DME Happenings

• THIS IS WRITTEN NOTIFICATION OF MEDICARE CHANGES •

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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	1-877-320-0390	8:30am-6pm CT Monday-Friday
Beneficiary Customer Service	1-800-633-4227	24 hours a day/7 days a week
Telephone Reopenings	1-888-826-5708	8am-4pm CT
Website: www.noridianmedicare.com/dme		
Fax		
Reopenings and Redeterminations MSP Inquiries and Refunds DME Recovery Auditor Redeterminations		1-701-277-7886
Refunds to Medicare Immediate Offsets		1-701-277-7894
DME Recovery Auditor Offsets		1-701-277-7896
Medical Review Medical Documentation		1-701-277-7888
CERT Medical Documentation		1-701-277-7890
NAS Email Addresses		
NAS DME Customer Service		dme@noridian.com
Reopenings and Redeterminations		dmeredeterminations@noridian.com
NAS DME Endeavor		dmeendeavor@noridian.com
Mailing Addresses		
Claims, Redetermination Requests, Correspondence, ADMC Requests and Medical Review Documentation Noridian Administrative Services PO Box 6727 Fargo ND 58108-6727		**Benefit Protection** Noridian Administrative Services Benefit Protection-DME PO Box 6736 Fargo ND 58108-6736
Administrative Simplification Compliance Act Exception Requests Noridian Administrative Services PO Box 6737 Fargo ND 58108-6737		**Qualified Independent Contractor** C2C Solutions, Inc. Attn: DME QIC PO Box 44013 Jacksonville FL 32202-4013
Electronic Funds Transfer Forms/Overpayment Redeterminations/DME Recovery Auditor Redeterminations Noridian Administrative Services PO Box 6728 Fargo ND 58108-6728		**DME Recovery Auditor Overpayments** Noridian Administrative Services PO Box 6759 Fargo ND 58108-6759
Other DME MACs		
Jurisdiction A: NHIC, Corp	1-866-419-9458	www.medicarenhic.com
Jurisdiction B: National Government Services	1-877-299-7900	www.ngsmedicare.com
Jurisdiction C: CGS	1-866-270-4909	www.cgsmedicare.com
Other Resources		
Pricing, Data Analysis and Coding	1-877-735-1326	www.dmepdac.com
National Supplier Clearinghouse	1-866-238-9652	www.palmettogba.com/nsc
Common Electronic Data Interchange Help Desk	1-866-311-9184	www.ngscedi.com
Centers for Medicare & Medicaid Services		www.cms.gov

1099 Information for 2011 Mailed for DME Jurisdiction D Suppliers

All 1099s for the Noridian Administrative Services DME Jurisdiction D were mailed January 30, 2012. To streamline the process, NAS has consolidated the 1099s for each Tax Identification Number (TIN) within a single mailing to ensure proper receipt. Previously, 1099s were generated and sent to the payee address received from the National Supplier Clearinghouse (NSC) which was also the same address used in sending Medicare payments and remittance advices.

The reporting requirements of the Internal Revenue Code, Section 6041A states that any service-recipient engaged in a trade or business that pays in the course of such trade or business during any calendar year remuneration for such services in the aggregate of **$600 or more**, must file an information return.

If you feel that the dollar amounts on the 1099 are incorrect, please contact the NAS Supplier Contact Center, (866) 243-7272, to report your concerns so we may further investigate.

If the address information or TIN listed on the 1099 form is incorrect, suppliers should work directly with the NSC, (866) 238-9652, http://www.palmettogba.com/nsc, in order to correct their DME supplier records.

2012 Supplier Contact Center and Telephone Reopenings Holiday and Training Closures

Supplier Contact Center

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

Event	Date	Closure Timeframe
Off-the-Phone Training	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

Event	Date	Closure Timeframe
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
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

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

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."

CMS.gov Website Upgrade Completed - Check Your Bookmarks

CMS has completed the upgrades to the http://www.cms.gov website. Bookmarked links to items posted in the "Downloads" sections on the CMS website have not been affected, but other bookmarked URLs are redirected to the index webpage for that topic. For example, if you bookmarked the page containing National Provider Calls and Events, you will be taken to the index page for National Provider Calls. On the index page, select the webpage you'd like to view from the left-hand side. Once you open the correct page, you can create a new bookmark. We appreciate your understanding and apologize for any inconvenience during this process.

Home Health:

http://www.cms.gov/Center/Provider-Type/Home-Health-Agency-HHA-Center.html

Hospice:

http://www.cms.gov/Center/Provider-Type/Hospice-Center.html

Customer Service Number Merging with IVR Number Effective 05/04/2012; (877) 320-0390

Effective May 4, 2012, suppliers will use a single telephone number, (877) 320-0390, to use the Interactive Voice Response (IVR) system and be connected with NAS DME Jurisdiction D Customer Service Representatives (CSRs). Information regarding this change is detailed within this article and should be shared with staff members who contact NAS Jurisdiction D with questions regarding Durable Medical Equipment, Prosthetics, Orthotics, and Supplies. By merging the phone numbers, the supplier authentication elements requested by the IVR will be transferred directly to the CSR at the time the call is transferred eliminating the need for suppliers to provide information already given. Suppliers will hear an informational message announcing the upcoming telephone number change when they call the CSR telephone number, (866) 243-7272, between April 3 and May 3, 2012. If the CSR telephone number is called after the May 4 transition date, the caller will be advised to disconnect and call the correct number, (877) 320-0390. This courtesy message is scheduled to occur for 60 days following the telephone number change.

To help facilitate calls, suppliers need to have the following information readily available prior to calling NAS for IVR inquiries and/or CSR inquiries:

- National Provider Identifier (NPI)
- Provider Transaction Access Number (PTAN)
- Last Five Digits of Tax Identification Number (TIN)
- Beneficiary Name (as it appears on the Medicare card)
  - Do not use nicknames (i.e. Liz instead of Elizabeth)
  - Provide all elements of a beneficiary name (i.e., Jr., Sr.)
- Beneficiary Medicare Health Insurance Claim Number (HICN)
- Beneficiary Date of Birth
- Date of Service

If an inquiry cannot be answered using options available on the IVR, suppliers may opt to connect with a CSR. Use of the IVR or similar self-service tool (i.e., NAS' portal, Endeavor) is mandated for certain inquiries; eligibility, same/similar equipment, and claim status. If a caller elects not to use the IVR for mandated self-service inquiries, the NAS CSR is required to refer the caller back to the IVR to obtain the requested information. The CSR may use this as an educational opportunity and conference the caller with the IVR to demonstrate proper use of the IVR features. Additional information regarding the mandated use of self-service tools is available in the CMS Internet Only Manual, Publication 100-09, Medicare Contractor Beneficiary and Provider Communications Manual, Chapter 6, Section 50.1.

Helpful IVR Tips

- Call from a quiet environment
- Be sure to have your supplier information immediately available; including PTAN, NPI, last five digits of the Tax Identification Number
- Speak clearly and naturally into the telephone

- Bypass the upfront messaging by saying "Main Menu" or pressing the # key on the telephone keypad or if you know the option you would like, speak or key it at any time during the upfront message
- Selections may be keyed or spoken without waiting for the entire prompt to play
- Say "Main Menu" at any time to go back to the beginning of the call flow
- If the IVR is having difficulty with the information as spoken, key the information with the telephone keypad
- Enter the full Medicare Health Insurance Claim Number including alpha character(s)
- When speaking the date use the full format, for example, say "July fifth, two thousand ten."
- In order to obtain accurate information, some Medicare numbers require you to verify the suffix each time, such as "B as in Boy," "D as in Dog," or "T as in Tom." To eliminate repetition, include this information when giving the Medicare number - "123456789B as in Boy"

The Customer Service Representatives continue to be available 8:30 a.m. to 6 p.m. CT. The IVR is available between the hours of 6 a.m. and 8 p.m. CT. Eligibility inquiries can be made 24 hours a day, seven days a week (excluding CMS scheduled maintenance dates).

Delayed Paperwork Implementation

The Centers for Medicare & Medicaid Services (CMS) is delaying the implementation date of the PWK (Paperwork) Segment. The PWK was due to be implemented on April 1, 2012, via Change Requests 7041, 7306, and 7330. The delay is being initiated in order to address system concerns and impacts raised by Medicare Administrative Contractors (MACs). MACs will continue to work through their user acceptance testing of the PWK while the concerns and impacts are addressed. CMS will communicate the revised implementation date once determined.

IVR and Endeavor Saturday Availability 2012 Dates

A listing of Saturdays in which suppliers and their staff can use the NAS DME Jurisdiction D Interactive Voice Response (IVR) and the NAS supplier portal, Endeavor, is provided within this article. The Saturday hours of availability are 7 a.m. until 3 p.m. Central Time. There are infrequent occasions in which the CMS contracted system maintainer requires the claims processing system to be unavailable for routine maintenance, quarterly system releases, and other enhancements.

- April 14, 21, and 28
- May 5, 12, 19, and 26
- June 2, 9, 16, 23, and 30
- July 14, 21, and 28 (Note: System not available July 7)
- August 4, 11, 18, and 25
- September 1, 8, 15, 22, and 29
- October 13, 20, and 27 (Note: System not available October 6)
- November 3, 10, 17, and 24
- December 1, 8, 15, and 22 (Note: System not available December 29)

NAS appreciates our supplier community and their use of the self service tools offered to assist with Medicare claim submission. Although the claims processing system hours of availability are not determined or administered by NAS, our goal is to inform the supplier community of the additional dates/times of availability.

Medicare Redesigns Claims and Benefits Statement

As part of National Consumer Protection Week, the CMS Acting Administrator, Marilyn Tavenner, announced the redesign of the statement that informs Medicare beneficiaries about their claims for Medicare services and benefits. The redesigned statement, known as the Medicare Summary Notice (MSN), will be available online and, starting in 2013, mailed out quarterly to beneficiaries.

This MSN redesign is part of a new initiative – "Your Medicare Information: Clearer, Simpler, At Your Fingertips" – which aims to make Medicare information clearer, more accessible, and easier for beneficiaries and their caregivers to understand. CMS will take additional actions this year to make information about benefits, providers, and claims more accessible and easier to understand for seniors and people with disabilities who have Medicare. This MSN redesign reflects more than 18 months of research and feedback from beneficiaries to provide enhanced customer service and respond to suggestions and input.

To see a side-by-side comparison of the former and redesigned MSNs, please visit http://www.CMS.gov/apps/files/msn_changes.pdf.

Starting later this week, the redesigned MSN will be available to beneficiaries on www.MyMedicare.gov, Medicare's secure online service for personalized information regarding Medicare benefits and services; in early 2013, paper copies of the redesigned MSN will start to replace the current version being mailed.

The full text of this excerpted CMS press release (issued Wed Mar 7) can be found at http://www.CMS.gov/apps/media/press/release.asp?Counter=4298.

MLN Updates

Oxygen Therapy Supplies: Complying with Documentation & Coverage Requirements" Fact Sheet Revised

The "Oxygen Therapy Supplies: Complying with Documentation & Coverage Requirements" fact sheet (ICN 904883) has been revised and is now available in downloadable format. This fact sheet is designed to provide education on common Comprehensive Error Rate Testing (CERT) Program errors related to oxygen therapy, and includes a checklist of the documentation needed to support a claim submitted to Medicare for oxygen therapy supplies.

New Fast Fact on MLN Provider Compliance Webpage

A new fast fact is now available on the MLN Provider Compliance webpage. This webpage provides the latest Medicare Learning Network products designed to help Medicare Fee-For-Service providers understand – and avoid – common billing errors and other improper activities. Please bookmark this page and check back often as a new fast fact is added each month!

"Updating Beneficiary Information with Coordination of Benefits Contractor" MLN Matters Article Released

MLN Matters Special Edition Article #SE1205, "Updating Beneficiary Information with the Coordination of Benefits Contractor," has been released and is available in downloadable format. This article is designed to provide education on initiatives that CMS and the Coordination of Benefits Contractor (COBC) are undertaking to maintain accurate beneficiary Medicare Secondary Payer (MSP) information on Medicare's Common Working File (CWF). It includes information that providers can use to understand how these initiatives will affect how they report beneficiary information to the COBC.

MLN Matters Articles Search Tips

Looking for the latest new and revised MLN Matters® articles? The Medicare Learning Network® offers several ways to search and quickly find articles of interest to you:

- *MLN Matters Search Engine* – An advanced search feature that allows you to search MLN Matters articles from 2004 to the current year. For more information and introductions on how to use the search engine, visit the MLN Matters Search Tips webpage at http://www.CMS.gov/MLNMattersArticles/02_Search.asp.
- *MLN Matters Index* – A list of common keywords and phrases contained within MLN Matters articles. Each index is organized by year with the ability to search by specific keywords and topics. Most indices link directly to the related article(s). For a list of available indices, visit http://www.CMS.gov/MLNMattersArticles/01_Overview.asp and scroll to the 'Downloads' section of the page.

- *MLN Matters Dynamic Lists* – An archive of previous and current articles organized by year with the ability to search by keyword, transmittal number, subject, article number, and release date. To view and search articles, select the desired year from the left column on the MLN Matters Article webpage at http://www.CMS.gov/MLNMattersArticles.
- *MLN Matters Electronic Mailing List* – A free notification of new and revised MLN Matters articles as they are released. For more information, including how to subscribe to the service, visit http://www.CMS.gov/MLNMattersArticles/downloads/What_Is_MLNMatters.pdf. You can also view and search an archive of previous messages at http://list.nih.gov/cgi-bin/wa.exe?A0=MLNMATTERS-L.

"Role of the Zone Program Integrity Contractors, Formerly the Program Safeguard Contractors" MLN Matters Article Released

MLN Matters Special Edition Article #SE1204, "The Role of the Zone Program Integrity Contractors (ZPICs), Formerly the Program Safeguard Contractors (PSCs)," has been released in downloadable format. This article is designed to provide education on the roles and responsibilities of the ZPICs, and includes an overview of the various program integrity functions that ZPICs perform and each of their seven designated zones.

February 2012 Version of Medicare Learning Network Products Catalog Now Available

The February 2012 version of the MLN Products Catalog is now available. The MLN Products Catalog is a free interactive downloadable document that links you to online versions of MLN products or the product ordering page for hardcopy materials. Once you have opened the catalog, you may either click on the title of an individual product or on "Formats Available." The catalog can be found at http://www.CMS.gov/MLNProducts/downloads/MLNCatalog.pdf.

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.

Redesigned Medicare Summary Notices

MLN Matters® Number: SE1218

Provider Types Affected

This MLN Matters® Special Edition Article is informational in nature and is intended for all providers who provide Medicare-covered services in the Medicare Fee-For-Service (FFS) program.

Background

The Centers for Medicare & Medicaid Services (CMS) has announced the redesign of the statement that informs Medicare beneficiaries about their claims for Medicare benefits.

What You Need to Know

CMS will make the redesigned statement, known as the Medicare Summary Notice (MSN), available online. Starting in 2013, CMS will mail the MSN to beneficiaries quarterly.

The MSN redesign is part of a new initiative, "Your Medicare Information: Clearer, Simpler, At Your Fingertips". This initiative aims to make Medicare information clearer, more accessible, and easier for beneficiaries and their caregivers to understand.

CMS will take additional actions this year to make information about benefits, providers, and claims more accessible and easier to understand for people who have Medicare. This MSN redesign reflects more than 18 months of research and feedback from beneficiaries to provide enhanced customer service and respond to suggestions and input.

Features of the Redesigned MSN

The redesign of the MSN includes several features that are not available in the current MSN, including:

- A clear notice on how to check the form for important facts and potential fraud;
- An easy-to-understand snapshot of: o The beneficiary's deductible status,
  - A list of the providers they saw, and
  - Whether Medicare approved their claims;
- Clearer language, including consumer-friendly descriptions for medical procedures;
- Definitions of all the column headers present in the form;
- Larger fonts to make it easier to read; and
- Information on preventive services available to Medicare beneficiaries.

For More Information

The redesigned MSN is available on www.mymedicare.gov, which is Medicare's secure online service for personalized information regarding Medicare benefits and services.

To see a side-by-side comparison of the former and redesigned MSNs, please visit http://www.cms.gov/apps/files/msn_changes.pdf on the CMS website.

To view the CMS press release on the MSN redesign, please visit: http://www.CMS.gov/apps/media/press/release.asp?Counter=4298 on the CMS website.

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
Appendix	Resources	Updated Supplier Contact Center phone number to 1-877-320-0390	05/04/12
Appendix	Contacting NAS and Inquiries	Updated Supplier Contact Center phone number to 1-877-320-0390	05/04/12
14	Reporting Fraud and Abuse	Updated Supplier Contact Center phone number to 1-877-320-0390	05/04/12
13	Reconsiderations	Replaced CMS 20033 Reconsideration form with NAS Reconsideration form	04/12/12
Appendix	Freedom of Information Act	Added more information	04/10/12

Updating Beneficiary Information with Coordination of Benefits Contractor

MLN Matters® Number: SE1205

Provider Types Affected

This MLN Matters® Special Edition Article is intended for physicians, other providers, and suppliers who provide products or services to Medicare beneficiaries with insurance in addition to Medicare.

Provider Action Needed

A new Medicare Secondary Payer (MSP) initiative will affect how you may update beneficiary information to the Coordination of Benefits Contractor (COBC).

This article describes initiatives that both the Centers for Medicare & Medicaid Services (CMS) and the COBC are undertaking to maintain the most up-to-date and accurate beneficiary MSP information on Medicare's Common Working File (CWF).

Background

There has been considerable discussion about the accuracy of beneficiary Medicare Secondary Payer (MSP) information on the CWF and who is responsible for keeping that information updated. Further, providers have stated that the update is not accepted when they attempt to update beneficiary information with the COBC by phone.

Therefore (as noted below), CMS and the COBC are both undertaking initiatives to resolve the issue and maintain the most up-to-date and accurate beneficiary information with regard to MSP.

CMS Initiatives

In compliance with Section 111 of the Medicare, Medicaid and State Children's Health Insurance Program (SCHIP) Extension Act of 2007 (known as Section 111 of the MMSEA), CMS has implemented a process through which private insurers (both Group Health Plans (GHP) and Non Group Health Plans (NGHP)) submit coverage information to the COBC when they also provide coverage to a Medicare beneficiary. A private GHP insurer reporting under Section 111 is known as a Responsible Reporting Entity (RRE), and the COBC receives Section 111 data input files from approximately 1,500 GHP insurers, and each file can include large numbers of individual coverage records.

This information permits CMS to more accurately determine who (either the private insurer or Medicare) has primary, or secondary, claims coverage responsibility.

Occasionally, information submitted to the COBC from any number of sources, including GHP RREs, service providers, and beneficiaries themselves can conflict with MSP information previously reported to the COBC. To reduce such conflicts in the future, CMS has developed and implemented a data management "Reporting Hierarchy" process, which the COBC administers (effective April 1, 2011). An explanation of the Hierarchy rules can be found at http://www.cms.gov/MandatoryInsRep/Downloads/GHpHierarchy.pdf on the CMS website.

COBC Initiatives

The COBC works closely with GHP RREs and other reporters in order to reduce "hierarchy" conflicts in future reporting. The following steps are in place to help providers update MSP records:

- **Provider attempting update with the beneficiary in the office**: The first time a call is made to update the record after April 4, 2011, it will be updated via the telephone call. For any subsequent calls made to update the record after April 4 2011, no update will be made on the call, but two options are available: 1) Proof of information can be faxed or mailed on the insurer or employer's company letterhead, and the update will be made in 10-15 business days; or 2) You can contact the insurer or employer organization that last updated the record.
- **Provider attempting update when the beneficiary is not in the office**: No update will be made from a telephone call. The provider has 3 options to have the record updated: 1) Have the Beneficiary contact COBC; 2) Contact the Beneficiary's insurer to resolve the issue; or 3) Fax or mail proof of information on the insurer or employer's company letterhead and the update will be made in 10-15 business days.
- **Provider with new information**: The COBC will take new information for a Beneficiary, but if the new information requires changes to an existing record, two options are available: 1) The Beneficiary will need to call to close out the record; or 2) Fax or mail proof of information on the insurer or employer's company letterhead and the update will be made in 10-15 business days.
- **Provider update for deceased beneficiary**: A SINGLE update can be made by ONE provider for a Deceased Beneficiary, once the date of death has been confirmed. Any subsequent updates would need to be handled by a family member with the appropriate documentation, including a death certificate.

Additional Information

An explanation of the GHP RRE Hierarchy rules can be found at http://www.cms.gov/MandatoryInsRep/Downloads/GHpHierarchy.pdf on the CMS website.

General information about Mandatory Insurer Reporting is available at http://www.cms.gov/mandatoryinsrep on the CMS website.

The COBC's contact information is:

Telephone: 1-800-999-1118 (8 AM to 8 PM Eastern Time)

Fax: 1-734-957-9598 (address the fax to Medicare Coordination of Benefits)

Mailing address:
Medicare –Coordination of Benefits
P.O. Box 33847
Detroit, MI 48232

APPEALS

Appealing a Refund Request

NAS, the Jurisdiction D Durable Medical Equipment Medicare Administrative Contractor (DME MAC) would like to remind suppliers of the importance of providing correct information when submitting requests for redetermination. Recently, NAS has seen an increase in the number of redeterminations being requested on overpayments where suppliers have not provided correct information (i.e., claim control number, refund request document control number, etc.).

When inaccurate information is provided when requesting a redetermination, this results in a delay in the processing of the request and could potentially result in an incorrect redetermination decision. Therefore, suppliers should always include a copy of the overpayment recovery letter when appealing a refund request.

Suppliers are reminded that the four DME MACs have developed a DME MAC redetermination request form, checklist, and DME MAC redetermination completion guide to assist with the proper completion of a redetermination request and determining whether appeal rights exist.

Appeals Ask the Contractor Teleconference Q&A – January 26, 2012

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

Change in Call Center Hours of Availability

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

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.

Electronic Remittance Advice Benefits

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

CMS also provides free software, Medicare Remit Easy Print (MREP), to download and print electronic remittance advices.

Reopening Updates and Unprocessable Claim Denials

Prior to calling Telephone Reopenings, please check your remittance advice for remittance message MA130. Claims with message MA130 are considered unprocessable and may not be reopened. For these, the claim should be corrected and resubmitted as a new claim.

Redetermination Request Form Completion

To ensure the most accurate and timely processing of your redetermination requests, we recommend that all requests be submitted using the Medicare DME Redetermination Request Form that is located under the Appeals tab on our website. The Appeals tab also includes a Redetermination Request Form Completion Guide to assist you in filling out the form in its entirety. Remember to include the requestor's signature on all requests as well as all relevant documentation and medical records. NAS has 60 days from the date the request is received to issue the decision.

Reconsideration Requests Transition to New Contractor

NAS is currently using both Qualified Independent Contractors (QIC) while we transition from RiverTrust Solutions to C2C Solutions. NAS encourages suppliers to be very thorough in completing the reconsideration request. Please include the supplier number, date(s) of service, claim control number(s) and correct health insurance claim numbers, when filling out your request.

Administrative Law Judge Questions

Please use the email address hearings@noridian.com for any Administrative Law Judge (ALJ) specific questions. Please do not send any Protected Health Information (PHI) through email, but note that the ALJ case number is not considered PHI. Also, contact information may be included in the email, and the ALJ department will be happy to answer your questions.

Questions Received Prior to ACT

Q: Some suppliers have several reconsiderations that were sent to RiverTrust in June and July of 2011 for which a decision has not been issued. Can the suppliers send those reconsiderations to the new contractor, C2C?
A: All reconsideration requests sent to RiverTrust prior to November 15, 2011, will be completed by RiverTrust. To check on the status of a reconsideration request, suppliers should go to https://www.q2a.com. If a decision has been made, suppliers can exercise their appeal rights by appealing the decision to the ALJ. Suppliers that have received an Escalation Option Notice (EON) letter can escalate their case to the ALJ by sending a written request to the QIC that issued the EON. More information can be found at http://www.rivertrustsolutions.com/faq.

Q: A supplier has been waiting for a reconsideration decision from RiverTrust Solutions that was to have been made by November 1, 2011. They have tried to check on the status with RiverTrust several times with no success. The supplier is concerned because they do not want any other claims for this patient to go past timely filing limits due to the reconsideration decision. What do they do?
A: C2C Solutions has provided the following instructions for checking on reconsideration requests:

- To check on status of an appeal, suppliers should go to https://www.q2a.com.
- If a decision has been made, suppliers need to exercise their appeal rights via the ALJ.
- If a supplier has received an Escalation Option Notice (EON), they have the right to escalate their case to the ALJ by sending a request in writing to the QIC that issued the EON.
- If a supplier seeks a reopening (wrong Medicare number, date of service or procedure code), they should submit the request in writing to the QIC that issued the decision.

Q: If a claim is denied due to a coding error (for example, the wrong HCPCS code was submitted), should a supplier call NAS Telephone Reopenings to change the HCPCS code, or do they have to send in a redetermination request?
A: HCPCS code changes are considered clerical errors that can be corrected by contacting Telephone Reopenings at 888-826-5708 or by submitting a written reopening request.

Q: When a supplier receives notification that a claim was selected for a prepay review and the information requested is not submitted in time, the claim is denied. When appealing the claim denial, what date should be used for filing the appeal? Is it the date on the prepay review letter or the date of the remittance advice denial?
A: If a supplier receives an additional documentation request or ADR letter and does not submit the requested documentation within 45 days, their claim will deny and can then be appealed. Suppliers have 120 days from the date on the remittance advice containing the claim denial to submit that redetermination request.

Q: What can a supplier do to be sure that the paperwork they send arrives at the department to which it was sent?
A: When sending in documentation requested in an ADR letter, the letter will specify to where the documentation should be faxed or mailed.

Q: When an audit or review is requested for a specific date of service and patients do not always see their physician every month, documentation will not always exist proving that the patient is using and benefiting from oxygen. If a supplier has documentation from six to twelve months prior to the date of service in question, since most patients are seen at least once a year, is this documentation substantial for an audit or review? If not, what is suggested to be a good business judgment?
A: From the Oxygen Local Coverage Determination (LCD) discussing continued need: "in addition to the documentation that justifies the initial provision of the items and/or supplies, there must be information in the beneficiary's medical record to support that the item continues to remain reasonable and necessary. Information used to justify this continued need must be timely for the date of service under review." To be considered timely, auditors generally look for supporting documentation in the medical record going back up to twelve months from the date of service. Other documentation can be considered on a case-by-case basis depending on the nature of the product or relevance of such documentation.

Q: A supplier has recently begun to see denials on oxygen audits and appeals because the physician's progress notes do not indicate that the patient is in a chronic stable state. The doctor indicates whether the patient is in a chronic stable state on the Certificate of Medical Necessity (CMN), and yet, if it is not also included in the progress notes, claims are being denied even when the progress notes do not document any acute or emergent non-chronic systems. What would be considered sufficient documentation in the progress notes to show the patient was in a chronic stable state when oxygen was ordered? Also, at what frequency must a patient visit their physician in order to document continued need?
A: A CMN alone is not sufficient documentation to support the medical necessity of the item. Per the Program Integrity Manual, there must be information in the patient's medical record that supports the medical necessity for the item and substantiates the answers on the CMN. Although NAS cannot say exactly what must be included, the medical records must support the chronic stable state. For the answer to the second question regarding continued need, NAS recommends that beneficiaries visit their doctor at least yearly.

Q: When submitting appeals, the supplier includes the prescription confirmation, delivery ticket and letter of medical necessity. These always seem to come back denied. What would the supplier need to do to get these paid?
A: In general, suppliers should submit any and all supporting medical records. That would include things like chart and progress notes, for example, along with the order and delivery ticket. And just to clarify, a letter of medical necessity is not a medical record. It is considered supplemental to the actual medical record.

Q: Where in the LCD does it state for how long a sleep study is good? Is it true that a sleep study should be no more than three months old in order to qualify a person for Continuous Positive Airway Pressure (CPAP) use? There are many reasons a person may have to delay therapy even though they have tested positive for Obstructive Sleep Apnea (OSA). Under what authority do audit contractors have to determine three months is the time limit patients have to initiate therapy? Also, if that position is maintained by CMS, does that mean they will pay for another sleep study if the patient decides to commence therapy at any point after the allotted 90 days?
A: The LCD does not specifically define how long a sleep study is valid. When reviewing documentation in an audit or appeal, NAS looks to see if the qualifying test was done within a reasonable time prior to the equipment being dispensed. The primary concern is ensuring the study and face-to-face evaluation most accurately represent the patient's current medical condition. NAS would have to look at each case individually to see if the medical records justify the delay in setup and if another sleep study is indeed not needed. As for whether Medicare will pay for another sleep study, that question would need to be posed to your Part B contractor.

Questions Asked During ACT

Q: Is it beneficial for the supplier to read and highlight pertinent information in the beneficiary's medical record prior to submitting the documentation to NAS with a redetermination request?
A: When NAS reviews medical record documentation sent with an appeal, we are responsible for reviewing all of the information provided, not just what is highlighted by the supplier.

Q: If a reconsideration request was previously sent to RiverTrust but no response has been received, can we just resend it to C2C?
A: Sending a reconsideration request to C2C that is already being worked on by RiverTrust will result in a duplicate request dismissal. Please follow the procedures outlined above to escalate a request if necessary.

Q: Regarding CPAP headgear, if the initial item ordered is no longer compatible, how can a supplier get paid for new headgear? How often can beneficiaries change masks?
A: The Positive Airway Pressure Device LCD defines how often CPAP supplies can be provided. For more information, see https://www.noridianmedicare.com/dme/coverage/docs/lcds/current_lcds/positive_airway_pressure_pap_devices_for_the_treatment_of_obstructive_sleep_apnea.htm. For claim specific questions, please call the Supplier Contact Center at 1-866-243-7272.

Q: For diabetic footwear, the statement of certifying physician (SCP) must be completed by an MD or DO. Can the clinical notes accompanying the SCP be completed by a nurse practitioner or physician assistant?
A: No, there must be information in the medical records of the certifying physician that:

a. Documents management of the patient's diabetes; and
b. Documents detailed information about the condition (2a-2f listed in the related Policy Article) that qualifies the patient for coverage.

Q: What is the process and required documentation required to appeal an item that is medically necessary but outside the guidelines set forth in the LCD and Policy Article (PA)? What would it take to get the LCD changed/updated in this type of situation?
A: When a beneficiary has a unique situation that does not fall within the LCD/PA guidelines, NAS seeks the advice of our medical director. If the supporting documentation confirms the unique circumstances to the point it warrants individual consideration, the medical director will review the medical documentation to determine if an exception can be made. These types of special scenarios are then considered by each DME MAC medical director to determine if the LCD and PA need to be revised (like they would if reviewing an LCD reconsideration request).

Q: How should a supplier respond to a Recovery Auditor request for proof of delivery if, for dates of service going back 4-5 years, the utilized shipping service no longer has records that old? The supplier's proof of delivery includes their reference number and the shipping service's tracking number but they can no longer obtain the actual record from the shipping service.
A: *A faxed example was requested but not received by NAS.* Supplier Standard #12 states: "A supplier is responsible for delivery and must instruct beneficiaries on use of Medicare covered items, and maintain proof of delivery." If utilizing a shipping or delivery service, the supplier must still get enough documentation to substantiate delivery to be in compliance with this standard. A tracking number alone is not sufficient to prove the beneficiary received the DMEPOS item(s). It is the supplier's responsibility (not the shipping service's) to get and retain the appropriate proof of delivery documentation for at least seven years.

