Jurisdiction D News from Noridian Administrative Services, LLC.

Happenings

February 2011
Issue No. 30

This Bulletin Shall Be Shared with All Health Care Practitioners and Managerial Members of Your Provider Staff. Bulletins Are Available at No Cost from Our website, https://www.noridianmedicare.com.

In This Issue...

FYI

Appeals

Billing

Don't be left in the dark. Sign up for the NAS e-mail listing to receive updates that contain the latest Medicare news. Visit the NAS website and select the "E-mail List Signup" from the DME Quick Links.

Modifiers

Nebulizers

NPI

Orthotics/Prosthetics

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Enteral Nutrition

PECOS

Pricing/Reimbursement

Recovery Audit Contractor

Remittance Advices

Timely Filing

Version 5010/ICD-10

Alphabetical Listing...

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 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: https://www.noridianmedicare.com/dme

Fax	
Reopenings and Redeterminations MSP Inquires and Refunds DME RAC Redeterminations	888-408-7405
Administrative Simplification Compliance Act (ASCA)	888-523-8449
Refunds to Medicare Immediate Offsets	888-529-3666
DME RAC Offsets	866-640-9459
ADMC Requests/Documentation	877-662-8445
Medical Review Medical Documentation	866-465-0213
CERT Medical Documentation	877-436-4479

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

Mailing Addresses	
Claims, Redetermination Requests, Correspondence and Medical Review Documentation Noridian Administrative Services PO Box 6727 Fargo ND 58108-6727	**Advance Determination of Medicare Coverage Requests** Noridian Administrative Services Jurisdiction D DME Medical Review PO Box 6747 Fargo ND 58108-6747
Administrative Simplification Compliance Act Exception Requests Noridian Administrative Services PO Box 6737 Fargo ND 58108-6737	**Benefit Protection** Noridian Administrative Services Benefit Protection-DME PO Box 6736 Fargo ND 58108-6736
Electronic Funds Transfer Forms / Overpayment Redeterminations/ DME RAC Redeterminations Noridian Administrative Services PO Box 6728 Fargo ND 58108-6728	**Qualified Independent Contractor** RiverTrust Solutions, Inc. 1 Cameron Hill Circle Ste 0011 Chattanooga TN 37402-0011

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

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

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."

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.

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 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 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
Presidents Day*	February 21	8 a.m. – 12:30 p.m. CT
Off-the-Phone Training*	March 18	8 a.m. – 12:30 p.m. CT
Off-the-Phone Training*	April 15	8 a.m. – 12:30 p.m. CT
Good Friday	April 22	Entire Day Closed 8 a.m. through 5:30 p.m. CT
Off-the-Phone Training*	May 20	8 a.m. – 12:30 p.m. CT
Memorial Day	May 30	Entire Day Closed 8 a.m. through 5:30 p.m. CT
Off-the-Phone Training*	June 17	8 a.m. – 12:30 p.m. CT
Independence Day Observed	July 1	Entire Day Closed 8 a.m. through 5:30 p.m. CT
Independence Day Observed	July 4	Entire Day Closed 8 a.m. through 5:30 p.m. CT
Off-the-Phone Training*	July 15	8 a.m. – 12:30 p.m. CT
Off-the-Phone Training*	August 19	8 a.m. – 12:30 p.m. CT
Labor Day	September 5	Entire Day Closed 8 a.m. through 5:30 p.m. CT
Off-the-Phone Training*	September 16	8 a.m. – 12:30 p.m. CT
Columbus Day*	October 10	8 a.m. – 12:30 p.m. CT
Veterans Day*	November 11	8 a.m. – 12:30 p.m. CT

Event	Date	Closure Timeframe
Thanksgiving	November 24	Entire Day Closed 8 a.m. through 5:30 p.m. CT
Thanksgiving – Day After Observed	November 25	Entire Day Closed 8 a.m. through 5:30 p.m. CT
Off-the-Phone Training*	December 16	8 a.m. – 12:30 p.m. CT
Christmas Eve Observed	December 23	Entire Day Closed 8 a.m. through 5:30 p.m. CT
Christmas Day Observed	December 26	Entire Day Closed 8 a.m. through 5:30 p.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 4:00 pm 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
Presidents Day*	February 21	8 a.m. – 12:30 p.m. CT
Off-the-Phone Training*	March 18	8 a.m. – 12:30 p.m. CT
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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.

Self Service Technology Must Be Used for Eligibility, Claim Status, and Same or Similar Effective January 17, 2011

Effective January 17, 2011, DME Jurisdiction D Suppliers shall be required to access eligibility, claim status, and 'same or similar' inquiries through either the Jurisdiction D IVR or online supplier portal, known as Endeavor. CMS requires suppliers to use "self-help" tools such as the Interactive Voice Recognition (IVR) system to access this type of information. The IVR offers a touch-pad inquiry option if a voice or accent is not recognized. Additionally, NAS offers a free, online supplier portal known as Endeavor which offers claim status, eligibility, claim-specific remittance advice, and 'same or similar' inquiry options. Visit our website, https://www.noridianmedicare.com/dme/claims/endeavor.html , to learn more about Endeavor.

Please review Chapter 6 of the Internet-Only Manual (IOM) Publication 100-9 for additional information regarding this requirement, http://www.cms.gov/manuals/downloads/com109c06.pdf. According to this IOM resource, "Providers shall be required to use IVRs to access claim status and beneficiary eligibility information. CSRs shall refer providers back to the IVR if they have questions about claims status or eligibility that can be handled by the IVR. CSRs may provide claims status and/or eligibility information if it is clear that the provider cannot access the information through the IVR because the IVR is not functioning."

The IVR offers claim status and 'same or similar' inquiries from 6 a.m. to 6 p.m. CT Monday through Friday. Eligibility inquiries can be obtained through the IVR and Endeavor 24/7. If suppliers have attempted to use the IVR and are experiencing difficulties, they should call the Supplier Contact Center at 1-866-243-7272 to allow our staff to work with you to research, identify, and report any IVR issues to our technical staff.

Resources

IVR Telephone Number	1-877-320-0390
IVR At-a-Glance	https://www.noridianmedicare.com/dme/contact/docs/ivr_at_a_glance.pdf
IVR User Guide	https://www.noridianmedicare.com/dme/contact/docs/ivr_guide.pdf
Endeavor Information	https://www.noridianmedicare.com/dme/claims/endeavor.html
Endeavor User Manual	https://www.noridianmedicare.com/dme/claims/docs/nas_endeavor_user_manual_v71.pdf
Endeavor Brochure	https://www.noridianmedicare.com/dme/claims/endeavor/brochure.pdf

Important reminders about using the IVR include:

- Call from a quiet environment as the IVR will pick up background noise.
- Do not call the IVR when using a speaker or cell phone.
- Use either the voice or touch key features to use the IVR. Callers with accents will need to use the touch key feature.
- Enter the beneficiary's name and Health Insurance Claim Number exactly as it appears on their Medicare card. (Retaining a photocopy of the card for your records is a good business practice.)
- The entry of the beneficiary's name in the IVR requires the complete last name and the first initial of the first name. However, when using the voice option to relay the beneficiary's name, speak the first name and then the last name.
- Information about Health Maintenance Organizations, Medicare Secondary Payer (MSP), home health, and hospice care will only be provided if the patient is actively enrolled for the date of service given. The IVR is "silent" if the patient is not enrolled.
- The IVR does not state "Medicare is primary." If the IVR does not give MSP information, Medicare is primary.
- Same or similar information is provided on equipment which requires a DME Information Form (DIF) or Certificate of Medical Necessity (CMN) on file in the past five years. If checking on equipment more than five years old, please call the Supplier Contact Center.
- A modifier is required when making same or similar inquiries. Valid entries are NU (*62*82), RR (*72*72), or none when appropriate. Failure to provide a modifier may result in incomplete information being returned.

NAS thanks our supplier community for their support as this requirement is implemented and continuously upheld. Please share this information and the referenced resource materials with staff who may have previously contacted our office to receive claim status, eligibility, and 'same or similar' information in the past.

NAS 2010 Efforts To Enhance Customer Service

As we begin the new year, NAS wants to continue to engage with you and listen to your feedback on how we can best serve you. A summary of the NAS DME Jurisdiction D Customer Service enhancements implemented within 2010 are highlighted within this article.

In response to your suggestions, NAS DME launched ***Endeavor***, a supplier portal, at the beginning of 2010 that offers free, online access to claim status, eligibility, and claim-specific remittance advices. Many suppliers are already utilizing this self-service tool. We have had a steady increase in the number of registered users and a steady increase in the number of inquiry transactions throughout 2010. NAS continues to work with CMS regarding the response time of eligibility inquiries as well as working to implement supplier suggestions; such as the November implementation of the same or similar inquiry option.

Our **Interactive Voice Recognition (IVR)** system (1-877-320-0390), has been enhanced with the following features for your convenience and in response to your suggestions:

a. An ordering/referring physician look-up tool for Provider Enrollment, Chain and Ownership System (PECOS) editing

b. Added offset/financial recoupment information so inquiries of this nature can be accommodated by the IVR

c. Added 24 hours a day / 7 days a week eligibility through the IVR by using a CMS-supplied eligibility data source

During the spring of 2011, we will be upgrading the IVR server and the voice recognition software to better serve you. This will make it easier for our IVR to distinguish regional accents. Web-based training to better understand how to use the IVR is also being offered to assist our supplier community with the functionality offered by the IVR.

To promote better understanding and consistency, we have expanded our staff training program to include external industry experts who conduct training with our Customer Service Representative as well as other DME teams (such as Medical Review, Appeals, Claims Processing, Education). Additionally, NAS Education Representatives present the same comprehensive educational materials that you receive to the Customer Service Representatives to keep staff current on all aspects of Medicare DMEPOS rules and processing requirements.

NAS continually improves our methods so that we offer you the best customer service, education, and efficient claims processing. Our Contact Center achieves an average speed of answer on telephone inquiries of 54 seconds; which exceeds the CMS expectation of 60 seconds. We also exceed CMS' expectation of 45 days in responding to supplier written inquiries and complex beneficiary inquiries.

NAS values the feedback received from our suppliers and we look forward to continuing to serve as your DME MAC for Jurisdiction D.

Beneficiary Request for Refill of Supplies, Accessories, and Drugs

NAS reminds suppliers of the guidelines for providing refills to beneficiaries.

The *Medicare Claims Processing Manual*, Chapter 20, Section 200 states:

> Suppliers/manufacturers 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. Contractor review should be done on a post-pay basis.
>
> A beneficiary or their caregiver must specifically request refills of repetitive services and/or supplies before a supplier dispenses them. A supplier may not initiate a refill of an order. The supplier must not automatically dispense a quantity of supplies on a predetermined regular basis.

Furthermore, the *Medicare Program Integrity Manual*, Chapter 4, Section 4.26.1 states:

> For DMEPOS products that are supplied as refills to the original order, suppliers must contact the beneficiary prior to dispensing the refill. This shall be done to ensure that the refilled item is necessary and to confirm any changes/modifications to the order. Contact with the beneficiary or designee regarding refills should take place no sooner than approximately 7 days prior to the delivery/shipping date. For subsequent deliveries of refills, the supplier should deliver the DMEPOS product no sooner than approximately 5 days prior to the end of usage for the current product. This is regardless of which delivery method is utilized. DME MACs shall allow for the processing of claims for refills delivered/shipped prior to the beneficiary exhausting his/her supply.

