ALL ACCESSORIES AND COMPONENTS, EACH
L6715	TERMINAL DEVICE, MULTIPLE ARTICULATING DIGIT, INCLUDES MOTOR(S), INITIAL ISSUE OR REPLACEMENT
L6880	ELECTRIC HAND, SWITCH OR MYOLELECTRIC CONTROLLED, INDEPENDENTLY ARTICULATINGDIGITS, ANY GRASP PATTERN OR COMBINATION OF GRASP PATTERNS, INCLUDES MOTOR(S)

CLAIM SUBMISSION CONT'D

	Narrative Changes	
Code	**Old Narrative**	**New Narrative**
E0638	STANDING FRAME SYSTEM, ONE POSITION (E.G. UPRIGHT, SUPINE OR PRONE STANDER), ANY SIZE INCLUDING PEDIATRIC, WITH OR WITHOUT WHEELS	STANDING FRAME/TABLE SYSTEM, ONE POSITION (E.G. UPRIGHT, SUPINE OR PRONE STANDER), ANY SIZE INCLUDING PEDIATRIC, WITH OR WITHOUT WHEELS
E0641	STANDING FRAME SYSTEM, MULTI-POSITION (E.G. THREE-WAY STANDER), ANY SIZE INCLUDING PEDIATRIC, WITH OR WITHOUT WHEELS	STANDING FRAME/TABLE SYSTEM, MULTI-POSITION (E.G. THREE-WAY STANDER), ANY SIZE INCLUDING PEDIATRIC, WITH OR WITHOUT WHEELS
E0642	STANDING FRAME SYSTEM, MOBILE (DYNAMIC STANDER), ANY SIZE INCLUDING PEDIATRIC	STANDING FRAME/TABLE SYSTEM, MOBILE (DYNAMIC STANDER), ANY SIZE INCLUDING PEDIATRIC
E0691	ULTRAVIOLET LIGHT THERAPY SYSTEM PANEL, INCLUDES BULBS/LAMPS, TIMER AND EYE PROTECTION; TREATMENT AREA 2 SQUARE FEET OR LESS	ULTRAVIOLET LIGHT THERAPY SYSTEM, INCLUDES BULBS/LAMPS, TIMER AND EYE PROTECTION; TREATMENT AREA 2 SQUARE FEET OR LESS
L6000	PARTIAL HAND, ROBIN-AIDS, THUMB REMAINING (OR EQUAL)	PARTIAL HAND, THUMB REMAINING
L0610	PARTIAL HAND, ROBIN-AIDS, LITTLE AND/OR RING FINGER REMAINING (OR EQUAL)	PARTIAL HAND, LITTLE AND/OR RING FINGER REMAINING
L0620	PARTIAL HAND, ROBIN-AIDS, NO FINGER REMAINING (OR EQUAL)	PARTIAL HAND, NO FINGER REMAINING
L7368	LITHIUM ION BATTERY CHARGER	LITHIUM ION BATTERY CHARGER, REPLACEMENT ONLY

	Discontinued Code	
Code	**Narrative**	**Crosswalk to Code**
L1500	THORACIC-HIP-KNEE-ANKLE ORTHOSIS (THKAO), MOBILITY FRAME (NEWINGTON, PARAPODIUM TYPES)	NONE
L1510	THKAO, STANDING FRAME, WITH OR WITHOUT TRAY AND ACCESSORIES	NONE
L1520	THKAO, SWIVEL WALKER	NONE
L4380	PNEUMATIC KNEE SPLINT, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	NONE
L7266	SERVO CONTROL, STEEPER OR EQUAL	NONE
L7272	ANALOGUE CONTROL, UNB OR EQUAL	NONE
L7274	PROPORTIONAL CONTROL, 6-12 VOLT, LIBERTY, UTAH OR EQUAL	NONE
L7500	REPAIR OF PROSTHETIC DEVICE, HOURLY RATE (EXCLUDES V5335 REPAIR OF ORAL OR LARYNGEAL PROSTHESIS OR ARTIFICIAL LARYNX)	NONE

CLAIM SUBMISSION CONT'D

Oral Antiemetic Drugs

	Added Code
Code	**Narrative**
Q0162	ONDANSETRON 1 MG, ORAL, FDA APPROVED PRESCRIPTION ANTI-EMETIC, FOR USE AS A COMPLETE THERAPEUTIC SUBSTITUTE FOR AN IV ANTI-EMETIC AT THE TIME OF CHEMOTHERAPY TREATMENT, NOT TO EXCEED A 48 HOUR DOSAGE REGIMEN

	Discontinued Code	
Code	**Narrative**	Crosswalk to Code
Q0179	ONDANSETRON HYDROCHLORIDE 8 MG, ORAL, FDA APPROVED PRESCRIPTION ANTI-EMETIC, FOR USE AS A COMPLETE THERAPEUTIC SUBSTITUTE FOR AN IV ANTI-EMETIC AT THE TIME OF CHEMOTHERAPY TREATMENT, NOT TO EXCEED A 48 HOUR DOSAGE REGIMEN	Q0162

Ostomy Supplies

	Added Code
Code	**Narrative**
A5056	OSTOMY POUCH, DRAINABLE, WITH EXTENDED WEAR BARRIER ATTACHED, WITH FILTER, (1PIECE), EACH
A5057	OSTOMY POUCH, DRAINABLE, WITH EXTENDED WEAR BARRIER ATTACHED, WITH BUILT IN CONVEXITY, WITH FILTER, (1 PIECE), EACH

Power Mobility Devices

	Added Code
Code	**Narrative**
E2358	POWER WHEELCHAIR ACCESSORY, GROUP 34 NON-SEALED LEAD ACID BATTERY, EACH
E2359	POWER WHEELCHAIR ACCESSORY, GROUP 34 SEALED LEAD ACID BATTERY, EACH (E.G. GEL CELL, ABSORBED GLASSMAT)

Wheelchair Options/Accessories

	Added Code
Code	**Narrative**
E0988	MANUAL WHEELCHAIR ACCESSORY, LEVER-ACTIVATED, WHEEL DRIVE, PAIR
E2626	WHEELCHAIR ACCESSORY, SHOULDER ELBOW, MOBILE ARM SUPPORT ATTACHED TO WHEELCHAIR, BALANCED, ADJUSTABLE
E2627	WHEELCHAIR ACCESSORY, SHOULDER ELBOW, MOBILE ARM SUPPORT ATTACHED TO WHEELCHAIR, BALANCED, ADJUSTABLE RANCHO TYPE
E2628	WHEELCHAIR ACCESSORY, SHOULDER ELBOW, MOBILE ARM SUPPORT ATTACHED TO WHEELCHAIR, BALANCED, RECLINING
E2629	WHEELCHAIR ACCESSORY, SHOULDER ELBOW, MOBILE ARM SUPPORT ATTACHED TO WHEELCHAIR, BALANCED, FRICTION ARM SUPPORT (FRICTION DAMPENING TO PROXIMAL AND DISTAL JOINTS)
E2630	WHEELCHAIR ACCESSORY, SHOULDER ELBOW, MOBILE ARM SUPPORT, MONOSUSPENSION ARMAND HAND SUPPORT, OVERHEAD ELBOW FOREARM HAND SLING SUPPORT, YOKE TYPE SUSPENSION SUPPORT

CLAIM SUBMISSION CONT'D

E2631	WHEELCHAIR ACCESSORY, ADDITION TO MOBILE ARM SUPPORT, ELEVATING PROXIMAL ARM
E2632	WHEELCHAIR ACCESSORY, ADDITION TO MOBILE ARM SUPPORT, OFFSET OR LATERAL ROCKER ARM WITH ELASTIC BALANCE CONTROL
E2633	WHEELCHAIR ACCESSORY, ADDITION TO MOBILE ARM SUPPORT, SUPINATOR

	Discontinued Code	
Code	**Narrative**	**Crosswalk to Code**
L3964	SHOULDER ELBOW ORTHOSIS, MOBILE ARM SUPPORT ATTACHED TO WHEELCHAIR, BALANCED, ADJUSTABLE, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	E2626
L3965	SHOULDER ELBOW ORTHOSIS, MOBILE ARM SUPPORT ATTACHED TO WHEELCHAIR, BALANCED, ADJUSTABLE RANCHO TYPE, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	E2627
L3966	SHOULDER ELBOW ORTHOSIS, MOBILE ARM SUPPORT ATTACHED TO WHEELCHAIR, BALANCED, RECLINING, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	E2628
L3968	SHOULDER ELBOW ORTHOSIS, MOBILE ARM SUPPORT ATTACHED TO WHEELCHAIR, BALANCED, FRICTION ARM SUPPORT (FRICTION DAMPENING TO PROXIMAL AND DISTAL JOINTS), PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	E2629
L3969	SHOULDER ELBOW ORTHOSIS, MOBILE ARM SUPPORT, MONOSUSPENSION ARM AND HAND SUPPORT, OVERHEAD ELBOW FOREARM HAND SLING SUPPORT, YOKE TYPE SUSPENSION SUPPORT, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	E2630
L3970	SEO, ADDITION TO MOBILE ARM SUPPORT, ELEVATING PROXIMAL ARM	E2631
L3972	SEO, ADDITION TO MOBILE ARM SUPPORT, OFFSET OR LATERAL ROCKER ARM WITH ELASTIC BALANCE CONTROL	E2632
L3974	SEO, ADDITION TO MOBILE ARM SUPPORT, SUPINATOR	E2633

COMPETITIVE BIDDING

Two DMEPOS Competitive Bidding Announcements

We have two announcements of interest to suppliers that are considering participating in the Round 2 and national mail-order competitions of the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program.

First, the Competitive Bidding Implementation Contractor (CBIC) has issued a new fact sheet providing antitrust guidance for bidders. To view the fact sheet, please go to the CBIC website at www.dmecompetitivebid.com and select Bidding Suppliers: Round 2 & National Mail-Order and then choose "Fact Sheets."

Second, four adjustable seat cushion codes have been removed from the Round 2 standard wheelchair product category. We are in the process of deleting these codes from the educational materials on the CBIC website. We will send a follow-up listserv notice when the updates to the educational materials are complete.

Allowing Contract or Non-contract Suppliers to Maintain and Service Enteral Nutrition Equipment Provided in 15th Continuous Month of Rental

MLN Matters® Number: MM7498 Revised
Related Change Request (CR) #: 7498
Related CR Release Date: December 23, 2011
Related CR Transmittal #: R1008OTN
Effective Date: January 1, 2012
Implementation Date: January 3, 2012

Note: This article was revised on December 27, 2011, to reflect a revised CR7498. In this article, the CR release date, transmittal number, effective date, and the Web address for accessing CR7498 are revised. All other information is the same.

Provider Types Affected
This article is for suppliers billing Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for the maintenance and servicing of enteral nutrition equipment provided to Medicare beneficiaries.

Provider Action Needed
This article is based on Change Request (CR) 7498 which outlines the requirements for the maintenance and servicing of enteral nutrition equipment under the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program.

CR7498 states that Medicare beneficiaries with Original Medicare who obtain competitive bidding items in designated Competitive Bidding Areas (CBAs) are required to obtain these items from a contract supplier, unless an exception applies. If an enteral nutrition pump was rented for at least 15 continuous months at the time of the implementation of the competitive bidding program, the supplier that provided the pump in the 15th month of the rental period is responsible for furnishing, maintaining and servicing the pump after the 15th rental month and can be paid for the maintenance and servicing, regardless of their status as a winning or non-winning supplier. The payment can be made until either the pump is no longer medically necessary or the end of the reasonable useful lifetime is reached.

Key Points

- Claims will be paid when submitted by a National Competitive Bidding (NCB) contract or non-contract supplier for the maintenance and servicing of enteral nutrition pumps, provided the supplier furnished the pump to the beneficiary in the 15th month of continuous rental and provided that, in the case of a non-contractor supplier, the 15th month of rental occurred before the start of the competitive bidding round.
- Claims will be denied if submitted by non-contract suppliers for maintenance and servicing if the supplier did not provide the item in the 15th month of the rental period or if the 15th month occurred on or after the start of the competitive bidding round.
- For denied claims, DME MACs will supply the following messages on the remittance advice:
- 96 – Non-covered charge(s).
  - M115 – This item is denied when provided to this patient by a non-contract or non-demonstration supplier.
  - M114 – This service was processed in accordance with rules and guidelines under the DMEPOS Competitive Bidding Program or other demonstration project. For more information regarding this project, contact your local contractor.
  - N211 – Alert: You may not appeal this decision.
  - MA13 – Alert: You may be subject to penalties if you bill the patient for amounts not reported with the PR (patient responsibility) group code.
  - Group Code CO.
- Suppliers will be paid the Medicare payment amount for maintenance and servicing of enteral nutrition equipment equal to a percentage of the fee schedule for the purchase or rental of the enteral equipment, as applicable.
- For maintenance and servicing claims submitted by a non-contract supplier, Medicare Contractors will pay 50 percent of the fee schedule amount for a single month's rental of enteral nutrition equipment.

- For maintenance and servicing claims submitted by contract suppliers, Medicare Contractors will pay 5 percent of the single payment amount for the purchase of enteral nutrition equipment.
- Payments are allowed for maintenance and servicing of enteral nutrition equipment furnished by contract or non-contract suppliers until the earlier of either a determination is made by the beneficiary's physician that the equipment is no longer medically necessary or the end of the Reasonable Useful Lifetime (RUL) of the equipment.
- DMEPOS Competitive Bidding Program claims submitted by non-contract suppliers for maintenance and servicing of enteral nutrition equipment with dates of service between January 1, 2011, and December 31, 2011, and which were previously denied, will be reprocessed by your Medicare contractor if the supplier submitting the adjustment received payment for the 15th month of equipment rental prior to the start of the competitive bidding round.

Additional Information
The official instruction, CR7498 issued to your DME/ MAC regarding this change may be viewed at http://www.cms.gov/Transmittals/downloads/R1008OTN.pdf on the CMS website.

April 2012 Quarterly Update for DMEPOS Competitive Bidding Program

MLN Matters® Number: MM7638
Related Change Request (CR) #: 7638
Related CR Release Date: December 2, 2011
Related CR Transmittal #: R2363CP
Effective Date: April 1, 2012
Implementation Date: April 2, 2012

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

Provider Action Needed
This article is based on Change Request (CR) 7638, which provides the DMEPOS April 2012 quarterly update. This update implements necessary changes to the Healthcare Common Procedure Coding System (HCPCS), ZIP code, and single payment amount files effective April 1, 2012. Be sure your billing staff is aware of these changes.

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 CBAs 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.

COMPETITIVE BIDDING CONT'D

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 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 requires 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/DMEPOSCompetitiveBid/ on the CMS website.

Competitive Bidding ZIP Codes

For competitive bidding, ZIP codes designated as mail order only are assigned a separate CBA number from the standard CBA. ZIP codes are established by the United States Postal Service (USPS). The CBA numbers and associated names are as follows:

- 16740 - Charlotte-Gastonia-Concord, NC-SC (non-mail order and mail order)
- 16741 - Charlotte-Gastonia-Concord, NC-SC (mail order only)
- 17140 - Cincinnati-Middletown, OH-KY-IN (non-mail order and mail order)
- 17141 - Cincinnati-Middletown, OH-KY-IN (mail order only)
- 17460 - Cleveland-Elyria-Mentor, OH (non-mail order and mail order)
- 17461 - Cleveland-Elyria-Mentor, OH (mail order only)
- 19100 - Dallas-Fort Worth-Arlington, TX (non-mail order and mail order)
- 19101 - Dallas-Fort Worth-Arlington, TX (mail order only)
- 28140 - Kansas City, MO-KS (non-mail order and mail order)
- 28141 - Kansas City, MO-KS (mail order only)
- 33100 - Miami-Fort Lauderdale-Pompano Beach, FL (non-mail order and mail order)
- 33101 - Miami-Fort Lauderdale-Pompano Beach, FL (mail order only)
- 36740 - Orlando- Kissimmee, FL (non-mail order and mail -order)
- 36741 - Orlando- Kissimmee, FL (mail order only)
- 38300 - Pittsburgh, PA (non-mail order and mail order)
- 38301 - Pittsburgh, PA (mail order only)
- 40140 - Riverside-San Bernardino-Ontario, CA (non-mail order and mail order)
- 40141 - Riverside-San Bernardino-Ontario, CA (mail order only)

Public Use Files

The competitive bidding ZIP codes and single payment amounts per product category and CBA are available on the CBIC website for interested parties like DMEPOS suppliers, State Medicaid agencies, and managed care organizations. The CBIC website can be accessed at http://www.dmecompetitivebid.com/palmetto/cbic.nsf or by going to http://www.cms.gov/DMEPOSCompetitiveBid/01_overview.asp on the CMS website. These files can be used to identify when a specific item furnished to a beneficiary is subject to the DMEPOS competitive bidding program.

Single Payment Amount

Currently, Medicare payment for most DMEPOS items is based on fee schedules in most areas of the country. However, the Social Security Act (Section 1847; see http://www.ssa.gov/OP_Home/ssact/title18/1847.htm on the Internet) mandates that competitive bidding single payment amounts replace the current DMEPOS fee schedule payment amounts for competitively bid items in CBAs. Therefore, the single payment amount is the Medicare allowed payment amount for competitively bid items for beneficiaries who reside in the Round One Rebid CBAs. Medicare pays contract

suppliers 80 percent of the single payment amount for each competitively bid item. Beneficiaries are responsible for the remaining 20 percent of the single payment amount. Payment for all claims is on an assignment-related basis. In no case can a beneficiary be charged more than the 20 percent coinsurance payment for medically necessary items. Single payment amounts remain the same throughout the term of suppliers' contracts.

In the CBA pricing file and the single payment amount public use file, the rental single payment amounts for capped rental DME and rented enteral nutrition equipment are 10 percent of the purchase single payment amount. This payment amount is for rental months one through three. The rental single payment amounts for months 4 through 13 for capped rental DME and for months 4 through 15 for rented enteral nutrition equipment are equal to 75 percent of the single payment amounts paid in the first three rental months. The changes to the power wheelchair payment rules made by section 3136 of the Affordable Care Act (see http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf on the Internet) do not apply to payment made for items furnished pursuant to competitive bidding contracts entered into prior to January 1, 2011, or for power wheelchairs in which the first rental month occurred before January 1, 2011. Therefore, under the Round One Rebid Competitive Bidding Program, contract and grandfathered suppliers furnishing rented power wheelchairs will continue to be paid under the capped rental payment methodology using 10 percent of the purchase single payment amount (or fee schedule amount for grandfathered suppliers) for the first three months and 75 percent of the single payment amounts (or fee schedule amounts for grandfathered suppliers) paid in the first three rental months for months 4 through 13. Similarly, the elimination of the lump sum purchase option for standard power wheelchairs, as required by the Section 3136 of the Affordable Care Act, does not apply to standard power wheelchairs furnished by contract suppliers under the Round One Rebid Program. Payment for standard power wheelchairs will continue to be made to Round One Rebid contract suppliers on either a lump sum purchase or rental basis.

For inexpensive and/or routinely purchased DME items, the recorded single payment amount for rental is 10 percent of the purchase single payment amount.

For all equipment furnished on a purchase basis, the recorded single payment amount for purchased used equipment is 75 percent of the purchase single payment amount.

Also included in the CBA pricing file and the single payment amount file is the maintenance and servicing single payment amounts for rented enteral nutrition infusion pumps described by HCPCS code B9000 and B9002, made in accordance with the "Medicare Claims Processing Manual" (Chapter 20, Section 40.3; see http://www.cms.gov/Manuals/downloads/clm104c20.pdf on the CMS website). The maintenance and servicing single payment amounts are equal to 5 percent of the single payment amount purchase price for the infusion pump.

Key Points of CR7638
Updates to the ZIP Code Files:
There are no updates to these files at this time

Updates to the HCPCS and Single Payment Amount Files:
There are no updates to these files at this time.

Additional Information
The official instruction associated with this CR7638 issued to your Medicare DME MAC or RHHI regarding this change may be viewed at http://www.cms.gov/Transmittals/downloads/R2363CP.pdf on the CMS website.

Credit Report/Score Requirements for DMEPOS Competitive Bidding

The Centers for Medicare & Medicaid Services has issued the following clarification to assist suppliers bidding in the Round 2 and national mail-order competitions of the Medicare DMEPOS Competitive Bidding Program. This information will also be posted on the Competitive Bidding Implementation Contractor (CBIC) website. If you have any questions, please contact the CBIC customer service center at 877-577-5331 between 9 a.m. and 9 p.m. Eastern time during the registration and bidding periods.

Q. The Request for Bids instructions say that suppliers must submit a copy of a credit report with numerical score that was prepared within 90 days prior to the opening of the bid window. Does this mean I can't submit a credit report and score that is dated after bidding opens but before bidding closes?

A. No. Credit reports and scores must not be prepared earlier than 90 days prior to the opening of the bid window, but they can be prepared after bidding opens as long as they are received by the CBIC by the close of the bid window. When bidding opens, CMS will post the specific date that is 90 days prior to the opening of the bid window on the CBIC website. Credit reports and scores that are older than this date will not be accepted.

DMEPOS Competitive Bidding Announcements: Bid Limits, Glucose Monitors Compliance Form, Adjustable Seat Cushion Codes

CMS has three announcements for suppliers that are interested in participating in the Round 2 and national mail-order competitions of the DMEPOS Competitive Bidding Program.

First, bid limits in the Round 2 Bid Preparation Worksheets have been revised for 14 Healthcare Common Procedure Coding System (HCPCS) codes for power wheelchairs (K0813 through K0829). The previous bid limits listed in the worksheet were erroneously based on 150 percent of the actual bid limits.

Second, we have made three clarifying updates to the list of glucose monitors on the 50 Percent Compliance Form, a required bid document for the national mail-order competition:

1. ASCENSIA AUTO DISC has been consolidated with ASCENSIA BREEZE 2. (ASCENSIA AUTO DISC is no longer manufactured but uses the same test strips as the ASCENSIA BREEZE 2.)
2. FREESTYLE FLASH has been consolidated with FREESTYLE and FREESTYLE FREEDOM. (FREESTYLE FLASH is no longer manufactured but uses the same test strips as FREESTYLE and FREESTYLE FREEDOM.)
3. Protégé has been consolidated with SMARTEST. (Protégé is no longer manufactured but uses the same test strips as SMARTEST.)

Third, CMS would like to remind potential bidders that four adjustable seat cushion codes (E2622 through E2625) have been removed from the Round 2 standard wheelchairs product category. The Competitive Bidding Implementation Contractor (CBIC) has deleted these codes from the bidder education materials.

All of these updates are now available on the CBIC website, http://www.dmecompetitivebid.com.

January 2012 Quarterly Update for DMEPOS Competitive Bidding Program

MLN Matters® Number: MM7632
Related Change Request (CR) #: CR 7632
Related CR Release Date: November 4, 2011
Related CR Transmittal #: R2341CP
Effective Date: January 1, 2012
Implementation Date: January 3, 2012

Provider Types Affected
Providers and suppliers submitting claims to Medicare Durable Medical Equipment (DME) Medicare Administrative Contractors (DME MACs), or Medicare Regional Home Health Intermediaries (RHHIs) for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) provided to Medicare beneficiaries.

Provider Action Needed
This article is based on Change Request (CR) 7632 which provides the January 2012 quarterly update for the DMEPOS Competitive Bidding Program files. CR7632 contains necessary changes to the Healthcare Common Procedure Coding System (HCPCS), Competitive Bidding Area (CBA) ZIP Code, and CBA Pricing files effective January 1, 2012. Be sure billing staff are aware of these changes.

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.

COMPETITIVE BIDDING CONT'D

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 CBAs 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 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 requires 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 of 2010 (ACA) 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 on the CMS website at http://www.cms.gov/DMEPOSCompetitiveBid/.

Competitive Bidding ZIP Codes

For competitive bidding, ZIP codes designated as mail order only are assigned a separate CBA number from the standard CBA. ZIP codes are established by the United States Postal Service (USPS). the CBA numbers and associated names are as follows:

- 16740 - Charlotte-Gastonia-Concord, NC-SC (non-mail order and mail order)
- 16741 - Charlotte-Gastonia-Concord, NC-SC (mail order only)
- 17140 - Cincinnati-Middletown, OH-KY-IN (non-mail order and mail order)
- 17141 - Cincinnati-Middletown, OH-KY-IN (mail order only)
- 17460 - Cleveland-Elyria-Mentor, OH (non-mail order and mail order)
- 17461 - Cleveland-Elyria-Mentor, OH (mail order only)
- 19100 - Dallas-Fort Worth-Arlington, TX (non-mail order and mail order)
- 19101 - Dallas-Fort Worth-Arlington, TX (mail order only)
- 28140 - Kansas City, MO-KS (non-mail order and mail order)
- 28141 - Kansas City, MO-KS (mail order only)
- 33100 - Miami-Fort Lauderdale-Pompano Beach, FL (non-mail order and mail order)
- 33101 - Miami-Fort Lauderdale-Pompano Beach, FL (mail order only)
- 36740 - Orlando- Kissimmee, FL (non-mail order and mail -order)
- 36741 - Orlando- Kissimmee, FL (mail order only)
- 38300 - Pittsburgh, PA (non-mail order and mail order)
- 38301 - Pittsburgh, PA (mail order only)
- 40140 - Riverside-San Bernardino-Ontario, CA (non-mail order and mail order)
- 40141 - Riverside-San Bernardino-Ontario, CA (mail order only)

COMPETITIVE BIDDING CONT'D

Updates to the ZIP Code Files
Six new ZIP codes have been added to the ZIP code file to conform with United States Postal Service ZIP code changes within CBAs:

ZIP	CBA
75033	19100 - Dallas-Fort Worth-Arlington, TX (non-mail order and mail order)
75033	19101 - Dallas-Fort Worth-Arlington, TX (mail order only)
33106	33100 - Miami-Fort Lauderdale-Pompano Beach, FL (non-mail order and mail order)
33106	33101 - Miami-Fort Lauderdale-Pompano Beach, FL (mail order only)
33206	33100 - Miami-Fort Lauderdale-Pompano Beach, FL (non-mail order and mail order)
33206	33101 - Miami-Fort Lauderdale-Pompano Beach, FL (mail order only)

Updates to the HCPCS and Single Payment Amount Files
There are no updates to these files at this time.

