DME Happenings

• THIS IS WRITTEN NOTIFICATION OF MEDICARE CHANGES •

August 2011 | Issue No. 32

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

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

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Jurisdiction D DME MAC Supplier Contacts and Resources

Phone Numbers		
Interactive Voice Response System	1-877-320-0390	24 hours a day, 7 days a week for all functions except Claim Status and Beneficiary Eligibility, which are available 6 am to 6 pm CT Monday – Friday
Supplier Contact Center	1-866-243-7272	8:30 am to 5:30 pm CT Monday – Friday
Beneficiary Customer Service	1-800-633-4227	24 hours a day/7 days a week
Telephone Reopenings	1-888-826-5708	8 am – 4 pm CT

Website: www.noridianmedicare.com/dme

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

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

Mailing Addresses	
Claims, Redetermination Requests, Correspondence 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** RiverTrust Solutions, Inc. 1 Cameron Hill Circle Ste 0011 Chattanooga TN 37402-0011
Electronic Funds Transfer Forms / Overpayment Redeterminations/DME RAC Redeterminations Noridian Administrative Services PO Box 6728 Fargo ND 58108-6728	**DME RAC Overpayments** Noridian Administrative Services PO Box 6759 Fargo ND 58108-6759

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

2011 Supplier Contact Center and Telephone Reopenings Holiday and Training Closures

Supplier Contact Center

The NAS Customer Service team (1-866-243-7272) will be closed for the entire day (8:30 a.m. through 5:30 p.m. CT) on nine days in 2011 in recognition of holidays. Additionally, the Customer Service team will be closed one day each month between 8:30 a.m. and 12:30 p.m. CT to receive training. 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
Labor Day	September 5	Entire Day Closed 8:30 a.m. – 5:30 p.m. CT
Off-the-Phone Training*	September 16	8:30 a.m. – 11:00 a.m. CT
Off-the-Phone Training*	September 30	8:30 a.m. – 11:00 a.m. CT
Columbus Day* Training	October 10	8:30 a.m. – 11:00 a.m. CT
Off-the-Phone Training*	October 28	8:30 a.m. – 11:00 a.m. CT
Veterans Day* Training	November 11	8:30 a.m. – 11:00 a.m. CT
Thanksgiving	November 24 and 25	Entire Day Closed 8:30 a.m. – 5:30 p.m. CT
Off-the-Phone Training*	December 16	8:30 a.m. – 11:00 a.m. CT
Christmas	December 23 and 26	Entire Day Closed 8:30 a.m. – 5:30 p.m. CT
Martin Luther King Day* Training	January 17	8:30 a.m. – 11:00 a.m. CT
Off-the-Phone Training*	January 27	8:30 a.m. – 11:00 a.m. CT
Off-the-Phone Training*	February 10	8:30 a.m. – 11:00 a.m. CT
President's Day* Training	February 20	8:30 a.m. – 11:00 a.m. CT

Days noted with a (*) are days that the NAS DME Jurisdiction D offices will be open and the Customer Service Representatives will be available from 12:30 – 5:30 p.m. CT.

Telephone Reopenings

The NAS Telephone Reopening Team will be closed for the entire day (8 a.m. through 4 p.m. CT) on nine days in 2011 in recognition of holidays. Additionally, the Telephone Reopening team will be closed one day each month between 8 a.m. and 12:30 p.m. CT to receive training. The holiday and training closures are provided below.

Event	Date	Closure Timeframe
Labor Day	September 5	Entire Day Closed 8:00 a.m. – 4:00 p.m. CT
Off-the-Phone Training*	September 16	8:00 a.m. – 12:30 p.m. CT
Columbus Day* Training	October 10	8:00 a.m. – 12:30 p.m. CT
Veterans Day* Training	November 11	8:00 a.m. – 12:30 p.m. CT
Thanksgiving	November 24 and 25	Entire Day Closed 8:00 a.m. – 4:00 p.m. CT
Off-the-Phone Training*	December 16	8:00 a.m. – 12:30 p.m. CT
Christmas Eve Observed	December 23	Entire Day Closed 8:00 a.m. – 4:00 p.m. CT
Christmas	December 26	Entire Day Closed 8:00 a.m. – 4:00 p.m. CT

Days noted with a (*) are days that the NAS DME Jurisdiction D offices will be open and the DME Telephone Reopening Examiners will be available from 12:30 – 4 p.m. CT.

ADMC PO Box Change Effective August 1, 2011

Effective August 1, 2011, the PO Box for Advance Determination of Medicare Coverage (ADMC) requests will be changed to:

Noridian Administrative Services
Jurisdiction D Medical Review – ADMC
PO Box 6727
Fargo ND 58108-6727

ADMC requests may also be submitted via fax: 1-701-277-7890.

NAS provides an ADMC Request Form to accompany submitted documentation to ensure all information is provided. This form is available at https://www.noridianmedicare.com/dme/forms/docs/ADMC_Request_form.pdf.

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

FYI CONT'D

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

Dear Physician Letter - Signature Authentication Tips

NORIDIAN® Administrative Services LLC

Medicare

July 2011

Dear Physician,

Medicare Record Authentication – Tips for Physicians

Medicare requires that healthcare providers ordering or documenting the medical necessity for items or services received by Medicare beneficiaries must be identifiable. The Comprehensive Error Rate Testing (CERT) contractor notes that the majority of CERT errors are related to inability to identify the author of a medical record. Medical record authorship is generally accomplished through a handwritten or electronic signature (signature stamps are not acceptable); however, when the author of a record is unclear, document(s) must be authenticated. Signature logs or attestation statements are two acceptable methods to authenticate a record (excluding orders and Certificates of Medical Necessity (CMNs)).

Signature Logs
Medicare contractors recommend that physicians consider preparing a single-page signature log or "key" to include when responding to requests for documentation. A signed and dated signature log identifies the author(s) associated with initials or "illegible" signatures within a set of medical records. When a physician's office receives a request for copies of a beneficiary's medical record, the signature log may then be included and returned to the requestor. This will help prevent follow-up contacts from suppliers and auditing entities for signature verification.

Attestation Statements
In some cases, a medical record or entry omits a legible identifier requiring the author to attest to the authenticity of the record. To be considered valid for Medicare medical review purposes, an attestation statement must be signed and dated by the author of the medical record entry and must contain sufficient information to identify the beneficiary. Should a provider choose to submit an attestation statement, they may choose to use the following statement:

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

While this sample statement is an acceptable format, CMS is neither requiring nor instructing providers to use a certain form or format. The above format has not been approved by the Office of Management and Budget (OMB) and therefore it is not mandatory. Note that attestation statements are not valid for orders or CMNs where the author's signature or initials are not authenticated. An overview of the key points of CMS' signature requirements, including signature logs and attestation statements, can also be found in MLN Matters article MM6698.

CMS CENTERS for MEDICARE & MEDICAID SERVICES

29312096 A CMS Contracted Medicare Administrative Contractor (3203)3-09

Electronic Signatures
Although CMS has not published formal regulations regarding electronic signatures, Medicare contractors recommend that an electronic signature be accompanied by a statement indicating that the signature was applied electronically. Some examples of electronic signature notations include (not all-inclusive):

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

Notations such as those listed above indicate to the reviewer that the author's name, typically applied in typed format, was electronically signed.

Sincerely,

Paul J. Hughes, M.D. Medical Director, DME MAC, Jurisdiction A NHIC, Corp.	Robert D. Hoover, Jr., MD, MPH, FACP Medical Director, DME MAC, Jurisdiction C CIGNA Government Services
Stacey V. Brennan, M.D., FAAFP Medical Director, DME MAC, Jurisdiction B National Government Services	Richard W. Whitten, MD, MBA, FACP Medical Director, DME MAC, Jurisdiction D Noridian Administrative Services

Hours Extended for IVR and Endeavor Supplier Claim-Related Inquiries

Effective July 6, 2011, suppliers are able to make claim-related inquiries using the NAS Interactive Voice Recognition (IVR) system (1-877-320-0390) or the free Endeavor supplier portal between the hours of 6 a.m. until 8 p.m. CT. Due to supplier feedback received through customer satisfaction surveys, NAS requested the claim processing system maintainer extend the hours of availability by two hours each day to better support the self-service inquiries of Jurisdiction D suppliers. The IVR and Endeavor will each continue to offer eligibility inquiries 24 hours a day / 7 days a week. Suppliers are encouraged to use the IVR and Endeavor for simple inquiries and rely on the Customer Service Representatives for more complex inquiries between the hours of 8:30 a.m. and 5:30 p.m. CT. It is important you share this change with your staff and coworkers who contact our office.

Important Information for PPTN, DDE, and CSI Users

A new version of the Medicare Claims Processing System (MCPS) Part A DDE, Part B PPTN, and DME CSI User Request Form will soon be available at https://www.noridianmedicare.com. Form version 1.5 (dated 06/30/2011) will be required effective 07/22/2011 and prior versions will no longer be accepted.

Effective Date: July 22, 2011

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."

Missouri Emergency-Related Policy and Procedure Q&As

Questions and answers regarding items and services furnished to Medicare beneficiaries within the state of Missouri are available on the CMS website.

These Q&As are displayed in two files:

1. Qs&As applicable without any Section 1135 or other formal waiver are posted at: http://www.cms.gov/Emergency/Downloads/Consolidated_Medicare_FFS_Emergency_QsAs.pdf
2. Qs&As applicable only with a Section 1135 waiver or, when applicable, a Section 1812(f) waiver are posted at: http://www.cms.gov/Emergency/downloads/MedicareFFS-EmergencyQsAs1135Waiver.pdf

In both cases, the link will open the most current document and the date included in the document filename will change as new information is added or existing information revised.

Change Request (CR) 6451 issued on July 31, 2009, applies to items and services furnished to Medicare beneficiaries within the State of Missouri from May 9, 2011, for the duration of the emergency, except that references in the CR to "formal waivers" are not effective until May 22, 2011. In accordance with CR 6451, use of the "CR" modifier is mandatory on claims for items and services for which Medicare payment is conditioned on the presence of a "formal waiver" including, but not necessarily limited to, waivers granted under either Section 1135 or Section 1812(f) of the Social Security Act.

NAS Supplier Call Center Hours 8:30 – 5:30 CT Effective June 6, 2011

NAS is changing our Supplier Contact Center (1-866-243-7272) hours of operation to be 8:30 a.m. to 5:30 p.m. Central Time effective Monday, June 6, 2011. This change is made to ensure our Customer Service Representatives are available to answer supplier inquiries during the busiest times of the day. It is important you share this change with your staff and coworkers who contact our office. Suppliers are able to access claim specific information between the hours of 6 a.m. and 6 p.m. Central Time using our Interactive Voice Recognition (IVR) 1-877-320-0390 and Endeavor supplier portal, https://www.noridianmedicare.com/dme/claims/endeavor.html.

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.

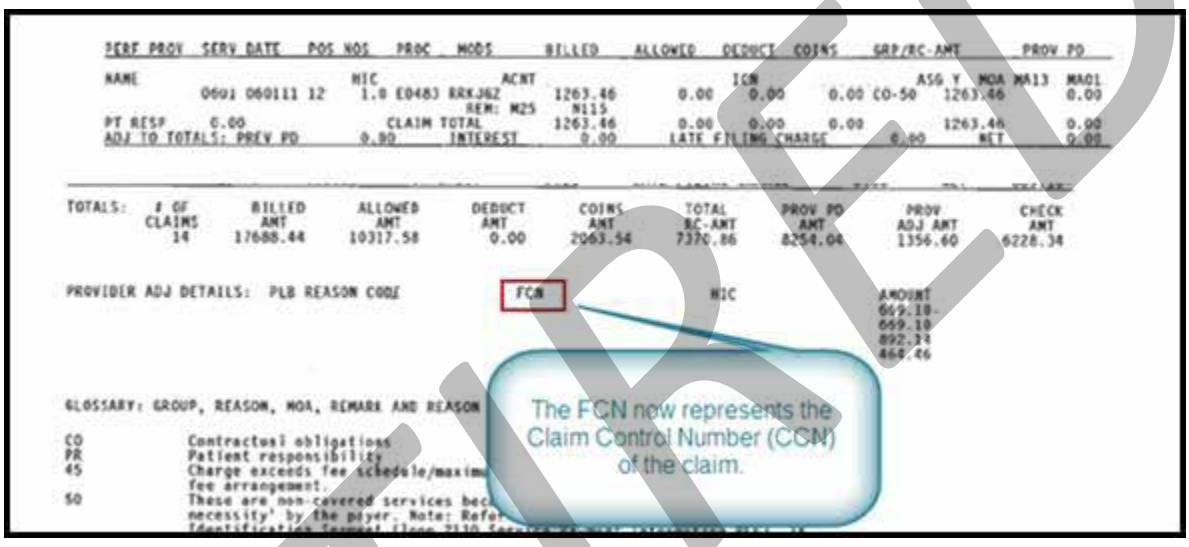
Remittance Advice Change to Financial Control Number Impacting IVR

Effective July 15, 2011 in response to CMS Change Request 7068, there has been a change to the information available on the remittance advice. The Financial Control Number (FCN) no longer displays the number associated with the offset. This field now displays the Claim Control Number of the claim which has been offset for all or a portion of the overpayment. Additionally, the Health Insurance Claim Number of the patient associated with the claim, and the amount applied to the debt are provided in the "PROVIDER ADJ DETAILS PLM REASON CODE" portion near the end of the remittance advice.

Although the label is still "FCN", it is important to understand this number cannot be used to inquire on an overpayment through the Interactive Voice Response (IVR) System. For Suppliers to learn the original patient and date of service that caused the overpayment on remittance advices dated 07/15/2011 and after, they may:

1. Refer to the original overpayment letter mailed to them by NAS or a different CMS-authorized entity (e.g., Recovery Audit Contractor)
2. Call the Contact Center Customer Service Representatives (1-866-243-7272) with your NPI, PTAN, TIN and remittance advice date. The CSRs can then provide you with the FCN associated with the overpayment. This information will enable you to obtain the overpayment details from the IVR.

Note: Customer Service Representatives are unable to release the details of the cause of an overpayment (patient's name, date of service, amount paid and denied on original claim).



We apologize for the inconvenience this has caused.

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 Chapter 16 Revised

The NAS DME Jurisdiction D Supplier Manual, Chapter 16, currently offers a list of HCPCS codes, descriptions, payment categories and Certificate of Medical Necessity (CMN)/DME Information Form (DIF) indicators. In order to provide consistent, accurate information, NAS will remove this information from Chapter 16 in June 2011. Suppliers are encouraged to ensure their staff that has traditionally used this content in the past begins using the PDAC Durable Medical Equipment coding System (DMECS) to obtain this information.

Below is a chart to assist in finding this information through other DME sources:

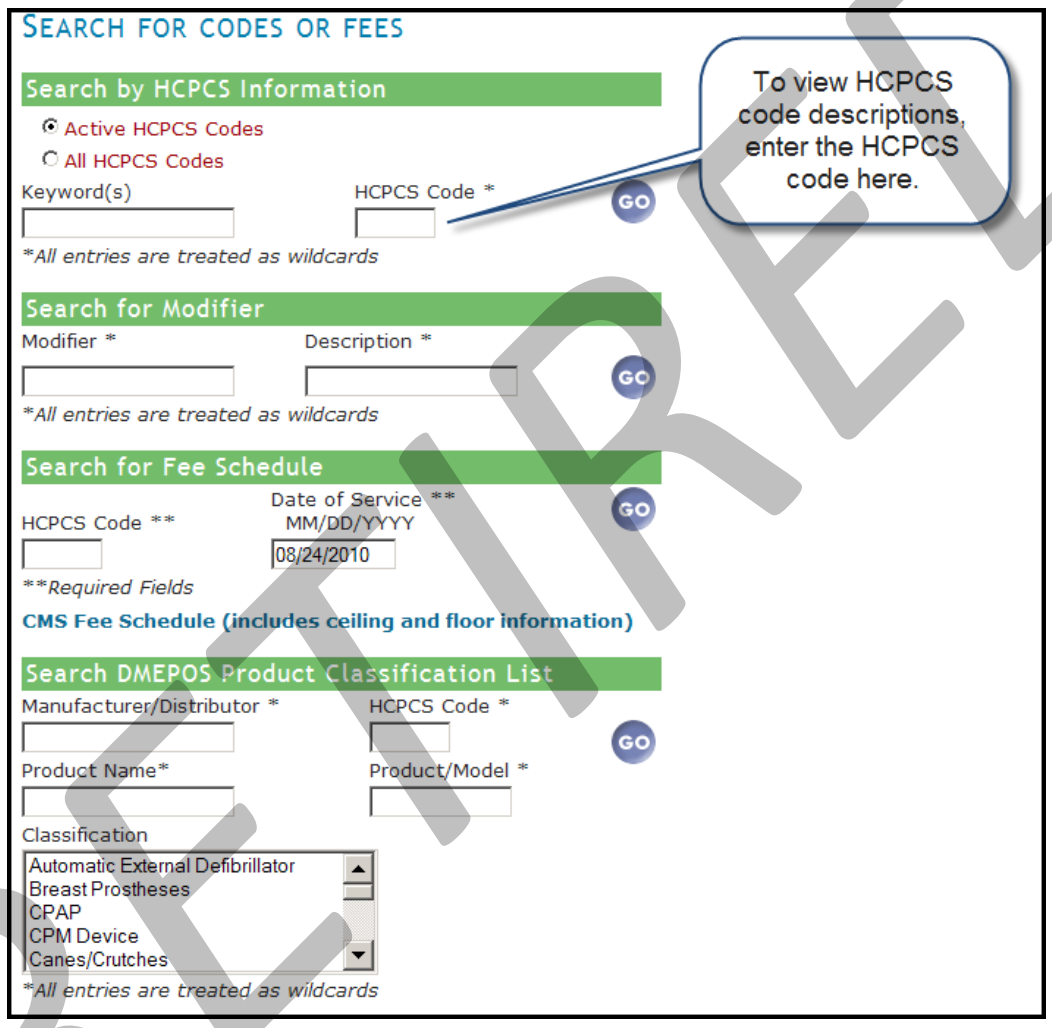
Item	Location
HCPCS Codes (including those that begin with the letters A, B, E, J, K, L, Q and V)	• Durable Medical Equipment Coding System (DMECS) • DMEPOS Fee Schedule
HCPCS Code Descriptions	• Durable Medical Equipment Coding System (DMECS) • DMEPOS Fee Schedule
Payment Categories	• Durable Medical Equipment Coding System (DMECS) • DMEPOS Fee Schedule
CMN/DIF Indicator	Documentation section of Local Coverage Determination (LCD)

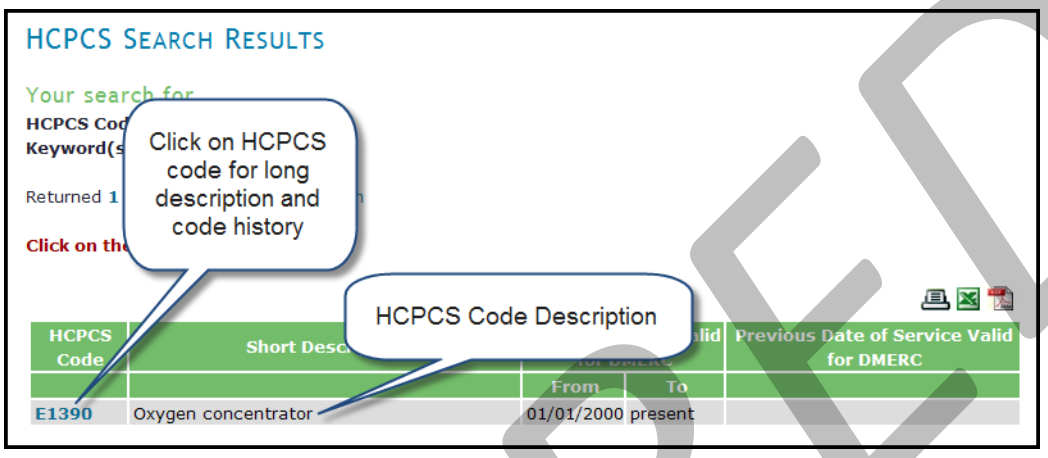
DMECS - Online Coding Assistance from the PDAC

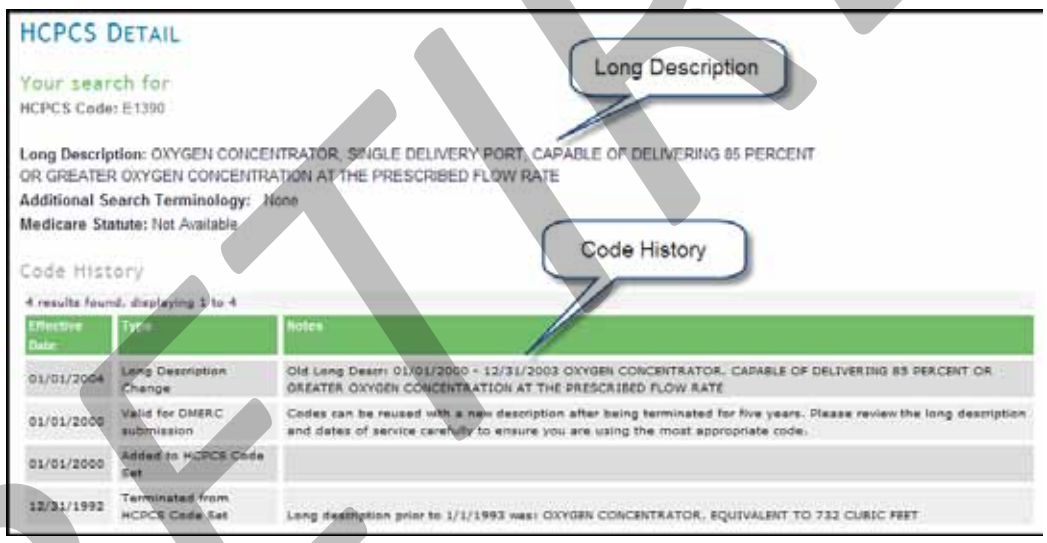
The DMECS (Durable Medical Equipment Coding System) is an online application that provides HCPCS coding assistance and national pricing information 24 hours a day. DMECS is designed to help Medicare suppliers quickly classify DMEPOS by combining information from a variety of sources to make HCPCS coding determinations for claim submission to the DME MACs easier. The first phase of DMECS includes a HCPCS and fee schedule look-up with capabilities to print or download information.

DMECS is maintained by the Pricing, Data Analysis and Coding (PDAC) contractor and available on the PDAC website at https://www.dmepdac.com/dmecs/index.html.

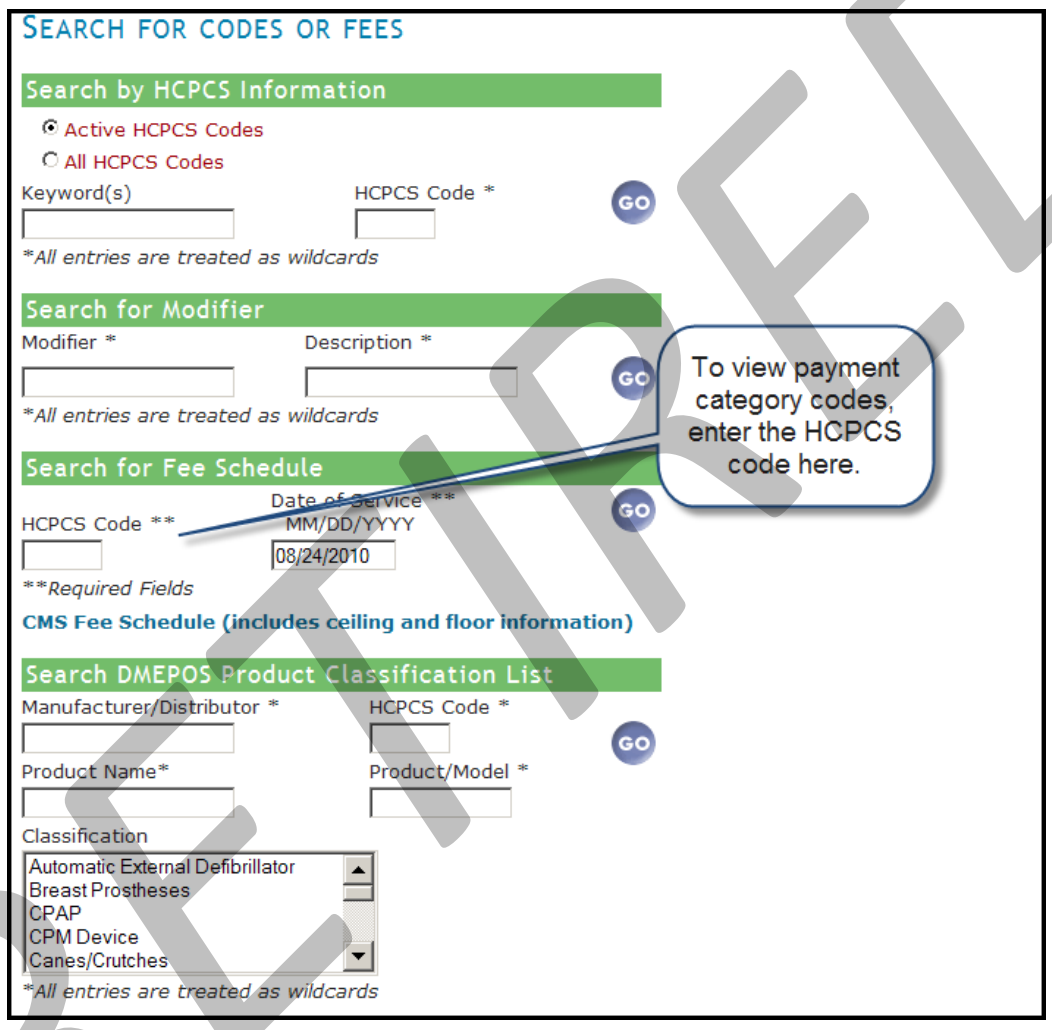
HCPCS Code Description







Payment Category



FEE SCHEDULE

Your search for

HCPCS Code: E1390
Long Description: OXYGEN CONCENTRATOR, SINGLE DELIVERY PORT, CAPABLE OF DELIVERING 85 PERCENT OR GREATER OXYGEN CONCENTRATION AT THE PRESCRIBED FLOW RATE

Date of service requested: August 24, 2010
HCPCS code fee schedule category: Oxygen and Oxygen Equipment

Payment (fee schedule) Category

Note: The start and end dates given for each HCPCS code reflect the effective dates of the fee schedule for the code, which include applicable grace periods.

Current Fee Schedule

Beneficiary State of Residence	Modifier	Modifi		ates:	
				From	To
AK	RR		$173.17	01/01/2010	12/31/2010
AL	RR		$173.17	01/01/2010	12/31/2010
AR	RR		$173.17	01/01/2010	12/31/2010
AZ	RR		$173.17	01/01/2010	12/31/2010

NAS hopes suppliers see the removal of this information offers improved search engine results while also directing suppliers to DMECS for the most current information regarding the HCPCS content previously published by NAS.

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
16	Modifiers	Updated RA and RB modifier descriptions	07/11/11
Appendix	Contacting NAS and Inquiries	Changed Endeavor hours of availability	07/11/11
Appendix	Resources	Changed ADMC PO Box	07/11/11
3	Detailed Written Orders	Specified capped rental item	06/28/11
1	What is Medicare?	Changed reference to Chapter 1	06/22/11
1	What is Medicare?	Added Lou Gehrig's disease	06/22/11
1	What is Medicare?	Changed number of suppliers from 24,000 to 30,000	06/22/11
1	NAS' Role as a DME MAC	Added Part A/B states, A/B legacy states, and PDAC	06/22/11
3	Supplier Documentation	Removed (if an ICD-9-CM code is required on the claim)	06/22/11
3	Supplier Documentation	Changed criterion to criteria as all policies have more than one criterion	06/22/11
3	Written Order Prior to Delivery	Changed statutorily noncovered or as not meeting the benefit category to excluded by statute	06/22/11
3	Repairs and Replacement Chart	Removed chart	06/22/11
4	Certificates of Medical Necessity and DME Information Forms	Forms are found in the Forms section, CMNs and DIFs, on the NAS DME website	06/22/11
4	Instructions for Completing a CMN and DIF	Removed PSCs	06/22/11
4	Transmission of CMN	Removed PSC	06/22/11
4	CMNs as Orders and Claim Submission	Removed PSC	06/22/11
4	Evidence of Medical Necessity for Oxygen CMN	Removed PSCs	06/22/11
4	Certificate of Medical Necessity – Common Scenarios	Removed PSCs	06/22/11
5	Capped Rental Items	Added PMD rental fee schedule information	06/22/11
5	Payments During Period of Continuous Use	Changed break in need to break in billing	06/22/11
5	Conditions Affecting Rental Periods	Remove least costly alternative information	06/22/11
5	Purchase Option of Capped Rental Items	Removed duplicate information and added purchase option for complex rehab power wheelchairs	06/22/11
5	Parenteral/Enteral Pump Rental/ Purchase	Removed requirement of beneficiary must be given option in 10th month	06/22/11

Chapter	Subheading	Supplier Manual Update	Change Date
5	DME MAC Services Excluded from Consolidated Billing in SNF	EPO and Home Dialysis not covered through DME MAC	06/22/11
8	Introduction	Updated 'Authorization Agreement for Electronic Funds Transfer' link	06/22/11
8	Step Four: Complete the EDI forms	Changed name of form to "CMS EDI Enrollment Form"	06/22/11
8	Step Four: Complete the EDI forms	Added "Sign, date, and fax both forms in together." and note to verify forms have RID.	06/22/11
9	Home Dialysis Supplies and Equipment	Home Dialysis not covered through DME MAC	06/22/11
9	Erythropoietin	EPO not covered through DME MAC	06/22/11
11	End Stage Renal Disease	COB Period: 12 months changed to 9–12 months	06/22/11
11	End Stage Renal Disease	February 29, 996 changed to 1996	06/22/11
11	Coordination of Benefits – Introduction	Updated Written Inquiries address	06/22/11
11	Medicare Secondary Payer on Capped Rental Items	Changed 'electric wheelchair' to 'complex rehabilitative power wheelchairs'	06/22/11
13	Reopenings	Changed supplier number to PTAN	06/22/11
13	Redeterminations	Added link to MA130	06/22/11
13	Appointment of Representative	Added information regarding CMS-1696 form	06/22/11
15	Recoupment Process	Appeals team changed to Redeterminations	06/22/11
16	Level II HCPCS	Removed section	06/22/11
17	Medicare Remittance Notice	Link for Understanding the Remittance Advice Errata Sheet – does not work	06/22/11
Appendix	Contacting NAS and Inquiries	Updated Supplier Contact Center hours of availability	06/22/11
Appendix	Resources	Updated CGS website	06/02/11
2	Supplier Standards	Changed 424 CFR to 42 CFR	05/09/11

Supplier Reminder Regarding EFT Agreements

DMEPOS suppliers are reminded to send Electronic Funds Transmittal (EFT) Agreements directly to the billing jurisdictions when making changes regarding electronic funds deposits. DMEPOS suppliers are only required to submit EFT agreements to the NSC when initially enrolling for Medicare billing privileges. Sending EFT information to the NSC for ensuing changes after enrollment will result in billing delays. For more information, please contact a DME MAC billing jurisdiction.