Beneficiaries cannot "authorize" in advance the routine dispensing of DMEPOS items. Also, because of the time frames specified, the request for subsequent delivery cannot be made at the time of or soon after the current delivery of items. For example, when a beneficiary receives a monthly supply of DMEPOS product, it would not be acceptable for the beneficiary to tell the supplier at that time to deliver a new supply of DMEPOS product in 1-3 months.

Suppliers should document the request for a refill. This could be documented in a number of ways, including but not limited to, a postcard signed and dated by the beneficiary, written record of phone conversation between the supplier and beneficiary/caregiver, etc. The document or "beneficiary attestation" should include name of beneficiary, name of contact if other then the beneficiary and relationship, date of contact and list of items that have been exhausted. Refer to https://www.noridianmedicare.com/dme/news/docs/2010/09_sep/request_for_refill.html.

The following Local Coverage Determinations (LCDs) specifically refers to these guidelines, but these instructions apply to all DMEPOS: Glucose Monitors, Negative Pressure Wound Therapy Pumps, Ostomy Supplies, Urological Supplies, Positive Airway Pressure (PAP) Devices for the Treatment of Obstructive Sleep Apnea, Respiratory Assist Devices, and Nebulizers.

CMS Launches the 2011 Medicare Contractor Provider Satisfaction Survey

It's that time again…time for you to let your voice be heard! The Centers for Medicare & Medicaid Services (CMS) has launched its annual Medicare Contractor Provider Satisfaction Survey (MCPSS). This survey offers Medicare FFS providers and suppliers an opportunity to give CMS feedback on their interactions with Medicare FFS contractors related to seven key business functions: Provider Inquiries, Provider Outreach & Education, Claims Processing, Appeals, Provider Enrollment, Medical Review, and Provider Audit & Reimbursement.

The survey was sent to a random sample of approximately 30,000 Medicare FFS providers and suppliers. Those who were selected to participate in the 2011 MCPSS were notified in December 2010. CMS understands that providers and suppliers themselves may not to be able to respond directly to the survey, but may have a staff member who can act as a proxy to respond on their behalf. The respondent can be anyone within the provider's organization that is knowledgeable of the Medicare claims process and is designated to respond to the MCPSS.

If you are selected to participate, please take the time to complete this important survey. CMS encourages providers and suppliers to complete the survey on the Internet via a secure website. Other modes of participation are available by mail, fax, or telephone. It will take no more than 20 minutes. You may also respond by mail, fax, or telephone.

CMS is listening and wants to hear from you. To learn more about the MCPSS, please visit the CMS website at http://www.cms.gov/MCPSS. If you have any questions or concerns, please call our toll-free MCPSS Provider Helpline number at **1-800-654-1431** or send an email to MCPSS_survey@scimetrika.com.

CMS to Conduct 2011 Medicare Contractor Provider Satisfaction Survey

The Centers for Medicare & Medicaid Services (CMS) is listening and wants to hear from you about the services provided by your Medicare Fee-for-Service (FFS) contractor responsible for processing and paying your Medicare claims. CMS is preparing to conduct its annual Medicare Contractor Provider Satisfaction Survey (MCPSS). This survey offers Medicare FFS providers and suppliers an opportunity to give CMS feedback on their interactions with Medicare FFS contractors related to seven key business functions: Provider Inquiries, Provider Outreach & Education, Claims Processing, Appeals, Provider Enrollment, Medical Review, and Provider Audit & Reimbursement.

The survey will be sent to a random sample of approximately 30,000 Medicare FFS providers and suppliers. Those who are selected to participate in the 2011 MCPSS will be notified starting in mid-December. CMS understands that providers and suppliers themselves may not be able to respond directly to the survey, but may have a staff member who can act as a proxy to respond on their behalf. The respondent can be anyone within the provider's organization who is knowledgeable of the Medicare claims process and is designated to respond to the MCPSS. If you are selected to participate, please take the time to complete this important survey. CMS encourages participation in the survey on the Internet via a secure website. It will take no more than 20 minutes. Other modes of participation are available by mail, fax, or telephone. To learn more about the MCPSS, please visit the CMS website at http://www.cms.hhs.gov/MCPSS. Thank you.

HIPAA Eligibility Transaction System (HETS)

On December 4, 2010, a new release of this system was installed. The system had been extensively tested with a number of clearinghouses. Although it performed well in the test environment, the system could not support the production traffic and was backed out on Monday, December 6th.

The system upgrade was designed to address increasing demands (e.g. volume of transactions) and correct connection problems that have been especially problematic during peak hours (9 a.m.-2 p.m. EST).

CMS is aware of the impact of the current performance and connection problems on Medicare providers using this system to get needed beneficiary eligibility information. We regret the inconvenience and want to assure the provider and clearinghouse community that correcting HETS problems is a top priority for CMS. Your continued patience is appreciated. HETS status information will be communicated to HETS submitters as information becomes available.

New Health Coverage Option for Uninsured – Pre-Existing Condition Plan

Are you providing care to uninsured patients who have a pre-existing condition and can't find health coverage? If so, a new federal program – the Pre-Existing Condition Insurance Plan – can change or save the lives of your patients who've been locked out of the health coverage market because of a medical condition.

This program does not base eligibility on income and enrollees receive comprehensive health coverage at the same price that healthy people pay.

To qualify for the program, applicants must:

- Be a citizen of the United States or residing here legally;
- Have been uninsured for at least 6 months; and
- Have a pre-existing condition or have been denied coverage because of a medical condition.

The Pre-Existing Condition Insurance Plan covers physician and hospital services and prescription drugs. All insurance benefits are available to enrollees – even to treat a pre-existing condition. Premiums vary by state and annual out-of-pocket expenses for enrollees are capped.

FYI CONT'D

Each state may use different methods to determine whether a person applying for the Pre-Existing Condition Insurance Plan has a pre-existing condition or whether he or she has been denied health coverage. As such, people need to check on how to establish eligibility in their state. For more information about the Pre-Existing Condition Insurance Plan and how to apply, visit https://www.pcip.gov or, between the hours of 8am and 11pm EST, call 866-717-5826 (TTY: 866-561-1604).

We hope you will tell your patients and colleagues about this important new health coverage option.

Important Information for DDE, PPTN, and CSI Users

A new version of the Medicare Claims Processing System (MCPS) Part A DDE, Part B PPTN, & DME CSI User Request Form will soon be available at www.noridianmedicare.com. Form version 1.4 (dated 12/17/2010) will be required effective 01/03/2011 and prior versions will no longer be accepted.

On the form, the EDI Submitter ID or Biller ID is now required and must be supplied with all requests for Part B and DME only.

Per CMS directive, the following changes will occur effective 01/03/2011:

For any NPI provided on the request form, access to the PTAN will **only** be granted to those listed on the NPPES website (https://nppes.cms.hhs.gov). Please ensure all of the PTANs associated with the NPI have been updated with NPPES. Only the information listed in NPPES will be allowed. If a PTAN is not listed, NAS will not be able to grant access to it.

Also, the facility name provided on the request form must match the Legal Business Name or Doing Business As (DBA) name listed with NPPES. If the facility name currently on file with NAS Data Security does not match, a signed and dated request on letterhead must be faxed to NAS Data Security indicating the name change.

Updates from Medicare Learning Network: ESRD and 5010

CMS reminds suppliers of updates regarding ESRD and 5010.

"End-Stage Renal Disease Prospective Payment System"
The new publication titled "End-Stage Renal Disease Prospective Payment System" (September 2010) provides information about the Medicare End-Stage Renal Disease Prospective Payment System that will be implemented on Jan 1, 2011, including the one-time election and transition period, payment rates for adult and pediatric patients, home dialysis, laboratory services and drugs, and beneficiary deductible and coinsurance. This fact sheet is now available in print format from the Medicare Learning Network®. To place your order, visit http://www.cms.gov/MLNGenInfo, scroll down to "Related Links Inside CMS" and select "MLN Product Ordering Page."

"End-Stage Renal Disease Composite Payment Rate System" Publication Revised
The revised publication titled "End-Stage Renal Disease Composite Payment Rate System" (September 2010) (previously titled "Outpatient Maintenance Dialysis - End-Stage Renal Disease") provides information about the Medicare End-Stage Renal Disease composite payment rate system, the one-time election and transition period, and separately billable items and services. This fact sheet is now available in print format by visiting http://www.cms.gov/MLNGenInfo, scrolling to "Related Links Inside CMS" and selecting "MLN Product Ordering Page."

"5010: Taking Electronic Billing and Electronic Data Interchange to the Next Level"
Now available to order in hardcopy! The new Medicare Learning Network® product titled "5010: Taking Electronic Billing and Electronic Data Interchange (EDI) to the Next Level" is now available in both downloadable and hardcopy formats. This educational tool is designed to provide education on the upcoming implementation of Versions 5010 and D.0, which will replace the current version that covered entities must use when conducting electronic HIPPA transactions. It includes a timeline and list of resources related to the implementation and is suggested for all Medicare Fee-For-Service Providers. To order a hardcopy, free of charge, please visit http://www.cms.gov/MLNGenInfo and click on "MLN Product Ordering Page" under the "Related Links Inside CMS" section at the bottom of the page. This product is also available in downloadable format at http://www.cms.gov/MLNProducts/downloads/5010EDI_RefCard_ICN904284.pdf.

Written Transcript of ESRD PPS 2011 Conference Call
The written transcript of the Medicare Program End-Stage Renal Disease Prospective Payment System (ESRD PPS) 2011 Conference Call, which provides an overview of the ESRD PPS that will be effective on Jan 1, 2011, is now available at http://www.cms.gov/ESRDPayment/10_CMS_Sponsored_Calls.asp

CSI Medicare System Security Semi-Annual Review

The Semi-Annual review of Claim Status Inquiry (CSI) access will not be conducted in January 2011. Advanced notification will be provided prior to the review being scheduled. If you have any questions, please contact NAS Data Security.

Contact information for NAS Data Security can be found at https://www.noridianmedicare.com/dme/claims/contacts.html.

Signature on Requisitions for Clinical Diagnostic Laboratory Tests

In the November 29, 2010, Medicare Physician Fee Schedule final rule, the Centers for Medicare & Medicaid Services (CMS) finalized its proposed policy to require a physician's or qualified nonphysician practitioner's (NPP) signature on requisitions for clinical diagnostic laboratory tests paid under the clinical laboratory fee schedule effective January 1, 2011. A requisition is the actual paperwork, such as a form, which is provided to a clinical diagnostic laboratory that identifies the test or tests to be performed for a patient.

Although many physicians, NPPs, and clinical diagnostic laboratories may be aware of, and are able to comply with, this policy, CMS is concerned that some physicians, NPPs, and clinical diagnostic laboratories are not aware of, or do not understand, this policy. As such, CMS will focus in the first quarter of next year on developing educational and outreach materials to educate those affected by this policy. As they become available, we will post this information on our website at http://www.cms.hhs.gov/ClinicalLabFeeSched and use the other channels we have to communicate with providers to ensure this information is widely distributed. Once our first quarter educational campaign is fully underway, CMS will expect requisitions to be signed.

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

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.