Q: Are there edits in place preventing claims for Budesonide and Brovana from paying without having to go to Redeterminations when billing a three-month supply?
A: *A faxed example was requested but not received by NAS.* LCD L11488 states that only 62 units each of Budesonide and Arformoterol (Brovana) are allowed on a monthly basis. As long as these are being billed with the Q0514 (90-day dispensing fee), the proper number of units for a 90-day supply and a narrative indicating the claim is for a three month supply, these should be allowed. If a claim that meets these requirements still denies, it can be reopened. However, if the number of units is determined to be a true overutilization, the claim would need to be appealed with proper substantiating documentation for the extra units.

Q: When a beneficiary's situation falls outside the coverage criteria found in the LCD, can a supplier request that the LCD be updated or send a request to the medical director for determination before submitting a claim?
A: If a supplier believes the criteria defined in the LCD is outdated or does not align with current medically approved practices, there is an LCD reconsideration process available on our website at https://www.noridianmedicare.com/dme/coverage/reconsider_process.html. For a single, unique situation that falls outside the coverage criteria found in the LCD, the supplier would have to submit their claim and upon receiving a denial, appeal it to see if an exception can be made based on the special circumstances of that individual beneficiary (with supporting documentation).

Q: For ADRs, what is an acceptable timeframe before or after the date of service in question for supporting documentation to be dated?
A: As mentioned earlier, NAS looks for documentation within 12 months prior to the date of service in question but that can be expanded if an individual situation warrants it. It is always important to check the LCD or PA for more specific guidelines.

Q: When replacing oxygen equipment once the reasonable useful lifetime (RUL) has been met, is a chart note from the treating physician within 30 days of the new initial CMN required?
A: An evaluation within 30 days prior to the new initial CMN is not required when replacing oxygen equipment due to RUL but suppliers must have medical documentation to support the continued need and use of that equipment.

Q: How long is the sleep study valid and how close to the CPAP therapy start date must the sleep study be?
A: There are no specific guidelines in the LCD for how long a sleep study is valid. The sleep study just needs to be conducted within a reasonable time prior to the start of CPAP therapy. NAS recommends three months as a reasonable timeframe for the study to reflect an accurate representation of the beneficiary's current medical condition. However, in situations where the beneficiary has been on CPAP therapy for years and is getting replacement equipment after the reasonable useful lifetime (RUL) has been met, the original sleep study can still be used (but proof of continued use and continued need must be obtained).

Q: Are there limits or medically unlikely edits (MUEs) regarding how much enteral formula (B4150, B4154) is covered by Medicare as reasonable and necessary for a beneficiary?
A: Medicare will cover what the physician deems reasonable and necessary for a beneficiary based on the DME Information Form (DIF) and supporting medical documentation. If a properly completed DIF is on file and a claim still gets denied, it may need to go through the appeals process to justify the number of calories prescribed.

Q: To prove the continued use of enteral formula in the case of an ADR, will documentation dated after the date of service in question be accepted?
A: *A faxed example was requested but not received by NAS.* The documentation supporting continued use should be in place prior to the service being provided. These need to be looked at on a case-by-case basis if any exceptions are to be made.

Q: If a claim is submitted for an E0784 (External ambulatory infusion pump, insulin) with the required DIF and pays, do we need to resend the DIF if a subsequent month's rental denies?
A: *A faxed example was requested but not received by NAS.* Generally, the DIF does not need to be resent. However, while NAS may have a DIF on file for a particular item, it is recommended suppliers always send all supporting documentation with each redetermination request even if the same information has already been submitted with a previous claim or appeal. A common problem with DIFs is that a shortened length of need is notated on the document when it is submitted electronically. This shortened length of need does not affect all dates of service but can cause later months to deny.

Q: What is the process for requesting a change to an existing LCD?
A: More information on the LCD Reconsideration Process can be found on our website at https://www.noridianmedicare.com/dme/coverage/reconsider_process.html.

Q: The Internet Only Manual (IOM) contains specific caloric guidelines for enteral nutrition where additional documentation may be needed to support a claim. Why is that same information not found in the LCD so suppliers can access everything all in one place?
A: Information found in the IOM is developed and published by CMS while all language in the LCD is created by all four DME MACs as determinations of medical necessity. CMS has specific guidelines and limitations for including information from the IOM in the LCDs. Any information from the IOM must be referenced in such a way that it is not interpreted as being the contractor's policy either by being in quotes or by referencing the specific chapter and section of the IOM. Any concerns with the content of the LCDs can be addressed through the LCD Reconsideration Process mentioned above.

Q: What is the proper way to bill the K0822 (single power wheelchair) and cushions when the doctor orders a higher level cushion than what normally comes with the base equipment and the beneficiary does not have a qualifying diagnosis for that higher level cushion?
A: *A faxed example was requested but not received by NAS.* In this circumstance, when the coverage criteria for special skin protection or position needs are not met, a power wheelchair with Captain's Chair (K0823) provides appropriate support. The K0822 and specialty cushion will deny as not reasonable and necessary. A properly executed ABN is recommended to protect the supplier from liability when billing the K0822 and cushions in this situation.

Q: Why do some requests to change the place of service on a claim get denied by Reopenings as being too complex and need to go to Redeterminations? Are place of service changes not considered clerical errors? The specific example for this question is E2402 (Negative pressure wound therapy pump).
A: It is left to each DME MAC's discretion to determine what can and cannot be reopened. In general, HCPCS codes that normally require additional documentation or medical review cannot be reopened, regardless of the reason.

Although Reopenings can usually change a place of service on a claim, certain HCPCS codes (including E2402) are deemed too complex to be handled as a reopening. For more information on what can and cannot be completed as a reopening, see https://www.noridianmedicare.com/dme/appeals/what_can_cannot_be_requested.html.

Q: A patient has a workers' compensation record on file from 2007 that is interfering with a new claim for a power wheelchair. The Medicare Coordination of Benefits department has instructed that any new claims would only be denied if related to that workers' compensation record. If it is unrelated, how can a supplier get this resolved and their claim paid?
A: For Medicare Secondary Payer (MSP) issues, the diagnoses on the new claim cannot be related to any diagnosis listed with the other insurance. In a case like this, if the other insurance is entirely unrelated, a request should be sent to the MSP department with any documentation supporting that fact. More information on MSP, including a link to the appropriate form, can be found at https://www.noridianmedicare.com/dme/claims/msp.html.

Q: Does a DIF expire?
A: A DIF is only valid for the length of need listed on the document or on the corresponding order. If the length of need for a particular service is limited on the DIF or order, then it is only valid for that limited timeframe and would expire at end of that defined time. Questions regarding specific claims should be directed to the Supplier Contact Center at 1-866-243-7272.

Q: For a mail order pharmacy, the date of service should be the date of shipment. What does a supplier do if, the day they ship an order, the beneficiary happens to be in the hospital or in a skilled nursing facility (SNF)? Can the date of service be changed to the date of discharge?
A: It is required that a supplier must contact the beneficiary prior to shipping a refill. Since the date of service must be the date of shipment, it is important to verify the beneficiary is at home prior to shipping the order (this contact should be documented and retained in the supplier's files). The only time a supplier can deliver to the beneficiary's home while they are in the hospital or SNF is if delivery is being made within two days in anticipation of discharge.

Q: How can a supplier avoid appealing claims for manually priced items through the ALJ level in situations where they respond to an ADR but the claim denies for missing documentation and then the same thing happens at the redetermination and reconsideration levels as well? In these situations, the required documents have sometimes been there from the beginning.
A: *A faxed example was requested but not received by NAS.* Claims go through three separate, independent reviews prior to reaching the ALJ level. At each level, all of the documentation received to date is reviewed. It is NAS' view that any oversights in this process are isolated incidents. NAS recommends suppliers thoroughly document manually priced items and submit such documentation at each level if necessary.

Q: When a claim has been denied by NAS on initial submission but has later been approved as medically necessary upon appeal at either the redetermination or reconsideration level, how is it possible for the Comprehensive Error Rate Testing (CERT) contractor to select the same claim for review? The CERT contractor is sent the exact same documentation that was provided at the redetermination and reconsideration levels; however, the CERT contractor denies the claim stating our documentation is insufficient. We should not have to prove medical necessity again.
A: *A faxed example was requested but not received by NAS.* The CERT contractor has notified NAS that an exclusion policy exists that specifically excludes claims from being selected when an appeal determination has been completed (effectuated) for that claim prior to the CERT processing date. The CERT contractor is permitted to select a claim that may be for a subsequent rental month than the original claim that was appealed. Medical necessity may be initially met; however, the requirement of continued need (continued medical necessity) must still occur. The NAS "Dear Physician" letter available on the NAS website at https://www.noridianmedicare.com/dme/coverage/resources/continued_med_nec.pdf, states, "Ongoing need for and use of the item must be documented in your patient's record in order for Medicare to continue reimbursement for the equipment or supplies." In the event suppliers notice a CERT request for a claim that has received a finalized appeal, they are encouraged to respond to the CERT contractor's request with the documentation (i.e., remittance advice or letter from redeterminations or reconsiderations) that clearly indicates the claim selected for CERT review has received a finalized appeal. Any discrepancies in this review process should be brought to NAS' attention for further research.

Q: Why would oxygen contents get denied once the supplier received payment for 36 rentals of the concentrator? The specific error message being received states the base equipment is not capped yet. Do suppliers need to add a narrative on the first claim for contents stating the equipment is capped?
A: *A faxed example was requested but not received by NAS.* Our system keeps track of the rentals and will automatically cap the CMN for the oxygen concentrator after 36 paid rentals so no narrative would be needed.

However, as a general rule, it could be a timing issue between the last rental paying and the first contents claim being received. It is a good idea to avoid billing for contents until after payment for the last rental is received. Another common problem occurs when a previously paid rental is recouped (often due to an inpatient or skilled nursing stay) after the CMN already capped which could prevent future contents claims from paying. It is a good practice to check the IVR (1-877-320-0390) to verify all 36 rentals have paid prior to submitting claims for contents.

Q: For ostomy and urology supplies (specifically A4351, A4358 and A4353) billed over the limits allowed in the LCD, what is required at the redetermination level to get these claims paid? (Supplier indicated they fax to appeals the medical documentation, letter of medical necessity, order and delivery ticket.)
A: Two examples of QIC denial letters were received and in both cases, the initial denial was correctly upheld at the reconsideration level for missing or incomplete documentation. For ostomy supplies, a valid written order, medical notes, proof of refill request (if applicable) and proof of delivery must be submitted with an appeal. A letter of medical necessity is not considered part of the medical record and will not be given weight in the review process. In addition, for all supplies being requested above Medicare's normal allowance, a clear statement from the physician is required stating how many units are needed along with a valid reason for the overutilization.

*General appeals processing questions can be sent to dmeredeterminations@noridian.com and will be answered by DME appeals staff within two business days. Please note that confidential information cannot be e-mailed. The Centers for Medicare & Medicaid Services (CMS) state that Protected Health Information (PHI), such as patient names, claim information, Health Insurance Claim (HIC) numbers, Social Security numbers, Claim Control numbers (CCNs) or supplier numbers cannot be transmitted via e-mail. Therefore, NAS will not respond to any requests that contain PHI. If you have a question that contains PHI, please call our Supplier Contact Center at 1-866-243-7272.

Appeals Confirmation of Receipt

Previously NAS sent letters to acknowledge all redetermination requests submitted. **Beginning April 3, 2012**, NAS Jurisdiction D will no longer acknowledge redetermination requests via mail. Suppliers must now use Endeavor or the IVR to verify appeal receipt. To use this functionality in Endeavor you must be a registered user: https://www.noridianmedicare.com/dme/claims/endeavor.html.

Disclaimer: The DME MAC reserves the right to process a request as a reopening rather than a redetermination when the issue is a clerical error or omission, per the direction given by CMS in the Internet Only Manual 100-4, Chapter 29, Section 200(D).

An independent review will be performed based on the data in the case file. Redetermination decisions will be made within 60 days from the date of receipt.

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.

BILLING

2012 DMEPOS HCPCS Code Jurisdiction

MLN Matters® Number: MM7679
Related Change Request (CR) #: 7679
Related CR Release Date: March 23, 2012
Related CR Transmittal #: R2427CP
Effective Date: January 1, 2012
Implementation Date: April 23, 2012

Provider Types Affected

This MLN Matters® Article is intended for suppliers submitting claims to Medicare contractors (Durable Medical Equipment Medicare Administrative Contractors (DME MACs), Part B carriers, and A/B MACs) for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) services provided to Medicare beneficiaries are affected.

Provider Action Needed

This article is informational and based on Change Request (CR) 7679 that notifies suppliers that the spreadsheet containing an updated list of HCPCS codes for DME MAC, Part B carrier, or A/B MAC jurisdictions is updated annually to reflect codes that have been added or discontinued (deleted) each year. The spreadsheet is helpful to billing staffs by showing the appropriate Medicare contractor to be billed for HCPCS appearing on the spreadsheet. The spreadsheet for the 2012 Jurisdiction List is an Excel® spreadsheet and is available under the Coding Category at http://www.cms.gov/center/dme.asp on the Centers for Medicare & Medicaid Services (CMS) website.

Note that as part of the 2012 update, HCPCS codes L8511, L8512, L8513, L8514, and L8515 are changing claims processing jurisdiction from DME MAC to joint local carrier and DME MAC jurisdiction. To facilitate the jurisdiction change, carriers and A/B MACs will manually price claims for codes L8511 through L8515 with dates of service on or after January 1, 2012, using the 2012 DMEPOS fee schedule amounts found in Attachment B of CR7679.

Additional Information

The official instruction, CR7679, issued to your Medicare A/B MAC, carrier, and DME/MAC regarding this change may be viewed at http://www.cms.gov/Transmittals/downloads/R2427CP.pdf on the CMS website. The 2012 Jurisdiction List and Attachment B showing the 2012 DMEPOS fee schedule amounts for HCPCS codes L8511, L8512, L8513, L8514, and L8515 are attached to CR7679.

CARC, RARC, MREP, and PC Print Update

MLN Matters® Number: MM7775
Related Change Request (CR) #: CR 7775
Related CR Release Date: April 6, 2012
Related CR Transmittal #: R2442CP
Effective Date: July 1, 2012
Implementation Date: July 2, 2012

Provider Types Affected

This MLN Matters® Article is intended for physicians, providers, suppliers, and vendors representing physicians/providers/suppliers receiving remittance advice from 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) 7775 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) 7775 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 (CR 7683 Transmittal 2372 published on December 22, 2011). It also instructs Fiscal Intermediary Standard System (FISS) and VIPs Medicare System (VMS) to update PC Print and Medicare Remit Easy Print (MREP) software respectively. Be sure your billing staff is aware of these changes.

If you use the MREP or PC Print software, be sure to download the updated software when available. See the Background and Additional Information Sections of this article for further details regarding 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) and 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 and coordination of benefits transactions. For transaction 835 (Health Care Claim Payment/Advice) and standard paper remittance advice, valid CARCs and RARCs must be used to report payment adjustments, appeal rights, and related information. If there is any adjustment, the appropriate Group Code must be reported as well.

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 for Medicare.

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). 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 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 CR7775, Medicare contractors must implement on the date specified on the WPC website.

The discrepancy between the dates may arise because the WPC website is updated only 3 times a year and may not match the CMS release schedule.

CR7775 lists only the changes that have been approved since the last code update CR (CR 7683 Transmittal 2372), 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.

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

1. **All:** All codes including deactivated and to be deactivated codes are included in this listing.
2. **To Be Deactivated:** Only codes to be deactivated at a future date are included in this listing.
3. **Deactivated:** Only codes with prior deactivation effective date are included in this listing.
4. **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. 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 January, and must be implemented, if appropriate for Medicare, by July 2, 2012.

New Codes – CARC:

None

Modified Codes – CARC:

Code	Modified Narrative	Effective Date
109	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.	11/1/2012
239	Claim spans eligible and ineligible periods of coverage. Rebill separate claims.	11/1/2012

Deactivated Codes – CARC:

None

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. Medicare uses the standard code sets (CARC and RARC) for paper remittance advice as well.

New Codes – RARC:

Code	Code Narrative	Effective Date
N547	A refund request (Frequency Type Code 8) was processed previously.	3/6/2012
N548	Alert: Patient's calendar year deductible has been met.	3/6/2012
N549	Alert: Patient's calendar year out-of-pocket maximum has been met.	3/6/2012
N550	Alert: You have not responded to requests to revalidate your provider/supplier enrollment information. Your failure to revalidate your enrollment information will result in a payment hold in the near future.	3/6/2012
N551	Payment adjusted based on the Ambulatory Surgical Center (ASC) Quality Reporting Program.	3/6/2012
N552	Payment adjusted to reverse a previous withhold/bonus amount.	3/6/2012
N553	Payment adjusted based on a Low Income Subsidy (LIS) retroactive coverage or status change.	3/6/2012

Modified Codes – RARC:

Code	Modified Narrative	Effective Date
N4	Missing/Incomplete/Invalid prior Insurance Carrier(s) EOB.	3/6/2012
N206	The supporting documentation does not match the information sent on the claim.	3/6/2012

Deactivated Codes – RARC:

None

Additional Information

The official instruction, CR7775, issued to your carriers, DME MACs, FIs, A/B MACs, and RHHIs regarding this change may be viewed at http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2442CP.pdf release on the CMS website.

Claim Status Category and Claim Status Codes Update – Revised

MLN Matters® Number: MM7670 Revised
Related Change Request (CR) #: 7670
Related CR Release Date: December 22, 2011
Related CR Transmittal #: R2371CP
Effective Date: April 1, 2012
Implementation Date: April 2, 2012

Note: This article was revised on January 30, 2012, to correct the Web address in the beginning of page 2. All other information is the same.

Provider Types Affected

All physicians, providers and suppliers submitting claims to Medicare contractors (Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), carriers, A/B Medicare Administrative Contractors (MACs) and Durable Medical Equipment MACs or DME MACs) for Medicare beneficiaries are affected.

What Providers Need to Know

This article, based on Change Request (CR) 7670, explains that the Claim Status and Claim Status Category Codes for use by Medicare contractors with the Health Care Claim Status Request and Response ASC X12N 276/277 and the Health Care Claim Acknowledgement ASC X12N 277 were updated during the February 2012 meeting of the national Code Maintenance Committee and code changes approved at that meeting were posted at http://www.wpc-edi.com/content/view/180/223/ on or about March 1, 2011. Included in the code lists are specific details, including the date when a code was added, changed, or deleted. Medicare contractors will implement these changes on April 2, 2012. All providers should ensure that their billing staffs are aware of the updated codes and the timeframe for implementations.

Background

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

Additional Information

The official instruction, CR7670, issued to your Medicare contractors (FI, RHHI, A/B MAC, DME MAC and carrier) regarding this change, may be viewed at http://www.cms.gov/transmittals/downloads/R2371CP.pdf on the CMS website.

Claim Status Category and Claim Status Codes Update

MLN Matters® Number: MM7793
Related Change Request (CR) #: CR 7793
Related CR Release Date: March 30, 2012
Related CR Transmittal #: R2436CP
Effective Date: July 1, 2012
Implementation Date: July 2, 2012

Provider Types Affected

This MLN Matters® Article is intended for physicians, other providers, and suppliers who submit claims to Medicare contractors (carriers, Durable Medical Equipment Medicare Administrative Contractors (DME MACs), Fiscal Intermediaries (FIs), A/B Medicare Administrative Contractors (A/B MACs), and/or Regional Home Health Intermediaries (RHHIs)) for services provided to Medicare beneficiaries.

What You Need to Know

This article is based on Change Request (CR) 7793 which explains that the Health Insurance Portability and Accountability Act (HIPAA) requires all health care benefit payers to use only Claim Status Category Codes and Claim Status Codes approved by the national Code Maintenance Committee to report the status of submitted claim(s). Proprietary codes may not be used in the X12 276/277 to report claim status. The code sets are available at http://www.wpc-edi.com/content/view/180/223/ on the Internet. The code lists include the date when a code was added, changed, or deleted. All code changes approved during the June 2012 committee meeting will be posted on that site on or about July 1, 2012.

Background

HIPAA requires all health care benefit payers to use Claim Status Category Codes and Claim Status Codes to report the status of submitted claim(s). Only codes approved by the national Code Maintenance Committee in the X12 276/277 Health Care Claim Status Request and Response format are to be used. Proprietary codes may not be used in the X12 276/277 to report claim status.

The national Code Maintenance Committee meets at the beginning of each X12 trimester meeting (February, June, and October) and makes decisions about additions, modifications, and retirement of existing codes. The code sets are available at http://www.wpc-edi.com/content/view/180/223/ or http://www.wpc-edi.com/codes on the Internet. All code changes approved during the June 2012 committee meeting will be posted on that site on or about July 1, 2012. The code lists include specific details, including the date when a code was added, changed, or deleted. Your Medicare contractors must complete entry of all applicable code text changes and new codes, and terminated use of deactivated codes by July 2, 2012.

Additional Information

The official instruction, CR7793, issued to your carriers, DME MACs, FIs, A/B MACs, and RHHIs regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2436CP.pdf on the CMS website.

Clarification on Submission of the Correct "Amount Paid" on Assigned Claims – Item 29 of the CMS-1500 Claim Form or Electronic Equivalent

The following instructions apply to "Assigned" Claims Only.

Suppliers are reminded that Item 29 of the CMS-1500 Claim Form or the electronic equivalent is to be completed with the "total amount the patient paid on the covered services only." Any beneficiary payment amount collected for the specific covered items submitted on the claim, (i.e., coinsurance and deductible) should be reflected with the claim submission. Suppliers should not report any money collected on non-covered items, upgraded items, or items expected to be denied as not reasonable and necessary with an ABN on file. In the event Medicare is the secondary payer, suppliers should not report any primary insurance payments in the "Amount Paid" field.

Suppliers are encouraged to follow the instructions above to ensure the beneficiary's Medicare Summary Notice (MSN) reflects the proper payment due to the supplier and any Medicare payment over the total patient responsibility amount will be sent to the beneficiary.

The DME MACs remind suppliers, there is never any certainty if a deductible will or will not be applied to the claim in question. The deductible will be applied based on the first claim to complete processing and not necessarily the claim with the earliest "date of service" in the year. The information available through the eligibility systems is only as current as of the date received and not a guarantee the deductible will be applied to a specific claim. Therefore, suppliers are strongly encouraged to wait and collect the deductible after a claim has been finalized and included on the remittance advice.

Ensure Ordering/Referring Name Matches PECOS To Avoid Warning Messages

The purpose of this article is to ensure Item 17 of the CMS-1500 claim form contains the correct ordering/referring entity name. Medicare compares the NPI and the first letter of the first name and the first four letters of the last name of the ordering/referring provider as reported on the claim to that same information in PECOS. It is important to ensure the name is in the correct order, does not contain 'nicknames', and does not include credentials (i.e., "Dr.") when submitted. Failure to follow the following instructions will result in warning messages on the remittance advice which, upon direction from CMS, may result in claim denials in the future.

Per Change Request 6421, the Provider Enrollment and Change of Ownership System (PECOS) contains only the physicians and non-physician practitioners who have current enrollment records. If an exact match is not found, an informational remittance advice message appears on the remittance advice.

> 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.

Per Medlearn Matters Special Edition Article 1011, "Make sure your claims are properly completed. Do not use "nicknames" on the claim, as their use could cause the claim to fail the edits (e.g., Bob Jones instead of Robert Jones will cause the claim to fail the edit, as the edit will look for R, not B, as the first letter of the first name). Do not enter a credential (e.g., "Dr.") in a name field. On paper claims (CMS-1500), in item 17, you should enter the Ordering/ Referring Provider's first name first, and last name second (e.g., John Smith)."

CMS maintains a listing of NPIs, first names, and last names of ordering/referring providers with current enrollment in PECOS. The file is large but may be downloaded from the CMS Medicare provider/supplier enrollment website www.cms.hhs.gov/MedicareProviderSupEnroll. Select "OrderingReferringReport" on the left-hand side of the webpage. This file is periodically updated by CMS.

A listing of all PECOS edit related information has been consolidated and is available on the NAS website, https://www.noridianmedicare.com/dme/news/pecos.html. Instructions for CMS-1500 claim form completion is also available on our website, https://www.noridianmedicare.com/dme/claims/cms1500_08-05_instructions.html#17.

Guidance for Correct Claims Submission When Secondary Payers Are Involved

MLN Matters® Number: SE1217

Provider Types Affected

This MLN Matters® Special Edition (SE) Article is intended for providers, physicians, and suppliers who bill Medicare contractors (Part A/B Medicare Administrative Contractors (A/B MACs), Durable Medical Equipment Medicare Administrative Contractors (DME MACs), Fiscal Intermediaries (FIs), and carriers (hereafter referred to as Medicare contractors)) for services provided to Medicare beneficiaries.

Provider Action Needed

To ensure accurate claim submissions and timely payment, providers, physicians, and other suppliers should:

- Collect full beneficiary health insurance information upon each office visit, outpatient visit, and hospital admission.
- Identify the primary payer prior to submission of a claim, and bill the appropriate responsible payer for related services.
- Use specific and correct diagnosis codes, especially for accident related claims.

Remember: A properly filed claim prevents Medicare contractors from inappropriately denying claims and expedites the payment process.

Background

Collect full beneficiary health insurance information

It is the responsibility of all Medicare providers, physicians, and other suppliers to identify the correct primary payer by asking their patients or patients' representative questions concerning the beneficiary's Medicare Secondary Payer (MSP) status. The model hospital admissions questionnaire, published by the Centers for Medicare & Medicaid Services (CMS), may be used as a guide to collect this information from beneficiaries. This tool is available online in the "MSP Manual" in Chapter 3, Section 20.2.1 at http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/msp105c03.pdf on the CMS website. Physicians and other suppliers may also use this questionnaire to ensure MSP information is captured for use at the time of billing, so that the appropriate primary payer is billed before Medicare as required by law.

Identify and bill the correct primary payer

Medicare regulations require that all entities that bill Medicare for services or items rendered to Medicare beneficiaries must determine whether Medicare is the primary payer for those services or items before submitting a claim to Medicare. When another insurer is identified as the primary payer, bill that insurer first. After receiving the primary payer remittance advice, then bill Medicare as the secondary payer, if appropriate. If a patient is seen for multiple services, each service should be billed to the appropriate primary payer.

Accident Related Claims

If the beneficiary has an open MSP Liability (L), No-Fault (NF), or Workers' Compensation (WC) record, bill the L, NF, or WC insurer primary for accident-related claims first. DO NOT deny treatment.

To expedite processing and payment, the following steps should be followed:

1. Submit the accident related claim to the L, NF, or WC insurer first. If the insurer denies the claim, then bill Medicare for payment. It is important that you include all necessary MSP payment information, as found on the primary payer's remittance advice (e.g., claim adjustment reason code specifying reason for denial), on the claim sent to Medicare. If the L, NF, or WC insurer did not make payment for the accident related services, Medicare will need this information to process your claim accordingly. **If you follow these procedures, you do not need to wait 120 days to submit your claim to Medicare for payment.**
2. If the beneficiary has both a Group Health Plan (GHP) MSP coverage and L, NF, or WC coverage, you are required to submit a claim to the GHP insurer and the L, NF, or WC insurer before submitting the claim to Medicare. Once you receive the GHP remittance advice, include the GHP information along with the remittance advice information from the L, NF, and WC insurer with your claim to Medicare. If the claim is sent to Medicare without the GHP information, and there is an open GHP MSP record on file, Medicare will deny your claim.
3. In situations where there is no L, NF, or WC accident or injury, but the beneficiary has employer GHP coverage that is primary to Medicare, you must submit the claim to the GHP insurer first before submitting the claim to Medicare for secondary payment.

If you believe a claim was inappropriately denied:

- Ensure that you have submitted a correctly completed claim to the appropriate payer(s).
- Contact your Medicare contractor if you still have reason to believe a claim was denied inappropriately.
- You may need to provide information to your Medicare contractor that demonstrates why the claim was denied inappropriately. For example, a diagnosis code may have been mistakenly applied to the beneficiary's L, NF, or WC MSP record. Indicate to the Medicare contractor that the service performed is not related to the accident or injury, and Medicare should adjust and pay the claim if it is a Medicare covered and payable service.

Contact the Coordination of Benefit Contractor (COBC) at 1-800-999-1118 if a beneficiary's MSP record needs to be updated.

- The COBC collects, manages, and maintains other insurance coverage for Medicare beneficiaries.
- Providers, physicians, or other suppliers may request an update to an MSP record if they have the appropriate documentation to substantiate the change. The documentation may need to be faxed to the COBC at 734-957-9598, or the beneficiary may need to be on the line to validate the change.
- Please do not call the COBC to adjust claims or about mistaken payments. They will not be able to assist you.

Key Points

- Collect full beneficiary health insurance information upon each office visit, outpatient visit, and hospital admission.
- Identify the primary payer prior to submission of a claim, and bill the appropriate responsible payer(s) for related services.
- For multiple services, bill each responsible payer(s) separately. Do not combine unrelated services on the same claim to Medicare. Consequently, if you render treatment to a beneficiary for accident related services and non-accident related services, do not submit both sets of services on the same claim to Medicare. Send separate claims to Medicare: one claim for services related to the accident and another claim for services not related to the accident.
- Providers, physicians, and other suppliers should always use specific diagnosis codes related to the accident or injury. Doing so will promote accurate and timely payments.
- Providers should report directly to the COBC any changes to beneficiary, spouse and/or family member's employment, accident, illness, or injury, Federal program coverage changes, or any other insurance coverage information.

Additional Information

- Specific claim-based issues or questions (including claim processing) should be addressed to the Medicare claims processing contractor at their toll-free number found at http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip on the CMS Website.
- If you need to report new beneficiary coverage that may be primary to Medicare or have questions regarding MSP status or claims investigation activities, contact the COBC's toll-free lines. For more information on contacting the COBC or the Medicare Coordination of Benefits process, visit the Medicare Coordination of Benefits Web page at http://www.cms.hhs.gov/Medicare/Coordination-of-Benefits/COBGeneralInformation/index.html on the CMS website.
- The Medicare Learning Network (MLN) has a Medicare Secondary Payer Fact Sheet for Provider, Physician, and Other Supplier Billing Staff (ICN 006903) at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads//MSP_Fact_Sheet.pdf on the CMS website. This fact sheet is designed to provide education on the MSP provisions. It includes information on MSP basics, common situations when Medicare may pay first or second, Medicare conditional payments, and the role of the COBC.

Healthcare Provider Taxonomy Codes April 2012 Update

Health Insurance Portability and Accountability Act (HIPAA) requires that covered entities comply with the requirements in the electronic transaction format implementation guides adopted as national standards. The *X12 837 Professional Implementation Guide* used for durable medical equipment (DME) claims requires the use of valid codes contained in the Healthcare Provider Taxonomy Codes (HPTC) set when there is a need to report provider type or physician, practitioner, or supplier specialty for a claim.

The HPTC set is maintained by the National Uniform Claim Committee (NUCC) for standardized classification of health care providers. The NUCC updates the code set twice a year with changes effective April 1 and October 1.