Source: National Supplier Clearinghouse

Guidelines to Allow Procedures for Accepting and Processing Reopenings via Secure Internet Portal/Application

MLN Matters® Number: MM7420
Related Change Request (CR) #: CR 7420
Related CR Release Date: June 17, 2011
Related CR Transmittal #: R2241CP
Effective Date: October 1, 2011
Implementation Date: October 3, 2011

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

Provider Action Needed
Effective October 1, 2011, you may have (depending on your contractor) an alternative, electronic method to submit your requests for Medicare Fee-For-Service (FFS) claim reopenings.

CR7420, from which this article is taken (effective October 1, 2011,) allows Medicare contractors to use a secure Internet portal/application to accept and process your requests for reopening Medicare FFS claims.

Background
In response to requests from Medicare contractors, CR7420 (from which this article is taken) updates the current instructions in the "Medicare Claims Processing Manual" Chapter 34 (Reopening and Revision of Claim Determinations and Decisions), to allow them to accept claimant initiated reopening requests via a secure Internet portal/application – effective October 1, 2011. (You can find this manual at http://www.cms.gov/manuals/downloads/clm104c34.pdf on the Centers for Medicare & Medicaid Services (CMS) website.)

Note: Medicare contractors may not require you to file a reopening via a secure Internet portal/application. Also, contractors are not required to offer this electronic capability.

Medicare will have a number of requirements for Medicare contractors utilizing a secure Internet portal/application for reopening. Specifically, to provide this access, contractors will:

- Incorporate a formal registration process that contains validation of the electronic signature on the reopening request, which will include, at a minimum, the use of restricted user identifiers (IDs) and passwords, and a method for authenticating that the party has completed the portal registration process and has been properly identified by the system as an appropriate user.
- Include, in the appeals case file, an indication and/or description of the validation methodology; should a redetermination and/or higher level of appeal be submitted following an adverse reopening decision.
- Ensure that secure Internet portal/applications developed for reopening activities adhere to the security standards in the Health Insurance and Portability and Accountability Act (HIPAA); and comply with all CMS security requirements regarding protected health information prior to implementation.
- Issue a reopening decision or refusal to reopen via a secure Internet portal/application only if the party has submitted the request for reopening through that application.
- Provide adequate education to participating parties:
  - Regarding system capabilities/limitations prior to implementation and utilization of the secure portal; and
  - Reminding them that participation/enrollment in the secure portal/application is at their discretion and that they bear the responsibility for the authenticity of the information being attested to in the request.
- Include a date, timestamp, and statement regarding the responsibility and authorship related to the electronic, digital, and/or digitized signature within the record. At a minimum, this will include a statement indicating that the document was, "electronically signed by" or "verified/approved by," etc.
- Ensure that appropriate procedures are in place, via the secure Internet/portal, to provide parties to the reopening with receipt confirmation of the reopening request, and instructions not to submit additional reopening requests for the same item/service via different venue (i.e., telephone, in writing, etc.).

- Consider decisions processed via a CMS approved secure Internet portal/application complete on the date the electronic reopening decision notice is transmitted to the party through the secure Internet portal/application.
- Ensure that there is a process in place by which a party can submit, via the secure application/portal; additional documentation/materials concurrent with the reopening request (i.e. ensure that the portal/application has the capability to accept additional documentation and/or other materials to support the reopening request.)
- Include a mechanism that tracks and marks the date/time of the notification so the submitting party is adequately informed about the timeframes required to ensure timely submission of future appeal requests for the item/service at issue, if applicable; and ensure that parties may save and print the refusal to reopen notice and the adverse revised determination/decision notice.
- Ensure that refusal to reopen and adverse revised determination notices transmitted via a secure Internet portal/application comply with the timeliness and content requirements as outlined in the "Medicare Claims Processing Manual," Chapter 34.
- Provide hard copy adverse revised determination/decision notices to parties to the reopening who do not have access to the secure Internet portal/application; and ensure that these notices are mailed and/or otherwise transmitted on the same day the notice is transmitted via the secure portal/application.)
- Include the adverse revised determination/decision notice and any other related materials in the appeals case file if a valid appeal on the item/service is later requested.

Contractors will not issue a refusal to reopen notice if they begin processing a valid and timely request for redetermination as a reopening (clerical error or otherwise) and later determine that a reopening cannot be performed, or the determination cannot be changed. Rather, they will process the request as a valid/timely redetermination (as originally requested by the party) in accordance with the "Medicare Claims Processing Manual," Chapter 29 (Appeals of Claims Decisions), which you can find at http://www.cms.gov/manuals/downloads/clm104c29.pdf on the CMS website.

Additional Information
You can find the official instruction, CR7420, issued to your FI or A/B MAC by visiting http://www.cms.gov/transmittals/downloads/R2241CP.pdf on the Centers for Medicare & Medicaid (CMS) website. You will find the updated "Medicare Claims Processing Manual," Chapter 34 (Reopening and Revision of Claim Determinations and Decisions), Sections 34.10 (Reopenings and Revisions of Claims Determinations and Decisions-General), 34.10.1 (Authority to Conduct a Reopening), 34.10.6.4 (Timeframes When a Party Requests an Adjudicator Reopen Their Decisions), 34.10.7 (Timeframes to Complete a Reopening Requested by a Party), 34.10.8 (Notice of a Revised Determination or Decision), and 34.10.13 (System and Processing Requirements for Use of Secure Internet Portal/Application to Support Reopening Activities) as an attachment to that CR.

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. Telephone Reopenings is limited to five dates of service per telephone call.

What Can be Done as a Reopening
The following is a list of clerical errors and omissions that can be completed as a telephone or written reopening. This list is not all-inclusive:

- Diagnosis changes/additions
- Date of service changes
- Procedure code changes
- Certificate of Medical Necessity (CMN)/DME Information Form (DIF) Updates (with the exception of parenteral and enteral nutrition, which must be done as a written redetermination and oxygen Break In Service (BIS) which can only be done as a written reopening)

- 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/Power Mobility Devices - HCPCS K0004 and lower

Disclaimer: If any of the above changes, upon research, are determined to be too complex, the requestor will be notified that the request needs to be sent in writing, with the appropriate documentation, as a redetermination.

What Can Not be Done as a Reopening
The following issues must be requested and completed as a redetermination rather than a telephone or written reopening:

- Any item billed over the allowance listed in the medical policy-documentation is required to support amount billed
- KX Modifier
- Parenteral and Enteral CMN/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
- Late Files
- Requests that require documentation
- ABN Issues
- GA/GY/GZ Modifiers
- Liability Issues
- Repairs to equipment
- Miscellaneous codes
- Labor codes

Claims with remittance message MA130 can never be submitted as a reopening. Claims with message MA130 are considered unprocessable. The claim is missing information that is needed for processing the claim or the claim information is invalid. Unprocessable claims do not have reopening or redetermination rights and must be corrected and submitted as a new claim.

BILLING

Billing Reminder – Billing for Supplies Prior To Delivery of the Base Item

Supplies are a loosely defined category of items that are used with base items of DME. They are either consumed (used up) or require frequent replacement. Many DME items require supplies be used in conjunction for the base item to be functional. Some examples (not all-inclusive) are masks and tubing used with PAP devices, strips and lancets used with home glucose monitors or the drugs used with infusion pumps and nebulizers.

Payment for supplies is contingent upon the coverage of the base DME item. If the DME item is covered (meets all applicable payment requirements) then supplies used with that item are also covered. Supplies sometimes have specific coverage criteria that must be met in addition to the base item before payment can be made.

No payment may be made for supplies that are billed with dates of service (DOS) prior to the initial DOS of the base item associated with the supplies. Supplies billed with a DOS before the initial DOS of the base item will be denied as statutorily non-covered (no benefit). Suppliers are encouraged to assure that the base item is delivered on or before the delivery date of any supplies in order to avoid unnecessary denials. Sometimes multiple suppliers may be involved as in the case of nebulizers and associated drugs. This may require close coordination between all parties to avoid needless denials.

For appeals, suppliers are reminded that it is necessary to provide information from the medical record demonstrating that the coverage criteria for all items were met and that the base item was ordered, along with any supplies, prior to the DOS of the denied supplies.

Refer to the applicable LCD and Policy Article and Supplier Manual for additional information.

Billing Reminders for Not Otherwise Classified Codes

The purpose of this article is to ensure that suppliers are billing Not Otherwise Classified (NOC) codes properly.

When billing for nuts, bolts, screws, or other small parts, these items are included in the allowance for the accessory with which they are being used. If these items are billed on a separate line using an NOC code, they will be denied as being included in the payment/allowance for another service/procedure.

HMO Listing Published and Available on CMS Website

CMS publishes a Health Maintenance Organization (HMO) plan directory (Microsoft Excel format) that includes the HMO company name, contract number (i.e., H1234), address and phone number. This information is accessible from the CMS website, http://www.cms.gov/MCRAdvPartDEnrolData/PDMCPDO. This resource should be accessed when a Medicare beneficiary eligibility inquiry indicates the patient has elected an HMO plan to assist a supplier in locating/billing the correct insurance company for the items they are providing.

Place of Service Codes on CMS Website

A new section for the Place of Service Codes is now available on the CMS Website. This section is located under the "Coding" category on the Medicare tab of the CMS website at: http://www.cms.gov/place-of-service-codes/. From that section, you can access a print-friendly version of the "Place of Service Codes for Professional Claims" document. This document is also available in the Downloads section on the following two web pages: HCPCS General Information and Physician Fee Schedule - Overview. This Place of Service Codes section was formerly located on the Medicaid website.

Edit to Deny Claims for Repairs to Capped Rental DME

MLN Matters® Number: MM7212 Revised
Related Change Request (CR) 7212
Related CR Release Date: May 13, 2011
Related CR Transmittal #: R901OTN
Effective Date: October 1, 2011
Implementation Date: October 3, 2011

Note: This article was revised on June 21, 2011, to correct the messages (page 2) used when a claim is denied. All other information is unchanged.

Provider Types Affected
This article is for suppliers and providers billing Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for rentals of capped Durable Medical Equipment (DME).

Provider Action Needed
Change Request (CR) 7212 instructs Medicare DME MACs to prohibit separate payment for repairs to capped rental items during the rental period. The rental period is not to exceed 13 continuous months. However, payment for all maintenance, servicing, and repair of capped rental equipment is included in the allowed rental payments. Under no circumstances will Medicare pay for these services prior to the end of the 13-month capped rental period. Suppliers of capped rental items need to be aware of this issue as it impacts maintenance and servicing of DME for Medicare beneficiaries as described in this article.

Key Points of CR7212

- Claims for replacement parts for capped rental items billed during the 13-month capped rental period with the "RB" modifier, including parts submitted using code E1399, will be denied.
- Claims for repairs that are billed with the Healthcare Common Procedure Coding System (HCPCS) code K0739 for the labor associated with repairs of capped rental equipment during the 13-month capped rental period will be denied.
- In denying these claims, DME MACs will use the following Claim Adjustment Reason Code (CARC), and Remittance Advice Remark Codes (RARCs) messages for claims denied or rejected for DME repairs during the capped rental period:
  - CARC 97: "The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. NOTE: refer to the 835 healthcare policy identification segment (loop 2110 service payment information ref), if present."
  - RARC MA13: "Alert: You may be subject to penalties if you bill the patient for amounts not reported with the Patient Responsibility (PR) group code." and
  - RARC N211: "Alert: You may not appeal this decision".

Additional Information
For complete details regarding this CR please see the official instruction (CR 7212) issued to your Medicare DME MAC. That instruction may be viewed by going to http://www.cms.gov/Transmittals/downloads/R901OTN.pdf on the Centers for Medicare and Medicaid Services (CMS) website. To review the recent 2010 report from the Office of the Inspector General on this issue, you may go to http://oig.hhs.gov/oei/reports/oei-07-08-00550.pdf on the Internet.

CARC, RARC, and MREP Update

MLN Matters® Number: MM7369
Related Change Request (CR) #: 7369
Related CR Release Date: May 6, 2011
Related CR Transmittal #: R2213CP
Effective Date: July 1, 2011
Implementation Date: July 5, 2011

Provider Types Affected
This article is for physicians, providers, and suppliers who submit claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), Medicare Administrative Contractors (MACs), and Durable Medical Equipment Medicare Administrative Contractors (DME MACs)) for service provided to Medicare beneficiaries.

Provider Action Needed
Change Request (CR) 7369, from which this article is taken, announces the latest update of Remittance Advice Remark Codes (RARCs) and Claim Adjustment Reason Codes (CARCs) that are effective on July 1, 2011 for Medicare. Be sure your billing staff is aware of these changes.

Background
The reason and remark code sets must be used to report payment adjustments in remittance advice transactions. The reason codes are also used in some Coordination-of-Benefits (COB) transactions. The RARC list is maintained by the Centers for Medicare & Medicaid Services (CMS), and used by all payers. Additions, deactivations, and modifications to the list may be initiated by any health care organization. The RARC list is updated 3 times a year – in early March, July, and November, although the Committee meets every month.

Both code lists are posted at http://www.wpc-edi.com/Codes on the Washington Publishing Company (WPC) website. The lists at the end of this article summarize the latest changes to these code lists, as announced in CR7369.

Additional Information
To see the official instruction (CR7369) issued to your Medicare Carrier, RHHI, DME MAC, FI and/or MAC, refer to http://www.cms.gov/Transmittals/downloads/R2213CP.pdf on the CMS website.

CR7369 Changes

New Codes – CARC

Code	Current Narrative	Effective Date per WPC Posting
236	This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same day according to the National Correct Coding Initiative.	1/30/2011

Modified Codes – CARC: None

Deactivated Codes – CARC: None

New Codes –RARC:

Code	Current Narrative	Medicare Initiated
N542	Missing income verification	No
N543	Incomplete/invalid income verification	No

Modified Codes – RARC:

Code	Modified Narrative	Medicare Initiated
M37	Not covered when the patient is under age 35.	No
M116	Processed under a demonstration project or program. Project or program is ending and additional services may not be paid under this project or program.	No
N62	Dates of service span multiple rate periods. Resubmit separate claims.	No
N356	Not covered when performed with, or subsequent to, a non-covered service.	No
N383	Not covered when deemed cosmetic.	No
N410	Not covered unless the prescription changes.	No
N428	Not covered when performed in this place of service.	No
N429	Not covered when considered routine.	No
N431	Not covered with this procedure.	No

Deactivated Codes – RARC: None

Prospective Billing for Refills of DMEPOS Items Provided on Recurring Basis

MLN Matters® Number: MM7452
Related Change Request (CR) #: 7452
Related CR Release Date: July 1, 2011
Related CR Transmittal #: R378PI
Effective Date: August 2, 2011
Implementation Date: August 2, 2011

Provider Types Affected
Suppliers who bill Medicare Durable Medical Equipment Medicare Administrative Contractors (DME MACs)) for DMEPOS items and supplies that are provided on a recurring basis.

What You Need to Know
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 will allow for the processing of claims for refills delivered/shipped prior to the beneficiary exhausting his/her supply.

Background
For DMEPOS items and supplies that are provided on a recurring basis, billing must be based on prospective, not retrospective use. The following scenarios are illustrative of this concept:

- Scenario 1: The treating physician writes an order for enteral nutrition which translates into the dispensing of 100 units of nutrient for one month. The supplier receives the order, delivers 100 units and bills the claim with a date of service as the date of delivery indicating 100 units. This is an example of prospective billing and is acceptable.
- Scenario 2: The treating physician writes an order for enteral nutrition which translates into the dispensing of 100 units of nutrient for one month. The supplier receives the order and delivers 100 units. A claim is not billed. At the end of the month, the supplier determines that the beneficiary used 90 units for the month and delivers 90 units to replace the nutrient used. A claim is then submitted with a date of service as the date of delivery indicating 90 units of enteral nutrition. This is an example of retrospective billing and is not acceptable.

Additional Information
The official instruction, CR 7452 issued to your DME MAC regarding this issue may be viewed at http://www.cms.gov/Transmittals/downloads/R378PI.pdf on the Centers for Medicare & Medicaid Services (CMS) website.

Medicare Contractor Annual Update of ICD-9-CM

MLN Matters® Number: MM7454
Related Change Request (CR) #: 7454
Related CR Release Date: June 24, 2011
Related CR Transmittal #: R2246CP
Effective Date: October 1, 2011
Implementation Date: October 3, 2011

Provider Types Affected
All Medicare providers and suppliers submitting claims to Fiscal Intermediaries (FI), Regional Home Health Intermediaries (RHHI), Carriers, A/B Medicare Administrative Contractors (MAC) and Durable Medical Equipment (DME) MACs are affected by this article.

Provider Action Needed
This article, based on Change Request (CR) 7454, informs you that the Centers for Medicare & Medicaid Services (CMS) is providing its annual reminder of the ICD-9-CM update that is effective for the dates of service on and after October 1, 2011 (effective for discharges on or after October 1, 2011, for institutional providers). Please be sure to inform your staffs of these updates.

Background
ICD-9 Information
The ICD-9-CM codes are updated annually. Effective since October 1, 2003, an ICD-9-CM code is required on all paper and electronic claims billed to Medicare contractors and MACs, with the exception of ambulance claims (specialty type 59).

CMS posts the new, revised and discontinued ICD-9-CM diagnosis codes annually at http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/07_summarytables.asp#TopOfPage on the CMS website. The updated diagnosis codes are effective for dates of service and discharges on and after October 1. You may view the new updated codes at this site in June. You may also visit the National Center for Health Statistics (NCHS) website at http://www.cdc.gov/nchs/icd.htm on the Internet. The NCHS will post the new ICD-9-CM Addendum on their website in June. You are also encouraged to purchase a new ICD-9-CM book or CD-ROM annually.

International Classification of Diseases, Tenth Revision (ICD-10) Information
CMS has posted a list of 2011 ICD-10-CM code descriptions in tabular order (the order they appear in the code book) at http://www.cms.gov/ICD10/11b1_2011_ICD10CM_and_GEMs.asp on the CMS website. The tabular order version of ICD-10-CM will assist those who wish to identify a range of codes and make certain they have correctly identified all codes within the range. In addition, a list of 2012 ICD-10-PCS codes is at http://www.cms.gov/ICD10/11b15_2012_ICD10PCS.asp on the CMS site. The 2012 ICD-10-CM list should be posted later this year and its posting will be conveyed via listserv notices.

Additional Information
The official instruction, CR 7454, issued to your FI, RHHI, carrier, A/B MAC, and DME MAC regarding this change, may be viewed at http://www.cms.gov/Transmittals/downloads/R2246CP.pdf on the CMS website.

Claim Status Category Code and Claim Status Code Update

MLN Matters® Number: MM7456
Related Change Request (CR) #: 7456
Related CR Release Date: June 17, 2011
Related CR Transmittal #: R2243CP
Effective Date: October 1, 2011
Implementation Date: October 3, 2011

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.

Provider Action Needed
This article, based on CR7456, explains that the Claim Status Codes and Claim Status Category Codes for use by Medicare contractors with the Health Claim Status Request and Response ASC X12N 276/277 and the Health Care

BILLING CONT'D

Claim Acknowledgement ASC X12N 277 were updated during the October 2011 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 November 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 October 3, 2011. All providers should ensure that their billing staffs are aware of the updated codes and the timeframe for implementation.

Background
The Health Insurance Portability and Accountability Act 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 and 005010X212). The Centers for Medicare & Medicaid Services (CMS) has also adopted as the CMS standard for contractor use the X12 277 Health Care Claim Acknowledgement (005010X214) as the X12 5010 required method to acknowledge the inbound 837 (Institutional or Professional) claim format. 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, CR7456 issued to your FI, A/B MAC, and DME MAC regarding this change may be viewed at http://www.cms.gov/transmittals/downloads/R2243CP.pdf on the CMS website.

CERT

CERT Documentation

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

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

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

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

Mail all requested documentation to:

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

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

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

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

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

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

COMPETITIVE BIDDING

First Quarter Health Outcomes Results for DMEPOS Competitive Bidding

On 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 program implementation, CMS has been conducting real-time claims analysis for groups of Medicare beneficiaries potentially affected by the program. We have now issued the 2011 first quarter DMEPOS Competitive Bidding Program health outcomes results, which show no significant changes in health outcomes for these groups. To view the results, please visit http://www.cms.gov/DMEPOSCompetitiveBid/.

DME National Competitive Bidding: Correction to Permit Payment for Certain Grandfathered Accessories and Supplies

MLN Matters® Number: MM7389
Related Change Request (CR) #: 7389
Related CR Release Date: May 6, 2011
Related CR Transmittal #: R896OTN
Effective Date: October 1, 2011
Implementation Date: October 3, 2011

Provider Types Affected
This article is for suppliers billing Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for certain grandfathered accessories and supplies furnished to Medicare beneficiaries after the start of a Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program (CBP).

Provider Action Needed
This article is based on Change Request (CR) 7389 which informs Medicare suppliers and DME MACs that Medicare payment is permissible to a non-contract, grandfathered supplier for furnishing certain purchased, covered accessories or supplies furnished for use with capped rental equipment.

There are limitations on the duration of this permission as well as constraints on the applicable Healthcare Common Procedure Coding System (HCPCS) codes. The KY modifier should not be annotated on claims for these HCPCS codes after September 31, 2011.

Background
Under the Medicare DMEPOS CBP a beneficiary who obtains competitive bidding items in a designated Competitive Bidding Area (CBA) must obtain these items from a contract supplier, unless an exception applies such as the ones presented below exist.

Exception 1:
A beneficiary may continue to obtain a capped rental item from a non-contract supplier if the beneficiary was receiving such rented item from the non-contract supplier when the CBP took effect in the CBA. Such a non-contract supplier would be considered a "grandfathered supplier" with respect to such rented item and such beneficiary for the remainder of the particular item's capped rental period.

Exception 2: (related to exception above
A beneficiary, who continues to obtain a capped rental competitive bidding item from a non-contract grandfathered supplier, may also obtain certain purchased, covered accessories or supplies furnished for use with such rented "grandfathered" capped rental equipment from the same non-contract grandfathered supplier. The purchased, covered accessories or supplies that are subject to this exception, identified by applicable HCPCS codes, are as follows:

- Continuous Positive Airway Pressure Devices, Respiratory Assistive Devices, and Related Supplies and Accessories – A4604, A7030, A7031, A7032, A7033, A7034, A7035, A7036, A7037, A7038, A7039, A7044, A7045, A7046, E0561, and E0562;
- Hospital Beds and Related Accessories – E0271, E0272, E0280, and E0310; and
- Walkers and Related Accessories – E0154, E0156, E0157 and E0158

Previously, non-contract grandfathered suppliers submitting claims for purchased, covered accessories or supplies under this exception were told to use the KY modifier on claims for such items with dates of service on or after January 1, 2011.

Key Points in CR7389
Effective October 1, 2011, the KY modifier is not required on these claims. Any claims submitted after September 30, 2011 with the KY modifier will be denied.

Medicare payment may be made to a non-contract, grandfathered supplier for furnishing certain purchased, covered accessories or supplies furnished for use with capped rental equipment, provided the non-contract supplier is also furnishing the capped rental equipment on a grandfathered basis. The purchased, covered accessories or supplies that are subject to this policy, identified by applicable HCPCS codes, are previously listed.

After the rental payment cap for the grandfathered equipment is reached:

- The beneficiary should obtain covered accessories and supplies only from a contract supplier;
- The supplier of the grandfathered equipment is no longer permitted to furnish the covered accessories and supplies;
- Medicare payment will no longer be made to a non-contract, grandfathered supplier for furnishing such purchased accessories or supplies and
- These claims will be denied, using the following messages:
  - B20 – Procedure /service was partially or fully furnished by another provider;
  - N211 – You may not appeal this decision;
  - M115 – This item is denied when provided to this patient by a non-contract or non-demonstration supplier; and
  - MSN 8.72: This item must be provided by a contract supplier under the DMEPOS competitive bidding program. You should not be billed for this item or service. You do not have to pay this amount. There are no Medicare appeal rights related to this item.

Medicare contractors will also assign group code CO (Contractual Obligation).

Additional Information
The official instruction associated with this CR7389, issued to your Medicare MAC regarding this change may be viewed at http://www.cms.gov/Transmittals/downloads/R896OTN.pdf on the CMS website. To review a complete listing of links to DME related information you may go to https://www.cms.gov/center/dme.asp on the CMS website. https://www.cms.gov/center/dme.asp.

Phase 3 of Manual Revisions to Reflect Payment Changes for DMEPOS Items

MLN Matters® Number: MM7401
Related Change Request (CR) #: 7401
Related CR Release Date: May 27, 2011
Related CR Transmittal #: R2231CP
Effective Date: August 28, 2011
Implementation Date: August 28, 2011

Provider Types Affected
This article is for Medicare DMEPOS suppliers that bill Durable Medical Equipment Medicare Administrative Contractors (DME MACs) as well as providers that bill Medicare Carriers, Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), or Part A/B Medicare Administrative Contractors (A/B MACs) for DMEPOS that they refer or order for Medicare beneficiaries.

What You Need to Know
Change Request (CR) 7401, from which this article is developed, is the third installment of, and adds information to, Chapter 36 DMEPOS Competitive Bidding Program in the "Medicare Claims Processing Manual" and provides additional information for Medicare contractors and suppliers on the Round One Rebid Implementation. CR 5978 provided the first installment of Chapter 36 and details the initial requirements of this program. The phase one MLN Matters® article CR5978 is available at http://www.cms.gov/MLNMattersArticles/downloads/MM5978.pdf on the Centers for Medicare & Medicaid services (CMS) website. CR 6119 provided the second installment of Chapter 36 and details the second phase of the manual revisions to this program. The related MLN Matters® article CR6119 is available at http://www.cms.gov/MLNMattersArticles/Downloads/MM6119.pdf on the CMS website.

COMPETITIVE BIDDING CONT'D

Background
The Medicare payment for most DMEPOS was traditionally based on fee schedules. When section 1847 of the Social Security Act (the Act), section 302(b) of the Medicare Prescription Drug Improvement, and Modernization Act of 2003 (MMA) was amended, a competitive bidding program was implemented to replace the current DMEPOS methodology for determining payment rates for certain DMEPOS items that are subject to competitive bidding under this statute.

CMS issued the regulation for the competitive bidding program on April 10, 2007 (72 Federal Register 17992). Round One of the National Competitive Bidding (NCB) Program was implemented on January 1, 2011. CR 7401 provides additional instructions on changes under the DMEPOS Competitive Bidding Program. This regulation is available at http://www.cms.hhs.gov/DMEPOSCompetitiveBid on the CMS website.

Key Points of CR7401
There are seven additions to section 50 of Chapter 36 of the "Medicare Claims Processing Manual"; one is an update and the other six are new additions:

- Section 50.3 is updated to include new HCPCS modifiers developed to facilitate implementation of various policies that apply to certain competitive bidding items. The KG, KK, KU, KW, and KY modifiers are pricing modifiers that suppliers must use to identify when the same supply or accessory HCPCS code is furnished in multiple competitive bidding product categories.
    - For example, HCPCS code E0981 (Wheelchair Accessory, Seat Upholstery, Replacement Only, Each) is found in both the standard and complex rehabilitative power wheelchair competitive bidding product categories. Contract suppliers for the standard power wheelchair product category must submit E0981 claims using the KG modifier, whereas contract suppliers for the complex rehabilitative power wheelchair product category must use the KK modifier. All suppliers, including grandfathered suppliers, shall submit claims for competitive bid items using the aforementioned competitive bidding modifiers.
    - The KG and KK modifiers are used in Round I of the competitive bidding program and the KU and KW modifiers are reserved for future program use.