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

Beneficiaries Call 1-800-MEDICARE

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

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

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

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

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

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

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

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

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
10	Guidelines	Removed five-year period	01/25/11
2	NSC Process for Becoming a DME Supplier	Changed twenty-six supplier standards to thirty	01/11/11
2	Accreditation	Updated link to accrediting organizations	01/11/11
Appendix	DME MAC Jurisdiction D Web Resources	Removed location of What's New and changed bulletin publication to quarterly. Removed Online Learning Center from Training/Events and replaced with self-paced tutorials	12/13/10
1	What is Medicare?	Changed deductible for 2011 to $162	12/13/10
5	Parenteral/Enteral Nutrition Therapy	Changed CMS reference	12/13/10
3	Supplier Documentation	Added "if applicable" to "verbal/dispensing/preliminary order" before submitting a claim.	12/02/10
3	Verbal/Dispensing/Preliminary Orders	Removed "electronically emailed"	12/02/10
4	Certificate of Medical Necessity – Common Scenarios	Changed row 8 from "recertification" to "revised"	11/30/10
3	Orders	Added Medicare Benefit Manual to the reference	11/23/10
13	Administrative Law Judge	Added information on in-person hearings	11/11/10

APPEALS

KX Modifier Reopening Requests No Longer Accepted Effective February 21, 2011

Telephone and written reopening requests to add, change, or remove the KX modifier will **no longer be accepted beginning February 21, 2011**. Requests to add, change or remove the KX modifier must be submitted as a redetermination request with all appropriate documentation.

For assistance with submitting a redetermination request refer to the NAS Appeals website at https://www.noridianmedicare.com/dme/appeals/ or you may submit your question to dmeredeterminations@noridian.com.

Revised DME Reopening and Redetermination Request Forms

The Medicare DME Reopening and Redetermination Request forms were revised to include a checkbox for suppliers to indicate the jurisdiction they are submitting the request to. Furthermore, in an effort to assist suppliers who submit requests for redeterminations via fax, the fax number for each jurisdiction has been added.

The Medicare DME Reopening and Redetermination Request Form Completion Guides have also been revised to include instructions regarding these changes.

The revised forms are valid in all four DME MAC jurisdictions. This means that suppliers who submit claims across multiple jurisdictions will only need to complete this one form regardless of which DME MAC to whom they are submitting their request.

The revised forms and completion guides are now available on the NAS website at:
https://www.noridianmedicare.com/dme/forms/appeals_forms.html

Telephone Reopenings: Resources for Success

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

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

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

What may I request as a telephone reopening?	The following is a list of clerical errors and omissions that may be completed as a telephone reopening. This list is not all-inclusive:
	• Diagnosis changes/additions
	• Date of service changes
	• HCPCS code changes
	• Certificate of Medical Necessity (CMN)/DME Information Form (DIF) updates (*with the exception of parenteral and enteral nutrition and oxygen Break In Service (BIS) which must be sent in as a written reopening or redetermination*)
	• Certain modifier changes/additions (not all inclusive list):
	  • KH - DMEPOS item, initial claim, purchase or first month
	  • KI - DMEPOS item, second or third month rental
	  • KJ - DMEPOS item, parenteral enteral nutrition (PEN) pump or capped rental, months four to fifteen
	  • RR - Rental

	• Surgical dressing (when number of services are within the policy - if the request is to allow over the policy amount, these must go to written redeterminations) • Wheelchairs - HCPCS K0004 and lower **NOTE:** If any of the above changes, upon research, are determined to be too complex, the requester will be notified that the request needs to be sent in writing, with the appropriate documentation, as a redetermination.
What is not accepted as a telephone reopening?	The following will not be accepted as a telephone reopening. These items must be submitted along with all supporting documentation as a redetermination. • Any item billed over the allowance listed in the medical policy - documentation is required to support amount billed • Parenteral and enteral DIF issues • Oxygen BIS • Wheelchairs/power mobility devices - HCPCS K0005 and higher • Recoupment/reduction of payment - complete Refunds to Medicare form • Medicare Secondary Payer (MSP)-send inquiry to MSP department • Timely denials – claims submitted within appropriate time frame • Late files – reopening and/or redetermination requests submitted within the appropriate time frame • Requests that require documentation • Advance Beneficiary Notice of Noncoverage (ABN) issues • GA modifier • GY modifier • GZ modifier • KX modifier • Liability issues • Repairs to equipment • Miscellaneous codes • Labor codes **NOTE:** Claims with remittance message MA130 can never be submitted as a reopening. Claims with message MA130 are considered unprocessable and do not have reopening or redetermination rights. The claim is missing information that is needed for processing the claim or the claim information is invalid. These claims must be resubmitted with a new corrected claim.
What do I do when I have a large amount of the same correction?	In the event that a supplier has more than 50 of the same correction, that is able to completed as a reopening, NAS encourages the supplier to notify the telephone representative. The telephone representative will gather the required information and provide the supplier with direction on what is needed and how to submit the request.
Where can I find more information on telephone reopenings?	Suppliers can utilize NAS website at https://www.noridianmedicare.com/dme, specifically • Supplier Manual, Chapter 13: https://www.noridianmedicare.com/dme/news/manual/chapter13.html • Appeals page: https://www.noridianmedicare.com/dme/appeals/
Additional Assistance Available	Suppliers can email questions and concerns regarding reopenings and redeterminations to dmeredeterminations@noridian.com, excluding any Protected Health Information (PHI) information.

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.

Claims Processing Reminder from CMS

CMS has learned from a recent review of DMEPOS supplier claims submitted in 2010 that many DMEPOS suppliers are incorrectly reporting the physicians or non-physician practitioners who ordered the items of DMEPOS. Specifically, DMEPOS suppliers are reporting the National Provider Identifier (NPI) of a non-person entity instead of the NPI of the physician or non-physician practitioner who ordered the DMEPOS.

This message is a reminder that Medicare requires items of DMEPOS to be ordered by physicians or certain non-physician practitioners, not by non-person entities (such as medical groups). Please ensure that your claims are properly completed.

Source: National Supplier Clearinghouse

Submit Claims with Correct Billing Number

The Centers for Medicare & Medicaid Services (CMS) has the following important reminder for all Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) suppliers:

> To ensure accurate claims processing, it is critically important for DMEPOS suppliers to submit each claim using the **billing number/ National Provider Identifier (NPI)*** of the location that furnished the item or service being billed. This has been a long standing CMS policy. If you submit a claim using a **billing number/NPI** for a location that is not the location that furnished the item or service, your claim may be denied. This is particularly important in competitive bidding areas, where only contract suppliers, grandfathered suppliers, and suppliers furnishing competitively bid items under a program exception are eligible to furnish and be paid for competitively bid items.

Place of Service Indicator for HCPCS Codes G0339 and G0340

The Pricing Indicator Code on the Alpha-Numeric HCPCS File has been changed from "00" to "13" for HCPCS codes G0339 and G0340. This change is effective for services furnished in CY 2006 – CY 2010.

ESRD PPS and Consolidated Billing for Limited Part B Services

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

Note: This article was revised on January 18, 2011. To reflect the revised CR 7064 that was issued on January 14, 2011. In this article, the CR release date, transmittal number, and the Web address for accessing CR 7064 were revised. All other information is the same.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Treatments furnished to pediatric patients:

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

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

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

The ESRD PPS 4-year Transition Period Blended Rate Determination

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

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

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

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

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

- The payment rate for a dialysis treatment is determined by wage adjusting the base rate and then applying any applicable:
- Patient-level adjustments;
- Outlier adjustments;
- Facility-level adjustments; and
- Training add-on payments (adjusted for area wage levels)

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

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

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

Three New Adjustments Applicable to the Adult Rate

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

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

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

Therefore, all home dialysis claims:

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

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

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

Other Billing Reminders

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

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

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

Update to Medicare Deductible, Coinsurance and Premium Rates for 2011

MLN Matters® Number: MM7224
Related Change Request (CR) #: 7224
Related CR Release Date: November 19, 2010
Related CR Transmittal #: R65GI
Effective Date: January 1, 2011
Implementation Date: January 3, 2011

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

Impact on Providers
This article is based on Change Request (CR) 7224 which provides the Medicare rates for deductible, coinsurance, and premium payment amounts for Calendar Year (CY) 2011.

Background
2011 Part A - Hospital Insurance (HI)
A beneficiary is responsible for an inpatient hospital deductible amount, which is deducted from the amount payable by the Medicare program to the hospital for inpatient hospital services furnished in a spell of illness.

When a beneficiary receives such services for more than 60 days during a spell of illness, he or she is responsible for a coinsurance amount that is equal to one-fourth of the inpatient hospital deductible per-day for the 61st-90th day spent in the hospital.

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

In addition, a beneficiary is responsible for a coinsurance amount equal to one-eighth of the inpatient hospital deductible per day for the 21st through the 100th day of Skilled Nursing Facility (SNF) services furnished during a spell of illness. **The 2011 inpatient deductible is $1,132.00.** The coinsurance amounts are shown below in the following table:

Hospital Coinsurance		Skilled Nursing Facility Coinsurance
Days 61-90	Days 91-150 (Lifetime Reserve Days)	Days 21-100
$283.00	$566.00	$141.50

Most individuals age 65 and older (and many disabled individuals under age 65) are insured for Health Insurance (HI) benefits without a premium payment. In addition, The Social Security Act provides that certain aged and disabled persons who are not insured may voluntarily enroll, but are subject to the payment of a monthly Part A premium. Since 1994, voluntary enrollees may qualify for a reduced Part A premium if they have 30-39 quarters of covered employment. When voluntary enrollment takes place more than 12 months after a person's initial enrollment period, a 2-year 10% penalty is assessed for every year they had the opportunity to (but failed to) enroll in Part A. The 2011 Part A premiums are as follows:

Voluntary Enrollees Part A Premium Schedule for 2011	
Base Premium (BP)	$450.00 per month
Base Premium with 10% Surcharge	$495.00 per month
Base Premium with 45% Reduction (for those with 30-39 quarters of coverage)	$248.00 (for those who have 30-39 quarters of coverage)
Base Premium with 45% Reduction and 10% Surcharge	$272.80 per month

2011 Part B - Supplementary Medical Insurance (SMI)
Under Part B, the Supplementary Medical Insurance (SMI) program, all enrollees are subject to a monthly premium. In addition, most SMI services are subject to an annual deductible and coinsurance (percent of costs that the enrollee must pay), which are set by statute. Further, when Part B enrollment takes place more than 12 months after a person's initial enrollment period, there is a permanent 10% increase in the premium for each year the beneficiary had the opportunity to (but failed to) enroll.

For 2011, the standard premium for SMI services is $115.40 a month; the deductible is $162.00 a year; and the coinsurance is 20%. The Part B premium is influenced by the beneficiary's income and can be substantially higher based on income. The higher premium amounts and relative income levels for those amounts are contained in CR 7224, which is available at http://www.cms.hhs.gov/Transmittals/downloads/R65GI.pdf on the Centers for Medicare & Medicaid Services (CMS) website.

Additional Information
The official instruction, CR 7224, issued to your carriers, DME MACs, FIs, A/B MACs, and RHHIs regarding this change may be viewed at http://www.cms.gov/Transmittals/downloads/R65GI.pdf on the CMS website.

CARC, RARC, and MREP Update

MLN Matters® Number: MM7250
Related Change Request (CR) #: 7250
Related CR Release Date: January 7, 2011
Related CR Transmittal #: R2131CP
Effective Date: April 1, 2011
Implementation Date: April 4, 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) 7250, from which this article is taken, announces the latest update of Remittance Advice Remark Codes (RARCs) and Claim Adjustment Reason Codes (CARCs), effective April 1, 2011. 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; and additions, deactivations, and modifications to it 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 lists, as announced in CR7250.

Additional Information
To see the official instruction (CR7250) issued to your Medicare Carrier, RHHI, DME/MAC, FI and/or MAC, refer to http://www.cms.gov/Transmittals/downloads/R2131CP.pdf on the CMS website.