Public Use Files
The competitive bidding ZIP codes and single payment amounts per product category and CBA are available on the CBIC Website for interested parties like DMEPOS suppliers, State Medicaid agencies, and managed care organizations. The CBIC Website can be accessed at http://www.dmecompetitivebid.com/palmetto/cbic.nsf or by going to http://www.cms.gov/DMEPOSCompetitiveBid/01_overview.asp on the CMS website. These files can be used to identify when a specific item furnished to a beneficiary is subject to the DMEPOS competitive bidding program.

Single Payment Amount
Currently, Medicare payment for most DMEPOS items is based on fee schedules in most areas of the country. However, the Social Security Act (Section 1847; see http://www.ssa.gov/OP_Home/ssact/title18/1847.htm on the Internet) mandates that competitive bidding single payment amounts replace the current DMEPOS fee schedule payment amounts for competitively bid items in CBAs. Therefore, the single payment amount is the Medicare allowed payment amount for competitively bid items for beneficiaries who reside in the Round One Rebid CBAs. Medicare pays contract suppliers 80 percent of the single payment amount for each competitively bid item. Beneficiaries are responsible for the remaining 20 percent of the single payment amount. Payment for all claims is on an assignment-related basis. In no case can a beneficiary be charged more than the 20 percent coinsurance payment for medically necessary items. Single payment amounts remain the same throughout the term of suppliers' contracts.

In the CBA pricing file and the single payment amount public use file, the rental single payment amounts for capped rental DME and rented enteral nutrition equipment are 10 percent of the purchase single payment amount. This payment amount is for rental months one through three. The rental single payment amounts for months 4 through 13 for capped rental DME and for months 4 through 15 for rented enteral nutrition equipment are equal to 75 percent of the single payment amounts paid in the first three rental months. The changes to the power wheelchair payment rules made by section 3136 of the ACA (see http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf on the Internet) do not apply to payment made for items furnished pursuant to competitive bidding contracts entered into prior to January 1, 2011, or for power wheelchairs in which the first rental month occurred before January 1, 2011. Therefore, under the Round One Rebid Competitive Bidding Program, contract and grandfathered suppliers furnishing rented power wheelchairs will continue to be paid under the capped rental payment methodology using 10 percent of the fee schedule amount for the first three months and 75 percent of the fee schedule amounts paid in the first three rental months for months 4 through 13. Similarly, the elimination of the lump sum purchase option for standard power wheelchairs, as required by the Section 3136 of the ACA, does not apply to standard power wheelchairs furnished by contract suppliers under the Round One Rebid Program. Payment for standard power wheelchairs will continue to be made to Round One Rebid contract suppliers on either a lump sum purchase or rental basis.

For inexpensive and/or routinely purchased DME items, the recorded single payment amount for rental is 10 percent of the purchase single payment amount.

For all equipment furnished on a purchase basis, the recorded single payment amount for purchased used equipment is 75 percent of the purchase single payment amount.

Also included in the CBA pricing file and the single payment amount file is the maintenance and servicing single payment amounts for rented enteral nutrition infusion pumps described by HCPCS code B9000 and B9002, made in accordance with the "Medicare Claims Processing Manual" (Chapter 20, Section 40.3; see http://www.cms.gov/Manuals/downloads/clm104c20.pdf on the CMS website). The maintenance and servicing single payment amounts are equal to 5 percent of the single payment amount purchase price for the infusion pump.

Additional Information
The official instruction, CR7632, issued to your DME MACs and RHHIs regarding this change may be viewed at http://www.cms.gov/Transmittals/downloads/R2341CP.pdf on the CMS website.

Medicare Announces Timeline for Bidding; Begins Bidder Education Program for DMEPOS Competitive Bidding

Bidding Timeline
The Centers for Medicare & Medicaid Services (CMS) has announced the bidding timeline for the Round 2 and national mail-order competitions of the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding Program. To view the timeline, visit the Competitive Bidding Implementation Contractor (CBIC) web site at http://www.dmecompetitivebid.com.

Bidder Education Program
CMS has also launched a comprehensive bidder education program. This program is designed to ensure that DMEPOS suppliers interested in bidding receive the information and assistance they need to submit complete bids in a timely manner. The CBIC is the official information source for bidders and the focal point for bidder education. The CBIC website, http://www.dmecompetitivebid.com, features a comprehensive array of important information for suppliers, including bidding rules, user guides, policy fact sheets, checklists, and bidding information charts. The education program will also include webcasts that will cover all the essential topics suppliers will need to know in order to bid. These webcasts will be posted on the CBIC web site and will be available 24 hours a day/7 days a week. When a webcast is posted, the CBIC will announce its availability through a CBIC e-mail update announcement. To sign up to receive webcast announcements and other key registration and bidding information, visit the CBIC web site at http://www.dmecompetitivebid.com and subscribe to e-mail updates.

In addition to viewing the information on the CBIC website, DMEPOS suppliers are encouraged to call the CBIC toll-free help desk, 1-877-577-5331, with their questions and concerns.

To view the Press Release, please click: http://www.cms.gov/apps/media/press_releases.asp

To view the Fact Sheet, please click: http://www.cms.gov/apps/media/fact_sheets.asp

Registration Now Open for DMEPOS Competitive Bidding

Registration is now open and available to all suppliers interested in participating in the Round 2 and national mail-order competitions of the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program. When bidding opens, suppliers will need to submit their bids using the DMEPOS on-line bidding system (DBidS). To help ensure bid security and privacy, suppliers interested in bidding must first register all employees that will enter information in DBidS to obtain a user ID and password through the Individuals Authorized Access to CMS Computer Services (IACS) system. Only supplier employees that have a user ID and password will be able to access DBidS; suppliers that do not register will not be able to bid.

If you are a supplier interested in bidding, register now – don't wait. Designate one authorized official (AO) listed on the CMS-855S enrollment form to act as your AO for registration purposes. The AO must register for a user ID and password first and must approve other supplier employees' requests to register. After an AO successfully registers, the AO may designate other authorized officials on the CMS-855S to serve as backup authorized officials (BAO). The AO and BAOs can designate other supplier employees as end users (EU). BAOs and EUs must also register for a user ID and password to be able to use the on-line bidding system. The name, date of birth, and Social Security number (SSN) of the AO and BAOs must match exactly with what is on file with the National Supplier Clearinghouse to register successfully.

COMPETITIVE BIDDING CONT'D

We strongly urge all AOs to register no later than December 22, 2011, to ensure that BAOs and EUs have time to register before bidding begins. We recommend that BAOs register no later than January 12, 2012, so that they will be able to assist AOs with approving EU registration. Registration will close on February 9, 2012, at 9 p.m. prevailing Eastern Time – no AOs, BAOs, or EUs can register after registration closes.

To register, go to the Competitive Bidding Implementation Contractor (CBIC) website and click on "REGISTRATION IS OPEN" above the Registration Clock on the home page. Please review the IACS Reference Guide posted on the website for step-by-step instructions on registration. You will also find a registration checklist and Quick Step guides on the CBIC website. If you have any questions about the registration process, please contact the CBIC Customer Service Center at 1-877-577-5331.

The CBIC is the official information source for bidders. All suppliers interested in bidding are urged to sign up for E-mail Updates on the home page of the CBIC website. For information about Round 2 and the national mail-order competition, including bidder education materials, please refer to the resources located under Bidding Suppliers: Round 2 & National Mail-Order on the CBIC website.

Revised Medicare DMEPOS Competitive Bidding Program Repairs and Replacements Fact Sheet

The Centers for Medicare & Medicaid Services (CMS) announced today a revised repairs and replacement policy for the DMEPOS Competitive Bidding Program. The revised policy continues to allow any Medicare enrolled supplier to repair medically necessary, beneficiary-owned equipment when necessary to make the equipment serviceable.

The policy now considers repair parts to include components that are needed to repair the base equipment, including batteries and tires. Additionally, the revised fact sheet provides guidance on billing the labor component and parts for the repair for beneficiaries who reside in competitive bid areas.

To read the revised Medicare Learning Network® fact sheet click here:

http://www.cms.gov/MLNProducts/downloads/DME_Repair_Replacement_Factsheet_ICN905283.pdf

CONSOLIDATED BILLING

Annual Update of HCPCS Codes Used for Home Health Consolidated Billing Enforcement

MLN Matters® Number: MM7599
Related Change Request (CR) #: 7599
Related CR Release Date: October 7, 2011
Related CR Transmittal #: R2317CP
Effective Date: January 1, 2012
Implementation Date: January 3, 2012

Provider Types Affected
Providers and suppliers submitting claims to Medicare contractors (carriers, DME Medicare administrative contractors (DME MACs), Fiscal Intermediaries (FIs), Part A/B Medicare Administrative Contractors (A/B MACs), and/or Regional Home Health Intermediaries (RHHIs)) for services provided to Medicare beneficiaries during an episode of home health care are affected.

Provider Action Needed
This article announces that Change Request (CR) 7599 is a recurring update notification that provides the annual HH consolidated billing update, effective January 1, 2012. Make sure your billing staff is aware of these changes.

Background
The Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of Healthcare Common Procedure Codes System (HCPCS) codes subject to the consolidated billing provision of the HH Prospective Payment System (HH PPS). With the exception of therapies performed by physicians, supplies incidental to physician services, and supplies used in institutional settings, services appearing on this list that are submitted on claims to Medicare contractors will not be paid separately on dates when a beneficiary for whom such a service is being billed is in a HH episode (i.e., under a HH plan

of care administered by a home health agency). Medicare will only directly reimburse the primary HH agencies that have opened such episodes during the episode periods. Therapies performed by physicians, supplies incidental to physician services and supplies used in institutional settings are not subject to HH consolidated billing.

The HH consolidated billing code lists are updated annually, to reflect the annual changes to the HCPCS code set itself. Additional updates may occur as frequently as quarterly in order to reflect the creation of temporary HCPCS codes (e.g., 'K' codes) throughout the calendar year. The new coding identified in each update describes the same services that were used to determine the applicable HH PPS payment rates. No additional services will be added by these updates. New updates are required by changes to the coding system, not because the services subject to HH consolidated billing are being redefined.

Key Points

The HCPCS codes in the table below are being added to the HH consolidated billing supply code list.

Added HCPCS Codes	Descriptor
A5056	Ostomy pouch, drainable, with extended wear barrier attached, with filter, (1 piece), each.
A5057	Ostomy pouch, drainable, with extended wear barrier attached, with built in convexity, with filter, (1 piece), each.

Additional Information
The official instruction (CR7599) issued to your Medicare Carrier/FI/RHHI/MAC is available at http://www.cms.gov/Transmittals/downloads/R2317CP.pdf on the CMS website on the CMS website.

DOCUMENTATION

Proof of Delivery and Delivery Methods

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

Note: This article was revised on November 1, 2011, to clarify the language in the "What You Need to Know" section. All other information is the same.

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

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

Additional Information
The official instruction, CR7410 issued to your DME MAC regarding this change may be viewed at http://www.cms.gov/Transmittals/downloads/R389PI.pdf on the CMS website.

NORIDIAN Administrative Services LLC

Medicare

January 2012

Durable Medical Equipment - Documenting Continued Use

Dear Physician,

Treating physicians' records often omit documentation of a beneficiary's continuing use of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS). By Medicare statute, lack of physician documentation regarding a beneficiary's continued need and use of an item of DMEPOS will result in claim denials.

Many "model charts" from various clinical organizations recommend maintenance of a medication list that indicates the medication(s), strength, dosing schedule, and what the patient is actually taking. At each visit, the date of the visit is recorded and notations made regarding the patient's adherence with each medication. In addition to the patient's current medications, items of DME can also be incorporated into the list. Hospital beds, respiratory equipment (e.g., nebulizers, CPAP, oxygen) and diabetes testing equipment and supplies are just some of the types of DME that can be monitored through this use of an "expanded" medication list.

In the event of a record request from the medical equipment supplier, this Equipment/Medication List can be provided along with office notes to support your patient's claim for Medicare coverage.

Thank you for your cooperation and your care of Medicare beneficiaries.

Paul J. Hughes, MD Medical Director, DME MAC, Jurisdiction A	Robert D. Hoover, Jr., MD, MPH, FACP Medical Director, DME MAC, Jurisdiction C
Stacey V. Brennan, MD, FAAFP Medical Director, DME MAC, Jurisdiction B	Richard W. Whitten, MD, MBA, FACP Medical Director, DME MAC, Jurisdiction D

CMS CENTERS for MEDICARE & MEDICAID SERVICES

25012096 A CMS Contracted Medicare Administrative Contractor (0203)3-09

DRUGS/BIOLOGICALS

January 2012 ASP Files Now Available

The Centers for Medicare and Medicaid Services (CMS) has posted the January 2012 Average Sales Price (ASP) and Not Otherwise Classified (NOC) pricing files and crosswalks and updated pricing files for October 2011 and July 2011.

All are available for download at: http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/ (see left menu for year-specific links).

January 2012 Quarterly ASP Medicare Part B Drug Pricing Files and Revisions to Prior Files

MLN Matters® Number: MM7624
Related Change Request (CR) #: CR 7624
Related CR Release Date: October 27, 2011
Related CR Transmittal #: R2331CP
Effective Date: January 1, 2012
Implementation Date: January 3, 2012

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

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

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

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

Files	Effective for Dates of Service
January 2012 ASP and ASP NOC	January 1, 2012, through March 31, 2012
October 2011 ASP and ASP NOC	October 1, 2011, through December 31, 2011
July 2011 ASP and ASP NOC	July 1, 2011, through September 30, 2011
April 2011 ASP and ASP NOC files	April 1, 2011, through June 30, 2011
January 2011 ASP and ASP NOC files	January 1, 2011, through March 31, 2011

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

Pharmacy Billing for Drugs Provided "Incident To" a Physician Service

MLN Matters® Number: MM7397 Revised
Related Change Request (CR) #: 7397
Related CR Release Date: December 15, 2011
Related CR Transmittal #: R2368CP
Effective Date: January 1, 2013
Implementation Date: January 1, 2013

Note: This article was revised on December 16, 2011, to reflect the revised CR7397 issued on December 15. The effective and implementation dates were changed. Also, the CR release date, transmittal number, and the Web address for accessing CR7397 were revised. All other information remains the same.

Provider Types Affected
Pharmacies that submit claims for drugs to Medicare contractors (Fiscal Intermediaries (FIs), Carriers, Regional Home Health Intermediaries (RHHIs), A/B Medicare Administrative Contractors (A/B MACs), and Durable Medical Equipment MACs) are affected.

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

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

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

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

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

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

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

Payment limits
The payment limits for drugs and biologicals that are not included in the average sales price (ASP) Medicare Part B Drug Pricing File or Not Otherwise Classified (NOC) Pricing File are based on the published Wholesale Acquisition Cost (WAC) or invoice pricing, except under the Outpatient Prospective Payment System (OPPS) where the payment allowance limit is 95 percent of the published average wholesale price (AWP). In determining the payment limit based on WAC, the payment limit is 106 percent of the lesser of the lowest-priced brand or median generic WAC.

Medicare contractors will not search their files to either retract payment for claims already paid or to retroactively pay claims, but will adjust claims brought to their attention.

Additional Information
The official instruction, CR 7397 issued to your Medicare contractor regarding this issue may be viewed at http://www.cms.gov/Transmittals/downloads/R2368CP.pdf on the Centers for Medicare & Medicaid Services (CMS) website.

The following manual sections regarding billing drugs and biological and "incident to" services may be helpful:

- "Medicare Claims Processing Manual", chapter 17, sections 20.1.3 and 50.B, available at http://www.cms.gov/manuals/downloads/clm104c17.pdf and
- "Medicare Benefit Policy Manual", chapter 15, sections 50.3 and 60.1, available at http://www.cms.gov/manuals/Downloads/bp102c15.pdf on the CMS website.

Widespread Prepayment Review for Immunosuppressive Drugs - Edit Effectiveness for 1st 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 fourth quarter edit effectiveness results from September 2011 through December 2011 are as follows:

The results of the review, for item J7507, identified 640 claims of which 494 were denied. A total of 378 claims were denied for no response to the additional documentation request. This resulted in an overall error rate of 80%.

The result of the review, for item J7517, identified 445 claims of which 317 were denied. A total of 242 claims were denied for no response to the additional documentation request. This resulted in an overall error rate of 71%.

The result of the review, for item J7518, identified 152 claims of which 127 were denied. A total of 103 claims were denied for no response to the additional documentation request. This resulted in an overall error rate of 82%.

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 valid written order
   a. No written order submitted with the documentation
   b. Insufficient or incomplete order

C. 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. 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.

C. 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

EDUCTIONAL

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 ACTs: 3 p.m. CT

Date	Topic	Call Information	Confirmation Number
01/26/12	Appeals	(800) 288-8968	231726
04/19/12	Power Mobility Devices (PMDs)	(800) 288-8976	231727
07/19/12	General	(800) 288-8976	231728
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

ENROLLMENT

Claims against Surety Bonds for Suppliers of DMEPOS

MLN Matters® Number: MM7167
Related Change Request (CR) #:7167
Related CR Release Date: January 20, 2012
Related CR Transmittal #: R403PI
Effective Date: February 21, 2012
Implementation Date: February 21, 2012

Provider Types Affected
DMEPOS suppliers that are required to obtain and maintain a surety bond as a condition of their enrollment in the Medicare program.

Provider Action Needed
This article is based on Change Request (CR) 7167, which outlines the procedures for CMS to make a claim against a DMEPOS supplier's surety bond. Be certain you are aware of these clarifications.

Background
In order to enroll in and to remain enrolled in the Medicare program DMEPOS suppliers must obtain and maintain a surety bond in the amount of $50,000 (unless an elevated bond amount is required) under 42 Code of Federal Regulations (CFR) section 424.57(d).

Key Points
According to 42 CFR section 424.57(d), a surety must pay the Centers for Medicare & Medicaid Services (CMS) - within 30 days of receiving written notice to do so - the following amounts up to the full penal sum of the bond:

- The amount of any unpaid claim, plus accrued interest, for which the DMEPOS supplier is responsible; and
- The amount of any unpaid claim, civil monetary penalty (CMP), or assessment imposed by CMS or the Office of the Inspector General (OIG) on the DMEPOS supplier, plus accrued interest.

For purposes of this surety bond requirement, an "unpaid claim" is defined as an overpayment (including accrued interest, as applicable) made by the Medicare program to the DMEPOS supplier for which the supplier is responsible.

A surety is liable for any overpayments incurred during the term of the surety bond. This includes overpayment determinations made on or after the surety bond effective date. These overpayment determinations can relate to payments made on or after March 3, 2009.

Additional Information
The official instruction, CR 7167, issued to your DME/MAC regarding this change, may be viewed at http://www.cms.gov/Transmittals/downloads/R403PI.pdf on the CMS website.

Medicare's surety bond requirements are summarized in detail in article MM6392 at http://www.cms.gov/MLNMattersArticles/downloads/MM6392.pdf on the CMS website.

Further Details on Revalidation of Provider Enrollment Information

MLN Matters® Number: SE1126 Revised

Note: This article was revised on November 1, 2011, to provide a new web address for payment of the Medicare enrollment application fees. Clarification language was also added on page 3, regarding the revalidation process. All other information remains the same.

Provider Types Affected
This Medicare Learning Network (MLN) Matters® Special Edition Article is intended for all providers and suppliers who enrolled in Medicare prior to March 25, 2011, via Medicare's Contractors (Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), Medicare Carriers, A/B Medicare Administrative Contractors (A/B MACs), and the National Supplier Clearinghouse (NSC)). These contractors are collectively referred to as MACs in this article.

Provider Action Needed
In Change Request (CR) 7350, the Centers for Medicare & Medicaid Services (CMS) discussed the final rule with comment period, titled, "Medicare, Medicaid, and Children's Health Insurance Programs; Additional Screening Requirements, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions and Compliance Plans for Providers and Suppliers" (CMS-6028-FC). This rule was published in the February 2, 2011, edition of the "Federal Register." A related MLN Matters® Article is available at http://www.cms.gov/MLNMattersArticles/downloads/MM7350.pdf on the CMS website. This article provides no new policy, but only provides further information regarding the revalidation requirements based on Section 6401 (a) of the Affordable Care Act.

All providers and suppliers enrolled with Medicare prior to March 25, 2011, must revalidate their enrollment information, but only after receiving notification from their MAC. Special Note: The Medicare provider enrollment revalidation effort does not change other aspects of the enrollment process. Providers should continue to submit routine changes – address updates, reassignments, additions to practices, changes in authorized officials, information updates, etc – as they always have. If you also receive a request for revalidation from the MAC, respond separately to that request.

ENROLLMENT CONT'D

When you receive notification from your MAC to revalidate:

- Update your enrollment through Internet-based PECOS or complete the 855;
- Sign the certification statement on the application;
- If applicable, pay your fee by going to https://pecos.cms.hhs.gov/pecos/feePaymentWelcome.do; and
- Mail your supporting documents and certification statement to your MAC.

Background
Section 6401 (a) of the Affordable Care Act established a requirement for all enrolled providers and suppliers to revalidate their enrollment information under new enrollment screening criteria. This revalidation effort applies to those providers and suppliers that were enrolled prior to March 25, 2011. **Newly enrolled providers and suppliers that submitted their enrollment applications to CMS on or after March 25, 2011, are generally not impacted.**

CMS has reevaluated the revalidation requirement in the Affordable Care Act, and believes it affords the flexibility to extend the revalidation period for another 2 years. This will allow for a smoother process for providers and contractors. Revalidation notices will now be sent through March of 2015. **IMPORTANT:** This does not affect those providers which have already received a revalidation notice. If you have received a revalidation notice from your contractor respond to the request by completing the application either through internet-based PECOS or by completing the appropriate 855 application form.

Therefore, between now and 2015, MACs will send out revalidation notices on an intermittent, but regular basis to begin the revalidation process for each -provider and supplier. Providers and suppliers must submit the revalidation application only after being asked by their MAC to do so. Please note that 42 CFR 424.515(d) provides CMS the authority to conduct these off-cycle revalidations. The first set of revalidation notices went to providers who are billing, but are not currently in PECOS. To identify these providers, contractors searched their local systems and if a Provider Transaction Access Number (PTAN) for a physician was not in PECOS, a revalidation request for that physician was sent. CMS asks all providers who receive a request for revalidation to respond to that request.

- **For providers NOT in PECOS** – the revalidation letter will be sent to the special payments or primary practice address because CMS does not have a correspondence address.
- **For providers in PECOS** – the revalidation letter will be sent to the special payments and correspondence addresses simultaneously. If these are the same, it will also be mailed to the primary practice address. If you believe you are not in PECOS and have not yet received a revalidation letter, contact your Medicare contractor. Contact information may be found at http://www.CMS.gov/MedicareProviderSupEnroll/downloads/contact_list.pdf on the CMS website.

Note: CMS has structured the revalidation processes to reduce the burden on the providers by implementing innovative technologies and streamlining the enrollment and revalidation processes. CMS will continue to provide updates as progress is made on these efforts. **The most efficient way to submit your revalidation information is by using the Internet-based PECOS.**

To revalidate via the Internet-based PECOS, go to https://pecos.cms.hhs.gov on the CMS website. PECOS allows you to review information currently on file, update and submit your revalidation via the Internet. Once submitted, YOU MUST print, sign, date, and mail the certification statement along with all required supporting documentation to the appropriate MAC IMMEDIATELY.

Section 6401(a) of the Affordable Care Act also requires the Secretary to impose a fee on each "institutional provider of medical or other items or services and suppliers." The application fee is $505 for Calendar Year (CY) 2011. CMS has defined "institutional provider" to mean any provider or supplier that submits a paper Medicare enrollment application using the CMS-855A, CMS-855B (except physician and non-physician practitioner organizations), or CMS-855S forms or associated Internet-based PECOS enrollment application.