Valid HPTCs are those codes approved by the NUCC for current use. Terminated codes are not approved for use after a specific date and newly approved codes are not approved for use prior to the effective date of the code set update in which each new code first appears. Although the NUCC generally posts their updates on the WPC Web page three months prior to the effective date, changes are not effective until April 1 or October 1 as indicated in each update. Specialty and/or provider type codes issued by any entity other than the NUCC are not valid and Medicare would be guilty of noncompliance with HIPAA if Medicare contractors accepted claims that contain invalid HPTCs.

The taxonomy code is not required for processing Medicare claims. However, if a taxonomy code is submitted, it must be valid according to the HPTC code set. The HPTC code set is named in the *X12 837 Professional Implementation Guide*, thus Common Electronic Data Interchange (CEDI) must validate the inbound taxonomy code.

The HPTC list is available from the Washington Publishing Company (WPC). To view the April 2012 changes, visit the WPC Website at: http://www.wpc-edi.com/codes/taxonomy.

Please contact the CEDI Help Desk at 866-311-9184 or by e-mail at ngs.cedihelpdesk@wellpoint.com if you have questions.

Modification to CWF, FISS, MCS and VMS to Return Submitted Information When There is a CWF Name and HIC Number Mismatch

MLN Matters® Number: MM7260
Related Change Request (CR) #: CR 7260
Related CR Release Date: April 26, 2012
Related CR Transmittal #: R2449CP
Effective Date: October 1, 2012
Implementation Date: October 1, 2012

Provider Types Affected

This MLN Matters® Article is intended all physicians, providers, and suppliers submitting claims to Medicare contractors (fiscal intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), carriers, A/B Medicare Administrative Contractors (MACs) and Durable Medical Equipment MACs or DME MACs) for Medicare beneficiaries.

Provider Action Needed

If Medicare systems reject a claim when the beneficiary name does not match the Health Insurance Claim Number (HICN), your Medicare contractor will return the claim to you as unprocessable with the identifying beneficiary information from the submitted claim as follows:

- Your contractor will return to provider (RTP) Part A claims.
- Your contractor will return as unprocessable Part B claims. Your contractor will use Reason Code 140 (Patient/ Insured health identification number and name do not match).

When returning these claims as unprocessable, your contractor will utilize remittance advice codes MA130 and MA61. Also, based on CR 7260, you will receive the beneficiary name information you originally submitted when the claim is returned rather than the beneficiary data associated with the potentially incorrectly entered HICN. Previously, Medicare returned the name of the beneficiary that is associated with that HICN within its files.

If an adjustment claim is received where the beneficiary's name does not match the submitted HICN, your contractor will suspend the claim and, upon their review, either correct, develop, or delete the adjustment, as appropriate.

All providers should ensure that their billing staffs are aware of these changes.

Additional Information

The official instruction, CR 7260 issued to your FI, A/B MAC, and DME/MAC regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2449CP.pdf on the Centers for Medicare & Medicaid Services (CMS) website.

New Physician Specialty Code for Sleep Medicine and Sports Medicine

MLN Matters® Number: MM7600
Related Change Request (CR) #: 7600
Related CR Release Date: April 27, 2012
Related CR Transmittal #: R2462CP and R209FM
Effective Date: April 1, 2012
Implementation Date: October 1, 2012

Provider Types Affected

This MLN Matters® Article is intended for physicians, non-physician practitioners, and suppliers who bill Medicare Carriers, Medicare Administrative Contractors (A/B MACs), or Durable Medical Equipment (DME) MACs for sleep medicine service and/or sports medicine services provided to Medicare beneficiaries.

Provider Action Needed

Effective April 2, 2012, you will need to use physician specialty code (C0) for sleep medicine services. In addition, claims submitted to DME MACs for sports medicine service should use the sleep medicine specialty code of 23.

You should make sure that your billing staffs are aware of this new specialty code for sleep medicine services.

Background

Medicare physician and non-physician practitioner specialty codes describe the specific or unique types of medical services that physicians and non-physician practitioners provide. While physicians self-designate their Medicare physician specialty on the Medicare enrollment application (CMS-855I) or Internet-based Provider Enrollment, Chain, and Ownership System (PECOS) when they enroll in the Medicare program, non-physician practitioners are assigned a Medicare specialty code when they enroll. The specialty code becomes associated with the claims submitted by physicians or non-physician practitioners. Medicare contractors also use specialty code data to develop claims processing edits.

New Specialty Code

CR 7600 announces that the Centers for Medicare & Medicaid Services (CMS) has established a new physician specialty code for Sleep Medicine. This new physician specialty code, which will be effective April 2, 2012, is C0. PECOS and your carrier or A/B MAC will recognize and use this new code as a valid primary and/or secondary specialty code for Sleep Medicine. Also, a new specialty code is established for sports medicine and that code is 23.

Additional Information

You can find more information about the new sleep medicine specialty code by going to CR7600, located at http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2462CP.pdf on the CMS website. A related transmittal that updates the "Medicare Financial Management Manual" is at http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R209FM.pdf on the CMS website.

Pharmacies - Date of Service is Date of Pickup for In-Store Orders

In response to an increase in pharmacy inquiries and claim processing observations, NAS is reminding pharmacy suppliers that the date of service is the physical date of delivery directly to the beneficiary or their authorized representative, the date the item was shipped if using a commercial delivery service, or the date of delivery to a nursing facility on behalf of the beneficiary. If the pharmacy delivers the product directly to the beneficiary in the store, the date the patient picks up the order is the date of service; which may occur one or more days after the order was placed. The records maintained by the pharmacy must support and prove the date of service was the date of delivery in this situation.

Proof of delivery documentation must be available to authorized Medicare contractors upon request. All services that do not have appropriate proof of delivery from the supplier will be denied and overpayments will be requested. Suppliers who consistently do not provide documentation to support the services may be referred to the Office of Inspector General (OIG) for imposition of Civil Monetary Penalties (CMPs) or Administrative Sanctions.

Additional information regarding proof of delivery and supplier documentation is available in the CMS Internet Only Manual, Publication 100-08, Medicare Program Integrity Manual, Chapter 5, Section 5.8, https://www.cms.gov/manuals/downloads/pim83c05.pdf.

Providers who Receive Error Codes H20203 and H45255 Need to Balance Bill

Providers who receive rejection codes H20203 and/or H45255 will need to balance bill their patients' supplemental payers for any balances left after Medicare. CMS deeply regrets that these error conditions have arisen.

On February 29, 2012, CMS alerted Medicare physicians/practitioners, providers, and suppliers to three edits that they may be seeing reflected on special provider notification letters that they receive from their local Fiscal Intermediary (FI), Carrier, A/B Medicare Administrative Contractor (MAC), or Durable Medical Equipment MAC (DME MAC). These edits had resulted, or are still resulting, from defects within our coordination of benefits (COB) *HIPAA* 837 compliance editing. The defects associated with the firing of edits H51108 and H20203 at the Coordination of Benefits Contractor (COBC) were resolved on January 16 and February 27, respectively. CMS has the following additional information updates to offer regarding edits H20203 and H45255:

- *H20203*: Element CLM16 is present though marked 'Not Used'
  - Update: Medicare was able to repair all affected 837 professional claims right after February 27, 2012. Unfortunately, due to more highly critical *HIPAA* 5010 fixes that were needed to the version 5010 837

institutional COB/crossover claims process, the Fiscal Intermediary Shared System (FISS) was unable to resend 837 institutional claims that incorrectly rejected with error code H20203. Fortunately, the overall volume of affected claims was determined to be very low. Providers that received rejection code H20203 on their provider notification letters issued from their FI or A/B MAC will need to balance bill their patients' supplemental payers for any balances left after Medicare.

- *H45255*: The Other Subscriber Primary Identifier (2330A NM109) Cannot be the same as the group or policy number (2320 SBR03)
  - Resolution: COBC's translation routine will scrub the duplicate identifier that is present in 2320 SBR03.
  - Updated confirmed fix date: May 18, 2012
  - Scope of Impact: The current problem seems to only be impacting *HIPAA* 5010A1 837 professional claims billed to Medicare by physicians/practitioners and DMEPOS suppliers. The error is principally impacting crossover claims that would have been transferred to North Dakota Medicaid. (*Note:* This is due to its reporting of the Medicare Health Insurance Claim Number (HICN) as the policy number for crossover claim purposes).
  - Update: Because certain Carriers, A/B MACs, and DME MACs have been holding generation of their provider notification letters tied to rejection code H45255 since February 2012, CMS has determined that a future claim repair action after May 18, 2012, would not be viable. Therefore, physicians/ practitioners and suppliers may be seeing error H45255 on their provider notification letters. If physicians/practitioner and supplier offices see this rejection code, they will need to balance bill their patients' supplemental payer for any balances remaining after Medicare.

Quarterly Update for HCPCS Codes Effective July 1, 2012

CMS 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/Medicare/Coding/HCPCSReleaseCodeSets/HCPCS_Quarterly_Update.html. Changes are effective on the date indicated on the update.

In response to shortage of liposomal doxorubicin (Doxil), the Food and Drug Administration is permitting the temporary importation of Lipodox, a brand of liposomal doxorubicin hydrochloride; visit http://www.FDA.gov/NewsEvents/Newsroom/PressAnnouncements/ucm292658.htm for additional information. The CMS HCPCS Quarterly Update includes two new codes (Q2048 and Q2049) for liposomal doxorubicin that will become effective Sun July 1. The code descriptors are worded in a manner that distinguishes Lipodox and Doxil. As of Sunday, July 1, HCPCS code J9001 will not be used for Medicare billing. CMS will release a Change Request (CR) with additional instructions in the near future.

CERT Documentation

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

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

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

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

Mail all requested documentation to:

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

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

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

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

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

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

COMPETITIVE BIDDING

Bidding Now Open for Round 2 and National Mail-Order Competitions of DMEPOS Competitive Bidding Program

The Centers for Medicare & Medicaid Services (CMS) is now soliciting bids for the Round 2 and national mail-order competitions of the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program.

All bids must be submitted in DBidS, the online bidding system, by 8:59:59 p.m. prevailing Eastern Time on March 30, 2012. All required hardcopy documents that must be included as part of the bid package must be RECEIVED by the Competitive Bidding Implementation Contractor (CBIC) on or before March 30, 2012. The contract period for the Round 2 and national mail-order competitions is July 1, 2013 – June 30, 2016.

All bidders must submit certain required hardcopy documents as specified in the Request for Bids (RFB) Instructions. CMS urges all bidders to take advantage of the covered document review process. Under this process, we will notify suppliers that submit their hardcopy financial documents by the covered document review date (CDRD) of any missing financial documents. The CDRD for the Round 2 and national mail-order competitions is February 29, 2012 – financial documents must be RECEIVED on or before February 29, 2012, to qualify for the covered document review process. This process only determines if there are any missing financial documents. It does not indicate if the documents are acceptable, accurate, or meet applicable requirements. Suppliers that submit financial documents by the CDRD will be notified of any missing financial documents within 90 days of the CDRD. Suppliers will be required to submit the missing financial document(s) within 10 business days of the notification.

Competitive bidding areas and product categories for the Round 2 and national mail order competitions, DBidS information, bid preparation worksheets, educational materials, and complete RFB instructions can be found on the CBIC website. Suppliers should review this information prior to submitting their bids. CMS will send important bidding updates via e-mail, so all suppliers interested in bidding are urged to sign up for e-mail updates on the CBIC website (at www.DMECompetitiveBid.com). If you have any questions about the bidding process, please contact the CBIC Customer Service Center at 1-877-577-5331.

The target registration dates for authorized officials (AOs) and backup authorized officials (BAOs) to register for a user ID and password in CMS' Individuals Authorized Access to the CMS Computer Services (IACS) system have passed. End users (EUs), as well as any AOs and BAOs who have not yet registered, should now be registering. Only suppliers that have registered in IACS and received a user ID and password will be able to access the online bidding system and submit bids. If the AO for your company has not already registered, we cannot guarantee that he or she will be able to complete the registration process before registration closes. If your AO does not register, you cannot bid and will not be eligible for a contract. In addition, suppliers whose AOs have not registered are at risk of experiencing delays in accessing the online bidding system to get a bidder number and thereby missing the opportunity to submit financial documents by the CDRD.

Registration will close on February 9, 2012, at 9 p.m. prevailing Eastern Time – no AOs, BAOs, or EUs can register after registration closes. Suppliers that do not register cannot bid and are not eligible for contracts.

Registration is typically a quick and easy process if you follow the step-by-step instructions in the "IACS Reference Guide" posted on the CBIC website. To register, visit the CBIC website and click on "REGISTRATION IS OPEN" above the Registration Clock on the homepage. You will also find a registration checklist and Quick Step guides on the CBIC website. Please note that suppliers with multiple locations typically must register only one Provider Transaction Access Number (PTAN) that will submit the bid for all locations. If you have any questions about the registration process, please contact the CBIC Customer Service Center.

To bid, visit the CBIC website and click on "BIDDING IS OPEN" above the clocks on the homepage.

Please note that the RFB instructions initially posted on the CBIC website contained target bid submission deadlines. CMS is in the process of updating these instructions to reflect the actual bid submission deadlines, which are shown in this announcement.

DMEPOS Competitive Bidding Round 1 Recompete Announced

CMS announced plans to recompete the supplier contracts awarded in the Round 1 Rebid of the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program. CMS is required by law to recompete contracts under the DMEPOS Competitive Bidding Program at least once every three years. The Round 1 Rebid contract period for all product categories, except mail order diabetic supplies expires on December 31, 2013. The Round 1 Recompete product categories are:

- Respiratory Equipment and Related Supplies and Accessories
  - Includes oxygen, oxygen equipment, and supplies; continuous positive airway pressure (CPAP) devices, respiratory assist devices (RADs), and related supplies and accessories; and standard nebulizers
- Standard Mobility Equipment and Related Accessories
  - Includes walkers, standard power and manual wheelchairs, scooters, and related accessories
- General Home Equipment and Related Supplies and Accessories
  - Includes hospital beds and related accessories, group 1 and 2 support surfaces, transcutaneous electrical nerve stimulation (TENS) devices, commode chairs, patient lifts, and seat lifts
- Enteral Nutrients, Equipment and Supplies
- Negative Pressure Wound Therapy Pumps and Related Supplies and Accessories
- External Infusion Pumps and Supplies

CMS is conducting the Round 1 Recompete in the same competitive bidding areas (CBAs) as the Round 1 Rebid.

A list of the specific items in each product category is available on the Competitive Bidding Implementation Contractor (CBIC) website. The specific ZIP codes in each Round 1 Recompete CBA are also available on the CBIC website.

To ensure that suppliers have ample time to prepare for the competition, CMS announced the following next steps for the program:

- Spring 2012
  - CMS begins pre-bidding supplier awareness program
- Summer 2012
  - CMS announces bidding schedule
  - CMS begins bidder education program
  - Bidder registration period to obtain user ID and password begins
- Fall 2012
  - Bidding begins

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

- Update your contact information: The following contact information in your enrollment file at the National Supplier Clearinghouse (NSC) must be up to date before you register to bid. If your file is not current, you may experience delays and/or be unable to register and bid. DMEPOS suppliers should review and update:
  - The name, Social Security number, and date of birth for all authorized official(s). If you have only one authorized official listed on your enrollment file, consider adding one or more authorized officials to help with registration and bidding; and
  - The correspondence address.

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

- Get licensed: Contracts are only awarded to suppliers that have all required state licenses at the time of bidding. Therefore, if you are bidding for a product category in a CBA, you must ensure that all required state licenses for that product category are either on file with the NSC or received by the NSC by close of bidding. Every location must be licensed in each state in which it provides services. If you have only one location and are bidding in a CBA that includes more than one state, you must have all required licenses for every state in that CBA. If you have more than one location and are bidding in a CBA that includes more than one state, your company must have all required licenses for the product category for every state in that CBA. Make sure that current versions of all required licenses are with the NSC before you bid. If any required licenses are expired or missing from your enrollment file, your bid(s) may be rejected.
- Get accredited: Suppliers must be accredited for all items in a product category in order to submit a bid for that product category. If you are interested in bidding for a product category and are not currently accredited for that product category, take action now to get accredited for that product category. Your accreditation organization will need to report any accreditation updates to the NSC. CMS cannot contract with suppliers who are not accredited by a CMS-approved accreditation organization.

More information about the DMEPOS accreditation requirements, including a list of the accreditation organizations and those who are exempt from accreditation, may be found on the DMEPOS Accreditation page on the CMS website.

Visit the DMEPOS Competitive Bidding page on the CMS website for more information about the DMEPOS competitive bidding program. View the Fact Sheet.

Extension of Licensure Deadline for Round 2 and National Mail-Order Competitions of DMEPOS Competitive Bidding Program

CMS is extending the licensure deadline for the Round 2 and national mail-order competitions of the DMEPOS Competitive Bidding Program. The original licensure deadline required suppliers to have all required state licenses on file with the National Supplier Clearinghouse (NSC) and indicated in the Provider Enrollment, Chain, and Ownership System (PECOS) before submitting a bid.

NEW DEADLINE: Bidding suppliers must now ensure that copies of all applicable state licenses are RECEIVED by the NSC on or before Tuesday, May 1, 2012.

Bids will be disqualified if a bidder does not meet all state licensure requirements for the applicable product categories and for every state in a competitive bidding area (CBA). Every supplier location is responsible for having all applicable license(s) for each state in which it provides services. For a multi-state CBA, the bidder must collectively have all applicable license(s) for every state in the CBA. Each location is not required to have licenses for every state in the CBA as long as each state has a bidding location licensed for the product category.

Please note that the extension of the licensure deadline does NOT change any other deadlines. All bids must be submitted in DBidS, the online bidding system, by 8:59:59 p.m. (prevailing Eastern Time) on Friday, March 30, 2012. All required hardcopy documents that must be included as part of the bid package must be RECEIVED by the Competitive Bidding Implementation Contractor (CBIC) on or before Friday, March 30, 2012.

A licensure directory for each state, the District of Columbia, and the territories may be found on the NSC website at http://www.palmettogba.com/NSC. Licensure requirements vary from state to state. The NSC licensure directory provides a good starting point to assist in identifying the licenses you need. State licensure requirements change periodically and may have exceptions, so the NSC's licensure directory serves only as a guide. It remains the bidding supplier's responsibility to ensure compliance with the most current state and federal laws and regulations.

For more information on licensure requirements, you may refer to the Licensure for Bidding Suppliers Fact Sheet and the Request for Bids (RFB) Instructions. 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.

Please note that the RFB instructions initially posted on the CBIC website contained the original licensure deadline. These instructions have now been updated to reflect the new licensure deadline shown in this announcement.

New DMEPOS Competitive Bidding Program Analysis Shows No Changes in Health Outcomes

On Saturday, January 1, 2011, the Centers for Medicare & Medicaid Services (CMS) launched the first phase of the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program in nine different areas of the country. Since the program's implementation, CMS has used real-time claims analysis to track groups of Medicare beneficiaries potentially affected by the program. This analysis has consistently shown that the competitive bidding program preserves beneficiary health outcomes.

CMS has now released a broad-view analysis that compares the impact of the program on the general Medicare population as well as Medicare beneficiaries likely to use competitively bid equipment based on their health conditions. For these groups, it compares rates of health outcomes (such as hospitalizations, length of hospital stays, and number of emergency department visits) in the competitive bidding areas to rates in regions without competitive bidding. The new analysis enables an easier comparison between subpopulations and between areas with competitive bidding and without competitive bidding. This results in a clearer depiction of the effect of the DMEPOS competitive bidding program on Medicare beneficiaries' health outcomes. Consistent with prior analyses, we find that beneficiary health outcomes are stable in competitive bidding areas. To view the results, please visit http://www.CMS.gov/DMEPOSCompetitiveBid.

New Education Materials for Round 2 and National Mail-Order Bidders

New educational materials for the Round 2 and national mail-order competitions of the Medicare DMEPOS Competitive Bidding Program are now available on the Competitive Bidding Implementation Contractor (CBIC) website at http://www.dmecompetitivebid.com. CMS urges all bidders to take advantage of these new materials as well as the many other helpful tools and resources on the CBIC website.

First, the DBidS Reference Guide has been issued. This guide provides step-by-step instructions for using the DMEPOS Bidding System (DBidS), the online bidding system.

Second, the final in a series of webcasts is now available. This webcast, titled How to Submit a Bid, explains how to submit a bid using the online bidding system, DBidS. All webcasts are available on demand to view at your convenience – 24 hours a day, seven days a week. There is no charge to view the webcasts, and a transcript for each webcast is also posted on the website. To view the webcasts, please go to the CBIC website, select *Bidding Suppliers: Round 2 & National Mail-Order*, and choose *Education Events*.

If you have any questions or need assistance, please contact the CBIC customer service center toll-free at 877-577-5331 from 9 a.m. to 9 p.m. prevailing Eastern Time, Monday through Friday, throughout the registration and bidding periods.

New Report: Competitive Bidding Saving Money for Taxpayers and People with Medicare

Health care law expands second round, program will save up to $42.8 billion

People with Medicare are already saving money on durable medical equipment (DME) through the Medicare competitive bidding program, according to a report issued April 18 by HHS Secretary Kathleen Sebelius.

According to the report, the program saved $202 million in its first year in nine metropolitan statistical areas – a reduction of 42 percent in costs and, as the program expands under the *Affordable Care Act* and earlier law, it could save up to $42.8 billion for taxpayers and beneficiaries over the next 10 years.

The report also released results that show, after extensive monitoring by CMS, there have been no negative effects on the health of people on Medicare or their access to needed supplies and services.

Key information in the report:

- Seniors, and people with disabilities in Medicare, will directly save a projected $17.1 billion due to lower co-insurance for durable medical equipment and lower premiums for Medicare over the next decade, while taxpayers are projected to save an additional $25.7 billion through the Medicare Supplementary Medical Insurance Trust Fund because of reduced prices.
- In the first year of implementation in nine metropolitan statistical areas, through a combination of lower prices and fewer unnecessary services, the competitive bidding program saved Medicare $202 million.

- Medicare beneficiaries in the nine areas had substantial reductions in their co-insurance for DME.
- Last year alone, people with Medicare saved up to $105 on hospital beds, $168 on oxygen concentrators, and $140 on diabetic test strips.
- A real-time claims monitoring system, set up to ensure that access to supplies was not compromised, has found that people on Medicare continue to have access to all necessary and appropriate items.

The *Affordable Care Act* expands Round 2 of the DME competitive bidding program from 70 to 91 metropolitan statistical areas across the country. CMS is evaluating bids from suppliers for the 91 areas. By 2016, all areas of the country will benefit from either the competitive bidding program or lower rates based on the competitively bid rates.

View the full report.

Full text of this excerpted CMS press release (issued April 18)

Revision of Medicare Summary Notice for Non-Competitive Bid Claims

MLN Matters® Number: MM7729
Related Change Request (CR) #: CR 7729
Related CR Release Date: March 9, 2012
Related CR Transmittal #: R1056OTN
Effective Date: July 1, 2012
Implementation Date: July 2, 2012

Provider Types Affected

This MLN Matters® Article is intended for providers and suppliers billing Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for services provided to Medicare beneficiaries who reside in Non-Competitive Bidding Areas.

Provider Action Needed

This article is based on Change Request (CR) 7729 which corrects Medicare Summary Notice (MSN) message (MSN 16.07) incorrectly displaying on MSNs for non-competitive bid claims.

CR7729 instructs your Medicare contractor to use MSN message 16.71 (as follows) for beneficiary submitted **non-National Competitive Bidding (non-NCB) related claims**: Your provider must complete and submit your claim. In addition, CR7729 instructs your Medicare contractor to use MSN 16.07 (as follows) for beneficiary submitted **NCB-related claims** (per CR7066): Your provider must complete and submit your claim in accordance with DMEPOS Competitive Bidding Program.

Background

The Medicare Summary Notices (MSN) is the primary vehicle by which beneficiaries are notified of decisions on their claims for Medicare benefits. Medicare contractors mail a single MSN at the end of the month to each beneficiary for whom a claim was processed during the month to inform the beneficiary of the disposition of their claims. The contractors issue No-Pay MSNs on a quarterly/90 day mailing cycle, and MSNs with checks (to the beneficiary) are mailed out as processed.

The Centers for Medicare & Medicaid Services (CMS) learned that a Durable Medical Equipment Prosthetic, Orthotic and Supplies (DMEPOS) National Competitive Bidding (NCB) MSN message, (MSN 16.07), is incorrectly displaying on MSNs for non-competitive bid claims.

MSN 16.07 currently reads "Your provider must complete and submit your claim in accordance with DMEPOS Competitive Bidding Program". This language was established for beneficiary-submitted NCB claims, effective with the implementation of CR7066 (Transmittal 777, September 24, 2010, "Durable Medical Equipment (DME) National Competitive Bidding (NCB) Implementation - Phase 11E: Remittance Advice (RA) and Medicare Summary Notice (MSN) Messages for Round One." You can review CR7066 at http://www.cms.gov/transmittals/downloads/R777OTN.pdf on the CMS website. Prior to the implementation of CR7066, MSN 16.07 read, "Your provider must complete and submit your claim."

In order to resolve the issue of the incorrect MSN being displayed, CR7729 instructs your Medicare contractor to:

- Use MSN message 16.71 for beneficiary submitted non-NCB related claims: Your provider must complete and submit your claim.
- Use MSN 16.07 for beneficiary submitted NCB- related claims (per CR7066). Your provider must complete and submit your claim in accordance with DMEPOS Competitive Bidding Program.

Additional Information

The official instruction, CR7729, issued to your DME MACs regarding this change may be viewed at www.cms.gov/transmittals/downloads/R1056OTN.pdf on the CMS website.

Round 2 and National Mail-Order Competitions of DMEPOS Competitive Bidding Program – Bid Deadline March 30, 2012

The Centers for Medicare & Medicaid Services (CMS) is currently accepting bids for the Round 2 and national mail-order competitions of the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program. *All bids must be submitted in DBidS, the online bidding system, by 8:59:59pm prevailing Eastern Time on Friday, March 30, 2012. All required hardcopy documents that must be included as part of the bid package must be RECEIVED by the Competitive Bidding Implementation Contractor (CBIC) on or before Friday, March 30, 2012.*

Here are some important reminders:

- The Round 2 and national mail-order competitive bidding areas, product categories, DBidS information, bid preparation worksheets, educational materials, and complete Request for Bids (RFB) instructions can be found on the CBIC website at www.DMECompetitiveBid.com. You should review this information prior to submitting your bid(s).
- You must submit your bid in DBidS using the user ID you received during registration. If you have not already logged in to DBidS, we strongly recommend that you do so NOW to have plenty of time to complete your bid. If you have forgotten your user ID and/or password, you may recover them by using the "Forgot your User ID?" and "Forgot your password?" buttons located on the "Individuals Authorized Access to the CMS Computer Services (IACS)" log-in page.
- Your Authorized Official or Backup Authorized Official must approve your Form A and certify your Form B before the close of bidding. If you modify your bid after it has been approved or certified, it will need to be reapproved or recertified. If Form A is not approved or Form B is not certified, your bid cannot be evaluated, and you will not be considered for a contract. You can verify the status of your forms by logging into DBidS and checking the status screen.
- All bidders must submit certain required hardcopy documents as specified in the RFB instructions. It is very important that you review the hardcopy document section and the sample financial statements of the RFB instructions to ensure your documents include the required information. We also encourage you to use the hardcopy document package checklist, which may be found in Appendix B of the RFB. If you have already submitted your financial documents, you may still amend those documents as long as they are RECEIVED by the CBIC on or before Friday, March 30, 2012. We cannot accept faxed or emailed documents, so you must mail your documents to the CBIC at the address in the RFB instructions.
- All bidders participating in the national mail-order competition for diabetic testing supplies must complete and submit the National Mail-Order 50 Percent Compliance form on the CBIC website. Only one form should be submitted per bidder number. You must not change the printed form in any way. Please ensure that all pages of the form are included in the hardcopy document package. If the form is not RECEIVED on or before Friday, March 30, 2012, your bid for the national mail-order competition will be disqualified. Please refer to the instructions on the form or the National Mail-Order for Diabetic Supplies factsheet for additional information.
- If you submitted financial documents by the Covered Document Review Date (CDRD) – Wednesday, February 29, 2012 – you will receive an email about your financial documents from the CBIC by Monday, May 14, 2012. If you did not submit all of the required financial documents, the email will alert you to expect a letter notifying you of the specific missing financial document(s). This letter will be mailed to your organization's authorized official. You will be required to submit the indicated missing financial document(s) within 10 business days of the notification.

If you submitted all required financial documents, the email will confirm that the CBIC received all required financial documents and that no further action from you is required. If you did not submit any financial documents by the CDRD, you will not receive an email or a letter about your financial documents.

- If you did not submit any hardcopy financial documents by the CDRD, you are still required to submit all required hardcopy documents specified in the RFB instructions on or before Friday, March 30, 2012.

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.