New Codes – CARC

Code	Current Narrative	Effective Date Per WPC Posting
W2	Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies, use only if no other code is applicable. Note: If adjustment is at the Claim Level, the payer must send, and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send, and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To be used for Workers' Compensation only.	10/17/2010

Modified Codes – CARC

Code	Modified Narrative	Effective Date Per WPC Posting
191	Not a work related injury/illness and thus not the liability of the workers' compensation carrier. This change effective 7/1/2011: Not a work related injury/illness and thus not the liability of the workers' compensation carrier. Note: If an adjustment is at the Claim Level, the payer must send, and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send, and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF).	10/17/10
214	Workers' Compensation claim adjudicated as non-compensable. This Payer not liable for claim or service/treatment. (Note: To be used for Workers' Compensation only) This change effective 7/1/2011: Workers' Compensation claim adjudicated as non-compensable. This Payer not liable for claim or service/treatment. Note: If adjustment is at the Claim Level, the payer must send, and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send, and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To be used for Workers' Compensation only	10/17/2010

218	Based on entitlement to benefits (Note: To be used for Workers' Compensation only) This change effective 7/1/2011: Based on entitlement to benefits. Note: If adjustment is at the Claim Level, the payer must send, and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send, and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To be used for Workers' Compensation only.	10/17/2010
219	Based on extent of injury (Note: To be used for Workers' Compensation only) This change effective 7/1/2011: Based on extent of injury. Note: If adjustment is at the Claim Level, the payer must send, and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send, and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF).	10/17/2010
221	Workers' Compensation claim is under investigation. (Note: To be used for Workers' Compensation only. Claim pending final resolution). This change effective 7/1/2011: Workers' Compensation claim is under investigation. Note: If adjustment is at the Claim Level, the payer must send, and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send, and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF).	10/17/2010
W1	Workers Compensation State Fee Schedule Adjustment. This change effective 7/1/2011: Workers' compensation jurisdictional fee schedule adjustment. Note: If adjustment is at the Claim Level, the payer must send, and the provider should refer to the 835 Class of Contract Code Identification Segment (Loop 2100 Other Claim Related Information REF). If adjustment is at the Line Level, the payer must send, and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF).	10/17/2010

Deactivated Codes – CARC
None

New Codes – RARC

Code	Current Narrative	Medicare Initiated
N540	Payment adjusted based on the interrupted stay policy.	Yes
N541	Mismatch between the submitted insurance type code and the information stored in our system.	Yes

Modified Codes – RARC

Code	Modified Narrative	Medicare Initiated
M25	The information furnished does not substantiate the need for this level of service. If you believe the service should have been fully covered as billed, or if you did not know and could not reasonably have been expected to know that we would not pay for this level of service, or if you notified the patient in writing in advance that we would not pay for this level of service and he/she agreed in writing to pay, ask us to review your claim within 120 days of the date of this notice. If you do not request an appeal, we will, upon application from the patient, reimburse him/her for the amount you have collected from him/her in excess of any deductible and coinsurance amounts. We will recover the reimbursement from you as an overpayment.	No

Deactivated Codes – RARC
None

2011 DMEPOS HCPCS Code Jurisdiction List

MLN Matters® Number: MM7257
Related Change Request (CR) #:7257
Related CR Release Date: January 14, 2011
Related CR Transmittal #: R2132CP
Effective Date: January 1, 2011
Implementation Date: February 15, 2011

Provider Types Affected
Suppliers submitting claims to Medicare contractors (DME Medicare Administrative Contractors (DME MACs), Part B Carriers, and Medicare Administrative Contractors (A/B MACs)) for DMEPOS services provided to Medicare beneficiaries are affected.

Provider Action Needed
This article is informational and based on Change Request (CR) 7257 that notifies providers that the spreadsheet containing an updated list of the Healthcare Common Procedure Coding System (HCPCS) codes for DME MAC, Part B carrier, or A/B MAC jurisdictions is updated annually to reflect codes that have been added or discontinued (deleted) each year. The spreadsheet is helpful to billing staff by showing the appropriate Medicare contractor to be billed for HCPCS appearing on the spreadsheet. The spreadsheet for the 2011 Jurisdiction List is an Excel® spreadsheet and is available under the Coding Category at http://www.cms.gov/center/dme.asp on the Centers for Medicare & Medicaid Services (CMS) website.

Additional Information
The official instruction, CR7257, issued to your Medicare A/B MAC, carrier and DME/MAC regarding this change may be viewed at http://www.cms.gov/Transmittals/downloads/R2132CP.pdf on the CMS website. The 2011 Jurisdiction List is also attached to CR7257.

2011 Jurisdiction List for DMEPOS

Note: Deleted codes are valid for dates of service on or before the date of deletion.

Note: Updated codes are in bold.

HCPCS	DESCRIPTION	JURISDICTION
A0021 - A0999	Ambulance Services	Local Carrier
A4206 - A4209	Medical, Surgical, and Self-Administered Injection Supplies	Local Carrier if incident to a physician's service (not separately payable). If other DME MAC.
A4210	Needle Free Injection Device	DME MAC
A4211	Medical, Surgical, and Self-Administered Injection Supplies	Local Carrier if incident to a physician's service (not separately payable). If other DME MAC.
A4212	Non Coring Needle or Stylet with or without Catheter	Local Carrier
A4213 - A4215	Medical , Surgical, and Self-Administered Injection Supplies	Local Carrier if incident to a physician's service (not separately payable). If other DME MAC.
A4216 - A4218	Saline	Local Carrier if incident to a physician's service (not separately payable). If other DME MAC.
A4220	Refill Kit for Implantable Pump	Local Carrier
A4221 - A4250	Medical, Surgical, and Self-Administered Injection Supplies	Local Carrier if incident to a physician's service (not separately payable). If other DME MAC.
A4252 - A4259	Diabetic Supplies	DME MAC
A4261	Cervical Cap for Contraceptive Use	Local Carrier
A4262 - A4263	Lacrimal Duct Implants	Local Carrier
A4264	Contraceptive Implant	Local Carrier
A4265	Paraffin	Local Carrier if incident to a physician's service (not separately payable). If other DME MAC.
A4266 - A4269	Contraceptives	Local Carrier

A4270	Endoscope Sheath	Local Carrier
A4280	Accessory for Breast Prosthesis	DME MAC
A4281 - A4286	Accessory for Breast Pump	DME MAC
A4290	Sacral Nerve Stimulation Test Lead	Local Carrier
A4300 - A4301	Implantable Catheter	Local Carrier
A4305 - A4306	Disposable Drug Delivery System	Local Carrier if incident to a physician's service (not separately payable). If other DME MAC.
A4310 - A4358	Incontinence Supplies/Urinary Supplies	If provided in the physician's office for a temporary condition, the item is incident to the physician's service & billed to the Local Carrier. If provided in the physician's office or other place of service for a permanent condition, the item is a prosthetic device & billed to the DME MAC.
A4360 - A4434	Urinary Supplies	If provided in the physician's office for a temporary condition, the item is incident to the physician's service & billed to the Local Carrier. If provided in the physician's office or other place of service for a permanent condition, the item is a prosth
A4450 - A4456	Tape; Adhesive Remover	Local Carrier if incident to a physician's service (not separately payable). If other DME MAC.
A4458	Enema Bag	DME MAC
A4461-A4463	Surgical Dressing Holders	Local Carrier if incident to a physician's service (not separately payable). If other DME MAC.
A4465 - A4466	Non-elastic Binder and Elastic Garment	DME MAC
A4470	Gravlee Jet Washer	Local Carrier
A4480	Vabra Aspirator	Local Carrier
A4481	Tracheostomy Supply	Local Carrier if incident to a physician's service (not separately payable). If other DME MAC.
A4483	Moisture Exchanger	DME MAC
A4490 - A4510	Surgical Stockings	DME MAC
A4520	Diapers	DME MAC
A4550	Surgical Trays	Local Carrier
A4554	Disposable Underpads	DME MAC
A4556 - A4558	Electrodes; Lead Wires; Con-	Local Carrier if incident to a physician's service (not separately payable). If other DME MAC.
A4559	Coupling Gel	Local Carrier if incident to a physician's service (not separately payable). If other DME MAC.
A4561 - A4562	Pessary	Local Carrier
A4565	Sling	Local Carrier
A4566	Shoulder Abduction Restrainer	DME MAC
A4570	Splint	Local Carrier
A4575	Topical Hyperbaric Oxygen Chamber, Disposable	DME MAC
A4580 - A4590	Casting Supplies & Material	Local Carrier
A4595	TENS Supplies	Local Carrier if incident to a physician's service (not separately payable). If other DME MAC.
A4600	Sleeve for Intermittent Limb Compression Device	DME MAC

A4601	Lithium Ion Battery for Non-Prosthetic Use	DME MAC
A4604	Tubing for Positive Airway Pressure Device	DME MAC
A4605	Tracheal Suction Catheter	DME MAC
A4606	Oxygen Probe for Oximeter	DME MAC
A4608	Transtracheal Oxygen Catheter	DME MAC
A4611 - A4613	Oxygen Equipment Batteries and Supplies	DME MAC
A4614	Peak Flow Rate Meter	Local Carrier if incident to a physician's service (not separately payable). If other DME MAC.
A4615 - A4629	Oxygen & Tracheostomy Supplies	Local Carrier if incident to a physician's service (not separately payable). If other DME MAC.
A4630 - A4640	DME Supplies	DME MAC
A4641 - A4642	Imaging Agent; Contrast Material	Local Carrier
A4648	Tissue Marker, Implanted	Local Carrier
A4649	Miscellaneous Surgical Supplies	Local Carrier if incident to a physician's service (not separately payable) or if supply for implanted prosthetic device or implanted DME. If other DME MAC.
A4650	Implantable Radiation Dosimeter	Local Carrier
A4651 - A4932	Supplies for ESRD	DME MAC
A5051 - A5093	Additional Ostomy Supplies	If provided in the physician's office for a temporary condition, the item is incident to the physician's service & billed to the Local Carrier. If provided in the physician's office or other place of service for a permanent condition, the item is a prosthetic device & billed to the DME MAC.
A5102 - A5200	Additional Incontinence and Ostomy Suppli	If provided in the physician's office for a temporary condition, the item is incident to the physician's service & billed to the Local Carrier. If provided in the physician's office or other place of service for a permanent condition, the item is a prosthetic device & billed to the DME MAC.
A5500 - A5513	Therapeutic Shoes	DME MAC
A6000	Non-Contact Wound Warming Cover	DME MAC
A6010-A6024	Surgical Dressing	Local Carrier if incident to a physician's service (not separately payable) or if supply for implanted prosthetic device or implanted DME. If other DME MAC.
A6025	Silicone Gel Sheet	Local Carrier if incident to a physician's service (not separately payable) or if supply for implanted prosthetic device or implanted DME. If other DME MAC.
A6154 - A6411	Surgical Dressing	Local Carrier if incident to a physician's service (not separately payable) or if supply for implanted prosthetic device or implanted DME. If other DME MAC.
A6412	Eye Patch	Local Carrier if incident to a physician's service (not separately payable) or if supply for implanted prosthetic device or implanted DME. If other DME MAC.
A6413	Adhesive Bandage	Local Carrier if incident to a physician's service (not separately payable) or if supply for implanted prosthetic device or implanted DME. If other DME MAC.
A6441 - A6512	Surgical Dressings	Local Carrier if incident to a physician's service (not separately payable) or if supply for implanted prosthetic device or implanted DME. If other DME MAC.