All institutional providers (i.e., all providers except physicians, non-physicians practitioners, physician group practices and non-physician practitioner group practices) and suppliers who respond to a revalidation request must submit an enrollment fee (reference 42 CFR 424.514) with their revalidation. In mid September, CMS revised the revalidation letter that contractors sent to providers to clarify who must pay the fee. You may submit your fee by ACH debit, or credit card. Revalidations are processed only when fees have cleared. To pay your application fee, go to https://pecos.cms.hhs.gov/pecos/feePaymentWelcome.do and submit payment as directed. A confirmation screen will display indicating that payment was successfully made. This confirmation screen is your receipt and you should print it for your records. CMS strongly recommends that you mail this receipt to the Medicare contractor along with the Certification Statement for the enrollment application. CMS will notify the Medicare contractor that the application

fee has been paid. Upon receipt of the revalidation request, providers and suppliers have 60 days from the date of the letter to submit complete enrollment forms. **Failure to submit the enrollment forms as requested may result in the deactivation of your Medicare billing privileges.**

Additional Information
For more information about the enrollment process and required fees, refer to MLN Matters® Article MM7350, which is available at http://www.cms.gov/MLNMattersArticles/downloads/MM7350.pdf on the CMS website.

For more information about the application fee payment process, refer to MLN Matters® Article SE1130, which is available at http://www.cms.gov/MLNMattersArticles/downloads/SE1130.pdf on the CMS website.

The MLN® fact sheet titled "The Basics of Internet-based Provider Enrollment, Chain and Ownership System (PECOS) for Provider and Supplier Organizations" is designed to provide education to provider and supplier organizations on how to use Internet-based PECOS to enroll in the Medicare Program and can be found at http://www.cms.gov/MLNProducts/downloads/MedEnroll_PECOS_ProviderSup_FactSheet_ICN903767.pdf on the CMS website.

To access PECOS, your Authorized Official must register with the PECOS Identification and Authentication system. To register for the first time go to https://pecos.cms.hhs.gov/pecos/PecosIAConfirm.do?transferReason=CreateLogin to create an account.

A sample letter requesting providers to review, update, and certify their enrollment information is available at http://www.cms.gov/MedicareProviderSupEnroll/Downloads/SampleRevalidationLetter.pdf on the CMS website.

For additional information about the enrollment process and Internet-based PECOS, please visit the Medicare Provider-Supplier Enrollment web page at http://www.cms.gov/MedicareProviderSupEnroll on the CMS website.

Implementation of Provider Enrollment Provisions in CMS-6028-FC

MLN Matters® Number: MM7350 Revised
Related Change Request (CR) #: 7350
Related CR Release Date: March 23, 2011
Related CR Transmittal #: R371PI
Effective Date: March 25, 2011
Implementation Date: March 25, 2011

Note: MM7350 was revised on October 31, 2011, to provide a new Web address for making payment of the application fees. All other information remains the same.

Provider Types Affected
All providers and suppliers submitting enrollment applications to Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), Medicare Carriers, A/B Medicare Administrative Contractors (A/B MACs), and the National Supplier Clearinghouse (NSC) are affected by this article.

Provider Action Needed
The Centers for Medicare & Medicaid Services (CMS) published a final rule with comment period, entitled, "Medicare, Medicaid, and Children's Health Insurance Programs; Additional Screening Requirements, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions and Compliance Plans for Providers and Suppliers" (CMS-6028-FC). This rule was published in the February 2, 2011, edition of the "Federal Register."

This rule finalized provisions related to the:

- Establishment of provider enrollment screening categories;
- Submission of application fees as part of the provider enrollment process;
- Suspensions of payment based on credible allegations of fraud; and
- Authority to impose a temporary moratorium on the enrollment of new Medicare providers and suppliers of a particular type (or the establishment of new practice locations of a particular type) in a geographic area.

This article is based on Change Request (CR) 7350, which describes how Medicare contractors will implement the changes related to provider enrollment screening, application fees, and temporary moratoria. (Payment suspensions will be addressed via separate CMS guidance.). Please ensure that your staffs are aware of these new provisions.

Background
CR7350 describes how Medicare will implement certain provisions of the final rule CMS-6028-FC. These details are provided in new sections 19 through 19.4 of Chapter 15 in the "Medicare Program Integrity Manual." Those manual sections are attached to CR7350 and are summarized as follows:

Screening Processes
Beginning on March 25, 2011, Medicare will place newly-enrolling and existing providers and suppliers in one of three levels of categorical screening: limited, moderate, or high. The risk levels denote the level of the contractor's screening of the provider or supplier when it initially enrolls in Medicare, adds a new practice location, or revalidates its enrollment information.

Chapter 15, Section 19.2.1 of the "Program Integrity Manual" (PIM) provides the complete list of these three screening categories, and the provider types assigned to each category, and a description of the screening processes applicable to the three categories (effective on and after March 25, 2011), and procedures to be used for each category. Once again, that new section of the PIM is attached to CR7350.

Although fingerprinting and criminal background checks are included in CMS-6028-FC as requirements for providers and suppliers in the "high" category of screening, these requirements will be implemented at a later date and providers and suppliers will be notified well in advance of their implementation.

Application Fees
With the exception of physicians, non-physician practitioners, physician group practices and non-physician group practices, providers and suppliers that are (1) initially enrolling in Medicare, (2) adding a practice location, or (3) revalidating their enrollment information, must submit with their application:

- An application fee in an amount prescribed by CMS, and/or
- A request for a hardship exception to the application fee.

This requirement applies to applications that your Medicare contractor receives on or after March 25, 2011. Note that a physician, non-physician practitioner, physician group, or non-physician practitioner group that is enrolling as a DMEPOS supplier via the CMS-855S application must pay the required application fee.

The application fee must be in the amount prescribed by CMS for the calendar year in which the application is submitted. The fee for March 25, 2011, through December 31, 2011, is $505.00. Fee amounts for future years will be adjusted by the percentage change in the consumer price index (for all urban consumers) for the 12-month period ending on June 30 of the prior year. CMS will give Medicare contractors and the public advance notice of any change in the fee amount for the coming calendar year.

The application fee is non-refundable, except if it was submitted with one of the following:

- A hardship exception request that is subsequently approved;
- An application that was rejected prior to the Medicare Contractor's initiation of the screening process; or
- An application that is subsequently denied as a result of the imposition of a temporary moratorium as described in 42 CFR 424.570.

The provider or supplier must pay the application fee electronically by going to https://pecos.cms.hhs.gov/pecos/feePaymentWelcome.do and paying their fee via credit card, debit card, or check. Providers and suppliers are strongly encouraged to submit with their application a copy of their receipt of payment. This may enable the contractor to more quickly verify that payment has been made.

Hardship Exception
A provider or supplier requesting a hardship exception from the application fee must include with its enrollment application a letter (and supporting documentation) that describes the hardship and why the hardship justifies an exception. If a paper CMS-855 application is submitted, the hardship exception letter must accompany the application. If the application is submitted via the Internet-based Provider Enrollment, Chain and Ownership System (PECOS), the hardship exception letter must accompany the certification statement. Hardship exception letters will not be considered if they were submitted separately from the application or certification statement, as applicable. If your Medicare contractor receives a hardship exception request separately from the application or certification statement, it will: (1) return it to you, and (2) notify you via letter, e-mail, or telephone, that it will not be considered.

Upon receipt of a hardship exception request with the application or certification statement, the contractor will send the request and all documentation accompanying the request to CMS. CMS will determine if the request should be approved. **During this review period, the contractor will not begin processing the provider's application.** CMS will communicate its decision to the institutional provider and the contractor via letter.

IMPORTANT: *In addition, the contractor will not begin to process the provider's application until: (1) the fee has been paid, or (2) the hardship exception request has been approved. Once processing commences, the application will be processed in the order in which it was received.*

Review of Hardship Exception Request
As already stated, the application fee for CY 2011 is $505. This generally should not represent a significant burden for an adequately capitalized provider or supplier. It is not enough for the provider to simply assert that the imposition of the application fee represents a financial hardship. The provider must instead make a strong argument to support its request, including providing comprehensive documentation (which may include, without limitation, historical cost reports, recent financial reports such as balance sheets and income statements, cash flow statements, tax returns, etc.).

Other factors that may suggest that a hardship exception is appropriate include the following:

a. Considerable bad debt expenses,

b. Significant amount of charity care/financial assistance furnished to patients,

c. Presence of substantive partnerships (whereby clinical, financial integration are present) with those who furnish medical care to a disproportionately low-income population;

d. Whether an institutional provider receives considerable amounts of funding through disproportionate share hospital payments, or

e. Whether the provider is enrolling in a geographic area that is a Presidentially-declared disaster under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. 5121-5206 (Stafford Act).

Note that if the provider fails to submit appropriate documentation to support its hardship exception request, the contractor is not required to contact the provider to request it. Ultimately, it is the provider's responsibility to furnish the necessary supporting evidence at the time it submits its hardship exception request.

Appeal of the Denial of Hardship Exception Decision
If the provider or supplier is dissatisfied with CMS's decision, it may file a written reconsideration request with CMS within 60 calendar days from receipt of the notice of initial determination. The request must be signed by the individual provider or supplier, a legal representative, or any authorized official within the entity. Failure to file a reconsideration request within this timeframe is deemed a waiver of all rights to further administrative review. To file a reconsideration request, providers and suppliers should follow the procedures outlined in Chapter 15, Section 19 of the "Program Integrity Manual" (PIM), which is attached to CR7350.

Temporary Moratoria
CMS may impose a moratorium on the enrollment of new Medicare providers and suppliers of a particular type or the establishment of new practice locations of a particular type in a particular geographic area.

The announcement of a moratorium will be made via the Federal Register. For initial and new location applications involving the affected provider and supplier type, the moratorium:

- Will not apply to applications for which an approval or a recommendation for approval has been made as of the effective date of the moratorium, even if the contractor has not yet formally granted Medicare billing privileges. Such applications can continue to be processed to completion.
- Will apply to applications that are pending as of the effective date of the moratorium and for which the contractor has not yet made a final approval/denial decision or recommendation for approval. The contractor will deny such applications and will return the application fee if it was submitted with the application.
- Will apply to initial applications that the contractor receives on or after the effective date of the moratorium, and for as long as the moratorium is in effect. The contractor will deny such applications and will return the application fee if it was submitted with the application.

If a particular moratorium is lifted, all applications pending with the contractor as of the effective date of the moratorium's cessation are no longer subject to the moratorium and may be processed. However, such applications will be processed in accordance with the "high" level of categorical screening. In addition, any initial application received from a provider or supplier: (a) that is of a provider or supplier type that was subject to a moratorium, and (b) within 6 months after the applicable moratorium was lifted, the contractor will process the application using the "high" level of categorical screening.

Additional Information
The official instruction, CR7350, issued to your FI, RHHI, carrier, and A/B MAC regarding this change, may be viewed at http://www.cms.gov/transmittals/downloads/R371PI.pdf on the CMS website. Complete details regarding this issue, as defined in the PIM revisions, are attached to CR7350.

MLN Matters® article SE1126, which is available at http://www.cms.gov/MLNMattersArticles/downloads/SE1126.pdf, has further details on the Affordable Care Act-required revalidation of provider enrollment information for all providers and suppliers who enrolled in the Medicare program prior to March 25, 2011.

For more information about the application fee payment process, refer to MLN Matters® article SE1130, which is available at http://www.cms.gov/MLNMattersArticles/downloads/SE1130.pdf on the CMS website. A sample letter requesting providers to review, update, and certify their enrollment information is available at http://www.cms.gov/MedicareProviderSupEnroll/Downloads/SampleRevalidationLetter.pdf on the CMS website.

Important Information on Revalidation of Medicare Provider Enrollment

CMS has reevaluated the revalidation requirement in the Affordable Care Act, and believe it affords the flexibility to extend the revalidation period for another two years. This will allow for a smoother process for provider and contractors. Revalidation notices will now be sent through March of 2015. IMPORTANT: This does not affect those providers which have already received a revalidation notice. If you have received a revalidation notice from your contractor, respond to the request by completing the application either through internet-based PECOS or completing the appropriate 855 application form.

The first set of revalidation notices went to providers who are billing, but are not currently in the Provider Enrollment, Chain and Ownership System (PECOS). To identify these providers, contractors searched their local systems and if a Provider Transaction Access Number (PTAN) for a physician was not in PECOS, a revalidation request for that physician was sent. We ask all providers who receive a request for revalidation to respond to that request.

For providers NOT in PECOS, the revalidation letter will be sent to the special payments or primary practice address because we don't have a correspondence address. For providers in PECOS, the revalidation letter will be sent to the special payments and correspondence addresses simultaneously; if these are the same it will also be mailed to the primary practice address. If you believe you are not in PECOS and have not yet received a revalidation letter, contact your Medicare contractor. Contact information may be found at http://www.CMS.gov/MedicareProviderSupEnroll/downloads/contact_list.pdf.

Institutional providers (i.e., all providers except physicians, non-physicians practitioners, physician group practices and non-physician practitioner group practices) must submit the application fee with their revalidation. In mid-September, CMS revised the revalidation letter that contractors sent to providers to clarify who must pay the fee.

CMS plans to post a list of providers who were sent requests to revalidate. We will make an announcement via CMS listservs when this information is posted. If you are signed up for your Medicare contractor's listserv you will get a notice that way. You may also sign up for a national listserv for your provider type by going to: http://www.CMS.gov/prospmedicarefeesvcpmtgen/downloads/Provider_Listservs.pdf.

Now Available Online: List of Providers Sent Revalidation Request

In response to provider requests, CMS has posted a listing of providers who have been sent a request to revalidate their Medicare enrollment information. The listing contains the name and national provider identifier (NPI) of each provider sent a letter, as well as the date the letter was sent. To see the listing, click on "Revalidation Phase 1 Listing" in the Downloads section of the Medicare Provider Supplier Enrollment Revalidation Page. Note: You must widen each column in the spreadsheet to view the contents. CMS will be updating this list monthly.

If you are listed, and have not received the request, please contact your Medicare contractor. Their toll free number may be found at Medicare Fee-For-Service Contact Information.

For more information on revalidation of Medicare provider enrollment, see MLN article 1126 Further Details on the Revalidation of Provider Enrollment Information.

ENROLLMENT CONT'D

Transcript of "Revalidation of Medicare Provider Enrollment" National Provider Call Now Available

All providers and suppliers who enrolled in the Medicare program prior to Friday, March 25, 2011, will be required to revalidate their enrollment under new risk screening criteria required by the Affordable Care Act (section 6401a). CMS hosted a National Provider Call on Thursday, October 27, 2011 to discuss:

- The Revalidation Process
- Improvements to the Provider Enrollment, Chain and Ownership System (PECOS)
- Advanced Diagnostic Imaging and Accreditation
- Application Fees
- Changes to the 855A Form

Don't miss this opportunity to hear from CMS experts on this important topic. Click on National Provider Call on Revalidation of Medicare Provider Enrollment to view the transcript. This transcript contains a number of post call clarifications – such as where to find the listing of providers which have received a notice to revalidate. The audio file will be posted in the near future.

ESRD

ESRD PPS and Consolidated Billing for Limited Part B Services

MLN Matters® Number: MM7064 Revised
Related Change Request (CR) #: 7064
Related CR Release Date: January 14, 2011
Related CR Transmittal #: R2134CP
Effective Date: January 1, 2011
Implementation Date: January 3, 2011

Note: This article was revised on December 21, 2011, to clarify the cost report language for low volume facility adjustments on page 6. All other information remains the same.

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

Provider Action Needed
This article is based on Change Request (CR) 7064 which announces the implementation of an End Stage Renal Disease (ESRD) bundled prospective payment system (PPS) effective January 1, 2011.

Once implemented, the ESRD PPS will replace the current basic case-mix adjusted composite payment system and the methodologies for the reimbursement of separately billable outpatient ESRD related items and services. The ESRD PPS will provide a single payment to ESRD facilities, i.e., hospital-based providers of services and renal dialysis facilities, that will cover all the resources used in providing an outpatient dialysis treatment, including supplies and equipment used to administer dialysis in the ESRD facility or at a patient's home, drugs, biologicals, laboratory tests, training, and support services. The ESRD PPS provides ESRD facilities a 4-year phase-in (transition) period under which they would receive a blend of the current payment methodology and the new ESRD PPS payment. In 2014, the payments will be based 100 percent on the ESRD PPS payment.

Since the ESRD PPS is effective for services on or after January 1, 2011, it is important that providers not submit claims spanning dates of service in 2010 and 2011. ESRD facilities have the opportunity to make a one time election to be excluded from the transition period and have their payment based entirely on the payment amount under the ESRD PPS as of January 1, 2011. Facilities wishing to exercise this option must do so on or before November 1, 2010. See the Background and Additional Information Sections of this article for further details regarding the ESRD PPS.

Background
The Medicare Improvements for Patients and Providers Act (MIPPA); Section 153(b); see http://www.govtrack.us/congress/billtext.xpd?bill=h110-6331 on the Internet) requires the Centers for Medicare & Medicaid services (CMS) to implement an End Stage Renal Disease (ESRD) bundled prospective payment system (PPS) effective January 1, 2011. Once implemented, the ESRD PPS will replace the current basic case-mix adjusted composite payment system and the methodologies for the reimbursement of separately billable outpatient ESRD related items and services.

Specifically, the ESRD PPS combines payments for composite rate and separately billable services into a single base rate. The per dialysis treatment base rate for adult patients is subsequently adjusted to reflect differences in:

- Wage levels among the areas in which ESRD facilities are located;
- Patient-level adjustments for case-mix;
- An outlier adjustment (if applicable);
- Facility-level adjustments;
- A training add-on (if applicable); and
- A budget neutrality adjustment during the transition period through 2013.

Patient-level Adjustments
The patient-level adjustments are patient-specific case-mix adjusters that were developed from a two-equation regression analysis that encompasses composite rate and separately billable items and services. Included in the case-mix adjusters for adults are those variables that are currently used in basic case-mix adjusted composite payment system, that is, age, body surface area (BSA), and low body mass index (BMI). In addition to those adjusters that are currently used, the ESRD PPS will also incorporate adjustments for six co-morbidity categories and an adjustment for the onset of renal dialysis.

Outlier Adjustment
ESRD facilities that are treating patients with unusually high resource requirements, as measured through their utilization of identified services beyond a specified threshold, will be entitled to outlier payments. Such payments are an additional payment beyond the otherwise applicable case-mix adjusted prospective payment amount.

ESRD outlier services are the following items and services that are included in the ESRD PPS bundle:

1. ESRD-related drugs and biologicals that were or would have been, prior to January 1, 2011, separately billable under Medicare Part B;
2. ESRD-related laboratory tests that were or would have been, prior to January 1, 2011, separately billable under Medicare Part B;
3. Medical/surgical supplies, including syringes, used to administer ESRD-related drugs that were or would have been, prior to January 1, 2011, separately billable under Medicare Part B; and
4. Renal dialysis service drugs that were or would have been, prior to January 1, 2011, covered under Medicare Part D, notwithstanding the delayed implementation of ESRD-related oral-only drugs effective January 1, 2014.

Note: Services not included in the PPS that remain separately payable, including blood and blood processing, preventive vaccines, and telehealth services, are not considered outlier services.

Facility-level Adjustments
The facility-level adjustments include adjusters to reflect urban and rural differences in area wage levels using an area wage index developed from Core Based Statistical Areas (CBSAs). The facility-level adjustments also include an adjuster for facilities treating a low-volume of dialysis treatments.

Training Add-On
Facilities that are certified to furnish training services will receive a training add-on payment amount of $33.44, which is adjusted by the geographic area wage index to account for an hour of nursing time for each training treatment that is furnished. The training add-on applies to both peritoneal dialysis (PD) and hemodialysis (HD) training treatments.

Adjustments Specific to Pediatric Patients
The pediatric model incorporates separate adjusters based on two age groups (<13, 13-17) and dialysis modality (hemodialysis, peritoneal dialysis). The per-treatment base rate as it applies to pediatric patients is the same base rate that applies for adult patients, which is also adjusted by the area wage index. However, due to the lack of statistical robustness, the base rate for pediatric patients is not adjusted by the same patient-level case-mix adjusters as for adult patients. Instead, the pediatric payment adjusters reflect the higher total payments for pediatric composite rate and separately billable services, compared to that of adult patients.

Treatments furnished to pediatric patients:

- Can qualify for a training add-on payment (when applicable), and
- Are eligible for an outlier adjustment.

Note: Pediatric dialysis treatments are not eligible for the low-volume adjustment.

ESRD PPS 4-year Phase-in (Transition) Period
The ESRD PPS provides ESRD facilities with a 4-year transition period under which they would receive a blend of payments under the prior case-mix adjusted composite payment system and the new ESRD PPS as noted in the following table:

The ESRD PPS 4-year Transition Period Blended Rate Determination

Calendar Year	Blended Rate
2011	75 percent of the old payment methodology and 25 percent of the new PPS payment
2012	50 percent of the old payment methodology and 50 percent of the new PPS payment
2013	25 percent of the old payment methodology and 75 percent of the new PPS payment
2014	100 percent of the PPS payment

For Calendar Year (CY) 2011, CMS will continue to update the basic case-mix composite payment system for purposes of determining the composite rate portion of the blended payment amount. CMS updated the composite payment rate, the drug add-on adjustment to the composite rate, the wage index adjustment, and the budget neutrality adjustment.

The **ESRD PPS base rate is $229.63**, which is applicable for both adult and pediatric ESRD patients effective January 1, 2011. This base rate will be wage adjusted as mentioned above where

- The labor-related share of the base rate from the ESRD PPS market basket is 0.41737, and
- The non labor-related share of the base rate is $133.79 ((229.63 X (1 - 0.41737) = $133.79).

During the transition, the labor-related share of the case-mix adjusted composite payment system will remain 0.53711.

The payment rate for a dialysis treatment is determined by wage adjusting the base rate and then applying any applicable:

- Patient-level adjustments;
- Outlier adjustments;
- Facility-level adjustments; and
- Training add-on payments (adjusted for area wage levels)

Once the payment rate for the dialysis treatment is determined, the last item in the computation to determine the final payment rate is the application of the transition budget neutrality factor of .969, that is, a 3.1 percent reduction.

The ESRD PRICER will provide the payment for existing composite rate, the new ESRD PPS payment rate, and the outlier payment (when applicable). These reimbursement amounts must be blended during a transition period for all ESRD facilities except those facilities opting out of the transition and electing to be paid 100 percent of the payment amount under the new ESRD PPS.

Note: Providers wishing to opt out of the transition period blended rate must notify their Medicare Contractor on or before November 1, 2010. Providers shall not submit claims spanning date of service in 2010 and 2011.

Three New Adjustments Applicable to the Adult Rate

1. **Comorbid Adjustments:** The new ESRD PPS provides for **3 categories of chronic comorbid conditions** and **3 categories for acute comorbid conditions**. A single adjustment will be made to claims containing one or more of the comorbid conditions. The highest comorbid adjustment applicable will be applied to the claim. The acute comorbid adjustment may be paid no greater than 4 consecutive months for any reported acute comorbid condition, unless there is a reoccurrence of the condition. The **3 chronic comorbid categories** eligible for a payment adjustment are:
   - Hereditary hemolytic and sickle cell anemia;
   - Monoclonal gammopathy (in the absence of multiple myeloma); and
   - Myelodysplastic syndrome.

   The **3 acute comorbid categories** eligible for a payment adjustment are:
   - Bacterial Pneumonia;
   - Gastrointestinal Bleeding; and
   - Pericarditis.
2. **Onset of Dialysis Adjustment:** An adjustment will be made for patients that have Medicare ESRD coverage during their first 4 months of dialysis. This adjustment will be determined by the dialysis start date in Medicare's Common Working File as provided on the CMS Form 2728, completed by the provider. When the onset of dialysis adjustment is provided, the claim is not entitled to a comorbid adjustment or a training adjustment.
3. **Low-Volume Facility Adjustment:** Providers will receive an adjustment to their ESRD PPS rate when the facility furnished less than 4,000 treatments in each of the three cost report years preceding the payment year and has not opened, closed, or received a new provider number due to a change in ownership during the three (3) years preceding the payment year. The provider must notify their Medicare Contractor if they believe they are eligible for the low-volume adjustment.

Change in Processing Home Dialysis Claims

For claims with dates of service on or after January 1, 2011, the payment of home dialysis items and services furnished under Method II, regardless of home treatment modality, are included in the ESRD PPS payment rate.

Therefore, all home dialysis claims:

- Must be submitted by a renal dialysis facility and
- Will be processed as Method I claims.

Note: CR 7064 instructs the DME MACs to stop separate payment to suppliers for Method II home dialysis items and services for claims with dates of service on or after January 1, 2011. Medicare will, however, allow separate billing for ESRD supply HCPCS codes (as shown on attachment 4 of CR 7064) by DME suppliers when submitted for services not related to the beneficiary's ESRD dialysis treatment and such services are billed with the AY modifier.