COVERAGE

LCD and Policy Article Revisions Summary for May 2012

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

Ankle-Foot/Knee-Ankle-Foot Orthosis

LCD

Revision Effective Date: 07/01/2012
INDICATIONS AND LIMITATIONS OF COVERAGE:
Added: Coverage of concentric adjustable torsion joints (Effective 3/13/2012)
DOCUMENTATION REQUIREMENTS:
Added: Documentation of custom-fabricated items

Policy Article

Revision Effective Date: 07/01/2012
CODING GUIDELINES:
Added: Coding guidelines for L1906
Revised: Coding guidelines for concentric adjustable torsion joints (Effective 3/13/2012)
Added: Coding verification for codes L1906, L1930, L1932, L1940, L1960, L1970 and L1971
Added: Repair and replacement guidelines

External Breast Prostheses

LCD

Revision Effective Date: 06/01/2012
INDICATIONS AND LIMITATIONS OF COVERAGE AND MEDICAL NECESSITY:
Revised: Order requirement language to specify a "detailed written order"
Added: Refill requirements per PIM 5.2.6 (effective 08/02/2011 per CR7452)
DOCUMENTATION REQUIREMENTS:
(Note: The effective date above is not applicable to this section. These revised and added requirements are existing Medicare requirements which are now included in the LCD for easy reference)
Revised: Prescription requirements
Added: Refill requirements, general medical record information requirements, continued use and continued need requirements, and proof of delivery requirements

Policy Article

Revision Effective Date: 06/01/2012
NON-MEDICAL NECESSITY AND COVERAGE AND PAYMENT RULES:
Revised: Preamble language
CODING GUIDELINES
Revised: Descriptions for L8000, L8001 & L8002

COVERAGE CONT'D

Glucose Monitors

LCD

Revision Effective Date: 07/01/2012
INDICATIONS AND LIMITATIONS OF COVERAGE:
Revised: Basic coverage criteria for glucose monitor and supplies
Revised: Coverage criteria for high utilization
Revised: Order requirements language to specify a "detailed written order"
Changed: Word "Patient" to "Beneficiary"
Clarified: Coverage of laser lancing devices and lens shield cartridges
DOCUMENTATION REQUIREMENTS:
(Note: The effective date above is not applicable to this section. These revised and added requirements are existing Medicare requirements which are now included in the LCD for easy reference)
Revised: Prescription requirements
Added: Medical Record Information
Added: Documentation of beneficiary training
Added: Documentation requirements for high utilization

Knee Orthoses

LCD

Revision Effective Date: 07/01/2012
INDICATIONS AND LIMITATIONS OF COVERAGE:
Revised: Order requirements language to specify a "detailed written order"
Added: Coverage for concentric adjustable torsion joints (Effective 3/13/2012)
Added: Code L2755 to Addition Codes – Eligible for Separate Payment table
Added: ICD-9 codes 733.81-733.82 and 905.4 for L1830, L1832, L1843, L1845 to coverage table per request for reconsideration.
Changed: Word "Patient" to "Beneficiary"
HCPCS CODES AND MODIFIERS
Added: Code L2755
ICD-9 CODES THAT SUPPORT MEDICAL NECESSITY:
Added: ICD-9 codes 733.81-733.82 and 905.4 for L1830, L1832, L1834, L1843, L1844, L1845, L1846 per request for reconsideration.
DOCUMENTATION REQUIREMENTS:
(Note: The effective date above is not applicable to this section. These revised and added requirements are existing Medicare requirements which are now included in the LCD for easy reference)
Added: Refill requirements, general medical record information requirements, continued use and continued need requirements, and proof of delivery requirements

Policy Article

Revision Effective Date: 07/01/2012
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: Reference to LCD for R & N requirements
Changed: Patient to Beneficiary
CODING GUIDELINES:
Added: Definition of code L2755
Added: Coding guidelines for concentric adjustable torsion joints (Effective 3/13/2012)

Mechanical In-exsufflation Devices

LCD

Revision Effective Date: 05/01/2012
INDICATIONS AND LIMITATIONS OF COVERAGE:
Revised: Prescription requirement
ICD-9 CODES THAT SUPPORT MEDICAL NECESSITY:
Added: ICD-9 359.71

DOCUMENTATION REQUIREMENTS:(Note: The effective date above is not applicable to this section. These revised and added requirements are existing Medicare requirements which are now included in the LCD for easy reference)
Revised: Prescription requirements
Added: Refill requirements, general medical record information requirements, continued use and continued need requirements, and proof of delivery requirements

Manual Wheelchair Bases

LCD

Revision Effective Date: 05/01/2012
INDICATIONS AND LIMITATIONS OF COVERAGE:
Revised: Order requirement language to specify a "detailed written order"
DOCUMENTATION REQUIREMENTS:(Note: The effective date above is not applicable to this section. These revised and added requirements are existing Medicare requirements which are now included in the LCD for easy reference)
Revised: Prescription requirements
Added: General medical record information requirements, continued use and continued need requirements, and proof of delivery requirements
Removed: paragraph about individual consideration and changed "patient" to "beneficiary".
Added: Clarified Home Assessment documentation

Policy Article

Revision Effective Date: 05/01/2012
CODING GUIDELINES:
Added general language, PDAC verification and E1161 to language about wheel design.
Changed: DMERC to DME MAC

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

Local Coverage Article for LCD and Policy Article Revisions Summary for March 1, 2012

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

Ankle-Foot/Knee-Ankle-Foot Orthosis

LCD

Revision Effective Date: 01/01/2012
INDICATIONS AND LIMITATIONS OF COVERAGE:
Revised: Order requirements language to specify a "detailed written order"
Changed: Word "Patient" to "Beneficiary"
DOCUMENTATION REQUIREMENTS:
(Note: The effective date above is not applicable to this section. These revised and added requirements are existing Medicare requirements which are now included in the LCD for easy reference)
Revised: Prescription requirements
Added: Medical Record Information

Immunosuppressive Drugs

LCD

Revision Effective Date: 01/01/2012
INDICATIONS AND LIMITATIONS OF COVERAGE AND MEDICAL NECESSITY:
Revised: Order requirement language to specify a "detailed written order"
Added: Refill requirements per PIM 5.2.6 (effective 08/02/2011 per CR7452)
HCPCS CODES:
Added: J8561
DOCUMENTATION REQUIREMENTS:
(Note: The effective date above is not applicable to this section. These revised and added requirements are existing

Medicare requirements which are now included in the LCD for easy reference)
Revised: Prescription requirements
Added: Refill Requirements, general medical record information requirements and proof of delivery requirements

Intravenous Immune Globulin

LCD

Revision History Effective Date: 01/01/2012
INDICATIONS AND LIMITATIONS OF COVERAGE AND MEDICAL NECESSITY:
Revised: Order requirement language to specify a "detailed written order"
Added: Refill requirements per PIM 5.2.6 (effective 08/02/2011 per CR7452)
HCPCS CODES:
Added: J1557
Revised: J1561 narrative
DOCUMENTATION REQUIREMENTS:
(Note: The effective date above is not applicable to this section. These revised and added requirements are existing Medicare requirements which are now included in the LCD for easy reference)
Revised: Prescription requirements
Added: Refill requirements, general medical record information requirements, continued use and continued need requirements, and proof of delivery requirements

Lower Limb Prostheses

LCD

Revision Effective Date: 01/01/2012
INDICATIONS AND LIMITATIONS OF COVERAGE
Revised: Order requirement language to specify a "detailed written order"
Changed: Word "Patient" to "Beneficiary"
HCPCS CODES AND MODIFIERS
Added: L5312
DOCUMENTATION REQUIREMENTS:
(Note: The effective date above is not applicable to this section. These revised and added requirements are existing Medicare requirements which are now included in the LCD for easy reference)
Revised: Prescription requirements
Added: Medical Record Information

Oral Antiemetic Drugs (Replacement for Intravenous Antiemetics)

LCD

INDICATIONS AND LIMITATIONS OF COVERAGE AND MEDICAL NECESSITY:
Revised: Order requirement language to specify a "detailed written order"
Added: Refill requirements per PIM 5.2.6 (effective 08/02/2011 per CR7452)
HCPCS CODES:
Added: Q0162
Deleted: Q0179
DOCUMENTATION REQUIREMENTS:
(Note: The effective date above is not applicable to this section. These revised and added requirements are existing Medicare requirements which are now included in the LCD for easy reference)
Revised: Prescription requirements
Added: Refill requirements, general medical record information requirements and proof of delivery requirements

Ostomy Supplies

LCD

Revision History Effective Date: 01/01/2012
INDICATIONS AND LIMITATIONS OF COVERAGE AND MEDICAL NECESSITY:
Revised: Order requirement language to specify a "detailed written order"
HCPCS CODES:
Added: A5056 and A5057

DOCUMENTATION REQUIREMENTS:
(Note: The effective date above is not applicable to this section. These revised and added requirements are existing Medicare requirements which are now included in the LCD for easy reference)
Added: General medical record information requirements and proof of delivery requirements

Suction Pumps

LCD

Revision Effective Date: 04/15/2012
INDICATIONS AND LIMITATIONS OF COVERAGE:
Added: Preamble
Added: A9272 (effective 01/01/2012)
Added: Refill requirements per PIM 5.2.6 (effective 08/02/2011 per CR7452)
Added: Gastric pump (E2000) coverage statement
Removed: Extra supplies statement
Added: Coverage statement about K0743 and related supplies
Revised: "Reasonable and necessary" for "medically necessary"
HCPCS CODES AND MODIFIERS
Added: A9272
Added: K0743 – K0746 (Effective 07/01/2011)
DOCUMENTATION REQUIREMENTS:
(Note: The effective date above is not applicable to this section. These revised and added requirements are existing Medicare requirements which are now included in the LCD for easy reference)
Revised: Prescription requirements
Added: Refill requirements, general medical record information requirements, continued use and continued need requirements, and proof of delivery requirements

PA

Revision Effective Date: 01/01/2012
NONMEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: Preamble
Added: Benefit Category Statement
Added: A9272 to noncovered statement about disposable devices.
CODING GUIDELINES:
Added: K0743 – K0746
Added: PDAC review requirement for K0743
Added: A9272
Revised: A9270 to exclude A9272 devices

Wheelchair Options/Accessories

LCD

INDICATIONS AND LIMITATIONS OF COVERAGE:
Revised: Order requirement
Added: E0988, E2358, E2359
HCPCS CODES AND MODIFIERS:
Added: E0988, E2358, E2359
Replaced: "Patient" with "beneficiary"
DOCUMENTATION REQUIREMENTS:
(Note: The effective date above is not applicable to this section. These revised and added requirements are existing Medicare requirements which are now included in the LCD for easy reference)
Revised: Prescription requirements
Added: General medical record information requirements, continued use and continued need requirements, and proof of delivery requirements

PA

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: E2359

CODING GUIDELINES:
Added: E0988
Clarified: billing instructions for Power Wheelchairs for armrests versus separate billing for detachable adjustable height armrests: corrected K0020 and added as adjustable. Removed K0020 from bundling table.

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

Standard Documentation Language for Local Coverage Determinations

Many errors reported in DME MAC MR Reviews and CERT Audits arise from problems associated with submitted documentation. Discussions about documentation issues commonly focus on inadequate medical record information not created by the billing supplier. However, in addition to medical record information related errors, numerous errors are identified due to noncompliance with non-medical record documents. These errors can often be avoided by the supplier. LCDs are being revised to include more detailed information about documentation requirements.

An expanded and standardized DOCUMENTATION REQUIREMENTS section has been developed. It is written in a modular format to allow each policy to contain information relevant to that policy while not including material that does not apply. This revised section includes considerable detailed information about existing Medicare requirements that has historically been found in the DME MAC Supplier Manual or in CMS interpretive manuals. Suppliers are strongly encouraged to review this material and use it to ensure that the records created will meet the standards required to justify payment for the DMEPOS item(s) provided.

This article provides a complete listing of all of the documentation requirement modules. All modules may not be used in every LCD. For example, the CMN sections would not be included in the DOCUMENTATION REQUIREMENTS section of an LCD for an item that does not require a CMN.

IMPORTANT

Many policies contain coverage and documentation requirements that are unique to that specific policy. Such unique information is not included in this article. It is important that suppliers review the actual LCD to be sure to have all of the relevant information necessary applicable to the item(s) provided.

In several places you will see "placeholders" like "XXX" or "###". Information specific to the policy will be inserted in these spots.

DOCUMENTATION REQUIREMENTS

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 beneficiary's medical records will reflect the need for the care provided. The beneficiary'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.

PRESCRIPTION (ORDER) REQUIREMENTS

GENERAL (PIM 5.2.1)

All items billed to Medicare require a prescription. 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 dispensed and/or billed that do not meet these prescription requirements and those below must be submitted with an EY modifier added to each affected HCPCS code.

DISPENSING ORDERS (PIM 5.2.2)

Equipment and supplies may be delivered upon receipt of a dispensing order except for those items that require a written order prior to delivery. A dispensing order may be verbal or written. The supplier must keep a record of the dispensing order on file. It must contain:

- Description of the item
- Beneficiary's name
- Prescribing Physician's name

- Date of the order and the start date, if the start date is different from the date of the order
- Physician signature (if a written order) or supplier signature (if verbal order)

For the "Date of the order" described above, use the date the supplier is contacted by the physician (for verbal orders) or the date entered by the physician (for written dispensing orders).

Signature and date stamps are not allowed. Signatures must comply with the CMS signature requirements outlined in PIM 3.3.2.4.

The dispensing order must be available upon request.

For items that are provided based on a dispensing order, the supplier must obtain a detailed written order before submitting a claim.

DETAILED WRITTEN ORDERS (PIM 5.2.3)

A detailed written order (DWO) is required before billing. Someone other than the ordering physician may produce the DWO. However, the ordering physician must review the content and sign and date the document. It must contain:

- Beneficiary's name
- Physician's name
- Date of the order and the start date, if start date is different from the date of the order
- Detailed description of the item(s) (see below for specific requirements for selected items)
- Physician signature and signature date

For items provided on a periodic basis, including drugs, the written order must include:

- Item(s) to be dispensed
- Dosage or concentration, if applicable
- Route of Administration
- Frequency of use
- Duration of infusion, if applicable
- Quantity to be dispensed
- Number of refills

For the "Date of the order" described above, use the date the supplier is contacted by the physician (for verbal orders) or the date entered by the physician (for written dispensing orders).

Frequency of use information on orders must contain detailed instructions for use and specific amounts to be dispensed. Reimbursement shall be based on the specific utilization amount only. Orders that only state "PRN" or "as needed" utilization estimates for replacement frequency, use, or consumption are not acceptable. (PIM 5.9)

The detailed description in the written order may be either a narrative description or a brand name/model number.

Signature and date stamps are not allowed. Signatures must comply with the CMS signature requirements outlined in PIM 3.3.2.4.

The DWO must be available upon request.

A prescription is not considered as part of the medical record. Medical information intended to demonstrate compliance with coverage criteria may be included on the prescription but must be corroborated by information contained in the medical record.

WRITTEN ORDERS PRIOR TO DELIVERY (PIM 5.2.4) (OPTIONAL)

A detailed written order prior to delivery (WOPD) is required for XXX. The supplier must have received a WOPD that has been both signed and dated by the treating physician and meets the requirements for a DWO before dispensing the item.

MEDICAL RECORD INFORMATION

GENERAL (PIM 5.7 -5.9)

The Indications and Limitations of Coverage and/or Medical Necessity section of this LCD contains numerous reasonable and necessary (R&N) requirements. The Nonmedical Necessity Coverage and Payment Rules section of the related Policy Article contains numerous non-reasonable and necessary, benefit category and statutory requirements that must be met in order for payment to be justified. Suppliers are reminded that:

- Supplier-produced records, even if signed by the ordering physician, and attestation letters (e.g. letters of medical necessity) are deemed not to be part of a medical record for Medicare payment purposes.
- Templates and forms, including CMS Certificates of Medical Necessity, are subject to corroboration with information in the medical record.

Information contained directly in the contemporaneous medical record is the source required to justify payment except as noted elsewhere for prescriptions and CMNs. The medical record is not limited to physician's office records but may include records from hospitals, nursing facilities, home health agencies, other healthcare professionals, etc. (not all-inclusive). Records from suppliers or healthcare professionals with a financial interest in the claim outcome are not considered sufficient by themselves for the purpose of determining that an item is reasonable and necessary.

CONTINUED USE

Continued use describes the ongoing utilization of supplies or a rental item by a beneficiary.

Suppliers are responsible for monitoring utilization of DMEPOS rental items and supplies. No monitoring of purchased items or capped rental items that have converted to a purchase is required. Suppliers must discontinue billing Medicare when rental items or ongoing supply items are no longer being used by the beneficiary.

Beneficiary medical records or supplier records may be used to confirm that a DMEPOS item continues to be used by the beneficiary. Any of the following may serve as documentation that an item submitted for reimbursement continues to be used by the beneficiary:

1. Timely documentation in the beneficiary's medical record showing usage of the item, related option/accessories and supplies.
2. Supplier records documenting the request for refill/replacement of supplies in compliance with the Refill Documentation Requirements This is deemed to be sufficient to document continued use for the base item, as well.
3. Supplier records documenting beneficiary confirmation of continued use of a rental item

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

CONTINUED MEDICAL NEED

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

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

1. A recent order by the treating physician for refills
2. A recent change in prescription
3. A properly completed CMN or DIF with an appropriate length of need specified
4. Timely documentation in the beneficiary's medical record showing usage of the item.

COVERAGE CONT'D

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

REFILL DOCUMENTATION (PIM 5.2.5-6) (OPTIONAL)

A routine refill prescription is not needed. A new prescription is needed when:

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

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

For items that are delivered to the beneficiary, documentation of a request for refill must be either a written document received from the beneficiary or a contemporaneous written record of a phone conversation/contact between the supplier and beneficiary. The refill request must occur and be documented before shipment. A retrospective attestation statement by the supplier or beneficiary is not sufficient. The refill record must include:

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

PROOF OF DELIVERY (PIM 4.26, 5.8)

Proof of delivery (POD) is a Supplier Standard and DMEPOS suppliers are required to maintain POD documentation in their files. For medical review purposes, POD serves to assist in determining correct coding and billing information for claims submitted for Medicare reimbursement. Regardless of the method of delivery, the contractor must be able to determine from delivery documentation that the supplier properly coded the item(s), that the item(s) delivered are the same item(s) submitted for Medicare reimbursement and that the item(s) are intended for, and received by, a specific Medicare beneficiary.

Suppliers, their employees, or anyone else having a financial interest in the delivery of the item are prohibited from signing and accepting an item on behalf of a beneficiary (i.e., acting as a designee on behalf of the beneficiary). The signature and date the beneficiary or designee accepted delivery must be legible.

For the purpose of the delivery methods noted below, designee is defined as "Any person who can sign and accept the delivery of durable medical equipment on behalf of the beneficiary."

Proof of delivery documentation must be available to the Medicare contractor on request. All services that do not have appropriate proof of delivery from the supplier will be denied and overpayments will be requested. Suppliers who consistently fail to provide documentation to support their services may be referred to the OIG for imposition of Civil Monetary Penalties or other administrative sanctions.

Suppliers are required to maintain POD documentation in their files. There are three methods of delivery:

1. Delivery directly to the beneficiary or authorized representative
2. Delivery via shipping or delivery service
3. Delivery of items to a nursing facility on behalf of the beneficiary

Method 1—Direct Delivery to the Beneficiary by the Supplier

Suppliers may deliver directly to the beneficiary or the designee. In this case, POD to a beneficiary must be a signed and dated delivery slip. The POD record must include:

- Beneficiary's name
- Delivery address

- Sufficiently detailed description to identify the item(s) being delivered (e.g., brand name, serial number, narrative description)
- Quantity delivered
- Date delivered
- Beneficiary (or designee) signature and date of signature

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 must be the date of service on the claim.

Method 2—Delivery via Shipping or Delivery Service Directly to a Beneficiary

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

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

If a supplier utilizes a shipping service or mail order, suppliers must use the shipping date as the date of service on the claim.

Suppliers may also utilize a return postage-paid delivery invoice from the beneficiary or designee as a POD. This type of POD record must contain the information specified above.

Method 3—Delivery to Nursing Facility on Behalf of a Beneficiary

When a supplier delivers items directly to a nursing facility, the documentation described for Method 1 (see above) is required.

When a delivery service or mail order is used to deliver the item to a nursing facility, the documentation described for Method 2 (see above) is required.

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

POLICY SPECIFIC DOCUMENTATION REQUIREMENTS

GENERAL

CERTIFICATE OF MEDICAL NECESSITY (PIM 5.3) (OPTIONAL)

A Certificate of Medical Necessity (CMN), which has been completed, signed, and dated by the treating physician, must be kept on file by the supplier and made available upon request. The CMN may act as a substitute for the detailed written order if it contains the same information as required in a detailed written order. The CMN for XXX is CMS Form ### (DME form ###). In addition to the order information that the physician enters in Section B, the supplier can use the space in Section C for a written confirmation of other details of the order or the physician can enter the other details directly.

(Add specific DIF instructions as needed)

COVERAGE CONT'D

A new CMN is not required just because the supplier changes assignment status on the submitted claim.

DME INFORMATION FORM (PIM 5.3) (OPTIONAL)

A DME Information Form (DIF), which has been completed, signed, and dated by the supplier, must be kept on file and made available upon request. The DIF for XXX is CMS Form ### (DME form ###).

(Add specific DIF instructions as needed)

REPAIR/REPLACEMENT (BPM Ch 15, §100.2)

Documentation Section

A new Certificate of Medical Necessity (CMN) and/or physician's order is not needed for repairs.

The supplier must maintain detailed records describing the need for and nature of all repairs including a detailed explanation of the justification for any component or part replaced as well as the labor time.

A physician's order and/or new Certificate of Medical Necessity (CMN), when required, is needed to reaffirm the medical necessity of the item for replacement of an item.

Refer to the specific LCD and DME MAC Supplier manual for additional information about documentation.

DRUGS/BIOLOGICALS

April 2012 ASP Files Now Available

CMS has posted the April 2012 Average Sales Price (ASP) and Not Otherwise Classified (NOC) pricing files and crosswalks. All are available for download at http://www.CMS.gov/McrPartBDrugAvgSalesPrice/01a17_2012ASPFiles.asp.

ASP Drug Pricing Files for April 2012 Quarterly Update and Revisions to Prior Files

MLN Matters® Number: MM7734
Related Change Request (CR) #: CR 7734
Related CR Release Date: January 26, 2012
Related CR Transmittal #: R2396CP
Effective Date: April 1, 2012
Implementation Date: April 2, 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), Durable Medical Equipment Medicare Administrative Contractors (DME MACs), and/or Regional Home Health Intermediaries (RHHIs)) for services provided to Medicare beneficiaries.

Provider Action Needed

Medicare will use the April 2012 quarterly Average Sales Price (ASP) Medicare Part B drug pricing files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after April 2, 2012, with dates of service April 1, 2012, through June 30, 2012.

Change Request (CR) 7734, from which this article is taken, instructs your Medicare contractors to download and implement the April 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), to also download and implement the revised January 2012, October 2011, July 2011, and April 2011 files.

You should make sure that your billing staff is aware of the release of these April 2012 ASP Medicare Part B drug files.

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 Medicare 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 (Part B Hospital (Including Inpatient Hospital Part B and OPPS)), Section 50 (Outpatient PRICER); 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
April 2012 ASP and ASP NOC	April 1, 2012, through June 30, 2012
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

Additional Information

You can find the official instruction, Change Request (CR) 7344, issued to your FI, carrier, A/B MAC, RHHI, or DME MAC by visiting http://www.cms.gov/Transmittals/downloads/R2396CP.pdf on the CMS website.

ASP Drug Pricing Files for July 2012 Quarterly Update and Revisions to Prior Files

MLN Matters® Number: MM7810
Related Change Request (CR) #: CR 7810
Related CR Release Date: April 6, 2012
Related CR Transmittal #: R2440CP
Effective Date: July 1, 2012
Implementation Date: July 2, 2012

Provider Types Affected

This MLN Matters® Article is intended 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 Medicare Administrative Contractors (DME MACs), and/or Regional Home Health Intermediaries (RHHIs)) for services provided to Medicare beneficiaries.

Provider Action Needed

Medicare will use the July 2012 quarterly Average Sales Price (ASP) Medicare Part B drug pricing files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after July 2, 2012, with dates of service July 1, 2012, through September 30, 2012.

Change Request (CR) 7810, from which this article is taken, instructs your Medicare contractors to download and implement the July 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), to also download and implement the revised April 2012, January 2012, October 2011, and July 2011 files.

You should make sure that your billing staff is aware of the release of these July 2012 ASP Medicare Part B drug files.

Background

The Average Sales Price (ASP) methodology is based on quarterly data submitted to CMS by manufacturers. CMS will supply Medicare 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 (Part B Hospital (Including Inpatient Hospital Part B and OPPS)), Section 50 (Outpatient PRICER); 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
July 2012 ASP and ASP NOC	July 1, 2012, through September 30, 2012
April 2012 ASP and ASP NOC	April 1, 2012, through June 30, 2012
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

Additional Information

You can find the official instruction, Change Request (CR) 7810, issued to your FI, carrier, A/B MAC, RHHI, or DME MAC by visiting http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R2440CP.pdf on the CMS website.

Pharmacy Billing for Drugs Provided "Incident To" Physician Service

MLN Matters® Number: MM7397 Revised
Related Change Request (CR) #: 7397
Related CR Release Date: April 4, 2012
Related CR Transmittal #: R2437CP
Effective Date: January 1, 2013
Implementation Date: January 1, 2013

Note: This article was revised on April 10, 2012, to reflect the revised CR7397 issued on April 4. In this article, 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.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2437CP.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.

Quarterly HCPCS Drug/Biological Code Changes – July 2012 Update

MLN Matters® Number: MM7831
Related Change Request (CR) #: CR 7831
Related CR Release Date: April 26, 2012
Related CR Transmittal #: R2450CP
Effective Date: July 1, 2012
Implementation Date: July 2, 2012

Provider Types Affected

This MLN Matters® Article is intended for physicians, other providers, and suppliers submitting claims to Medicare contractors (fiscal intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), carriers, A/B Medicare Administrative Contractors (MACs) and Durable Medical Equipment MACs or DME MACs) for services provided to Medicare beneficiaries.

Provider Action Needed

CR7831 announces the quarterly updating of specific Healthcare Common Procedure Coding System (HCPCS) codes, effective for claims with dates of service on or after July 1, 2012. You should make sure that your billing staffs are aware of these HCPCS code changes.

Background

The HCPCS code set is updated on a quarterly basis. CR7831 describes the Centers for Medicare & Medicaid Services (CMS) process for updating specific HCPCS codes.

Key Points of CR7831

Effective for claims with dates of service on or after July 1, 2012, the following HCPCS codes will no longer be payable for Medicare:

HCPCS Code	Short Description	Long Description	MPFSDB* Status Indicator
J1680	Human fibrinogen conc inj	INJECTION, HUMAN FIBRINOGEN CONCENTRATE, 100 MG	I
J9001	Doxorubicin hcl liposome inj	INJECTION, DOXORUBICIN HYDROCHLORIDE, ALL LIPID FORMULATIONS, 10 MG	I

* Medicare Physician Fee Schedule Data Base (MPFSDB)

Effective for claims with dates of service on or after July 1, 2012, the following HCPCS codes will be payable for Medicare:

HCPCS Code	Short Description	Long Description	Type of Service (TOS) Code	MPFSDB Status Indicator
Q2034	Agriflu vaccine	INFLUENZA VIRUS VACCINE, SPLIT VIRUS, FOR INTRAMUSCULAR USE (AGRIFLU)	V	X
Q2045	Human fibrinogen conc inj	INJECTION, HUMAN FIBRINOGEN CONCENTRATE, 1 MG	1, 9	E
Q2046	Aflibercept injection	INJECTION, AFLIBERCEPT, 1 MG	1, 9	E
Q2047	Peginesatide injection	INJECTION, PEGINESATIDE, 0.1 MG (FOR ESRD ON DIALYSIS)	L	E

Additional Information

The official instruction, CR 7831, issued to your Medicare contractor regarding this change may be viewed at http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2450CP.pdf on the CMS website.

Widespread Prepayment Review for Immunosuppressive Drugs – Edit Effectiveness for 2nd 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 second quarter edit effectiveness results from January 2012 through March 2012 are as follows:

The results of the review, for item J7507, identified 1098 claims of which 809 were denied. A total of 594 claims were denied for no response to the additional documentation request. This resulted in an overall error rate of 76%.

The result of the review, for item J7517, identified 747 claims of which 543 were denied. A total of 398 claims were denied for no response to the additional documentation request. This resulted in an overall error rate of 73%.

The result of the review, for item J7518, identified 242 claims of which 182 were denied. A total of 148 claims were denied for no response to the additional documentation request. This resulted in an overall error rate of 77%.

The result of the review, for item J7520, identified 94 claims of which 81 were denied. A total of 61 claims were denied for no response to the additional documentation request. This resulted in an overall error rate of 89%.

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
   - No written order submitted with the documentation
   - Insufficient or incomplete order

C. No proof of delivery
   - No proof of delivery submitted with the documentation
   - 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

EDUCATIONAL

2012 Ask the Contractor Teleconferences

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

Upcoming 2012 ACTs: 3 p.m. CT

Date	Topic	Call Information	Confirmation Number
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

Training Manual Mailed to Active NAS DME Jurisdiction D Suppliers – February 2012

In response to supplier feedback received and analysis conducted, each active NAS DME Jurisdiction D supplier was mailed a "Supplier Training Manual" in February 2012. This one-time mailing was sent to assist in Comprehensive Error Rate Testing (CERT) error reduction by making suppliers aware of coverage and claim submission resources available from NAS. This article describes the contents of the article as well as the email process to obtain a duplicate copy of the manual.

It is a supplier's choice if he/she chooses to maintain the manual based on resources received at educational events, electronic mailings, and updates to the https://www.noridianmedicare.com/dme website. The training manual includes:

1. Contact information for multiple contractors
    a. NAS DME
    b. Common Electronic Data Interchange (CEDI)
    c. National Supplier Clearinghouse (NSC)
    d. Pricing, Data Analysis and Coding (PDAC)
    e. Competitive Bidding Implementation Contractor (CBIC)
    f. CMS Contractor Entities At a Glance
2. 2012 outreach and education events
3. Self-Service Tools
    a. Endeavor Overview
    b. Interactive Voice Recognition (IVR) System User Guide and At-a-Glance Guide
    c. Top Tasks on NAS DME Website
    d. NAS DME Email Updates
    e. CMS Email Updates
    f. Fee Schedule Lookup Tool
    g. Remittance Advice Tutorial
    h. DME Coding System (DMECS)

EDUCATIONAL CONT'D

4. Intake Process
    a. Suggested Intake Form
    b. Consolidated Billing
    c. Inpatient Stays
    d. Benficiaries Transferring from Health Maintenance Organization (HMO) to Medicare Fee-for-Service (FFS)
    e. Medicare Secondary Payer (MSP)
    f. Same or Similar
5. Documentation
    a. Verbal and Written Orders
    b. Written Order Prior to Delivery
    c. Requirement of New Orders
    d. Certificates of Medical Necessity (CMNs)/DME Information Forms (DIFs)
    e. Beneficiary Authorization
    f. Proof of Delivery
    g. Pickup Slips
    h. Documentation Checklists
    i. Letters to Physicians
    j. CMS Signature Fact Sheet
6. Coverage
    a. Local Coverage Determinations (LCDs)
    b. Policy Articles
    c. National Coverage Determinations (NCDs)
    d. Advance Beneficiary Notice of Noncoverage (ABNs)
7. Claim Submission
    a. CMS 1500 Claim Form and Instructions
    b. Upgrades
    c. Break in Service vs Break in Billing
    d. Common Abbreviations to User as Narratives
    e. Electronic Remittance Advices
    f. Medicare Remit Easy Print (MREP)
    g. Fraud and Abuse
8. Refunds and Overpayments
    a. Refund and Overpayment Submission Options
    b. Refunds to Medicare Form
    c. MSP Inquiry and Refunds Form
    d. Recovery Auditor Offset Request Form

9. Appeals
    a. Reopenings
    b. Redeterminations
    c. Helpful Hints
    d. Appeals Levels 2-5
    e. Request Forms
10. Reviews
    a. Comprehensive Error Rate Testing (CERT)
    b. CERT Frequently Asked Questions
    c. CERT Letter to Physicians
    d. NAS Medical Review
    e. Recovery Auditor
    f. Recovery Auditor Flowchart
    g. Supplier Options Chart
11. DME Happenings Index to Articles (October 2006 through December 2011)

Replication of the contents within the Training Manual is permitted by suppliers for the purpose of training staff within their office. This training manual is not to be confused with the NAS Supplier Manual accessible from our website which is maintained quarterly, https://www.noridianmedicare.com/dme/news/manual/index.html.