A6513	Compression Burn Mask	DME MAC
A6530 - A6549	Compression Gradient Stockings	DME MAC
A6550	Supplies for Negative Pressure Wound Ther	DME MAC
A7000 - A7002	Accessories for Suction Pumps	DME MAC
A7003 - A7039	Accessories for Nebulizers, Aspirators and V	DME MAC
A7040 - A7041	Chest Drainage Supplies	Local Carrier
A7042 - A7043	Pleural Catheter	Local Carrier
A7044 - A7046	Respiratory Accessories	DME MAC
A7501-A7527	Tracheostomy Supplies	DME MAC
A8000-A8004	Protective Helmets	DME MAC
A9150	Non-Prescription Drugs	Local Carrier
A9152 - A9153	Vitamins	Local Carrier
A9155	Artificial Saliva	Local Carrier
A9180	Lice Infestation Treatment	Local Carrier
A9270	Noncovered Items or Services	DME MAC
A9273	Noncovered Items or Services	DME MAC
A9274 - A9278	Glucose Monitoring	DME MAC
A9279	Monitoring Feature/Device	DME MAC
A9280	Alarm Device	DME MAC
A9281	Reaching/Grabbing Device	DME MAC
A9282	Wig	DME MAC
A9283	Foot Off Loading Device	DME MAC
A9284	Non-electric Spirometer	DME MAC
A9300	Exercise Equipment	DME MAC
A9500 - A9700	Supplies for Radiology Procedures	Local Carrier
A9900	Miscellaneous DME Supply or Accessory	Local Carrier if used with implanted DME. If other, DME MAC.
A9901	Delivery	DME MAC
A9999	Miscellaneous DME Supply or Accessory	Local Carrier if used with implanted DME. If other, DME MAC.
B4034 - B9999	Enteral and Parenteral Therapy	DME MAC
D0120 - D9999	Dental Procedures	Local Carrier
E0100 - E0105	Canes	DME MAC
E0110 - E0118	Crutches	DME MAC
E0130 - E0159	Walkers	DME MAC
E0160 - E0175	Commodes	DME MAC
E0181 - E0199	Decubitus Care Equipment	DME MAC
E0200 - E0239	Heat/Cold Applications	DME MAC
E0240 - E0248	Bath and Toilet Aids	DME MAC
E0249	Pad for Heating Unit	DME MAC
E0250 - E0304	Hospital Beds	DME MAC
E0305 - E0326	Hospital Bed Accessories	DME MAC

E0328 - E0329	Pediatric Hospital Beds	DME MAC
E0350 - E0352	Electronic Bowel Irrigation System	DME MAC
E0370	Heel Pad	DME MAC
E0371 - E0373	Decubitus Care Equipment	DME MAC
E0424 - E0484	Oxygen and Related Respiratory Equipment	DME MAC
E0485 - E0486	Oral Device to Reduce Airway Collapsibility	DME MAC
E0487	Electric Spirometer	DME MAC
E0500	IPPB Machine	DME MAC
E0550 - E0585	Compressors/Nebulizers	DME MAC
E0600	Suction Pump	DME MAC
E0601	CPAP Device	DME MAC
E0602 - E0604	Breast Pump	DME MAC
E0605	Vaporizer	DME MAC
E0606	Drainage Board	DME MAC
E0607	Home Blood Glucose Monitor	DME MAC
E0610 - E0615	Pacemaker Monitor	DME MAC
E0616	Implantable Cardiac Event Recorder	Local Carrier
E0617	External Defibrillator	DME MAC
E0618 - E0619	Apnea Monitor	DME MAC
E0620	Skin Piercing Device	DME MAC
E0621 - E0636	Patient Lifts	DME MAC
E0637 - E0642	Standing Devices/Lifts	DME MAC
E0650 - E0676	Pneumatic Compressor and Appliances	DME MAC
E0691 - E0694	Ultraviolet Light Therapy Systems	DME MAC
E0700	Safety Equipment	DME MAC
E0705	Transfer Board	DME MAC
E0710	Restraints	DME MAC
E0720 - E0745	Electrical Nerve Stimulators	DME MAC
E0746	EMG Device	Local Carrier
E0747 - E0748	Osteogenic Stimulators	DME MAC
E0749	Implantable Osteogenic Stimulators	Local Carrier
E0755	Reflex Stimulator	DME MAC
E0760	Ultrasonic Osteogenic Stimulator	DME MAC
E0761	Electromagnetic Treatment Device	DME MAC
E0762	Electrical Joint Stimulation Device	DME MAC
E0764	Functional Neuromuscular Stimulator	DME MAC
E0765	Nerve Stimulator	DME MAC
E0769	Electrical Wound Treatment Device	DME MAC
E0770	Functional Electrical Stimulator	DME MAC
E0776	IV Pole	DME MAC
E0779 - E0780	External Infusion Pumps	DME MAC

E0781	Ambulatory Infusion Pump	Billable to both the local carrier and the DME MAC. This item may be billed to the DME MAC whenever the infusion is initiated in the physician's office but the patient does not return during the same business day.
E0782 - E0783	Infusion Pumps, Implantable	Local Carrier
E0784	Infusion Pumps, Insulin	DME MAC
E0785 - E0786	Implantable Infusion Pump Catheter	Local Carrier
E0791	Parenteral Infusion Pump	DME MAC
E0830	Ambulatory Traction Device	DME MAC
E0840 - E0900	Traction Equipment	DME MAC
E0910 - E0930	Trapeze/Fracture Frame	DME MAC
E0935 - E0936	Passive Motion Exercise Device	DME MAC
E0940	Trapeze Equipment	DME MAC
E0941	Traction Equipment	DME MAC
E0942 - E0945	Orthopedic Devices	DME MAC
E0946 - E0948	Fracture Frame	DME MAC
E0950 - E1298	Wheelchairs	DME MAC
E1300 - E1310	Whirlpool Equipment	DME MAC
E1353 - E1392	Additional Oxygen Related Equipment	DME MAC
E1399	Miscellaneous DME	Local Carrier if implanted DME. If other, DME MAC.
E1405 - E1406	Additional Oxygen Equipment	DME MAC
E1500 - E1699	Artificial Kidney Machines and Accessories	DME MAC
E1700 - E1702	TMJ Device and Supplies	DME MAC
E1800 - E1841	Dynamic Flexion Devices	DME MAC
E1902	Communication Board	DME MAC
E2000	Gastric Suction Pump	DME MAC
E2100 - E2101	Blood Glucose Monitors with Special Featur	DME MAC
E2120	Pulse Generator for Tympanic Treatment of	DME MAC
E2201 - E2397	Wheelchair Accessories	DME MAC
E2402	Negative Pressure Wound Therapy Pump	DME MAC
E2500 - E2599	Speech Generating Device	DME MAC
E2601 - E2625	Wheelchair Cushions	DME MAC
E8000 - E8002	Gait Trainers	DME MAC
G0008 - G0329	Misc. Professional Services	Local Carrier
G0333	Dispensing Fee	DME MAC
G0337 - G0365	Misc. Professional Services	Local Carrier
G0372	Misc. Professional Services	Local Carrier
G0378 - G9147	Misc. Professional Services	Local Carrier
J0120 - J3570	Injection	Local Carrier if incident to a physician's service or used in an implanted infusion pump. If other, DME MAC.
J3590	Unclassified Biologicals	Local Carrier
J7030 - J7130	Miscellaneous Drugs and Solutions	Local Carrier if incident to a physician's service or used in an implanted infusion pump. If other, DME MAC.

J7184	Wilate injection	Local Carrier
J7185 - J7195	Antihemophilic Factor	Local Carrier
J7196 - J7197	Antithrombin III	Local Carrier
J7198	Anti-inhibitor; per I.U.	Local Carrier
J7199	Other Hemophilia Clotting Factors	Local Carrier
J7300 - J7307	Intrauterine Copper Contraceptive	Local Carrier
J7308 - J7309	Aminolevulinic Acid HCL	Local Carrier
J7310	Ganciclovir, Long-Acting Implant	Local Carrier
J7311 - J7312	Fluocinolone Acetonide, intravitreal implan	Local Carrier
J7321 - J7325	Hyaluronan	Local Carrier
J7330	Autologous Cultured Chondrocytes, Implan	Local Carrier
J7335	Capsaicin	Local Carrier
J7500 - J7599	Immunosuppressive Drugs	Local Carrier if incident to a physician's service or used in an implanted infusion pump. If other, DME MAC.
J7604 - J7699	Inhalation Solutions	Local Carrier if incident to a physician's service. If other, DME MAC.
J7799	NOC, Other than Inhalation Drugs	Local Carrier if incident to a physician's service. If other, DME MAC.
J8498	Anti-emetic Drug	DME MAC
J8499	Prescription Drug, Oral, Non	Local carrier if incident to a physician's Chemotherapeutic service. If other, DME MAC.
J8501 - J8999	Oral Anti-Cancer Drugs	DME MAC
J9000 - J9999	Chemotherapy Drugs	Local Carrier if incident to a physician's service or used in an implanted infusion pump. If other, DME MAC.
K0001 - K0108	Wheelchairs	DME MAC
K0195	Elevating Leg Rests	DME MAC
K0455	Infusion Pump used for Uninterrupted Adm	DME MAC
K0462	Loaner Equipment	DME MAC
K0552	External Infusion Pump Supplies	DME MAC
K0601 - K0605	External Infusion Pump Batteries	DME MAC
K0606 - K0609	Defibrillator Accessories	DME MAC
K0669	Wheelchair Cushion	DME MAC
K0672	Soft Interface for Orthosis	DME MAC
K0730	Inhalation Drug Delivery System	DME MAC
K0733	Power Wheelchair Accessory	DME MAC
K0738	Oxygen Equipment	DME MAC
K0739	Repair or Nonroutine Service for DME	Local Carrier if implanted DME. If other, DME MAC
K0740	Repair or Nonroutine Service for Oxygen Eq	DME MAC
K0800 - K0899	Power Mobility Devices	DME MAC
L0112 - L2090	Orthotics	DME MAC
L2106 - L2116	Orthotics	DME MAC
L2126 - L4398	Orthotics	DME MAC
L4631	Orthotics	DME MAC

L5000 - L5999	Lower Limb Prosthetics	DME MAC
L6000 - L7499	Upper Limb Prosthetics	DME MAC
L7500 - L7520	Repair of Prosthetic Device	Local Carrier if repair of implanted prosthetic device. If other, DME MAC.
L7600	Prosthetic Donning Sleeve	DME MAC
L7900	Vacuum Erection System	DME MAC
L8000 - L8485	Prosthetics	DME MAC
L8499	Unlisted Procedure for Miscellaneous Prost	Local Carrier if implanted prosthetic device. If other, DME MAC.
L8500 - L8501	Artificial Larynx; Tracheostomy Speaking Va	DME MAC
L8505	Artificial Larynx Accessory	DME MAC
L8507	Voice Prosthesis, Patient Inserted	DME MAC
L8509	Voice Prosthesis, Inserted by a Licensed He	Local Carrier for dates of service on or after 10/01/2010, DME MAC for dates of service prior to 10/01/2010
L8510 - L8515	Voice Prosthesis	DME MAC
L8600 - L8699	Prosthetic Implants	Local Carrier
L9900	Miscellaneous Orthotic or Prosthetic Comp	Local Carrier if used with implanted prosthetic device. If other, DME MAC.
M0064 - M0301	Medical Services	Local Carrier
P2028 - P9615	Laboratory Tests	Local Carrier
Q0035	Influenza Vaccine; Cardio-kymography	Local Carrier
Q0081	Infusion Therapy	Local Carrier
Q0083 - Q0085	Chemotherapy Administration	Local Carrier
Q0091	Smear Preparation	Local Carrier
Q0092	Portable X-ray Setup	Local Carrier
Q0111 - Q0115	Miscellaneous Lab Services	Local Carrier
Q0138-Q0139	Ferumoxytol Injection	Local Carrier
Q0144	Azithromycin Dihydrate	Local Carrier if incident to a physician's service. If other, DME MAC.
Q0163 - Q0181	Anti-emetic	DME MAC
Q0480 - Q0506	Ventricular Assist Devices	Local Carrier
Q0510 - Q0514	Drug Dispensing Fees	DME MAC
Q0515	Sermorelin Acetate	Local Carrier
Q1003 - Q1005	New Technology IOL	Local Carrier
Q2004	Irrigation Solution	Local Carrier
Q2009	Fosphenytoin	Local Carrier
Q2017	Teniposide	Local Carrier
Q2025	Oral Anti-Cancer Drugs	DME MAC
Q2026-Q2027	Injectable Dermal Fillers (Effective July 1, 20	Local Carrier
Q2035 - Q2039	Influenza Vaccine	Local Carrier
Q3014	Telehealth Originating Site Facility Fee	Local Carrier
Q3025 - Q3026	Vaccines	Local Carrier
Q3031	Collagen Skin Test	Local Carrier
Q4001 - Q4051	Splints and Casts	Local Carrier