Consolidated Billing

CR 7064 provides an ESRD consolidated billing requirement for limited Part B services included in the ESRD facility bundled payment. Certain laboratory services and limited drugs and supplies will be subject to Part B consolidated billing and will no longer be separately payable when provided for ESRD beneficiaries by providers other than the renal dialysis facility. Should these lab services, and limited drugs be provided to a beneficiary, but are not related to the treatment for ESRD, the claim lines must be submitted by the laboratory supplier or other provider with the new AY modifier to allow for separate payment outside of ESRD PPS. ESRD facilities billing for any labs or drugs will be considered part of the bundled PPS payment unless billed with the modifier AY. In addition, as noted above, Medicare will, however, allow separate billing for ESRD supply HCPCS codes (as shown on attachment 4 of CR 7064) by DME suppliers when submitted for services not related to the beneficiary's ESRD dialysis treatment and such services are billed with the AY modifier.

Other Billing Reminders

- Note that with the ESRD PPS changes, Medicare systems will also reject any lines reporting revenue code 0880 as of January 1, 2011. These rejections will be made with remittance advice remark code (RARC) M81 (You are required to code to the highest level of specificity), and assign a group code of CO (provider liability) to such lines.
- Medicare will return claims to the provider with dates of service spanning 2010 and 2011.
- Telehealth services billed with HCPCS Q3014, preventive services covered by Medicare, and blood and blood services are exempt from the ESRD PPS and will be paid based on existing payment methodologies.
- When claims are received without the AY modifier for items and services that are not separately payable due to the ESRD PPS consolidated billing process, the claims will be returned with claim adjustment reason code (CARC) 109 (Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.), RARC N538 (A facility is responsible for payment to outside providers who furnish these services/supplies/drugs to its patients/residents.), and assign Group code CO.
- All 72X claims from Method II facilities with condition code 74 will be treated as Method I claims as of January 1, 2011. Effective that same date, Medicare will no longer enter Method selection forms data into its systems.
- Services included in the existing composite rate continue to not be reported on the claim unless they are clinical lab services subject to the 50/50 rule. The only additional data that must be reported on or after January 1, 2011 are any oral and other equivalent forms of injectable drugs identified as outlier services. Oral and other equivalent forms of injectable drugs should be reported with the revenue code 0250. The drug NDC code must be reported with quantity field reflecting the smallest available unit.
- Payment for ESRD-related Aranesp and ESRD-related Epoetin Alfa (EPO) is included in the ESRD PPS for claims with dates of service on or after January 1, 2011.
- Effective January 1, 2011, section 153b of the MIPPA requires that all ESRD-related drugs and biologicals are included in the ESRD PPS and must be billed by the renal dialysis facility.

Additional Information

The official instruction, CR 7064, issued to your carriers, DME MACs, FIs and/or A/B MACs regarding this change may be viewed at http://www.cms.gov/Transmittals/downloads/R2134CP.pdf on the CMS website. Attached to CR 7064, you may find the following documents to be helpful:

- Attachment 3, which is a list of outlier services;
- Attachment 4, which is a list of DME ESRD Supply HCPCS codes used in for ESRD PPS consolidated billing edits;
- Attachment 5, which contains a list of DME ESRD Supply HCPCS codes that are NOT payable to DME suppliers;
- Attachment 6, which is a list of laboratory CPT/HCPCS codes subject to ESRD consolidated billing;
- Attachment 7, which lists the drug codes subject to ESRD consolidated billing; and
- Attachment 8, which lists by ICD-9-CM codes, the comorbid categories and diagnosis codes.

Also see MM7388 (http://www.cms.gov/MLNMattersArticles/downloads/MM7388.pdf) for the criteria for a low volume facility and instructions on how to receive the ESRD low volume adjustment for low volume facilities.

You may also want to review the following articles:

- MLN Matters® article MM7476 (http://www.cms.gov/MLNMattersArticles/downloads/MM7476.pdf), which alerts providers to changes to Attachments 4, 5 and 8 of CR7064; and
- MM7497 (http://www.cms.gov/MLNMattersArticles/downloads/MM7497.pdf), which informs independent laboratories (ILs) that effective January 1, 2012, CMS has eliminated the requirement for ILs to bill separately for each individual AMCC laboratory test included in organ disease panel codes for ESRD eligible beneficiaries. It states that organ disease panels will be paid under the Clinical Laboratory Fee Schedule and will not be subject to the 50/50 rule when billed by ILs.

FRAUD & ABUSE

The Obama Administration and Expanded Efforts to Fight Fraud

On Tuesday, December 13, 2011, the Obama Administration announced recovery of over $5.6 billion in fraudulent payments in fiscal year 2011, a 167 percent increase from 2008. President Obama's health care reform law includes new resources and tools to help fight fraud in Medicare and Medicaid, and to protect taxpayer dollars. In addition, CMS is taking steps to strengthen controls to identify and prevent prescription drug fraud and abuse in the Medicare Part D program.

CMS released a notice to Part D prescription drug plan sponsors that contains information and guidance to immediately take steps to stop prescription drug misuse and fraud. Pain killers like OxyContin are the fifth most filled classes of drugs in Medicare, with spending in 2009 totaling $3.9 billion. Recently, the Government Accountability Office identified evidence of fraud and drug abuse in Medicare for these types of drugs, which pose a threat to public health as well as the federal budget. Among the messages conveyed to the plans:

- Investigate and Stop Payment for Suspect Claims
- Use Tools to Help Manage Proper Utilization of Drugs
- Limit Prescriptions to 30-Day Doses

These efforts build on significant progress already made by the Obama Administration to fight fraud across the health care sector – progress that has been sped up by resources from the Affordable Care Act, the healthcare law of 2010. This progress has contributed to the 167 percent increase in fraud recoveries since 2008.

In addition, under a demonstration announced in November, Medicare will implement a prior authorization process for all power mobility device claims in 7 high risk states, guaranteeing that beneficiaries receive access to the services they need but preventing payment in cases where medical need is not established. This will make it more difficult to get fraudulent claims through Medicare's claims payment systems.

To read the full CMS fact sheet issued Tuesday, December 13, 2011 visit http://www.CMS.gov/apps/media/press/factsheet.asp?Counter=4217.

ICD-10

2012 ICD-10-CM Code Updates Now Available from CMS

The Centers for Medicare & Medicaid Services (CMS) has posted the 2012 ICD-10-CM code updates to the CMS website, including the 2012 ICD-10-CM index and tabular, code titles, addendum, General Equivalence Mappings (GEMs), and reimbursement mappings files. The 2012 ICD-10-CM 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. These files are available on the 2012 ICD-10-CM and GEMs webpage at http://www.cms.gov/ICD10/11b14_2012_ICD10CM_and_GEMs.asp. To access the files, scroll to the bottom of the page to the "Downloads" section.

The 2012 ICD-10-PCS (procedure) files were posted in June on the 2012 ICD-10-PCS and GEMs webpage at http://www.cms.gov/ICD10/11b15_2012_ICD10PCS.asp.

CMS Created Implementation Handbooks to Help Transition to ICD-10

All entities covered under the Health Insurance Portability and Accountability Act (HIPAA) must transition to the ICD-10 code sets by October 1, 2013. CMS has developed four Implementation Handbooks to assist you with your transition to ICD-10. These handbooks are step-by-step guides specifically for small and medium provider practices, large provider practices, small hospitals, and payers.

The appendix of each handbook references relevant templates which are available for download in both Excel and PDF files below. The templates are customizable and have been created to help entities clarify staff roles, set internal deadlines/responsibilities and assess vendor readiness.

ICD-10 CONT'D

View the step-by-step plans and relevant templates for each of the following audiences:

- Small/Medium Provider Practices
  - Relevant templates
- Large Provider Practices
  - Relevant templates
- Small Hospitals
  - Relevant templates
- Payers
  - Relevant templates

The ICD-10 Implementation Handbooks outline suggested steps and processes to take for a smooth transition to ICD-10. Providers, hospitals, and payers may use the guides to:

- Ensure the appropriate steps and actions are taken throughout the ICD-10 implementation process
- Stay on top of deadlines by viewing the timelines within the handbooks
- Customize your transition plan by filling out the Excel templates listed in the appendices; the templates will assist you with clarifying staff roles, setting internal deadlines and responsibilities, and assessing vendor readiness

Reminder - The Version 5010 compliance deadline is less than 60 days away!
All affected entities must first convert to Version 5010 by Sunday, January 1, 2012, in order for the ICD-10 medical code sets to work. In order to meet this compliance deadline, you need to conduct both Level I Internal Testing, and Level II External Testing of transactions. Once your practice is fully transitioned to Version 5010, take the necessary steps listed in the ICD-10 Implementation Handbooks to help you prepare for ICD-10.

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, and to download and share the implementation widget today!

Third Anniversary of ICD-10 Rule

Three years ago, on January 16, 2009, the U.S. Department of Health and Human Services published final rules mandating that all organizations covered by HIPAA upgrade to Version 5010 by **January 1, 2012,** and transition to ICD-10 coding sets by **October 1, 2013**. As a result of the enforcement discretion period for Version 5010, all organizations must complete their Version 5010 upgrade by no later than **March 31, 2012.** Upgrading to Version 5010 is an important step to take before transitioning to ICD-10, which is quickly approaching.

To help with this transition, CMS has developed a number of resources available on the CMS ICD-10 website. These resources include:

- **Fact sheets** , including: Ensuring a Smooth Transition to Version 5010, ICD-10 Transition: An Introduction, ICD-10 Basics for Medical Practices, ICD-10 FAQS, and Talking to Your Vendors about the Transition to ICD-10.
- **Implementation widget**, which outline the steps to take to ensure compliance with Version 5010 and ICD-10, available in a widget format. CMS encourages you to download or share the widget and take advantage of printer-friendly versions of the timelines available for small provider practices, large provider practices, payers, and vendors.
- **Timelines**: Printer-friendly checklists that complement the widget, which are available for small providers, large providers, payers, and vendors.

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, and to download and share the implementation widget today!

Video Slideshow Presentation and Podcasts of "ICD-10 Implementation Strategies and Planning"

CMS has released a YouTube video slideshow presentation and podcasts from the November 17, 2011, National Provider Call on "ICD-10 Implementation Strategies and Planning."

YouTube Video Slideshow Presentation
Did you miss the November 17th ICD-10 National Provider Call? The call presentation is now available on the CMS YouTube Channel as a video slideshow that includes the call audio with captions.

Podcasts
Limited on time? Podcasts are perfect for the office, in the car, or anywhere you carry a portable media player or smartphone. The following podcasts are now available from the November 17th ICD-10 call:

- Podcast 1 of 4: Introduction, General ICD-10 Requirements, and CMS Implementation Planning
- Podcast 2 of 4: General Implementation Planning and Strategies
- Podcast 3 of 4: NCVHS Meeting Update and Medicare FFS Claims Processing, Billing, and Reporting Guidelines
- Podcast 4 of 4: Question and Answer Session

The podcasts are now available on the CMS website at http://www.cms.gov/ICD10/Tel10/itemdetail.asp?itemID=CMS1253081.

The four podcasts with corresponding written transcripts, as well as the complete audio file and complete written transcript can be accessed by scrolling to the "Downloads" section at the bottom of the web page. To access the YouTube video slideshow presentation, select the link in the "Related Links Outside CMS" section of the web page.

Available 24/7, YouTube video presentations and podcasts make learning about the ICD-10 transition easy and convenient. Check them out today!

Video Slideshow Presentations from ICD-10 National Provider Calls Available on CMS YouTube Channel

Is your organization preparing for a smooth transition to ICD-10 on Tuesday, October 1, 2013? ICD-10 National Provider Calls, hosted by the CMS Provider Communications Group, can help you prepare for the US healthcare industry's change from ICD-9 to ICD-10 for diagnosis and inpatient procedure coding.

Video slideshow presentations from the following National Provider Calls are available on the CMS YouTube Channel. These video slideshows include the call slide presentation and audio with captions; each call includes presentations by CMS subject matter experts, followed by a question and answer session.

- ICD-10 Implementation Strategies and Planning – Thursday, November 17, 2011
  - The ICD-9-CM and ICD-10 Cooperating Parties – CMS, the American Hospital Association (AHA), the American Health Information Management Association (AHIMA), and the Centers for Disease Control and Prevention (CDC) – discuss ICD-10 implementation strategies and planning, and the CMS Provider Billing Group discuss the Medicare FFS claims processing guidance issued in August 2011.
- ICD-10 Implementation Strategies for Physicians – Wednesday, August 3, 2011
  - CMS subject matter experts discuss how physician offices can prepare for the change to ICD-10 for medical diagnosis and inpatient procedure coding and provide updates on national ICD-10 implementation issues affecting all providers.
- CMS ICD-10 Conversion Activities – Wednesday, May 18, 2011
  - CMS subject matter experts discuss the ICD-10 conversion process currently taking place within CMS, including a case study from the Coverage and Analysis Group on their transition to ICD-10 for the lab national coverage determinations (NCDs).

Podcasts, complete audio files, and complete written transcripts for these ICD-10 National Provider Calls are also available on the CMS ICD-10 webpage at http://www.CMS.gov/ICD10/Tel10/list.asp.

Available 24/7, YouTube video presentations and podcasts make learning about the ICD-10 transition easy and convenient. Check them out today.

MOBILITY DEVICES

CMS Announces Delay to Prepayment Review and Prior Authorization for Power Mobility Devices Demonstration and the Recovery Audit Prepayment Review Demonstration

On November 15, 2011, the Centers for Medicare & Medicaid Services (CMS) announced the Prepayment Review and Prior Authorization for Power Mobility Devices (PMD) demonstration and the Recovery Audit Prepayment Review demonstration. These demonstrations were scheduled to begin on January 1, 2012. However, the CMS received many comments/ suggestions regarding these demonstrations and the CMS is carefully considering these comments. Therefore, CMS will delay implementation of these demonstrations. CMS will provide at least 30 days notice before the demonstrations begin.

The Part A to Part B rebilling demonstration remains on schedule and will begin on January 1, 2012.

Please continue to check http://go.cms.gov/cert-demos for updated information.

CMS Announces New Demonstrations to Help Curb Improper Medicare, Medicaid Payments

Efforts will Build on 2011 Decreases in Medicare, Medicaid Improper Payments

In 2010, the President announced three goals for cutting improper payments by 2012: reducing overall payment errors by $50 billion, cutting the Medicare fee-for-service error rate in half, and recovering $2 billion in improper payments.

To help achieve these goals, the Centers for Medicare & Medicaid Services (CMS) has announced it will launch demonstration programs beginning in January 2012 targeting some of the most common factors that lead to improper payments.

Cost Saving Projects will Help Protect Medicare and Medicaid

Beginning on January 1, 2012, CMS will conduct demonstration projects that will strengthen Medicare by aiming at eliminating fraud, waste, and abuse. Reductions in improper payments will help ensure the sound future of the Medicare Trust Fund and protect Medicare beneficiaries who depend upon it such as:

- Recovery Audit Prepayment Review
- Prior Authorization for Certain Medical Equipment
- Part A to Part B Rebilling

This past May, HHS announced a pilot project under the Partnership Fund for Program Integrity Innovation to test an automated tool to screen providers for the risk of fraud. Currently, HHS and States lack standardized Medicaid provider data, which hampers detection of potential fraud. If successful, this tool will not only help prevent improper payments by weeding out fraudulent providers, but it will help States focus their resources where fraud is most likely to occur.

New Projects Build on 2011 Savings

The 2012 projects announced will build on accomplishments in 2011 to reduce Medicare and Medicaid improper payment rates.

CMS is also reporting for the first time a composite improper payment rate for the Medicare Part D prescription drug program. The improper payment rate for the Children's Health Insurance Program (CHIP) will not be published until 2012.

While improper payment rates are not necessarily an indicator of fraud in Medicare, Medicaid or CHIP, they do provide HHS, CMS and States with a more complete assessment of factors leading to error rates and new ways to help prevent them.

CMS is continuing to invest time and resources to work with providers across the country and eliminate errors through increased and improved training, education, and outreach.

To read the full CMS fact Sheet is issued click here: http://www.cms.gov/apps/media/press/factsheet.asp?Counter=4176

Additional Fact sheets issued Tuesday (11/15/11):

- CMS Prior Auth Fact Sheet- https://www.cms.gov/apps/media/press/factsheet.asp?Counter=4168
- CMS Rebilling Fact Sheet - http://www.cms.gov/apps/media/press/factsheet.asp?Counter=4169
- CMS Recovery Audit (RAC) Demo Fact Sheet- http://www.cms.gov/apps/media/press/factsheet.asp?Counter=4170
- CMS Medicaid Fact Sheet- http://www.cms.gov/apps/media/press/factsheet.asp?Counter=4171
- CMS Medicare D fact sheet http://www.cms.gov/apps/media/press/factsheet.asp?Counter=4172
- CMS Medicare C fact sheet and http://www.cms.gov/apps/media/press/factsheet.asp?Counter=4175
- CMS Medicare FFS Improper payments Fact Sheet- http://www.cms.gov/apps/media/press/factsheet.asp?Counter=4174

Also, please see the White House Press Release- We Can't Wait: Agencies Cut Nearly $18 Billion in Improper Payments, Announce New Steps for Stopping Government Waste- http://www.whitehouse.gov/the-press-office/2011/11/15/we-can-t-wait-agencies-cut-nearly-18-billion-improper-payments-announce-

Agency improper payment data is being updated Tuesday afternoon at www.paymentaccuracy.gov.

Correct Coding – Safety Equipment Packages with Power Operated Vehicles

Recently the Durable Medical Equipment Medicare Administrative Contractors (DME MACs) received questions regarding correct coding and billing of POVs (K0800–K0808, K0812), specifically the basic safety equipment that is considered included in the initial issue of a POV.

The Power Mobility Device local coverage determination (LCD) and related policy article (PA) detail the basic equipment package included with initial issue for a POV. The PA states:

POV Basic Equipment Package – Each POV is to include all these items on initial issue (i.e., no separate billing/ payment at the time of initial issue)

- Battery or batteries required for operation
- Battery charger, single mode
- Weight appropriate upholstery and seating system
- Tiller steering
- Non-expandable controller with proportional response to input
- Complete set of tires
- All accessories needed for safe operation

All accessories necessary for the safe operation of the POV are included in the reimbursement at the time of initial issue. This includes such items as safety belts, anti-tipper devices and braking mechanisms. There is no separate billing of these items even if the supplier incurs a separate charge for the items from the manufacturer. Claims for these items, when billed separately at initial issue, will be denied for unbundling.

For correct coding, all POVs (K0800–K0808, K0812) must have all components listed in the POV Basic Equipment Package.

Suppliers should refer to the DME MAC Supplier Manual, LCD and related PA for additional coverage, coding and documentation requirements.

Reimbursement for Wheelchair Center Mount Leg Rest

NAS explains the amount reimbursed for HCPCS code K0108 (Wheelchair Component or Accessory, Not Otherwise Specified) when submitted for a center mount leg rest.

NAS will reimburse a center mount leg rest, which is to be billed as a K0108, on the fixed price it has established based on the CMS instructed pricing methodology from directions in the Code of Federal Regulations Section 405.501 and 405.502.

The Code of Federal Regulations Section 405.501 states: "Medicare pays no more for Part B medical and other health services than the "reasonable charge" for such service. The reasonable charge is determined by the carriers." The Code of Federal Regulations Section 405.502 states that the criteria for determining what charges are "reasonable," and includes, but is not limited to, the customary charges for similar services generally made by the physician or other person furnishing such services and the prevailing charges in the locality for similar services.

Results of Widespread Prepayment Review of Manual Wheelchairs (K0001)

Jurisdiction D DME MAC Medical Review completed the widespread prepayment review of claims for Manual Wheelchairs with HCPC code K0001 (standard wheelchair) along with related accessories and seating. This review was initiated based on the results of Comprehensive Error Rate Testing (CERT) review analysis.

A total of 100 claims were developed for additional documentation. Responses to the Additional Documentation Request (ADR) were not received for 19 of the claims. Of the 81 claims for which responses were received, 73 were denied. The error rate, calculated by taking the total denied allowance amount (dollar amount of allowable charges for services determined to be billed in error) and dividing it by the total allowance amount of services medically reviewed, was 93%. Based on the results of this prepayment review, NAS will close this probe review and begin a widespread targeted review on HCPC code K0001 and related accessories and seating.

The following are the top reasons for denial:

1. Criteria B of LCD L11454 was not met.
2. Criteria A of LCD L11454 was not met.
3. Criteria C of LCD L11454 was not met.
4. Criteria D of LCD L11454 was not met.

Explanation and information regarding the denial reasons are as follows:

1. Per 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.
2. Per 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.
3. Per LCD L11454, a manual wheelchair is not covered if there is no documentation that supports the patient's home provides adequate access between rooms, maneuvering space, and surfaces for use of the manual wheelchair that is provided.
4. Per 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.

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.

Information about probe/error validation reviews may be found in CMS Publication 100-8, *Program Integrity Manual* (PIM), Chapter 3.

Results of Widespread Prepayment Review of Manual Wheelchairs (K0003)

NAS Jurisdiction D DME MAC Medical Review completed the widespread prepayment review of claims for Manual Wheelchairs with HCPC code K0003 (Lightweight wheelchair) along with related accessories and seating. This review was initiated based on the results of Comprehensive Error Rate Testing (CERT) review analysis.

A total of 99 claims were developed for additional documentation. Responses to the Additional Documentation Request (ADR) were not received for 18 of the claims. Of the 81 claims for which responses were received, 77 were denied. The error rate, calculated by taking the total denied allowance amount (dollar amount of allowable charges for services determined to be billed in error) and dividing it by the total allowance amount of services medically reviewed, was 97%. Based on the results of this prepayment review, NAS will close this probe review and begin a widespread targeted review on HCPC code K0003 and related accessories and seating.

The following are the top reasons for denial:

1. Criteria B of LCD L11454 was not met.
2. Criteria A of LCD L11454 was not met.
3. Criteria C of LCD L11454 was not met.
4. Criteria D of LCD L11454 was not met.

Explanation and information regarding the denial reasons are as follows:

1. Per 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.
2. Per 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.
3. Per LCD L11454, a manual wheelchair is not covered if there is no documentation that supports the patient's home provides adequate access between rooms, maneuvering space, and surfaces for use of the manual wheelchair that is provided.
4. Per 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.

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.

Information about probe/error validation reviews may be found in CMS Publication 100-8, *Program Integrity Manual* (PIM), Chapter 3.

Results of Widespread Prepayment Review of Manual Wheelchairs (K0004)

Jurisdiction D DME MAC Medical Review completed the widespread prepayment review of claims for Manual Wheelchairs with HCPC code K0004 (Lightweight wheelchair) along with related accessories and seating. This review was initiated based on the results of Comprehensive Error Rate Testing (CERT) review analysis.

A total of 96 claims were developed for additional documentation. Responses to the Additional Documentation Request (ADR) were not received for 16 of the claims. Of the 80 claims for which responses were received, 75 were denied. The error rate, calculated by taking the total denied allowance amount (dollar amount of allowable charges for services determined to be billed in error) and dividing it by the total allowance amount of services medically reviewed, was 95%. Based on the results of this prepayment review, NAS will close this probe review and begin a widespread targeted review on HCPC code K0004 and related accessories and seating.

The following are the top reasons for denial:

- Criteria B of LCD L11454 was not met.
- Criteria A of LCD L11454 was not met.
- Criteria C of LCD L11454 was not met.
- Criteria D of LCD L11454 was not met.

Explanation and information regarding the denial reasons are as follows:

1. Per 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.
2. Per 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:

   c. Prevents the patient from accomplishing an MRADL entirely, or

   d. Places the patient at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to perform an MRADL; or

   e. Prevents the patient from completing an MRADL within a reasonable time frame.
3. Per LCD L11454, a manual wheelchair is not covered if there is no documentation that supports the patient's home provides adequate access between rooms, maneuvering space, and surfaces for use of the manual wheelchair that is provided.
4. Per 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.

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.

Information about probe/error validation reviews may be found in CMS Publication 100-8, *Program Integrity Manual* (PIM), Chapter 3.

Wheelchairs Eligible for Advance Determination of Medicare Coverage (ADMC) – Group 4 Power Wheelchairs Removed

Advance Determination of Medicare Coverage (ADMC) is a process by which the DME MAC provides the supplier and beneficiary with a decision regarding the medical necessity for the item billed prior to submission of the claim and delivery of the product. Effective for ADMC request dates on or after January 1, 2012, the wheelchairs eligible for ADMC have changed.

Because of the February 2011 elimination of Least Costly Medically Appropriate Alternative, ADMC eligibility for Group 4 Power Wheelchairs (PWC) is eliminated. According to the local coverage determination (LCD) for Power Mobility Devices, Group 4 PWCs are considered not reasonable and necessary; therefore, no ADMC is possible for this category of PWC.

Group 4 PWCs are often provided as an upgrade to a covered Group 2 or 3 PWC. The ADMC request should be submitted based upon the covered PWC base.

The following wheelchairs are eligible for ADMC:

- Manual wheelchairs
  - E1161, K0005, and K0009
  - E1231–E1234
- Power wheelchairs
  - Group 2 (K0835–K0843)
  - Group 3 (K0856–K0864)
  - Group 3 (K0848–K0855) provided with an alternative drive control interface (E2321–E2322, E2325, E2327–E2330)
  - Group 5 (K0890, K0891)

The Power Mobility LCD will be updated in a future revision.

Refer to the Supplier Manual and the Power Mobility Devices LCD and related Policy Article for additional information about the ADMC process.