Suppliers may request one additional copy of the manual by sending an email to dme@noridian.com with the following information::

- Email subject line "Supplier Training Manual Request"
- Name of Requestor
- Company Name
- National Provider Identifier (NPI)

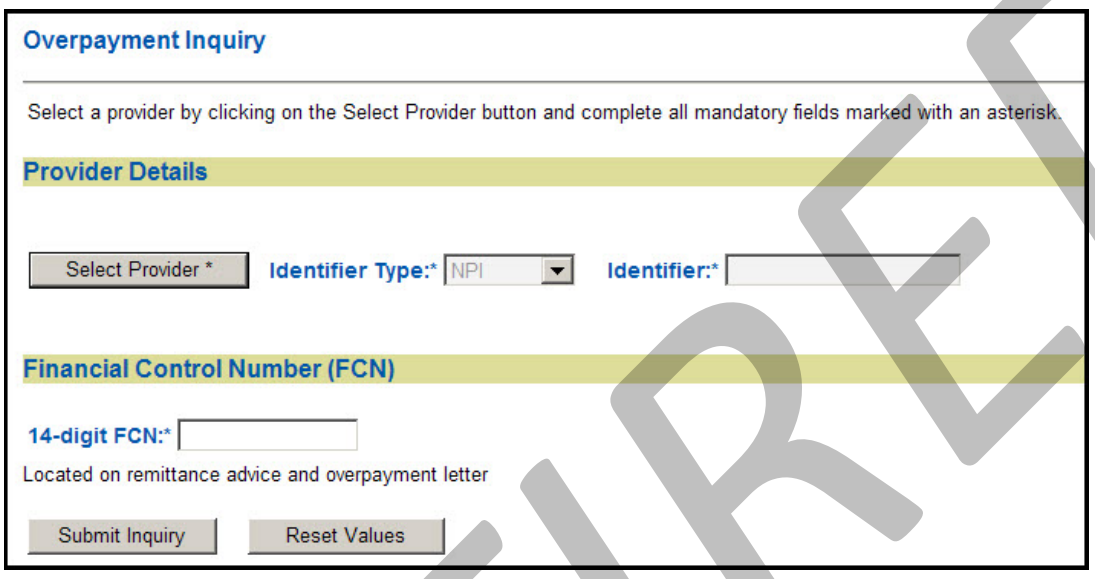
Note: Manuals will only be mailed until the inventory is depleted.

NAS hopes suppliers use this as a foundation of Medicare knowledge.

Overpayment Information Available in Endeavor

Effective April 27, 2012, DME suppliers can access overpayment information by entering the Financial Control Number (FCN) within the NAS DME Jurisdiction D supplier portal, Endeavor. This option does not require additional registration if claim status and/or remittance advice has already been approved for the user. Note: Due to different claim processing systems pertaining to financial inquiries, the feature is specific to DME and is not available for NAS Part A or Part B providers.

To view this information, select the NPI from the approved listing and enter the 14-digit FCN found on the remittance advice and overpayment letter.



Endeavor provides the following information regarding the overpayment:

- Overpayment Letter Date
- Current Balance

Cause of Overpayment Results:

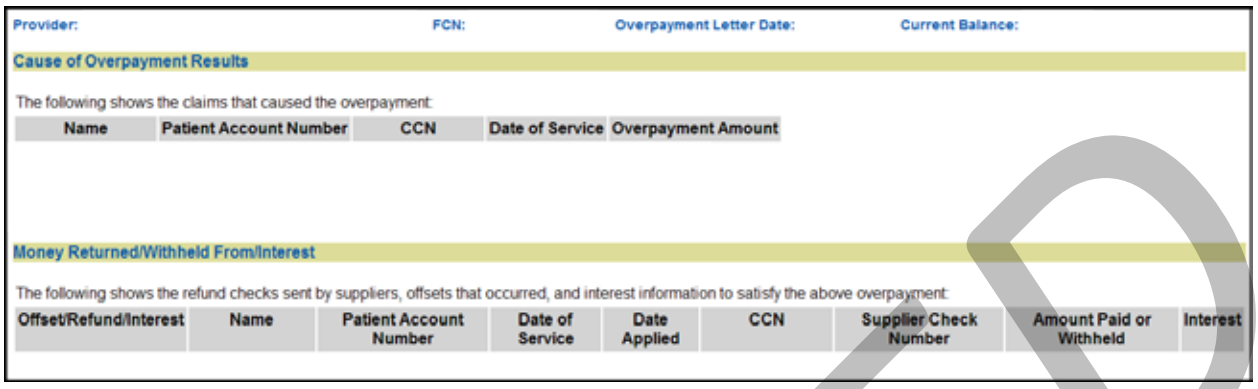
- Beneficiary Name
- Patient Account Number
- Claim Control Number (CCN)
- Date of Service
- Overpayment Amount

Money Returned/Withheld From/Interest

- Offset/Refund/Interest Indicator
- Beneficiary Name
- Patient Account Number
- Date of Service
- Date Applied
- Claim Control Number
- Supplier Check Number
- Amount Paid or Withheld
- Interest Amount

ENDEAVOR CONT'D

For suppliers not already registered for Endeavor, go to https://www.noridianmedicare.com/dme/claims/endeavor.html for registration instructions.



Provider: FCN: Overpayment Letter Date: Current Balance:

Cause of Overpayment Results

The following shows the claims that caused the overpayment:

Name	Patient Account Number	CCN	Date of Service	Overpayment Amount

Money Returned/Withheld From/Interest

The following shows the refund checks sent by suppliers, offsets that occurred, and interest information to satisfy the above overpayment:

Offset/Refund/Interest	Name	Patient Account Number	Date of Service	Date Applied	CCN	Supplier Check Number	Amount Paid or Withheld	Interest

Suppliers may view the Endeavor User Guide and additional information at https://www.noridianmedicare.com/dme/claims/endeavor.html.

Reopening and Redetermination Submission & Status Inquiry Now Available Through Endeavor

Based on supplier feedback, NAS now accepts reopenings and redeterminations electronically through Endeavor. Suppliers can request the reopening or redetermination, submit the supporting documentation, and check the status all online within Endeavor.

Reopening and Redetermination Submission

- Submit the request and supporting documentation via Endeavor.

Check Status of Submitted Reopening or Redetermination

- **Important**: When inquiring on status, enter the patient's Medicare number or confirmation number to narrow the number of results and avoid timing out.
- Pending (Reopening/redetermination has been received by NAS)
- Request for Documentation (A documentation request has been sent to your office. Return the additional documentation to NAS within 14 days from the date of the letter.)
- Complete (Reopening/redetermination is finalized)

Registration for Existing Endeavor Users

1. Log into Endeavor.
2. Click on "Add Provider" in the left column.
3. Complete the form.
   - Ensure the correct Medicare Program is selected.
   - Enter the National Provider Identifier (NPI).
   - Check the Redetermination box.
   - Click the "Add to Provider List" button.
4. Repeat steps 1–4 for each requested NPI.
5. Click on the "Complete Registration" button.

ENDEAVOR CONT'D

Notes:

- NPIs will *not* be automatically added to accounts. Each NPI must be processed by NAS Endeavor staff.
- Users will receive an approval/denial fax after processing.

Registration for Providers New to Endeavor

1. Go to www.noridianmedicare.com/dme.
2. Click Log In/Register in the right column.
3. Click on "New User Registration".
4. Read the Registration Requirements and accept the terms of the agreements.
5. Complete the Organization page providing first and last name, organization name, and user type.
6. Complete the Contact page providing address, phone number, fax number, email address and System Security Official information.
7. Complete the Provider page entering the Medicare Program, NPI and selecting the transactions (eligibility, claim status, remittance advice, redeterminations).

Notes:

- Once submitted, NAS Endeavor staff will process the registration.
- Each person using Endeavor must register for their own User ID.

User Manual

Instructions on using Endeavor and this new functionality are available in the User Manual located on the Claims page.

Benefits of Reopening and Redetermination Submission and Status

- The benefits of submitting redeterminations through Endeavor include:
- No hidden fees, Endeavor is a free provider portal
- No software to download or install, Endeavor uses an Internet connection
- Registration is fast and easy
- User friendly
- Cost savings – no mailing of redeterminations (save on faxing, paper, postage and which could result in quicker payment turnaround)
- Timeliness – redeterminations are received instantly when submitted electronically via Endeavor
- Confirmation – receive confirmation of redetermination receipt
- Go Green – records can be submitted electronically

Hours of Availability

- Eligibility:
  - 24 hours/day, 7 days/week
- Claim Status, Same or Similar, Claim-Specific Remittance Advices and Reopening and Redetermination Submission/Status:
  - Monday – Friday: 6 a.m. – 8 p.m. CT
  - Saturday: 7 a.m. – 3 p.m. CT

Questions

Questions regarding DME Endeavor must be directed to dmeendeavor@noridian.com.

ENROLLMENT

DMEPOS Suppliers Can Easily Update Authorized Official and Ownership Information Using Medicare's Online Enrollment System

Has there been a change in your Authorized Official (AO) or entity which owns 5% or more of your organization? Since February 11, 2012, it's been easy to update the information on file with Medicare using Medicare's online enrollment system (PECOS). PECOS is pre-populated with current AO and ownership information. When viewing the Individual and Organization control topic sections, you can modify or delete the pre-populated individual and organization control data and changes will be reflected across all enrollment applications for your Provider or Supplier and Tax Identification Number.

Major Improvements to Medicare Online Enrollment System

Over the last year, CMS has listened to your feedback about the Medicare online enrollment system (PECOS) and made improvements to:

- Incorporate search capabilities on the My Enrollments page
- Increase access to information, and
- Allow electronic signature of the Certification Statement and Electronic Funds Transfer Agreement.

The following upgrades are now available:

Overall Usability

Users will now have a search and filter feature that will allow the user to filter enrollments on the My Enrollments Page. Users will be able to filter the enrollments shown on the My Enrollments Page based on: Medicare ID, National Provider Identifier (NPI), or by selecting an Enrollment Type, Enrollment Status, or State. Additional data has been added to the enrollment data on the My Enrollments Page, i.e., Enrollment Type, Medicare ID, and Practice Location.

Access to More Information

Users will also be able to see if a request for revalidation has been sent by the Medicare Administrative Contractor (MAC). A "Revalidation Notice Sent" date will be displayed on the My Enrollments page. This will reflect the date in which the Revalidation Letter was mailed by the MAC to the provider/supplier. The date will be displayed on the My Enrollments page for 120 days.

In addition, users will be able to identify those enrollments that are accredited for Advanced Diagnostic Imaging (ADI) Services. An ADI Services indicator will be visible on the My Enrollments page as either a "Yes" or "No".

Electronic Submission and Signature of Electronic Funds Transfer (EFT) Agreement

Users can now complete and submit EFT Agreements electronically with the option to e-sign the document. If the provider/supplier submits the EFT agreement electronically and chooses not to e-sign, they shall include a hardcopy form of the completed and signed EFT agreement with its supporting documentation to the contractor. Providers/suppliers are still required to physically mail confirmation of account information on bank letterhead, or a voided check whether the EFT is submitted electronically or via the paper version. Along with the documentation, it is also important that the provider/supplier print and mail the enrollment submission confirmation page containing the web tracking ID. This will ensure that the supporting documents mailed to your MAC get associated with your electronic application submission.

Did you know?

All FFS providers, including Federally Qualified Health Centers (FQHCs), End Stage Renal Disease (ESRD) Facilities, and Rural Health Clinics (RHCs) can take advantage of Internet-Based PECOS to check and update Medicare enrollment information.

To access internet-based PECOS, go to the PECOS Website.

Medicare Enrollment/Revalidation: Requests for IRS Form CP 575

The IRS Form CP 575 is an Internal Revenue Service (IRS) generated letter you receive from the IRS granting your Employer Identification Number (EIN). A copy of your CP 575 may be required by the Medicare contractor to verify the provider or supplier's legal business name and EIN.

When is the CP 575 is required to be submitted to the Medicare contractor?

- If the applicant is enrolling as a professional corporation, professional association, or limited liability corporation
- If the applicant is enrolling as a sole proprietor using an EIN
- If the Medicare contractor determines a discrepancy between the provider or supplier's legal business name and EIN provided in Section 2 of the CMS-855 form
- The CP 575 May be requested by the CMS External User Services (EUS) Help Desk, for verification, when the Authorized Official (AO) of the provider or supplier organization registers for Internet-based PECOS access.

If you do not have a form CP 575: contact the IRS on 1-800-829-4933 from 7 a.m. to 7 p.m.

Save Time - Submit Your Medicare Enrollment Application through Internet-Based PECOS, Now with e-Signature

Internet-based PECOS (Provider Enrollment, Chain, and Ownership System) now allows providers and suppliers to *sign Medicare enrollment applications electronically*. Save time and expedite review of your application by using internet-based PECOS. (This feature does not change who is required to sign the application.)

In internet-based PECOS, all *Individual Provider applications* that do not include new reassignments may e-sign the application as part of the submission process. This applies to Physicians and Non-Physician Practitioners, including those enrolling just to order and refer.

Any *Organizational Provider applications* that are submitted via internet-based PECOS will require the user completing the application to provide an email address for the authorized official/delegated official (AO/DO) of the application as part of the submission process. The AO/DO can then follow the instructions in the email and electronically sign the application. This applies to Institutional Providers; Clinics, Group Practices, and Certain Other Suppliers; and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Suppliers.

Any Individual Provider application (855-I) containing new reassignments (855-R) can be electronically signed as part of the submission process; however, you must select the AO/DO for the Organization that is accepting the reassignment and enter that official's email address. The official then will be required to follow the instruction in the email and electronically sign the application.

If an individual provider or AO/DO does not want to make use of the e-signature process, they can simply follow the current process of printing and signing the certification statement (which then needs to be mailed to their appropriate contractor).

Learn more about PECOS at https://PECOS.CMS.hhs.gov, and be on the look-out for more enhancements in the coming months! Questions concerning a system issue regarding PECOS should be referred to the CMS EUS Help Desk at 866-484-8049 or EUSSupport@cgi.com.

Sign Your Medicare Enrollment Application Electronically

Internet-based PECOS (Provider Enrollment, Chain, and Ownership System) now allows providers to sign Medicare enrollment applications electronically. Save time and expedite review of your application by using internet-based PECOS. This feature does not change who is required to sign the application.

Any Organizational Provider applications that are submitted via internet-based PECOS will require the user completing the application to provide an email address for the authorized signer of the application as part of the submission process. The authorized signer can then follow the instructions in the email and electronically sign the application. This applies to applications using the following forms:

- 855-A for Institutional Providers
- 855-B for Clinics, Group Practices, and Certain Other Suppliers, and
- **855-S** for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Suppliers

In internet-based PECOS, all Individual Provider applications submitted by the individual provider that do not include new reassignments may be e-signed as part of the submission process. This applies to applications using the following forms:

- 855-I for Physicians and Non-Physician Practitioners, and
- 855-O for Eligible Ordering and Referring Physicians and Non-physician Practitioners

Any Individual Provider application (855-I) containing new reassignments (855-R) can be electronically signed as part of the submission process; however, you must select the Authorized Official / Delegated Official (AO/DO) for the Organization that is accepting the reassignment and enter that official's email address. The official then will be required to follow the instruction in the email and electronically sign the application.

If an individual provider or AO/DO does not want to make use of the e-signature process, they can simply follow the current process of printing and signing the certification statement (which then needs to be mailed to the appropriate contractor).

Questions concerning a system issue regarding PECOS should be referred to the CMS EUS Help Desk at 866-484-8049 or EUSSupport@cgi.com.

Submit Medicare Enrollment Application Up to 60 Days Before Effective Date

Providers and suppliers can now submit their enrollment applications 30 days sooner. CMS-855 enrollment applications and Internet-based PECOS applications may now be submitted 60 days prior to the effective date.

Note: This does not apply to providers and suppliers submitting a Form CMS-855A application, Ambulatory Surgical Centers (ASCs), or Portable X-ray Suppliers (PXRSs).

Were You Sent a Request to Revalidate Your Medicare Enrollment?

Lists of providers sent notices to revalidate their Medicare enrollment may be found on the CMS website at http://www.CMS.gov/MedicareProviderSupEnroll/11_Revalidations.asp and in the links below. Information on revalidation letters sent in February will be posted in late March.

- Revalidations Mailed September through October 2011
- Revalidations Mailed November through December 2011
- Revalidations Mailed January 2012

CMS is working to make this information available in Internet-based PECOS (Provider Enrollment, Chain, and Ownership System) in mid April.

FRAUD AND ABUSE

Health Care Law Protects Against Fraud, Saves Nearly $1.6 Billion

Law Requires Stronger Standards for Ordering and Certifying Medical Services, Equipment, and Supplies

On April 24, CMS announced a final rule that prevents fraud in Medicare and is estimated to save taxpayers nearly $1.6 billion over 10 years.

This rule ensures that only qualified, identifiable providers and suppliers can order or certify certain medical services, equipment and supplies for people with Medicare. The rule also helps ensure beneficiaries receive quality care because CMS will verify the credentials of a provider who is ordering or certifying equipment and supplies.

In addition, the final rule continues to require that all providers and suppliers who qualify for a unique identification number, the National Provider Identifier (NPI), include their NPI on applications to enroll in Medicare and Medicaid and on all reimbursement claims submitted. This gives CMS and States the ability to tie specific claims to the ordering or certifying physician or eligible professional and to check for suspicious ordering activity.

This rule builds on the work CMS is also doing in Medicare Part D by requiring that all prescriptions include an NPI for prescribing physicians. In conjunction with Part D, these efforts will help better safeguard the Medicare Trust Funds by giving CMS the ability to know which providers are ordering, certifying, and prescribing items and services to Medicare beneficiaries.

To see the final rule, visit the Office of the Federal Register website.

Full text of this excerpted CMS press release (issued April 24).

HHS and Department of Justice Highlight Health Reform Tools to Combat Medicare Fraud

HHS Secretary and the Attorney General hosted the Seventh Regional Health Care Fraud Prevention Summit on Wednesday, April 4. At this Chicago summit highlighting a new high-tech war against healthcare fraud, HHS Secretary Kathleen Sebelius and Attorney General Eric Holder discussed how the *Affordable Care Act* and the Obama Administration's Health Care Fraud Prevention and Enforcement Action Team (HEAT) are helping fight Medicare fraud.

The regional summits bring together a wide array of public and private partners, and are part of the HEAT partnership between HHS and the Department of Justice to prevent and combat healthcare fraud. The Obama Administration's HEAT efforts have resulted in record-breaking healthcare fraud recoveries. In FY2011, for the second year in a row, the departments' anti-fraud activities resulted in more than $4 billion in recoveries, an all-time high.

New tools provided by the *Affordable Care Act* are strengthening the Obama Administration's efforts to fight healthcare fraud. As a result of *Affordable Care Act* provisions:

- Criminals face tougher sentences for healthcare fraud, 20-50 percent longer for crimes that involve more than $1 million in losses
- Contractors that police the Medicare program for waste, fraud, and abuse will expand their work to Medicaid, Medicare Advantage, and Medicare Part D programs
- Government entities, including states, CMS, and law enforcement partners at the Office of the Inspector General (OIG) and DOJ, have greater abilities to work together and share information so that CMS can prevent money from going to bad actors by using its authority to suspend payments to providers and suppliers engaged in suspected fraudulent activity

On Wednesday, April 4, the Obama Administration also announced more progress from its anti-fraud efforts, beyond the nearly $4.1 billion recovered last year:

- In the early phase of revalidating the enrollment of providers in Medicare, 234 providers were removed from the program because they were deceased, debarred, or excluded by other federal agencies, or were found to be in false storefronts or otherwise invalid business locations
- In 2011, HHS revoked 4850 Medicaid providers and suppliers and deactivated 56,733 Medicare providers and suppliers as HHS took steps to close vulnerabilities in the Medicare program
- In 2011, HHS saved $208 million through pre-payment edits that stop implausible claims before they're paid

- Prosecutions are up: the number of individuals charged with fraud increased from 797 in FY2008 to 1430 in FY2011 – nearly a 75 percent increase
- In the first few weeks of enhanced site visits required under the *Affordable Care Act* screening requirements, HHS found 15 providers and suppliers whose business locations were non-operational and terminated their billing privileges
- Through outreach and engagement efforts, more than 49,000 complaints of fraud from seniors and people with disabilities reported to 1-800-MEDICARE were referred for further evaluation

A recent redesign of the quarterly Medicare Summary Notices received by Medicare beneficiaries makes it easier to spot and report fraud

The full text of this excerpted HHS press release (issued Wed Apr 4) can be found at http://www.HHS.gov/news/press/2012pres/04/20120404a.html.

Role of ZPICs, Formerly PSCs

MLN Matters® Number: SE1204 Revised

Note: This article was revised on February 29, 2012, to add Hawaii and several territories to ZPIC Zone 1 and to add Puerto Rico and the Virgin Islands to ZPIC Zone 7 of the table on page 2. All other information is the same.

Provider Types Affected

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

Background

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 established the Medicare Integrity Program (MIP). MIP was established, in part, to strengthen the Centers for Medicare & Medicaid Services' (CMS') ability to detect and deter potential fraud, waste, and abuse in the Medicare program. MIP allows CMS to carry out program safeguard functions effectively and efficiently. As part of this program, CMS created new entities, Program Safeguard Contractors (PSCs), to perform program integrity functions.

On December 8, 2003, the Medicare Modernization Act (MMA) was signed into law. Section 911 of the MMA directed implementation of Medicare Fee-For-Service Contracting Reform. This required CMS to use competitive procedures to replace its current FIs and carriers with a uniform type of administrative entity, referred to as Medicare Administrative Contractors (MACs).

As a result of these changes, seven program integrity zones were created based on the newly-established MAC jurisdictions. New entities entitled Zone Program Integrity Contractors (ZPICs) were created to perform program integrity functions in these zones for Medicare Parts A, B, Durable Medical Equipment Prosthetics, Orthotics, and Supplies, Home Health and Hospice and Medicare-Medicaid data matching. Medicare Part C and D program integrity efforts are handled separately by one national contractor known as the Medicare Drug Integrity Contractor (MEDIC) (Health Integrity, LLC is the current MEDIC). The ZPICs and the MEDIC work under the direction of the Center for Program Integrity (CPI) in CMS.

The following table lists all of the ZPICs and their zones.

ZPIC	Zone	States in Zone
Safeguard Services (SGS)	1	California, Hawaii, Nevada, American Samoa, Guam, and the Mariana Islands
AdvanceMed	2	Washington, Oregon, Idaho, Utah, Arizona, Wyoming, Montana, North Dakota, South Dakota, Nebraska, Kansas, Iowa, Missouri, Alaska
Cahaba	3	Minnesota, Wisconsin, Illinois, Indiana, Michigan, Ohio, Kentucky
Health Integrity	4	Colorado, New Mexico, Texas, and Oklahoma

ZPIC	Zone	States in Zone
AdvanceMed	5	Arkansas, Louisiana, Mississippi, Tennessee, Alabama, Georgia, North Carolina, South Carolina, Virginia, West Virginia
Under Protest	6	Pennsylvania, New York, Delaware, Maryland, D.C., New Jersey, Massachusetts, New Hampshire, Vermont, Maine, Rhode Island, Connecticut
Safeguard Services (SGS)	7	Florida, Puerto Rico, Virgin Islands

Medicare Fraud

Fraud frequently arises from false statements or misrepresentations made that are material to entitlement or payment under the Medicare Program. A violator may be a provider, a beneficiary, or an employee of a provider or some other business entity including a billing service. Providers have an obligation, under law, to conform to the requirements of the Medicare Program. Fraud committed against the program may be prosecuted under various provisions of the United States Code and could result in the imposition of restitution, fines, and, in some instances, imprisonment. In addition, a wide range of administrative sanctions (such as deactivation or revocation of Medicare enrollment or billing privileges, suspension of payments, or exclusion from participation in the Medicare Program) and civil monetary penalties may be imposed when facts and circumstances warrant such action. An investigation that demonstrates potential fraud may be referred to law enforcement for further investigation.

Contacts for Reporting Potential Fraud

Beneficiaries may report Medicare fraud by calling 1-800-MEDICARE or the Department of Health and Human Services (DHHS) Office of Inspector General (OIG) hotline at 1-800-HHS-TIPS (1-800-447-8477). Providers may report fraud by calling the DHHS Office of Inspector General hotline at 1-800-HHS-TIPS (1-800-447-8477).

ZPIC Functions

The primary goal of ZPICs is to investigate instances of suspected fraud, waste, and abuse. ZPICs develop investigations early, and in a timely manner, take immediate action to ensure that Medicare Trust Fund monies are not inappropriately paid. They also identify any improper payments that are to be recouped by the MAC. Actions that ZPICs take to detect and deter fraud, waste, and abuse in the Medicare Program include:

- Investigating potential fraud and abuse for CMS administrative action or referral to law enforcement;
- Conducting investigations in accordance with the priorities established by CPI's Fraud Prevention System;
- Performing medical review, as appropriate;
- Performing data analysis in coordination with CPI's Fraud Prevention System;
- Identifying the need for administrative actions such as payment suspensions and prepayment or auto-denial edits; and,
- Referring cases to law enforcement for consideration and initiation of civil or criminal prosecution.

In performing these functions, ZPICs may, as appropriate:

- Request medical records and documentation;
- Conduct an interview;
- Conduct an onsite visit;
- Identify the need for a prepayment or auto-denial edit and refer these edits to the MAC for installation;
- Withhold payments; and,
- Refer cases to law enforcement.

ZPICs also support victims of Medicare identity theft. A provider or supplier who believes that he/she may have had their provider information stolen and used to submit Medicare claims for which payment was made can request that the ZPIC for their zone investigate the case. The ZPIC will then work with CMS to determine the appropriate remedial action to assist the provider. Guidance on how to avoid and report Medicare identity theft and information on current scams can be found at http://www.cms.gov/MedicareProviderSupEnroll/downloads/ProviderVictimPOCs.pdf on the CMS website.

FRAUD AND ABUSE CONT'D

Non-ZPIC Functions

The following are some of the major functions that the ZPICs do not perform. These functions are performed by the MAC:

- Claims processing, including paying providers/suppliers;
- Provider outreach and education;
- Recouping monies lost to the Trust Fund (the ZPICs identify these situations and refer them to the MACs for the recoupment);
- Medical review not for benefit integrity purposes;
- Complaint screening;
- Claims appeals of ZPIC decisions;
- Claim payment determination;
- Claims pricing; and
- Auditing provider cost reports.

Additional Information

More information about Medicare contracting reform is available at http://www.cms.gov/MedicareContractingReform on the CMS website.

The Medicare Learning Network® (MLN) brochure titled "The Medicare Appeals Process: Five Levels to Protect Providers, Physicians and Other Suppliers," which is designed to provide education on the Medicare Part A and B administrative appeals process, is available at http://www.cms.gov/MLNProducts/downloads/MedicareAppealsprocess.pdf on the CMS website.

The MLN fact sheet titled "Medicare Fraud & Abuse: Prevention, Detection, and Reporting," which is designed to provide education on preventing, detecting and reporting Medicare fraud and abuse, is available at available at available at http://www.cms.gov/MLNProducts/downloads/Fraud_and_Abuse.pdf on the CMS website. For the latest educational products designed to help Medicare Fee-For-Service providers understand – and avoid – common billing errors and other improper activities, please visit the MLN Provider Compliance web page at http://www.cms.gov/MLNProducts/45_ProviderCompliance.asp on the CMS website.

GLUCOSE MONITORS

Glucose Monitors – Policy Revision Summary

Effective for dates of service on or after 07/01/2012, the local coverage determination (LCD) for home blood glucose monitors and supplies is being revised. The changes primarily reflect standardization of language and simplification of coverage criteria. Highlights of the changes include:

Indications and Limitations of Coverage and/or Medical Necessity Section

- Consolidated basic coverage criteria into two criteria
- Revised the training requirement (Basic criterion 2)
- Clarified that utilization parameters are based on insulin use status
- Standardized strip utilization parameters based on three (3) month billing timeframe
- Clarified the coverage requirements for usual utilization and high utilization of testing strips
- Moved treating physician documentation of strip utilization from Indications and Limitations of Coverage and/or Medical Necessity (ILCMN) Section to Documentation Section

Documentation Requirements Section

- Added standard documentation requirements, including orders, refill documentation, continued use, continued need and proof of delivery
- Clarified that on the Detailed Written Order (DWO), listing the frequency of use is only required for strips and lancets

GLUCOSE MONITORS CONT'D

Policy-Specific Documentation Requirements Section

- Changed section name from "Miscellaneous Information" to "Policy-Specific Information"
- Moved from ILCMN Section requirements for documenting medical necessity for high utilization beneficiaries
- Provided additional details for documentation of in-person visit with the treating physician

Note that the requirement for the beneficiary to maintain a log of testing results has been removed from the LCD. Documentation of continued medical need for usual utilization beneficiaries is addressed in the "Continued Need" section. Documentation of continued medical need for high utilization beneficiaries is addressed in the "Policy-Specific Information" section.

This article only summarizes the changes in the LCD. Suppliers are strongly encouraged to read the entire LCD and related policy article for additional information on the coverage, coding and documentation of blood glucose monitors, supplies and related accessories.

Glucose Resource Booklet Mailed February 2012

In February 2012, NAS mailed a glucose booklet to active suppliers billing glucose monitors and testing supplies as this policy group has an impact on the Comprehensive Error Rate Testing (CERT) error rate. The contents, with the exception of the introductory letter, may be accessed from our website and have been reflected below in the event suppliers choose to maintain current copies of the material or reproduce additional copies for training purposes.

1. Promotion for workshop registration for 03/29, 04/19 and 05/17; https://www.noridianmedicare.com/dme/train/schedule.html
2. Presentation Glucose Monitors and Testing Supplies https://www.noridianmedicare.com/dme/train/presentations/glucose_monitors.pdf
3. Local Coverage Determination (LCD) https://www.noridianmedicare.com/dme/coverage/docs/lcds/current_lcds/glucose_monitors.htm
4. Policy Article https://www.noridianmedicare.com/dme/coverage/docs/lcds/current_articles/glucose_monitors.htm
5. CERT Review Process; https://www.noridianmedicare.com/dme/coverage/cert.html
6. CERT Educational Fact Sheet from CMS: http://www.cms.gov/MLNProducts/downloads/GlucSup_DocCvge_FactSheet_ICN905104.pdf
7. MR, NCI Edits, MUEs, CERT and RAC Booklet
8. Glucose Documentation Checklist https://www.noridianmedicare.com/dme/coverage/docs/checklists/glucose_monitors_and_supplies.pdf
9. Patient Documentation Form – Insulin Using
10. Patient Documentation Form – Non-Insulin Using
11. Physician Documentation Requirements – Blood Glucose Strips and Lancets
12. Physician Letter – Signature Authentication Tips
13. Physician Letter – Continued Medical Necessity
14. Dear Physician Letter – Continued Use
15. Physician Letter – Medical Records
16. DME MAC Redetermination Request
17. Acronym Listing: https://www.noridianmedicare.com/dme/news/manual/acronyms.html
18. IVR at a Glance
19. Endeavor Brochure
20. E-mail List Sign-up Instructions

We hope you find the booklet of value as you work with Medicare coverage criteria and billing requirements.

HCPCS A4253 KS – Notification of Prepayment Review

NAS Jurisdiction D DME MAC Medical Review will be initiating a widespread prepayment review of claims for HCPCS code A4253 (blood glucose test or reagent strips for home blood glucose monitor, per 50 strips). The review will be focused on non-insulin treated beneficiaries (KS modifier) who are receiving quantities of supplies that exceed the utilization guidelines defined in the Glucose Monitors LCD. For non-insulin treated patients, the guidelines are:

A4253 Two units of service (100 strips) in a 90 day period

Widespread reviews are used to determine the extent of potential problem areas across multiple suppliers. This review is being initiated based on the results of Comprehensive Error Rate Testing (CERT) review analysis and previous review results.