Q4074	Inhalation Drug	Local Carrier if incident to a physician's service. If other, DME MAC.
Q4081	Epoetin	DME MAC for method II home dialysis. If other, Local Carrier.
Q4082	Drug Subject to Competitive Acquisition Pro	Local Carrier
Q4100 - Q4121	Skin Substitutes	Local Carrier
Q5001 - Q5010	Hospice Services	Local Carrier
Q9951 - Q9954	Imaging Agents	Local Carrier
Q9955 - Q9957	Microspheres	Local Carrier
Q9958 - Q9968	Imaging Agents	Local Carrier
R0070 - R0076	Diagnostic Radiology Services	Local Carrier
V2020 - V2025	Frames	DME MAC
V2100 - V2513	Lenses	DME MAC
V2520 - V2523	Hydrophilic Contact Lenses	Local Carrier if incident to a physician's service. If other, DME MAC.
V2530 - V2531	Contact Lenses, Scleral	DME MAC
V2599	Contact Lens, Other Type	Local Carrier if incident to a physician's service. If other, DME MAC.
V2600 - V2615	Low Vision Aids	DME MAC
V2623 - V2629	Prosthetic Eyes	DME MAC

Claim Status Category and Claim Status Code Update

MLN Matters® Number: MM7259
Related Change Request (CR) #: 7259
Related CR Release Date: December 17, 2010
Related CR Transmittal #: R2120CP
Effective Date: April 1, 2011
Implementation Date: April 4, 2011

Provider Types Affected
All physicians, providers, and suppliers submitting claims to Medicare contractors (Fiscal Intermediaries (FI), Regional Home Health Intermediaries (RHHI), carriers, Part A/B Medicare Administrative Contractors (MAC) and Durable Medical Equipment MACs or DME MACs) for Medicare beneficiaries are affected.

Provider Action Needed
This article, based on Change Request (CR) 7259, 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 along with the 277 Health Care Claim Acknowledgement were updated during the January 2011 meeting of the national Code Maintenance Committee and code changes approved at that meeting are to be posted at http://www.wpc-edi.com/content/view/180/223/ on or about March 1, 2011. Included in the code lists are specific details, including the date when a code was added, changed, or deleted. Medicare contractors will implement these changes on April 4, 2011. All providers should ensure that their billing staffs are aware of the updated codes and the timeframe for implementations.

Background
The Health Insurance Portability and Accountability Act 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). 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, (CR7259), issued to your Medicare contractor regarding this change may be viewed at http://www.cms.gov/Transmittals/downloads/R2120CP.pdf on the CMS website.

CEDI

CEDI Recertification Process

Beginning in 2011, the National Government Services, Inc. Common Electronic Data Interchange (CEDI) will begin requiring all CEDI Trading Partners to **re-certify their user access on an annual basis**. This initiative is to strengthen the security of our gateway and ensure that all Trading Partners accessing the CEDI gateway are valid. CEDI plans to begin implementation of this recertification process starting January 18, 2011.

Recertification will be the responsibility of the owner of the Trading Partner ID used to exchange electronic transactions with CEDI. The recertification will be s taggered, allowing Trading Partners a timeframe to contact our CEDI Help Desk:

- January 2011 –A08 Trading Partner IDs
- February 2011 – D08 Trading Partner IDs
- March 2011 – C08 Trading Partner IDs
- April 2011 – B08 Trading Partner IDs

The timeframe is built to allow the approximately 13,000 CEDI Trading Partners the ability to migrate to this new process without hindering their business functionality or by overwhelming the CEDI Help Desk or Enrollment units.

This migration is scheduled to be completed by August 2011. CEDI Trading Partners who have not recertified will be made inactive sixty (60) days after the end of the migration.

CEDI Trading Partners will be asked to fill out the Recertification Form. Incomplete forms will be returned to the applicant, thus delaying processing. Trading Partners will be asked to fax their completed forms to the CEDI fax number 317-595-4999. If forms cannot be faxed, the Trading Partner may email the forms to ngs.cedihelpdesk@wellpoint.com.

Once the forms have been received and processed, CEDI will notify the Trading Partner via the email address submitted on the Recertification Form.

For additional questions, please contact the CEDI Help Desk at 866-311-9184, or you may submit your questions via e-mail ngs.cedihelpdesk@wellpoint.com.

CERT

CERT Documentation

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

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

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

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

Mail all requested documentation to:

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

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

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

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

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

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

COMPETITIVE BIDDING

Three Important DMEPOS Competitive Bidding Updates

Three updates that will be of interest to the provider community regarding the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program:

1. **DMEPOS Competitive Bidding Program Information Mailed to Referral Agents**

The DMEPOS Competitive Bidding Program will go into effect for nine product categories in nine competitive bidding areas (CBAs) on Sat Jan 1, 2011. When the program becomes effective, beneficiaries with Original Medicare who obtain competitively bid items in CBAs must obtain these items from a contract supplier for Medicare to pay, unless an exception applies.

The nine product categories are: Oxygen, oxygen equipment, and supplies; Standard power wheelchairs, scooters and related accessories; Complex rehabilitative power wheelchairs and related accessories (Group 2 only); Mail-order diabetic supplies; Enteral nutrients, equipment, and supplies; Continuous Positive Airway Pressure (CPAP) devices and Respiratory Assist Devices (RADs) and related supplies and accessories; Hospital beds and related accessories; Walkers and related accessories; and Support surfaces (Group 2 mattresses and overlays in Miami-Fort Lauderdale-Pompano Beach, FL only).

The nine competitive bidding areas are: 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; Riverside-San Bernardino-Ontario, CA.

It is crucial that health care professionals who order items included in the program understand how this program will affect their Medicare patients so that Medicare will continue to pay for covered services. Therefore, the Centers for Medicare & Medicaid Services (CMS) is in the process of mailing a letter to referral agents in CBAs to remind them that the program is starting on Sat Jan 1, 2011. For purposes of the Medicare DMEPOS Competitive Bidding Program, "referral agent" includes such entities as Medicare enrolled providers, physicians, treating practitioners, discharge planners, social workers, and pharmacists who refer beneficiaries for services in a CBA. A copy of the letter is now available on the CMS website at http://www.cms.gov/DMEPOSCompetitiveBid/04_Educational_Resources.asp.

2. **Supplier Locator Tool Updated for DMEPOS Competitive Bidding**

CMS has updated its online supplier locator tool with new features for the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program. Here's how to access a list of DMEPOS competitive bidding contract suppliers for a particular beneficiary's competitive bidding area using the updated online supplier locator tool:

1. Visit http://www.medicare.gov/Supplier.
2. Enter the Medicare beneficiary's zip code and click "Submit."
3. A list of product categories will appear; those product categories with a star icon next to them are included in the Competitive Bidding Program.
4. After selecting a competitive bidding product category, click "View Results."
5. A page will display stating you've selected a competitive bidding product category and briefly explain the program; click "Continue."
6. A list of all Medicare contract supplier locations in the competitive bidding area will appear.

A list of the CMS-designated Medicare DMEPOS Competitive Bidding Program contract suppliers for each CBA can also be found at http://www.cms.gov/DMEPOSCompetitiveBid/01A2_Contract_Supplier_Lists.asp.

3. **DMEPOS Competitive Bidding Program "Repairs and Replacements Fact Sheet" Now Available from the Medicare Learning Network**

The DMEPOS Competitive Bidding Program "Repairs and Replacements Fact Sheet" is now available to download, free of charge, from the Medicare Learning Network®.

Once the DMEPOS competitive bidding program becomes effective on Sat Jan 1, 2011, beneficiaries with Original Medicare who obtain competitively bid items in competitive bidding areas (CBAs) must obtain these items from a contract supplier for Medicare to pay, unless an exception applies. One exception occurs when an item of DMEPOS that a beneficiary already owns needs to be repaired.

This fact sheet contains helpful information on competitive bidding program rules that apply when an item of DMEPOS that is owned by a beneficiary needs to be repaired or requires replacement parts. It includes information on which items and services non-contract suppliers may provide, and which Healthcare Common Procedure Coding System (HCPCS) codes can be considered replacement parts associated with repair of base equipment. To view the fact sheet, please visit the DMEPOS Competitive Bidding Educational Resources page at http://www.cms.gov/DMEPOSCompetitiveBid/04_Educational_Resources.asp, Scroll down to "Downloads," and select "DMEPOS Competitive Bidding Fact Sheets."

Note: If you have problems accessing any hyperlink in this message, please copy and paste the URL into your Internet browser.

DMEPOS Program Changes Coming January 1, 2011

Changes Coming January 1, 2011, to DMEPOS Program: What Medicare-Enrolled Providers, Physicians, Treating Practitioners, Discharge Planners, Social Workers, and Pharmacists Need to Know

Medicare is phasing in a new program that changes the amount Medicare pays for certain durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) and requires Medicare contract suppliers to furnish these items in most cases. Health care providers play a key role in helping their patients understand how they will be affected by this change and what they need to do in order to continue to have Medicare pay for the high-quality equipment and supplies they need.

Starting January 1, 2011, if your patients with Original Medicare live in or visit one of the communities listed below, and must obtain any of the equipment or supplies included in the program (also listed below), they will almost always have to use Medicare contract suppliers for Medicare to help pay for the item.

COMPETITIVE BIDDING CONT'D

The first nine areas included in the new program are:

- Charlotte - Gastonia-Concord, NC - SC
- Cincinnati - Middletown, Ohio - Kentucky - Indiana
- Cleveland - Elyria - Mentor, Ohio
- Dallas - Fort Worth - Arlington, Texas
- Kansas City, Missouri - Kansas
- Miami - Fort Lauderdale - Pompano Beach, Florida
- Orlando - Kissimmee, Florida
- Pittsburgh, Pennsylvania
- Riverside - San Bernardino - Ontario, California

The products and equipment included in the program are:

- Oxygen, oxygen equipment, and supplies
- Standard power wheelchairs, scooters, and related accessories
- Complex rehabilitative power wheelchairs and related accessories (Group 2 only)
- Mail-order diabetic supplies
- Enteral nutrients, equipment, and supplies
- Continuous positive airway pressure (CPAP) devices and respiratory assist devices (RADs) and related supplies and accessories
- Hospital beds and related accessories
- Walkers and related accessories
- Support surfaces (Group 2 mattresses and overlays in Miami-Fort Lauderdale-Pompano Beach only)

If your patients currently rent oxygen and oxygen equipment or durable medical equipment, they may be able to continue renting these items from their current supplier when the program takes effect, if the supplier decides to participate in the program as a "grandfathered" supplier.