Widespread Prepayment Review for K0823 Power Wheelchair – Edit Effectiveness for 1st 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 first quarter edit effectiveness results from July 2011 through October 2011 are as follows:

The results of the review identified 432 total claims of which 389 were denied. This resulted in an overall error rate of 90%. Thirty-one (31) 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:

Insufficient medical records submitted to justify the medical necessity for the wheelchair and required documentation not submitted in full or was not complete

- Medical records did not include the basic policy coverage criteria A-C
- The face-to-face mobility examination conducted by the physician was missing or lacking in documentation to support the medical necessity for the power wheelchair base.

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 nonpowered accessories.

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.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.hhs.gov/manuals/downloads/pim83c03.pdf

Widespread Prepayment Review for K0823 Power Wheelchair – Edit Effectiveness for 2nd 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 second quarter edit effectiveness results from October 8, 2011 to January 7, 2012 are as follows:

The results of the review identified 1154 total claims of which 1023 were denied. This resulted in an overall error rate of 88%. One hundred four (104) 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:

Insufficient medical records submitted to justify the medical necessity for the wheelchair and required documentation not submitted in full or was not complete.

- Medical records did not include the basic policy coverage criteria A-C.
- The face-to-face mobility examination conducted by the physician was missing or lacking in documentation to support the medical necessity for the power wheelchair base.

As a reminder, the Local Coverage Determination (LCD) for Power Mobility Devices (L23598) states in part:

MOBILITY DEVICES CONT'D

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 nonpowered accessories.

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

Nebulizer Claims May Be Denied Without Modifier KO, KP, or KQ

Suppliers providing nebulizer inhalation drugs are reminded that whenever a unit dose form code is billed, it must have a KO, KP or KQ modifier. (Exception: The KO, KP and KQ modifiers should not be used with code J7620.) If a unit dose code does not have one of these modifiers, it will be denied as an invalid code. The KO, KP and KQ modifiers are not used with the concentrated form codes.

Modifiers defined:

KO - Single drug unit dose formulation

KP - First drug of a multiple drug unit dose formulation

KQ - Second or subsequent drug of a multiple drug unit dose formulation

Additional information within the LCD and related Policy Article should be reviewed and is accessible from the following websites:

LCD L11488: https://www.noridianmedicare.com/dme/coverage/docs/lcds/current_lcds/nebulizers.htm

Policy Article A2494: https://www.noridianmedicare.com/dme/coverage/docs/lcds/current_articles/nebulizers.htm

Without the required modifiers, suppliers will receive an unprocessable denial and would need to resubmit as a new claim. Appeal rights are not available for unprocessable claim denials. The remittance advice remark code that will display on the remittance advice is M51, as defined as follows:

M51: Missing/incomplete/invalid procedure code(s).

It is important suppliers share these modifier requirements and policy resources with their staff.

Widespread Prepayment Review for Nebulizer Drugs – Edit Effectiveness for 4th Quarter

The Jurisdiction D DME MAC Medical Review Department is conducting a widespread complex review of HCPCS codes J7626 and J7605 and the fourth quarter edit effectiveness results from June 2011 through September 2011 are as follows:

The results of the review of the claims identified 2,037 claims of which 1,381 were denied. This resulted in an overall error rate of 67%. This is an increase from 50% during the first quarter, 56% during the second quarter and remains the same has 3rd quarter of this review. Due to the error rate remaining high, NAS will continue with the widespread complex review for the above mentioned nebulizer drugs with future reporting on each HCPCS code individually.

The following are the top reasons for denial:

A. No valid written order
    1. No written order submitted with the documentation
    2. Insufficient or incomplete order
B. No beneficiary evidence of exhaustion
C. No medical documentation to support medical necessity
D. No Proof Of Delivery
    1. No proof of delivery submitted with the documentation
    2. Invalid proof of delivery
E. Requested documentation was not provided within the allotted time frame as referenced in the Medicare guidelines

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

A. For an item to be covered by Medicare, a written signed and dated order must be received by the supplier before a claim is submitted. If the supplier bills for an item addressed in this policy without first receiving the completed order, the item will be denied as not medically necessary.

    An order for each item billed 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.

    The order for any drug must clearly specify the type of solution to be dispensed to the patient and the administration instructions for that solution. The type of solution is described by a combination of: (a) the name of the drug and the concentration of the drug in the dispensed solution and the volume of solution in each container, or (b) the name of the drug and the number of milligrams/grams of drug in the dispensed solution and the volume of solution in that container.
B. The pharmacist is responsible for assessing how much inhalation solution a patient is actually using. Considering this information, the pharmacist is responsible for assuring that the patient has used almost all of his/her supply on hand prior to dispensing a new supply. As referenced in the Program Integrity Manual (Internet-Only Manual, CMS Pub. 100-8, Chapter 4.26.1) "Contact with the beneficiary or designee regarding refills should take place no sooner than approximately 7 days prior to the delivery/shipping date. For subsequent deliveries of refills, the supplier should deliver the DMEPOS product no sooner than approximately 5 days prior to the end of usage for the current product."
C. 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.

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.

E. 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.

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

Widespread Prepayment Review for Nebulizer Drugs – Edit Effectiveness for 1st 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 first quarter edit effectiveness results from September 2011 through December 2011 are as follows:

The results of the review, for item J7626, identified 737 claims of which 442 were denied. A total of 247 claims were denied for no response to the additional documentation request. This resulted in an overall error rate of 59%.

The results of the review, for item J7605, identified 277 claims of which 159 were denied. A total of 72 claims were denied for no response to the additional documentation request. This resulted in an overall error rate of 58%.

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.

NEBULIZERS CONT'D

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

PAP DEVICES

Bi-Level Positive Airway Pressure (Bi-PAP) Device with Back-up Rate Feature (E0471) – Recovery Auditor Identified Issue

The Recovery Auditor, previously known as the Recovery Audit Contractor (RAC), identified an issue in which Medicare was paying for HCPCS E0471 when the primary diagnosis was Obstructive Sleep Apnea (OSA), ICD-9-CM 327.23. According to the Positive Airway Pressure (PAP) Local Coverage Determination (LCD), a bi-level positive airway pressure device with back-up rate (E0471) is not reasonable and necessary if the primary diagnosis is OSA. Suppliers are notified if HCPCS E0471 is billed with the primary diagnosis of OSA, it will be denied by Medicare as not reasonable and necessary.

Coverage, coding and documentation requirements for the use of the E0470 and E0471 for diagnoses other than OSA are addressed in the Respiratory Assist Devices (RAD) LCD (L11493) and Policy Article (A23902). A RAD (E0470, E0471) is covered for those patients with clinical disorder groups characterized as (I) restrictive thoracic disorders (i.e., neuromuscular diseases or severe thoracic cage abnormalities), (II) severe chronic obstructive pulmonary disease (COPD), (III) central sleep apnea (CSA) or complex sleep apnea (Comp SA), or (IV) hypoventilation syndrome, and who meet the criteria defined within the RAD LCD, https://www.noridianmedicare.com/dme/coverage/docs/lcds/current_lcds/respiratory_assist_devices.htm.

Resources pertaining to this Recovery Auditor identified issue:

- LCD for PAP Devices (L171), https://www.noridianmedicare.com/dme/coverage/docs/lcds/current_lcds/positive_airway_pressure_pap_devices_for_the_treatment_of_obstructive_sleep_apnea.htm
- Policy Article for PAP Devices (A19827), https://www.noridianmedicare.com/dme/coverage/docs/lcds/current_articles/positive_airway_pressure_pap_devices_for_the_treatment_of_obstructive_sleep_apnea.htm
- RAC "New Issues Approved by CMS", Issue Number D001172011, http://racinfo.healthdatainsights.com/Public1/NewIssues.aspx.
- CMS Internet Only Manual, Publication 100-3, Medicare National Coverage Determinations Manual, Chapter 1, Section 240.4, https://www.cms.gov/manuals/downloads/ncd103c1_Part4.pdf

NAS has created a webpage with consolidated resources to assist suppliers with accessing the PAP resources, https://www.noridianmedicare.com/dme/news/pap_devices.html.

PAP Devices Ask the Contractor Teleconference Q&A – October 12, 2011

The information provided in this document is correct at the time of publishing. Prior to taking questions, NAS provided the following updates:

IVR and Endeavor Hours Extended
Effective July 5, 2011, suppliers are now able to make claim-related inquiries using the NAS interactive voice recognition (IVR) system at 1-877-320-0390, or the free Endeavor supplier portal between the hours of 6 a.m. until 8 p.m. The IVR and Endeavor will each continue to offer eligibility inquiries 24 hours a day, 7 days a week. Suppliers are encouraged to use the IVR and Endeavor for simple inquiries and rely on customer service representatives for more complex inquiries between the hours of 8:30 and 5:30 CT.

Email Updates
If suppliers are not already signed up for our email updates, we strongly encourage everyone to do so. NAS sends emails every Tuesday and Friday containing the latest news, updates, workshop announcements, and more. To sign up, go to our website and click on "Email Newsletter Signup" on the left side of any webpage.

Endeavor
Suppliers are also encouraged to register for Endeavor which offers free online access to patient eligibility, claim status, same or similar inquiries, and claim-specific remittance advices. Suppliers, billers, and third parties may register for Endeavor. Each person accessing Endeavor is required to register for their own user ID. To register, go to the Claims page of our website.

Version 5010 Transition
All covered entities under the HIPAA Insurance Portability and Accountability Act (HIPAA) must be ready to implement the version 5010 transaction standards on January 1, 2012. External testing with business partners in the new version 5010 format will ensure that suppliers are able to send and receive compliant transactions prior to the deadline. Suppliers should begin testing as soon as possible. Steps to take include identifying the partners suppliers are currently conducting transactions with, creating a schedule and timeline for external testing with each partner, and identifying priority partners to conduct testing with. Detailed information regarding version 5010 is made available by the Common Electronic Data Interchange (CEDI) on their website or by calling them at (866) 311-9184.

Questions Received Prior to ACT

Q: When are face-to-face examinations with the physician by the beneficiary required throughout the process of prescribing and proving compliance of a positive airway pressure (PAP) device?
A: There are three specific face-to-face requirements written into the policy:

1. The patient must have a face-to-face clinical evaluation by the treating physician prior to the sleep test to assess the patient's obstructive sleep apnea.
2. The treating physician must conduct a clinical reevaluation and document that the beneficiary is benefitting from the PAP therapy no sooner than the 31st day, but no later than the 91st day after initiating therapy
3. This does not apply to all, but for beneficiaries who received PAP devices prior to enrollment into fee-for-service Medicare, the beneficiary must have a face-to-face evaluation by their treating physician who documents in the beneficiary's medical records that:
   d. The beneficiary has a diagnosis of obstructive sleep apnea, and
   e. The beneficiary continues to use the PAP device.

Q: We recently received a patient order for an E0601 (Continuous airway pressure device (CPAP)) and this patient had previously received an E0470 (Respiratory assist device without backup) from another provider approximately three years ago while on Medicare. The patient recently went through another CPAP titration study and their apnea-hypopnea index (AHI) was reduced to less than five via CPAP, so the physician would like them to be set up with a new CPAP. Do we need to have the patient complete an Advance Beneficiary Notice of Noncoverage (ABN) for same or similar? Would this patient's CPAP be reimbursed providing they meet all the coverage requirements?
A: If Medicare has paid for the E0470 within the last five years, then the supplier can expect a same or similar denial and an ABN may be executed. The supplier may request an appeal with medical records that support why the E0470 is being replaced with the E0601.

Q: Are DME suppliers allowed to contact patients who had received CPAP or Bi-PAP machine greater than five years ago to see if they would like to have their machines replaced?
A: A DME supplier may continue to contact their existing patients and should provide clinically-appropriate and needed services including indicated and needed replacement after the reasonable useful lifetime of five years for DME items.

Q: If a patient has CPAP, HCPCS code E0601, failure after 90 days and is switched to a Bi-PAP machine, HCPCS code E0470, and all criteria are met, does a new capped rental period begin for the E0470?
A: Yes, a new capped rental period would begin.

Q: We have a patient whose face-to-face examination and sleep study were both performed two years ago. At that time, the patient met all criteria for a CPAP machine; however for one reason or another, the patient was never set up with a CPAP machine. Now the doctor is prescribing a CPAP machine and is trying to use the face-to-face examination and sleep study from two years ago to qualify the patient. Is that acceptable?
A: No, the face-to-face examination and sleep study should have occurred within a reasonable timeframe from the start of the PAP treatment. The two year delay in treatment has rendered the old visit and test too out of date to comply. A new visit is needed as is repeat testing. If the patient qualifies, and an item is actually provided, the compliance visit will also be required.

Questions Asked During ACT

Q: I have a patient who had a sleep study and qualified for a CPAP. At this point he does not want a new CPAP; but wants to use his daughter's CPAP. Is it okay to bill for supplies? What will happen if he wants his own CPAP at a later date? How should a supplier handle this situation?
A: Yes, beneficiaries can enter the Medicare program with a previously owned CPAP device; therefore, billing for supplies is fine. But, after Medicare enrollment, Medicare requires that the patients with previously owned equipment have a face-to-face examination which supports the beneficiary having obstructive sleep apnea and that the beneficiary continues to use the PAP machine. When the beneficiary currently owns a PAP and does not want to have a new CPAP, the suppliers need add a narrative to the claim advising Medicare that the item is owned. The narrative should include state beneficiary owned, the date the beneficiary acquired the equipment, the equipment name, and HCPCS code. The supplier needs to make sure all Medicare guidelines have been met. The same is true for beneficiaries who are currently on Medicare and have access to their own CPAP. However in order to continue to pay for supplies after the first three months, all compliance requirements must be met.

Q: Does a supplier have to follow PAP guidelines like on a regular CPAP or bi-level for HCPCS code E0471, an Adapt SV? It does not state anywhere that the compliance of 70 percent has to be met like with the other PAP devices.
A: Medicare does not cover the E0471 for obstructive sleep apnea. Refer to the Respiratory Assist Device LCD for continued coverage criteria of the E0471 beyond the first three months. The adherence to therapy guidelines are addressed and written differently in the RAD policy. While patients may be evaluated at earlier intervals, for continued coverage of an E0471, the patient must be reevaluated by his/her physician no sooner than 61 days after treatment began. This visit must document progress of the relevant symptoms and patient usage of the device. Failure to consistently use the device consistently in those previous 60 days of an average of 4 hours per 24 hour period would represent noncompliance and constitute a reason for Medicare to deny continued coverage.

Q: Do beneficiaries who received a PAP device prior to November 2008 need to have a face-to-face examination and trial period for compliance if they are getting a second device five years later?
A: For replacement items, there must be a face-to-face evaluation by the treating physician that documents the need and that the beneficiary continues to use that device, but there is no requirement for a repeat sleep study or a trial period.

Q: We have a patient who is new to Medicare and received an E0601 previously. The patient had a sleep study which met Medicare guidelines. He had a face-to-face but in those records the physician noted the patient had been non-compliant previously, but due to a recent open heart surgery, the doctor wanted him to reinitiate CPAP therapy and needs CPAP supplies. Would this patient need to be retested and start the requalification process over again?
A: Because the patient was not previously enrolled in Medicare then the "entering Medicare guidelines" would normally be followed (documenting that the beneficiary continues to use the device and they have a diagnosis of obstructive sleep apnea). But because the patient has never been compliantly using the device prior to Medicare enrollment, a face-to-face, new sleep study and adherence to therapy guidelines must be met and documented.

Follow-up Question: Would the patient need a new sleep study? The sleep study is six years old and it qualifies but does not meet today's guidelines, or would you recommend having the patient go through a 90-day compliance period and another face-to-face without initiating a new study?
Answer: Because the patient was never compliantly using the device, yes a new sleep study would be required and all the current requirements would need to be met.

Q: The LCD states that a new prescription is required when there is a change in items. So for example, if a patient wants to try a new or a different mask, do we have to get a new prescription for that?
A: It depends on how the order was written. If the order states, for example, CPAP mask, that would still fall under the same code and a new order is not required. If it is identified as a certain mask on your order, then a new order is required.

Follow-up Question: So if the patient goes from a full-face mask to a nasal cannula a new order is required?
Answer: Yes. If you are changing brands or something falls within the same category that does not require a new order; however, changing from a face mask to a nasal cannula would require a new order.

Q: I have a patient that had a study in January 2009, was with a different provider, did not meet the criteria including the face-to-face documentation that was necessary. We are coming on as a new provider. If we get that qualifying criteria, as far as the compliance and the face-to-face documentation, does the patient still have to repeat the study?
Answer: Yes, because the patient did not meet the adherence to therapy requirements within the first three months a new facility based sleep study and face-to-face evaluation is required to determine medical necessity.

Q: If we have a physician who works in an accredited sleep lab through the AASM, is he only allowed to read sleep studies from that lab or can he then read at any lab?
A: If the basis for his being able to read it is that he is on the staff of one that is accredited, but he himself does not meet the accreditation requirements, he cannot transfer that somewhere else.

Q: A patient was with a previous company five months and during their trial period it was determined they were not compliant. Is that sleep study not valid anymore?
A: If it was determined during their compliance period that they were not compliant there is no adherence to therapy proof. They would have to have a new facility-based sleep study and a face-to-face examination identifying why they were not compliant.

Q: If Medicare is secondary, do you still have to show that they are compliant?
A: Yes, even if Medicare is secondary, Medicare rules still apply.

Q: About a year ago we were at a conference in Riverside, California where we were told that the sleep studies were only good for 90 days. If the patient was not set up within those 90 days that a new sleep study was required. Is that still correct?
A: The time between when a patient is set up and when they took that sleep study needs to be reasonable. If it has been over three months then it may not be reasonable any longer because their condition may have changed. NAS considers three months a reasonable time frame.

Follow-up Question: The reason I ask is because somebody came up with a sleep study that was 91 days old. To me it is still reasonable to set them up, but we did not set them up according to the conference.
Answer: We as a primary contractor do not have the authority to make an exception. However, both the qualified independent contractor and the Administrative Law Judge (ALJ) do have the authority to provide substantial deference to our policy, but make a reasonable exception. I cannot guarantee that that will happen, but I can tell you that is a possibility and that is a business decision you will have to make from that point of view.

Q: We were approached by a company who had set up three Medicare patients but did not become accredited. The patients were in the middle of their rental process and it has been over a year since any claims were sent to Medicare. What happens with those patients when another supplier picks them up?
A: They would start where the last rental month ended if a new supplier picked them up. If you, a supplier, were providing it for the first three months and they went to another supplier, the second supplier would continue billing beginning with the fourth month. If adherence to therapy and re-evaluation requirements were not met then a new sleep study and face-to-face evaluation would be required.

Follow-up Question: From another supplier's standpoint, then that supplier would only be getting, in this particular case, there were eight months of claims that were processed through Medicare and then the facility did not become accredited so the second provider then is only going to receive another five months' worth of rental claims.
Answer: That is correct and since the beneficiary continued to use it; it is considered a break in billing.

Follow-up Question: This same company that was not accredited had another patient that went south in the second month of rent and did not follow through with the face-to-face before the 91st day. Will this patient that have to start over?
Answer: Yes, they are not going to meet the compliance requirements and they are going to have to have that new face-to-face and facility-based sleep study. However, a new 13 month rental period would not begin.

Q: If a patient has a PAP machine with another company and comes to us just for supplies, are we required to get the original sleep test or can we just go off of what they have been getting and bill from that?
A: Regardless if a supplier is providing the CPAP or accessories/supplies, coverage criteria must be met and supporting documentation must be available upon request from the supplier billing for a CPAP or accessories/supplies. The supplier of accessories and supplies may need to reach out to the supplier of the CPAP for testing results and supporting documentation. However suppliers are not required to maintain documentation past 7 years. If a claim is denied for documentation that is older than 7 years the supplier should appeal.

Q: If a patient is not compliant with their downloader or their face-to-face visit after the initial three months of therapy, are we not to bill for any supplies if Medicare is no longer paying for that machine?
A: There is a requirement for the patient to go through and get another facility-based sleep study, a face-to-face examination, and start their compliance over again. If they do not do that then you could not use the KX modifier which indicates that the coverage criteria are met. Without that KX modifier you will get a contractual obligation denial. If the patient insisted on receiving the supplies even though criteria were not met, you could execute an ABN to shift liability to the patient.

Q: If we take on new patients and we have a new prescription, how old can the sleep study be? I know you were talking about the seven years, was that talking about a sleep study can only be seven years old?
A: If available, meets current guidelines, and patient continues to use PAP a sleep study older than seven years may be used to qualify a patient. However if compliance guidelines are not met or patient was never set up with a PAP, a new facility based sleep study is required.

Follow-up Question: Then it can be their original sleep study as long as we have a new prescription and any supporting documents from the doctor?
Answer: Yes, as long as all other criteria is met.

Q: We have a provider in our town that sent a letter to its patients saying that it was closing its doors and if the patients wanted to return their equipment, they could. If not, it was theirs to keep. We have patients that are calling us thinking that they own their equipment when in fact, when you check same or similar, it is in a rental period. We tried to explain this to the patient, but when it comes time for repairs, I know it's going to be patient cost because it is never actually going be their equipment and we cannot get medical records from this provider. What is the best way to communicate this with the patient?
A: For the legal question of whether or not that constitutes transfer of title, you are going to have to resolve on your own with your attorneys and advisors. When you do bill, or if you bill later on for a repair, make sure you include a narrative that indicates the beneficiary now owns the equipment or a comment that says that the ownership has been transferred over to them.

Q: I have a patient who was within the five years of the reasonable useful lifetime (RUL) of the equipment, and they have already owned the equipment. It has already been a 13 month convert to purchase but the previous supplier went out of business. Now that CPAP is broken. Are we allowed to replace this equipment and if so, what documentation does Medicare want in order to state that the previous supplier went out of business and the CPAP is broken?
A: Inside the five year RUL, Medicare will not replace it other than irreparable damage due to a specific incident or if was lost or stolen. But if it is no longer working, Medicare will pay for the repair up to the purchase price.

PAP DEVICES CONT'D

Follow-up Question: So we cannot provide the patient with a new piece of equipment?
Answer: No, not inside the RUL.

Q: What would the billing code be for that repair?
A: Suppliers may bill for parts and labor when repairing beneficiary owned equipment. Some of the articles we have published to our website regarding repair include:

- Repair and Replacement Reminders
- Repair Labor Billing and Payment Policy
- Repair and Replacement – Frequently Asked Questions

Q: If a patient who has never been set up on a PAP machine before has a Medicare-approved sleep study from 2008 and even though it meets guidelines from then, he/she would need a new sleep study that is within 90 days?
A: Yes, if the patient has never been set up with a PAP the test should occur within a reasonable time frame. Over 90 days old is not reasonable.

PECOS

PECOS Warning Message Returned on Remittance Advices

Effective January 1, 2012, the DME MACs will begin to return the warning messages if the ordering or referring provider on the claim is not eligible to order or refer DME supplies as determined from PECOS. These messages will be returned on the Electronic Remittance Advice (ERA) or Standard Paper Remit (SPR) with the following Remittance Advice Remark Code (RARC) and will apply to both 4010A1 and 5010A1 formatted claims:

> 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.

Through January 29, 2012, CEDI will continue to return the PECOS warning edits for 4010A1 claims on the GenResponse Report.

CMS and the DME MACs will communicate when the edits will become denials when that date is determined.

If you have any questions regarding the CEDI PECOS warning edits, please send an e-mail to ngs.cedihelpdesk@wellpoint.com or call 866-311-9184.

Important Reminder for Providers and Suppliers Who Provide Services and Items Ordered or Referred by Other Providers and Suppliers

MLN Matters® Number: SE1201

Provider Types Affected
This MLN Matters® Special Edition Article is intended for providers and suppliers (including 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.

Provider Action Needed
Medicare will only pay for items or services for Medicare beneficiaries that have been ordered by a physician or eligible professional who is enrolled in Medicare and their individual National Provider Identifier (NPI) has been provided on the claim. The ordering provider or supplier (physician or eligible professional) must also be enrolled with a specialty type that is eligible (per Medicare statute and regulation) to order and refer those particular items or services.

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.

PECOS CONT'D

Background
CMS emphasizes that generally Medicare will only reimburse for specific items or services when those items or services are ordered or referred by providers or suppliers authorized by Medicare statute and regulation to do so. Claims that a billing provider or supplier submits in which the ordering/referring provider or supplier is not authorized by statute and regulation will be denied as a non-covered service. The denial will be based on the fact that neither statute nor regulation allows coverage of certain services when ordered or referred by the identified supplier or provider specialty.

CMS would like to highlight the following limitations:

- Chiropractors are not eligible to order or refer supplies or services for Medicare beneficiaries. All services ordered or referred by a chiropractor will be denied.
- Home Health Agency (HHA) services may only be ordered or referred by a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.) or Doctor of Podiatric Medicine (DPM). Claims for HHA services ordered by any other practitioner specialty will be denied.
- Portable X-Ray services may only be ordered by a Doctor of Medicine or Doctor of Osteopathy. Portable X-Ray services ordered by any other practitioners will be denied.