The six sections added to Chapter 36: 50.10 through 50.15 as follows:

- 50.10 - Claims Submitted for Hospitals Who Furnish Competitively Bid Items;
    - Under DMEPOS Competitive Bidding, hospitals may furnish certain types of competitively bid DME to their patients on the date of discharge without submitting a bid and being awarded a contract. The DME items that a hospital may furnish as part of the exception are limited to crutches, canes, walkers, folding manual wheelchairs, blood glucose monitors, and infusion pumps. Payment for items furnished under this exception will be made based on the single payment amount for the item for the Competitive Bidding Area (CBA) where the beneficiary resides. Separate payment is not made for walkers and related accessories furnished by a hospital on the date of admission because payment for these items are included in the Part A payment for inpatient facility services. Refer to the "Medicare Claims Processing Manual", Chapter 1, 10.1.1.1 for instructions for submitting claims at http://www.cms.gov/manuals/downloads/clm104c01.pdf on the CMS website.
- 50.11 - Claims Submitted for Medicare Beneficiaries Previously Enrolled in a Medicare Advantage Plan;
    - Under DMEPOS Competitive Bidding, if a beneficiary resides in a CBA and elects to leave their MA plan or loses his/her coverage under this plan, the beneficiary may continue to receive items requiring frequent and substantial servicing, capped rental, oxygen and oxygen equipment, or inexpensive or routinely purchased rented items from the same DME supplier under the MA plan without going to a contract supplier under the Medicare DMEPOS Competitive Bidding Program. However, the supplier from whom the beneficiary previously received the item under the plan must be a Medicare enrolled supplier, meet the Medicare Fee-For-Service coverage criteria and documentation requirements, and must elect to become a grandfathered supplier. All competitive bid grandfathering rules apply in these situations.
- 50.12 – Claims for Repairs and Replacements;
    - Under the DMEPOS Competitive Bidding Program, any DMEPOS supplier, provided they have a valid Medicare billing number, can furnish and bill for services (labor and parts) associated with the repair of DME or enteral nutrition equipment owned by beneficiaries who reside in a CBA. In these situations, Medicare payment for labor will be made based on the standard payment rules. Medicare payment for replacement parts associated with repairing competitively bid DME or enteral nutrition equipment that are submitted with the RB modifier

will be based on the single payment amount for the part, if the part and equipment being repaired are included in the same competitive bidding product category in the CBA. Otherwise, Medicare payment for replacement parts associated with repairing equipment owned by the beneficiary will be made based on the standard payment rules.

- The replacement of an entire item, as opposed to the replacement of a part for repair purposes, which is subject to the DMEPOS Competitive Bidding Program, must be furnished by a contract supplier. Medicare payment for the replacement item would be based on the single payment amount for the item in the beneficiary's CBA. Refer to the "Medicare Claims Processing Manual", Chapter 20, 10-2 at http://www.cms.gov/manuals/downloads/clm104c20.pdf for instruction for submitting claims for repairs and replacements.

- 50.13 - Billing for Oxygen Contents to Suppliers After the 36th Month Rental Cap;
  - The Medicare law requires that the supplier that furnishes liquid or gaseous oxygen equipment (stationary or portable) for the 36th continuous month must continue to furnish the oxygen contents necessary for the effective use of the liquid or gaseous equipment during any period after the payment cap and of medical need for the remainder of the reasonable useful lifetime established for the equipment. This requirement continues to apply under the Medicare DMEPOS Competitive Bidding Program, regardless of the role of the supplier (i.e., contract supplier, grandfathered supplier, or non-contract supplier) and the location of the beneficiary (i.e. residing within or outside a CBA).
  - Should a beneficiary travel or temporarily relocate to a CBA, the oxygen supplier that received the payment for the 36th continuous month must make arrangements for furnishing oxygen contents with a contract supplier in the CBA in the event that the supplier that received the 36th month payment elects to make arrangements for a temporary oxygen contents billing supplier.
  - The Medicare payment amount is always based on the location in which the beneficiary maintains a permanent residence. If the beneficiary resides in a CBA, payment for the oxygen contents will be based on the single payment amount for that CBA. If the beneficiary resides outside of a CBA and travels to a CBA, payment for the oxygen contents will be based on the fee-schedule amount for the area where the beneficiary maintains a permanent residence.
- 50.14 - Purchased Accessories & Supplies for Use With Grandfathered Equipment; and
  - Non-contract grandfathered suppliers must use the KY modifier on claims for CBA-residing beneficiaries with dates of service on or after January 1, 2011 for purchased, covered accessories or supplies furnished for use with rented grandfathered equipment. The following HCPCS codes are the codes for which use of the KY modifier is authorized:
    - Continuous Positive Airway Pressure Devices, Respiratory Assistive Devices, and Related Supplies and Accessories – A4604, A7030, A7031, A7032, A7033, A7034, A7035, A7036, A7037, A7038, A7039, A7044, A7045, A7046, E0561, and E0562;
    - Hospital Beds and Related Accessories – E0271, E0272, E0280, E0310; and
    - Walkers and Related Accessories – E0154, E0156, E0157 and E0158.
  - Grandfathered suppliers that submit claims for the payment of the aforementioned purchased accessories and supplies for use with grandfathered equipment should submit the applicable single payment amount for the accessory or supply as their submitted charge on the claim. Non-contract grandfathered suppliers should be aware that purchase claims submitted for these codes without the KY modifier will be denied. In addition, claims submitted with the KY modifier for HCPCS codes other than those listed above will be denied.
  - After the rental payment cap for the grandfathered equipment is reached, the beneficiary must obtain replacement supplies and accessories from a contract supplier. The supplier of the grandfathered equipment is no longer permitted to furnish the supplies and accessories once the rental payment cap is reached.
- 50.15 - Hospitals Providing Walkers and Related Accessories to Their Patients on the Date of Discharge.
  - Hospitals may furnish walkers and related accessories to their own patients for use in the home during an admission or on the date of discharge and receive payment at the applicable single payment amount, regardless of whether the hospital is a contract supplier or not. Separate payment is not made for walkers furnished by a hospital for use in the hospital, as payment for these items is included in the Part A payment for inpatient hospital services.

- To be paid for walkers as a non-contract supplier, the hospital must use the modifier J4 in combination with the following HCPCS codes: A4636; A4637; E0130; E0135; E0140; E0141; E0143; E0144; E0147; E0148; E0149; E0154; E0155; E0156; E0157; E0158; and E0159. Under this exception, hospitals are advised to submit the claim for the hospital stay before or on the same day as they submit the claim for the walker to ensure timely and accurate claims processing.
- Hospitals that are located outside a CBA that furnish walkers and/or related accessories to travelling beneficiaries who live in a CBA must affix the J4 modifier, to claims submitted for these items.
- The J4 modifier should not be used by contract suppliers.

Additional Information
The official instruction associated with this CR7401, issued to your Medicare MAC regarding this change may be viewed at http://www.cms.gov/Transmittals/downloads/R2231CP.pdf on the CMS website.

Additional information regarding this program, including tip sheets for specific Medicare provider audiences, can be found at http://www.cms.hhs.gov/DMEPOSCompetitiveBid/ on the CMS website. Click on the "Provider Educational Products and Resources" tab and scroll down to the "Downloads" section.

October 2011 Quarterly Update DMEPOS Competitive Bidding Program

MLN Matters® Number: MM7425
Related Change Request (CR) #: 7425
Related CR Release Date: May 20, 2011
Related CR Transmittal #: R2225CP
Effective Date: October 1, 2011
Implementation Date: October 3, 2011

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

Provider Action Needed
This article is based on Change Request (CR) 7425 which provides the DMEPOS October 2011 quarterly update. This update implements necessary changes to the Healthcare Common Procedure Coding System (HCPCS), ZIP code, single payment amount and supplier files, effective October 1, 2011. Be sure your billing staffs are aware of these changes.

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

A list of the HCPCS codes that are included in each of the Round One Rebid product categories can be accessed by visiting the Competitive Bidding Implementation Contractor's (CBIC) website at http://www.dmecompetitivebid.com/palmetto/CBIC.nsf/DocsCat/Home on the Internet.

Key Points of CR7425
Competitive Bidding ZIP Codes
For competitive bidding, ZIP codes designated as mail order only are assigned a separate CBA number from the standard CBA number. The competitive bidding CBA numbers and associated names are as follows:

- 16740 - Charlotte-Gastonia-Concord, NC-SC (non-mail order and mail order);
- 16741 - Charlotte-Gastonia-Concord, NC-SC (mail order only);
- 17140 - Cincinnati-Middletown, OH-KY-IN (non-mail order and mail order);
- 17141 - Cincinnati-Middletown, OH-KY-IN (mail order only);
- 17460 -Cleveland-Elyria-Mentor, OH (non-mail order and mail order);
- 17461 - Cleveland-Elyria-Mentor, OH (mail order only);

- 19100 - Dallas-Fort Worth-Arlington, TX (non-mail order and mail order);
- 19101 - Dallas-Fort Worth-Arlington, TX (mail order only);
- 28140 - Kansas City, MO-KS (non-mail order and mail order);
- 28141 - Kansas City, MO-KS (mail order only);
- 33100 - Miami-Fort Lauderdale-Pompano Beach, FL (non-mail order and mail order);
- 33101 - Miami-Fort Lauderdale-Pompano Beach, FL (mail order only);
- 36740 - Orlando- Kissimmee, FL (non-mail order and mail order);
- 36741 - Orlando- Kissimmee, FL (mail order only);
- 38300 - Pittsburgh, PA (non-mail order and mail order);
- 38301 - Pittsburgh, PA (mail order only);
- 40140 - Riverside-San Bernardino-Ontario, CA (non-mail order and mail order); and
- 40141 - Riverside-San Bernardino-Ontario, CA (mail order only).

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

Single Payment Amount
The single payment amount is the Medicare allowed payment amount, instead of the previous fee schedule amount, for competitive bidding items for beneficiaries who reside in CBAs. Medicare will pay contract suppliers 80 percent of the single payment amount for each competitively bid item. The beneficiaries will be responsible for the remaining 20 percent of the single payment amount. Payment for all claims is on an assignment-related basis. In no case can a beneficiary be charged more than the 20 percent coinsurance payment for medically necessary items.

In the CBA pricing file and the single payment amount public use file, the rental single payment amounts for capped rental DME and rented enteral nutrition equipment are 10 percent of the purchase single payment amount. This payment amount is for rental months one through three. The rental single payment amounts for months 4 through 13 for capped rental DME and for months 4 through 15 for rented enteral nutrition equipment are equal to 75 percent of the single payment amounts paid in the first three rental months.

The changes to the power wheelchair payment rules made by Section 3136 of the Affordable Care Act do not apply to payment made for items furnished pursuant to competitive bidding contracts entered into prior to January 1, 2011, or for power wheelchairs in which the first rental month occurred before January 1, 2011. Therefore, under the Round One Rebid Competitive Bidding Program, contract and grandfathered suppliers furnishing rented power wheelchairs will continue to be paid under the capped rental payment methodology using 10 percent of the single payment amount for the first three months and 75 percent of the single payment amounts paid in the first three rental months for months 4 through 13. Similarly, the elimination of the lump sum purchase option for standard power wheelchairs, as required by Section 3136 of the Affordable Care Act, does not apply to standard power wheelchairs furnished by contract suppliers under the Round One Rebid Program. Payment for standard power wheelchairs will continue to be made to Round One Rebid contract suppliers on either a lump sum purchase or rental basis.

For inexpensive and/or routinely purchased DME items, the recorded single payment amount for rental is 10 percent of the purchase single payment amount. For all equipment furnished on a purchase basis, the recorded single payment amount for purchased used equipment is 75 percent of the purchase single payment amount.

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

Additional Information
The official instruction associated with this CR7425 issued to your Medicare DME MAC or RHHI regarding this change may be viewed at http://www.cms.gov/transmittals/downloads/R2225CP.pdf on the CMS website.

For a more expansive coverage of the January 2011 DMEPOS competitive bidding program and HCPCS codes see MLN Matters® article MM7181 at http://www.cms.gov/MLNMattersArticles/Downloads/MM7181.pdf on the CMS website.

Claims Modifiers for Use in DMEPOS Competitive Bidding Program

MLN Matters Number: SE1035 Revised

Note: This article was revised on June 21, 2011 to provide a new Web address on page 5 for the single payment amounts. All other information remains unchanged.

Provider Types Affected
All Medicare Fee-For-Service (FFS) providers and suppliers who provide Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) to Medicare beneficiaries with Original Medicare who reside in a Competitive Bidding Area (CBA), including: contract and non-contract suppliers; physicians and other treating practitioners providing walkers to their own patients; hospitals providing walkers to their own patients; and Skilled Nursing Facilities (SNFs) and Nursing Facilities (NFs) that provide enteral nutrition to residents with a permanent residence in a CBA.

Background
Under the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program, beneficiaries with Original Medicare who obtain competitive bidding items in designated CBAs are required to obtain theseitems from a contract supplier, unless an exception applies. The first phase of the program begins on January 1, 2011, in nine CBAs for nine product categories.

In order for Medicare to make payment, where appropriate, for claims subject to competitive bidding, it is important that all providers and suppliers who provide DMEPOS affected by the program use the appropriate modifiers on each claim.

Note: To ensure accurate claims processing, it is critically important for suppliers to submit each claim using the billing number/ National Provider Identifier (NPI) of the location that furnished the item or service being billed.

Competitive Bidding Modifiers
New Healthcare Common Procedure Coding System (HCPCS) modifiers have been developed to facilitate implementation of various policies that apply to certain competitive bidding items. The new HCPCS modifiers used in conjunction with claims for items subject to competitive bidding are defined as follows:

- J4-DMEPOS Item Subject to DMEPOS Competitive Bidding Program that is Furnished by a Hospital Upon Discharge.
- KG- DMEPOS Item Subject to DMEPOS Competitive Bidding Program Number 1.
- KK- DMEPOS Item Subject to DMEPOS Competitive Bidding Program Number 2.
- KU- DMEPOS Item Subject to DMEPOS Competitive Bidding Program Number 3.
- KW-DMEPOS Item Subject to DMEPOS Competitive Bidding Program Number 4.
- KY-DMEPOS Item Subject to DMEPOS Competitive Bidding Program Number 5.
- KL-DMEPOS Item Delivered via Mail.
- KV-DMEPOS Item Subject to DMEPOS Competitive Bidding Program that is Furnished as Part of a Professional Service.
- KT-Beneficiary Resides in a Competitive Bidding Area and Travels Outside that Competitive Bidding Area and Receives a Competitive Bid Item.

Suppliers should submit claims for competitive bidding items using the appropriate HCPCS code and corresponding competitive bidding modifier in effect during a contract period. The competitive bidding modifiers should be used with the specific, appropriate competitive bidding HCPCS code when one is available. The modifiers associated with

particular competitive bid codes, such as the KG, KK, or KL modifiers, are listed by competitive bid product category on the single payment amount public use charts found under the supplier page at http://www.dmecompetitivebid.com/Palmetto/Cbic.nsf on the Competitive Bidding Implementation Contractor (CBIC) website.

Failure to use or inappropriate use of a competitive bidding modifier on a competitive bidding claim leads to claims denial. The use of a competitive bidding modifier does not supersede existing Medicare modifier use requirements for a particular code, but rather should be used in addition, as required.

Another modifier was developed to facilitate implementation of DMEPOS fee schedule policies that apply to certain competitive bidding items that were bid prior to July 1, 2008, under the initial Round I of the DMEPOS Competitive Bidding Program. The KE modifier is defined as follows:

- KE-DMEPOS Item Subject to DMEPOS Competitive Bidding Program for use with Non-Competitive Bid Base Equipment.

How to Use the Modifiers

Hospitals Providing Walkers and Related Accessories to Their Patients on the Date of Discharge - The J4 Modifier

Hospitals may furnish walkers and related accessories to their own patients for use in the home during an admission or on the date of discharge and receive payment at the applicable single payment amount, regardless of whether the hospital is a contract supplier or not. Please note that separate payment is not made for walkers furnished by a hospital for use in the hospital, as payment for these items is included in the Part A payment for inpatient hospital services.

To be paid for walkers as a non-contract supplier, the hospital must use the modifier J4 in combination with the following HCPCS codes: A4636; A4637; E0130; E0135; E0140; E0141; E0143; E0144; E0147; E0148; E0149; E0154; E0155; E0156; E0157; E0158; and E0159. Under this exception, hospitals are advised to submit the claim for the hospital stay before or on the same day as they submit the claim for the walker to ensure timely and accurate claims processing.

Hospitals that are located outside a CBA that furnish walkers and/or related accessories to travelling beneficiaries who live in a CBA must affix the J4 modifier, to claims submitted for these items.

The J4 modifier should not be used by contract suppliers.

Modifiers for HCPCS Accessory or Supply Codes Furnished in Multiple Product Categories - The KG, KK, KU, and KW Modifiers

The **KG, KK, KU and KW** modifiers are modifiers that identify when the same supply or accessory HCPCS code is furnished in multiple competitive bidding product categories or when the same code can be used to describe both competitively and non-competitively bid items. For example, HCPCS code E0981 Wheelchair Accessory, Seat Upholstery, Replacement Only, Each is found in both the standard and complex rehabilitative power wheelchair competitive bidding product categories. Contract suppliers for the standard power wheelchair product category as well as other suppliers submitting claims for this accessory item furnished for use with a standard power wheelchair shall submit E0981 claims using the KG modifier. Contract suppliers for the complex rehabilitative power wheelchair product category as well as other suppliers submitting claims for this accessory item furnished for use with a complex power wheelchair shall submit claims for E0981 using the KK modifier. Another example of the use of the KG modifier is with code A4636 Replacement, Handgrip, Cane, Crutch, or Walker, Each. Contract suppliers for the walkers and related accessories product category in addition to other suppliers submitting claims for this accessory item when used with a walker shall submit A4636 claims using the KG modifier.

All suppliers that submit claims for beneficiaries that live in a CBA, including contract, non-contract, and grandfathered suppliers, should submit claims for competitive bid items using the above mentioned competitive bidding modifiers. Non-contract suppliers that furnish competitively bid supply or accessory items to traveling beneficiaries who live in a CBA must use the appropriate KG or KK modifier with the supply or accessory HCPCS code when submitting their claim. Also, grandfathered suppliers that furnish competitively bid accessories or supplies used in conjunction with a grandfathered item must include the appropriate KG or KK modifier when submitting claims for accessory or supply codes. The KG and KK modifiers are used in the Round I Rebid of the competitive bidding program as pricing modifiers and the KU and KW modifiers are reserved for future program use.

The competitive bidding HCPCS codes and their corresponding competitive bidding modifiers (i.e. KG, KK, KL) are denoted in the single payment amount public use charts found under the supplier page at http://www.dmecompetitivebid.com/Palmetto/Cbic.nsf on the CBIC website.

Purchased Accessories & Supplies For Use With Grandfathered Equipment - The KY Modifier
Non-contract grandfathered suppliers must use the KY modifier on claims for CBA-residing beneficiaries with dates of service on or after January 1, 2011, for purchased, covered accessories or supplies furnished for use with rented grandfathered equipment. The following HCPCS codes are the codes for which use of the KY modifier is authorized:

- Continuous Positive Airway Pressure Devices, Respiratory Assistive Devices, and Related Supplies and Accessories – A4604, A7030, A7031, A7032, A7033, A7034, A7035, A7036, A7037, A7038, A7039, A7044, A7045, A7046, E0561, and E0562;
- Hospital Beds and Related Accessories – E0271, E0272, E0280, and E0310; and
- Walkers and Related Accessories – E0154, E0156, E0157 and E0158

Until notified otherwise, grandfathered suppliers that submit claims for the payment of the aforementioned purchased accessories and supplies for use with grandfathered equipment should submit the applicable single payment amount for the accessory or supply as their submitted charge on the claim. The single payment amounts for items included in the Round 1 Rebid of the DMEPOS Competitive Bidding Program can be found under the Single Payment Amount tab on the following website: http://www.dmecompetitivebid.com/SPA on the Internet.. Non-contract grandfathered suppliers should be aware that purchase claims submitted for these codes without the KY modifier will be denied. Also, claims submitted with the KY modifier for HCPCS codes other than those listed above will be denied.

After the rental payment cap for the grandfathered equipment is reached, the beneficiary must obtain replacement supplies and accessories from a contract supplier. The supplier of the grandfathered equipment is no longer permitted to furnish the supplies and accessories once the rental payment cap is reached.

Mail Order Diabetic Supplies - The KL Modifier
Contract suppliers must use the KL modifier on all claims for diabetic supply codes that are furnished via mail order. Non contract suppliers that furnish mail order diabetic supplies to beneficiaries who do not live in CBAs must also continue to use the KL modifier with these codes. Suppliers that furnish mail-order diabetic supplies that fail to use the HCPCS modifier KL on the claim may be subject to significant penalties. For claims with dates of service prior to implementation of a national mail order competitive bidding program, the KL modifier is not used with diabetic supply codes that are not delivered to the beneficiary's residence via mail order or are obtained from a local supplier storefront. Once a national mail order competitive bidding program is implemented, the definition for mail order item will change to include all diabetic supply codes delivered to the beneficiary via any means. At this time, the KL modifier will need to be used for all diabetic supply codes except for claims for items that a beneficiary or caregiver picks up in person from a local pharmacy or supplier storefront.

Physicians and Treating Practitioners Who Furnish Walkers and Related Accessories to Their Own Patients but Who Are Not Contract Suppliers - The KV Modifier
The **KV modifier** is to be used by physicians and treating practitioners who are not contract suppliers and who furnish walkers and related accessories to beneficiaries in a CBA. Walkers that are appropriately furnished in accordance with this exception will be paid at the single payment amount.

To be paid for walkers as a non-contract supplier, physicians and treating practitioners should use the modifier KV in combination with the following HCPCS codes: A4636; A4637; E0130; E0135; E0140; E0141; E0143; E0144; E0147; E0148; E0149; E0154; E0155; E0156; E0157; E0158; and E0159. On the claim billed to the Durable Medical Equipment Medicare Administrative Contractor (DME MAC), the walker line item must have the same date of service as the professional service office visit billed to the Part A/Part B MAC. Physicians and treating practitioners are advised to submit the office visit claim and the walker claim on the same day to ensure timely and accurate claims processing.

Physicians and treating practitioners who are located outside a CBA who furnish walkers and/or related accessories as part of a professional service to traveling beneficiaries who live in a CBA must affix the KV modifier to claims submitted for these items.

The KV modifier should not be used by contract suppliers.

Traveling Beneficiaries - The KT Modifier
Suppliers must submit claims with the KT modifier for non-mail-order DMEPOS competitive bidding items that are furnished to beneficiaries who have traveled outside of the CBA in which they reside. If a beneficiary who lives in a CBA travels to an area that is not a CBA and obtains an item included in the competitive bidding program, the non contract supplier must affix this modifier to the claim. Similarly, if a beneficiary who lives in a CBA travels to a different CBA and obtains an item included in the competitive bidding program from a contract supplier for that CBA, the contract supplier must use the KT modifier.

SNFs and NFs that are not contract suppliers and are not located in a CBA must also use the KT modifier on claims for enteral nutrition items furnished to residents with a permanent home address in a CBA. SNF or NF claims that meet these criteria and are submitted without the KT modifier will be denied.

Claims for mail-order competitive bidding diabetic supplies submitted with the KT modifier will be denied. Contract suppliers must submit mail-order diabetic supply claims for traveling beneficiaries using the beneficiary's permanent home address.

To determine if a beneficiary permanently resides in a CBA, a supplier should follow these two simple steps:

1. Ask the beneficiary for the ZIP code of his or her permanent residence. This is the address on file with the Social Security Administration (SSA).
2. Enter the beneficiary's ZIP code into the CBA finder tool on the home page of the Competitive Bidding Implementation Contractor (CBIC) website, found at www.dmecompetitivebid.com on the Internet.

The KE Modifier
Section 154(a)(2) of the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 mandated a fee schedule covered item update of -9.5% for 2009 for items included in the Round I of the DMEPOS Competitive Bidding Program. This covered item update reduction to the fee schedule file applies to items furnished on orafter January 1, 2009, in any geographical area. In order to implement the covered item update required by MIPPA, the KE modifier was added to the DMEPOS fee schedule file in 2009 to identify Round I competitively bid accessory codes that could be used with both competitively bid and non-competitively bid base equipment. All suppliers must use the **KE modifier** on all Part B Fee-For-Service claims to identify when a Round I bid accessory item is used with a non-competitively bid base item (an item that was not competitively bid prior to July 2008).

For example, HCPCS code E0950 *Wheelchair Accessory,* Tray, Each can be used with both Round I competitively bid standard and complex rehabilitative power wheelchairs (K0813 thru K0829 and K0835 thru K0864), as well as with non-competitively bid manual wheelchairs (K0001 thru K0009) or a miscellaneous power wheelchair (K0898). All suppliers must use the KE modifier with the accessory code to identify when E0950 is used in conjunction with a non-competitively bid manual wheelchair (K0001 thru K0009) or a miscellaneous power wheelchair (K0898). The KE modifier should not be used with competitive bid accessory HCPCS codes that are used with any competitive bid base item that was included in the initial Round I of the Competitive Bidding Program prior to July 1, 2008. Therefore, in the above example, KE is not valid for use with accessory code E0950 when used with standard power wheelchairs, complex rehabilitative power wheelchairs (Group 2 or Group 3), or any other item selected for competitive bidding prior to July 1, 2008.

For beneficiaries living in competitive bid areas on or after January 1, 2011, suppliers should not use the KE modifier to identify competitively bid accessories used with base equipment that was competitively bid under the Round I Rebid Competitive Bidding Program. Rather, such claims should be submitted using the appropriate KG or KK modifiers as identified on the single payment amount public use charts found under the supplier page at www.dmecompetitivebid.com/Palmetto/Cbic.nsf on the CBIC website.

Below is a chart that illustrates the relationship between the competitive bid modifiers (KG, KK, KU, and KW) and the KE modifier using competitively bid accessory code E0950:

Accessory Code E0950 used with a:	Base Code Competitive Bid Status	Claim for a Beneficiary who Permanently Lives in a CBA	Claim for a Beneficiary who Permanently Lives Outside a CBA*
• Manual Wheelchair (K0001 thru K0009) or Miscellaneous Power Wheelchair (K0898)	• Non- Bid	• Bill with KE modifier	• Bill with KE modifier
• Standard Power Wheelchair (K0813 thru K0829)	• Bid in Round 1 and the Round 1 Rebid	• Bill with KG modifier	• Bill without KE modifier
• Complex Rehabilitative Group 2 Power Wheelchair (K0835 thru K0843)	• Bid in Round 1 and the Round 1 Rebid	• Bill with KK modifier	• Bill without KE modifier
• Complex Rehabilitative Group 3 Power Wheelchair (K0848 thru K0864)	• Bid in Round 1	• Bill without KE, KK or KG modifier	• Bill without KE modifier

* The competitive bid modifiers (KG, KK, KU, and KW) are only used on claims for beneficiaries that live in a Competitive Bidding Area (CBA).

Additional Information

The Medicare Learning Network® (MLN) has prepared several fact sheets with information for non-contract suppliers and referral agents, including fact sheets on the hospital and physician exceptions, enteral nutrition, mail order diabetic supplies, and traveling beneficiaries, as well as general fact sheets for non-contract suppliers and referral agents. They are all available, free of charge, at http://www.cms.gov/MLNProducts/downloads/DMEPOS_Competitive_Bidding_Factsheets.pdf on the Internet.

For more information about the DMEPOS Competitive Bidding Program, including a list of the first nine CBAs and items included in the program, visit http://www.cms.gov/DMEPOSCompetitiveBid on the Centers for Medicare & Medicaid Services (CMS) dedicated website.

Information for contract suppliers can be found at the CBIC website at http://www.dmecompetitivebid.com/palmetto/cbic.nsf/DocsCat/Home on the Internet.

Beneficiary-related information can be found at http://www.medicare.gov on the Internet.

COVERAGE

Coverage Reminder – Chiropractor Limitations

DMEPOS suppliers are reminded that the Social Security Act (1861(r)) restricts ordering by chiropractors to treatment by means of manual manipulation of the spine to correct a subluxation, provided such treatment is legal in the State where performed. Claims for any other item(s) or services prescribed by a chiropractor, including durable medical equipment, prosthetics, orthotics or supplies, are denied as statutorily noncovered.

LCD and Policy Article Revisions – Summary for May 12, 2011

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

Immunosuppressive Drugs
Policy Article
Revision Effective Date: 6/01/2011
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: Preamble language
Revised: Supply fee guidelines for additional billing of Q0510, Q0511

Oral Anticancer Drugs
Policy Article
Revision Effective Date: June 1, 2011
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: Preamble language
Revised: Supply fee guidelines for additional billing of Q0511

Oral Antiemetic Drugs (Replacement for Intravenous Antiemetics)
Policy Article
Revision Effective Date: June 1, 2011
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Revised: Supply fee guidelines for additional billing of Q0511

Power Mobility Devices
LCD
Revision Effective Date: 06/01/2011
INDICATIONS AND LIMITATIONS OF COVERAGE:
Added: Denial statement for Group 2 POVs
Added: Denial statement for Group 4 PWCs
DOCUMENTATION
Deleted: KX modifier use with Group 4 PWCs
Revised: Requirements for the detailed product description
Added: Clarification of 7-element order requirements

Policy Article
Revision Effective Date: 06/01/2011
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: Benefit category statement
Added: Statutory reference for 7-element order requirements
Removed: Noncoverage statement for Group 2 POVs and Group 4 PWCs.

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.

LCD and Policy Article Revisions – Summary for May 26, 2011

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

Knee Orthoses
LCD
Revision Effective Date: 07/01/2011
ICD-9 CODES THAT SUPPORT MEDICAL NECESSITY:
Added: ICD-9 codes 340.91 and 340.92 for L1832, L1843 – L1846

Oral Appliances for Obstructive Sleep Apnea
LCD
Revision Effective Date: 09/01/2011
NONMEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: Preamble
Added: Benefit category statement
CODING GUIDELINES:
Added: PDAC review requirement for E0486

Policy Article
Revision Effective Date: 09/01/2011
NONMEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: Preamble
Added: Benefit category statement
CODING GUIDELINES:
Added: PDAC review requirement for E0486

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

LCD and Policy Article Revisions – Summary for June 23, 2011

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

Glucose Monitor
Policy Article
Revision Effective Date: 07/01/2011
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: Preamble language
Added: Institutional use glucose monitor benefit language
CODING GUIDELINES:
Added: Definitions for glucose monitors E0607, E2100, E2101
Added: Instructions for billing "kits" with initial issue of glucose monitors
Added: Bundling table

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

LCD and Policy Article Revisions Summary for July 14, 2011

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

Wheelchair Options and Accessories
LCD
Revision Effective Date: June 1, 2011
DOCUMENTATION REQUIREMENTS:
Revised: Language for detailed product description

Wheelchair Seating
LCD
Revision Effective Date: June 1, 2011
DOCUMENTATION REQUIREMENTS:
Revised: Language for detailed product description

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.