In order to evaluate compliance with Medicare coverage and coding rules, all suppliers billing Jurisdiction D for HCPCS code A4253 with the KS modifier are subject to this review. Suppliers of the selected claims will receive an *Additional Documentation Request* (ADR) letter asking for specific information to determine if the item billed complies with the existing reasonable and necessary criteria. Failure to supply the requested information within 45 days of the date on the letter will result in the claim being denied as not medically necessary. The ADR letter will provide instruction for submitting documentation.

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Glucose Monitors Local Coverage Determination (LCD) L196 and Policy Article A33673.

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

Results of Widespread Prepayment Review of Diabetic Supplies

The Jurisdiction D DME MAC Medical Review Department has completed a widespread complex review of HCPCS code A4253 (Blood glucose test or reagent strips for home blood glucose monitor, per 50 strips) and the resulting edit effectiveness from September 2011 through February 2012 are as follows:

The results for the insulin using diabetic, A4253KX modifier review were of the 1,905 identified for the review 1,579 claims were denied. A total of 552 claims were denied for no response to the additional documentation request. This resulted in an overall error rate of 60%.

The results for the non-insulin using diabetic A4253KS modifier review were of the 4,962 identified for the review 4,760 were denied. A total of 1,740 were denied for no response to the additional documentation request. This resulted in an overall error rate of 81%.

DME MAC D will close these reviews for A4253 blood glucose test or reagent strips for home blood glucose monitor, per 50 strips. By closing this file, medical review will no longer request documentation for the specified criteria. Contractors are required to monitor the utilization patterns of suppliers and observe for medical necessity and appropriate coding practices. Claims will be subject to the routine claims processing system and edits that may suspend claims for review.

The following are the top reasons for denial:

1. Requested documentation was not provided within the allotted time frame as referenced in the Medicare guidelines
2. Documentation submitted did not support testing frequency above utilization guidelines
3. Invalid or no beneficiary evidence of exhaustion
4. Claims were submitted with incorrect modifier

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

1. 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 National Supplier Clearinghouse (NSC).

GLUCOSE MONITORS CONT'D

2. Criteria d, e and f of Local Coverage Determination (LCD) L196 address the requirements needed to support above utilization guideline testing. The LCD states the following:
   - d. The treating physician has ordered a frequency of testing that exceeds the utilization guidelines and has documented in the patient's medical record the specific reason for the additional materials for that particular patient.
   - e. The treating physician has seen the patient and has evaluated their diabetes control within 6 months prior to ordering quantities of strips and lancets, or lens shield cartridges that exceed the utilization guidelines.
   - f. If refills of quantities of supplies that exceed the utilization guidelines are dispensed, there must be documentation in the physician's records (e.g., a specific narrative statement that adequately documents the frequency at which the patient is actually testing or a copy of the beneficiary's log) or in the supplier's records (e.g., a copy of the beneficiary's log) that the patient is actually testing at a frequency that corroborates the quantity of supplies that have been dispensed. If the patient is regularly using quantities of supplies that exceed the utilization guidelines, new documentation must be present at least every six months.
3. Documentation must be provided to meet criterion C per LCD L196 supporting the beneficiary has nearly exhausted the supply of test strips and lancets, or useful life of one lens shield cartridge previously dispensed.
   - For DMEPOS products (A4233-A4236, A4253, A4256, A4258 and A5259) 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.
4. The documentation provided must support the modifier used that the claim was billed with.
   - If the patient is being treated with insulin injections, the KX modifier must be added to the code for the monitor and each related supply on every claim submitted. The KX modifier must not be used for a patient who is not treated with insulin injections.
   - If the patient is not being treated with insulin injections, the KS modifier must be added to the code for the monitor and each related supply on every claim submitted.

To be eligible for coverage of home blood glucose monitor and related accessories and supplies, the patient must meet the criteria as noted in Local Coverage Determination (LCD) L196 and Policy Article A33673. It is important for suppliers to be familiar with the documentation requirements outlined in the Glucose Monitor LCD and Policy Article. Please ensure when submitting additional documentation, that all supporting medical necessity documentation is provided. Supplier responses should also be submitted timely.

The following references were used in the medical review of these claims and can be accessed on our NAS DME website at https://www.noridianmedicare.com/dme/:

- Glucose Monitors LCD (L196)
- Glucose Monitors Policy Article (A33673)
- Home Blood Glucose Monitors (National Coverage Determination 40.20)
- Supplier Manual
- Program Integrity Manual: http://www.cms.gov/manuals/downloads/pim83c04.pdf

In addition, there are other educational resources that can be found on our website:
https://www.noridianmedicare.com/dme/news/glucose_monitors_testing_supplies.html

HOSPITAL BEDS

HCPCS E0260 – Notification of Prepayment Review

NAS Jurisdiction D DME MAC Medical Review will be initiating a widespread prepayment review of claims for Hospital Beds with HCPCS E0260 (Hospital bed, semi-electric, head and foot adjustment, with any type of side rails, with mattress) and related accessories. Widespread reviews are used to determine the extent of potential problem areas across multiple suppliers. This review is being initiated based on the results of Comprehensive Error Rate Testing (CERT) analysis and previous review results.

In order to evaluate compliance with Medicare coverage and coding rules, all suppliers billing Jurisdiction D for HCPCS E0260 are subject to this review. Suppliers of the selected claims will receive an *Additional Documentation Request* (ADR) letter asking for specific information to determine if the item billed complies with the existing reasonable and necessary criteria. Failure to supply the requested information within 45 days of the date on the letter will result in the claim being denied as not medically necessary. The ADR letter will provide instruction for submitting documentation.

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Hospital Beds and Accessories Local Coverage Determination (LCD) L11572 and related Policy Article A37079.

Information about prepayment 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

ICD-10

30-Day Comment Period Now Open for HHS Proposed Rule to Delay ICD-10

On April 9, HHS Secretary Kathleen Sebelius announced a proposed rule that would delay the compliance date for ICD-10 from October 1, 2013 to October 1, 2014. Comments are due to HHS no later than 5 p.m. ET on May 17.

HHS believes the change in the compliance date for ICD-10, as proposed in this rule, will give providers and other covered entities more time to prepare and fully test their systems to ensure a smooth and coordinated transition among all industry segments.

The 30-day comment period for this rule is an important way to provide feedback to HHS about the proposed ICD-10 compliance date change. You can submit comments in the following ways:

- Electronically by following the ‘‘Submit a comment’’ instructions on the Regulations.gov website
- By regular mail sent to:

  Centers for Medicare & Medicaid Services
  Department of Health and Human Services
  Attention: CMS–0040–P
  P.O. Box 8013
  Baltimore, MD 21244–8013

More information about the proposed rule can be found in the One-Year Delay of ICD-10 Compliance Date fact sheet, which outlines the background of the ICD-10 compliance date, and highlights provisions of the proposed rule and standards compliance date.

HHS Announces Intent to Delay ICD-10 Compliance Date

As part of President Obama’s commitment to reducing regulatory burden, Health and Human Services Secretary Kathleen G. Sebelius today announced that HHS will initiate a process to postpone the date by which certain health care entities have to comply with International Classification of Diseases, 10th Edition diagnosis and procedure codes (ICD-10).

The final rule adopting ICD-10 as a standard was published in January 2009 and set a compliance date of October 1, 2013 – a delay of two years from the compliance date initially specified in the 2008 proposed rule. HHS will announce a new compliance date moving forward.

“ICD-10 codes are important to many positive improvements in our health care system,” said HHS Secretary Kathleen Sebelius. “We have heard from many in the provider community who have concerns about the administrative burdens

they face in the years ahead. We are committing to work with the provider community to reexamine the pace at which HHS and the nation implement these important improvements to our health care system."

ICD-10 codes provide more robust and specific data that will help improve patient care and enable the exchange of our health care data with that of the rest of the world that has long been using ICD-10. Entities covered under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) will be required to use the ICD-10 diagnostic and procedure codes.

ICD-10: It's Closer Than It Seems - Have You Completed Your 5010 Implementation?

Recently, CMS announced it will not initiate enforcement action against any HIPAA-covered entity for an additional three months, through Saturday, June 30, for the updated HIPAA transaction standards (ASC X12 Version 5010, NCPDP Versions D.0 and 3.0). Although much progress has been made in the successful receipt and processing of claims in the Version 5010 format, CMS is aware that there are still challenges and issues impeding an industry-wide upgrade.

During these additional 90 days during which CMS will not initiate enforcement penalties, you should collaborate more closely with trading partners on appropriate strategies to resolve any remaining problems. Two steps providers can take to ensure a smooth upgrade include:

1. Establish a line of credit: To avoid potential cash flow disruptions, providers should consider establishing or increasing a line of credit. By doing so, they can prepare for possible delays and denials in payer claims reimbursements if noncompliant Version 5010 transactions are submitted.
2. Check partner readiness: Because a provider's Version 5010 upgrade can be dependent upon his or her vendor, it is important for providers to be aware of their vendor's transition status. If your vendor is behind schedule for Version 5010 adoption, get confirmation of their timeline to be compliant, and encourage them to take action so that your system will be prepared to handle your claims.

Other steps to prepare for the Version 5010 upgrade can be found in the "Version 5010: Ensuring a Smooth Transition" factsheet, which provides an overview of several actions providers can take to maintain continuity of operations for their practices as they prepare to complete Version 5010 testing.

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!

CMS.gov Website Upgrade: Please take note that CMS is in the process of making upgrades to the www.CMS.gov website. If you encounter problems accessing information while on the site, please refresh the page or check back later. We appreciate your understanding and apologize for any inconvenience

New Health Care Law Provisions Cut Red Tape, Save up to $4.6 Billion

ICD-10 Compliance Delayed Until Oct 1, 2014

HHS Secretary Kathleen Sebelius today announced a proposed rule that would establish a unique health plan identifier under the *Health Insurance Portability and Accountability Act of 1996* (*HIPAA*). The proposed rule would implement several administrative simplification provisions of the *Affordable Care Act.*

The proposed changes would save health care providers and health plans up to $4.6 billion over the next ten years, according to estimates released by the HHS today. The estimates were included in a proposed rule that cuts red tape and simplifies administrative processes for doctors, hospitals, and health insurance plans.

The rule simplifies the administrative process for providers by proposing that health plans have a unique identifier of a standard length and format to facilitate routine use in computer systems. This will allow provider offices to automate and simplify their processes, particularly when processing bills and other transactions.

The proposed rule also delays required compliance by one year—from October 1, 2013, to October 1, 2014—for new codes used to classify diseases and health problems. These codes, known as the International Classification of Diseases, 10th Edition (ICD-10) diagnosis and procedure codes will include new procedures and diagnoses and improve the quality of information available for quality improvement and payment purposes.

ICD-10 CONT'D

The proposed rule announced today is the third in a series of administrative simplification rules in the new health care law. HHS released the first in July of 2011 and the second in January of 2012, and plans to announce more in the coming months.

More information on the proposed rule is available on fact sheets at http://www.CMS.gov/apps/media/fact_sheets.asp.

The proposed rule may be viewed at www.ofr.gov/inspection.aspx. Comments are due 30 days after publication in the *Federal Register*.

The full text of this excerpted CMS press release (issued Monday, April 9) can be found at http://www.CMS.gov/apps/media/press/release.asp?Counter=4329.

IVR

Appeal Status Now Available Through IVR System

Beginning Wednesday, February 29, 2012, suppliers will be able to obtain appeal status through the NAS Jurisdiction D Interactive Voice Response (IVR) System. Below are instructions on how to utilize this new menu option.

Appeals

To access the appeals option from the main menu, key or speak the selection as below:

Touch-tone Option	Vocal Option
8	Appeals

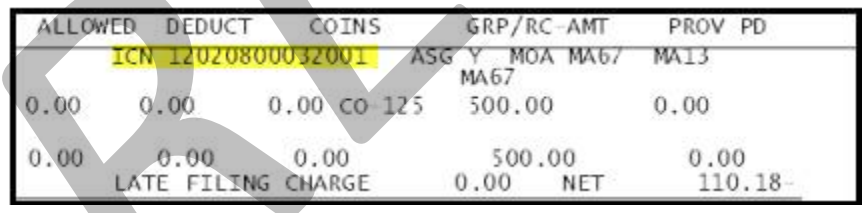
The IVR will obtain the supplier authentication elements before proceeding. When requested, key or speak the following information:

- National Provider Identifier (NPI)
- Provider Transaction Access Number (PTAN)
- Last five digits of supplier Tax Identification Number (TIN)

After the authentication elements have been verified the IVR will request the information related to the appeal. When requested, key or speak the following information:

- Beneficiary's Medicare number
- Beneficiary's name as it appears on the Medicare card
- 14-digit claim control number (CCN)

The CCN can be found on the remittance advice in the field labeled ICN (Internal Control Number).



Successful Request

If the request is successful, the IVR will provide the Document Control Number (DCN) assigned to all open or closed supplier appeals attached to the CCN provided. If the appeal is open, the IVR will provide an additional description of its' current status such as "pending a decision from medical review." If the appeal is closed, the IVR will state it is closed and provide additional information regarding the appeal such as whether the appeal was fully/partially favorable, unfavorable, or dismissed. If multiple appeals are attached to the claim say "next appeal" to move the next appeal in the list.

Unsuccessful Request

If the request is unsuccessful, the IVR will advise the caller no appeal was found with the information provided. Verify that the correct CCN was entered. If the claim was submitted multiple times, the appeal will be attached to the first

claim submission denied with appeal rights. Be sure to enter the CCN for the first claim submission denied with appeal rights even if a subsequent CCN was entered on the appeal form.

Navigation

Once all information has been provided, key or speak the selection as below to continue:

Touch-tone Option	Vocal Option
1	Repeat That
4	Another Appeal
5	Change Medicare Number
6	Change NPI

Note: NAS Jurisdiction D will be changing the process for acknowledging redetermination requests. The current process is to mail acknowledgement letters. This will be changing as suppliers must now use Endeavor or the IVR to verify receipt. With the addition of Appeals to the IVR, some of the menu options have changed. Refer to the updated IVR User Guide and IVR At-A-Glance brochure for complete instructions on how to use the updated IVR.

Overlapping or Frequency Denials Available on NAS IVR

Effective May 4, 2012, the NAS DME Jurisdiction D Interactive Voice Recognition (IVR) system was enhanced to offer an overlapping claims inquiry option. For claims denied as duplicate or due to frequency/overutilization, the IVR offers information on other claims that potentially led to the denial. The specific ANSI messages reported on the remittance advice for claims for which suppliers are able to utilize the new feature are listed below:

N115 and N150 reported for the same line- Frequency/Overutilization

N111 and N18 reported for the same line- Duplicate

This new inquiry feature should **not** be used for same or similar equipment inquiries. Instructions on accessing this feature are detailed below:

1. Dial the IVR 1-877-320-0390
2. Select menu option 1 or speak "Claim Status"
3. Enter the National Provider Identifier (NPI), Provider Transaction Access Number (PTAN), and the last five digits of the supplier Tax Identification Number (TIN)
4. A new sub-menu option plays; when prompted, enter 2 or speak "Overlapping Claims"
5. Key or speak the beneficiary's Medicare Health Insurance Claim Number (HICN)
6. Key or speak the beneficiary's name as it appears on the Medicare card
7. Enter the date of service of the denied claim
8. Enter the HCPCS code

On duplicate denials the IVR provides the following information to the caller:

1. "To" and "from" date of service of all paid and/or denied claims containing duplicate information as the inquired upon claim. The IVR does not return other claims which also received a duplicate denial. Based on the claims information returned a determination can be made if a payment was already made to the same or another supplier on a previous claim submission, or if an earlier claim submission was denied with appeal rights. The claim status option maybe used in conjunction with the overlapping claims to make this determination. Instances where an earlier submission was denied with appeal rights will require the supplier to follow the appeals process to receive payment.
2. Allowed amount
3. Number of services
4. Supplier Name

5. Supplier Phone Number
6. On frequency/overutilization denials the IVR provides the following information to the caller:
7. "To" and "from" date of service of all paid claims which potentially caused the denial.
8. Allowed amount
9. Number of services
10. Supplier Name
11. Supplier Phone Number

If multiple claims are returned, use the following options to navigate through the claims and obtain the claim information:

1. Repeat That
2. Next Claim
3. Previous Claim

To obtain information on a different claim, key or speak the selection as below:

4. Change Date
5. Change HCPCS
6. Change Medicare Number
7. Main Menu

Please be aware that if the frequency/overutilization denial resulted from a complex medical review the IVR may not be able to provide insight into the denial. The most common HCPCs codes receiving a frequency/overutilization denial which this IVR feature can assist in resolving are found below:

A4253, A4258-A4259, A4314-A4316, A4327, A4332-A4334, A4338-A4346, A4351-A4352, A4354, A4356-A4358, A4361-A4362, A4367, A4369, A4371, A4377, A4381, A4397-A4399, A4404-A4406, A4414-A4427, A4429, A4431-A4432, A4434, A4450, A4452, A4557, A4595, A4604, A4619, A4624, A4629, A5051-A5055, A5061-A5063, A5071-A5073, A5081-A5083, A5093, A5102, A5112, A5120, A5122, A5126, A5131, A6154, A6196-A6198, A6200-A6224, A6231-A6248, A6251-A6259, A6266, A6402-A6404, A6407, A6545, A6550, A7000, A7003-A7007, A7010-A7017, A7027-A7039, A7046, A7525, B4034-B4036, B4081-B4083, B4087-B4088, E0486, E2402, J2545, J7605-J7606, J7608, J7611-J7614, J7616, J7620, J7621, J7626, J7628, J7629, J7631, J7635-J7636, J7639, J7642-J7644, J7648-J7649, J7658-J7659, J7668-J7669, J7680-J7681, J7686, K0503, K0506-K0509, K0511, K0514-K0516, K0519-K0526, K0672, L4392, L8001-L8002, L8020, L8030-L8032, V2624-V2626.

Please see the IVR Guide for complete instructions on using the IVR. NAS continues to evaluate supplier recommendations, frequent inquiries, and claim submission statistics to enhance NAS' IVR as well as the free supplier portal, Endeavor.

Main Menu Options Have Changed on IVR System

On Wednesday, February 29, 2012, Jurisdiction D is introducing a new menu option (Appeals) into the Interactive Voice Response (IVR) System. With this addition the main menu options have changed. See the key below to determine how to select the appropriate option.

Touch-tone Option	Vocal Option
1	Claim Status
2	Eligibility
3	Pricing
4	Same or Similar HCPCS Lookup
5	Duplicate Remittance Advice

Touch-tone Option	Vocal Option
6	Provider Enrollment
7	Financial
8	Appeals
9	Questions

The IVR Guide and IVR At-A-Glance have also been updated to reflect this new information. For more information on the new menu option see the article Appeal Status Now Available Through IVR System.

Rental Months and Purchase Information Available With Same or Similar IVR Inquiries

Effective March 16, 2012, the NAS Interactive Voice Recognition (IVR) system was enhanced to include the rental months and purchase information on file as part of the Same or Similar (S/S) equipment inquiry response for non oxygen HCPCS codes. The number of oxygen rentals paid remains a separate S/S equipment menu option. Below is a summary of the IVR inquiry responses for this new feature.

- If there is no rental or no lump sum payment on file for the equipment, the IVR will return, "Our records indicate there has not been a payment made by Medicare. This equipment may be beneficiary owned equipment on file to allow the purchases of accessories or may be the result of a return."
- If the equipment has been rented to the purchase price or was lump sum purchased, the IVR will return, "Our records indicate there has been a purchase made by Medicare."
- If the equipment is currently being rented but has not capped/met the purchase price, the IVR will return, "Our records indicate the equipment was rented for (number) months."

The following information is intended to assist suppliers with using the IVR:

- The IVR main menu options were changed February 29, 2012, to support the addition of appeal status inquiries. See the IVR at a Glance.
- Have the IVR at a Glance (PDF) guide readily available when calling the IVR.
- Call the IVR from a quiet location and use a handset or headset to conduct IVR inquiries.
- Calling from a cell phone or using the speaker phone settings is not recommended.
- Menu options may be keyed or spoken without waiting for the entire prompt to play.
- Say "main menu" at any time to go back to the beginning of the call flow.
- If the IVR is having difficulty understanding the information as spoken, try keying the information with the telephone keypad.
- The appropriate modifier must be provided when checking S/S equipment. For more information on which modifier to use see the article Modifier Required When Using the IVR for S/S equipment inquiries.
- Ensure the correct touchtone format is used.
  - The three-key combination should be used to key the beneficiary's name outside the hours of 6:00 a.m. to 8:00 p.m. CT or anytime the beneficiary's name is requested in the first initial of the first name, first six of the last name format. It should also be used to key the HCPCS code and modifier for pricing and S/S equipment and the alpha character in the beneficiary's Medicare Health Insurance Claim Number.

Three Key Conversion Table			
Letter	Key Combo	Letter	Key Combo
A	*21	N	*62
B	*22	O	*63
C	*23	P	*71
D	*31	Q	*11
E	*32	R	*72
F	*33	S	*73
G	*41	T	*81
H	*42	U	*82
I	*43	V	*83
J	*51	W	*91
K	*52	X	*92
L	*53	Y	*93
M	*61	Z	*12

- The single key conversion should be used to key the beneficiary's name during the hours of 6:00 a.m. to 8:00 p.m. CT.

Single Key Conversion Table			
Letter	Key Combo	Letter	Key Combo
A	2	N	6
B	2	O	6
C	2	P	7
D	3	Q	1
E	3	R	7
F	3	S	7
G	4	T	8
H	4	U	8
I	4	V	8
J	5	W	9
K	5	X	9
L	5	Y	9
M	6	Z	1

Suppliers are encouraged to register for the free online NAS supplier portal, Endeavor. Endeavor offers eligibility, claim status, S/S equipment, claim-specific remittance advices, and appeal status inquiries in addition to the ability to submit written reopenings and/or redeterminations with supporting documentation. Information regarding Endeavor is accessible at https://www.noridianmedicare.com/dme/claims/endeavor.html.

Suppliers are required to use self-service tools to complete simple inquiries such as claim status and eligibility (including S/S). Information regarding this requirement was published by NAS January 3, 2011, and is accessible at https://www.noridianmedicare.com/dme/news/docs/2011/01_jan/self_service_technology_must_be_used_011711.html.

MOBILITY DEVICES

CMS Announces Prior Authorization of Power Mobility Devices Demonstration and Recovery Audit Prepayment Review Demonstration

On Tuesday, November 15, 2011, the Centers for Medicare & Medicare Services (CMS) announced three demonstration projects that aim to strengthen Medicare by eliminating fraud, waste, and abuse. Reductions in improper payments will help ensure the sustainability of the Medicare Trust Funds and protect beneficiaries who depend upon the Medicare program.

CMS is pleased to announce that the Prior Authorization of Power Mobility Devices (PMDs) Demonstration and the Recovery Audit Prepayment Review Demonstration – which were delayed from their initial Sunday, January 1 start-date, are expected to move forward on or after Friday, June 1, 2012. For additional information on these demonstrations, please visit http://go.CMS.gov/cert-demos.

These demonstrations will begin after receipt of a *Paperwork Reduction Act* (PRA) Office of Management and Budget control number. CMS posted a *PRA* notification for these demonstrations on Friday, February 3 at http://www.CMS.gov/PaperworkReductionActof1995/PRAL/list.asp.

CMS significantly revised the Prior Authorization of PMDs demonstration in response to provider and supplier concerns. For more information on the adopted changes please visit http://go.CMS.gov/PAdemo.

The Part A to Part B Rebilling Demonstration began on Sunday, January 1, 2012.

To view the relevant *Federal Register* notice, visit https://s3.amazonaws.com/public-inspection.federalregister.gov/2012-02821.pdf.

Widespread Prepayment Review for K0001, K0003, and K0004 Manual Wheelchairs – Edit Effectiveness for 1st Quarter

The Jurisdiction D DME MAC Medical Review Department is conducting a widespread complex review of HCPCS codes K0001, K0003, K0004 and the 1st quarter edit effectiveness results from January 2012 through March 2012 are as follows:

The results of the review, for item K0001, identified 258 claims of which 232 were denied. A total of 15 claims were denied for no response to the additional documentation request. This resulted in an overall error rate of 88%. Total dollars allowed were $1849.93, total dollars denied were $14,131.69.

The results of the review, for item K0003, identified 145 claims of which 140 were denied. A total of 11 claims were denied for no response to the additional documentation request. This resulted in an overall error rate of 98%. Total dollars allowed were $218.44, total dollars denied were $12,477.36.

The results of the review, for item K0004, identified 149 claims of which 133 were denied. A total of 8 claims were denied for no response to the additional documentation request. This resulted in an overall error rate of 89%. Total dollars allowed were $2217.39, total dollars denied were $18,673.29.

Due to this high error rate, NAS will continue with the widespread complex review for all 3 codes.

The following are the top reasons for denial:

1. Documentation not submitted to support need for the wheelchair.
2. Criteria A of LCD L11454 was not met.
3. Criteria B of LCD L11454 was not met.
4. Criteria D of LCD L11454 was not met.

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

A. Per LCD L11454, a manual wheelchair must be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member. Coverage criteria must be submitted in the form of a medical record. Coverage criteria for K0003 and K0004 must be submitted in the medical record also.

   a. Documentation that the coverage criteria have been met must be present in the patient's medical record. The exception is information about whether the patient's home can accommodate the wheelchair (Criterion C) which may be documented by the supplier. For manual wheelchairs, the assessment does not need to be

conducted in the patient's home. Information from the patient's medical record and the supplier must be available upon request. The patient's medical record is not limited to the physician's office records. It may include hospital, nursing home, or home health agency records and records from other professionals including, but not limited to, nurses, physical and occupational therapists, prosthetists, and orthotists.

b. A lightweight wheelchair (K0003) is covered when a patient:

1. Cannot self-propel in a standard wheelchair in the home; and
2. The patient can and does self-propel in a lightweight wheelchair.

c. A high strength lightweight wheelchair (K0004) is covered when a patient meets the criteria in (1) and/or (2):

1. The patient self-propels the wheelchair while engaging in frequent activities in the home that cannot be performed in a standard or lightweight wheelchair.
2. The patient requires a seat width, depth, or height that cannot be accommodated in a standard, lightweight or hemi-wheelchair, and spends at least two hours per day in the wheelchair.

B. Per Criteria A of LCD L11454, a manual wheelchair is not covered if there is no documentation that supports that the patient has a mobility limitation that significantly impairs his/her ability to participate in one or more mobility-related activities of daily living (MRADLs) such as toileting, feeding, dressing, grooming, and bathing in customary locations in the home.

A mobility limitation is one that:

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

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

c. Prevents the patient from completing an MRADL within a reasonable time frame.

C. Per Criteria B of LCD L11454, a manual wheelchair is not covered if there is no documentation provided to indicate that the patient's mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker.

D. Per Criteria D of LCD L11454, a manual wheelchair is not covered if there is no documentation to justify that the use of a manual wheelchair will significantly improve the patient's ability to participate in MRADLs and the patient will use it on a regular basis in the home.

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 Article A17265 and Supplier Manual Chapter 3: https://www.noridianmedicare.com/dme/news/manual/chapter3.html.

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

Widespread Prepayment Review for K0823 Power Wheelchair – Edit Effectiveness for 3rd 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 third quarter edit effectiveness results from January 8, 2012 to April 7, 2012 are as follows:

The results of the review identified 1076 total claims of which 890 were denied. This resulted in an overall error rate of 82%. Thirty-four (34) 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:

MOBILITY DEVICES CONT'D

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 non-powered 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

HCPCS Q4074 & J7686 - Notification of Prepayment Review

NAS Jurisdiction D DME MAC Medical Review will be initiating a widespread prepayment probe review of claims for HCPCS code Q4074 (ILOPROST, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, UNIT DOSE FORM, UP TO 20 MICROGRAMS) and HCPCS code J7686 (TREPROSTINIL, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, UNIT DOSE FORM, 1.74 MG).

Widespread reviews are used to determine the extent of potential problem areas across multiple suppliers. This review is being initiated based on the results of Comprehensive Error Rate Testing (CERT) review analysis.

In order to evaluate compliance with Medicare coverage and coding rules, all suppliers billing Jurisdiction D for HCPCS code Q4074 and J7686 are subject to this review. Suppliers of the selected claims will receive an *Additional Documentation Request* (ADR) letter asking for specific information to determine if the item billed complies with the existing reasonable and necessary criteria. Failure to supply the requested information within 45 days of the date on the letter will result in the claim being denied as not medically necessary. The ADR letter will provide instruction for submitting documentation.

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Nebulizer Local Coverage Determination (LCD) L11488 and Policy Article A24942.

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 Nebulizer Drugs – Edit Effectiveness for 2nd 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 second quarter edit effectiveness results from January 2012 through March 2012 are as follows:

The results of the review, for item J7626, identified 1287 claims of which 659 were denied. A total of 290 claims were denied for no response to the additional documentation request. This resulted in an overall error rate of 51%.

The results of the review, for item J7605, identified 469 claims of which 211 were denied. A total of 70 claims were denied for no response to the additional documentation request. This resulted in an overall error rate of 45%.

Due to the error rate remaining high, NAS will continue with the widespread complex review for the above mentioned nebulizer drugs.

The following are the top reasons for denial:

A. Requested documentation was not provided within the allotted time frame as referenced in the Medicare guidelines

B. There was no medical documentation provided to support the medical necessity for the billed items.

C. There was no beneficiary evidence of exhaustion submitted regarding refills.

D. There was no Proof of Delivery for the billed items provided and/or the proof of delivery provide was invalid as it did not meet Medicare guidelines.

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

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

B. Section 1833(e) of the Social Security Act precludes payment to any provider of services unless "there has been furnished such information as may be necessary in order to determine the amounts due such provider." It is expected that the patient's medical records will reflect the need for the care provided. The patient's medical records include the physician's office records, hospital records, nursing home records, home health agency records, records from other healthcare professionals and test reports. This documentation **must** be available upon request.

C. The Program Integrity Manual chapter 5 section 5.2.6 states, "For DMEPOS products that are supplied as refills to the original order, suppliers must contact the beneficiary prior to dispensing the refill and not automatically ship on a pre-determined basis, even if authorized by the beneficiary. This shall be done to ensure that the refilled item remains reasonable and necessary, existing supplies are approaching exhaustion, and to confirm any changes/modifications to the order. Contact with the beneficiary or designee regarding refills must take place no sooner than 14 calendar days prior to the delivery/shipping date. For delivery of refills, the supplier must deliver the DMEPOS product no sooner than 10 calendar days prior to the end of usage for the current product. This is regardless of which delivery method is utilized. DME MACs shall allow for the processing of claims for refills delivered/shipped prior to the beneficiary exhausting his/her supply."

D. Suppliers are required to maintain proof of delivery documentation in their files. Documentation must be maintained in the supplier's files for seven years. Proof of delivery is required in order to verify that the beneficiary received the DMEPOS. Proof of delivery is one of the supplier standards as noted in 42 CFR, 424.57(12). Proof of delivery documentation must be made available to the DME MAC, DME PSC, and ZPIC upon request. The date of signature on the delivery slip must be the date that the DMEPOS item was received by the beneficiary or

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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

ORTHOTICS AND PROSTHETICS

CMS Furnishes List of Off-the-Shelf Orthotic HCPCS Codes

On Thursday, February 9, CMS issued guidance that initially identifies specific Healthcare Common Procedure Coding System (HCPCS) codes that are considered Off-The-Shelf (OTS) orthotics.