MLN Matters® Special Edition Article SE1011 provides further details about edits on the ordering/referring provider information on claims. The article is available at http://www.cms.gov/MLNMattersArticles/downloads/SE1011.pdf on the CMS website.

Additional Information
For more information about the Medicare enrollment process, visit http://www.cms.gov/MedicareProviderSupEnroll 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/MedicareProviderSupEnroll/Downloads/Contact_list.pdf on the CMS website.

The Medicare Learning Network® (MLN) fact sheet titled, "Medicare Enrollment Guidelines for Ordering/Referring Provider," is available at
http://www.cms.gov/MLNProducts/downloads/MedEnroll_OrderReferProv_factSheet_ICN906223.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 https://www.cms.gov/MLNMattersArticles/downloads/MM7097.pdf on the CMS website.

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/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/MLNMattersArticles/downloads/MM6421.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/MLNMattersArticles/downloads/MM6129.pdf on the CMS website.

PROSTHETICS & ORTHOTICS

Ankle-Foot Orthoses – Arizona-Type – Correct Coding – Revised

Arizona AFO is a company that manufactures a line of custom fabricated ankle-foot orthoses. Other companies manufacture similar products. The Pricing, Data Analysis, and Coding (PDAC) contractor has recently reviewed the Arizona AFO line of products and determined the appropriate HCPCS codes to be used when billing for these and similar items.

For the Arizona Short and Arizona Tall, or similar custom fabricated braces, only the following codes should be used:

L1940	Ankle foot orthosis, plastic or other material, custom fabricated
L2330	Addition to lower extremity, lacer molded to patient model, for custom fabricated orthosis only
L2820	Addition to lower extremity orthosis, soft interface for molded plastic below knee section

L2330 is used whether the closure is a lacer closure or a Velcro closure. L2820 is used only if a soft interface, either leather or other material, is provided.

This section has been revised from the original article, titled Ankle-Foot Orthoses – Arizona Type – Correct Coding, posted on December 4, 2008. DMECS has been updated to reflect any applicable changes.

For the Arizona Extended and the Arizona Unweighting or similar custom fabricated braces, only the following codes should be used:

L1960	Ankle foot orthosis, posterior solid ankle, plastic, custom-fabricated
L2330	Addition to lower extremity, lacer molded to patient model, for custom fabricated orthosis only
L2820	Addition to lower extremity orthosis, soft interface for molded plastic below knee section

The following codes must not be used for these orthoses:

L2275	Addition to lower extremity, varus/valgus correction, plastic modification, padded/lined
L2280	Addition to lower extremity, molded inner boot

For the Arizona Extended and the Arizona Unweighting or similar custom fabricated braces, only the following codes should be used:

For the Arizona Partial Foot model or similar orthosis, use codes:

L1940	Ankle foot orthosis, plastic or other material, custom-fabricated
L2330	Addition to lower extremity, lacer molded to patient model, for custom fabricated orthosis only
L2820	Addition to lower extremity orthosis, soft interface for molded plastic, below knee section
L5000	Partial foot, shoe insert with longitudinal arch, toe filler.

Suppliers, manufacturers and distributors are reminded to check the product listing on Product Classification List located on Durable Medical Equipment Coding System (DMECS), if there are any changes they are to notify the PDAC.

Suppliers who have incorrectly coded these orthoses should submit a voluntary refund to the DME MAC.

For questions about correct coding, contact the PDAC Contact Center at (877) 735-1326 during the hours of 8:30 a.m. to 4 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.

Coding Guidelines for Ankle Foot Orthoses

Recently the Durable Medical Equipment Medicare Administrative Contractors (DME MACs) and the Pricing, Data Analysis and Coding (PDAC) contractor received questions regarding coding guidelines for Ankle Foot Orthoses. In an effort to address these questions, the following definitions for certain orthoses will clarify their meaning and assist suppliers in correct coding of these devices.

L2340 ADDITION TO LOWER EXTREMITY, PRE-TIBIAL SHELL, MOLDED TO PATIENT MODEL

A pre-tibial shell, custom fabricated, provides a rigid overlapping interlocking anterior tibial control between the tibial tuberosity to a point no greater than 3 inches proximal to the medial malleolus. The pre-tibial shell can be constructed from thermosetting materials, thermoplastics, or composite type materials.

L1906 ANKLE FOOT ORTHOSIS, MULTILIGAMENTOUS ANKLE SUPPORT, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT

A multiligamentous ankle support provides control of the ankle joint between the medial and lateral malleoli while allowing for dorsiflexion and plantar flexion. This off-the-shelf ankle support includes a rigid stirrup and foot plate

which provides functional tracking of the ankle with hind-foot and mid-foot stability during ambulation. This, in conjunction with wrap-around straps and the inherent gauntlet design, offers areas of multiligamentous support as described by the code. There are no additional HCPCS codes for this type of prefabricated ankle orthosis.

L1960 ANKLE FOOT ORTHOSIS, POSTERIOR SOLID ANKLE, PLASTIC, CUSTOM-FABRICATED

An Ankle Foot Orthosis (AFO) provides ankle control for patients with musculoskeletal or neuromuscular dysfunction. The AFO is designed to provide rigid immobilization of the ankle-foot complex in the sagittal, coronal, and transverse planes. The custom fabricated solid ankle AFO can be constructed from thermosetting materials, thermoplastics, or composite type materials. The proximal boarder of an Ankle Foot Orthosis (L1960) shall extend to a height no greater than 1.5 inches distal to the apex of the head of the fibula.

Effective for claims with dates of service on or after April 1, 2012, the only products which may be billed to Medicare using code L1906 (ANKLE FOOT ORTHOSIS, MULTILIGAMENTUS ANKLE SUPPORT, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT) are those for which a written coding verification has been made by the PDAC contractor and that are listed in the Product Classification Matrix of the DME Coding System (DMECS) maintained on the PDAC website, https://www.dmepdac.com/dmecsapp/do/search. Products which have not received coding verification review from the PDAC must be billed with code A9270.

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/.

This information will be added to a future revision of the AFO LCD and related policy article.

Correct Coding – Articulating Digit(s) and Prosthetic Hands

Two new codes were released by the Centers for Medicare & Medicaid Services as part of the HCPCS 2012 Annual Release. These codes are effective for dates of service on or after January 1, 2012. The new codes are:

- L6715 TERMINAL DEVICE, MULTIPLE ARTICULATING DIGIT, INCLUDES MOTOR(S), INITIAL ISSUE OR REPLACEMENT
- L6880 ELECTRIC HAND, SWITCH OR MYOELECTRIC CONTROLLED, INDEPENDENTLY ARTICULATING DIGITS, ANY GRASP PATTERN OR COMBINATION OF GRASP PATTERNS, INCLUDES MOTOR(S).

HCPCS code L6715 describes multiple articulating digit(s) (fingers and/or thumb) which are used on initial issue when paired with a partial hand base procedure code (L6000, L6010, L6020). The articulating digit(s) can also be used as a "replacement digit(s)" with the use of the RB modifier as part of a prosthetic repair. The following base procedure codes include a custom fabricated socket.

- L6000 PARTIAL HAND, THUMB REMAINING
- L6010 PARTIAL HAND, LITTLE AND/OR RING FINGER REMAINING
- L6020 PARTIAL HAND, NO FINGER REMAINING

HCPCS Code L6025 (TRANSCARPAL/METACARPAL OR PARTIAL HAND DISARTICULATION PROSTHESIS, EXTERNAL POWER, SELF-SUSPENDED, INNER SOCKET WITH REMOVABLE FOREARM SECTION, ELECTRODES AND CABLES, TWO BATTERIES, CHARGER, MYOELECTRIC CONTROL OF TERMINAL DEVICE) describes a complete prosthesis. This base procedure code includes all necessary components. This base procedure code includes a custom fabricated socket. The use of L6715 on initial issue will be denied as unbundling.

HCPCS code L6880 describes a complete hand prosthesis, which consists of the terminal device, all articulating digits and motors. This base procedure code does not include a custom fabricated socket. This base procedure code includes all necessary components. The use of L6715 on initial issue will be denied as unbundling.

HCPCS code L7499 (UPPER EXTREMITY PROSTHESIS, NOT OTHERWISE SPECIFIED) must not be used for the billing of any additional features or components, programming, adjustment, etc. with L6025 or L6880 as these codes are considered all-inclusive. The use of L7499 on initial issue will be denied as unbundling.

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/

PROSTHETICS & ORTHOTICS CONT'D

Correct Coding and Billing for Microprocessor-Controlled Knee Systems

Recent claim reviews note that suppliers are billing miscellaneous code L5999 (lower extremity prosthesis, not otherwise classified) for various elements of microprocessor-controlled knee systems such as the Otto Bock C-Leg®, C-Leg Compact™, or Genium™. This use of miscellaneous codes is not correct. For example, functions performed by the on-board microprocessors and/or sensors (e.g., "real-time gait assessment," "electronically controlled static stance regulator, adjustable"), or programming necessary for use, must not be billed using L5999. Use of additional codes is limited to those specified below. There is no separate billing and reimbursement for any other features or functions since the allowance for all functions and features is included in the payment for codes listed below.

Base code L5856
The following are the only HCPCS codes billable for C-Leg®, Genium™ or any similar microprocessor controlled knee systems:

- L5828 – addition, endoskeletal knee-shin system, single axis, fluid swing and stance phase control
- L5845 – addition, endoskeletal knee-shin system, stance flexion feature, adjustable
- L5848 – addition to endoskeletal knee-shin system, fluid stance extension, dampening feature, with or without adjustability
- L5856 – addition to lower extremity prosthesis, endoskeletal knee-shin system, microprocessor control feature, swing and stance phase, includes electronic sensor(s), any type

Base code L5858
The following are the only HCPCS codes billable for C-Leg Compact™ or any similar microprocessor controlled knee systems:

- L5828 – addition, endoskeletal knee-shin system, single axis, fluid swing and stance phase control
- L5845 – addition, endoskeletal knee-shin system, stance flexion feature, adjustable
- L5858 – addition to lower extremity prosthesis, endoskeletal knee shin system, microprocessor control feature, stance phase only, includes electronic sensor(s), any type

For any of the above microprocessor controlled knee systems:

- HCPCS code L5930 (addition, endoskeletal system, high activity knee control frame) may only be used with K4 functional level patients.
- Do not bill separately at initial issue miscellaneous code L5999 for the pylon with sensor for use with microprocessor controlled knee systems. It is considered included in the payment for L5856 and L5858.

Additional information about coverage, coding and correct billing may be found in the supplier manual, local coverage determinations and on the Pricing, Data Analysis and Coding Contractor (PDAC) website at www.dmepdac.com.

RECOVERY AUDITOR

Recovery Audit Program: MAC-issued Demand Letters

MLN Matters® Number: MM7436 Revised
Related Change Request (CR) #: 7436
Related CR Release Date: January 6, 2012
Related CR Transmittal #: R202FM
Effective Date: January 1, 2012
Implementation Date: January 3, 2012

Note: This article was revised on January 9, 2012, to reflect the revised CR7436 issued on January 6, 2012. In the article, the CR release date, transmittal number, and the Web address for accessing CR7436 were revised. All other information is the same.

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

RECOVERY AUDITOR CONT'D

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

Recovery Auditors will, however, submit claim adjustments to your Medicare contractor, who will perform the adjustments based on the Recovery Auditor's review, and issue an automated demand letter to you.

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

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

Additional Information
To see the official instruction (CR7436) issued to your Medicare contractor, see http://www.cms.gov/Transmittals/downloads/R202FM.pdf on the CMS website.

Recovery Auditor Timeliness Calculator Available for Various Actions Suppliers May Pursue

The NAS website contains a Recovery Auditor webpage, https://www.noridianmedicare.com/dme/claims/recoupment/rac.html, which offers a Recovery Auditor Timeliness Calculator. This tool allows a supplier to enter the date of the Recovery Auditor Demand Letter. The supplier then receives results that provide the timeline for a rebuttal to the Recovery Auditor, date interest will begin accruing, the date an offset will occur, and the deadline to submit a redetermination request to NAS based on the Recovery Auditor's findings. Suppliers are encouraged to access this Recovery Auditor Timeliness Calculator and related resources available on the Recovery Auditor portion of our website.

REFUNDS/OVERPAYMNETS

Changes to Medicare Overpayment Notification Process

CMS has made changes to the Medicare Overpayment Notification Process. If an outstanding balance has not been resolved, providers previously received three notification letters regarding Medicare Overpayments, an Initial Demand Letter (1st Letter), a Follow-up-Letter (2nd Letter), and an Intent to Refer Letter (3rd Letter). CMS would send the second demand letter to providers 30 days after the initial notification of an overpayment. Recent review has determined that this is not efficient since the majority of providers respond to the initial demand letter and pay the debt.

Currently recoupment action happens 41 days after the initial letter. The remittance advice which describes this action serves as another notice to providers of the overpayment. Therefore, effective Tuesday, November 1, 2011, the second demand letters are no longer being sent to providers. Provider appeal rights will remain unchanged.

If an overpayment is not paid within 90 days of the initial letter, providers will continue to receive a letter explaining CMS' intention to refer the debt for collection.

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.

REFUNDS/OVERPAYMNETS CONT'D

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

REIMBURSEMENT

2012 Fee Schedule Update for DMEPOS

MLN Matters® Number: MM7635
Related Change Request (CR) #: CR 7635
Related CR Release Date: November 4, 2011
Related CR Transmittal #: R2340CP
Effective Date: January 1, 2012
Implementation Date: January 3, 2012

Provider Types Affected
Providers and suppliers submitting claims to Medicare contractors (carriers, DME Medicare Administrative Contractors (DME MACs), Fiscal Intermediaries (FIs), Medicare Administrative Contractors (MACs), and/or Regional Home Health Intermediaries (RHHIs)) for DMEPOS items or services paid under the DMEPOS fee schedule need to be aware of this article.

Provider Action Needed
Updates and information in CR 7635 can impact reimbursement for your claims for DMEPOS items or services.

This article, based on Change Request (CR) 7635, advises you of the Calendar Year (CY) 2012 annual update for the Medicare DMEPOS fee schedule. The instructions include information on the data files, update factors, and other information related to the update of the DMEPOS fee schedule.

Key points about these changes are summarized in the Background section below. These changes are effective for DMEPOS provided on or after January 1, 2012.

Background and Key Points of CR 7635
Payment on a fee schedule basis is required for durable medical equipment, prosthetic devices, orthotics, prosthetics, and surgical dressings (DMEPOS) by Sections 1834(a), (h), and (i) of the Social Security Act (the Act); and for parenteral and enteral nutrition (PEN) by 42 CFR, Section 414.102.

In accordance with these statutes and regulations, the DMEPOS fee schedules are updated annually; and the process for this update is documented in the "Medicare Claims Processing Manual", Chapter 23 Fee Schedule Administration and Coding Requirements) , Section 60 (Durable Medical Equipment Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule at http://www.cms.gov/manuals/downloads/clm104c23.pdf on the Centers for Medicare & Medicaid Services (CMS) website.

CR 7635, from which this article is taken, provides instructions regarding annual the DMEPOS fee schedule annual update for 2012.

Fee Schedule Files
The DMEPOS fee schedule file will be available on or after November 16, 2011, for State Medicaid Agencies, managed care organizations, and other interested parties at http://www.cms.hhs.gov/DMEPOSFeeSched/ on the CMS website.

HCPCS Codes Added

The following new codes are effective as of January 1, 2012:

- A9272 which has no assigned payment category;
- A5056 and A5057 in the ostomy, tracheostomy, and urological supplies (OS) payment category;
- E0988 in the capped rental (CR) category;
- L5312, L6715, and L6880 in the prosthetics and orthotics category; and
- E2358, E2359, E2626, E2627, E2628, E2629, E2630, E2631, E2632, and E2633 in the inexpensive/routinely purchased (DME) payment category.

The fee schedule amounts for the above new codes will be established as part of the July 2012 DMEPOS Fee Schedule Update, when applicable. Also when applicable, DME MACs will establish local fee schedule amounts to pay claims for the new codes from January 1, 2012 through June 30, 2012. The new codes are not to be used for billing purposes until they are effective on January 1, 2012.

Please note that the HCPCS codes listed as new codes in this CR may not be final and are subject to change pending release of the CY 2012 HCPCS file.

For gap-filling purposes, the 2011 deflation factors by payment category are listed in the following table:

Factor	Category
0.485	Oxygen
0.488	Capped Rental
0.490	Prosthetics and Orthotics
0.621	Surgical Dressings
0.676	Parenteral and Enteral Nutrition

HCPCS Codes Deleted

The following codes are being deleted from the HCPCS effective January 1, 2012, and are therefore being removed from the DMEPOS fee schedule files:

- E0571
- L1500, L1510, L1520, L3964, L3965, L3966, L3968, L3969, L3970, L3972, L3974, L4380, L5311, L7266, L7272, L7274, and L7500.

Specific Coding and Pricing Issues

CMS has learned that the current language in the "Medicare Claims Processing Manual", Chapter 23 (Fee Schedule Administration and Coding Requirements), Section 60.3(Gap-filling DMEPOS Fees), that describes the longstanding methodology for calculating gap-filled fee schedule amounts, can be misinterpreted.

For this reason, CR 7635 revises the first paragraph of this section by replacing the phrase "previous data base period" with "fee schedule data base year," and later in the same sentence replacing the phrase "database year" with "fee schedule database year." These revisions closely approximate the original gap-fill instructions as they appeared in the "Medicare Carriers Manual", Part 3 (Claims Process), Section 5102 (Fee Schedules For Durable Medical Equipment and Orthotic/Prosthetic Devices). In addition, CR 7635 revises this section to include the addition of the 2011 deflation factors, as noted above.

CR 7635 also announces other coding and pricing changes, effective January 1, 2012:

- New HCPCS codes: E2626, E2627, E26268, E 2629, E2630, E2631, E2632, and E2633 (for wheelchair accessories for shoulder elbow arm supports) are re-designated from codes L3964-L3974 and the fee schedule amounts will be directly assigned from the deleted codes to the new codes.
- The fee schedule amounts for shoe modification HCPCS codes A5503 through A5507 are being adjusted to reflect more current allowed service data. Section 1833(o)(2)(C) of the Act required that the payment amounts for shoe modification codes A5503 through A5507 be established in a manner that prevented a net increase in expenditures when substituting these items for therapeutic shoe insert codes (A5512 or A5513). To establish the original fee schedule amounts for the shoe modification codes, the base fees for codes A5512 and A5513 were weighted based

on the approximated total allowed services for each code for items furnished during the second quarter of calendar year 2004. For 2012, the base fees for A5512 and A5513 will be weighted based on the approximated total allowed services for each code for items furnished during the calendar year 2010 and the fee schedule amounts for shoe modification codes A5503 through A5507 are being revised to reflect this change.

KE Modifier Update
To ensure appropriate modifier processing when submitting claims for HCPCS code E0776 (IV Pole), suppliers should bill using the following modifiers depending upon the type of pump that the IV pole is used with:

- For use with infusion pumps – submit E0776RR, E0776NU, or E0776UE;
- For use with parenteral pumps – submit E0776RRBAKE, E0776NUBAKE, or E0776UEBAKE;
- For use with enteral pumps – submit E0776RRBA, E0776NUBA or E0776UEBA; or
- For use with enteral pumps by beneficiaries that permanently reside in Round I Rebid competitively bid areas - submit E0776RRBAKG, E0776NUBAKG or E0776UEBAKG.

Similarly, when submitting claims for a replacement HCPCS code E2373 (POWER WHEELCHAIR ACCESSORY, HAND OR CHIN CONTROL INTERFACE, COMPACT REMOTE JOYSTICK) suppliers should bill using the following modifiers depending upon the associated base wheelchair:

- For use with a power wheelchair HCPCS code that was bid in Round I of the DMEPOS Competitive Bidding Program – submit E2373KCRR, E2373KCNU or E2373KCUE;
- For use with a power wheelchair HCPCS code that was not bid in Round I of the DMEPOS Competitive Bidding Program – submit E2373KCRRKE, E2373KCNUKE or E2373KCUEKE; or
- For beneficiaries that permanently reside in Round I Rebid competitively bid areas when used with a power wheelchair HCPCS code that was bid in the Round I Rebid of the DMEPOS Competitive Bidding Program – submit E2373KCRRKK, E2373KCNUKK or E2373KCUEKK.

Note: The above billing instructions supersede the E0776 and E2373 KC billing instructions furnished in Transmittal 1630, CR6270, dated November 7, 2008.

Attachment B to CR 7635 contains a list of the HCPCS codes that were selected in 2008 for Round I of the DMEPOS Competitive Bidding Program. For beneficiaries who permanently reside in Round I Rebid competitive bid areas, a list of the Round 1 Rebid competitively bid items is available in the single payment amount charts located at http://www.dmecompetitivebid.com/palmetto/cbic.nsf/DocsCat/Single%20Payment%20Amounts on the Competitive Bidding Implementation Contractor (CBIC) website.

CY 2012 Fee Schedule Update Factor
For CY 2012, the update factor of 2.4 percent is applied to the applicable CY 2011 DMEPOS fee schedule amounts.

In accordance with section 1834(a)(14) of the Act, the DMEPOS fee schedule amounts are to be updated for 2012 by the percentage increase in the consumer price index for all urban consumers (United States city average) or CPI-U for the 12-month period ending with June of 2011, adjusted by the change in the economy-wide productivity equal to the 10-year moving average of changes in annual economy-wide private non-farm business multi-factor productivity (MFP).

The MFP adjustment is 1.2 percent and the CPI-U percentage increase is 3.6 percent. Thus, the 3.6 percentage increase in the CPI-U is reduced by the 1.2 percentage increase in the MFP resulting in a net increase of 2.4 percent for the MFP-adjusted update factor.

2011 Update to Labor Payment Rates
2012 Fees for Healthcare Common Procedure Coding System (HCPCS) labor payment codes K0739, L4205, L7520 are increased by 3.6 percent effective for dates of service on or after January 1, 2012 through December 31, 2012, and those rates are as follows:

STATE	K0739	L4205	L7520		STATE	K0739	L4205	L7520
AK	$26.47	$30.16	$35.48		**NC**	$14.05	$20.94	$28.43
AL	14.05	20.94	28.43		**ND**	17.51	30.10	35.48
AR	14.05	20.94	28.43		**NE**	14.05	20.92	39.64

AZ	17.37	20.92	34.98		NH	15.08	20.92	28.43
CA	21.56	34.38	40.07		**NJ**	18.96	20.92	28.43
CO	14.05	20.94	28.43		**NM**	14.05	20.94	28.43
CT	23.47	21.41	28.43		**NV**	22.39	20.92	38.75
DC	14.05	20.92	28.43		**NY**	25.88	20.94	28.43
DE	25.88	20.92	28.43		**OH**	14.05	20.92	28.43
FL	14.05	20.94	28.43		**OK**	14.05	20.94	28.43
GA	14.05	20.94	28.43		**OR**	14.05	20.92	40.88
HI	17.37	30.16	35.48		**PA**	15.08	21.54	28.43
IA	14.05	20.92	34.03		**PR**	14.05	20.94	28.43
ID	14.05	20.92	28.43		**RI**	16.75	21.56	28.43
IL	14.05	20.92	28.43		**SC**	14.05	20.94	28.43
IN	14.05	20.92	28.43		**SD**	15.70	20.92	38.00
KS	14.05	20.92	35.48		**TN**	14.05	20.94	28.43
KY	14.05	26.81	36.35		**TX**	14.05	20.94	28.43
LA	14.05	20.94	28.43		**UT**	14.09	20.92	44.27
MA	23.47	20.92	28.43		**VA**	14.05	20.92	28.43
MD	14.05	20.92	28.43		**VI**	14.05	20.94	28.43
ME	23.47	20.92	28.43		**VT**	15.08	20.92	28.43
MI	14.05	20.92	28.43		**WA**	22.39	30.69	36.45
MN	14.05	20.92	28.43		WI	14.05	20.92	28.43
MO	14.05	20.92	28.43		**WV**	14.05	20.92	28.43
MS	14.05	20.94	28.43		**WY**	19.59	27.91	39.64
MT	14.05	20.92	35.48					

2012 National Monthly Payment Amounts for Stationary Oxygen Equipment

CR 7635 implements the 2012 national monthly payment amount for stationary oxygen equipment (HCPCS codes E0424, E0439, E1390 and E1391), effective for claims with dates of service on or after January 1, 2012. As required by statute, the payment amount must be adjusted annually, as necessary, to ensure budget neutrality of the new payment class for oxygen generating portable equipment (OGPE).

The updated national 2012 monthly payment amount of $176.06 for stationary oxygen equipment codes is included in the DMEPOS fee schedule.

Please note that when the stationary oxygen equipment fees are updated, corresponding updates are made to the fee schedule amounts for HCPCS codes E1405 and E1406 for oxygen and water vapor enriching systems. Since 1989, the fees for codes E1405 and E1406 have been established based on a combination of the Medicare payment amounts for stationary oxygen equipment and nebulizer codes E0585 and E0570, respectively.

2012 Maintenance and Servicing Payment Amount for Certain Oxygen Equipment

CR 7635 also updates the 2012 payment amount for maintenance and servicing for certain oxygen equipment.