LCD Revisions Released for Comment – Automatic External Defibrillators, Pneumatic Compression Devices, and Suction Pumps

The Centers for Medicare and Medicaid Services (CMS) assigned to the Durable Medical Equipment Medicare Administrative Contractors (DME MACs) the task of developing local coverage determinations (LCDs) for processing and reviewing Medicare claims for Durable Medical Equipment, Prostheses, Orthoses, and Supplies (DMEPOS). The DME MACs are proposing revisions to three LCDs: Automatic External Defibrillators, Pneumatic Compression Devices, and Suction Pumps.

These three LCDs are revisions to existing LCDs; therefore not all of the material in each policy is new. The major revisions are summarized below; however, each LCD should be completely reviewed in the preparation of comments.

Automatic External Defibrillator LCD changes

- Revised coverage criteria for wearable (K0606) and non-wearable (E0617) defibrillators
- Added definition for myocardial infarction to maintain consistency with national coverage determination for implantable defibrillators
- Revised covered diagnosis code list

Pneumatic Compression Devices (PCD) LCD changes

- Added coverage for peripheral arterial disease using arterial insufficiency devices (E0675)
- Revised coverage criteria for PCDs E0650, E0651 and E0652

Suction Pumps LCD changes

- Added not reasonable and necessary statement for wound suction pumps (K0743) and related supplies (K0744-K0746)
- Added coverage criteria for gastric suction (E2000)

We are soliciting comments on these draft policies from physicians, manufacturers, suppliers and other professionals involved in the ordering or provision of these items. We recommend that you distribute these draft policies to selected members of your organization for review and comment. If you disagree with any aspect of a policy, you should be very specific in your comment and, if possible, offer an alternative. You should provide a clinical rationale for your position including references from the published clinical literature (e.g. standard textbooks, peer-reviewed journals, etc.). We encourage a written response if you agree with this policy. **If you are providing comments on more than one LCD, please provide separate comments for each policy with the policy indicated in the subject line of the submission.**

All comments will be collected at a single point of contact. **Please submit your comments electronically to the DME MAC medical directors at the e-mail address below no later than September 23, 2011**. Comments may also be submitted hardcopy although e-mail is preferred.

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A joint DME MAC public meeting will be held on August 30, 2011 in Baltimore, MD. Interested parties from any DME MAC jurisdiction may attend this public meeting. This meeting is for oral presentations only. Meeting minutes are not taken and there is no Question and Answer component to the meeting. In order for comments to be considered, they must be presented in writing through the formal comment process. Advance registration is required. Information regarding this meeting will be posted in the near future on each DME MAC web site.

IMPORTANT REMINDER: Suppliers are cautioned not to make any changes based upon the information contained in these draft documents. Drafts are often substantially revised based upon the comments received. When all comments have been reviewed, revisions will be considered. The final policies will be published in the CMS Medicare Coverage Database and on individual DME MAC websites, allowing for adequate notice before the policies' effective date.

Thank you for your participation in our policy revision process.

Refer to each DME MAC web site for additional information about policy development and copies of the draft LCDs.

- Jurisdiction A – www.medicarenhic.com
- Jurisdiction B – www.ngsmedicare.com
- Jurisdiction C – www.cgsmedicare.com/jc
- Jurisdiction D – www.noridianmedicare.com/dme

Supplies Used With Functional Electrical Stimulators (FES) – E0770

Electrodes used with a covered E0770 (FUNCTIONAL ELECTRICAL STIMULATOR, TRANSCUTANEOUS STIMULATION OF NERVE AND/OR MUSCLE GROUPS, ANY TYPE, COMPLETE SYSTEM, NOT OTHERWISE SPECIFIED) are eligible for reimbursement as long as the E0770 device meets the coverage criteria outlined in the CMS National Coverage Determination and are used by the patient. Functional electrical stimulators are a type of neuromuscular stimulator (NMES), therefore supply codes used with NMES devices are to be used with FES devices. Electrodes are billed with code

A4595 – ELECTRICAL STIMULATOR SUPPLIES, 2 LEAD, PER MONTH, (E.G. TENS, NMES)

A4595 is an allowance for all necessary supplies used during the month regardless of the number of lead/electrode changes made. All necessary supplies such as electrodes, coupling gel, adhesive, adhesive remover, etc. are considered as included in the monthly allowance. If two FES leads/electrodes are required then a maximum of one unit of Code A4595 would be allowed per month; if four FES leads/electrodes are necessary, a maximum of two units per month would be allowed.

There is no separate payment for supplies provided with an initial claim. Initial provision of an E0770 includes all necessary supplies. Separate billing of supplies with the initial claim is considered unbundling.

For additional information about the coverage of FES and supplies, refer to CMS IOM Pub. 100-03 National Coverage Determination (NCD) Manual, section 160.12.

Drugs Used With External Infusion Pumps – Coverage and Billing Reminders

Coverage of drugs used with external infusion pumps may have differing denials. It is important for suppliers of these drugs to understand the issues related to coverage and denials. Understanding coverage necessarily starts with a discussion of benefit category. Fee-for-Service Medicare is a defined benefit program. Without a statutorily defined benefit, there can be no reimbursement from Medicare. External infusion pumps are covered under the DME benefit, however, there is no separate, specific benefit established for the payment of drugs used in external infusion pumps. Drugs used in conjunction with a covered pump are considered a supply item for the pump and are eligible for reimbursement only on that basis. This means that all infusion drug claims not associated with an external infusion pump will receive a statutorily non-covered denial.

Coverage must also take into consideration the applicable reasonable and necessary (R&N) criteria (also known as medical necessity criteria). National and Local Coverage Determinations (NCD and LCD) contain the R&N rules that are applicable to pumps and infusion drugs. For external infusion pumps, the LCD lists the only covered drugs. For many of the drugs, additional specific R&N criteria also apply. Reimbursement for the pump and drug is possible only when a listed drug is provided to a beneficiary meeting all the criteria specified in the LCD. Failure to meet these criteria results in a not reasonable and necessary denial.

Four possible scenarios can result when billing the DME MAC for drugs used with an external infusion pump:

1. Billing for an infusion drug alone (no pump being used). There is no statutory infusion drug benefit to allow coverage. All infusion drugs and any associated supplies will be denied as statutorily noncovered.
2. Billing for a pump with an infusion drug not listed in the LCD. The pump is eligible for coverage under the DME benefit, but because the drug is not listed in the LCD, all items (the pump, drug, and any associated supplies) will be denied as not reasonable and necessary.
3. Billing for a pump with a drug listed in the LCD but the R&N criteria for the drug are not met. The pump, drug, and any associated supplies will be denied as not reasonable and necessary.
4. Billing for a pump with a drug listed in the LCD where the R&N criteria for the drug are met. The pump, drug and any associated supplies are payable if other conditions of coverage are met.

Billing Instructions – ABNs and Modifiers

When the beneficiary does not meet the R&N criteria in an LCD, if the supplier elects to hold the beneficiary financially liable, suppliers may execute an Advance Beneficiary Notice of Non-coverage (ABN) for all items addressed by the policy. Refer to the Supplier Manual for additional information on the use of ABNs.

There are several modifiers associated with the billing of external infusion pumps, infusion drugs, and associated supplies. Each modifier has specific associated usage criteria that are discussed in the *Documentation Requirements* section of the LCD. Incorrect or inappropriate application of modifiers can result in claim denials or improper assignment of liability. For items addressed by the External Infusion Pump LCD, the modifiers are:

EY – *No physician or other licensed health care provider order for this item or service.* Use this modifier when the supplier does not have a compliant detailed written order. Use of an EY modifier in this LCD results in an R&N denial.

GA – *Waiver of liability statement issued as required by payer policy, individual case.* Use this modifier when the R&N criteria in the LCD are not met, i.e. scenarios 2 & 3 above, and the supplier elected to obtain an ABN. Use of a GA modifier results in an R&N denial with beneficiary liability.

GY – *Item or service statutorily excluded or does not meet the definition of any Medicare benefit.* Use this modifier for items that fall into scenario 1 above. There items receive a statutory denial with beneficiary liability. An ABN is not required in order to hold the beneficiary financially liable; however, it may be used as a voluntary notice.

GZ – *Item or service expected to be denied as not reasonable and necessary.* Use this modifier when the R&N criteria in the LCD are not met, i.e. scenarios 2 & 3 above, and the supplier elected not to obtain an ABN. Use of a GZ modifier results in an R&N denial with supplier liability.

KX – *Requirements specified in the medical policy have been met.* In this LCD, this modifier is used only with external insulin pumps and supplies. Use this modifier when the R&N criteria in the LCD are met, i.e. scenario 4 above. Use of the KX modifier results in payment for the items addressed in this LCD.

JB – *Administered Subcutaneously.* In this LCD, this modifier is used with immune globulins used for the treatment of primary immune deficiency administered with an external pump (E0779) via the subcutaneous route. Immune globulins not administered subcutaneously must meet the criteria in the Intravenous Immune Globulin LCD.

Vancomycin
Vancomycin does not require the use of a covered external infusion pump for administration. As discussed above, the type of denial associated with claims for vancomycin depends on whether or not an external infusion pump is billed with the drug. Scenarios 1 and 2 above apply to vancomycin:

- If vancomycin is billed without a covered pump, a statutorily non-covered denial will be applied as described in scenario 1. A GY modifier is used.
- If vancomycin is billed with a covered pump, the pump, all associated supplies, and the vancomycin will be denied as not R&N as described by scenario 2. The GA or GZ modifier is used depending upon whether an ABN is executed. Use of the GY modifier is incorrect.

Refer to the External Infusion Pumps LCD, Policy Article, and Supplier Manual for additional information.

Medicare Part B Average Sales Price - Payments for Wilate and Flulaval

For the April 2011 Average Sales Price quarterly update, CMS is not publishing a payment limit for HCPCS code J7184 [Injection, Von Willebrand Factor Complex (Human), Wilate, Per 100 iu VWF:RCO] for claims with dates of service between Friday, April 1 and Thursday, June 30, 2011. A price for Wilate can be found on the "April 2011 ASP Not Otherwise Classified (NOC)" pricing file available on the CMS website. Additionally, as per updated CR #7234, CMS has updated the price for Q2036 (Flulaval vacc, 3 yrs & >, im) to $8.784 for the April 2011 ASP quarterly update. This updated price is effective for claims with dates of service on or after Friday, October 1, 2010. The revised price has been added to the October 2010 and January 2011 ASP pricing files.

These pricing files can be found on the CMS website at http://www.CMS.gov/McrPartBDrugAvgSalesPrice.

NDC for Capecitabine (Xeloda®) 500 mg. Dosage Form – European Formulation Blister Pack

The Pricing, Data Analysis, and Coding Contractor (PDAC) has the new NDC for this preparation of capecitabine included in the NDC Crosswalk posted on www.dmepdac.com.

NDC number 00004-1101-75 for the European version of Xeloda 500 mg. dosage form in the blister pack is effective for claims with dates of service on or after 3/29/2011 received by the DME MAC on or after 5/9/2011.

Refer to the Oral Anticancer Drug LCD and Policy article for additional information.

Revised July 2010 - April 2011 ASP Files Now Available

CMS has posted revised Average Sales Price (ASP) files for July 2010 through April 2011. All are available for download at: http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/ (see left menu for year-specific links).

Widespread Prepayment Review for Immunosupressive Drugs Edit Effectiveness for 3rd Quarter

The Jurisdiction D DME MAC Medical Review Department is conducting a widespread complex review of HCPCS codes J7507, J7517, J7518 and J7520 and the third quarter edit effectiveness results from February 2011 through May 2011 are as follows:

The results of the review of the claims identified 3,798 claims of which 2,861 were denied. This resulted in an overall error rate of 74%. This is a decrease from 79% during the second quarter of this review. Due to the high error rate, NAS will continue with the widespread complex review.

The following are the top reasons for denial:

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

B. No valid written order

   a. No written order submitted with the documentation

   b. Insufficient or incomplete order

C. No Proof Of Delivery

   a. No proof of delivery submitted with the documentation

   b. Invalid proof of delivery

D. No office notes/medical records provided to support the KX modifier

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

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

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

B. 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.

D. KX and GY Modifiers

   The KX modifier must be added to the claim line(s) for the immunosuppressive drug(s) only if:

   a. The supplier obtains from the ordering physician the date of the organ transplant, and

   b. The beneficiary was enrolled in Medicare Part A at the time of the organ transplant (whether or not Medicare paid for the transplant), and

   c. The transplant date precedes the date of service on the claim.

If these three requirements are not met, the KX modifier may not be added to 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

Quarterly HCPCS Drug/Biological Code Changes – July 2011 Update

MLN Matters® Number: MM7303
Related Change Request (CR) #: 7303
Related CR Release Date: May 24, 2011
Related CR Transmittal #: R2227CP
Effective Date: July 1, 2011
Implementation Date: July 5, 2011

Provider Types Affected
This article is for physicians, other providers, and suppliers who bill Medicare contractors (carriers, Fiscal Intermediaries (FI), Regional Home Health Intermediaries (RHHI), Medicare Administrative Contractors (A/B MAC), or Durable Medical Equipment Medicare Administrative Contractors (DME MAC)) for services provided to Medicare beneficiaries.

What You Need to Know
CR7303 announces the quarterly updating of specific Health Care Procedure Code System (HCPCS) codes, effective for claims with dates of service on or after July 1, 2011. You should make sure that your billing staffs are aware of these HCPCS code changes.

Non-payable Code
Effective for claims with dates of service on or after July 1, 2011, Medicare will not pay for the following HCPCS code:

HCPCS Code	Short Description	Long Description	Medicare Physician Fee Schedule Data Base (MPFSDB) Status Indicator
J7184	Wilate injection	INJECTION, VON WILLEBRAND FACTOR COMPLEX (HUMAN), WILATE, 100 I.U. VWF-RCO	I

Payable Codes

Contractors will accept the codes in the following table as payable HCPCS codes for dates of service on or after July 1, 2011, using Type of Service (TOS) 1, 9, and Medicare Physician Fee Schedule Database (MPFSDB) Status Indicator "E" (Excluded from Physician Fee Schedule by Regulation):

HCPCS Code	Short Description	Long Description
Q2041	Wilate Injection	INJECTION, VON WILLEBRAND FACTOR COMPLEX (HUMAN), WILATE, 1 I.U. VWF-RCO
Q2042	Hydroxyprogesterone caproate	INJECTION, HYDROXYPROGESTERONE CAPROATE, 1 MG
Q2043	Sipuleucel-T auto CD54+	SIPULEUCEL-T, MINIMUM OF 50 MILLION AUTOLOGOUS CD54+ CELLS ACTIVATED WITH PAP-GM-CSF, INCLUDING LEUKAPHERESIS AND ALL OTHER PREPARATORY PROCEDURES, PER INFUSION
Q2044	Belimumab injection	INJECTION, BELIMUMAB, 10 MG

Additional Information
You can find the official instruction, CR7303, issued to your Medicare contractor by visiting http://www.cms.gov/Transmittals/downloads/R2227CP.pdf on the CMS website.

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

MLN Matters® Number: MM7397 Revised
Related Change Request (CR) #: 7397
Related CR Release Date: August 5, 2011
Related CR Transmittal #: R2271CP
Effective Date: October 1, 2011
Implementation Date: October 1, 2011

Note: This article was revised on August 9, 2011, to reflect the revised CR7397 issued on August 5. The effective and implementation dates were changed. Also, the CR release date, transmittal number, and the Web address for accessing CR7397 were revised. All other information remains the same.

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

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

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

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

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

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

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

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

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

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

Additional Information
The official instruction, CR 7397 issued to your Medicare contractor regarding this issue may be viewed at http://www.cms.gov/Transmittals/downloads/R2271CP.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.

October 2011 Quarterly ASP Medicare Part B Drug Pricing Files and Revisions

MLN Matters® Number: MM7488
Related Change Request (CR) #: 7488
Related CR Release Date: July 29, 2011
Related CR Transmittal #: R2264CP
Effective Date: October 1, 2011
Implementation Date: October 3, 2011

Provider Types Affected
This article is for all physicians, providers and suppliers who submit claims to Medicare contractors (Medicare Administrative Contractors (MACs), Fiscal Intermediaries (FIs), Carriers, Durable Medical Equipment Medicare Administrative Contractors (DME MACs), or Regional Home Health Intermediaries (RHHIs)) for services provided to Medicare beneficiaries.

Provider Action Needed
This article is based on Change Request (CR) 7488, which instructs Medicare contractors to download and implement the October 2011 Average Sales Price (ASP) drug pricing file for Medicare Part B drugs; and, if released by the Centers for Medicare & Medicaid Services (CMS), the revised July 2011, April 2011, January 2011, and October 2010 files. Medicare will use these files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after October 1, 2011, with dates of service October 1, 2011, through December 31, 2011. Contractors will not search and adjust claims that have already been processed unless brought to their attention. Please ensure that your staffs are aware of this quarterly update.

Background
The ASP methodology is based on quarterly data submitted to CMS by manufacturers. CMS supplies 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 Outpatient Prospective Payment System (OPPS) are incorporated into the Outpatient Code Editor (OCE) through separate instructions.

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

Files	Effective for Dates of Service
October 2011 ASP and ASP NOC	October 1, 2011, through December 31, 2011
July 2011 ASP and ASP NOC	July 1, 2011, through September 30, 2011
April 2011 ASP and ASP NOC files	April 1, 2011, through June 30, 2011
January 2011 ASP and ASP NOC files	January 1, 2011, through March 31, 2011
October 2010 ASP and ASP NOC files	October 1, 2010, through December 31, 2010

Additional Information
The official instruction (CR 7488) issued to your Medicare MAC, carrier, and FI may be found at http://www.cms.gov/Transmittals/downloads/R2264CP.pdf on the CMS website.

Ask the Contractor Teleconference Questions and Answers – April 27, 2011

Email Listserv
We encourage everyone to have Medicare DME information delivered to you in a timely, categorized, summarized, convenient format by signing up for our DME Email Listserv. Benefits of becoming a subscriber include having the latest information from NAS and CMS delivered to you each Tuesday and Friday. This is a great way to keep current with Medicare regulations, workshop and educational events, Medical policy updates, and payment/reimbursement updates.

Go to our NAS DME website and click on "E-mail Newsletter Sign Up" on the left side of the page to subscribe.

Endeavor
Suppliers are encouraged to register for Endeavor which offers free, online access to patient eligibility, claim status, same or similar inquiries and remittance advices. The hours of availability include:

- Eligibility: 24 hours/day, 7 days/week
- Claim Status, Same or Similar Inquires and Remittance Advices: 6 a.m. - 6 p.m. CT Monday - Friday; 7 a.m. - 3 p.m. Saturday and Sunday

Suppliers, billers and third parties may register for Endeavor.

Each person accessing Endeavor must register for their own User ID. User IDs cannot be used by more than one person.

To register, go to the claims page of our website. Many suppliers are already taking advantage of this tool and we highly encourage you all to do so as well!

Same or Similar IVR and Endeavor Supplier Portal Inquiries
Failure to use the appropriate modifier when checking same or similar equipment inquiries may result in inaccurate or incomplete same or similar information being returned. The payment categories and modifiers which would be appropriate to use when checking same or similar equipment in the Interactive Voice Response (IVR) system and Endeavor include:

- Capped Rental Items; using modifiers RR or NU
- Inexpensive and Routinely Purchased DME; using modifiers RR, NU or UE
- Oxygen and Oxygen Equipment; using modifier RR
- Parenteral/Enteral Nutrients; a modifier is not required for this payment category
- Parenteral/Enteral Pumps; using modifier RR

Diabetic supplies, diabetic shoes, orthotics, prosthetics, lenses and frames are some of the items which do not offer same or similar inquiries through the IVR, Endeavor, or our customer service representatives. A Same or Similar Reference Chart of the HCPCS codes that are tracked for same or similar purposes is available within the claim section of our website.

Fax Numbers Changed
New fax numbers for NAS went into effect on April 11, 2011. Suppliers must use new fax numbers when sending NAS DME Jurisdiction D information and supporting documentation for reopenings, redeterminations, refunds, and other NAS departments. Documentation faxed to the old number will be forwarded to the correct department for a minimal timeframe. After that time, the intended faxed content sent to the outdated fax number is not transmitted to a functioning fax number and is therefore not received by NAS. For a list of the new fax numbers see the Contact section of our website.

Q1. Regarding Positive Airway Pressure (PAP) devices, we have a patient who has obstructive sleep apnea (OSA) and it is documented in the report that the patient is unable to tolerate PAP therapy. In the same chart in the documentation, the physician is also ordering oxygen due to low saturation levels. Would the oxygen be covered?
A1. In order for a patient to qualify for oxygen, they need to be in a chronic stable state. If they are not in a chronic stable state, which OSA would indicate they are not, then the coverage criteria is not met. It would be expected that the patient would have received their therapy from the PAP device and have that condition under control and then have them tested for oxygen therapy.

Q2. The diagnostic section of a sleep study was done in October. The patient's apnea-hypopnea index (AHI) was 9.1. The titration section of the sleep study was done in January with an AHI of 13.4. The physician is still ordering the PAP. Possibly the increase of the AHI is due to a cold. Can we use the 13.4 for initial coverage of PAP therapy?
A2. The titration in January is not a requirement of the PAP policy. In the first three months of therapy, the patient must meet the adherence to therapy criteria (>than 4 hours 70% of 30 consecutive days) and be re-evaluated no sooner than the 31st day of therapy. The re-evaluation must document both improvement in subjective symptoms of OSA and objective data related to adherence to PAP therapy. If the treating physician determines the therapy is not improving the patient's condition, Medicare will not continue to pay for the CPAP device.

Q3. Do you require an Advance Beneficiary Notice of Noncoverage (ABN) if you feel that an item is not going to be covered or on an unassigned claim?
A3. Assignment does not matter. If it is non-assigned and the claim denies as not reasonable and necessary, the supplier is still held liable under the refund requirements. If you know coverage criteria is not met and the claim will deny as not reasonable and necessary, then it would be appropriate for you to execute an ABN to protect yourself from liability.

Follow-up: The coverage criterion is met but Medicare's allowable is lower than our price for an item. Is it correct that an ABN would not be appropriate and if we want to charge the beneficiary for our full charge, we should file the claim non-assigned as long as we are a nonparticipating supplier?
A. That is correct.

Q4. I have a patient that failed their compliance in the first 90 days of their sleep therapy and a year later went back and got the follow-up sleep study and face-to-face with the doctor and everything was okay. Their condition did not change. Do we start with month four when we redeliver the machine if there has been a year gap (we picked up our original piece of equipment)? Do we have to do another 90 days of compliance?
A4. Since the patient's condition has not changed, you would continue with month four. The patient still needs to meet compliance in the next 90 days per the Local Coverage Determination (LCD) when they requalify. Eventually the patient needs to be compliant if Medicare is to continue payment for supplies.

Follow-up: Is there a time limit on when it is enough justification to start over with month one versus month four?|
A: No, not if the condition never changed.

Q5. My question is in regards to PAP therapy adherence, the 31-90 day treatment review. We have been getting what looks like an order from the clinic that has the patient information on it which reads "met face-to-face with the patient and reviewed objective evidence of adherence to use the PAP device". It then lists their download report which shows the patient is using it 70 percent of nights during a consecutive 30 day period. At the bottom it says "assessment of clinical response to treatment indicates the patient is obtaining benefit and should continue treatment as ordered". Is this good enough?
A5. There needs to be a medical record of the re-evaluation in the form of chart notes. The physician must document the face-to-face visit the way any other visit would be documented.

Follow-up: If this is how they type it up and they put it as part of a medical record, it still has to be your typical office note?
A: Yes, it must be like they would document any of their office visits.

Q6. We have a patient who failed their first 12 weeks of PAP therapy. They go back to the doctor for a re-evaluation and also have a repeat sleep test. We have already billed months 1-3 but the patient does not come back to us until what would be month five. What month do we continue billing with? Do we execute an ABN for month four and five and bill the patient? And then start with month six when they requalify? Or do we start over again with month one when we do the new trial period?
A6. Eventually the goal is to get 13 months rental paid. If the patient does not qualify and you cannot bill month four or five, you can execute an ABN. That might be some kind of incentive for them to use the device for 70 percent of 30 consecutive days. However, for paying purposes, month four is going to start when they qualify.

Q7. How do we verify electronic signatures for an audit?
A7. The record should have a clear appearance that it really is an electronic signature. This would include a specific date and usually a specific time. The most common electronic signature will indicate that they initially filled in the date signed so it looks more complete. As a general guideline, the electronic signature must have been by the person alleged to have signed it and no one else could have had the possibility of generating that signature. So if you have discussed it with the provider's office and it is possible for someone else to have generated it, then it will not meet the criteria. You can also get your own legal advice.

More clarification has been asked of CMS and will be posted to our website and come out in the listserv as soon as it becomes available. In the meantime, a new "Signature Requirements" fact sheet has been created by CMS and posted to our website.

Q8. If you have a patient that leaves the hospital and goes into a nursing home or just goes into a nursing home and is on oxygen and are being discharged to their home, it is my understanding that the nursing home cannot qualify them through oxygen saturation for oxygen. Is this true? It has to be either a physician's office or a hospital?
A8. There are two different references in the National Coverage Determination (NCD) of who can perform the test including a provider or supplier of laboratory services or a physician. If the nursing home has a laboratory, either they or a physician can do either the arterial blood gas (ABG) test or test oximetry.

Q9. If a PAP patient is non-compliant between the 31st and 90th day, do they have to have another sleep study and face-to-face in order to requalify?
A9. Yes, they must have a facility-based sleep study as well as have a face-to-face evaluation with their physician to determine why they did not meet the qualifications in order to begin the requalification process.

Follow-up: You are saying we have to get another compliance download in another 90 days on the fourth month of billing?
A: No, you are going to have another three months in order to meet adherence to therapy defined as use of the PAP ≥4 hours per night on 70% of nights during a consecutive 30 day period.

Follow-up: What happens if Medicare pays for 13 rental months because the patient continues to go back for another sleep study and face-to-face examination but during the entire 13 months the patient never had a good compliance download?
A: Medicare will not cover any of the supplies or accessories if the patient does not meet coverage criteria for the PAP device. The KX modifier should not be used in order to get them covered.

Follow-up: If the patient had a compliant download but did not have the face-to-face evaluation within the 31st and 90th day, once they have the face-to-face evaluation, you can then bill for month four?
A: Yes, month four would begin once the face-to-face evaluation occurred as long as they met adherence to therapy guidelines in the first 90 days.

Follow-up: Technically Medicare could pay for 13 rental months for the CPAP but if there is no compliant download, supplies will not be paid, correct?
A: Correct. The KX modifier should not be used because the patient did not requalify.

Q10. Is there anything newer than the old DMERC information on neuromuscular electrical stimulators?
A10. Nothing new has been published; however, you should follow what is written in NCD 160.12 for neuromuscular electrical stimulators.

Q11. During the diagnostic section of the sleep test the patient's AHI was 9.1 in October. During the titration in January, the patient's AHI increased to 13.4 rather than decreasing like it should. The doctor followed the results and stated in the sleep study or recorded that this is an inconclusive study for the usefulness of CPAP on this patient. Would the patient still qualify?
A11. The titration in January is not a requirement of the PAP policy. In the first three months of therapy, the patient must meet the adherence to therapy criteria (> than 4 hours 70% of 30 consecutive days) and be re-evaluated no sooner than the 31st day of therapy. The re-evaluation must document both improvement in subjective symptoms of OSA and objective data related to adherence to PAP therapy. If the treating physician determines the therapy is not improving the patient's condition, Medicare will not continue to pay for the CPAP device.

Q12. We have a patient that just met the five year reasonable useful lifetime (RUL) on oxygen. He started with an order for an E1390 (concentrator) and E0431 (portable). The patient refused the E0431 two months later and returned it. He then restarted using it about the time of the recertification. So we had to recert the concentrator and portable. The patient refused to use the portable again. Years went by. We did the five year exchange on just the concentrator. Four months later the doctor ordered the portable again. Do we use the revised certificate of medical necessity (CMN) and do we add a narrative?
A12. If the fiver year replacement initial CMN only included the concentrator, then yes, you will need a revised CMN to add the portable.

Q13. We have a patient who was provided a BiPAP in March 2006 by another supplier. We were told the last maintenance and service claim was in 2008. If the equipment needs to be repaired, will our claim get denied because the system has a previous maintenance and service claim in the system from years ago?
A13. As of January 2006, capped rental items are paid for 13 months and then are owned by the patient with no maintenance and servicing. Since this BiPAP was originally provided to the patient after January 2006, no maintenance and service claims will be paid. The repair claim should go through the normal claims processing channels.

Follow-up: If we find out the equipment is repairable for a minimum cost and has reached the five year RUL, can we repair it versus replacing it?
A: Yes. If the beneficiary would rather have their piece of equipment repaired, you can repair the item and submit a repair claim.

Q14. Do we still have to send a rent to purchase letter to patients on enteral therapy pumps?
A14. No. The beneficiary can elect to purchase enteral pumps at any time before the 15th month. There is no 10 month purchase option for enteral pumps.

Follow-up: Is it recommended that we use the BP modifier on the 13th month claim?
A. Enteral pumps process similar to the old capped rental rules. The claims system will look for a modifier in the 12th month. Although there is not a 10 month purchase option required, suppliers must include either the BP, BR, or BU modifier on the 12th month claims.