Section 1847(a)(2) of the *Social Security Act* defines OTS orthotics as those orthotics described in section 1861(s)(9) of the Act for which payment would otherwise be made under section 1834(h) of the Act, which require minimal self-adjustment for appropriate use and do not require expertise in trimming, bending, molding, assembling, or customizing to fit to the individual. Orthotics that are currently paid under section 1834(h) of the Act and described in section 1861(s)(9) of the Act are leg, arm, back, and neck braces.

The Medicare Benefit Policy Manual (Publication 100-02), Chapter 15, Section 130 provides the longstanding Medicare definition of "braces" as "rigid or semi-rigid devices which are used for the purpose of supporting a weak or deformed body member or restricting or eliminating motion in a diseased or injured part of the body." CMS regulations at 42 CFR 414.402 also define the term "minimal self-adjustment" to mean an adjustment that the beneficiary, caretaker for the beneficiary, or supplier of the device can perform and that does not require the services of a certified orthotist (that is, an individual who is certified by the American Board for Certification in Orthotics and Prosthetics, Inc, or by the Board for Orthotist/Prosthetist Certification) or an individual who has specialized training.

To view the list of OTS orthotic HCPCS codes, please visit http://www.cms.gov/DMEPOSFeeSched/04_OTS_Orthotics.asp. Comments on the OTS list of codes may be submitted to CMS through Thursday, March 8.

Comment Period Extended for Off-The-Shelf Orthotic HCPCS Codes

The Centers for Medicare & Medicaid Services (CMS) has announced an extension of time for submitting comments on the list of HCPCS codes initially designated as off-the-shelf orthotics (OTS).

Comments on the list of OTS HCPCS codes may be submitted until close of business on Friday, March 16, 2012, via email to OTSComments@cms.hhs.gov.

This extension is being granted in response to a request from stakeholders.

For more information and to view the list of OTS HCPCS codes, please visit http://www.CMS.gov/DMEPOSFeeSched/04_OTS_Orthotics.asp.

Concentric Adjustable Torsion Joints – Correct Coding

Based on a benefit category determination from the Centers for Medicare & Medicaid Services (CMS), the Durable Medical Equipment Medicare Administrative Contractors (DME MACs) are revising the Knee Orthosis and Ankle-Foot/Knee-Ankle-Foot Orthosis policy articles. The revision includes information about the proper coding of concentric adjustable torsion-style mechanisms incorporated into orthotics.

The distinction in coding relates to the indicated use of the joint and the beneficiary's medical condition(s). Concentric adjustable torsion-style joints used solely to provide an assistive function for joint motion must be coded L2999 or L3999. When concentric adjustable torsion-style joints are used for any condition other than to provide an assistive function for joint motion, they must be coded as durable medical equipment using the following codes:

E1800 – Dynamic adjustable elbow extension/flexion device

E1802 – Dynamic adjustable forearm pronation/supination device

E1805 – Dynamic adjustable wrist extension/flexion device

E1810 – Dynamic adjustable knee extension/flexion device

E1815 – Dynamic adjustable ankle extension/flexion device

The effective date of the local coverage determination (LCD) and related Policy Article revision for the concentric adjustable torsion-style mechanisms will be for claims with dates of service on or after March 13, 2012. The remainder of the LCD and related Policy Article revisions will be effective for dates of service on or after July 1, 2012.

Suppliers of these products are strongly encouraged to read the AFO/KAFO and KO local coverage determinations and related policy articles for additional information on coverage, coding and documentation.

Correct Billing for Upper Limb Prosthesis with L6895 Instead of L7499

The Durable Medical Equipment Medicare Administrative Contractors (DME MACs), have discovered suppliers billing healthcare common procedure coding system, HCPCS L7499, [upper extremity prosthesis, not otherwise specified] for upper limb prosthetic cosmetic features such as; coloring, veins, hair, etc. Suppliers should be billing L6895 [addition to upper extremity prosthesis, glove for terminal device, any material, custom fabricated].

HCPCS L6895 is the appropriate code to bill for a prosthetic cosmetic glove including matching color, hair, skin, and wrinkles. Suppliers should NOT bill using HCPCS L7499 for the cost of the additional cosmetic features. The long narrative description for the L6895 indicates "any material" and therefore includes all of these cosmetic features.

If suppliers believe the addition of these features changes the narrative description, they are encouraged to seek a new HCPCS code through the Pricing, Data Analysis and Coding (PDAC) Contractor in order to bill for such features.

Lower Limb Prostheses – Certain Prosthetic Addition Codes Not Allowed

Upon review of Lower Limb Prosthesis claim processing, the Office of Inspector General (OIG) has identified payment errors associated with suppliers billing improper combinations of prosthetic substitutions and components with initial and preparatory below-knee and above-knee prostheses. This article addresses substitutions and /or additions for HCPCS L5500, L5510–L5530, L5540, L5535, L5505, L5560–L5580, L5590–L5600 and L5585.

The Local Coverage Determination (LCD) describes which prosthetic substitutions and components are not reasonable and necessary when billed with initial and preparatory base codes.

- When an initial below knee prosthesis (L5500) or a preparatory below knee prosthesis (L5510–L5530, L5540) is provided, prosthetic substitutions and/or additions of procedures and components are covered in accordance with the functional level assessment except for codes L5629, L5638, L5639, L5646, L5647, L5704, L5785, L5962, and L5980 which will be denied as not reasonable and necessary.
- When a below knee preparatory prefabricated prosthesis (L5535) is provided, prosthetic substitutions and/or additions of procedures are covered in accordance with the functional level assessment except for codes L5620, L5629, L5645, L5646, L5670, L5676, L5704, and L5962 which will be denied as not reasonable and necessary.
- When an above knee initial prosthesis (L5505) or an above knee preparatory (L5560–L5580, L5590–L5600) prosthesis is provided, prosthetic substitution and/or additions of procedures and components are covered in accordance with the functional level assessment except for codes L5610, L5631, L5640, L5642, L5644, L5648, L5705, L5706, L5964, L5980, and L5710–L5780, L5790–L5795 which will be denied as not reasonable and necessary.
- When an above knee preparatory prefabricated prosthesis (L5585) is provided, prosthetic substitution and/or additions of procedures and components are covered in accordance with the functional level assessment except for codes L5624, L5631, L5648, L5651, L5652, L5705, L5706, L5964, and L5966 which will be denied as not reasonable and necessary.

More information and additional coverage criteria for Lower Limb Prostheses are available on our website.

- LCD L11453 for Lower Limb Prostheses: https://www.noridianmedicare.com/dme/coverage/docs/lcds/current_lcds/lower_limb_prostheses.htm

- LCD Policy Article A25367 for Lower Limb Prostheses: https://www.noridianmedicare.com/dme/coverage/docs/lcds/current_articles/lower_limb_prostheses.htm
- Detailed information regarding the OIG published review can be accessed at http://oig.hhs.gov/oei/reports/oei-02-10-00170.pdf.

Lower Limb Prostheses – Ensure LCD Criteria Are Fulfilled

The Office of Inspector General (OIG) completed a review of Lower Limb Prostheses claim processing and identified payment errors which included billing duplicate units of service, billing for combinations of prostheses that were not allowed, lack of the ordering physician evaluation, lack of amputation in the patient's claim history, and lack of required modifiers to reflect patient functional levels. When NAS is informed of claims paid in error, actions are taken to recover the improper payments and to ensure claim processing procedures are implemented to prevent future improper payments from occurring.

The local coverage determination states that a beneficiary is classified into one of five potential functional levels based on the reasonable expectations of the supplier and the referring physician. The supplier uses a modifier on the claim to indicate the beneficiary's potential functional level (K0 to K4).

- K0 - Lower limb extremity prosthesis functional Level 0 - does not have the ability or potential to ambulate or transfer safely with or without assistance and a prosthesis does not enhance their quality of life or mobility
  - Note: Prostheses are not considered medically necessary if the beneficiary has the lowest potential functional level (K0), which indicates that he or she does not have the ability or the potential to walk.
- K1 - Lower extremity prosthesis functional Level 1 - has the ability or potential to use a prosthesis for transfers or ambulation on level surfaces at fixed cadence. Typical of the limited and unlimited household ambulatory
- K2 - Lower extremity prosthesis functional Level 2 - has the ability or potential for ambulation with the ability to traverse low level environmental barriers such as curbs, stairs, or uneven surfaces. Typical of the limited community ambulator
- K3 - Lower extremity prosthesis functional Level 3 - has the ability or potential for ambulation with variable cadence. Typical of the community ambulator who has the ability to traverse most environmental barriers and may have vocational, therapeutic, or exercise activity that demands prosthetic utilization beyond simple locomotion
- K4 - Lower extremity prosthesis functional Level 4 - has the ability or potential for prosthetic ambulation that exceeds basic ambulation skills, exhibiting high impact, stress, or energy levels. Typical of the prosthetic demands of the child, active adult, or athlete

A supplier must submit the RT or LT modifier for the applicable HCPCS for the prostheses to be considered for payment. Additionally, if the patient was not seen by a physician or the prosthesis was not ordered by a physician, suppliers may submit their claim with modifier EY to indicate "No physician or other licensed health care provider order for this item or service".

Coverage criteria for Lower Limb Prosetheses are available on our website.

- Local Coverage Determination (LCD) Lower Limb Prostheses, L11453; https://www.noridianmedicare.com/dme/coverage/docs/lcds/current_lcds/lower_limb_prostheses.htm
- LCD Policy Article A25367 for Lower Limb Prostheses: https://www.noridianmedicare.com/dme/coverage/docs/lcds/current_articles/lower_limb_prostheses.htm

Suppliers who received prior payments for Lower Limb Prostheses in which the claim was processed without fulfilling the LCD criteria are subject to having the claim payment recovered (aka recoupment). If the supplier disagrees with a claim processing decision, they are entitled to complete and submit a Redetermination Request Form. It is highly recommended that all criteria in the LCD and Policy Article be documented and included with redetermination requests.

Detailed information regarding the OIG published review can be accessed at http://oig.hhs.gov/oei/reports/oei-02-10-00170.pdf.

Questionable Billing by Suppliers of Lower Limb Prostheses

MLN Matters® Number: SE1213

Provider Types Affected

This MLN Matters® Special Edition Article is intended for providers who bill Medicare for lower limb prostheses. No new policies are contained in this article.

What You Need to Know

This article highlights the August 2011 report from the Department of Health and Human Services (DHHS), Office of Inspector General (OIG) study titled "Questionable Billing By Suppliers of Lower Limb Prostheses." It also discusses Medicare policy regarding the coverage of lower limb prostheses under its Part B Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) benefit.

The study was designed to meet the following objectives:

1. Identify payments for lower limb prostheses in 2009 that did not meet certain Medicare requirements;
2. Identify Medicare payments for lower limb prostheses in 2009 for beneficiaries with no claims from their referring physicians;
3. Identify suppliers of lower limb prostheses that had questionable billing in 2009; and
4. Describe the program safeguards in place in 2009 and the first half of 2010 to prevent inappropriate payments for lower limb prostheses.

Background

Between 2005 and 2009, Medicare spending for lower prostheses increased 27 percent, from $517 million to $655 million. The number of Medicare beneficiaries receiving lower limb prostheses decreased by 2.5 percent, from almost 76,000 to about 74,000. Medicare policy requires that a supplier have an order from the referring physician before providing prostheses to the beneficiary. Upon receipt of the referring physician's order, the supplier can move forward with the prostheses fitting for the beneficiary with the applicable prostheses. Medicare policy also requires that suppliers follow local coverage determination policies. These policies provide guidelines for determining the beneficiary's potential functional level and specify how suppliers must submit claims for certain types and combinations of prostheses. The study completed by the OIG was based on an analysis of Medicare Part B claims for lower limb prostheses from 2009 and Part A and Part B claims from 2004 to 2009 for beneficiaries who received lower limb prostheses in 2009. OIG staff also completed interviews with the four DME Medicare Administrative Contractors (MACs), three Zone Program Integrity Contractors (ZPICs), and two DME Program Safeguard Contractors (PSCs). The OIG considered a paid claim did not meet the requirements if the supplier:

- Did not indicate whether the prosthesis was for the right or left limb;
- Billed for a prosthesis for both limbs on the same date using two claims;
- Did not meet potential functional level requirements;
- Billed for a higher number of units of a prosthesis than allowed on a claim;
- Billed for combinations of prostheses that were not allowed; or
- Billed for prostheses that were not covered.

Claims data was an additional component of the OIG's analysis to determine the number of claims for beneficiaries with no claims from their referring physicians during the last 5 years and the Medicare payments for these claims. The following elements were analyzed to identify suppliers that had questionable billing:

- Suppliers that had at least 10 beneficiaries, and
- Suppliers that were paid at least $100,000 for lower limb prostheses in 2009.

This sample included 1,632 of the 4,575 Medicare suppliers who had a paid claim for lower limb prostheses in 2009, which accounted for 92 percent of the $655 million who billed for lower limb prostheses.

Findings

In 2009, the study found that:

1. In 2009, Medicare inappropriately paid $43 million for lower limb prostheses that did not meet certain requirements. These payments could have been prevented by using claims processing edits.
2. Medicare paid an additional $61 million for beneficiaries with no claims from their referring physicians.
3. In 2009, 267 suppliers of lower limb prostheses had questionable billing. Approximately 136 suppliers frequently submitted claims that did not meet certain Medicare requirements or were for beneficiaries with no claims from their referring physicians. An additional 131 suppliers had other questionable billing. This included billing for a high percentage of beneficiaries with no history of an amputation or missing limb or a high percentage of beneficiaries with unusual combinations of prostheses.
4. Medicare contractors conducted varying degrees of program safeguard activities related to lower limb prostheses.
   - The four DME MACs had varying claims processing edits in place, but none had edits for all requirements.
   - None of the DME MACs conducted medical reviews, and not all had conducted data analyses or provided education related to lower limb prostheses.
   - All ZPICs and DME PSCs conducted data analyses and opened investigations related to lower limb prostheses.

Recommendations

The Centers for Medicare & Medicaid Services (CMS) concurred with five of the six recommendations made by the OIG. In response to the first recommendation, to implement additional claims processing edits, CMS concurred and stated it would instruct the DME MACs to implement consistent claims processing edits based on local coverage determination requirements. In response to the second recommendation, to strengthen monitoring of billing for lower limb prostheses, CMS concurred and stated it would issue guidance to the DME MACs and instruct them to consider the measures used in the OIG report as supplemental criteria for detecting high-risk suppliers. In response to the third recommendation, to implement requirements for a face-to-face encounter to establish a beneficiary's need for prostheses, CMS concurred and stated it is exploring its current authorities to implement such requirements. CMS also stated that it would issue an educational article to further explain policy requirements for lower limb prostheses and to providers and suppliers.

In response to the fourth recommendation, to revise the local coverage determination, CMS concurred and stated it would review the definitions for the functional levels and develop refinements as appropriate. CMS also stated it would consider adapting an algorithm to guide determination of the functional status of the beneficiary. In response to the fifth recommendation, to enhance screening for currently enrolled suppliers of lower limb prostheses, CMS did not concur and stated that it has in place sufficient tools that allow for increased scrutiny of existing DMEPOS suppliers. CMS noted that if an existing supplier meets one of several triggering events, that supplier automatically is elevated to the high-risk level. In response to the sixth recommendation, to take appropriate action on the suppliers with questionable billing, CMS concurred and stated it would share the information with the DME MACs and the Recovery Audit Contractors. Recovery Audit Contractors review Medicare claims on a post payment basis to identify inappropriate payments. The following section reviews Medicare policy for coverage of lower limb prostheses.

Key Points

Medicare Requirements for Lower Limb Prostheses

Provisions of the Social Security Act (the Act) govern Medicare payment for all items or services, including lower limb prostheses. The Act states that Medicare will cover only services and items considered reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body part. In addition, Medicare requires that a supplier have an order from a physician before providing prostheses to the beneficiary. This physician is known as the referring physician. Upon receiving the order, the supplier consults with the referring physician, as needed, to confirm the order and recommend any necessary changes and evaluates the beneficiary. The supplier fits the beneficiary with the most appropriate prostheses. The supplier then determines the group of codes that best describes the prostheses provided, choosing from 178 Healthcare Common Procedure Coding System (HCPCS) codes that are specific to lower limb prostheses. Further, local coverage determination policies provide additional Medicare requirements for lower limb prostheses. These policies, consistent with policies for other DMEPOS, are identical across the country. The local coverage determination specifies how suppliers must submit claims for certain types and combinations of prostheses. In particular, it states that each claim must include a modifier to indicate whether

the prosthesis is for the right or left limb. When a supplier provides prosthesis for each limb on the same date, the supplier must submit only one claim and include both the right and left modifiers on the claim.

The local coverage determination also has guidelines for determining the beneficiary's potential functional level. Specifically, it states that a beneficiary is placed at one of five potential functional levels based on the reasonable expectations of the supplier and the referring physician. When determining the potential functional level, suppliers must take into account the beneficiary's history, current condition, and desire to walk. The supplier then uses a modifier on the claim to indicate the beneficiary's potential functional level (K0 to K4). Prostheses are not considered medically necessary if the beneficiary has the lowest potential functional level (K0), which indicates that he or she does not have the ability or the potential to walk. In addition, for some prostheses, the local coverage determination specifies the minimum potential functional level that the beneficiary must have for the prosthesis to be considered medically necessary. Further, the local coverage determination limits the number of certain prostheses that can be billed on a claim. If the number of units of these prostheses exceeds the limit, the additional items will be denied as not medically necessary. The local coverage determination also considers certain combinations of prostheses to be medically unnecessary. For example, certain sockets are not allowed for use with temporary base prostheses. Finally, the local coverage determination states that HCPCS L5990, a specific type of foot addition, will be denied as not medically necessary. In addition, CMS recently established new screening procedures for provider enrollment. For example, screening may include licensure and criminal background checks. CMS created three levels of screening – limited, moderate, and high – based on the risk of fraud, waste, and abuse. New DMEPOS suppliers were placed at the high risk level, while currently-enrolled DMEPOS suppliers were placed at the moderate risk level. Lastly, recent legislation established a face-to-face encounter requirement for certain DMEPOS. For specified DMEPOS that require a written order prior to delivery, the referring physician must document that a physician, physician assistant, nurse practitioner, or clinical nurse specialist has had a face-to-face encounter with the beneficiary before writing the order for the item.

Note: You should ensure that any items or services submitted on Medicare claims are referred or ordered by Medicare-enrolled providers of a specialty type authorized to order or refer the same. You must also place the ordering or referring provider or supplier's NPI on the claim you submit to Medicare for the service or item you provide. You may want to review MLN Matters® Article SE1201 at http://www.cms.gov/MLNMattersArticles/downloads/SE1201.pdf for important reminders on the requirements for Ordering and Referring Physicians.

Additional Information

The entire OIG report titled "Questionable Billing By Suppliers of Lower Limb Prostheses" is available at http://oig.hhs.gov/oei/reports/oei-02-10-00170.pdf on the OIG website.

OXYGEN

HCPCS E0439 and E0434 – Notification of Prepayment Review

NAS Jurisdiction D DME MAC Medical Review will be initiating a widespread prepayment review of claims for HCPCS E0439 (stationary liquid oxygen system, rental; includes container, contents, regulator, flowmeter, humidifier, nebulizer, cannula or mask and tubing) and E0434 (portable liquid oxygen system, rental; includes portable container, supply reservoir, humidifier, flowmeter, refill adaptor, contents gauge, cannula or mask and tubing). Widespread reviews are used to determine the extent of potential problem areas across multiple suppliers. This review is being initiated based on the results of Comprehensive Error Rate Testing (CERT) analysis.

In order to evaluate compliance with Medicare coverage and coding rules, all suppliers billing Jurisdiction D for HCPCS code E0439 and E0434 are subject to this review. Suppliers of the selected claims will receive an *Additional Documentation Request* (ADR) letter asking for specific information to determine if the item billed complies with the existing reasonable and necessary criteria. Failure to supply the requested information within 45 days of the date on the letter will result in the claim being denied as not medically necessary. The ADR letter will provide instruction for submitting documentation.

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in Oxygen and Oxygen Equipment Local Coverage Determination (LCD) L11457 and Policy Article A33677. Suppliers can find additional Oxygen and Oxygen Equipment resources on the NAS website at https://www.noridianmedicare.com/dme/news/oxygen_equipment.html

Information about prepayment 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

Notification of Prepayment Oxygen Review with RA modifier for HCPCS E1390, E0431, E0439 and E0434

NAS Jurisdiction D DME MAC Medical Review will be initiating a widespread prepayment review of claims for HCPCS E0439 (stationary liquid oxygen system, rental; includes container, contents, regulator, flowmeter, humidifier, nebulizer, cannula or mask and tubing), E0434 (portable liquid oxygen system, rental; includes portable container, supply reservoir, humidifier, flowmeter, refill adaptor, contents gauge, cannula or mask and tubing), E1390 (oxygen concentrator, single delivery port, capable of delivering 85 percent or greater oxygen concentration at the prescribed flow rate) and E0431 (portable gaseous oxygen system, rental; includes regulator, flowmeter, humidifier, cannula or mask and tubing) submitted with an RA modifier. For replacement equipment; claims for the initial rental month (and only the initial rental month) must have the RA modifier (Replacement of DME item) added to the HCPCS code for the equipment when there is replacement due to reasonable useful lifetime or replacement due to damage, theft, or loss. This review is being initiated based on the results of Comprehensive Error Rate Testing (CERT) analysis.

In order to evaluate compliance with Medicare coverage and coding rules, all suppliers billing Jurisdiction D for HCPCS code E0439, E0434, E1390 and E0431 with the RA modifier are subject to this review. Suppliers of the selected claims will receive an *Additional Documentation Request* (ADR) letter asking for specific information to determine if the item billed complies with the existing reasonable and necessary criteria. Failure to supply the requested information within 45 days of the date on the letter will result in the claim being denied as not medically necessary. The ADR letter will provide instruction for submitting documentation.

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in Oxygen and Oxygen Equipment Local Coverage Determination (LCD) L11457 and Policy Article A33677. Suppliers can find additional Oxygen and Oxygen Equipment resources on the NAS website at https://www.noridianmedicare.com/dme/news/oxygen_equipment.html

Information about prepayment 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

Oxygen Resource Booklet Mailed February 2012

In February 2012, NAS mailed a booklet to active suppliers billing Oxygen and Oxygen Equipment as this policy group has an impact on the Comprehensive Error Rate Testing (CERT) error rate. The contents, with the exception of the introductory letter, may be accessed from our website and have been reflected below in the event suppliers choose to maintain current copies of the material or reproduce additional copies for training purposes.

1. Promotion for workshop registration for 03/27, 04/17, and 05/15, https://www.noridianmedicare.com/dme/train/schedule.html
2. Presentation Oxygen and Oxygen Equipment https://www.noridianmedicare.com/dme/train/presentations/oxygen.pdf
3. Local Coverage Determination (LCD) https://www.noridianmedicare.com/dme/coverage/docs/lcds/current_lcds/oxygen_and_oxygen_equipment.html
4. Policy Article https://www.noridianmedicare.com/dme/coverage/docs/lcds/current_articles/oxygen_and_oxygen_equipment.htm
5. CERT Review Process; https://www.noridianmedicare.com/dme/coverage/cert.html
6. CERT Educational Fact Sheet from CMS http://www.cms.gov/MLNProducts/downloads/OxgnThrpy_DocCvg_FactSheet_ICN904883.pdf
7. CMS Claim Reviewers; MR, NCI Edits, MUEs, CERT and RAC Booklet
8. Physician Documentation Checklist: Oxygen and Oxygen Equipment; https://www.noridianmedicare.com/dme/coverage/docs/checklists/oxygen_and_oxygen_equipment.pdf
9. Physician Letter – Signature Authentication Tips
10. Physician Letter – Continued Medical Necessity
11. Dear Physician Letter – Continued Use

12. Physician Letter – Medical Records
13. CMS 484 CMN - Oxygen
14. DME MAC Redetermination Request
15. Acronym Listing; https://www.noridianmedicare.com/dme/news/manual/acronyms.html
16. IVR at a Glance
17. Endeavor Brochure
18. E-mail List Sign-up Instructions

We hope you find the booklet of value as you work with Medicare coverage criteria and billing requirements.

Results of Widespread Prepayment Review of Oxygen and Oxygen Equipment

Jurisdiction D DME MAC Medical Review completed the widespread prepayment review of claims for Oxygen and Oxygen equipment with HCPC code E1390 (Oxygen concentrator) along with E0431 (Portable gaseous oxygen system). This review was initiated based on the results of a high error rate in a previous probe review of the codes.

The results of the review of the claims for oxygen concentrator, code E1390, identified 4,783 claims of which 3,501 were denied. This resulted in an overall error ratio of 74%.

The results of the review of the claims for portable oxygen, code E0431, identified 2,036 claims of which 1,482 were denied. This resulted in an overall error ratio of 74%.

DME MAC D will close these reviews for E1390, oxygen concentrators, and E0431, portable oxygen. By closing this file, medical review will no longer request documentation for the specified criteria. Contractors are required to monitor the utilization patterns of suppliers and observe for medical necessity and appropriate coding practices. Claims will be subject to the routine claims processing system and edits that may suspend claims for review.

The following are the top reasons for denial:

A. No office visit notes to determine medical necessity within 30 days of certification or 90 days within recertification were submitted.
B. No qualifying blood gas study submitted.
C. No documentation submitted providing continued use of the equipment.
D. No documentation submitted providing continued need of the equipment.

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

A. The patient must be seen and evaluated by the treating physician within 30 days prior to the date of Initial Certification.

   For patients initially meeting Group I or II criteria, the patient must be seen and re-evaluated by the treating physician within 90 days prior to the date of any recertification. If the physician visit is not obtained within the 90-day window but the patient continues to use oxygen and the visit is obtained at a later date, coverage would resume beginning with the date of that visit.

B. In this policy, the term blood gas study includes both an oximetry test and an arterial blood gas test.

   Group I criteria include any of the following:

   1. An arterial PO 2 at or below 55 mm Hg or an arterial oxygen saturation at or below 88 percent taken at rest (awake), or
   2. An arterial PO 2 at or below 55 mm Hg, or an arterial oxygen saturation at or below 88 percent, for at least 5 minutes taken during sleep for a patient who demonstrates an arterial PO 2 at or above 56 mm Hg or an arterial oxygen saturation at or above 89 percent while awake, or
   3. A decrease in arterial PO 2more than 10 mm Hg, or a decrease in arterial oxygen saturation more than 5

percent, for at least 5 minutes taken during sleep associated with symptoms (e.g., impairment of cognitive processes and [nocturnal restlessness or insomnia]) or signs (e.g., cor pulmonale, "P" pulmonale on EKG, documented pulmonary hypertension and erythrocytosis) reasonably attributable to hypoxemia, or

4. An arterial PO 2 at or below 55 mm Hg or an arterial oxygen saturation at or below 88 percent, taken during exercise for a patient who demonstrates an arterial PO 2 at or above 56 mm Hg or an arterial oxygen saturation at or above 89 percent during the day while at rest. In this case, oxygen is provided for during exercise if it is documented that the use of oxygen improves the hypoxemia that was demonstrated during exercise when the patient was breathing room air.

   Group II criteria include the presence of (a) an arterial PO 2 of 56-59 mm Hg or an arterial blood oxygen saturation of 89 percent at rest (awake), during sleep for at least 5 minutes, or during exercise (as described under Group I criteria) and (b) any of the following:

   1. Dependent edema suggesting congestive heart failure, or
   2. Pulmonary hypertension or cor pulmonale, determined by measurement of pulmonary artery pressure, gated blood pool scan, echocardiogram, or "P" pulmonale on EKG (P wave greater than 3 mm in standard leads II, III, or AVF), or
   3. Erythrocythemia with a hematocrit greater than 56 percent.

C. Documentation must be provided to meet criteria of LCD L11457 for continued use.

   Suppliers are responsible for monitoring utilization of DMEPOS items and must discontinue billing Medicare when an item is no longer being used by the beneficiary. Ongoing use must be periodically documented. Either beneficiary medical records or supplier records are sufficient to confirm that a DMEPOS item continues to be used by the beneficiary.

D. Documentation must be provided to meet criteria of LCD L11457 for continued need.

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

   For DMEPOS items for which there is on-going use, in addition to information described above that justifies the initial provision of the item(s) and/or supplies, there must be information in the beneficiary's medical record to support that the item continues to remain reasonable and necessary. Information used to justify this continued need must be timely for the DOS under review.

It is important for suppliers to be familiar with the documentation requirements as outlined in the Oxygen and Oxygen Equipment LCD and policy article. Please ensure when submitting additional documentation, that all supporting medical necessity documentation is provided. Supplier responses should also be submitted timely.

- Oxygen and Oxygen Equipment LCD L11457
- Oxygen and Oxygen Equipment Policy Article A33677
- Program Integrity Manual: http://www.cms.gov/manuals/downloads/pim83c04.pdf
- DME MAC Jurisdiction D Supplier Manual: https://www.noridianmedicare.com/dme/news/manual/index.html

PAP DEVICES

HCPCS E0601 – Notification of Prepayment Review

NAS Jurisdiction D DME MAC Medical Review will be initiating a widespread prepayment review of claims for HCPCS E0601 (Continuous airway pressure (CPAP) device) and related options and accessories. Widespread reviews are used to determine the extent of potential problem areas across multiple suppliers. This review is being initiated based on the results of Comprehensive Error Rate Testing (CERT) review analysis.

In order to evaluate compliance with Medicare coverage and coding rules, all suppliers billing Jurisdiction D for HCPCS code E0601 are subject to this review. Suppliers of the selected claims will receive an *Additional Documentation Request* (ADR) letter asking for specific information to determine if the item billed complies with the existing reasonable and necessary criteria. Failure to supply the requested information within 45 days of the date on the letter will result in the claim being denied as not medically necessary. The ADR letter will provide instruction for submitting documentation.

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Positive Airway Pressure (PAP) Devices for the Treatment of Obstructive Sleep Apnea Local Coverage Determination (LCD) L171 and Policy Article A19827. Suppliers can find additional CPAP resources on the NAS website at https://www.noridianmedicare.com/dme/news/pap_devices.html

Information about prepayment 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

PECOS

Ordering/Referring Reports Now Contain Complete National Provider Identifier

In response to concerns raised by the provider community, CMS is including the complete NPI on the following ordering & referring reports found on the CMS website at http://www.CMS.gov/MedicareProviderSupEnroll/06_MedicareOrderingandReferring.asp (in the 'Downloads' section of the page):

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

Ordering and Referring Providers Editing Expansion – Ninth Revision

MLN Matters® Number: MM6417 Revised
Related Change Request (CR) #: 6417
Related CR Release Date: November 1, 2011
Related CR Transmittal #: R991OTN
Effective Dates: Phase 1: October 5, 2009,
Implementation Dates: Phase 1: October 5, 2009, Phase 2: To Be Announced

Note: This article was revised on March 7, 2012, to reference MLN Matters® Article SE1201 (http://www.cms.gov/MLNMattersArticles/downloads/SE1201.pdf) for important reminders on the requirements for Ordering and Referring Physicians. Also remember that the Centers for Medicare & Medicaid Services has not yet decided when it will begin to reject claims if an ordering/referring provider does not have a PECOS record. CMS will give providers ample notice before claim rejections begin. Please note, the implementation and effective dates in this article are different than what is in the related CR. The "To Be Announced" implementation and effective dates in this article are the correct dates. All other information is unchanged.