You can read more about payment for claims for maintenance and servicing of oxygen equipment in MLN Matters® Articles, MM6792 Maintenance and Servicing Payments for Certain Oxygen Equipment, which you can find at http://www.cms.gov/MLNMattersArticles/downloads/MM6792.pdf and MM6990 Clarification of the Date of Service for Maintenance and Servicing Payments for Certain Oxygen Equipment after July 1, 2010, which you can find at https://www.cms.gov/MLNMattersArticles/downloads/MM6990.pdf on the CMS website.

To summarize, payment for maintenance and servicing of certain oxygen equipment can occur every 6 months beginning 6 months after the end of the 36th month of continuous use or end of the supplier's or manufacturer's warranty, whichever is later for either HCPCS code E1390, E1391, E0433 or K0738, billed with the "MS" modifier. Payment cannot occur more than once per beneficiary, regardless of the combination of oxygen concentrator equipment and/or transfilling equipment used by the beneficiary, for any 6-month period.

Per 42 CFR Section 414.210(5)(iii), the 2010 maintenance and servicing fee for certain oxygen equipment was based on 10 percent of the average price of an oxygen concentrator. For CY 2011 and subsequent years, the maintenance and servicing fee is adjusted by the covered item update for DME as set forth in Section 1834(a)(14) of the Act. Thus, the 2011 maintenance and servicing fee is adjusted by the 2.4 percent MFP-adjusted covered item update factor to yield a CY 2012 maintenance and servicing fee of $67.51 for oxygen concentrators and transfilling equipment.

Additional Information
You can find the official instruction, CR 7635, issued to your carrier, DME MAC, FI, A/B MAC, or RHHI by visiting http://www.cms.gov/Transmittals/downloads/R2340CP.pdf on the CMS website. You will find the updated "Medicare Claims Processing Manual", Chapter 23 (Fee Schedule Administration and Coding Requirements, Section 60.3 (Gap-filling DMEPOS Fees) as an attachment to that CR.

Reasonable Charge Update for 2012 for Splints, Casts, and Certain Intraocular Lenses

MLN Matters® Number: MM7628
Related Change Request (CR) #: CR 7628
Related CR Release Date: November 18, 2011
Related CR Transmittal #: R2349CP
Effective Date: January 1, 2012
Implementation Date: January 3, 2012

Provider Types Affected
This article is for physicians, providers, and suppliers billing Medicare contractors (carriers, Fiscal Intermediaries (FIs), and Medicare Administrative Contractors (MACs)) for splints, casts, and certain intraocular lenses.

What Providers Need to Know
Change Request (CR) 7628, on which this article is based, announces that payment of claims for splints, casts, and for intraocular lenses implanted in a physician's office (codes V2630, V2631, V2632) continues to be made on a reasonable charge basis subject to certain payment limits. CR7628 also announces that the update factor for the Inflation Indexed Charge (IIC) for 2012 is 3.6 percent.

Background
Payment continues to be made on a reasonable charge basis for splints, casts, and intraocular lenses (codes V2630, V2631, and V2632) implanted in a physician's office. For splints and casts, the Q-codes are to be used when supplies are indicated for cast and splint purposes. This payment is in addition to the payment made under the Medicare Physician Fee Schedule for the procedure for applying the splint or cast.

CR7628 provides instructions regarding the calculation of reasonable charges for payment of claims for splints, casts, and intraocular lenses furnished in Calendar Year 2012. Payment on a reasonable charge basis is required for these items by regulations contained in 42 CFR 405.501.

The Inflation Indexed Charge (IIC) is calculated using the lowest of the reasonable charge screens from the previous year updated by an inflation adjustment factor or the percentage change in the Consumer Price Index (CPI) for all urban consumers (United States city average) or CPI-U for the 12-month period ending with June 30, 2011. The 2012 payment limits for splints and casts will be based on the 2011 limits that were announced in CR7225 last year, increased by 3.6 percent, the percentage change in the CPI-U for the 12-month period ending June 30, 2011. (You can read the MLN Matters® article associated with CR7225 at http://www.cms.gov/MLNMattersArticles/downloads/MM7225.pdf on the Centers for Medicare & Medicaid (CMS) website.) The IIC update factor for 2012 is 3.6 percent.

A list of the 2012 payment limits for splints and casts are listed in the table that follows.

2012 Payment Limits for Splints and Casts							
A4565	$8.12	Q4013	$14.88	Q4026	$111.41	Q4039	$7.78
Q4001	$46.21	Q4014	$25.08	Q4027	$17.85	Q4040	$19.44
Q4002	$174.65	Q4015	$7.44	Q4028	$55.72	Q4041	$18.88

Q4003	$33.19	Q4016	$12.54	Q4029	$27.29	Q4042	$32.23
Q4004	$114.91	Q4017	$8.60	Q4030	$71.83	Q4043	$9.45
Q4005	$12.24	Q4018	$13.71	Q4031	$13.64	Q4044	$16.12
Q4006	$27.58	Q4019	$4.31	Q4032	$35.91	Q4045	$10.96
Q4007	$6.13	Q4020	$6.86	Q4033	$25.45	Q4046	$17.63
Q4008	$13.79	Q4021	$6.36	Q4034	$63.30	Q4047	$5.47
Q4009	$8.17	Q4022	$11.48	Q4035	$12.72	Q4048	$8.82
Q4010	$18.39	Q4023	$3.20	Q4036	$31.66	Q4049	$2.00
Q4011	$4.08	Q4024	$5.74	Q4037	$15.53		
Q4012	$9.20	Q4025	$35.68	Q4038	$38.90		

Additional Information
You can find the official instruction, CR7628, issued to your carrier, FI, MAC by visiting http://www.cms.gov/Transmittals/downloads/R2349CP.pdf on the CMS website.

Detailed instructions for calculating:

1. Reasonable charges are located in the "Medicare Claims Processing Manual," Chapter 23 (Fee Schedule Administration and Coding Requirements), Section 80 (Reasonable Charges as Basis for Carrier/DMERC Payments);
2. Customary and prevailing charges are located in "Medicare Claims Processing Manual," Chapter 23 (Fee Schedule Administration and Coding Requirements), Sections 80.2 (Updating Customary and Prevailing Charges) and 80.4 (Prevailing Charge); and
3. The IIC are located in "Medicare Claims Processing Manual," Chapter 23 (Fee Schedule Administration and Coding Requirements), Sections 80.6 (Inflation Indexed Charge (IIC) for Nonphysician Services).

Chater 23 of the "Medicare Claims Processing Manual" is available at http://www.cms.gov/manuals/downloads/clm104c23.pdf on the CMS website.

REMITTANCE ADVICE

Claim Adjustment Reason Code, Remittance Advice Remark Code, Medicare Remit Easy Print, and PC Print Update

MLN Matters® Number: MM7683
Related Change Request (CR) #: CR 7683
Related CR Release Date: December 22, 2011
Related CR Transmittal #: R3372CP
Effective Date: April 1, 2012
Implementation Date: April 2, 2012

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

Provider Action Needed
This article is based on Change Request (CR) 7683 which updates Claim Adjustment Reason Codes (CARCs), Remittance Advice Remark Codes (RARCs), Medicare Remit Easy Print (MREP), and PC Print for Medicare.

Change Request (CR) 7683 instructs Medicare contractors and the Shared System Maintainers (SSMs) to make programming changes to incorporate new, modified, and deactivated CARCs and RARCs that have been added since the last recurring code update CR. It also instructs Fiscal Intermediary Standard System (FISS) and VIPs Medicare System (VMS) to update PC Print and Medicare Remit Easy Print (MREP) software. Be sure your billing staff is aware of these changes.

Background
The Health Insurance Portability and Accountability Act (HIPAA) of 1996, instructs health plans to be able to conduct standard electronic transactions adopted under HIPAA using valid standard codes. Medicare policy states that Claim Adjustment Reason Codes (CARCs) are required in the remittance advice and coordination of benefits transactions. Medicare policy further states that appropriate Remittance Advice Remark Codes (RARCs) that provide either supplemental explanation for a monetary adjustment or policy information that generally applies to the monetary adjustment are required in the remittance advice transaction. For transaction 835 (Health Care Claim Payment/Advice) and standard paper remittance advice, CARCs and RARCs must be used to report payment adjustments, appeal rights, and related information. If there is any adjustment, appropriate Group Code must be reported as well. Additionally, for transaction 837 COB, CARC must be used.

The CARC and RARC changes that impact Medicare are usually requested by the Centers for Medicare & Medicaid Services (CMS) staff in conjunction with a policy change. Medicare contractors and Shared System Maintainers (SSMs) are notified about these changes in the corresponding instructions from the specific CMS component that implements the policy change, in addition to the regular code update notification. If a modification has been initiated by an entity other than CMS for a code currently used by Medicare, then Medicare contractors must either use the modified code or another code if the modification makes the modified code inappropriate to explain the specific reason for adjustment.

Medicare contractors will stop using codes that have been deactivated on or before the effective date specified in the comment section (as posted on the Washington Publishing Company (WPC) website) if they are currently being used. In order to comply with any deactivation, Medicare may have to stop using the deactivated code in original business messages before the actual "Stop Date" posted on the WPC website because the code list is updated three times a year and may not align with the Medicare release schedule. Note that a deactivated code used in derivative messages must be accepted even after the code is deactivated if the deactivated code was used before the deactivation date by a payer who adjudicated the claim before Medicare. Medicare contractors must stop using any deactivated reason and/or remark code past the deactivation date whether the deactivation is requested by Medicare or any other entity.

The regular code update Change Request (CR) will establish the implementation date for all modifications, deactivations, and any new code for Medicare contractors and the SSMs. If another specific CR has been issued by another CMS component with a different implementation date, the earlier of the two dates will apply for Medicare implementation. If any new or modified code has an effective date past the implementation date specified in CR7683, Medicare contractors must implement on the date specified on the WPC website.

The discrepancy between the dates may arise because the WPC website gets updated only 3 times a year and may not match the CMS release schedule. CR7683 lists only the changes that have been approved since the last code update CR (CR 7514 Transmittal 2304), and does not provide a complete list of codes in these two code sets. You must get the complete list for both CARC and RARC from the WPC website that is updated three times a year – around March 1, July 1, and November 1 – to get the comprehensive lists for both code sets, but the implementation date for any new or modified or deactivated code for Medicare contractors is established by this recurring code update CR published three or four times a year according to the Medicare release schedule (see above for exception).

The WPC website (at http://www.wpc-edi.com/Reference on the Internet) has four listings available for both CARC and RARC:

- **All:** All codes including deactivated and to be deactivated codes are included in this listing.
- **To Be Deactivated:** Only codes to be deactivated at a future date are included in this listing.
- **Deactivated:** Only codes with prior deactivation effective date are included in this listing.
- **Current:** Only currently valid codes are included in this listing.

NOTE: In case of any discrepancy in the code text as posted on WPC website and as reported in any CR, the WPC version is implemented by Medicare.

Claim Adjustment Reason Code (CARC): A national code maintenance committee maintains the health care Claim Adjustment Reason Codes (CARCs). The Committee meets at the beginning of each X12 trimester meeting (January/February, June and September/October) and makes decisions about additions, modifications, and retirement of existing reason codes. The updated list is posted three times a year around early March, July, and November. To access the updated list see http://www.wpc-edi.com/Reference on the Internet.

The new codes usually become effective when approved unless mentioned otherwise. Any modification or deactivation becomes effective on a future date to provide lead time for implementing necessary programming changes. Exception: The effective date for a modification may be as early as the approval or publication date if the requester can provide enough justification to have the modification become effective earlier than a future date. A health plan may decide to implement a code deactivation before the actual effective date posted on WPC website as long as the deactivated code is allowed to come in on Coordination of Benefits (COB) claims if the previous payer(s) has (have) used that code prior to the deactivation date. In most cases Medicare will stop using a deactivated code before the deactivation becomes effective per the WPC website to accommodate the Medicare release schedule. The following new Claim Adjustment Reason Codes were approved by the Code Committee in October, and must be implemented, if appropriate, by April 2, 2012.

New Codes – CARC:

Code	Current Narrative	Effective Date
238	Claim spans eligible and ineligible periods of coverage, this is the reduction for the ineligible period (use Group Code PR).	3/1/2012
239	Claim spans eligible and ineligible periods of coverage. Rebill separate claims (use Group Code OA).	3/1/2012

Modified Codes – CARC:

Code	Modified Narrative	Effective Date
18	Exact duplicate claim/service (Use with Group Code OA).	1/1/2013

Deactivated Codes – CARC:

Code	Current Narrative	Effective Date
141	Claim spans eligible and ineligible periods of coverage.	7/1/2012

Remittance Advice Remark Codes (RARC): CMS is the national maintainer of the remittance advice remark code list. This code list is used by reference in the ASC X12 N transaction 835 (Health Care Claim Payment/Advice) version 004010A1 and 005010A1 Implementation Guide (IG)/Technical Report (TR) 3. Under HIPAA, all payers, including Medicare, have to use reason and remark codes approved by X12 recognized code set maintainers instead of proprietary codes to explain any adjustment in the claim payment. CMS as the X12 recognized maintainer of RARCs receives requests from Medicare and non- Medicare entities for new codes and modification/deactivation of existing codes. Additions, deletions, and modifications to the code list resulting from non-Medicare requests may or may not impact Medicare. Remark and reason code changes that impact Medicare are usually requested by CMS staff in conjunction with a policy change.

CR7683 contains no new, modified, or deactivated RARC codes.

Additional Information
The official instruction, CR7683, issued to your carriers, DME MACs, FIs, A/B MACs, and RHHIs regarding this change may be viewed at http://www.cms.gov/Transmittals/downloads/R2372CP.pdf on the CMS website.

Electronic Remittance Advices Offer Many Advantages

If your office receives claims information via the Standard Paper Remittance (SPR) Advice, you should consider receiving Electronic Remittance Advices (ERAs).

The electronic remittance advice provides the same information as the paper version, and, if your software has the capability, the payment information can be posted automatically to your accounting or billing system.

Advantages of ERAs include:

- Faster receipt of payment information
- Easily downloaded and stored for future reference
- Payment information is portable, reusable, and easily retrieved
- Faster account reconciliation via electronic posting

- Improved office productivity
- Automation of follow-up actions
- Paperwork reductions

By receiving electronic remittance advices, you may be able to take advantage of financial reporting provided by many software vendors. CMS also provides free software, Medicare Remit Easy Print (MREP), to download and print electronic remittance advices. Download this software from www.cms.gov/AccesstoDataApplication/02_MedicareRemitEasyPrint.asp.

MREP software features include:

- Easy navigation and viewing of the ERA
- Prints ERA in the SPR format
- Search capabilities to easily find claim information
- Print and export reports including denied, adjusted and deductible applied claims
- Easy archival, restoration and deletion of ERAs

As of July 1, 2011, MREP software is compatible with Microsoft Windows 7 (32 or 64 bit), Vista (32 or 64 bit), and XP (32 or 64 bit) operating systems.

For further information on how to receive ERAs, call the CEDI Help Desk at (866) 311-9184 between the hours of 8 a.m. and 6 p.m. CT, Monday through Friday.

MREP Upgrade to Version 3.2.2

Version 3.2.2 of the Medicare Remit Easy Print (MREP) software is available for download at http://www.cms.gov/AccesstoDataApplication/02_MedicareRemitEasyPrint.asp on the CMS website.

Previous versions currently installed on the computer will not need to be removed before installing the upgrade to the software.

The issue related to the MREP software not printing large remit files has been resolved with this update.

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: August 5, 2011
Related CR Transmittal #: R993OTN
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 9, 2012 for supplier claims submitted to DME MACs

Note: This article was revised on November 7, 2011, to reflect changes made to CR7499. In this article, the implementation dates (see above), the CR release date, transmittal number, and the Web address for accessing CR7499 were revised. 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/MLNMattersArticles/downloads/MM6870.pdf and CR7068 can be reviewed at http://www.cms.gov/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.

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/Transmittals/downloads/R993OTN.pdf on the CMS website.

Use of Revised Remittance Advice Remark Code N103 When Denying Services Furnished to Federally Incarcerated Beneficiaries

MLN Matters® Number: MM7678
Related Change Request (CR) #: 7678
Related CR Release Date: January 6, 2012
Related CR Transmittal #: R1012OTN
Effective Date: July 1, 2012
Implementation Date: July 2, 2012

Provider Types Affected
Providers submitting claims to Medicare contractors (Fiscal Intermediaries (FIs), carriers, A/B Medicare Administrative Contractors (MACs) and Durable Medical Equipment MACs or DME MACs) for Medicare beneficiaries who are incarcerated in a Federal facility.

Provider Action Needed
This article is based on Change Request (CR) 7678 which informs Medicare contractors that the Centers for Medicare & Medicaid Services (CMS) is amending Remittance Advice Remark Code (RARC) N103 to include language that further explains the newly modified RARC N103—denying claims for services to federally incarcerated beneficiaries.

CR7678 is limited to providers billing for services for beneficiaries while they are in Federal, State, or local custody and the goal of this CR7678 is to be more specific in explaining the accompanying adjustment.

Background
The following exclusions presumptively apply to individuals who are incarcerated in a Federal facility under Federal authority:

- According to Federal regulations at 42 Code of Federal Regulations (CFR) Section 411.4 Medicare does not pay for services furnished to a beneficiary who has no legal obligation to pay for the service and no other person or organization has a legal obligation to provide or pay for the service;
- Under 42 CFR 411.6, Medicare does not pay for services furnished by a federal provider of services or by a federal agency; and
- Under 42 CFR 411.8, Medicare does not pay for services that are paid for directly or indirectly by a governmental entity.

Key Points
When denying claims for services furnished to federally incarcerated Medicare beneficiaries, the newly modified RARC N103 will be used (in addition to remittance advice language already in use) and it reads as follows:

"Social Security records indicate that this patient was a prisoner when the service was rendered. This payer does not cover items and services furnished to an individual while he or she is in a Federal facility, or while he or she is in State or local custody under a penal authority, unless under State or local law, the individual is personally liable for the cost of his or her health care while incarcerated and the State or local government pursues such debt in the same way and with the same vigor as any other debt."

Additional Information
The official instruction, CR7678, issued to your Medicare contractors (FIs, A/B MACs, DME MACs, and carriers) regarding this change, may be viewed at http://www.cms.gov/Transmittals/downloads/R1012OTN.pdf on the CMS website.

OXYGEN

Maintenance and Servicing Payments for Certain Oxygen Equipment after July 1, 2010

MLN Matters® Number: MM6792 Revised
Related Change Request (CR) #: 6792
Related CR Release Date: February 5, 2010
Related CR Transmittal #: R635OTN
Effective Date: July 1, 2010
Implementation Date: July 6, 2010

Note: This article was revised on November 18, 2011, to correct two dates in the example provided at the top of page 3. All other information remains the same.

Provider Types Affected
This article is for suppliers submitting claims to Medicare contractors (Regional Home Health Intermediaries (RHHIs), Medicare Administrative Contractors (MACs) and/or Durable Medical Equipment Medicare Administrative Contractors (DME MACs)) for oxygen services provided to Medicare beneficiaries.

What You Need to Know
CR 6792, from which this article is taken, announces instructions regarding payment for maintenance and servicing of oxygen equipment furnished for dates of service on or after July 1, 2010. Please see the Background section, below, for details.

Background
Section 1834(a)(5)(F)(ii)(III) of the Social Security Act provides for the payment of charges for reasonable and necessary maintenance of, and servicing of, oxygen equipment that you furnish after the 36-month rental payment cap for parts and labor that are not covered by the supplier's or manufacturer's warranty.

CR 6716, titled Continuation of Maintenance and Servicing Payments in CY 2010 for Certain Oxygen Equipment as a Result of the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 and released November 2, 2009, provides instructions relating to the maintenance and servicing payments for oxygen equipment furnished through

June 30, 2010. (You can find the related MLN Matters® Article at http://www.cms.hhs.gov/mlnmattersarticles/downloads/MM6716.pdf on the Centers for Medicare & Medicaid Services (CMS) website.)

CR 6792, from which this article is taken, is a one-time notification that announces instructions regarding the payment for maintenance and servicing of oxygen equipment furnished for dates of service on or after July 1, 2010.

Specifically, CR 6792 provides that (effective for oxygen equipment, other than stationary or portable gaseous or liquid oxygen equipment, furnished on or after July 1, 2010) a maintenance and servicing fee of $66 is paid every 6 months, either beginning: 1) 6 months after the 36th paid rental month; or 2) when the item is no longer covered under the supplier's or manufacturer's warranty (whichever is later).

The maintenance and servicing fee, which will be updated annually through program instructions that are based on the covered item update for DME, covers all maintenance and servicing through the following 6 months that are needed in order to keep the oxygen equipment in good working order.

A single payment ($66 for dates of service July 1, 2010 through December 31, 2010) is made per beneficiary regardless of:

- The number of pieces of equipment serviced (stationary concentrator, portable concentrator, and/or transfilling equipment);
- When the maintenance and servicing is performed during each 6-month period; or

How often the equipment must be maintained and serviced.

You must make at least one maintenance/servicing visit to inspect the equipment and provide any maintenance and servicing needed at the time of the visit during the first month of each 6-month period. For example:

- 36th monthly payment amount made for month ending June 30, 2010;
- 6-month period with no payment ends December 31, 2010;
- Maintenance and servicing payment may begin on January 1, 2011, provided warranty coverage ended on June 30, 2010, or earlier;
    - You must make at least one in-home visit during January 2011; and
    - Payment covers all maintenance and servicing through June 30, 2011.
- Second maintenance and servicing payment may be made on July 1, 2011;
    - You must make at least one in-home visit during July 2011, and
    - Payment covers all maintenance and servicing through December 31, 2011.

Note: You will not receive payment for maintenance and servicing of gaseous or liquid oxygen equipment (stationary or portable), or for maintenance and servicing of beneficiary-owned oxygen equipment.

Billing Guidance
You should use:

- Healthcare Common Procedure Coding System (HCPCS) codes E1390, E1391, E0433, or K0738 along with the MS modifier to bill and receive payment for maintenance and servicing of oxygen equipment other than gaseous or liquid oxygen equipment;
- HCPCS code E1390 for maintenance and servicing for a beneficiary using a single delivery port stationary oxygen concentrator or portable concentrator, and for maintenance and servicing for beneficiaries renting a combination of single delivery port stationary oxygen concentrators and gaseous or liquid oxygen transfilling equipment;
- HCPCS code E1391 for maintenance and servicing for a beneficiary using a dual delivery port stationary oxygen concentrator or for beneficiaries renting a combination of dual delivery port stationary oxygen concentrators and gaseous or liquid oxygen transfilling equipment;
- HCPCS code K0738 only in situations in which the beneficiary owns stationary oxygen equipment, but rents gaseous oxygen transfilling equipment; and
- HCPCS code E0433 only in situations in which the beneficiary owns stationary equipment but rents liquid oxygen transfilling equipment.

OXYGEN CONT'D

Notes: 1) Use HCPCS code E1390 (and not E1392) for maintenance and servicing of portable oxygen concentrator equipment; and 2) Bill the appropriate HCPCS code for the equipment or combination of equipment, as applicable, with the "MS" modifier.

You should remember that only one maintenance and servicing payment can be made for any combination of oxygen equipment used by the beneficiary that is classified under HCPCS codes E1390, E1391, E1392, E0433 or K0738.

For example, if maintenance and servicing is billed for a column I code/modifier, additional payment for the maintenance and servicing of any of the column II codes/modifiers will not be made.

Column 1	Column II
E1390MS	E1391MS, K0738MS, E0433MS
E1391MS	E1390MS, K0738MS, E0433MS
K0738MS	E1390MS, E1391MS, E0433MS
E0433MS	E1390MS, E1391MS, K0738MS

Further, the maintenance and servicing payments following the 36th month rental cap for oxygen concentrators and transfilling equipment terminate if the stationary oxygen equipment is replaced and a new 36-month rental period commences.

Finally, be aware that your RHHI, MAC, or DME MAC will deny your claims for the maintenance and servicing of beneficiary-owned oxygen equipment or equipment that you bill with HCPCS codes E0424, E0439, E0431, E0434, E1405, E1392 or E1406 and the "MS" modifier. They will also deny claims for more than one payment per beneficiary, regardless of the combination of oxygen concentrator equipment and/or transfilling equipment used by the beneficiary, for any 6-month period for either HCPCS code E1390, E1391, E0433, or K0738, billed with the "MS" modifier.

When denying such claims, they will:

- Use the following remittance advice reason and remark codes:
  - Reason code A1: Claim/Service denied;
  - Remark Code M6 (revised) – Alert: You must furnish and service this item for any period of medical need for the remainder of the reasonable useful lifetime of the equipment.
  - Remark Code N372: Only reasonable and necessary maintenance/service charges are covered.
- Assign group code CO (contractual obligation); and
- Use the following Medicare Summary Notice (MSN) messages for denied claims:
  - 8.28 - Maintenance, servicing, replacement, or repair of this item is not covered;
  - 16.35: You do not have to pay for this amount.

Additional Information
You can find more information about the maintenance and servicing payments for certain oxygen equipment after July 1, 2010 by going to CR 6792, located at http://www.cms.hhs.gov/Transmittals/downloads/R635OTN.pdf on the CMS website.