Q15. Regarding the 90 day recertification for oxygen, we have been getting verification from the physician as far as the date they did the recertification. What would you expect to see when you do an audit of the chart? They have to directly document in their notes the oxygen?
A15. We are looking for medical documentation that there was a physician evaluation, face-to-face and they evaluated the patient for the use of oxygen.

Q16. Regarding the five year RUL for PAP devices and the face-to-face, I'm wondering if there is a timeframe that is restricted on that. For instance, if the patient has been in continuous contact with their doctor and already had a face-to-face six months before the five year RUL ran out, is that okay? Or do they have to wait until after the RUL before they get a new one?
A16. Speaking for NAS, we have a default of one year. So if it was within that one year period and the face-to-face specifically addresses the issue, then we would accept it.

Q17. We have some demanding customers who are asking for specific PAP models that we do not normally dispense for a starter kit. Can we have them sign an ABN and pay extra to get the model they want?
A17. No, that is not acceptable. You can make the claim non-assigned and bill for whatever you feel is reasonable for that particular model but this would not be an acceptable reason to use an ABN.

Q18. A patient purchased a BiPAP from BCBS in 2003. His last sleep study was in 2006. However, the BiPAP that he has now is not holding the pressure. Can we give him a new BiPAP machine without another sleep study?
A18. Per the PAP LCD, there must be documentation that the beneficiary had a sleep test that meets the Medicare AHI/RDI (respiratory disturbance index) coverage criteria in effect at the time that the beneficiary seeks Medicare coverage of the replacement and also have a face-to-face evaluation by their treating physician who documents in the beneficiary's medical record that the beneficiary has a diagnosis of OSA and they continue to use the PAP device.

Ask the Contractor Teleconference Questions and Answers – July 7, 2011

Change in System Hours
Effective July 5, 2011, suppliers are able to make claim-related inquiries using the NAS Interactive Voice Recognition (IVR) system (1-877-320-0390) or the free Endeavor supplier portal between the hours of 6 a.m. until 8 p.m. CT. Due to supplier feedback received through customer satisfaction surveys, NAS requested the claim processing system maintainer extend the hours of availability by two hours each day to better support the self-service inquiries of Jurisdiction D suppliers. The IVR and Endeavor will each continue to offer eligibility inquiries 24 hours a day / 7 days a week. Suppliers are encouraged to use the IVR and Endeavor for simple inquiries and rely on the Customer Service Representatives for more complex inquiries between the hours of 8:30 a.m. and 5:30 p.m. CT. It is important you share this change with your staff and coworkers who contact our office.

Supplier Contact Center Change in Hours
NAS changed our Supplier Contact Center hours of operation to be 8:30 a.m. to 5:30 p.m. Central Time effective Monday, June 6, 2011. This change is made to ensure our Customer Service Representatives are available to answer supplier inquiries during the busiest times of the day. If you have not done so already, please share this change with your staff and coworkers who contact our office.

Email Listserv
If you aren't already signed up for our email updates, we strongly encourage you to do so. We send emails every Tuesday and Friday containing the latest news, updates, workshop announcements, and more. To sign-up, go to our website, and click on E-mail Newsletter Sign Up on the left-side of any page.

Endeavor
Suppliers are 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 must register for their own User ID. User IDs cannot be used by more than one person.

To register, go to the claims page of our website. Many suppliers are already taking advantage of this tool and we highly encourage you all to do so as well!

Q1. Medicare has been covering the rental of a Group 2 Power Wheelchair for a patient for eight months. Now the patient qualifies (with medical justification) for a Group 2 with Power Option which is a category we can do a sale or purchase type claim. How does that work? Will you expect us to pick up the rental and then Medicare will pay us like new for a purchase of the one they now qualify for?
A1. You need to ensure there is medical documentation justifying the need for the new wheelchair. It needs to be reasonable and necessary and well documented in the patient's medical records. Pick up the K0823 once they qualify for the higher level Group 2. At that point in time you need to go through the whole process over again with a new face-to-face, new order, etc. Then you will be able to go ahead and get that purchased.

Q2. I have a client who received a continuous positive airway pressure device (CPAP) in November 2006. His machine quit working and needs a new blower and PCA board which will cost $449. How do I know if he qualifies for a new machine? And if he does, will it reject since it hasn't been five years?
A2. The Medicare rules on replacement inside the five years are only for lost, stolen or irreparably damaged items. Otherwise, it is expected that any type of durable medical equipment (DME) will last five years. In this case, you would not be able to get the replacement. You can bill for repairs not covered by warranty up to the cost of replacement.

Q3. We have recently been receiving denials on repairs and adjustments to orthotics and prosthetics stating they want the original L code, original date of purchase and whether or not the item is owned or rented. We have never been asked for this information before. I can't find where this rule is stated. I have also been supplying this information with my redetermination and am still receiving denials. Why is it being required and still denied?
A3. This information is required when you submit your claim; however, at the redetermination level, medical documentation is required to support the patient owned the equipment and it is medically necessary. Current medical documentation to support the need would also suffice. More information can be found at the following webpage: https://www.noridianmedicare.com/dme/news/docs/2010/09_sep/beneficiary_owned_equipment.html.

Q4. If we were to bill the 36th month for oxygen on July 7, 2011, what would the first date we are allowed to bill for maintenance and servicing (M&S)?
A4. Maintenance and servicing should be performed in the **first month, 6 months after the 36 month period ends**, which would end on 01/06/12 in the example given. In order to bill for M&S it should occur between 1/07/12 – 2/6/12 unless unavoidable reasons prevent the M&S. Unavoidable reasons are listed in MLN Matters Article 6990: https://www.noridianmedicare.com/dme/news/docs/2010/06_jun/mm6990.pdf. M&S is only covered for concentrators and transfilling equipment.

Q5. Regarding the face-to-face examination for power mobility, when we are involved in a multidisciplinary evaluation with the occupational therapist (OT) or physical therapist (PT) and our assistive technology professional (ATP), is it inappropriate for our ATP to sign off on the OT's report and is it a conflict when we send in the attestation saying we have no financial relationships with those other clinicians?
A5. Your ATP must not have any financial relationship with the PT/OT who is doing the review. It is fine that they are doing the evaluation together as a group approach, but understand the medical records are going to be the records that are created by the PT, not the ATP. The ATP should be writing his/her own notes during this evaluation. The ordering physician may sign and date the report and state concurrence or any disagreement, not the supplier employed ATP.

Follow-up: He can write his own report and also sign off on the PT or OT's report, is this correct?
A: Yes, the ATP can create his own report and should have in-person involvement in wheelchair selection for Group 2 Single Power Options and above. However, for medical review purposes NAS will need to see the PT or OT's report.

Q6. The doctors are having a hard time changing their face-to-face date if they were not involved in that appointment and say they saw the patient prior to that evaluation with the OT/PT. They will not change the face-to-face date to the day they sign off on the report. I know there is information to explain that that becomes the face-to-face date but some of these doctors still refuse to say that that's the actual face-to-face date.
A. For your purposes it is going to be the date they sign the PT/OT evaluation. They need to either agree or disagree with the PT/OT evaluation and sign an agreement or disagreement. If they disagree, they need to indicate why. That is going to be your indication of when the face-to-face actually happened which is when the physician signs off on it. This is what we are going to be looking for.

Follow-up: They do sign off on it but refuse to put on the prescription the day they sign the PT report as their face-to-face date. It makes it difficult because we have the day they initially saw the patient, then they went to the OT, then they signed off on the OT report, and now they are saying I can't bill for this date because I did not see them in my office.
A. The face-to-face examination guidelines are clearly documented in the PMD policy article. NAS recommends providing that to the physician who is having a hard time understanding.

> For a power operated vehicle (POV) or power wheelchair (PWC) to be covered, the treating physician must conduct a face-to-face examination of the patient before writing the order and the supplier must receive a written report of this examination within 45 days after completion of the face-to-face examination and prior to delivery of the device. If this requirement is not met, the claim will be denied as noncovered. (Exceptions: If this examination is performed during a hospital or nursing home stay, the supplier must receive the report of the examination within 45 days after discharge. If the POV or PWC is a replacement during the 5 year useful lifetime of an item in the same performance group that was previously covered by Medicare, a face-to-face examination is not required. Note: Replacement during an item's useful lifetime is limited to situations involving loss or irreparable damage from a specific accident or natural disaster [e.g., fire, flood, etc.].)
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> The physician may refer the patient to a licensed/certified medical professional, such as a physical therapist (PT) or occupational therapist (OT), who has experience and training in mobility evaluations to perform part of the face-to-face examination. This person may have no financial relationship with the supplier. (Exception: If the supplier is owned by a hospital, PT or OT working in the inpatient or outpatient hospital setting may perform part of the face-to-face examination.)
>
> If the patient was referred before being seen by the physician, then once the physician has received and reviewed the written report of this examination, the physician must see the patient and perform any additional examination that is needed. The report of the physician's visit shall state concurrence or any disagreement with the LCMP examination. In this situation, the physician must provide the supplier with a copy of both examinations within 45 days after the face-to-face examination with the physician.

If the physician saw the patient to begin the examination before referring the patient to an LCMP, then if the physician sees the patient again in person after receiving the report of the LCMP examination, the 45-day period begins on the date of that second physician visit. However, it is also acceptable for the physician to review the written report of the LCMP examination, to sign and date that report, and to state concurrence or any disagreement with that examination. In this situation, the physician must send a copy of the note from his/her initial visit to evaluate the patient plus the annotated, signed, and dated copy of the LCMP examination to the supplier. The 45-day period begins when the physician signs and dates the LCMP examination.

Follow-up: Do we hold up the paperwork if they refuse to send it in for the Advance Determination of Medicare Coverage (ADMC) or should we just explain with the ADMC that they are not willing to sign or change the date?
A. The physician needs to indicate agreement with or modify the PT's notes if those notes are being incorporated into the face-to-face. If they are not going to sign that, it is not complete. You do need that 7-element order to go through the ADMC process. It is ok for the doctor to put down the initial face-to-face and then indicate amended, completed, resolved, for example, and sign and date it with the update date.

Q7. My question has to do with DME provided in a skilled nursing facility (SNF), specifically about patients who are on long-term care and whether or not the services they are receiving are being billed to Part A or Part B. This has a bearing on whether or not the supplier is able to provide a speech generating device.
A7. DME has a specific defined benefit category with a definition of it being used in the patient's home. Per the Social Security Act, a SNF is not considered a patient's home even if the facility becomes their home of record. DME would not be covered for place of service 31 (SNF) or 32 (nursing home). This does not change even if they have exhausted their Part A benefits. This rule is different for things such as orthotics, prosthetics, supplies, therapeutic shoes, oral anti-cancer drugs and oral antiemetic drugs. More information can be found in Chapter 5 of the NAS DME Supplier Manual.

Q8. I have received denials from the complex medical review NAS is conducting on oxygen and have questions regarding them. The denial states we do not have the physician evaluation 30 days prior to the initial certification but this is not required for replacement oxygen. Are we being asked to get the initial evaluation within 30 days prior to the initial certificate of medical necessity (CMN) that may go back to 1996?
A8. We need to know you are reporting the most recent qualifying result on the CMN for the replacement. We need to have some kind of proof that the test existed.

Follow-up: Are they also asking for the evaluation prior to the initial oxygen test?
A: Yes. You can call the Supplier Contact Center at 866-243-7272 and they can relay information to the MR review nurse if you have specific questions.

Q9. What justification in the medical record needs to exist for transcutaneous electrical nerve stimulators (TENS)?
A9. A written order with the diagnosis is not sufficient. You need to have medical records that support the coverage criteria. Read the TENS local coverage determination (LCD) and policy article and verify all coverage criteria exist for that particular item. You will need a written order prior to delivery (WOPD) so check with the physician well ahead of delivering the piece of equipment to the beneficiary.

Follow-up: The doctor should put the time and link of the TENS unit?
A: That is correct.

Q10. For enteral nutrition, we did not obtain the proper documentation prior to submitting our claim and we did not indicate so and received a denial. Is this appealable?
A10. If you can't verify coverage criteria has been met after attempting to obtain the medical records, you can execute an advance beneficiary notice of noncoverage (ABN) to protect yourself from liability. When submitting your claim to Medicare, you would append the GA modifier to the code. If you do not have an ABN, you could bill with the GZ modifier. The GZ modifier will deny as contractual obligation and you would be able to appeal that determination.

Follow-up: In the case of the CMN or DME information form (DIF), we specify we now have the correct documentation by changing the answer and appeal the claim?
A: You will want to correct and revise your DIF with the appropriate information and send this in with your appeal. When requesting an appeal you should submit all supporting medical documentation in the form of medical records. As long as the medical justification indicated prior to you delivering the item or supplies, that should be fine and appealable.

Q11. We have a scenario where a patient moved from Sacramento (non-competitive bid area [CBA]) to Riverside (CBA) and our Los Angeles store will be providing service to them. The Sacramento store originally gave them their equipment. We were told a new order was required because the two stores have different provider transaction access number (PTAN) and national provider identifier (NPI). For a power wheelchair, does it require a new face-to-face and a new 7-element order or does it just require a new 7-element order?
A11. If the supplier in Sacramento is considered a different supplier from the Los Angeles location, a new order and detailed product description is required. A new face-to-face examination would not be required as long as all of the documentation supports the wheelchair.

Q12. The older LCD for CPAP from 6/3/2008 clearly stated that quantities of supplies greater than those described in the policy as a usual maximum amount, in the absence of documentation clearly explaining the medical necessity of the excess quantities, will be denied as not medically necessary. The subsequent revisions did not indicate that this wording was removed and the rule of replacing them not more than five days before the monthly anniversary replacement day was not added to the PAP for obstructive sleep apnea (OSA) LCD until February 2010. During the interim, many suppliers obtained letters of medical necessity when the quantities in excess were provided. These claims were submitted with an explanation and narrative and were paid. This led us to believe they were legitimately covered. Now, three years later, many of us have been hit very hard with these Recovery Audit Contractor (RAC) audits and we've had to return a lot of money and spend a lot of time on appeals. We were told the RAC audits were unable to detect the narratives so they weren't even looking for them. Is there any recourse for this?
A12. The language was changed in the LCD effective March 13, 2008. Suppliers can appeal quantities above the guideline.

Q13. We have a patient who resides in a nursing home who will be receiving an upgrade in formula and the nursing home is willing to pay for the difference in the upgrade. Do we still need to get an ABN for the upgrade in order to bill the facility or can we bill using the upgrade modifier to charge the patient but bill the facility the difference?
A13. You are still required to bill following the upgrade guidelines. An ABN will make it patient responsible and if there is no ABN on file, the denial will be supplier liable.

Q14. We are trying to get a patient qualified for oxygen equipment. Can we use the results if the patient is tested on oxygen? They don't have to be tested at four liters, just be tested on two as long as the result is 88% or below.
A14. The qualifying blood gas study may be performed while the patient is on oxygen as long as the reported blood gas values meet the Group I or Group II criteria. If basic oxygen coverage criteria have been met, a higher allowance for a stationary system for a flow rate of greater than 4 liters per minute (LPM) will be paid only if a blood gas study performed while the patient is on 4 LPM meets Group I or II criteria.

Q15. Regarding repairs, I know you look for additional information when the RB modifier is used but do you want a specific description in each line stating what is wrong with the part that we are repairing?
A15. Yes. If you are repairing tires, you should put whatever is wrong with them. This should be on the line that corresponds with the item you are repairing.

Follow-up: Would putting 'worn' be sufficient? How detailed do you need to be?
A: You should tell us what is wrong so we know the reason for replacement.

Q16. We have a patient that is renting oxygen and went into a facility. We did not pick up the equipment. They are discharged from the facility and it's been more than 60 days. The diagnosis remained the same, but to continue to bill, do we need new stats, chart notes or CMNs? If so, what type of CMN?
A16. The patient had a break in billing not a break in use because the diagnosis remained the same. When billing your claim you will need to put 'break in billing' in the narrative and your claims will continue to process as they had before. A new order is not required when there is a break in billing.

Q17. When executing an ABN, for the reason we believe Medicare will not pay, can we indicate we did not have medical documentation or clinical evidence at the time of the service to determine Medicare coverage?
A17. This cannot be done on a routine basis just because you haven't obtained the documentation. This would only be acceptable when you make a good faith effort to obtain the documentation to verify whether or not coverage criterion was met and could not obtain it.

Q18. When a physician is prescribing DME, what, if any information is required on that prescription about the physician? Does it have to have his address or his phone number?
A18. For DME, it needs to be clear who the physician is. You also need their signature and date.

Q19. My question is regarding special formulas. I was on a call with Region C. They are requesting a trial on B4150 and B4152 to show the difference when the patient was on the lower paying formula than the specialty formula. When I look at the LCD it says the medical necessities for special formulas must be justified in each patient. This LCD does not point out what you are looking for. In the case of a diabetic, we are showing medical records to show the patient is an insulin dependent diabetic. We are showing lab values and the daily glucose testing. What else are you looking for?
A19. Your record would need to document why the other formula could not be used. Merely saying a patient is diabetic and can't use a certain formula will not suffice. There needs to be more evidence than that. The record should be clear that that has been considered and reviewed and the medical necessity is documented.

Follow-up: When the dietician evaluates the patient and makes notes of the lab value and that the patient should continue on Glucerna, would the dietician be able to write why they were not tried on the B4150 or B4152 or does the physician? The physician usually goes off of the dietician's recommendations.
A: Just because the dietician recommends something and the physician agrees with it doesn't necessarily mean it is good documentation. This information needs to be detailed in the medical records. It could be well documented in the dietician's note. You would more than likely need more documentation than you would get from the dietician; some dieticians write good notes and some do not. You can't strictly rely on what is in the dietician's notes. The justification needs to be clearly spelled out. The whole purpose of the notation is to prove the medical necessity.

Q20. Regarding the three month follow-up for PAP devices, I have the downloaded compliance information from the smart card which shows they adhere to therapy but they haven't had their follow-up evaluation. Can I use this documentation or do they have to go to the doctor?
A20. You cannot bill for the fourth month until the beneficiary sees their physician but you can use the data from the download to justify the first three months. Also, the date of service for the fourth month would be the date they see their physician.

Q21. Looking at the External Breast Prosthesis LCD, it states you can't dispense more than a three month supply at one time. How is quantity of supplies being defined? Is it based on the reasonable useful lifetime (RUL) of the product?
A21. You dispense to the patient what is reasonable and necessary for that three month time frame.

Q22. A beneficiary is in a SNF or an unskilled nursing facility (place of service 31 or 32) and they are in a Part B stay. We are providing enteral or total parenteral nutrition and there is DME involved with the pump and in some cases an IV pole. Do I understand that the pump and IV pole cannot be provided by an outside DME supplier?
A22. DME is not covered in POS 31 or 32. Enteral nutrition falls under the prosthetic benefit category. If the beneficiary is not in a Part A covered stay, the DME MAC may be billed for the enteral nutrition.

Q23. With the oxygen complex medical review requests that are being sent out, we are being asked for additional items not related to the oxygen. I called the supplier contact center and I was told that if it is on the letter, I must send it in. Is there any way to tailor those letters to be more specific to what's actually being looked at?
A23. If you have questions on the complex medical review letters, call the Supplier Contact Center and tell them you are in need of details from the Medical Review staff. The representative will be able to forward your questions on to the Medical Review staff for research and a call will be made back to you.

Q24. I delivered enteral formula to a patient who then changed to a different formula. We have documentation for all the necessary requirements stating the new formula is needed. How do I bill for that? Do I put both formulas on the same claim? They changed the formula three days before they were suppose to end the first formula.
A24. An initial DIF is required for both formulas. It is ok to bill both formulas on the same claim. The from dates will be different and both lines will be considered for coverage.

Q25. My question is regarding the E0471 in the respiratory assist device (RAD) LCD. After the first three months, based on the download, the patient is not compliant. Does the patient need to do a new sleep study or do we just hold our billing and then see if they are compliant the next month?
A25. The PAP and RAD policies are separate. The RAD LCD contains specific conditions that need to be met including restrictive thoracic disorders, severe chronic obstructive pulmonary disease (COPD), central sleep apnea or complex sleep apnea and hypoventilation syndrome. Not all of these conditions require a sleep study. The PAP LCD contains instructions for OSA patients and not being compliant.

Q26. We have some questions about the code E1028. We do a lot of complex rehab and seating systems. E1028 is billed for swing-away hardware. Do you want them whether it's for repair or purchase? Do you want them always billed on separate claim lines?
A26. If you are providing the swing-away hardware, the individual claim lines for the E1028 must indicate in the narrative section of the claim what that swing-away hardware is related to. The accessory it is related to must be billed on the same claim as the E1028.

Follow-up: Some of the items have paid but the swing-aways are not so I'm not able to do that. Should I just put those hard coded back on there so you know what it is for and you will deny another duplicate?
A: No, you must go through appeals if the swing-away hardware was not originally allowed.

Follow-up: They are denying because you retro bill. You make a change and then go back on the previous claims. On the ones that went back, the pads had paid but the swing-aways denied C016 saying I was missing the description. These claims have to be resent through to claims. I can't appeal. When we originally billed the claims, the policy was not in place yet. We sent them in with no description in the narrative and received the C016.
A: Examples were requested and not received.

Q27. Is the RT or LT modifier required on the E1028 or repairs?
A27. If the supplier is providing a bilateral accessory that requires swing-away hardware, the RT/LT will help to identify what side of the chair it is on. The supplier must include a description in the narrative section of the claim that could also explain if the swing-away hardware is for the left or right side.

Q28. Is the K0462 (loaner) only payable every two years? A Q&A document posted to the NAS DME website states this.
A28. The Q&A is giving an example that Medicare will pay for a one-month payment or rental per piece of loaner equipment per repair. If the piece of equipment needs to be fixed now and two years down it needs to be repaired again, Medicare will consider payment again. Again, the two years is just an example.

Q29. My question is regarding a child that we have that has a secondary insurance, California Children Services, and they have different medical criteria than Medicare. He qualifies for a K0005 wheelchair through his secondary insurance but doesn't under Medicare guidelines. Do we bill using the upgrade guidelines?
A29. Yes, you need to follow the upgrade guidelines and execute an ABN and submit your claim with the GA modifier appended to the K0005 on the first line and the K0004 on the second line with the appropriate modifier if you would like a provider responsible denial for the difference. You could also bill the K0004 with the GL modifier, but there would be no provider responsible denial for the difference that you could potentially bill to secondary insurance.

Follow-up: My problem is we are going from a purchase chair to a rental chair and because the secondary is Medi-Cal we are going to be getting our explanation of benefits (EOB) back saying he does meet the criteria for the K0004 which we are going to have to bill as a rental but then we can't use that to bill as a K0005. Is there any way to do this with the secondary insurance he has?
A: Not if the secondary insurance is going to pay for it outright.

Follow-up: The secondary insurance only pays for it based on the EOB we receive from Medicare. Since he does meet the criteria for the K0004, there is no way to bill this. I just wanted to make sure I wasn't missing anything.
A: On a monthly basis you will be getting the patient responsibility for the difference between the two which can be submitted to the secondary on a monthly basis. The secondary insurance would have to authorize it as a rental.

MLN Matters® – Feedback Requested

Your feedback is important to CMS as they use your suggestions to help improve their MLN Matters® articles so they better meet your educational needs. To evaluate MLN Matters® articles, please visit http://www.CMS.gov/MLNProducts/85_Opinion.asp, select "MLN Evaluations" from the "Related Links Inside CMS" section, and then select "MLN Matters Articles" from the list of products. Please send any comments or suggestions for MLN Matters® articles to MLN@cms.hhs.gov.

Updates from the Medicare Learning Network

"Fast Facts" Now Available on MLN Provider Compliance Webpage
As part of ongoing efforts by CMS to keep Medicare Fee-For-Service providers aware of new and improved educational products, CMS encourages you to visit the MLN Provider Compliance webpage, containing educational FFS provider materials to help you understand, and avoid, common billing errors and other improper activities identified through claim review programs. You can now review quick tips on relevant provider compliance issues and corrective actions directly from this webpage. Be sure to bookmark this page and check back often as a new "fast fact" will be added each month!

April 2011 Issue of Quarterly Provider Compliance Newsletter Released
Just released! The next issue of the "Medicare Quarterly Provider Compliance Newsletter" is now available in downloadable format from the Medicare Learning Network® at http://www.CMS.gov/MLNProducts/downloads/MedQtrlyComp_Newsletter_ICN903696.pdf. This educational tool is designed to provide education on how to avoid common billing errors and other erroneous activities when dealing with the Medicare Program and is released on a quarterly basis. In this issue, a number of Recovery Audit findings that affect inpatient rehabilitation facilities, inpatient hospitals, physicians, non-physician practitioners, and outpatient hospitals are presented. The newsletter now features a series of tips and suggestions on relevant topics and an interactive index of previously-issued newsletters, which can be found at http://www.CMS.gov/MLNProducts/downloads/MedQtrlyCompNL_Archive.pdf.

Redesigned MLN Matters Article Index
The 2004 through 2011 MLN Matters® Article indices have been redesigned! These indices are based on common keywords and were updated to link directly to related MLN Matters® Articles. To view an article associated with a particular keyword or phrase, simply click on the link related to that keyword or phrase from the index. Visit the MLN Matters® Articles webpage or http://www.cms.gov/MLNProducts for a complete index of articles released since 2004.

New and Revised "Guided Pathways" Booklets (Basic, A & B, and Provider Specific)
The revised MLN Guided Pathways curriculum is designed to allow learners to easily identify and select resources by clicking on topics of interest. The curriculum begins with basic knowledge for all providers and then branches to information for either those enrolling on the 855B, I, and S forms or on the 855A form (or Internet-Based PECOS equivalents). The new "MLN Guided Pathways Provider Specific" resource booklet provides various specialties of healthcare professionals, suppliers, and providers with resources specific to their specialty including Internet-Only Manuals (IOMs), Medicare Learning Network® publications, CMS webpages, and more.

There are four resource booklets included in the series:

- MLN Guided Pathways to Medicare Resources – Basic Curriculum for Healthcare Professionals, Suppliers, and Providers (April 2011, PDF)
- MLN Guided Pathways to Medicare Resources Intermediate Curriculum for Healthcare Providers (Part A – April 2011, PDF)
- MLN Guided Pathways to Medicare Resources Intermediate Curriculum for Healthcare Professionals and Suppliers (Part B – April 2011, PDF)
- MLN Guided Pathways to Medicare Resources Provider Specific (April 2011, PDF)

All of the MLN Guided Pathways booklets above can be located at http://www.CMS.gov/MLNEdWebGuide/30_Guided_Pathways.asp.

"World of Medicare" Web-Based Training Revised
The "World of Medicare" web-based training course has been revised (as of January 2011). It is designed for healthcare professionals who want to understand the fundamentals of the Medicare program, and covers Medicare Part A, Part B, Part C, and Part D; identifying Medicare beneficiary health insurance options; eligibility and enrollment; as well as recognizing how Medigap and Medicaid work with the Medicare program. This WBT course offers continuing education credits; please see the course description for details.

To access the training course, visit http://www.CMS.gov/MLNGenInfo, scroll to "Related Links Inside CMS," select "Web-Based Training (WBT) Modules," and then select "World of Medicare (Developed: January 2010 / Revised January 2011)" from the list of trainings provided.

"Your Office in the World of Medicare" Web-Based Training Revised
"Your Office in the World of Medicare" web-based training course has been revised (as of February 2011). It is designed to provide education on the fundamentals of the Medicare Program, and includes information about Parts A, B, C, and D; beneficiary health insurance options; eligibility and enrollment; and how Medigap and Medicaid work with the Medicare Program. This WBT course offers continuing education credits; please see the course description for details.

To access the training course, visit http://www.CMS.gov/MLNGenInfo, scroll to "Related Links Inside CMS," select "Web-Based Training (WBT) Modules," and then select "Your Office in the World of Medicare (Developed: January 2010 / Revised February 2011)" from the list of trainings provided.

"How to Search the Medicare Coverage Database" Fact Sheet Revised
The publication titled "How to Search the Medicare Coverage Database" (revised April 2011) is now available in downloadable format from the Medicare Learning Network®. It was designed to provide education about how to use the Medicare Coverage Database (MCD) and includes an explanation of the database and how to use the search, indexes and reports, and download features.

"Form CMS-1500 At A Glance" Fact Sheet Revised
The revised publication titled "Form CMS-1500 At A Glance" (revised February 2011) is now available from the **Medicare Learning Network®** at http://www.CMS.gov/MLNProducts/downloads/form_cms-1500_fact_sheet.pdf. This fact sheet is designed to provide education on the CMS Form 1500, which is the standard paper claim form used by healthcare professionals to bill for Medicare Part B services, and includes background information and a descriptive crosswalk of fields in the paper versus the electronic form.

"Basics of DMEPOS Accreditation" Fact Sheet Now Available in Hardcopy
The "Basics of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Accreditation" fact sheet is now available in hard copy format from the Medicare Learning Network; this fact sheet is designed to provide education on the DMEPOS accreditation requirements, the types of providers who are exempt, and the process for becoming accredited. To place your order, visit the MLN Product Ordering Page at http://CMS.meridianksi.com/kc/pfs/pfs_lnkfrm_fl.asp?lgnfrm=reqprod&function=pfs.

"DMEPOS Quality Standards" Fact Sheet Now Available in Hardcopy
The "Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Quality Standards" fact sheet is now available in a hard copy format from the Medicare Learning Network; this fact sheet is designed to provide education on DMEPOS quality standards for Medicare-deemed Accreditation Organizations (AOs) for DMEPOS suppliers. To place your, visit the MLN Product Ordering Page at http://CMS.meridianksi.com/kc/pfs/pfs_lnkfrm_fl.asp?lgnfrm=reqprod&function=pfs.