Provider Types Affected

This article is intended for physicians, non-physician practitioners, and other Part B providers and suppliers submitting claims to Carriers or Part B Medicare Administrative Contractors (MACs) for items or services that were ordered or referred. (A separate article (MM6421) discusses similar edits affecting claims from suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) for items or services that were ordered or referred, and relates to CR 6421 at http://www.cms.gov/MLNMattersArticles/downloads/MM6421.pdf on the CMS website.

Provider Action Needed

This article is based on change request (CR) 6417, which requires Medicare implementation of system edits to assure that Part B providers and suppliers bill for ordered or referred items or services only when those items or services are ordered or referred by physician and non-physician practitioners who are eligible to order/refer such services. Physician and non-physician practitioners who order or refer must be enrolled in the Medicare Provider Enrollment, Chain and Ownership System (PECOS) and must be of the type/specialty who are eligible to order/refer services for Medicare beneficiaries. Be sure billing staff is aware of these changes that will impact Part B provider and supplier claims for ordered or referred items or services that are received and processed on or after October 5, 2009.

Background

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

The providers who can order/refer are:

- Doctor of Medicine or Osteopathy;
- Dental Medicine;
- Dental Surgery;
- Podiatric Medicine;
- Optometry;
- Physician Assistant;
- Certified Clinical Nurse Specialist;
- Nurse Practitioner;
- Clinical Psychologist;
- Certified Nurse Midwife; and
- Clinical Social Worker.

Claims that are the result of an order or a referral must contain the National Provider Identifier (NPI) and the name of the ordering/referring provider and the ordering/referring provider must be in PECOS or in the Medicare carrier's or Part B MAC's claims system with one of the above types/specialties.

Key Points

- **During Phase 1 (October 5, 2009- until further notice):** When a claim is received, the MultiCarrier System (MCS) will determine if the ordering/referring provider is required for the billed service. If the ordering/referring provider is not on the national PECOS file and is not on the contractor's master provider file, or if the ordering/referring provider is on the contractor's master provider file but is not of the specialty eligible to order or refer, the claim will continue to process but a message will be included on the remittance advice notifying the billing provider that the claims may not be paid in the future if the ordering/referring provider is not enrolled in Medicare or if the ordering/referring provider is not of the specialty eligible to order or refer.
- **During Phase 2 (Start Date to Be Announced):** If the billed service requires an ordering/referring provider and the ordering/referring provider is not on the claim, the claim will not be paid. If the ordering/referring provider is on the claim, MCS will verify that the ordering/referring provider is on the national PECOS file. If the ordering/referring provider is not on the national PECOS file, MCS will search the contractor's master provider file for the ordering/referring provider. If the ordering/referring provider is not on the national PECOS file and is not on the contractor's master provider file, or if the ordering/referring provider is on the contractor's master provider file but is not of the specialty eligible to order or refer, the claim will not be paid.
- In **both phases**, Medicare will verify the NPI and the name of the ordering/referring provider reported in the claim against PECOS or, if the ordering/referring provider is not in PECOS, against the claims system. In paper claims, be sure not to use periods or commas within the name of the ordering/referring provider. Hyphenated names are permissible.

PECOS CONT'D

- Providers who order and refer may want to verify their enrollment or pending enrollment in PECOS. You may do so by:
  - Using Internet-based PECOS to look for your PECOS enrollment record. (You will need to first set up your access to Internet-based PECOS.) For more information, regarding PECOS enrollment go to http://www.cms.gov/MedicareProviderSupEnroll/Downloads/Instructionsforviewingpractitionerstatus.pdf on the CMS website. If no record is displayed, you do not have an enrollment record in PECOS.
  - Checking the Ordering Referring Report at http://www.cms.gov/MedicareProviderSupEnroll/06_MedicareOrderingandReferring.asp#TopOfPage on the CMS website.
- **I don't have an enrollment record. What should I do?** Internet-based PECOS is the fastest and most efficient way to submit your enrollment application. For instructions, see "Basics of Internet-based PECOS for Physicians and Non-Physician Practitioners" at http://www.cms.gov/MLNProducts/downloads/MedEnroll_PECOS_PhysNonPhys_FactSheet_ICN903764.pdf on the CMS website.

PLEASE NOTE: The changes being implemented with CR 6417 do not alter any existing regulatory restrictions that may exist with respect to the types of items or services for which some of the provider types listed above can order or refer or any claims edits that may be in place with respect to those restrictions. Please refer to the Background Section, above, for more details.

Additional Information

You can find the official instruction, CR6417, issued to your carrier or B MAC by visiting http://www.cms.gov/Transmittals/downloads/R991OTN.pdf on the CMS website.

PRESSURE REDUCING SUPPORT SURFACES

Notification of Prepayment Review for HCPCS E0181, E0185 and E0277, Pressure Reducing Support Surfaces

NAS Jurisdiction D DME MAC Medical Review will be initiating a widespread prepayment review of claims for pressure reducing support surfaces Group 1 with HCPCS E0181 (Powered pressure reducing mattress overlay/pad, alternating, with pump, includes heavy duty) and E0185 (Gel or gel-like pressure pad for mattress, standard mattress length and width) and the Group 2 HCPCS E0277 (Powered pressure-reducing air mattress). Widespread reviews are used to determine the extent of potential problem areas across multiple suppliers. This review is being initiated based on the results of Comprehensive Error Rate Testing (CERT) analysis and previous review results.

In order to evaluate compliance with Medicare coverage and coding rules, all suppliers billing Jurisdiction D for HCPCS codes E0181, E0185 and E0277 are subject to this review. Suppliers of the selected claims will receive an *Additional Documentation Request* (ADR) letter asking for specific information to determine if the item billed complies with the existing reasonable and necessary criteria. Failure to supply the requested information within 45 days of the date on the letter will result in the claim being denied as not medically necessary. The ADR letter will provide instruction for submitting documentation.

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in:

- Pressure Reducing Support Surfaces – Group 1 Local Coverage Determination (LCD) L11578 and Policy Article A33678,
- Pressure Reducing Support Surfaces – Group 2 Local Coverage Determination (LCD) L11579 and Policy Article A35422, and

Information about prepayment 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

Immediate Recoupment for Fee for Service Claims Overpayments

MLN Matters® Number: MM7688 Revised
Related Change Request (CR) #: 7688
Related CR Release Date: February 9, 2012
Related CR Transmittal #: R205FM
Effective Date: July 1, 2012
Implementation Date: July 2, 2012

Note: This article was revised on February 10, 2012, to reflect the revised CR7688 issued on February 9, 2012. In the article, the CR release date, transmittal number, and the Web address for accessing CR7688 were revised. All other information is the same.

Provider Types Affected

This MLN Matters® article is intended for all Part A, and all Part B Providers, Physicians, and Suppliers who bill Medicare contractors (carriers, Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), Medicare Administrative Contractors (A/B MACs) Durable Medical Equipment (DME MACs),) for services to Medicare beneficiaries.

Provider Action Needed

Change Request (CR) 7688 is policy that implements a standard "immediate recoupment" process that gives providers the option to avoid interest from accruing on claims overpayments when the debt is recouped in full prior to or by the 30th day from the initial demand letter date. See the Key Points section of this article for specifics.

Background

Currently, Medicare contractors begin recoupment of an overpayment on Day 41 from the date of the initial demand letter. Interest accrues and assesses on an overpayment if not paid in full by day 30.

Key Points

The "immediate recoupment" process implemented in CR7688 allows providers to request that recoupment begin prior to day 41. Providers who elect this option may avoid paying interest if the overpayment is recouped in full prior to day 31.

Key to understanding this change is that providers who request an immediate recoupment must realize it is considered a voluntary repayment. Also, note the following:

1. Providers who choose immediate recoupment must do so in writing to the contractors.
2. The request may be for:
   a. a one-time request for a specific demanded overpayment (the total amount of the demanded overpayment); or
   b. a permanent request for the specific demanded overpayment and all future overpayments.
3. The request may be submitted via regular mail, facsimile, or e-mail and the request must include the Provider's name, contact phone number, Medicare number and/or National Provider Identifier (NPI), Provider or Chief Financial Officer's signature, demand letter number and what option the provider is requesting.
4. By choosing immediate recoupment, providers must understand that they are waiving their rights to interest under Section 935 of the Medicare Modernization Act (MMA) should the overpayment be reversed at the Administration Law Judge level (ALJ) or subsequent higher levels.
5. Providers can terminate the immediate recoupment process at anytime. The request to terminate must be in writing.

Providers should note that Medicare contractors will not consider any recoupment after Qualified Independent Contractor (QIC) proceedings (30 days after a QIC decision) as voluntary payments. Medicare contractors will follow the rules proscribed by Section 935 of the MMA for all recoupment activity after a QIC decision. These rules are explained in Chapter 3, Section 200 of the "Medicare Financial Management Manual" that is available at http://www.cms.gov/manuals/downloads/fin106c03.pdf on the Centers for Medicare & Medicaid Services (CMS) website.

You may further review all of the specifics of this change along with the applicable manual section changes by reading the official instruction for CR7688 issued to your Medicare contractor. The web address for CR7688 is listed in the Additional Information section of this article.

Additional Information

The official instruction, CR7688, issued to your Medicare contractor regarding this change may be viewed at http://www.cms.gov/Transmittals/downloads/R205FM.pdf on the Centers for Medicare & Medicaid Services (CMS) website.

Overpayment Recovery from Suppliers of DMEPOS

MLN Matters® Number: MM7744
Related Change Request (CR) #: CR 7744
Related CR Release Date: April 20, 2012
Related CR Transmittal #: R208FM
Effective Date: May 20, 2012
Implementation Date: May 20, 2012

Provider Types Affected

This MLN Matters® Article is intended for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (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) 7744, which outlines the procedures for the Centers for Medicare & Medicaid Services (CMS) and its DME Medicare Administrative Contractors (DME MACs) to make a claim against a DMEPOS supplier's surety bond. Be certain you are aware of this information.

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 CMS, within 30 days of receiving written notice to do so, the amount of any unpaid claim, plus accrued interest, for which the DMEPOS supplier is responsible up to the full penal sum of the bond.

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, CR7744, issued to your DME MAC regarding this change, may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R208FM.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.

Refunds to Medicare

When submitting a voluntary refund to Medicare, please include the Refunds to Medicare form found on the Forms page of the NAS DME website. This form provides Medicare with the necessary information to process the refund properly. This is an interactive form, which NAS has created to make it easy for you to type and print out. We've included a highlight button to ensure you don't miss required fields. When filling out the form, be sure to refer to the Refunds to Medicare form instructions.

A separate interactive form has been created for MSP Inquiries & Refunds. Please use the MSP form for MSP issues.

Processing of the refund will be delayed if adequate information is not included. Medicare may contact the supplier directly to find out this information before processing the refund. If the specific patient name, HIC or claim number information is not provided, no appeal rights can be afforded.

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

Source: Transmittal 50, Change Request 3274, dated July 30, 2004

Revised RARC N103 - Denying Services Furnished to Federally Incarcerated Beneficiaries – Revised

MLN Matters® Number: MM7678 Revised
Related Change Request (CR) #: 7678
Related CR Release Date: March 7, 2012
Related CR Transmittal #: R1054OTN
Effective Date: July 1, 2012
Implementation Date: July 2, 2012

Note: This article was revised on March 9, 2012 to reflect the revised CR7678 issued on March 7. In this article, the CR release date, transmittal number, and the Web address for accessing CR7678 were revised. All other information is the same.

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.

See the Background, Key Points, and Additional Information Sections of this article for details regarding these changes.

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/R1054OTN.pdf on the CMS website.

TENS

HCPCS E0720, E0730 and E0731 – Notification of Prepayment Review

NAS Jurisdiction D DME MAC Medical Review will be initiating a widespread prepayment review of claims for HCPCS codes E0720 (transcutaneous electrical nerve stimulation device, two lead, localized stimulation), E0730 (transcutaneous electrical nerve stimulation device, four or more leads, for multiple nerve stimulation) and E0731 (form-fitting conductive garment for delivery of TENS of NMES, with conductive fibers separated from the patient's skin by layers of fabric). Widespread reviews are used to determine the extent of potential problem areas across multiple suppliers. This review is being initiated based on the results of Comprehensive Error Rate Testing (CERT) analysis and previous review results.

In order to evaluate compliance with Medicare coverage and coding rules, all suppliers billing Jurisdiction D for HCPCS codes E0720, E0730 and E0731 are subject to this review. Suppliers of the selected claims will receive an *Additional Documentation Request* (ADR) letter asking for specific information to determine if the item billed complies with the existing reasonable and necessary criteria. Failure to supply the requested information within 45 days of the date on the letter will result in the claim being denied as not medically necessary. The ADR letter will provide instruction for submitting documentation.

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Transcutaneous Electrical Stimulators (TENS) Local Coverage Determination(LCD) L11495 and Policy Article A37074.

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

THERAPEUTIC SHOES

First Quarter Edit Effectiveness for Therapeutic Shoes Review

The Jurisdiction D DME MAC Medical Review Department is conducting a widespread complex review of HCPCS codes A5500. The first quarter edit effectiveness results from September 2011 through December 2011 are as follows:

This review identified 214 claims of which 207 were denied. A total of 42 claims were denied for no response to the additional documentation request. This resulted in an overall error rate of 97%. Due to this high error rate, NAS will continue with the widespread complex review.

The following are the top reasons for denial:

A. Criterion 2 was not met per Policy Article (PA) A37076

B. Criterion 3 was not met per PA A37076

C. Requested documentation was not provided within the allotted time frame as referenced in the Medicare guidelines

D. There was no documentation from the supplier to support an in-person visit at the time of delivery per Local Coverage Determination (LCD) L157 and PA A37076

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

There must be documentation to support that the certifying physician has documented in the patient's medical record one or more of the following conditions:

A. Previous amputation of the other foot, or part of either foot, or

   a. History of previous foot ulceration of either foot, or

   b. History of pre-ulcerative calluses of either foot, or

   c. Peripheral neuropathy with evidence of callus formation of either foot, or

   d. Foot deformity of either foot, or

   e. Poor circulation in either foot;

In order to meet criterion 2, the certifying physician must either:

I. Personally document one or more of criteria a – f in the medical record of an in-person visit within 6 months prior to delivery of the shoes/inserts and prior to or on the same day as signing the certification statement; or

II. Obtain, initial/sign, date (prior to or on the same day as signing the certification statement), and indicate agreement with information from the medical records of an in-person visit with a podiatrist, other M.D or D.O., physician assistant, nurse practitioner, or clinical nurse specialist that is within 6 months prior to delivery of the shoes/inserts, and that documents one of more of criteria a – f.

Note: The certification statement is not sufficient to meet the requirement for documentation in the medical record.

B. There must be documentation to support that the certifying physician has certified that indications (1) and (2) are met and that he/she is treating the patient under a comprehensive plan of care for his/her diabetes and that the patient needs diabetic shoes. For claims with dates of service on or after 1/1/2011, the certifying physician must:

- Have an in-person visit with the patient during which diabetes management is addressed within 6 months prior to delivery of the shoes/inserts; and
- Sign the certification statement (refer to the Documentation Requirements section of the related Local Coverage Determination) on or after the date of the in-person visit and within 3 months prior to delivery of the shoes/inserts.

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

D. There must be documentation to support that at the time of delivery of the items selected, the supplier must conduct and document an in-person visit with the patient. The in-person evaluation of the patient by the supplier at the time of delivery (refer to related Policy Article, Non-Medical Necessity Coverage and Payment Rules, criterion 5) must be conducted with the patient wearing the shoes and inserts and must document that the shoes/inserts/modifications fit properly.

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Therapeutic Shoes for Persons with Diabetes Local Coverage Determination (LCD) L157 and Policy Article A37076. Suppliers can also review the Therapeutic Shoes documentation checklist on the NAS website at https://www.noridianmedicare.com/dme/coverage/docs/checklists/therapeutic_shoes.pdf.

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

Second Quarter Edit Effectiveness for Therapeutic Shoes Review

The Jurisdiction D DME MAC Medical Review Department is conducting a widespread complex review of HCPCS codes A5500. The first quarter edit effectiveness results from December 2011 through March 2012 are as follows:

This review identified 455 claims of which 440 were denied. A total of 69 claims were denied for no response to the additional documentation request. This resulted in an overall error rate of 97%. Due to this high error rate, NAS will continue with the widespread complex review.

The following are the top reasons for denial:

A. Criterion 2 was not met per Policy Article (PA) A37076

B. Criterion 3 was not met per PA A37076

C. Criterion 4 was not met per PA A37076

D. Criterion 5 was not met per PA A37076

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

Criteria 2:

There must be documentation to support that the certifying physician has documented in the patient's medical record one or more of the following conditions:

a. Previous amputation of the other foot, or part of either foot, or

b. History of previous foot ulceration of either foot, or

c. History of pre-ulcerative calluses of either foot, or

d. Peripheral neuropathy with evidence of callus formation of either foot, or

e. Foot deformity of either foot, or

f. Poor circulation in either foot;

In order to meet criterion 2, the certifying physician must either:

i. Personally document one or more of criteria a – f in the medical record of an in-person visit within 6 months prior to delivery of the shoes/inserts and prior to or on the same day as signing the certification statement; or

ii. Obtain, initial/sign, date (prior to or on the same day as signing the certification statement), and indicate agreement with information from the medical records of an in-person visit with a podiatrist, other M.D or D.O., physician assistant, nurse practitioner, or clinical nurse specialist that is within 6 months prior to delivery of the shoes/inserts, and that documents one of more of criteria a – f.

Note: The certification statement is not sufficient to meet the requirement for documentation in the medical record.

Criteria 3:

There must be documentation to support that the certifying physician has certified that indications (1) and (2) are met and that he/she is treating the patient under a comprehensive plan of care for his/her diabetes and that the patient needs diabetic shoes. For claims with dates of service on or after 1/1/2011, the certifying physician must:

- Have an in-person visit with the patient during which diabetes management is addressed within 6 months prior to delivery of the shoes/inserts; and
- Sign the certification statement (refer to the Documentation Requirements section of the related Local Coverage Determination) on or after the date of the in-person visit and within 3 months prior to delivery of the shoes/inserts.

Criteria 4:

There must be documentation to support that the supplier conducted and documented an in-person visit with the patient prior to selecting the specific items to be provided. The in-person evaluation of the patient by the supplier at the time of selecting the items that will be provided (refer to related Policy Article, Non-Medical Necessity Coverage and Payment Rules, criterion 4) must include at least the following:

1. An examination of the patient's feet with a description of the abnormalities that will need to be accommodated by the shoes/inserts/modifications.
2. For all shoes, taking measurements of the patient's feet.
3. For custom molded shoes (A5501) and inserts (A5513), taking impressions, making casts, or obtaining CAD-CAM images of the patient's fee that will be used in creating positive models of the feet.

Criteria 5:

There must be documentation to support that the supplier conducted and documented an in-person visit with the patient at the time of delivery of the items selected. The in-person evaluation of the patient by the supplier at the time of delivery (refer to related Policy Article, Non-Medical Necessity Coverage and Payment Rules, criterion 5) must be conducted with the patient wearing the shoes and inserts and must document that the shoes/inserts/modifications fit properly.

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Therapeutic Shoes for Persons with Diabetes Local Coverage Determination (LCD) L157 and Policy Article A37076. Suppliers can also review the Therapeutic Shoes documentation checklist on the NAS website at https://www.noridianmedicare.com/dme/coverage/docs/checklists/therapeutic_shoes.pdf.

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

VERSION 5010

51 Days to Transition to 5010/D.0 Formats

After 3 p.m. Eastern Time (ET) on Friday, June 29, 2012, CEDI will no longer accept claims sent in the X12 4010A1 or NCPDP 5.1 formats. If you have not already transitioned to 5010/D.0, contact your software vendor immediately to find out when you will be transitioned to the new format. If your vendor will not be upgrading your current software product, you need to find a new software vendor, billing service or clearinghouse **NOW** to avoid any disruption in submission of your claims.

If you are a vendor who has not been approved by CEDI for 5010 and/or D.0 production transactions, you need to complete testing as soon as possible to avoid negative impacts to your customers.

If you have any questions, please contact the CEDI Help Desk at ngs.cedihelpdesk@wellpoint.com or at 866-311-9184.

Extension of Enforcement Discretion Period for Updated HIPAA Transaction Standards through June 30, 2012

(March 15, 2012) The Centers for Medicare & Medicaid Services' Office of E-Health Standards and Services (OESS) is announcing that it will not initiate enforcement action for an additional three (3) months, through June 30, 2012, against any covered entity that is required to comply with the updated transactions standards adopted under the *Health Insurance Portability and Accountability Act of 1996 (HIPAA)*: ASC X12 Version 5010 and NCPDP Versions D.0 and 3.0.

On November 17, 2011, OESS announced that, for a 90-day period, it would not initiate enforcement action against any covered entity that was not compliant with the updated versions of the standards by the January 1, 2012 compliance date. This was referred to as enforcement discretion, and during this period, covered entities were encouraged to complete outstanding implementation activities including software installation, testing and training.

Health plans, clearinghouses, providers, and software vendors have been making steady progress: the Medicare Fee-for-Service (FFS) program is currently reporting successful receipt and processing of over 70 percent of all Part A claims and over 90 percent of all Part B claims in the Version 5010 format. Commercial plans are reporting similar numbers. State Medicaid agencies are showing progress as well, and some have made a full transition to Version 5010.

Covered entities are making similar progress with Version D.0. At the same time, OESS is aware that there are still a number of outstanding issues and challenges impeding full implementation. OESS believes that these remaining issues warrant an extension of enforcement discretion to ensure that all entities can complete the transition. OESS expects that transition statistics will reach 98 percent industry wide by the end of the enforcement discretion period.

Given that OESS will not initiate enforcement actions through June 30, 2012, industry is urged to collaborate more closely on appropriate strategies to resolve remaining problems. OESS is stepping up its existing outreach to include more technical assistance for covered entities. OESS is also partnering with several industry groups as well as Medicare FFS and Medicaid to expand technical assistance opportunities and eliminate remaining barriers. Details will be provided in a separate communication.

The Medicare FFS program will continue to host separate provider calls to address outstanding issues related to Medicare programs and systems. The Medicare Administrative Contractors (MAC) will continue to work closely with clearinghouses, billing vendors, or healthcare providers requiring assistance in submitting and receiving Version 5010 compliant transactions.

The Medicaid program staff at CMS will continue to work with individual States regarding their program readiness. Issues related to implementation problems with the States may be sent to Medicaid5010@cms.hhs.gov.

OESS strongly encourages industry to come together in a collaborative, unified way to identify and resolve all outstanding issues that are impacting full compliance, and looks forward to seeing extensive engagement in the technical assistance initiative to be launched over the next few weeks.

HIPAA 5010 Claims Translation Issues Affecting Medicare Crossover Claims - Error Codes H51108, H20203, and H45255

Currently, after A/B Medicare Administrative Contractors (MACs), Durable Medical Equipment MACs (DME MACs), fiscal intermediaries (FIs), and carriers have finalized payment of incoming provider/physician/supplier claims, they transmit the adjudicated claims to the Coordination of Benefits Contractor (COBC) for Medicare claims crossover purposes. The COBC translates the claims into the required HIPAA ANSI 837 claim formats for claims crossover purposes, then subjects them to HIPAA compliance validation; normally, it is within this module that HIPAA compliance problems are identified.

When the COBC identifies HIPAA compliance problems, it notifies the A/B MAC, DME MAC, FI, or carrier that its processed claims could not be crossed over. This entity, in turn, mails the affected provider/physician/or supplier a special letter that indicates "The claim(s) could not be crossed over due to claim data errors…" and includes the specific error code (eg. H51000) with accompanying error description. The assumption is that once providers/physicians/suppliers receive these letters from Medicare, they will then take steps to bill their patients' supplemental payer for the balances owed after Medicare.

In recent weeks, three issues have arisen that were caused by defects in the COBC compliance validation process:

- H51108: '237' is not a valid 'Line Level Adjustment Reason Code'
  - Issue: COBC was incorrectly rejecting claims that contained a claim adjustment reason code (CARC) 237. The rejection occurred because COBC's vendor inadvertently did not have reason code 237 loaded to its CARC table.
  - Fix date: Mon Jan 16
- H20203: Element CLM16 is present though marked 'Not Used'
  - Issue: COBC's vendor's translation routine was copying the value from 2300 CLM20 and incorrectly creating that value within 2300 CLM16 ('Not Used')
  - Projected fix date: Mon Feb 27
  - Steps taken: As of the week of Mon Feb 13, CMS asked its A/B MACs, DME MACs, FIs, and carriers to hold the letters they would normally generate that contain error code H20203. Effective Mon Feb 27, our Medicare contractors will be able to resend the affected claims to the COBC so that they may be successfully crossed over.
- H45255: The Other Subscriber Primary Identifier (2330A NM109) cannot be the same as the group or policy number (2320 SBR03)
  - Resolution: COBC scrubs the duplication that is present in 2320 SBR03
  - Project fix date: TBD, but hopefully not later than early April 2012
  - NOTE: Currently, error H45255 is prohibiting the sending of Medicare crossover claims to North Dakota Medicaid in certain instances.
  - Steps taken: CMS is requesting that Medicare contractors hold the letters that would normally be generated for error code H45255. Once a fix date is identified for this issue, CMS will notify the Medicare contractors to resend the affected claims to the COBC so that they may be successfully crossed over.

CMS sincerely regrets that the above error conditions have arisen. We are actively partnering with the COBC to address these problems as quickly as possible.

Slides and Comments from WEDI-CMS Industry Collaboration and Problem Solving Webinar Now Posted

Last week, the Workgroup for Electronic Data Interchange (WEDI) in collaboration with CMS held a webinar on Industry Collaboration and Problem Solving for Version 5010. Officials from CMS, WEDI, and other industry partners discussed and highlighted efforts to resolve ASC X12 5010 implementation issues. If you were unable to attend the webinar, you can watch a replay of the webinar with the slides presented online.

WEDI is also pleased to present the new ASC X12 implementation reporting system, which is available at WEDI Online. This resource can help covered entities in their compliance efforts.

CMS, WEDI, and other industry partners are planning additional webinars for the near future, and will post the dates once they are confirmed. You can post your issues and concerns related to ASC X12 5010 implementation online, and these may be used to inform an upcoming webinar.

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.

Take a Look at CMS Version 5010 FAQs, Webpage and Resources

CMS will not initiate enforcement action against *HIPAA*-covered entities for an additional three months, through Saturday, June 30, 2012, for the updated *HIPAA* transaction standards (ASC X12 Version 5010, NCPDP Versions D.0 and 3.0). CMS is aware that there are still challenges and issues affecting an industry wide upgrade. To help *HIPAA*-covered entities with the upgrade, CMS continues to update and improve their Version 5010 resources.

Updated FAQ System

CMS has updated the FAQ system and the way it is organized. There are now three ways to more easily find Version 5010 FAQs by going to the CMS FAQs Page and:

- Click on the Topic *HIPAA Administrative Simplification* on the left side of the page
  - Click on the Subtopic *Versions 5010 and D.0* that will appear as a dropdown under the topic (FAQs on Version 5010 and D.0 will be listed on the right side of the page)
- Click on the Topic *Coding* on the left side of the page
  - Click on the Subtopic *ICD-10* that will appear as a dropdown under the topic (FAQs on Version 5010 will be listed out on the right side of the page)
- Entering the search term "Version 5010" in the *Search* box on the upper left side of the page

CMS' Version 5010 and D.0 FAQs can also be found on the Version 5010 page of the ICD-10 website, on the FAQs: Versions 5010 and D.0 Transition Basics fact sheet. The newest FAQ recently added by CMS is:

Question: Is my Version 5010 837 claim compliant if it includes situational data that the TR3 Report does not prohibit, and is not needed or used by a specific health plan?

Answer: Yes. If a submitter sends claim information to a primary payer that may not be needed by that payer, but is needed by a secondary or tertiary payer, the primary payer should disregard the unneeded information and accept the compliant claim. For example:

- A data element in the TR3 Report has situational usage and language that says "If not required by this implementation guide, do not send."
- The submitter submits that data element because it is needed for processing by a particular payer that may be secondary or tertiary to the primary payer.
- A payer that does not need or use that data element cannot reject a claim because it contains a data element or information that it does not need or use, provided usage of the data element is compliant with the TR3 Report.

Version 5010 Testing Readiness Fact Sheet

CMS also has a Version 5010 Testing Readiness Fact Sheet, which explains the Version 5010 upgrade and necessary Phase I Internal and Phase II External testing. This fact sheet can help providers to determine steps to successfully complete testing phases for Version 5010.

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Two Version 5010 Messages from CMS

1. ICD-10: It's Closer Than It Seems – Steps to Take to Refine your Version 5010 Upgrade

The Version 5010 upgrade deadline was Sunday, January 1. CMS initiated an enforcement discretion period for 90 days, which ends on Saturday, March 31. You should be finalizing your upgrade to Version 5010 if you have not yet done so.

Once you have finished your upgrade to Version 5010, you'll need to ensure your system continues to run properly. Providers should look for the following indicators to make sure there are no problems with their system upgrade:

- *An Increase in Rejections or Denials of Claims* – An increase in rejections or denials of claims may be an indication that there is not sufficient or correct data provided to meet Version 5010 standards. Partners, such as payers, also have a part in correcting this issue, since forwarding, converting, or formatting data can result in rejections or denials. Monitor your claims closely to determine the reasons for rejection or denial of claims and coordinate with payers to ensure that data is properly processed to avoid claim delays.
- *Issues with Non-Electronic Funds Transfer (non-EFT) Payments* – Version 5010 includes changes to claims formatting, including a full nine-digit zipcode and inclusion of provider billing address. Submitting claims with only a five-digit zipcode will result in rejection. If your practice has not submitted the correct billing or mailing address as part of your Version 5010 claim, your non-EFT payments or Explanation of Benefits (EOBs) information may be mailed to the wrong physical location. Make sure to coordinate with your payers to verify how they use enrollment information and process claims data, as this will also be affected by the mailing address on file. Being diligent in tracking your claims and remittances (EOBs) will help identify and address any issues that may arise.
- *Formatting Discrepancies with Partners* – Your trading partners should also have upgraded to Version 5010; however, your organization may interpret the new standards differently than your external partners, which can result in rejected claims. You should coordinate with your payers and/or clearinghouse to determine any gaps or discrepancies in claims submissions. You and your partners should monitor claims that are automatically transferred between payers and address new response formats or data as claims are processed.

Make sure to take a look at the Version 5010 section of the ICD-10 website to find helpful factsheets on the upgrade to Version 5010 and previous listserv messages discussing the Version 5010 upgrade.

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!

2. Important Update – "*HIPAA* Version 5010/D.0 Implementation" Document has been Updated

Updates have been made to the recently-posted document titled "Important Update Regarding *HIPAA* Version 5010/D.0 Implementation" – specifically, CMS has modified information related to the Diagnosis Related Group (DRG) code. The document can be found at the top of the *HIPAA* Versions 5010 & D.0 Overview webpage, at http://www.CMS.gov/versions5010andd0/01_overview.asp.

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