Medicare has a variety of resources available to help you understand the new program at http://www.cms.gov/DMEPOSCompetitiveBid; DMEPOS Competitive Bidding Program Medicare Learning Network® (MLN) Fact Sheets can be found at http://www.cms.gov/MLNProducts/downloads/DMEPOS_Competitive_Bidding_Factsheets.pdf.

Clarification: Important Information for Non-Contract Grandfathered DMEPOS Suppliers

This message, which was first sent Monday, January 3rd, is being reissued to include instructions regarding the submitted charge on the claim. This additional sentence can be found in bold, near the end of the message below.

The Centers for Medicare & Medicaid Services (CMS) has important information for non-contract, grandfathered suppliers that submit claims for the payment of purchased accessories and supplies for use with grandfathered equipment under the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program.

Through testing of the Medicare claims-processing system, CMS has identified a possible problem when non-contract, grandfathered suppliers submit claims for the payment of purchased accessories and supplies for use with grandfathered equipment under the DMEPOS Competitive Bidding Program. CMS has created a temporary solution that will enable affected suppliers to continue to receive Medicare payment for such items. This temporary solution will require affected suppliers to append affected Healthcare Common Procedure Coding System (HCPCS) codes with the "KY" modifier.

Specifically, in order to secure payment, grandfathered suppliers must use the KY modifier on claims with dates of service on or after Sat Jan 1, 2011, for purchased, covered accessories or supplies furnished for use with grandfathered equipment. The HCPCS codes identified below 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, E0562
- Hospital Beds and Related Accessories: E0271, E0272, E0280, E0310
- Walkers and Related Accessories: E0154, E0156, E0157, E0158

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.

The correct payment for covered accessories and supplies used in conjunction with a grandfathered item under a competitive bidding program is 80 percent of the single payment amount calculated for the item for the Competitive Bidding Area in which the beneficiary maintains a permanent residence. However, payments made under this temporary solution will result in payment on a fee schedule basis rather than payment using the single payment amounts. **In order to mitigate the need to adjust claims in the future, suppliers should submit the applicable single payment amount for the accessory or supply as their submitted charge on the claim.**

Further information related to whether and how claims will be adjusted when such claims are paid using fee schedule amounts, rather than single payment amounts, will be provided in a future communication. Suppliers may submit appeals of denied claims for purchased accessories and supplies used in conjunction with grandfathered items to the appropriate DME MAC for consideration. Further information concerning when a permanent solution will be implemented will be communicated as soon as possible.

"DMEPOS Competitive Bidding Procedures for Upgrades" Fact Sheet

The "Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Billing Procedures for Upgrades" Fact Sheet is now available to download, free of charge, from the Medicare Learning Network®.

Once the DMEPOS Competitive Bidding Program became effective on Saturday, January 1, 2011, beneficiaries with Original Medicare who obtain competitively bid items in competitive bidding areas (CBAs) must obtain these items from a contract supplier for Medicare to pay, unless an exception applies. This fact sheet contains helpful information on Competitive Bidding Program rules that apply when a beneficiary wants to obtain an upgrade – that is, an item or a component of an item that exceeds the beneficiary's medical need. It includes information on which DMEPOS suppliers can provide the item, how the item will be paid, beneficiary liability, and Advance Beneficiary Notice (ABN) requirements.

To view the fact sheet, please visit the DMEPOS Competitive Bidding Educational Resources page at http://www.cms.gov/DMEPOSCompetitiveBid/04_Educational_Resources.asp. Scroll to "Downloads" and select "DMEPOS Competitive Bidding Fact Sheets."

January 2011 Quarterly Update for DMEPOS Competitive Bidding Program

MLN Matters® Number: MM7181
Related Change Request (CR) #:7181
Related CR Release Date: November 5, 2010
Related CR Transmittal #: R2088CP
Effective Date: January 1, 2011
Implementation Date: January 3, 2011

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

Provider Action Needed
This article is based on Change Request (CR) 7181, which provides the January 2011 quarterly update for the DMEPOS competitive bidding single payment amounts. CR 7181 also provides necessary changes to Healthcare Common Procedure Coding System (HCPCS) codes and ZIP codes for the competitive bidding program. The single payment rates for the Round One Rebid of the DMEPOS competitive bidding program are implemented through CR 7181 and are effective January 1, 2011. Be sure billing staff are aware of these changes.

Background
The Medicare DMEPOS competitive bidding program was mandated by the Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003. The program's objectives include:

- Assuring beneficiary access to quality DMEPOS items;
- Reducing the amount Medicare pays for DMEPOS items; and
- Reducing the financial burden on beneficiaries by reducing the coinsurance they pay for DMEPOS items.

The Round One Rebid Competitive Bidding Program will be 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.

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

Key Points of 7181
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)
- 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 also available on the Competitive Bidding Implementation Contract (CBIC) website for interested parties like DMEPOS suppliers, State Medicaid agencies, and managed care organizations. The Competitive Bidding Implementation Contractor (CBIC) website can be accessed at http://www.dmecompetitivebid.com/palmetto/cbic.nsf 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.

HCPCS Code Changes
The following HCPCS codes are changing from "K" codes to "E" codes in the HCPCS file, effective January 1, 2011:

- K0734 is crosswalked to E2622
- K0735 is crosswalked to E2623
- K0736 is crosswalked to E2624
- K0737 is crosswalked to E2625

This change to "E" codes for the aforementioned codes will be reflected in the competitive bidding files and public use files as part of this update.

Instructions for Competitive Bidding Modifiers
HCPCS modifiers were developed to facilitate implementation of various policies that apply to certain competitive bidding items. The HCPCS modifiers used in conjunction with claims for items subject to competitive bidding, along with their corresponding effective dates are:

- KG – DMEPOS Item Subject to DMEPOS Competitive Bidding Program Number 1; effective 7/1/2007
- KK – DMEPOS Item Subject to DMEPOS Competitive Bidding Program Number 2: effective 7/1/2007
- KU – DMEPOS Item Subject to DMEPOS Competitive Bidding Program Number 3; effective 7/1/2007
- KW – DMEPOS Item Subject to DMEPOS Competitive Bidding Program Number 4: effective 1/1/2008
- KY – DMEPOS Item Subject to DMEPOS Competitive Bidding Program Number 5; effective 1/1/2008
- KL – DMEPOS Item Delivered via Mail; effective 7/1/2007
- KV – DMEPOS Item Subject to DMEPOS Competitive Bidding Program that is furnished as part of a Professional Service; effective 1/1/2008
- KT – Beneficiary Resides in a Competitive Bidding Area and Travels Outside that Competitive Bidding Areas and Receives a Competitive Bidding Item; effective 4/1/2008
- J4 – DMEPOS Item Subject to DMEPOS Competitive Bidding Program that is furnished by a Hospital upon Discharge; effective 1/1/2010

The KG, KK, KU, KW, and KY modifiers are modifiers that suppliers must use on claims for beneficiaries residing in CBAs to identify when the same supply or accessory HCPCS code is furnished in multiple competitive bidding product categories. All suppliers, including grandfathered suppliers, should submit claims for competitive bid items using the aforementioned competitive bidding modifiers. The KG and KK modifiers are treated as pricing modifiers in the Round One Rebid of the competitive bidding program and the KU, KW and KY modifiers are reserved for future program use.

Suppliers began using the KL modifier as an informational modifier to identify diabetic supplies (HCPCS codes A4233-A4236, A4253, A4256, A4258, and A4259) furnished on or after July 1, 2007 (See the MLN Matters article related to CR5641 at http://www.cms.gov/MLNMattersArticles/downloads/MM5641.pdf on the CMS website.) Effective January 1, 2009, the KL modifier changed from an informational modifier to a pricing modifier in the HCPCS file. Suppliers should use the KL modifiers on all claims for the aforementioned diabetic supply codes that are furnished via mail order to beneficiaries. The KL modifier is not used with diabetic supply codes that are not delivered to the beneficiary's residence and are obtained from local supplier storefronts. Contract suppliers must use the KL modifier on all claims for the diabetic supply codes identified above that are furnished via mail order.

The KV modifier is to be used to identify claims for items subject to the exceptions provided in regulations at 42 CFR 414.404(b) for certain competitive bid items that can be furnished by physicians and other practitioners who are not contract suppliers in a competitive bidding area. **Physicians and treating practitioners who are not contract suppliers** and who furnish walkers and related accessories to beneficiaries

residing in a CBA must submit the informational KV modifier with claims for items/HCPCS codes in competitive bidding product category 9 (Walkers and Related Accessories), that are appropriately furnished in accordance with this exception to receive payment for these items at the applicable single payment amount. Physicians and practitioners **located outside a CBA who furnish walkers and/or related accessories as part of a professional service to traveling beneficiaries residing in a CBA must also affix the KV modifier** to claims submitted for these items.

The **KV modifier should not be used** by contract suppliers for competitive bidding product category 9, Walkers & Related Accessories, when submitting competitive bidding claims for this category.

Suppliers should submit claims with the **KT modifier** for non-mail order DMEPOS competitive bidding items that are furnished to beneficiaries that have traveled outside of the CBA in which they reside. This travel modifier must be affixed to competitive bidding claims submitted by non-contract suppliers for traveling beneficiaries residing in CBAs and by contract suppliers in CBAs that are different from the CBA where the traveling beneficiary resides.

Physicians and treating practitioners that are located outside a CBA who furnish walkers and/or related accessories in competitive bidding product category 9 as part of a professional service to traveling beneficiaries must **affix the KT modifier, in addition to the KV modifier**, to claims submitted for these items.

Non-contract Skilled Nursing Facilities (SNFs) and Nursing Facilities (NFs) that are not located in a CBA should also use the KT modifier on claims for residents with a permanent home address in a CBA. SNF or NF claims that meet the above requirement 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 should submit mail-order diabetic supply claims for traveling beneficiaries using the beneficiary's permanent home address.

The J4 modifier is used under the DMEPOS Competitive Bidding Program to denote certain competitively bid items that a hospital can furnish to their patients on the date of discharge without submitting a bid and being awarded a competitive bidding contract. The DME items that a hospital may furnish as part of this exception are limited to: crutches, canes, walkers, folding manual wheelchairs, blood glucose monitors, and infusion pumps. For the Competitive Bidding Program Round One Rebid, the DME competitive bid items that a hospital may furnish as part of this exception are limited to walkers and related accessories. For additional information on this exception, please see (See the MLN Matters® article related to CR 6677 at http://www.cms.gov/MLNMattersArticles/downloads/MM6677.pdf on the CMS website). Hospitals located outside a CBA, who provide walkers and/or related accessories on the date of discharge to traveling beneficiaries residing in a CBA, must also affix the J4 modifier to claims submitted for these items. The J4 modifier should not be used by contract suppliers for the Walkers and Related Accessories competitive bidding product category when submitting competitive bidding claims for this category.

The KE modifier (*Bid Under Round One of the DMEPOS Competitive Bidding Program for Use With Non-Competitive Bid Base Equipment*) was added to the HCPCS file effective January 1, 2009 as a pricing modifier that suppliers must use on all Part B Fee-For-Service claims to identify when the same accessory item can be furnished in multiple DMEPOS Competitive Bidding Program and non-Competitive Bidding Program product categories. For additional information on the use of the KE modifier, please refer to the instructions contained in the MLN Matters® article related to CR 6270 at http://www.cms.gov/MLNMattersArticles/downloads/MM6270.pdf on the CMS website. For beneficiaries residing in competitive bid areas, suppliers should not use the KE modifier to identify competitively bid accessories used with competitively bid base equipment. Rather, such claims should be submitted using the appropriate KG or KK modifier.