"DMEPOS New Information for Pharmacies" Booklet Now Available in Hardcopy
The "Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) New Information for Pharmacies" booklet is now available in hard copy format from the Medicare Learning Network; this booklet is designed to provide education for new pharmacies on how to obtain a DMEPOS accreditation exemption. In order to supply DMEPOS, pharmacies must be accredited by CMS-approved independent national Accreditation Organization (AO) or must obtain an accreditation exemption. To place your order, visit the MLN Product Ordering Page at http://CMS.meridianksi.com/kc/pfs/pfs_lnkfrm_fl.asp?lgnfrm=reqprod&function=pfs.

EDUCATIONAL CONT'D

Are You Submitting a Handwritten Medicare Enrollment Application?

Medicare enrollment application forms are fillable on your computer. This means that you can fill out the information required by typing into the open fields while the form is displayed on your computer monitor. Filling out the forms this way before printing, signing and mailing means more easily-readable information – which means fewer mistakes, questions, and delays when your application is processed. Be sure to make a copy of the signed form for your records before mailing.

You'll find the Medicare provider enrollment application forms available on the CMS website:

- CMS 855S – Application for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Suppliers

Signatures are still required to be handwritten. Don't forget to complete this important step prior to mailing your typed form(s).

Keep in mind that typed forms are easier for Medicare to process, but the most efficient method for submitting your enrollment application is to use the Internet –Based Provider Enrollment, Chain and Ownership System (PECOS). PECOS guides you through the enrollment application so you only supply information relevant to your application. PECOS also reduces the need for follow-up because of incomplete applications. Using Internet-based PECOS results in a more accurate application and saves you time and administrative costs. Visit Internet-Based PECOS to learn more.

ESRD

Medicare Proposes Revisions to ESRD Prospective Payment System

The Centers for Medicare & Medicaid Services (CMS) today issued a proposed rule that would update Medicare policies and payment rates for dialysis facilities, while strengthening incentives for improved quality of care and better outcomes for beneficiaries diagnosed with End-stage Renal Disease (ESRD). The proposals would affect payments for dialysis treatments furnished on or after January 1, 2012 under the new bundled ESRD Prospective Payment System (PPS) that was implemented in calendar year (CY) 2011.

CMS is projecting that payment rates for dialysis treatments will increase by 1.8 percent, representing a projected inflation (or ESRD market basket) increase of 3.0 percent, less a projected productivity adjustment of 1.2 percent. CMS estimates that payments to ESRD facilities in 2012 will total $8.3 billion.

CMS is also proposing to strengthen the Quality Incentive Program (QIP) that will adjust payment rates to individual facilities based on how well they meet specified performance standards. Please refer to the OCSQ webpage for more information.

The proposed rule also includes several proposals that are not related to the ESRD PPS and QIP. These include proposing a one-year extension of certain payment rate increases for both ground and air ambulance services, and proposing to establish a 3-year minimum lifetime for equipment to be considered durable for purposes of payment under the benefit category for durable medical equipment, prosthetics, orthotics, and supplies.

For more information, please go to: http://www.cms.gov/ESRDPayment/PAY/list.asp

Quarterly Update to End-Stage Renal Disease Prospective Payment System

MLN Matters® Number: MM7476
Related Change Request (CR) #: 7476
Related CR Release Date: July 15, 2011
Related CR Transmittal #: R2255CP
Effective date s: 10/1/2011-ICD-9 Updates; 1/1/2011-DME Updates
Implementation Date: October 3, 2011

Provider Types Affected
Physicians, providers, and suppliers, including End-Stage Renal Disease (ESRD) facilities and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) suppliers, submitting claims to Fiscal Intermediaries (FIs), DME Medicare Administrative Contractors (DME MACs), or A/B MACs for ESRD supplies and services provided to Medicare beneficiaries are affected by this article.

Provider Action Needed
This article, based on Change Request (CR) 7476, advises you about the following corrections to Attachment 4 and Attachment 5 provided in CR7064:

- Removes equipment and supply codes from Attachment 4 that are not separately payable to DMEPOS suppliers, and
- Adds these removed codes to Attachment 5.

You are also advised of the update to Attachment 8 provided with CR7064, which is the list of ICD-9-CM codes eligible for the ESRD Prospective Payment System (PPS) co-morbidity payment adjustment. The list of ICD-9-CM codes that are eligible for a co-morbidity payment adjustment effective January 1, 2011 and the list of ICD-9-CM codes that are eligible for a co-morbidity payment adjustment effective October 1, 2011 is available at http://www.cms.gov/ESRDPayment/40_Comorbidity_Conditions.asp#TopOfPage on the Centers for Medicare & Medicaid Services (CMS) website.

The revised attachments 4 and 5 are attached to CR7476 at http://www.cms.gov/Transmittals/downloads/R2255CP.pdf on the CMS website. Items and services that are subject to the ESRD PPS consolidated billing requirements can be found at http://www.cms.gov/ESRDPayment/50_Consolidated_Billing.asp#TopOfPage on the CMS website.

Background
MM7064, entitled "End Stage Renal Disease (ESRD) Prospective Payment System (PPS) and Consolidated Billing for Limited Part B Services," advised you about the implementation of a new bundled payment system for renal dialysis items and services provided on and after January 1, 2011. You may review this article by going to http://www.cms.gov/MLNMattersArticles/downloads/MM7064.pdf on the CMS website.

The ESRD PPS provides payment adjustments for six categories (three acute and three chronic) of co-morbid conditions. When applicable, ESRD facilities can report specific ICD-9-CM diagnosis codes on ESRD facility claims to be eligible for a co-morbidity payment adjustment.

The ICD-9-CM codes are updated annually and are published in the Federal Register in April/May of each year as part of the Proposed Changes to the Hospital Inpatient Prospective Payment Systems and are effective each October 1. CR7476 provides updates to attachment 8 of CR7064, which includes the ICD-9-CM codes eligible for the ESRD PPS co-morbidity payment adjustment in accordance with the annual ICD-9-CM update, which is effective October 1, 2011.

Changes to the ICD-9-CM codes that are eligible for a co-morbidity payment adjustment effective October 1, 2011 include:

1. In the chronic comorbid conditions under the hereditary hemolytic and sickle cell anemia category, ICD-9 code 282.41 – Sickle-cell thalassemia without crisis has been revised to include microdrepanocytosis.
2. In the chronic comorbid conditions under the hereditary hemolytic and sickle cell anemia category, the 5 new ICD-9 codes added are as follows:

   - 282.43 Alpha thalassemia

   - Alpha thalassemia major
   - Hemoglobin H Constant Spring
   - Hemoglobin H disease
   - Hydrops fetalis due to alpha thalassemia
   - Severe alpha thalassemia
   - Triple gene defect alpha thalassemia

   Excludes: alpha thalassemia trait or minor (282.46); hydrops fetalis due o isoimmunization (773.3); hydrops fetalis not due to immune hemolysis (778.0)

   - 282.44 Beta thalassemia

   - Beta thalassemia major
   - Cooley's anemia
   - Homozygous beta thalassemia
   - Severe beta thalassemia

- Thalassemia intermedia
- Thalassemia major

Excludes: beta thalassemia minor (282.46); beta thalassemia trait (282.46); delta-beta thalassemia (282.45); hemoglobin E beta thalassemia (282.47); sickle-cell beta thalassemia (282.41, 282.42)

- 282.45 Delta-beta thalassemia

- Homozygous delta-beta thalassemia
- Excludes: delta-beta thalassemia trait (282.46)

- 282.46 Thalasesmia minor

- Alpha thalassemia minor
- Alpha thalassemia trait
- Alpha thalassemia silent carrier
- Beta thalassemia minor
- Beta thalassemia trait
- Delta-beta thalassemia trait
- Thalassemia trait NOS

Excludes: alpha thalassemia (282.43); beta thalassemia (282.44); delta beta thalassemia (282.45); hemoglobin E-beta thalassemia (282.47); sickle-cell trait (282.5)

- 282.47 Hemoglobin E-beta thalassemia

Excludes: beta thalassemia (282.44); beta thalassemia minor (282.46); beta thalassemia trait (282.46); delta-beta thalassemia (282.45); delta-beta thalassemia trait (282.46); hemoglobin E disease (282.7); other hemoglobinopathies (282.7); sickle-cell beta thalassemia (282.41, 282.42)

3. In the chronic comorbid conditions under the hereditary hemolytic and sickle cell anemia category, ICD-9 code 282.49 – Other thalassemia has been revised to no longer include Cooley's anemia, Hb-Bart's disease, Microdrepanocytosis, Thalassemia (alpha) (beta) (intermedia) (major) (minima) (minor) (mixed) (trait), and Thalassemia NOS.
4. In the chronic comorbid conditions under hereditary hemolytic and sickle cell anemia category, ICD-9 code 282.49 – Other thalassemia has been revised to include Dominant thalassemia, Hemoglobin C thalassemia, Mixed thalassemia, and continues to include Thalassemia with other hemoglobinopathy.
5. In the chronic comorbid conditions under hereditary hemolytic and sickle cell anemia category, ICD-9 code 282.49 – Other thalassemia has been revised to exclude hemoglobin C disease (282.7); hemoglobin E disease (282.7); other hemoglobinopathies (282.7); sickle cell anemias (282.60-282.69); and sickle-cell beta thalassemia (282.41-282.42)

Attachment 4 of CR7064, DME ESRD Supply Healthcare Common Procedure Coding System (HCPCS) for ESRD PPS Consolidated Billing Edits, included the list of equipment and supplies that are ESRD-related but can be used in other provider settings for reasons other than for the treatment of ESRD. Attachment 5 of CR7064, DME ESRD Supply HCPCS Not Payable to DME Suppliers, included the list of the DME ESRD supply codes that are no longer separately payable to Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) suppliers. To allow DMEPOS suppliers to get paid for furnishing these services under other circumstances covered by Medicare, CR7064 provided instructions stating that DMEPOS suppliers may bill the items listed on Attachment 4 with the AY modifier to indicate that the item is used for reasons other than for the treatment of ESRD. Currently, there are equipment and supplies listed on Attachment 4 that are not used in other provider settings and would therefore never be used for reasons other than for the treatment of ESRD. Therefore, these items would not be covered by Medicare because there is no other benefit category that can provide coverage. CR7476 rescinds and replaces Attachments 4 and 5 of CR7064 as follows: Removes equipment and supply codes from Attachment 4 that are either not separately payable or not payable by Medicare and add these codes to Attachment 5. Surgical dressing code A6204 will also be included in Attachment 5.

Additional Information
The official instruction, CR7476, issued to your Medicare contractor regarding this change, may be viewed at http://www.cms.gov/Transmittals/downloads/R2255CP.pdf on the CMS website.

FORMS

ABN Form: Revised Version Mandatory Use November 1, 2011

The latest version of the Advance Beneficiary Notice of Noncoverage (ABN) (release date of 3/2011 printed in lower left hand corner) is now available for immediate use and should be accessed on the Forms page of our website. In order for suppliers to have time to transition to using the new ABN form, mandatory use of this version begins on November 1, 2011. All ABNs with the release date of 3/2008 that are issued on or after November 1, 2011, will be considered invalid if used for new DMEPOS. The form is considered by CMS to be an Office of Management and Budget (OMB) form and therefore must be replaced every three years.

GLUCOSE MONITORS

Widespread Prepayment Review for Diabetic Supplies Edit Effectiveness for 3rd Quarter

The Jurisdiction D DME MAC Medical Review Department is conducting a widespread complex review of HCPCS code A4253 (Blood glucose test or reagent strips for home blood glucose monitor, per 50 strips) and the third quarter edit effectiveness results from February 2010 through May 2011 are as follows:

The results of the review of the claims identified 6,576 claims of which 5,355 were denied. This resulted in an overall error rate of 75%. This is an increase from 73% during the second quarter of this review. However, because the error rate remains high, NAS will continue with the widespread complex review.

The following are the top reasons for denial:

- Requested documentation was not provided within the allotted time frame as referenced in the Medicare guidelines
- Physician order was invalid or missing
- Invalid or no beneficiary evidence of exhaustion
- Documentation submitted did not support testing frequency above utilization guidelines
- Claims were submitted with incorrect modifier
- Multiple suppliers billing for same beneficiary

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

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

MOBILITY DEVICES

HCPCS K0001, K0003, K0004 - Notification of Prepayment Review

NAS Jurisdiction D DME MAC Medical Review will be initiating widespread prepayment probe reviews of claims for HCPCS codes K0001 (Standard Wheelchair), K0003 (Lightweight Wheelchair), and K0004 (High Strength, Lightweight Wheelchair), along with related accessories and seating. 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 codes K0001, K0003, and K0004 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 **30 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 following Local Coverage Determinations (LCDs) and Policy Articles (PAs):

- Manual Wheelchair Bases – LCD L11454, PA A25378
- Wheelchair Options/Accessories – LCD L11462, PA A19846
- Wheelchair Seating – LCD L15670, PA A17265

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

HCPCS Code K0823 – Notification of Prepayment Review

NAS Jurisdiction D DME MAC Medical Review will be initiating a widespread prepayment review of claims for HCPCS code K0823 (Power wheelchair, group 2 standard, captain's chair, patient weight capacity up to and including 300 pounds) and related options/accessories.

Widespread reviews are used to determine the extent of potential problem areas across multiple suppliers and monitor corrective action measures implemented to reduce improper payments. 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 K0823 and related options/accessories are subject to this review. Suppliers of the selected claims will receive an *Additional Documentation Request* (ADR) letter asking for specific information to determine if the item billed complies with the existing reasonable and necessary criteria. Failure to supply the requested information within 30 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 Local Coverage Determination (LCD) (Power Mobility Devices – L23598; Wheelchair Options/Accessories – L11462) and Policy Article (Power Mobility Devices – A41127; Wheelchair Options/Accessories – A19846).

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

Power Wheelchair Rental – Frequently Asked Questions – Updated June 2011

Effective for items provided on or after January 1, 2011, standard power wheelchairs (K0813 – K0831, K0898) must be furnished on a monthly rental basis like other capped rental durable medical equipment (DME). The following are questions and answers from suppliers regarding application of the Power Mobility Devices medical policy and CMS payment policy rules to rented power wheelchairs.

Short-term use

1. When standard power wheelchairs (PWCs) are provided on a rental basis, can they be covered for short-term indications?
   Response: No. The change in the payment policy status for power wheelchair does not change the policy statement that PWCs are not covered for patients with short term, reversible conditions.

2. A short-term rental would occur if the beneficiary were to pass away in the second month of the rental period. Will a short duration in billing signal that a short-term rental has occurred and flag the claim for review?
   Response: If all the criteria are met for coverage of a PWC and the initial rental months are paid but the beneficiary dies within the first 3 months or the patient goes into a nursing home on a permanent basis during the first 3 months, that does not affect coverage of those initially paid rental months.

Change of residence

3. Is it advisable for the supplier to document in their records that they have contacted the beneficiary and confirmed that the beneficiary is able to use the PWC they are renting in their new residence?
   Response: There is no requirement for a supplier to reassess the home in the event that a beneficiary changes residence.

4. If the new residence will not accommodate the PWC the beneficiary is currently renting and a different base (same HCPCS code) is required will the supplier need to obtain a new detailed product description for the item that can be used in the home?
   Response: Medicare would not start a new-capped rental period in this situation. If the supplier elects to provide a different wheelchair base (different HCPCS code), a new signed and dated detailed product description is needed but a new face-to-face examination or 7-element order is not needed.

5. If a patient with a PWC moves and their new home will no longer accommodate the PWC that they have, will Medicare pay for a new PWC?
   Response: No. Medicare covers a replacement only if an item is lost, stolen, irreparably damaged, or reaches the 5 year reasonable useful lifetime. Medicare covers a different item only if there is a change in the beneficiary's medical condition.

Break in service

6. A PWC is being rented and the beneficiary goes into a hospital and nursing home for an extended stay. The supplier elects to pick up the wheelchair. When the beneficiary is ready to go back home, would there be a problem with providing a different model wheelchair within the same HCPCS code?
   Response: If the supplier chooses to deliver a different model of PWC within the same code, a new detailed product description must be obtained. A new face-to-face (FTF) examination or 7-element order is not needed.

7. If a patient who is renting a PWC goes into a hospital/nursing home for an extended time and the supplier picks up the wheelchair and the beneficiary is discharged to home, would a new capped rental period start and what documentation would be required?
   Response: Existing capped rental rules for beginning a new rental period apply to power wheelchairs. That policy states that a new capped-rental period will begin only if there has been a break in medical necessity of at least 60 days plus the days remaining in the last paid rental month. In the situation that is described, "medical necessity" would continue while the patient was in a facility. If the patient is receiving the same type of PWC (same code) on discharge that they previously had, then the rental period resumes where it left off and no additional documentation is needed (other than a new detailed product description if the make/model of the wheelchair has changed). If the patient needs a different type of PWC on discharge because of a change in their medical condition, all the requirements for a new PWC must be met (i.e., FTF exam, 7-element order, etc.).

8. If the beneficiary is renting a PWC coded K0823 prior to entering the hospital, would a new rental episode begin if, while in the hospital, they develop a Stage II decubitus ulcer over the sacrum and upon discharge require a PWC coded K0822 and a skin protection cushion, E2603?
   Response: Yes. However, following standard rules, since it is a different item, there would have to be a new face-to-face-examination (which documents the medical necessity for the new item), 7-element order, detailed product description, home assessment, etc.

Repair / Replacement

9. If, during a capped rental period, a PWC is lost, stolen, or irreparably damaged and a new PWC is provided, does a new CR period start?
   Response: Yes. Replacement of power wheelchairs will follow the same rules as any other rented DME item.

10. Medicare provides for the replacement of lost, stolen, or irreparably damaged items but we are concerned as to how this fits with Supplier Standard # (14), which states: "Must maintain and replace at no charge or repair directly, or through a service contract with another company, Medicare-covered items it has rented to beneficiaries. The item must function as required and intended after being repaired or replaced." Can you please clarify, as this is a significant concern for providers and beneficiaries?
Response: The Supplier Standards address situations related to non-function or damage of an item that can be repaired or to replacement of an item due to wear and tear. Lost, stolen, or irreparably damaged items are a different category.

    The Medicare Benefit Policy Manual, Chapter 15, Section 110.2(A) states:

    "Since renters of equipment recover from the rental charge the expenses they incur in maintaining in working order the equipment they rent out, separately itemized charges for repair of rented equipment are not covered. This includes items in the frequent and substantial servicing, oxygen equipment, capped rental and inexpensive or routinely purchased payment categories which are being rented."

    "Irreparable wear refers to deterioration sustained from day-to-day usage over time and a specific event cannot be identified. Replacement of equipment due to irreparable wear takes into consideration the reasonable useful lifetime of the equipment." (This means that replacement due to wear and tear is possible only after the 5-year reasonable useful lifetime.)

    The Medicare Benefit Policy Manual, Chapter 15, Section 110.2(C) defines payment policy for items that are lost or that have been irreparably damaged by an acute incident:

    "Equipment which the beneficiary owns or is a capped rental item may be replaced in cases of loss or irreparable damage. Irreparable damage refers to a specific accident or to a natural disaster (e.g., fire, flood)."

11. Is there any situation in which a supplier can be paid for repair to a PWC during a capped period – e.g., if the supplier has information to indicate that the repair is required due to "malicious damage" or "culpable neglect" by the beneficiary?
Response: There can be no payment for the repair of rented items under any circumstances. Reimbursement for repairs is included in the rental payments.

    If the supplier believes that a wheelchair repair is required because of malicious damage or culpable neglect by the beneficiary, the supplier can present the information to the DME MAC for investigation. If the DME MAC, in consultation with the CMS, agrees that the beneficiary is responsible for the damage, the supplier can charge the beneficiary.

12. How does a supplier alert the DME MAC that they believe the PWC requires a repair secondary to malicious damage or culpable neglect?
Response: The supplier can contact the provider customer service department. That staff will forward the information to the appropriate DME MAC staff.

13. Who is responsible for determining when a beneficiary is responsible for the damage and how will this be communicated?
Response: As discussed in a previous question, the DME MAC will consult with CMS to make that determination. Since these are very rare situations, there is no established procedure. They will be handled on an individual basis.

14. Unique to power wheelchairs is the fact that beneficiaries often use the products outside the home as well as inside. This is generally not done with other capped rental items (e.g., hospital beds never leave the home). If a PWC is damaged outside the home, since that is not an approved use per Medicare, will the supplier be expected to repair the chair "at no charge" during the rental period?
Response: Yes, the supplier is responsible for the repair. Statutory coverage of DME requires that it be needed for use inside the home. However, if that requirement is met, the item may be used outside the home. Portable oxygen, nebulizers, walkers, canes, crutches, POVs, manual and power wheelchairs are among the many item, both rental and purchase, that are routinely used outside of the home setting. During the rental period, the supplier is expected to repair an item if the repair was related to damage that occurred either inside or outside the home. For purchased and rental items where the title has transferred, repairs are covered under the general repair rules.

15. How would a supplier prove the damage occurred outside the home (unless it is obvious, like sand/mud/water in the motor?
Response: Use of a DME item outside of the home is not deemed evidence of deliberate malicious damage or culpable neglect.

16. If the beneficiary has a power chair under rental and the power chair has a service/repair issue, is it permissible to provide the beneficiary with a loaner manual wheelchair while the power wheelchair is being repaired or is the supplier required to replace the power wheelchair?
    Response: The supplier is required to provide a loaner item that meets the beneficiary's medical need.
17. While their rental power wheelchair is being repaired, does monthly billing for the power wheelchair continue?
    Response: Yes, monthly billing for the power wheelchair would continue. There should be no separate billing and/or payment for the loaner wheelchair during the 13 month capped rental period.
18. If a replacement power wheelchair of the same HCPCS code is provided, but it is a different manufacturer, make or model than the power wheelchair listed on the detailed product description (DPD) is a new DPD required for billing the months following the replacement.
    Response: Replacement of a PMD at the end of the 5 yr. useful lifetime requires a complete reassessment following the same rules as if a new initial PMD was being provided.

Miscellaneous

19. If the beneficiary weighs 478 pounds and is renting a heavy-duty PWC coded K0827 prior to a hospitalization and/or SNF stay has a significant weight loss taking them below the 300 pounds limit for standard power wheelchairs, would a new rental episode begin upon return to home, for a standard PWC coded K0825?
    Response: No. If the patient loses weight, the original wheelchair would still meet the patient's needs. If the supplier elects to provide a lower weight capacity PWC, a new capped-rental period would not begin.
20. How will the "look back" period affect the review of PWCs?
    Response: There is a general policy that coverage of items that are provided on an ongoing basis, including rented DME, is dependent on there being continued need for the item and continued use by the beneficiary. CMS and the DME MACs have not published any information regarding the look back period.
21. Will elevating leg rests (already a mandatory capped rental item) be paid at 15% in months 1–3 and 6% in months 4–13 or will they remain at a payment rate of 10% in months 1–3 and 7.5% in months 4–13?
    Response: Payment policy for accessories is not changing.
22. If payment for separately billable items at initial issue will be at the front loaded rate how will these items be distinguished as receiving a different payment methodology from the same items (other than batteries) on a MWC?
    Response: Payment policy for accessories is not changing.
23. Will a "patient requested upgrade" from a Group 2 power wheelchair (K0822 – K0831) to a Group 3 power wheelchair base (K0848 – K0855) retain the option to purchase the chair in the first month?
    Response: No, the application of upgrade provisions does not change the payment rules for any item.
24. Do PMD documentation requirements differ in any way since the elimination of the first month purchase option for beneficiaries living in a zip-coded area outside of a competitive bid area (CBA)?
    Response: The documentation requirements do not differ based upon whether the Power Mobility Device is paid as a rental in a non-CBA or as a purchase in a CBA.
25. Must supplier records document ongoing use of the power mobility device by the beneficiary during the 13-month rental or is a physician order indicating Lifetime Use sufficient?
    Response: For power mobility devices that are provided under the rent to purchase guidelines over 13 months, it is expected that the supplier records will substantiate the beneficiary's ongoing use of the PMD for the period for which claims are submitted.
26. Is there a requirement mandating that contact with the beneficiary must be made at certain intervals to determine if a PMD meets the ongoing use requirement?
    Response: If a beneficiary discontinues use of a rental DME item, the supplier may not continue to bill Medicare for that item. Although Medicare does not have specific guidelines on how a supplier should monitor and document use, each claim submitted may be subject to review. Supplier records must clearly demonstrate ongoing monitoring and use of the rental item by the beneficiary if audited.
27. If a physician's order documents lifetime medical necessity for a PMD, must the physician's medical record indicate that the patient has been seen during the 13-month period and document that ongoing medical necessity is met?
    Response: The PMD policy does not mandate that the treating physician must formally monitor and/or recertify these devices on a scheduled basis. However, each claim may be subject to review to determine whether payment continues to be justified. Thus, some evidence must be present in the medical record demonstrating that the initial qualifying medical condition(s) continues to be present and that the need for the item continues. This may be noted intermittently throughout the course of the rental cycle.

ORAL APPLIANCES

E0486 – Custom Fabricated Oral Appliance for OSA – Coding and Utilization Guidelines

Code E0486 describes a custom fabricated oral appliance used for the treatment of obstructive sleep apnea.

E0486 - ORAL DEVICE/APPLIANCE USED TO REDUCE UPPER AIRWAY COLLAPSIBILITY, ADJUSTABLE OR NON-ADJUSTABLE, CUSTOM FABRICATED, INCLUDES FITTING AND ADJUSTMENT

Effective for claims submitted on or after September 1, 2011, the only products that may be billed using code E0486 are those that have undergone Coding Verification Review by the Pricing, Data Analysis and Coding (PDAC) Contractor and that are listed in the DMECS Product Classification List on the PDAC website.

Questions concerning the coding of these products should be referred to the PDAC. For additional information about coverage, refer to the Oral Appliances for the Treatment of Obstructive Sleep Apnea LCD and policy Article.

OXYGEN

Widespread Prepayment Review for Oxygen and Oxygen Equipment Edit Effectiveness for 4th Quarter

The Jurisdiction D DME MAC Medical Review Department is conducting a widespread complex review of HCPCS codes E1390 and E0431 and the fourth quarter edit effectiveness results from February 2010 through May 2011 are as follows:

The results of the review of the claims 2,451 identified claims of which 1,746 were denied. This resulted in an overall error rate of 50%. This is a decrease from previous quarters 54% during the first quarter, 67% in the second quarter and 66% in the 3rd quarter of this review. However, because the error rate remains high, NAS will continue with the widespread complex review.

The following are the top five reasons for denial:

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

B. No office visit notes to determine medical necessity within 30 days of certification or 90 days within recertification were submitted

C. No/invalid qualifying blood gas study submitted

D. No documentation to support diagnosis

E. No documentation to support alternative treatment has been tried/considered

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. 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.

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

Group I criteria include any of the following:

1. An arterial PO 2 at or below 55 mm Hg or an arterial oxygen saturation at or below 88 percent taken at rest (awake), or

2. An arterial PO 2 at or below 55 mm Hg, or an arterial oxygen saturation at or below 88 percent, for at least 5 minutes taken during sleep for a patient who demonstrates an arterial PO 2 at or above 56 mm Hg or an arterial oxygen saturation at or above 89 percent while awake, or
3. A decrease in arterial PO 2more than 10 mm Hg, or a decrease in arterial oxygen saturation more than 5 percent, for at least 5 minutes taken during sleep associated with symptoms (e.g., impairment of cognitive processes and [nocturnal restlessness or insomnia]) or signs (e.g., cor pulmonale, "P" pulmonale on EKG, documented pulmonary hypertension and erythrocytosis) reasonably attributable to hypoxemia, or
4. An arterial PO 2 at or below 55 mm Hg or an arterial oxygen saturation at or below 88 percent, taken during exercise for a patient who demonstrates an arterial PO 2 at or above 56 mm Hg or an arterial oxygen saturation at or above 89 percent during the day while at rest. In this case, oxygen is provided for during exercise if it is documented that the use of oxygen improves the hypoxemia that was demonstrated during exercise when the patient was breathing room air.

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

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

Group III includes patients with arterial PO 2 levels at or above 60 mm Hg or arterial blood oxygen saturations at or above 90 percent. For these patients there is a rebuttable presumption of noncoverage.

As a reminder, the Local Coverage Determination (LCD) for Oxygen and Oxygen Equipment (L11457) states in part:

Home oxygen therapy is covered only if all of the following conditions are met:

1. The treating physician has determined that the patient has a severe lung disease or hypoxia-related symptoms that might be expected to improve with oxygen therapy, and
2. The patient's blood gas study meets the criteria, and
3. The qualifying blood gas study was performed by a physician or by a qualified provider or supplier of laboratory services, and
4. The qualifying blood gas study was obtained under the following conditions:
   - If the qualifying blood gas study is performed during an inpatient hospital stay, the reported test must be the one obtained closest to, but no earlier than 2 days prior to the hospital discharge date, or
   - If the qualifying blood gas study is not performed during an inpatient hospital stay, the reported test must be performed while the patient is in a chronic stable state – i.e., not during a period of acute illness or an exacerbation of their underlying disease, and
5. Alternative treatment measures have been tried or considered and deemed clinically ineffective.

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

Oxygen and Oxygen Equipment ACT Questions and Answers – June 14, 2011

The information provided in this document is correct at the time of publishing.

Prior to taking questions, NAS provided the following updates:

Email Listserv
NAS encourage everyone to have Medicare DME information delivered to you in a timely, categorized, summarized, convenient format by signing up for our DME Email Listserv. Benefits of becoming a subscriber include having the latest information from NAS and CMS delivered to you each Tuesday and Friday. This is a great way to keep current with Medicare regulations, workshop and educational events, Medical policy updates, and payment/ reimbursement updates.

Go to our NAS DME website and click on "E-mail Newsletter Sign Up" on the left side of the page to subscribe.

Endeavor
Suppliers are encouraged to register for Endeavor which offers free, online access to patient eligibility, claim status, and remittance advices. The hours of availability include:

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

Suppliers, billers and third parties may register for Endeavor.

Each person accessing Endeavor must register for their own User ID. User IDs cannot be used by more than one person.