VERSION 510

Additional HIPAA 837 5010 Transitional Changes and Further Modifications COBA National Crossover Process

MLN Matters® Number: SE1137 Revised

Note: This article was revised on January 17, 2012, to add a section to clarify Medicare's capability to cross over HIPAA Version 4010A1 or National Council for Prescription Drug Programs (NCPDP) Version 5.1 batch claims to the Coordination of Benefits Agreement (COBA) supplemental payers that have cut-over to exclusive receipt of claims in the Version 5010 837 claim formats or NCPDP D.0 batch claim formats. It also clarifies the crossover impact for the providers that are permitted to submit claims using the CMS 1500 or UB04 hardcopy formats. All other information remains unchanged.

Provider Types Affected
This MLN Matters® Special Edition (SE) Article is intended to alert 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.

What Providers Need to Know
Supplemental payers are transitioning to HIPAA 5010 or NCPDP D.0 under the National Crossover Process. Currently, the Centers for Medicare & Medicaid Services (CMS) is transitioning supplemental payers that participate in the national COBA crossover process from their production Version 4010A1, HIPAA 837 claims to HIPAA Versions 5010A1 and 5010A2 837 claimsAs COBA supplemental payers move into production on the 5010A1 and A2 claim formats, CMS requires that they continue to accept their "pre-HIPAA 5010" production Version 4010A1 claims for 14 full calendar days after their cut-over to the new claim formats.

The following is an example to further illustrate this point:

Payer A moved to HIPAA 5010 production on November 7, 2011. Medicare will then systematically transfer to Payer A all "clean" electronically received 4010A1 claims that are already on the payment floor and tagged for crossover as of November 3 and 4, 2011. Beginning with claims that CMS' Coordination of Benefits Contractor (COBC) received that have a file date of November 22, 2011, Medicare, through the COBC, will no longer be able to transfer production 4010A1 claims to payer A. This is because 14 full calendar days have elapsed since Payer A moved into production on the HIPAA 5010 claim formats.

NOTE: The same premise will hold for inbound Version 5.1 batch NCPDP claims when a supplemental payer moves into production on the NCPDP D.0, Version 5.2 batch format for receipt of crossover claims.

As provided in CMS Change Requests (CRs) 6658* and 6664*, the COBC activates the following edits once COBA trading partners move into HIPAA 5010 or NCPDP D.0 production:

- N22226—"4010A1 production claim received, but the COBA trading partner is not accepting 4010A1 production claims."
- N22230—"NCPDP 5.1 production claim received, but the COBA trading partner is not accepting NCPDP 5.1 production claims."
- *To review the entire CR6658, visit http://www.cms.gov/transmittals/downloads/R1844CP.pdf on the CMS website.
- *To review the entire CR6664, visit http://www.cms.gov/transmittals/downloads/R1841CP.pdf on the CMS website.

Providers, physicians, and suppliers should note that they will see the foregoing edit codes on the special provider notification letters that Medicare mails to them at their on-file correspondence address when Medicare is unable to send various claims for crossover purposes. Receipt of these codes on the special provider notification letters denotes that:

1. The patient's supplemental payer has moved into HIPAA 5010 or NCPDP D.0 production receipt for all Medicare crossover claims; and
2. For a limited timeframe (likely 30 days after a supplemental payer cuts over to Version 5010 for crossover claims receipt), providers, physicians, and suppliers will need to file the affected claims directly with their patients' supplemental payers.

Key Points

- Your Medicare contractor will not attempt to repair claims that the COBC returns via the COBC Error Reports with error codes N22226 through N22229, regardless of error percentage.
- Your Medicare contractor will create special provider letters to their affiliate suppliers in association with "production" claims that the COBC rejects with error code N22226 or N22228. Per CMS instruction, these letters indicate that Medicare cannot cross the listed patient-specific claims over to patient's supplemental payer and include a specific "222" error code and accompanying description. MLN Matters® Article MM3709 details the initial CMS instructions to contractors and may be reviewed at http://www.cms.gov/MLNMattersArticles/downloads/MM3709.pdf on the CMS website
- Complete details of the COBA Error Notification process are included in the official instruction issued to your Medicare contractor and may be viewed at http://www.cms.hhs.gov/transmittals/downloads/R474CP.pdf on the CMS website.
- Be aware of the claims not being crossed over automatically and take appropriate action to obtain payments from the supplemental payer/insurer.

Additional Clarification of the Crossover Claims Process
There is some confusion in the provider community concerning whether billing of hardcopy CMS 1500 or UB04 claims or HIPAA Version 4010A1 or NCPDP Version 5.1 batch claims to Medicare will result in Medicare being unable to cross those claims over to COBA supplemental payers that have cut-over to exclusive receipt of crossover claims in the Version 5010 837 claim formats or NCPDP D.0 batch claim formats.

In other words, there is an assumption being made that billing vendors or physician/practitioner, provider, or supplier offices that bill Medicare will continue to receive error code N22226 for every occasion that they bill claims to Medicare using a hardcopy (paper) claim format (CMS-1500 or UB-04) or Version 4010A1 or NCPDP 5.1 batch formats. This assumption is incorrect, as explained below.

During the 90 day non-enforcement period (January 1, 2012—March 31, 2012), Medicare will have the systematic capability to convert incoming claim formats in accordance with external supplemental payer specifications concerning production claims format. That is, Medicare will have the ability to:

- Take incoming claims submitted by the provider community in hardcopy (paper) format or Version 4010A1 or NCPDP 5.1 batch claim formats and convert them to HIPAA Version 5010A1 or 5010A2 claim formats, as appropriate, or NCPDP D.0 batch claim formats for those COBA supplemental payers that already have cut-over to exclusive receipt of Version 5010 COB claims in production; and
- Take incoming claims submitted by the provider community in the Version 5010A1 or 5010A2 or NCPDP D.0 batch claim formats and convert them to HIPAA Version 4010A1 claim formats or NCPDP 5.1 COB batch claim format for those supplemental payers that have not cut-over to production use of the HIPAA Version 5010 COB claim formats or NCPDP D.0 batch claim format.

This action is controlled by information that Medicare's Common Working File (CWF) receives concerning individual supplemental payers' ability to accept HIPAA 5010 or NCPDP D.0 claim formats in "production" mode. **With the exception of incoming hardcopy claims, this practice will discontinue at the conclusion of the 90 day non-enforcement period.**

Note: For physicians/practitioners, providers, and suppliers that have the authorization under the Administrative Simplification Compliance Act (ASCA) to submit claims to Medicare using a hardcopy format, Medicare has the systematic capability to convert keyed claims into outbound compliant HIPAA 837 claim formats for crossover claim transmission purposes. **This is true at all times, not just during the 90 day non-enforcement period.**

Summary
During the 90 day non-enforcement period, Medicare has the ability to take incoming claims formats (hardcopy, Version 4010A1, Version 5010A1 or 5010A2, NCPDP 5.1 batch, or NCPDP D.0 batch) and transform them into alternative Version HIPAA claim or NCPDP claim formats for COB purposes to address the "production" specifications of various supplemental payers. With the exception of incoming hardcopy claims, this practice will discontinue at the conclusion of 90 day non-enforcement period.

Additional Information
If you have any questions about Electronic Data Interchange (EDI) Medicare, customers may call their regional EDI Helpline to access information. These regional toll free numbers may be found in the "Downloads" section of the Electronic Billing & EDI Transactions web page at http://www.cms.gov/ElectronicBillingEDITrans/ on the CMS website.

CEDI Reminder: 5010A1/D.0 Implementation Plans

The January 1, 2012, date to be compliant with the 5010A1/D.0 formats has not changed. However, CMS enforcement of compliance with the 5010A1/D.0 standards will be deferred until March 31, 2012. CEDI continues to encourage vendors to complete testing with CEDI as soon as possible and to have Trading Partners move to the 5010A1/D.0 transaction formats once approved.

Effective December 15, 2011, CEDI began execution of the CMS directive to maximize compliance of the 5010A1/D.0 transaction formats in order to reach full compliance no later than March 31, 2012. In accordance with this directive, the following actions will be taken:

- Vendors who have tested and been approved by CEDI for the 5010A1/D.0 transaction formats but are still submitting the 4010A1/5.1 transaction format must migrate all Trading Partners using their software to the 5010A1/D.0 transaction format no later than January 17, 2012.
- Vendors who have not begun testing or are currently testing with CEDI for the 5010A1/D.0 transaction formats must submit a testing/transition plan to CEDI no later than January 17, 2012 providing how they will complete their transition to the 5010A1/D.0 transaction formats no later than March 31, 2012. To submit your testing/transition plan to CEDI, please visit the CEDI website http://www.ngscedi.com and click on the 5010/D.0 Implementation Information Page. Complete the "Vendor Testing/Transition Plan" form.
- All transactions must be 5010A1/D.0 compliant no later than March 31, 2012.
- Trading Partners are not required to submit an implementation plan to CEDI. However, any Trading Partner who has not completed the migration to the 5010A1/D.0 formats should contact their software vendor immediately to find out when they will be moved to the new formats.

CEDI will continue with current enrollment processes and will not setup any new Trading Partners or add any new providers to existing Trading Partners in the 4010A1/5.1 transaction formats. The CEDI Enrollment Department will only process enrollment forms for the new 5010A1/D.0 transaction formats.

Trading Partners who have already migrated to the new 5010A1/D.0 transaction formats will not be permitted to change back to the 4010A1/5.1 transaction formats.

If you are not signed up for the CEDI listserv, please visit the CEDI website at http://www.ngscedi.com/listserv/subscribe.htm to sign up and begin receiving important information regarding your DME electronic transactions.

If you have any questions regarding this information, please contact the CEDI Help Desk at ngs.cedihelpdesk@wellpoint.com.

Clarification Concerning HIPAA 5010 and NCPDP D.0 Cut-Over and Impacts on Crossover Claims

On Monday, December 5, 2011, CMS issued a Special Edition MLN Matters Article (SE1137) entitled "Additional Health Insurance Portability and Accountability Act (HIPAA) 837 5010 Transitional Changes and Further Modifications to the Coordination of Benefits Agreement (COBA) National Crossover Process." CMS issued this guidance for the benefit of physicians/practitioners, providers, and suppliers to help them understand why they were seeing greater instances of Medicare correspondence letters that made reference to error N22226 as the basis for why their patients' claims could not be crossed over.

CMS has since learned that concern exists in the provider community concerning whether billing of hardcopy CMS 1500 or UB04 claims or HIPAA version 4010A1 or National Council for Prescription Drug Programs (NCPDP) version 5.1 batch claims will result in Medicare being unable to cross those claims over to COBA supplemental payers that have cut-over to exclusive receipt of crossover claims in the version 5010 837 claim formats or NCPDP D.0 batch claim formats. This is not true.

During the 90-day Version 5010 non-enforcement period (Sunday, January 1, 2012, through Saturday, March 31, 2012), Medicare will have the systematic capability to perform up- or down-version conversion of incoming claim formats (i.e., convert incoming hardcopy formats to HIPAA equivalent claim formats and convert incoming version 4010A1 claim formats to 5010 formats and vice-a-versa), in accordance with external supplemental payer specifications concerning production claims format. This practice will discontinue, however, at the conclusion of the 90-day non-enforcement period, with the exception below. (This action is controlled by information that the Common Working File receives concerning individual supplemental payers' ability to accept HIPAA 5010 or NCPDP D.0 claim formats in "production" mode.)

Note that physicians/practitioners, providers, and suppliers that have authorization under the Administrative Simplification Compliance Act (ASCA) to submit claims using a hardcopy format should know that Medicare has the systematic capability to convert keyed claims into outbound-compliant HIPAA 837 claim formats for crossover claim transmission purposes. This is true at all times, not just during the 90-day non-enforcement period.

How Version 5010 Changes Modify Your Transition

90-Day Period of Enforcement Discretion for Compliance with Version 5010 Deadline
The Centers for Medicare & Medicaid Services (CMS) recently announced a 90-day enforcement discretion period for all HIPAA covered entities regarding the Version 5010 (ASC X12 Version 5010) transition.

The compliance deadline for the implementation of Version 5010 is still **January 1, 2012**; however, CMS will not initiate enforcement action until **March 31, 2012**. CMS made this decision based on industry feedback that many organizations and their trading partners were not yet ready to finalize system upgrades for this transition.

CMS encourages you to continue internal testing and external testing of Version 5010 transactions with trading partners to ensure compliance for Version 5010. Although enforcement action will not be taken prior to March 31, 2012, it is important that you continue to move forward to meet Version 5010 requirements as soon as possible.

During the 90-day enforcement discretion period, the Office of E-Health Standards and Services (OESS) will continue to accept complaints associated with compliance with Version 5010, NCPDP D.0 and NCPDP 3.0 transaction standards beginning January 1, 2012. HIPAA covered entities that are subject to these complaints must produce evidence of either compliance or an established plan to become compliant within the enforcement discretion period. In addition to testing, if you have not yet created a transition plan for Version 5010, you should do so in order to meet these compliance deadlines.

Please visit the CMS ICD-10 Website Latest News page for additional resources and more information on this enforcement discretion period.

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, and to download and share the implementation widget today!

Important Medicare Fee-for-Service Statement Regarding Versions 5010 and D.0

On November 17, 2011, the Centers for Medicare & Medicaid Services' Office of E-Health Standards and Services (OESS) announced that it would not initiate enforcement with respect to any HIPAA covered entity that is not in compliance on January 1, 2012, with the ASC X12 Version 5010 (Version 5010), NCPDP Telecom D.0 (NCPDP D.0) and NCPDP Medicaid Subrogation 3.0 (NCPDP 3.0) standards until March 31, 2012. Notwithstanding OESS' discretionary application of its enforcement authority, the compliance date for use of these new standards remains January 1, 2012 (small health plans have until January 1, 2013 to comply with NCPDP 3.0).

Medicare Fee-for-Service (FFS) will soon issue direction to the Medicare Administrative Contractors (MACs) on how these transactions are to be processed on January 2, 2012. Further guidance related to Medicare Fee-for-Service will be available via listserv messages and the CMS website.

Make Sure You are Prepared for Version 5010: Risk Mitigation Strategies

All entities covered by the Health Insurance Portability and Accountability Act (HIPAA) that submit transactions electronically are required to upgrade from Version 4010/4010A to Version 5010 transaction standards by Sunday, January 1, 2012. It is important to remember that the upcoming Version 5010 transition is not only mandatory, but is also an integral step toward a successful ICD-10 transition.

It is essential to test both internally and externally with business partners prior to the Version 5010 deadline in order to assure that all trading partners are able to send and receive compliant transactions effectively, and in advance of the transition deadline. Take action now to ensure compliance and avoid problems with submitting claims for reimbursement after Sunday, January 1, 2012.

If you have not yet begun external testing, you should make use of the following risk mitigation strategies:

- Communicate with vendors and trading partners regularly. Encourage them to take action now and establish a communication plan.
- Reach out to a clearinghouse for assistance. A clearinghouse ensures that claims smoothly transition between practices and payers and can serve as a translator for non-compliant transactions from the Version 4010/4010A to the Version 5010 system. If you are concerned that your internal systems may not be ready by Sunday, January 1, using a clearinghouse that is already ready to process Version 5010 claims can help ensure your reimbursements are not interrupted while you bring your own systems into compliance.

- Establish a line of credit. Establishing or increasing a line of credit will help cover potential cash flow disruptions from delayed reimbursement claims.
- Take advantage of available resources. There are many different resources offering valuable information to organizations looking to streamline their Version 5010 transition. CMS offers several tools to help you plan and execute your transitions to Version 5010 and ICD-10. Beyond CMS, many professional societies and organizations offer guidance and resources to help you transition.

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, and to download and share the implementation widget today!

Medicare FFS Policy Regarding 90 Day Discretionary Enforcement Period for Non-Compliant HIPAA Covered Entities

The Centers for Medicare and Medicaid Services (CMS) announced it would not initiate enforcement action with respect to any HIPAA covered entity that is non-compliant with Version 5010, NCPDP, NCPDP D.0 and 3.0 standards until 90 days after the upcoming **January 1, 2012**, compliance date. Although compliance will not be enforced for Version 5010 until April 1, 2012, it is important to continue to take the necessary steps to complete your transition to Version 5010 as soon as possible.

What the 90 Day Discretionary Enforcement Period Means For Medicare Fee-For-Service
Medicare Fee-For-Service (FFS) has experienced significant increases in 5010 production transactions during the last few months. However, there are many submitters that have tested but not taken the step to move into production for 5010 and D.0. In addition, there are many submitters that have not yet initiated testing with their Medicare Administrative Contractor (MAC). Therefore, to ensure that submitters and receivers continue to make progress, Medicare FFS is planning to take the following steps for submitters and receivers of Medicare Part B and Durable Medical Equipment (DME) transactions:

- In December 2011, submitters and receivers that have tested and been approved for 5010/D.0 will be notified that they have 30 days to cutover to the 5010/D.0 versions.
- Submitters and receivers that have not yet tested will be notified in December 2011 that they must submit their transition plans and timelines to their MAC within 30 days.
- MACs will notify the submitters and receivers, but submitters/receivers have the responsibility to notify the providers they service.

Note: Submitters and receivers of Medicare Part A transactions will follow the same action plan starting 30 days after Part B and DME.

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New ASC X12 Version 5010 FAQs Posted to CMS Website (Revised Link)

Medicare Fee-For-Service (FFS) issued an announcement Wednesday, December 14, 2011, regarding its plan for the 90 Day Discretionary Enforcement Period for non-compliant HIPAA covered entities. CMS has published six FAQ items related to this plan. These new FAQs can be found at:
http://www.cms.gov/Versions5010andD0/Downloads/QandA_for_90_day_announcement.pdf.

For more information on ASC X12 Version 5010, NCPDP D.0, and NCPDP 3.0; please visit www.CMS.gov/Versions5010andD0.

Non-Specific Procedure Code Description Requirement for HIPAA Version 5010 Claims

MLN Matters® Number: SE1138 Revised

Note: This article was revised on January 13, 2012, to correct the last part of the Background Section. That section incorrectly stated that "simply using Not Otherwise Classified as the description does not pass editing and the claim will be rejected". **The claim will not be rejected if "Not Otherwise Classified" is submitted as the description.** All other information is unchanged.

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.

What You Need to Know
The Office of E-Health Standards and Services (OESS) announced on November 17, 2011, that although the 5010/D.0 compliance date of January 1, 2012 will not change, HIPAA enforcement of compliance with the standards will be deferred until March 31, 2012.

The 5010 versions of the institutional and professional claim implementation guides mandate that when claims use non-specific procedure codes a corresponding description of the service is now required.

Please make certain your billing and coding staff follow these requirements for submitting a HIPAA compliant claim when Non-Specific Procedure codes are used. Please ensure these implementation guide requirements are followed when submitting a HIPAA compliant claim for all Non-Specific Procedure codes.

Background
The HIPAA Version 5010 implementation guide describes Non-Specific Procedure Codes as codes that may include, in their descriptor, terms such as: "Not Otherwise Classified (NOC); Unlisted; Unspecified; Unclassified; Other; Miscellaneous; Prescription Drug Generic; or Prescription Drug, Brand Name". If a procedure code containing any of these descriptor terms is billed, a corresponding description of that procedure is required; otherwise, the claim is not HIPAA compliant. Note that there is no crosswalk of non-specified procedure codes with corresponding descriptions.

Detailed information regarding this new requirement can be found in the 837I and 837P implementation guides (837I – 005010X223A2 and 837P – 005010X222A1). If the corresponding non-specific procedure code description is not submitted, the transaction does not comply with the implementation guide and is not, therefore, HIPAA compliant.

Additional Information
A complete listing of Not Otherwise Classified (NOC) Code Set is available at http://www.cms.gov/ElectronicBillingEDITrans/40_FFSEditing.asp on the Centers for Medicare & Medicaid Services (CMS) website.

For 5010/D.O implementation information and deadlines, refer to MLN Matters® Special Edition Article #SE1131, which is available at http://www.cms.gov/MLNMattersArticles/downloads/SE1131.pdf on the CMS website.

If you are not ready, consider contacting your Medicare contractor to receive the free Version 5010 software (PC-Ace Pro32) and begin testing now. Or, consider contracting with a Version 5010 compliant clearinghouse who can translate the non-compliant transactions into compliant 5010 transactions.

If you are billing Part B and DME claims, you may download the free Medicare Remit Easy Print (MREP) software to view and print compliant HIPAA 5010 835 remittance advices. This software is available at http://www.cms.gov/AccesstoDataApplication/02_MedicareRemitEasyPrint.asp on the CMS website. Part A billers may download the free PC-Print software to view and print a compliant HIPAA 5010 835 remittance advice from their A/B MACs website.

Contact your respective professional associations and other payers for guidance and resources in order to meet their deadlines.

Please note, Change Request (CR) 7392, "Common Edits and Enhancements Module (CEM) and Receipt, Control, and Balancing Updates," dated July 21, 2011, established the requirements that all procedures shall comply with the HIPAA 5010 version claim process. CR7392 was implemented by Medicare contractors on October 1, 2011, and does not override any previous claims processing instructions.

Preparing for January 1, 2012 Version 5010 Deadline

The compliance deadline for the transition to Version 5010 is only two weeks away! Though the Centers for Medicare & Medicaid Services (CMS) has announced an enforcement discretionary period of 90 days for Version 5010 compliance, the deadline remains **January 1, 2012.** Enforcement will not be exercised until **April 1, 2012;** however, it is important that organizations continue to complete the transition to Version 5010 as soon as possible, if they have not done so already.

Version 5010 Resources
CMS is committed to helping organizations make a smooth transition to Version 5010 and ICD-10. The CMS ICD-10 website has been updated to include a new web page dedicated to Version 5010 information and resources. CMS has also posted a new fact sheet, which discusses steps providers should be taking now to ensure a timely transition to Version 5010 by **January 1, 2012**.

Other materials on Version 5010 include the following fact sheets:

- FAQs: Versions 5010 and D.0 Transition Basics
- Versions 5010, D.0, and 3.0 Overview
- Version 5010: Testing Readiness, What You Need to Know
- Talking to Your Vendors About ICD-10 and Version 5010

Additional Resources
Stay on top of deadlines and action items for Version 5010 and ICD-10 by referencing the following resources on the CMS ICD-10 website:

- Interactive Widget: A user-friendly tool that outlines the steps to take to ensure compliance with Version 5010 and ICD-10.
- Timelines: Printer-friendly checklists that complement the widget, which are available for large providers, small providers, payers and vendors.
- Implementation Handbooks: Detailed step-by-step guides on how to implement ICD-10, which have been customized for different audiences including small/medium provider practices, large provider practices, small hospitals, and payers.

Keep Up to Date on Version 5010 and ICD-10
Please visit the CMS ICD-10 website for the latest news and resources, and to download and share the implementation widget today!

Stay on Track and Complete Your Version 5010 Upgrade

As 2012 begins, it is important to keep your focus on compliance with Version 5010 and beginning to plan for the transition to ICD-10.

The Version 5010 deadline was on January 1, 2012; however, because of the 90-day enforcement discretion period for all HIPAA covered entities upgrading to Version 5010 (ASC X12 Version 5010), CMS will not initiate enforcement action until April 1, 2012. CMS made this decision based on industry feedback that many organizations and their trading partners were not yet ready to finalize system upgrades to be compliant.

CMS encourages you to continue internal testing as well as external testing of Version 5010 transactions with trading partners to ensure compliance for Version 5010. Although enforcement action will not be taken prior to April 1, 2012, it is important that you continue to move forward to meet Version 5010 requirements as soon as possible. In addition to testing, if you have not yet created a plan for Version 5010, you should do so in order to meet these compliance deadlines.

To find out about steps to take toward a successful upgrade, consult the new CMS fact sheet: Version 5010: How Health Care Providers Can Ensure a Smooth Transition.

Remember: Upgrading to Version 5010 is a critical first step for the nationwide transition to ICD-10 that will take place on October 1, 2013. It is important that you finish this process, so that you can continue to prepare your organization for the ICD-10 transition.

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, and to download and share the implementation widget today!

Version 5010 Benefits and Resources

The Version 5010 compliance deadline remains **January 1, 2012**. Upgrading from Version 4010/4010A standards to Version 5010 is a critical step necessary for the ICD-10 transition, and must be implemented before ICD-10 implementation is possible.

Version 5010 offers great improvement over Version 4010/4010A; for example, Version 5010:

- Greatly improves standardization of administrative data and supports both ICD-9 and ICD-10 codes sets;
- Supports electronic submission of claims;
- Provides greater specificity of clinical data and patient information; and
- Has a more logical structure, which will assist in faster code selection and improved ease of use.

Version 5010 Resources
Please visit the Version 5010 and Latest News pages on the CMS ICD-10 website for resources to assist with the Version 5010 transition. Resources include:

- Fact sheets about making a smooth Version 5010 transition, Version 5010 readiness, and Frequently Asked Questions on Version 5010
- Implementation Handbooks tailored for Large Provider Practices, Payers, Small Hospitals, and Small/Medium Provider Practices
- An interactive widget as well as printer friendly timelines for large provider practices, small provider practices, payers, and vendors

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