To register, go to the Claims page of our website. Many suppliers are already taking advantage of this tool and we highly encourage you all to do so as well!

Questions received prior to the call:

Q1. Please explain the documentation requirements for portable oxygen coverage. Per the Local Coverage Determination (LCD) "a home portable oxygen system is covered if the patient is mobile within the home". Please give an example of documentation charted in the patient's medical record that would justify Medicare coverage for portable oxygen.
A1. Chart notes must indicate the patient is mobile within the home. In addition to the coverage criteria for portable oxygen, they must meet the basic criteria for home oxygen (criteria 1-5) as well.

Q2. Per the oxygen policy article "Suppliers must provide whatever quantity of oxygen contents are needed for a patient's activities both inside and outside the home". If the patient only uses portable oxygen outside of the home and stationary oxygen system adequately meets the patient's in home need for oxygen is portable oxygen covered? If yes, please give an example of documentation charted in the patient's medical record that would justify Medicare coverage for the portable oxygen.
A2. Yes, to qualify for portable oxygen prescribed by the treating physician the LCD states:

"A portable oxygen system is covered if the patient is mobile within the home and the qualifying blood gas study was performed while at rest (awake) or during exercise. If the only qualifying blood gas study was performed during sleep, portable oxygen will be denied as not reasonable and necessary. Chart notes should indicate patient is mobile."

Q3. Question #49 from the last Ask the Contractor Teleconference (ACT) states "What tests need to be performed in order to qualify a patient for home oxygen?". The answer was "The patient must have a qualifying blood gas study which includes both an oximetry test and an arterial blood gas test." Is this correct? Please clarify.
A3. The referenced question is indicating that both an arterial blood gas (ABG) and oximetry are considered a blood gas study. However, only one or the other is required. The LCD also states: When both the ABG and oximetry tests have been performed on the same day under the same conditions, the ABG result will be used to determine if the coverage criteria were met.

Q4. Please explain how a patient in a skilled nursing facility (SNF) that requires oxygen therapy on discharge can be tested for Medicare coverage of home oxygen. If the SNF does not have a lab or a physician available can the oximetry testing be done by a nurse at the SNF and signed off by the physician?
A4. The laboratory evidence in the National Coverage Determination (NCD) states that an arterial blood gas is the usual method, but also allows for oxygen saturation under the following conditions:

"A measurement of arterial oxygen saturation obtained by ear or pulse oximetry, however, is also acceptable when ordered and evaluated by the attending physician and performed under his or her supervision **OR** when performed by a qualified provider or supplier of laboratory services."

Q5. We have sent in several redetermination requests on several different oxygen patients. We include clear instructions on the redetermination requests with all appropriate paperwork attached, such as Certificate of Medical Necessity (CMN), delivery tickets, and physician orders. We then get denial letters and find out when we call in to customer service that the CMNs we had requested be loaded and updated haven't been and we are told that we can appeal. We are very disheartened after all our hard work in doing the redeterminations that we now have to appeal again. This doesn't seem fair as it was your error for not loading the CMNs in the first place! Why does this keep happening to us?
A5. Claim examples were requested and various CMN issues were identified. If CMN guidelines are not followed it can result in claim denials. Refer to the LCD or Chapter 4 of the NAS Supplier Manual.

Q6. We have some divided opinions on what constitutes 'exercise' for the purpose of oxygen testing. I have some record review staff here who believe the word implies 'formal exercise' – such as being on a stair stepper, a treadmill, doing aerobics and similar activities. My take is that 'exercise' is a less than optimal choice of words, and the distinction is more a question of 'at rest' versus 'not at rest'. In that context, walking around the office, climbing the stairs, engaging in activities of daily living (ADL) would all be considered 'during exercise'. Can you comment/provide direction?
A6. In general, a patient is considered at rest when sitting or lying down while awake. Any activity other than rest would be considered "exercise" as each patient tolerates activity levels differently.

Q7. Does the initial 36 month rental period accumulate or include months that a supplier did not request or receive payment?
A7. No. The policy allows for 36 paid months.

Q8. Question 2 on the oxygen CMN asks if the testing was done with the patient in a chronic stable state as an outpatient or within two days prior to discharge from an inpatient facility to home. In this question is an inpatient facility only referring to a hospital or can it also be referring to a SNF?
A8. Yes it can refer to a SNF

Q9. We just need some clarification on the new five year rule with portability. If a patient has an oxygen concentrator for a year and then adds portability; when the 36 month cap hits for the concentrator, does payment for both stop now? Or is the portability still billed until it reaches its 36 month cap and then they both start over when the concentrator hit its five year rule?
A9. Correct, you can still bill for all 36 months on the portable system. The reasonable useful lifetime (RUL) for the portable will start over when the concentrator reaches five years.

Q10. Can you provide more guidance as to what is considered "compliantly using a properly fitted and titrated positive airway pressure (PAP) device" A DME company recently advised us that they would require 30 days documentation. If a patient continues to be hypoxemic after becoming compliant on PAP therapy within a shorter time frame (ex: seven days), are they eligible to undergo qualifying nocturnal oximetry assessment and initiation of supplemental oxygen therapy in addition to their PAP therapy if indicated? Would this fall under #5 in LCD11457 which states "alternative treatment measures have been tried or considered and deemed clinically ineffective"?
A10. The PAP supplier is using the 30 days of documentation based on the PAP LCD which states: Adherence to therapy is defined as use of PAP = 4 hours per night on 70% of nights during a consecutive thirty (30) day period anytime during the first three (3) months of initial usage. Medicare wouldn't consider 7 days of usage as compliantly using the PAP to treat the obstructive sleep apnea (OSA). There would need to be documentation of at least 21 consecutive days or 21 total days in 30 days to meet the 70% in 30 days requirement.

Q11. If a patient is chronically not being treated for OSA because of intolerance to therapy options or other issues, wouldn't they be in a chronic stable state? Does this mean that a person who undergoes evaluation for oxygen therapy in a hospital, for example, would be denied coverage based on their chronically untreated OSA?
A11. The NCD describes chronic stable state as "…not during a period of an acute illness or an exacerbation of their underlying disease." Based on this NCD definition, all other hypoxia-inducing co-existing diseases or conditions must be addressed before oxygen therapy is considered. In the case of OSA, it is expected that the OSA be appropriately treated such that the patient is in the chronic stable state before oxygen saturation results are considered qualifying for oxygen therapy. For patients who are unable to tolerate PAP therapy, the documentation must demonstrate that all measures to encourage compliance with PAP have been considered (e.g., mask changes, consideration of bi-level use, nasal decongestants, etc) and/or consideration of other accepted treatments for OSA (e.g. weight loss, lifestyle changes, smoking cessation, surgical intervention, oral appliances, etc).

Q12. Why do you consider OSA not a chronic stable state? The patient has tried and failed to be able to tolerate PAP therapy. They still are desaturating and need supplemental oxygen. OSA does not go away, it is a chronic condition. What would you advise for therapy for this patient to correct the oxygen desaturation if PAP therapy is not working?
A12. Untreated OSA is not considered a chronic stable state because there is an exacerbation of their underlying disease. Prior to initiating home oxygen therapy the beneficiary must received a face-to-face evaluation with their treating physician. That examination must include all considerations and indications listed in the previous answered questions #11.

Questions taken during the call:

Q13. If someone only requires portable oxygen outside of the home and they're fine inside of the home with their concentrator, is portable still covered by Medicare?
A13. As long as the patient meets the coverage criteria, are mobile within the home, the required testing is not taken during sleep, and the physician is ordering portable oxygen for the beneficiary's use, it is covered, yes.

Q14. What exactly needs to be in the notes for the reevaluation for recertification?
A14. The re-evaluation with the beneficiary's treating physician should be documented like any other evaluation within the patient's medical records. The re-evaluation should specifically address the beneficiary's home oxygen therapy needs and results, and must be conducted within 90 days of the recertification date.

Q15. In a sleep lab a patient de-saturated while awake. The sleep lab reported that during sleep the patients OSA improved with continuous positive airway pressure (CPAP) therapy, but that there was something else wrong with this patient to cause the de-sat while awake. The sleep lab interpreting physician ordered oxygen and then referred the patient to a pulmonologist. Is the test taken at the sleep lab, while awake, sufficient to meet the oxygen policy testing criteria? The patient does have a history of congestive heart failure and chronic obstructive pulmonary disease (COPD).
A15. The test taken during rest may be allowed, but the patient would still be required to have a treating physician evaluation within 30 days prior to dispensing the oxygen that clearly documents the need for oxygen based on other conditions such as the congestive heart failure and COPD.

Q16. If a patient has an oximetry test taken in the nursing home can the physician just review the test and agree with it?
A16. Oximetry testing must be taken by the physician or under his supervision.

Q17. One of our patients have a concentrator that will reach the five year RUL very shortly but the portable system still has three months left until the 36 months are paid. Do we wait until the portable system reaches 36 months to start a new five years RUL on the concentrator?
A17. No. The RUL is based on the stationary system. So in this case the RUL for the portable equipment is shortened and both the portable and stationary system can be replaced when the RUL for the stationary system is met. When the stationary and the portable oxygen equipment are replaced, a new 36-month rental period and new RUL is started for both the replacement stationary oxygen equipment and the replacement portable oxygen equipment.

Q18. Who is allowed to do the oximetry test during an inpatient stay? Is a nurse, physical therapist or respiratory therapist allowed to conduct the oximetry?
A18. The oximetry test must be ordered and evaluated by the attending physician and performed under his or her supervision. The level of supervision based on inpatient or outpatient Medicare regulations for diagnostic testing must be followed, which is outside the scope of the DME MAC.

PECOS

Reminder: No Date Set for Expanded Ordering/Referring Provider Claim Edits

The Centers for Medicare & Medicaid Services (CMS) has not yet determined when it will begin to apply the expanded edit for ordering/referring provider claims. These edits are applicable to ordering/referring providers that do not have a record in the Provider Enrollment, Chain, and Ownership System (PECOS). As previously stated, CMS will give providers ample notice before the ordering/referring provider claim edit is applied.

For information on the requirements for billing for ordering/referred services, review the Medicare Learning Network's "Medicare Enrollment Guidelines for Ordering/Referring Providers" fact sheet at http://www.CMS.gov/MLNProducts/downloads/MedEnroll_OrderReferProv_FactSheet_ICN906223.pdf.

PROSTHETICS & ORTHOTICS

Correct Coding - L0174 Coding Review

HCPCS code L0174 (CERVICAL, COLLAR, SEMI-RIGID, THERMOPLASTIC FOAM, TWO PIECE WITH THORACIC EXTENTION) describes a cervical collar that is constructed of thermoplastic foam. It is a two piece system with posterior and anterior thoracic extensions. The thoracic extension must overlap the manubrium sternum anteriorly and to the thoracic vertebra T-1 posteriorly.

Products currently coded with L0174 which are listed on DMECS will be end dated as of August 31, 2011. A new coding application will need to be submitted for any product requesting this code. When the products are coded by the PDAC, those meeting the code specifications will be listed in the Product Classification Matrix on DMECS. Only those products listed may be billed using code L0174.

The PDAC coding verification application required for these products is the Orthotics application. This application is located on the PDAC website, https://www.dmepdac.com/review/apps_check.html.

For questions about correct coding, contact the PDAC Contact Center at (877) 735-1326 during the hours of 8:30 a.m. to 4 p.m. CT, Monday through Friday, or e-mail the PDAC by completing the DME PDAC Contact Form located on the PDAC website: https://www.dmepdac.com.

Reprocessing of Customized Prosthetic Devices

Part-B payment can be made for items of Prosthetics, Orthotics, and Supplies (POS) when they are furnished to a beneficiary who is in a non-covered Part-A stay at a hospital or Skilled Nursing Facility (SNF). If these items are furnished to beneficiaries residing in a covered Part-A hospital or SNF stay, under Inpatient Prospective Payment System or SNF Consolidated Billing (CB) payment rules, the items would be bundled into the global Part-A payment for the covered stay itself. An exception to this policy is when certain customized prosthetic devices are furnished to beneficiaries residing in a covered Part-A SNF stay as these items were carved out of the SNF CB provision by the Balanced Budget Refinement Act of 1999 (BBRA, PL 106-113, Appendix F, Section 103).

Since Monday, April 4, our claims processing system has been erroneously denying claims for certain custom prosthetic devices.

CMS is issuing instructions to correct this processing error but the correction will not be implemented until Sunday, January 1, 2012. In the interim, the Durable Medical Equipment Medicare Administrative Contractors (DME MACs) will reprocess any claims for custom prosthetic devices (identified by the "L" series of HCPCS codes) that were inappropriately denied when such claims are brought to their attention.

RECOVERY AUDIT CONTRACTOR

Recovery Audit Program: MAC-issued Demand Letters

MLN Matters® Number: MM7436
Related Change Request (CR) #: 7436
Related CR Release Date: July 29, 2011
Related CR Transmittal #: R192FM
Effective Date: January 1, 2012
Implementation Date: January 3, 2012

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

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

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

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

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

Additional Information
To see the official instruction (CR7436) issued to your Medicare contractor, see http://www.cms.gov/Transmittals/downloads/R192FM.pdf on the CMS website.

REFILLS

Items Provided on a Recurring Basis and Request for Refill Requirements

For all DMEPOS items that are provided on a recurring basis, suppliers are required to have contact with the beneficiary or caregiver/designee prior to dispensing a new supply of items. CMS has revised the requirements for refills effective for dates of service on or after August 2, 2011.

Requirements
For all DMEPOS items and supplies provided on a recurring basis, billing must be based on prospective, not retrospective use.

For DMEPOS products that are supplied as refills to the original order, suppliers must contact the beneficiary prior to dispensing the refill and not automatically ship on a pre-determined basis, even if authorized by the beneficiary. This shall be done to ensure that the refilled item remains reasonable and necessary, existing supplies are approaching exhaustion, and to confirm any changes/modifications to the order. Contact with the beneficiary or designee regarding refills must take place no sooner than 14 calendar days prior to the delivery/shipping date. For delivery of refills, the supplier must deliver the DMEPOS product no sooner than 10 calendar days prior to the end of usage for the current product. This is regardless of which delivery method is utilized.

REFILLS CONT'D

For all DMEPOS items that are provided on a recurring basis, suppliers are required to have contact with the beneficiary or caregiver/designee prior to dispensing a new supply of items. Suppliers must not deliver refills without a refill request from a beneficiary. Items delivered without a valid, documented refill request will be denied as not reasonable and necessary.

Suppliers must not dispense a quantity of supplies exceeding a beneficiary's expected utilization. Suppliers must stay attuned to changed or atypical utilization patterns on the part of their clients. Suppliers must verify with the ordering physicians that any changed or atypical utilization is warranted. Regardless of utilization, a supplier must not dispense more than a one- or three-month quantity at a time. See below for billing frequencies.

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

- There is a change of supplier
- There is a change in treating physician
- 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

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

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

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

This information must be kept on file and be available upon request.

Billing Frequencies
For refills of surgical dressings, enteral and parenteral nutrients and supplies, immunosuppressive drugs, oral anti-cancer drugs, intravenous immune globulin, external infusion pump drugs and supplies, and oral antiemetic drugs, only a one-month quantity of supplies may be dispensed.

For all other refills that are provided on a recurring basis, including but not limited to DME accessories or supplies, nebulizer drugs, urological and ostomy supplies, suppliers may dispense no more than a three-month supply at any one time.

Miscellaneous
The Local Coverage Determinations affected by these requirements will be updated in a future revision. The following policies are subject to these requirements:

- Automatic External Defibrillators
- Enteral Nutrition
- External Infusion Pumps
- Glucose Monitors
- Immunosuppressive Drugs
- Intravenous Immune Globulin
- Nebulizers
- Negative Pressure Wound Therapy

REFILLS CONT'D

- Oral Anticancer Drugs
- Oral Antiemetic Drugs
- Ostomy Supplies
- Oxygen (for billable contents)
- Parenteral Nutrition
- Positive Airway Pressure Devices
- Respiratory Assist Devices
- Suction Pumps
- Surgical Dressings
- Tracheostomy Supplies
- Transcutaneous Electrical Nerve Stimulator (TENS)
- Urologic Supplies

These requirements are not limited to DMEPOS refills for items addressed in LCDs only. All DMEPOS items that are refilled on a recurring basis are subject to these requirements.

This article replaces the articles "Request for Refill – Documentation Requirements," published in September 2010 and "Dispensing DMEPOS Items: Quantity Limits" published in June 2007.

For additional information, refer to CMS' Program Integrity Manual, Internet-Only Manual, and CMS Pub. 100-8, Chapter 5, Section 5.2.5 and 5.2.6, the applicable Local Coverage Determination and the Supplier Manual.

REFUNDS/OVERPAYMENTS

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.

July Quarterly Update for 2011 DMEPOS Fee Schedule

MLN Matters® Number: MM7416
Related Change Request (CR) #: 7416
Related CR Release Date: June 3, 2011
Related CR Transmittal #: R2236CP
Effective Date: January 1, 2011, for fee schedule amounts for codes effective on that date; otherwise July 1, 2011
Implementation Date: July 5, 2011

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

Provider Action Needed
This article is based on Change Request (CR) 7416 and alerts providers that the Centers for Medicare & Medicaid Services (CMS) issued instructions updating the DMEPOS fee schedule payment amounts. Be sure your billing staffs are aware of these changes.

Background
The DMEPOS fee schedules are updated on a quarterly basis, when necessary, in order to implement fee schedule amounts for new codes and to revise any fee schedule amounts for existing codes that were calculated in error. The quarterly update process for the DMEPOS fee schedule is documented in the "Medicare Claims Processing Manual," Chapter 23, Section 60 at https://www.cms.gov/manuals/downloads/clm104c23.pdf on CMS website.

Key Points of CR7416
Fees Added
The July Quarterly Update for the 2011 DMEPOS Fee Schedule Part B files established fee schedule amounts for Healthcare Common Procedure Coding System (HCPCS) codes A7020, E1831, and L5961, effective for claims with dates of service on or after January 1, 2011.

Note: Claims for codes A7020, E1831, and L5961 with dates of service on or after January 1, 2011, that were previously processed may be adjusted to reflect the newly established fees if you bring those claims to your contractor's attention.

Temporary "K" Codes
The following new K codes will be added to contractor's system effective for dates of service July 1, 2011:

- K0743 – SUCTION PUMP, HOME MODEL, PORTABLE, FOR USE ON WOUNDS
- K0744 – ABSORPTIVE WOUND DRESSING FOR USE WITH SUCTION PUMP, HOME MODEL, PORTABLE, PAD SIZE 16 SQUARE INCHES OR LESS
- K0745 – ABSORPTIVE WOUND DRESSING FOR USE WITH SUCTION PUMP, HOME MODEL, PORTABLE, PAD SIZE MORE THAN 16 SQUARE INCHES BUT LESS THAN OR EQUAL TO 48 SQUARE INCHES
- K0746 – ABSORPTIVE WOUND DRESSING FOR USE WITH SUCTION PUMP, HOME MODEL, PORTABLE, PAD SIZE GREATER THAN 48 SQUARE INCHES

Note: The addition of these codes does not imply any health insurance coverage. Medicare contractors will follow their normal processes in determining whether sufficient evidence exists to determine if these items are reasonable and necessary and covered under Medicare.

Code Updates

- HCPCS code E0571 (AEROSOL COMPRESSOR, BATTERY POWERED, FOR USE WITH SMALL VOLUME NEBULIZER) will be made invalid for Medicare claims, effective July 1, 2011.
- The payment category for HCPCS code A4619 (FACE TENT) is being revised as part of this quarterly update to move this nebulizer accessory from the DME payment category for oxygen and oxygen equipment to the DME payment category for inexpensive or other routinely purchased items, effective July 1, 2011. The DMEPOS fee schedule file will be updated to reflect this change.

Payment for Oxygen Contents

Payment for both oxygen contents used with stationary oxygen equipment and oxygen contents used with portable oxygen equipment is included in the monthly payments for oxygen and oxygen equipment (stationary oxygen equipment payment) made for codes E0424, E0439, E1390, or E1391. After the 36-month rental payment period (cap), separate payment may be made for oxygen contents for the remainder of the equipment's reasonable useful lifetime. However, separate payment for oxygen contents ends when replacement stationary oxygen equipment is furnished causing a new 36-month rental payment period to begin. Also, separate oxygen contents payment is allowable for beneficiary-owned stationary or portable gaseous or liquid oxygen equipment. Beginning with dates of service on or after the end date of service for the month representing the 36th payment for the stationary oxygen equipment (codes E0424, E0439, E1390 or E1391), a supplier may bill on a monthly basis for furnishing oxygen contents (stationary and/or portable), but only in accordance with the following chart:

Oxygen Equipment Furnished in Month 36	Monthly Contents Payment after the Stationary Cap
Oxygen Concentrator (E1390, E1391, or E1392)	None
Portable Gaseous or Liquid Transfilling Equipment (K0738 or E0433)	None
E0424 Stationary Gaseous System	E0441 Stationary Gaseous Contents
E0439 Stationary Liquid System	E0442 Stationary Liquid Contents
E0431 Portable Gaseous System	E0443 Portable Gaseous Contents
E0434 Portable Liquid System	E0444 Portable Liquid Contents

If the beneficiary began using portable gaseous or liquid oxygen equipment (E0431 or E0434) more than one month after they began using stationary oxygen equipment, monthly payments for portable gaseous or liquid oxygen contents (E0433 or E0444) may begin following the stationary oxygen equipment payment cap AND before the end of the portable equipment cap (E0431 or E0434). As long as the beneficiary is using covered gaseous or liquid portable oxygen equipment, payments for portable oxygen contents may begin following the stationary oxygen equipment payment cap. This will result in a period during which monthly payments for E0431 and E0443, in the case of a beneficiary using portable gaseous oxygen equipment, or E0434 and E0444, in the case of a beneficiary using portable liquid oxygen equipment, overlap. In these situations, after the 36-month portable equipment cap for E0431 or E0434 is reached, monthly payments for portable oxygen contents (E0443 or E0444) would continue.

If the beneficiary began using portable gaseous or liquid oxygen equipment (E0431 or E0434) following the 36-month stationary oxygen equipment payment period, payments may be made for both the portable equipment (E0431 or E0434) and portable contents (E0443 or E0444).

In all cases, separate payment for oxygen contents (stationary or portable) would end in the event that a beneficiary receives new stationary oxygen equipment and a new 36-month stationary oxygen equipment payment period begins (i.e., in situations where stationary oxygen equipment is replaced because the equipment has been in continuous use by the patient for the equipment's reasonable useful lifetime or is lost, stolen, or irreparable damaged). **Under no circumstances would monthly payment be made for both stationary oxygen equipment and either stationary or portable oxygen contents.**

Proof-of-Delivery Requirements for Oxygen Contents

Following the oxygen equipment payment cap, oxygen content billing should be made on the anniversary date of the oxygen equipment billing.

At all times, the supplier is responsible for ensuring that the beneficiary has a sufficient quantity of oxygen contents and is never in danger of running out of contents. A maximum of 3 months of oxygen contents can be delivered to the beneficiary at one time and billed on a monthly basis. In these situations, the delivery date of the oxygen contents does not have to equal the date of service (anniversary date) on the claim, but in order to bill for contents for a specific month (i.e. the second or third month in the three month period), the supplier must have delivered quantities of oxygen that are sufficient to last for one month following the date of service on the claim. Suppliers should have proof-of-delivery for each actual delivery of oxygen, which may be less than monthly within the three month period. If the supplier delivers more than one month of oxygen contents at a time (2 to 3), the supplier is not entitled to payment for additional months 2 and 3 if medical need ceases before the date when the supplier would be entitled to bill for those months.

Payment for Replacement of Equipment After Repairs
Under the regulations at 42 CFR 414.210(e)(4), a supplier that transfers title to a capped rental DME item to the beneficiary is responsible for furnishing replacement equipment at no cost to the beneficiary or to the Medicare program if it is determined that the item will not last until the end of its 5 year reasonable useful lifetime. In making this determination, Medicare contractors may consider whether the accumulated costs of repairing the item exceed 60 percent of the purchase fee schedule amount for the item.

Furthermore, 42 CFR 424.57(14) requires a DMEPOS supplier to maintain or replace a Medicare-covered item it has rented to beneficiaries to its intended status after being repaired. Recent cases have arisen whereupon after multiple repairs, the item continues to malfunction. CR7416 instructs your Medicare contractor to be aware of and educate suppliers of these regulatory requirements to replace DME items for which repairs have not restored the item. Also, after receipt of multiple repair claims, contractors will investigate suspicious claims for replacement equipment billed with its HCPCS code and the RA modifier.

Additional Information
The official instruction associated with this CR7416 issued to your Medicare Carrier, FI, DME MAC, RHHI or A/B MAC regarding this change may be viewed at http://www.cms.gov/Transmittals/downloads/R2236CP.pdf on the CMS website.

REMITTANCE ADVICE

Medicare Remit Easy Print Upgrade to Version 3.1

Version 3.1 of the Medicare Remit Easy Print (MREP) software is available for download at http://www.cms.gov/AccesstoDataApplication/02_MedicareRemitEasyPrint.asp on the CMS website.

An enhancement has been added to the installation process for the MREP software. Previous versions currently installed on the computer will no longer need to be removed before installing the upgrade to the software.

Since changes are being made to the MREP software, the updated Claim Adjustment Reason Codes/Remittance Advice Remark Codes file is included with version 3.1 of the MREP software. However, the separate Codes.ini file is also provided with version 3.1 of the MREP software.

MREP and PC Print User Guide Update for Implementation of Version 5010A1

MLN Matters® Number: MM7466
Related Change Request (CR) #: 7466
Related CR Release Date: July 29, 2011
Related CR Transmittal #: R926OTN
Effective Date: January 1, 2012
Implementation Date: January 3, 2012

Provider Types Affected
This article is for physicians, providers, and suppliers using the Medicare Remit Easy Print (MREP) and PC Print software in relation to remittance advices they receive from Medicare contractors (carriers, Fiscal Intermediaries (FIs), DME Medicare Administrative Contractors (DME MACs) and/or Part A/B Medicare Administrative Contractors (MACs)) for services provided to Medicare beneficiaries.

What You Need to Know
MREP and PC Print have been updated to include the latest enhancements as part of implementing version 5010A1 for Transaction 835 - Health Care Claim Payment/Advice. Specifically:

- The MREP User Guide is being updated to reflect the changes in the software related to the HIPAA 5010A1; and
- The PC Print User Guide is being updated to reflect the changes in the software related to the HIPAA 5010A1 version for ASC X12 Transaction 835.

If you use MREP or PC Print, be sure to download the updated user guide for 835 version 5010A1 when they are available.

Background
The Centers for Medicare and Medicaid Services (CMS) is implementing the new standard for Transaction 835 (Health Care Claim Payment/Advice) Version 5010A1 adopted under the Health Insurance Portability and Accountability Act (HIPAA). Providers/Suppliers must transition to the new version on or before January 1, 2012. CMS has made MREP and PC Print software available to providers/suppliers to enable them to view/print/download the electronic remittance advice in version 5010A1 in a human readable format.

Additional Information
The official instruction, CR7466 issued to your carrier, FI, A/B MAC, and DME/MAC regarding this change may be viewed at http://www.cms.gov/Transmittals/downloads/R926OTN.pdf on the CMS website. For more information on the Version 5010 transition and implementation, visit http://www.cms.gov/Versions5010andD0/ on the CMS website.

SUCTION PUMPS

New K-Codes for Wound Suction Pumps and Associated Dressings – Coding Guidelines

New HCPCS codes have been created to describe wound suction pumps and the dressing sets associated with them. These new K-codes are effective for claims with dates of service on or after July 1, 2011.

The new codes are:

- K0743 - SUCTION PUMP, HOME MODEL, PORTABLE, FOR USE ON WOUNDS
- K0744 - ABSORPTIVE WOUND DRESSING FOR USE WITH SUCTION PUMP, HOME MODEL, PORTABLE, PAD SIZE 16 SQUARE INCHES OR LESS
- K0745 - ABSORPTIVE WOUND DRESSING FOR USE WITH SUCTION PUMP, HOME MODEL, PORTABLE, PAD SIZE MORE THAN 16 SQUARE INCHES BUT LESS THAN OR EQUAL TO 48 SQUARE INCHES
- K0746 - ABSORPTIVE WOUND DRESSING FOR USE WITH SUCTION PUMP, HOME MODEL, PORTABLE, PAD SIZE GREATER THAN 48 SQUARE INCHES

Wound suction is provided with an integrated system of components. This system contains a pump (K0743) and dressing sets (K0744 – K0746). It does not include a separate collection canister (A7000), a defining component of Negative Pressure Wound Therapy (NPWT). Instead, exudate is retained in the dressing materials. Therefore, wound suction systems are not classified as NPWT systems. These codes will be added to the Suction Pump LCD in a future revision to that policy.

Systems that do not contain all of the required components are not classified as wound suction systems. See below for component specifications.

Code K0743 describes a suction pump for wounds which provides controlled subatmospheric pressure that is designed for use with dressings (K0744 – K0746) without a canister.

Codes K0744 - K0746 describe an allowance for dressing sets that are used in conjunction with a stationary or portable suction pump (K0743) but not used with a canister. Each of these codes (K0744 – K0746) is used for a single, complete dressing change, and contains all necessary components, including but not limited to non-adherent porous dressing, drainage tubing, and an occlusive dressing which creates a seal around the wound site for maintaining subatmospheric pressure at the wound. These dressing sets are selected based upon wound size using the smallest size necessary to cover the wound. For multiple wounds located close together, a single large dressing must be used rather than multiple smaller dressing sets if it is possible to fit the wounds under a single larger dressing set.

Disposable wound suction system pumps must be coded A9270 (Noncovered item or service).

Supplies, including dressings, used with disposable wound suction systems must be coded as A9270 (Noncovered item or service).

Only products reviewed by the PDAC and placed on the product category list may use the NPWT codes E2402 and A6550.

SUCTION PUMPS CONT'D

New K Codes for Suction Pumps and Wound Dressings

MLN Matters® Number: MM7411
Related Change Request (CR) #: CR 7411
Related CR Release Date: April 29, 2011
Related CR Transmittal #: R2206CP
Effective Date: July 1, 2011
Implementation Date: July 5, 2011

Provider Types Affected
Providers and suppliers who bill Medicare Administrative Contractors (A/B MACs) or Durable Medical Equipment contractors (DME MACs) for providing suction pumps and accompanying surgical dressings to Medicare beneficiaries.

Provider Action Needed
Effective July 1, 2011, Medicare will allow four new K codes for billing suction pumps and accompanying surgical dressings. Ensure that your billing staffs are aware of these new K codes, which are effective for dates of service on or after July 1, 2011. The codes and their descriptors are as follows:

- K0743 - SUCTION PUMP, HOME MODEL, PORTABLE, FOR USE ON WOUNDS;
- K0744 - ABSORPTIVE WOUND DRESSING FOR USE WITH SUCTION PUMP, HOME MODEL, PORTABLE, PAD SIZE 16 SQUARE INCHES OR LESS;
- K0745 - ABSORPTIVE WOUND DRESSING FOR USE WITH SUCTION PUMP, HOME MODEL; PORTABLE, PAD SIZE MORE THAN 16 SQUARE INCHES BUT LESS THAN OR EQUAL TO 48 SQUARE INCHES; and
- K0746 - ABSORPTIVE WOUND DRESSING FOR USE WITH SUCTION PUMP, HOME MODEL, PORTABLE, PAD SIZE GREATER THAN 48 SQUARE INCHES.

Note: The coverage type for these codes is "C," and their coverage is subject to your contractor's discretion. Further, the addition of these codes does not imply their coverage by Medicare.

Additional Information
You can find the official instruction, CR7411, issued to your A/B MAC or DME MAC by visiting http://www.cms.gov/Transmittals/downloads/R2206CP.pdf on the Centers for Medicare & Medicaid (CMS) website.

THERAPEUTIC SHOES

Foot Care Coverage Guidelines

MLN Matters Number: SE1113

Provider Types Affected
This article is for informational purposes only for providers billing Medicare for foot care services. It is an overview of existing policy and no change in policy is being conveyed.

Medicare Podiatry Services
The scope of the practice for Podiatry is defined by state law and the individual state laws should be consulted in determining a specific podiatrist's (or doctor of podiatric medicine) scope of practice.

This article covers routine care of the foot as well as care related to underlying systemic conditions such as metabolic, neurologic or peripheral vascular disease, or injury, ulcers, wounds, and infections.

Medicare Covered Foot Care Services
According to the "Medicare Benefit Policy Manual" (MBPM), Chapter 15, Section 290, Medicare covered foot care services only include medically necessary and reasonable foot care.

Exclusions from Coverage
Certain foot care related services are not generally covered by Medicare. In general, the following services, whether performed by a podiatrist, osteopath, or doctor of medicine, and without regard to the difficulty or complexity of the procedure, are not covered by Medicare:

THERAPEUTIC SHOES CONT'D

1. Treatment of Flat Foot
   The term "flat foot" is defined as a condition in which one or more arches of the foot have flattened out. Services or devices directed toward the care or correction of such conditions, including the prescription of supportive devices, are not covered.
2. Routine Foot Care
   Except as discussed below in the section entitled "Conditions that Might Justify Coverage", routine foot care is excluded from coverage. Services that normally are considered routine and not covered by Medicare include the following:
   - The cutting or removal of corns and calluses;
   - The trimming, cutting, clipping, or debriding of nails; and
   - Other hygienic and preventive maintenance care, such as cleaning and soaking the feet, the use of skin creams to maintain skin tone of either ambulatory or bedfast patients, and any other service performed in the absence of localized illness, injury, or symptoms involving the foot.
3. Supportive Devices for Feet
   Orthopedic shoes and other supportive devices for the feet generally are not covered, except Medicare does cover such a shoe if it is an integral part of a leg brace, and its expense is included as part of the cost of the brace. Also, a narrow exception permits coverage of special shoes and inserts for certain patients with diabetes.

Conditions that Might Justify Coverage
The presence of a systemic condition such as metabolic, neurologic, or peripheral vascular disease may require scrupulous foot care by a professional that in the absence of such condition(s) would be considered routine (and, therefore, excluded from coverage). Accordingly, foot care that would otherwise be considered routine may be covered when systemic condition(s) result in severe circulatory embarrassment or areas of diminished sensation in the individual's legs or feet. In these instances, certain foot care procedures that otherwise are considered routine (e.g., cutting or removing corns and calluses, or trimming, cutting, clipping, or debriding nails) may pose a hazard when performed by a nonprofessional person on patients with such systemic conditions.

Although not intended as a comprehensive list, the following metabolic, neurologic, and peripheral vascular diseases (with synonyms in parentheses) most commonly represent the underlying conditions that might justify coverage for routine foot care:

- Diabetes mellitus*
- Arteriosclerosis obliterans (A.S.O., arteriosclerosis of the extremities, occlusive peripheral arteriosclerosis)
- Buerger's disease (thromboangiitis obliterans)
- Chronic thrombophlebitis*
- Peripheral neuropathies involving the feet
  - Associated with malnutrition and vitamin deficiency*
    - Malnutrition (general, pellagra)
    - Alcoholism
    - Malabsorption (celiac disease, tropical sprue)
    - Pernicious anemia
  - Associated with carcinoma*
  - Associated with diabetes mellitus*
  - Associated with drugs and toxins*
  - Associated with multiple sclerosis*
  - Associated with uremia (chronic renal disease)*
  - Associated with traumatic injury
  - Associated with leprosy or neurosyphilis

- Associated with hereditary disorders
  - Hereditary sensory radicular neuropathy
  - Angiokeratoma corporis diffusum (Fabry's)
  - Amyloid neuropathy

When the patient's condition is one of those designated above by an asterisk (*), routine procedures are covered only if the patient is under the active care of a doctor of medicine or osteopathy who documents the condition.

In addition, the following may be covered:

- The treatment of warts (including plantar warts) on the foot is covered to the same extent as services provided for the treatment of warts located elsewhere on the body.
- In the absence of a systemic condition, treatment of mycotic nails may be covered. **The treatment of mycotic nails for an ambulatory patient** is covered only when the physician attending the patient's mycotic condition documents that (1) there is clinical evidence of mycosis of the toenail, and (2) the patient has marked limitation of ambulation, pain, or secondary infection resulting from the thickening and dystrophy of the infected toenail plate. **The treatment of mycotic nails for a nonambulatory patient** is covered only when the physician attending the patient's mycotic condition documents that (1) there is clinical evidence of mycosis of the toenail, and (2) the patient suffers from pain or secondary infection resulting from the thickening and dystrophy of the infected toenail plate.

Presumption of Coverage for Routine Services
When evaluating whether the routine services can be reimbursed, a presumption of coverage may be made where the evidence available discloses certain physical and/or clinical findings consistent with the diagnosis and indicative of severe peripheral involvement. For the purposes of applying this presumption, please refer to the "Medicare Benefit Policy Manual", Chapter 15, Section 290.

When the routine services are rendered by a podiatrist, your Medicare carrier may deem the active care requirement met if the claim or other evidence available discloses that the patient has seen an M.D. or D.O. for treatment and/or evaluation of the complicating disease process during the six-month period prior to the rendition of the routine-type services.

The carrier may also accept the podiatrist's statement that the diagnosing and treating M.D. or D.O. also concurs with the podiatrist's findings as to the severity of the peripheral involvement indicated.

Foot Care for Patients with Chronic Disease
Diabetic Sensory Neuropathy: Loss of Protective Sensation (LOPS)
Effective for services furnished on or after July 1, 2002, Medicare covers an evaluation (examination and treatment) of the feet no more often than every six months for individuals with a documented diagnosis of diabetic sensory neuropathy and LOPS, as long as the beneficiary has not seen a foot care specialist for some other reason in the interim.

The diagnosis of diabetic sensory neuropathy with LOPS should be established and documented prior to coverage of foot care. Other causes of peripheral neuropathy should be considered and investigated by the primary care physician prior to initiating or referring for foot care for persons with LOPS.

Please refer to the "National Coverage Determination (NCD), entitled "Services Provided for the Diagnosis and Treatment of Diabetic Sensory Neuropathy with Loss of Protective Sensation (LOPS) (aka Diabetic Peripheral Neuropathy)" for more information. This NCD is available at http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=171&ncdver=1&bc=BAAAgAAAAAAA& on the Centers for Medicare & Medicaid Services (CMS) website.

Lower Extremity Wound Care

Electrostimulation and Electromagnetic Therapy for Wounds (Claims submitted on or after July 6, 2004)
The Centers for Medicare & Medicaid Services (CMS) will allow for coverage for the use of electrical stimulation and electromagnetic therapy for chronic Stage III and Stage IV pressure ulcers, arterial ulcers, diabetic ulcers, and venous stasis ulcers when certain conditions are met.

For more detailed information, please refer to National Coverage Determination (NCD) for "Electrical Stimulation (ES) and Electromagnetic Therapy for the Treatment of Wounds," which can be found at http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=131&ncdver=3&bc=BAABAAAAAAAA on the CMS website.

Hyperbaric Oxygen (HBO) Therapy for Hypoxic Wounds and Diabetic Wounds of the Lower Extremities (CAG-00060N)

For claims submitted on or after April 1, 2000, HBO therapy in the treatment of diabetic wounds of the lower extremities will be covered in patients who meet each of the following three criteria. Patient has:

- Type I or Type II Diabetes and has a lower extremity wound that is due to diabetes;
- A wound classified as Wagner grade III or higher; and has
- Failed an adequate course of standard wound therapy (defined below).

The use of HBO therapy will be covered as adjunctive therapy only after there are no measurable signs of healing for at least 30-days of treatment with standard wound therapy and must be used in addition to standard wound care.

Failure to respond to standard wound care occurs when there are no measurable signs of healing for at least 30 consecutive days. Wounds must be evaluated at least every 30 days during administration of HBO therapy. Continued treatment with HBO therapy is not covered if measurable signs of healing have not been demonstrated within any 30-day period of treatment.

For more information about HBO therapy for diabetic wounds of the lower extremities, please refer to the NCD for Hyperbaric Oxygen Therapy, which is available at http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=12&ncdver=3&NCAId=37&ver=7&NcaName=Hyperbaric+Oxygen+Therapy+for+Hypoxic+Wounds+and+Diabetic+Wounds+of+the+Lower+Extremities&fromdb=true&IsPopup=y&bc=AAAAAAAAEAgA& on the CMS website.

Additional Billing Guidelines

Claims Involving Complicating Conditions

- When submitting claims for services furnished to Medicare beneficiaries who have complicating conditions, the name of the M.D. or D.O. who diagnosed the complicating condition must be submitted with the claim, along with the approximate date that the beneficiary was last seen by the indicated physician.
- Document carefully any convincing evidence showing that non-professional performance of a service would have been hazardous for the beneficiary because of an underlying systemic disease. Stating that the beneficiary has a complicating condition such as diabetes does not of itself indicate the severity of the condition.
- Exceptional situations include initial diagnostic services performed in connection with a specific symptom or complaint if it seems likely that its treatment would be covered even though the resulting diagnosis may be one requiring only non-covered care.
- The exclusion of foot care is determined by the nature of the service and not according to who provides the service. When an itemized bill shows both covered services and non-covered services that are not integrally related to the covered service, the portion of the charges that are attributable to the non-covered services should be denied.
- Sometimes payment is made for incidental non-covered services that are performed as a necessary and integral part of, and secondary to, a covered procedure. For example, if toenails must be trimmed in order to apply a cast to a fractured foot, then the charge for the trimming of nails would be covered.
- However, a separately itemized charge for this excluded service would not be allowed. Please refer to your Medicare contractor for questions about coverage that is "incident to" a covered procedure.
- Information about coverage Incident to Physician's Professional Services can also be found in the "Medicare Benefit Policy Manual," Chapter 15, Covered Medical and Other Health Services, Section 60 – Services and Supplies.

Therapeutic Shoes for Individuals with Diabetes (MBPM, Chapter 15, Section 140)

- Coverage of depth or custom-molded therapeutic shoes and inserts for individuals with diabetes is available as of May 1, 1993.
- These diabetic shoes are covered if the requirements specified in the "Medicare Benefits Policy Manual," Chapter 15, Section 140, regarding certification and prescription are met.

THERAPEUTIC SHOES CONT'D

- This benefit provides for a pair of diabetic shoes each equipped so that the affected limb, as well as the remaining limb, is protected, , even if only one foot suffers from diabetic foot disease.
- Claims for therapeutic shoes for diabetics are processed by the Durable Medical Equipment Medicare Administrative Contractors (DME MACs). Therapeutic shoes for diabetics are not DME and are not considered DME or orthotics, but a separate category of coverage under Medicare Part B.

Related Links

Medicare Manuals

- The "Medicare Benefit Policy Manual," Publication 100-2, Chapter 15, can be found at http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf on the CMS website.
- The "Medicare Program Integrity Manual" can be found at http://www.cms.hhs.gov/manuals/downloads/pim83c05.pdf on the CMS website.
- The "National Coverage Determination Manual" can be found at http://www.cms.gov/Manuals/IOM/itemdetail.asp?itemID=CMS014961 on the CMS website.

Local Coverage Decisions

- The Medicare Coverage Database provides access to local coverage decision articles published for Medicare contractors. These articles can be found at http://www.cms.hhs.gov/mcd/index_local_alpha.asp?from=alphaarticle&letter=P on the CMS website.

Related Change Requests and MLN Matters Articles

- Program Memorandum Transmittal AB-02-096, Change Request 2269, "Coverage and Billing of the Diagnosis and Treatment of Peripheral Neuropathy with Loss of Protective Sensation in People with Diabetes" can be found at http://www.cms.hhs.gov/Transmittals/downloads/AB02096.pdf on the CMS website.
- Program Memorandum Transmittal AB-02-105, Change request 2272, "Medical Review of Medicare Payments for Nail Debridement Services," can be found at http://www.cms.hhs.gov/Transmittals/Downloads/AB02105.pdf on the CMS website.
- MLN Matters article, MM3430, "Reasonable charge update for 2005 splints, casts, dialysis supplies, dialysis equipment, therapeutic shoes and certain intraocular lenses" can be found at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3430.pdf on the CMS website.

VENTILATORS

Correct Coding Instructions – Porta-Lung® Negative Pressure Ventilator

This article serves as notification to suppliers of the appropriate coding guidelines for billing the Porta-Lung® negative pressure ventilator. The following Healthcare Common Procedure Coding System (HCPCS) code that was assigned to this product by the Centers for Medicare and Medicaid Services (CMS) Alpha Numeric Work Group effective January 1, 1990, must be used:

E0460 NEGATIVE PRESSURE VENTILATOR; PORTABLE OR STATIONARY

This is the only code that is used to describe the Porta-Lung® negative pressure ventilator. Use of any other code(s), including the miscellaneous code E1399, is incorrect.

All current DME products coded by the PDAC are found on the PDAC website on Durable Medical Equipment Coding System (DMECS), https://www.dmepdac.com/dmecsapp/do/search. For questions about correct coding, contact the PDAC Contact Center at (877) 735-1326 during the hours of 8:30 a.m. to 4:00 p.m. CT, Monday through Friday, or e-mail the PDAC by completing the DME PDAC Contact Form located on the PDAC website: https://www.dmepdac.com.

Companion Guide Updated for 5010 Transaction Format

The Companion Guide for the 5010 transactions has been updated on the CEDI website under Technical Specifications at the following link: http://www.ngscedi.com/TechnicalSpec/techindex.htm

This guide contains information regarding the following transactions; the 837 claim format, the 835 remittance notice, and the 276/277 transaction in the 5010 format. This is intended as a reference to be used in addition to the ANSI ASC X12 Technical Reports (TR3). This document references only Medicare DMEPOS specific information. The TR3 (5010) can be downloaded for a fee at www.x12.org.

The timeline for implementing the 5010A1 837 claims format is:

- **April 2011:** Testing 5010A1 was opened to vendors and those who do their own programming (also referred to as in-house programmers)
- **April – December 2011:** Once vendors have passed testing for 5010A1, they may begin moving their customers into production.
- **April – December 2011:** Once in-house programmers have passed testing of 5010A1, they may move into production.
- **January 1, 2012:** Only 5010A1 transactions will be allowed.

The Centers for Medicare & Medicaid Services (CMS) will be sponsoring two HIPAA 5010 National Testing Days. June 15, 2011 will be the first 5010 testing day to generate enthusiasm, awareness and interest with vendors, billing services, and clearinghouses to increase 5010 testing with CEDI. For more information, visit the CEDI Web site at http://www.ngscedi.com and click the link for 5010 and D.0 Implementation Information.

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

Delayed Implementation of X12N Version 5010 Paperwork Segment

CMS is delaying the implementation of the PWK (paperwork) segment associated with the X12N Version 5010 837 Professional and Institutional electronic claim transaction originally scheduled for July and October 2011. This means Medicare billers will continue to submit additional documentation which is needed for claims adjudication following the existing process established by their Medicare claims administration contractor.

CMS will give Medicare billers ample notice before implementing change requests (CR) #7041 and #7306, which change how additional documentation for claims adjudication is submitted. For additional information related to CR #7041 and #7306, please refer to the MLN Matters articles associated with these CRs:

- http://www.CMS.gov/MLNMattersArticles/downloads/MM7041.pdf
- http://www.CMS.gov/MLNMattersArticles/downloads/MM7306.pdf

ICD-10 Video Slideshow Presentation, Podcasts, and Written Transcripts Now Available

CMS has released four podcasts and a video slideshow presentation of the May 18, 2011, national provider call on "CMS ICD-10 Conversion Activities, Including a Lab Case Study."

Did you miss the May 18th ICD-10 national provider call? The entire presentation is now available on the CMS YouTube Channel as a video slideshow that includes the call audio and captioning.

Limited on time? Podcasts are perfect for the office, in the car, or anywhere you carry a portable media player or smartphone:

- Podcast 1of 4: Welcome and ICD-10 Overview
- Podcast 2 of 4: Case Study on Translating the Lab NCDs
- Podcast 3 of 4: ICD-10 Updates from CMS Subject Matter Experts
- Podcast 4 of 4: Question and Answer Session

The podcasts, slideshow presentation, and written transcripts are now available on the CMS website at http://www.cms.gov/ICD10/Tel10/itemdetail.asp?itemID=CMS1246998. The four audio podcasts with corresponding written transcripts, as well as the full written transcript of the call can be accessed by scrolling to the "Downloads" section at the bottom of the page. To access the video slideshow presentation, select the link in the "Related Links Outside CMS" section of the webpage.

Materials from AAPC-CMS ICD-10 Code-a-Thon Posted to ICD-10 Website

If you weren't able to join us for the AAPC-CMS ICD-10 Code-a-thon held on April 26, 2011, or if you just want a closer look at all the materials from the presentation, they are now available on the CMS website in the Latest News section.

Posted materials include:

- Presentations from AAPC and CMS on ICD-10 and Version 5010
- A transcript and audio of the presentations given during the webinar

These materials should be helpful in getting informed and learning about the transitions to Version 5010 and ICD-10. Feel free to share this information with colleagues, staff, or anyone interested in learning more about these important transitions.

Keep Up to Date on Version 5010 and ICD-10
Please visit http://www.cms.gov/icd10 for the latest news and resources to help you prepare!

New Frequently Asked Questions Available about HIPAA Version 5010 Implementation

CMS has posted 18 new FAQs about HIPAA Version 5010 implementation, and one PDF document containing 27 Q&As specific to the Wednesday, March 30th CMS-hosted 5010 national provider teleconference on provider testing and readiness. To review these FAQs, visit the CMS FAQ database at http://questions.CMS.hhs.gov and search for "5010" (or use a direct link to the "5010" search results), or go directly to the Q&As specific to the Wed Mar 30 provider testing and readiness national provider teleconference.

Please check the CMS FAQ database regularly for newly-posted or updated information related to 5010.

New Podcasts Available from January 12, 2011 Call on "Preparing for ICD-10 Implementation in 2011"

Limited on time? CMS has created four new podcasts from the audio of the Wednesday, January 12 national provider call on "Preparing for ICD-10 Implementation in 2011." These podcasts are perfect for the office, the car, or anywhere you carry a portable media player.

- Welcome and ICD-10 Overview – Pat Brooks, CMS
- Implementation Strategies for 2011 – Sue Bowman, AHIMA
- Question and Answer Session, part 1
- Question and Answer Session, part 2

These podcasts are now available at http://www.CMS.gov/ICD10/Tel10/itemdetail.asp?itemID=CMS1242831, in the "Downloads" section at the bottom of the page. Listen to all four or just the ones that fit your needs.

Six Month Check-in: Act Now for Version 5010 Transition

The Version 5010 transition is less than six months away for all HIPAA covered entities. This means that to submit transactions electronically, all covered entities must upgrade from Version 4010/4010A to Version 5010. Version 5010, unlike Version 4010, accommodates the new ICD-10 code sets, and is a required preliminary step for the use of the new ICD-10 medical code sets.

Before the compliance deadline of January 1, 2012, you should conduct internal and external transactions within your organizations and with your billing partners – including payers, vendors, clearinghouses and providers. External testing should take place now in order to make sure that you are able to send and receive compliant transactions effectively. Testing now will help identify any potential issues that may arise, and allow the necessary time to address them.

The CMS ICD-10 website has resources to support providers, payers and vendors as they make the transition to Version 5010 and ICD-10.

Keep Up to Date on Version 5010 and ICD-10
Please visit http://www.cms.gov/ICD10 for the latest news and resources to help you prepare.

What You Should Know About GEMS and Partial Code Freeze

General Equivalence Mappings (GEMs)
The Centers for Medicare & Medicaid Services (CMS) and the Centers for Disease Control and Prevention (CDC) created the national version of the GEMs to ensure that consistency in national data is maintained. The GEMs are tools that act mainly as a crosswalk between the ICD–9 and ICD–10 codes. You can look up an ICD–9 code and be provided with the most appropriate ICD–10 matches and vice versa. They are not a substitute for learning the new ICD–10 codes; however, they can assist users doing the following:

- Translating lists of codes, code tables, or other coded data
- Converting a system or application containing ICD–9–CM codes
- Creating a "one-to-one" applied mapping (aka crosswalk) between code sets that will be used in an ongoing way to translate records or other coded data
- Studying the differences in meaning between the ICD–9–CM classification systems and the ICD–10-CM/PCS classification systems by looking at the GEMs entries for a given code or area of classification

The 2011 GEMs are posted to the CMS ICD–10 website. As a reminder, if you plan to use a GEM, per the Affordable Care Act, you must use the GEMs posted to the CMS website.

For more information on the GEMs, look at the GEMs Fact Sheet and the GEMs pages of the ICD–10 website.

Partial Code Freeze
Because continuous updates and changes to the existing code sets has the potential to make the transition to ICD–10 difficult, CMS will be implementing a partial code freeze on October 1, 2011. This is the last day for regular updates to both the ICD-9 and ICD–10 code sets.

Starting October 1, 2012 there will be only limited code updates to ICD–9–CM and ICD–10 code sets to capture new technology and new diseases. There will be no updates to ICD–9–CM on October 1, 2013 as the system will no longer be a HIPAA standard.

Keep Up to Date on Version 5010 and ICD–10
Please visit http://www.cms.gov/ICD10 for the latest news and resources to help you prepare!

Modifications to Implementation of PWK Segment for X12N Version 5010

MLN Matters® Number: MM7306 Revised
Related Change Request (CR) #: 7306
Related CR Release Date: June 22, 2011
Related CR Transmittal #: R908OTN
Effective Date: July 1, 2011, except October 1, 2011, for claims submitted to DME MACs
Implementation Date: July 5, 2011, except October 3, 2011, for claims submitted to DME MACs

Note: This article was revised on June 23, 2011, to reflect a revised CR7306, which was issued on June 22. In this article, the effective and implementation dates have been revised for claims handled by DME MACs. Also, the CR release date, transmittal number and the Web address for accessing CR7306 have been revised. All other information is the same.

Provider Types Affected
This article is for physicians, suppliers, and providers billing Medicare contractors (carriers, Part A/B Medicare Administrative Contractors (MACs), Durable Medical Equipment Medicare Administrative Contractors (DME MACs), and Fiscal Intermediaries (FIs) including Regional Home Health Intermediaries (RHHIs)).

What You Need to Know
This article is based on Change Request (CR) 7306, which instructs Medicare contractors about additional business requirements that are necessary to complete the implementation of the PWK segment scheduled for July 2011 (except October 2011 for DME MACs) under CR 7041. An article related to CR 7041 is available at http://www.cms.gov/MLNMattersArticles/downloads/MM7041.pdf on the CMS website. Of significance to the provider community is a change whereby Medicare contractors will only return an incomplete/incorrect fax/mail cover sheet, when such is received. In CR 7041, the attached data was to be returned as well, but that is no longer the case. Also, note that CR 7306 requires your contractor to mask any Protected Health Information (PHI) on the fax/cover sheet returned to you.

In addition, the following changes will result from CR 7306:

- In PWK02, Medicare contractors will only use values BM and FX and will communicate that via the companion document. Other values will be accepted only in CMS-approved electronic claims attachment pilots based on agreements with willing trading partners.
- Medicare contractors will have the ability to accept the PWK02 value of EL for those contractors in a CMS-approved electronic claims attachment pilot.
- Contractors will allow seven calendar "waiting" days (from the date of receipt) for additional information to be submitted when the PWK02 value is EL.

Additional Information
The official instruction, CR7306, issued to your FI, carrier, A/B MAC, and DME/MAC regarding this change, may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R908OTN.pdf on the CMS website.

Populating REF Segment for Healthcare Claim Payment/Advice or Transaction 835 Version 5010A1

MLN Matters® Number: MM7484
Related Change Request (CR) #: CR 7484
Related CR Release Date: July 29, 2011
Related CR Transmittal #: R927OTN
Effective Date: January 1, 2012
Implementation Date: January 3, 2012

Provider Types Affected
This article is for physicians, other providers, and suppliers who bill Medicare Carriers, Fiscal Intermediaries (FIs), Medicare Administrative Contractors (A/B MACs), Regional Home Health Intermediaries (RHHIs), or Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for Part B services provided to Medicare beneficiaries.

Provider Action Needed
The Centers for Medicare and Medicaid Services (CMS) has decided that populating the Healthcare Claim Payment/Advice or Transaction 835 version 5010A1 REF segment (Other Claim Related Adjustment) at Loop 2100 (for Part B) would provide useful information to providers and suppliers, and starting in January 2012, this segment will be populated for the Part B remittance advice.

CR7484, from which this article is taken, instructs Medicare systems, effective January 1, 2012, to populate the REF segment (Other Claim Related Adjustment) at Loop 2100 with qualifiers designated in the updated Flat File attached to CR7484. Note that CR also updates the 835 flat file by adding:

- PLB Code 90; and
- Qualifier "PQ" to be used in Loop 1000B REF – Payee Additional Information under some special situations where the National Provider Identifier (NPI) is not available.

Background
Currently the Healthcare Claim Payment/Advice or Transaction 835 REF segment (Other Claim Related Adjustment) at Loop 2100 is not being populated for the Part B remittance advice, and the 835 Flat File identifies this with a note: "N/U by Part B."

CMS has decided that using this segment would provide useful information to providers and suppliers. Therefore, CR7484, from which this article is taken, instructs the VIPS Medicare System (VMS) and the Multi Carrier System (MCS) to populate this segment, effective January 1, 2012, under specific situations (e.g., for cost avoid claims) using one of the qualifiers included in the updated Flat File that is an attachment to CR7484.

Specifically, VMS and MCS will use one of the following Reference Identification Qualifiers in REF01 as appropriate:

- 28: Employee Identification Number
- 6P: Group Number

  (When they use this 6P qualifier, they will also populate NM1 – Corrected Priority Payer Name segment at Loop 2100 and REF02 with the Other Insured Group Number for the payer identified in NM1, and use Claim Status Code 2 in CLP02 in CLP – Claim Payment Information segment at Loop 2100);
- EA: Medical Record Identification Number
- F8: Original Reference

Note: Medicare will update Medicare Remit Easy Print (MREP) software to include this additional REF segment in the MREP Remittance Advice for version 5010A1.

Additional Information
You can find the official instruction, CR7484, issued to your FI, carrier, A/B MAC, RHHI, or DME MAC by visiting http://www.cms.gov/Transmittals/downloads/R927OTN.pdf on the CMS website. You will find the updated 835 T 5010A1 flat file containing the qualifiers as an attachment to that CR.

Additionally, you can learn more about CMS's implementation activities to convert from Health Insurance Portability and Accountability Act (HIPAA) Accredited Standards Committee (ASC) X12 version 4010A1 to ASC X12 version 5010A1 and National Council for Prescription Drug Programs (NCPDP) version 5.1 to NCPDP version D.0, by going to http://www.cms.gov/MFFS5010D0/01_Overview.asp#TopOfPage on the CMS website.

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NAS prints and mails the bulletin to DME suppliers who have indicated they are unable to utilize the website. Our goal is to provide accurate and timely information to our suppliers. We continue to utilize our website as the main avenue of co mmunication and encourage suppliers to allow their staff to have access to the Internet for quicker access to bulletins, CMS guidelines and NAS updates. Suppliers are encouraged to view, print and search the bulletin information by using the following steps:

1. Visit www.noridianmedicare.com
2. Select ‘Durable Medical Equipment’
3. Read and ‘Accept’ the End User Agreement
4. Select ‘Bulletins’ under the ‘News/Publications’ section
5. Select the desired issue
6. Search using the Adobe Acrobat internal search function

Providers are encouraged to sign up for the DME e-mail list today.

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