The competitive bidding modifiers should be used with the specific, appropriate competitive bidding HCPCS code when one is available. The competitive bidding HCPCS codes and their corresponding competitive bidding modifiers are denoted in the single payment amount public use charts found under the supplier page on the CBIC website: www.dmecompetitivebid.com/Palmetto/Cbic.nsf on the Internet.

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.

Reminders Regarding the Single Payment Amount

Under the competitive bidding program, single payment amounts replace the current DMEPOS fee schedule payment amounts for competitive bidding items 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 the section 3136 of the Affordable Care Act, does not apply to standard power wheelchairs furnished by contract suppliers under the Round One Rebid Program. Payment for standard power wheelchairs will continue to be made to Round One Rebid contract suppliers on either a lump sum purchase or rental basis.

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

Also included in the CBA pricing file and the single payment amount file is the maintenance and servicing single payment amounts for rented enteral nutrition infusion pumps described by HCPCS code B9000 and B9002, made in accordance with section 40.3 of Chapter 20 of the Medicare Claims Processing Manual. That manual information 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, CR 7181 issued to your RHHI and DME MAC regarding this change may be viewed at http://www.cms.gov/Transmittals/downloads/R2088CP.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 January 10, 2011 to clarify and add language regarding the use of modifier KY. 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 these items 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/Palmetto/Cbic.nsf/docsCat/Suppliers 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:

- 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).
- 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 http://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 or after 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

COMPETITIVE BIDDING CONT'D

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

Local Coverage Determinations – Elimination of Least Costly Alternative

CMS has instructed contractors that they may no longer make partial payment for claims based on a "least costly alternative" (LCA) determination. Therefore, for claims with dates of service on or after February 4, 2011, the following rules apply under this new guidance:

- If the local coverage determination (LCD) currently states that an item will always be paid based on the allowance for the least costly item (if the criteria for the less costly item are met), then under the new policy a claim for that item will always be denied as not medically necessary. (Type 1 LCA denial)
- If the LCD currently states that an item will be paid in full if specific additional coverage criteria are met but will be paid based on the allowance for the least costly item if the additional coverage criteria for the billed item are not met (and if the criteria for the less costly item are met), then under the new policy a claim for that item will be denied as not medically necessary if all of the additional coverage criteria for that item are not met. (Type 2 LCA denial)
  - The claim will be paid in full if the additional coverage criteria are met.
  - If a KX modifier is required to attest to the additional coverage criteria being met, claims without a KX modifier (and with a GA, GY, or GZ modifier) will be denied.

COVERAGE CONT'D

If a base code for an item of durable medical equipment, prosthesis, or orthosis is denied as not medically necessary, all related accessories, supplies, additions, and drugs will be denied as not medically necessary.

Least costly alternative statements are found in the following LCDs (Note: The information may not be all-inclusive; refer to each LCD for details.):

- Ankle-Foot/Knee-Ankle-Foot Orthoses
  - Custom fabricated AFOs/KAFOs (L1900, L1904, L1907, L1920, L1940-L1950, L1960, L1970, L1980-L2034, L2036-L2108, L2126, L2128)(Type 2)
- Canes and Crutches
  - Underarm articulating spring assisted crutch (E0117) (Type 1)
- Cervical Traction Devices
  - Cervical traction by headboard attachment (E0840) (Type 1)
  - Cervical traction by freestanding frame (E0850) (Type 1)
  - Cervical traction, free standing stand/frame, traction force to other than mandible (E0849) (Type 2)
  - Cervical traction, not requiring stand/frame (E0855) (Type 2)
- Commodes
  - Commode – extra wide/heavy duty (E0168) (Type 2)
- Enteral Nutrition
  - Special enteral nutrients (B4149,B4153-B4157,B4161,B4162) (Type 2)
  - Pump supply kit (B4035) (Type 2)
- External Breast Prostheses
  - Breast prostheses, silicone or equal, with integral adhesive (L8031) (Type 1)
  - Custom fabricated breast prosthesis (L8035) (Type 1)
- External Infusion Pumps
  - Infusion pump used with subcutaneous immune globulin (E0781, E0791) (Type 1)
- Glucose Monitors
  - Glucose monitors with special features (E2100, E2101) (Type 2)
  - Laser lancing device and lens shield cartridge (E0620, A4257) (Type 1)
- Hospital Beds
  - Total electric hospital bed (E0265, E0266, E0296, E0297) (Type 1)
  - Other hospital beds (E0255-E0261, E0292-E0295, E0301-E0304, E0329) (Type 2)
- Knee Orthoses
  - Knee orthosis with inflatable bladder (L1847) (Type 1)
  - Custom fabricated orthoses (L1834, L1840, L1844, L1846, L1860) (Type 2)
- Manual Wheelchairs
  - Manual wheelchairs (K0002 – K0007) (Type 2)
- Nebulizer Equipment and Related Drugs
  - Small volume ultrasonic nebulizer (E0574) (Type 1)
  - Battery-powered nebulizer (E0571) (Type 1) (Exception: Coding for these items is being changed.)
  - Controlled dose delivery system (K0730) (Type 2)
- Patient Lifts
  - Patient support system with integrated lift (E0636) (Type 2)
  - Multipositional patient transfer systems (E1035, E1036) (Type 2)
- Pneumatic Compression Devices
  - Segmented device with manual chamber control (E0652) (Type 2)
- Positive Airway Pressure Devices for the Treatment of Obstructive Sleep Apnea
  - Bi-level without backup (E0470) (Type 2)
  - Bi-level with backup used for OSA (E0471) (Type 1)
- Power Mobility Devices
  - Power operated vehicles – Group 1 (K0801, K0802) (Type 2)
  - Power operated vehicles – Group 2 (K0806 – K0808) (Type 1) (Exception: Will be denied as statutorily noncovered.)
  - Power wheelchairs – Group 2 with seat elevator and Group 4 (K0830, K0831, K0868 – K0886) (Type 1) (Exception: Will be denied as statutorily noncovered.)
  - Power wheelchairs – Groups 1, 2, 3, and 5 (K0813 – K0829, K0835 – K0864, K0890, K0891) (Type 2)
- Respiratory Assist Devices
  - Bi-level without backup (E0471) (Type 2)
- Seat Lift Mechanisms
  - Seat lift mechanism incorporated into chair (E0627) (Type 1) (Exception: E0627 will be paid in full.)
- Surgical Dressings
  - Water or saline impregnated gauze (A6228-A6230) (Type 1)
- Therapeutic Shoes for Persons with Diabetes
  - Custom fabricated shoes (A5501) (Type 2)
- Tracheostomy Supplies
  - Tracheostomy starter kit (A4625) (Type 2)

- Urological Supplies
  - Specialty indwelling catheter (A4340) (Type 2)
  - All silicone catheter (A4344, A4312, or A4315) (Type 2)
  - Three way indwelling catheter either alone (A4346) or with other components (A4313 or A4316) (Type 2)
  - Drainage bags containing gel matrix or other material (Type 1)
  - Coude (curved) tip catheter (A4352) (Type 2)
  - Specialty type male external catheters (A4326) (Type 2)
  - Catheter/tube anchoring device (A5200) (Type 2)
- Walkers
  - Heavy duty walker (E0148, E0149) (Type 2)
  - Heavy duty, multiple braking system, variable wheel resistance walker (E0147) (Type 2)
  - Walker with an enclosed frame (E0144) (Type 1)
  - Walker with trunk support (E0140) (Type 2)
- Wheelchair Options and Accessories
  - Dual mode battery charger (E2367) (Type 1)
- Wheelchair Seating
  - General use seat and back cushion (when used with power WC with sling/solid seat) (Type 2)
  - Skin protection seat cushion, positioning seat cushion, or combination skin protection and positioning seat cushion (E2603-E2608, E2613-E2616, E2620, E2621, E2622-E2625) (Type 2)
  - Positioning back cushion (E2613-E2616, E2620, E2621) (Type 2)
  - Custom fabricated cushion (E2609, E2617) (Type 2)

Revisions of these LCDs incorporating these changes are being published – refer to the individual policies for details.

For capped rental DME items, elimination of LCA determinations will apply only to claims in which the date of service (DOS) for the initial rental month is on or after February 4, 2011. If an LCA determination is made on an item with an initial rental month DOS prior to February 4, 2011, subsequent claims for that item will continue to be adjudicated using the LCA determination for the duration of that rental period.

If an item is denied in full due to elimination of LCA, partial payment based on LCA will not be possible through the appeals process.

For items that were previously paid based on an LCA determination, suppliers can receive partial payment at the time of initial determination if they elect to bill using one of the upgrade modifiers, GK or GL. Refer to the related article titled Use of Upgrade Modifiers.

Further instructions will be forthcoming concerning the options that a supplier has if a claim is submitted without upgrade modifiers and is denied as not medically necessary and the supplier subsequently decides that it would like to utilize the upgrade modifiers.

LCD and Policy Article Revisions - Summary for December 2010

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

Ankle-Foot / Knee-Ankle-Foot Orthosis
LCD
Revision Effective Date: 02/04/2011
INDICATIONS AND LIMITATIONS OF COVERAGE:
Added: Statement from policy article regarding routine replacement of components.
Deleted: Least costly alternative for custom fabricated orthoses
HCPCS CODES AND MODIFIERS (Effective 1/1/2011):
Added: Code L4631
Revised: GA modifier
ICD-9 CODES THAT SUPPORT MEDICAL NECESSITY:
Added: Code L4631 and ICD-9 code 713.5

Policy Article
Revision Effective Date: 02/04/2011
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: Preamble language
Revised: Clarified noncoverage statements for L4392, L4394, L4396 and L4398
CODING GUIDELINES:
Added: Definition of L4631
Revised: Clarified proper coding instructions based on brace use

Canes and Crutches
LCD
Revision Effective Date: 02/04/2011
INDICATIONS AND LIMITATIONS OF COVERAGE:
Revised: Preamble language
Deleted: Least costly alternative language for code E0117

Cervical Traction Devices
LCD
Revision Effective Date: 02/04/2011
INDICATIONS AND LIMITATIONS OF COVERAGE:
Deleted: Least costly alternative for multiple codes
HCPCS CODES AND MODIFIERS:
Revised: GA modifier

Commodes
LCD
Revision Effective Date: 02/04/2011
INDICATIONS AND LIMITATIONS OF COVERAGE:
Deleted: Least costly alternative language for code E0168
HCPCS CODES AND MODIFIERS:
Revised: GA modifier

Enteral Nutrition
LCD
Revision Effective Date: 02/04/2011
INDICATIONS AND LIMITATIONS OF COVERAGE:
Deleted: Least costly alternative language for special enteral formulas and supply kits
HCPCS CODES AND MODIFIERS:
Revised: B4034, B4035, B4036

COVERAGE CONT'D

External Breast Prosthesis
LCD
Revision Effective Date: 02/04/2011
INDICATIONS AND LIMITATIONS OF COVERAGE AND/OR MEDICAL NECESSITY:
Added: 198.81, 457.0, V10.3 as covered indications
Deleted: Least costly alternative for multiple codes
COVERED ICD-9 CODES:
Added: 198.81, 457.0, V10.3

Policy Article
Revision Effective Date: 02/04/2011
NON-MEDICAL NECESSITY AND COVERAGE AND PAYMENT RULES:
Added: Preamble language
CODING GUIDELINES
Revised: RT/LT modifier instructions for inherently bilateral items

External Infusion Pumps
LCD
Revision Effective Date: 02/04/2011
INDICATIONS AND LIMITATIONS OF COVERAGE:
Deleted: The least costly alternative Language for E0779
Added: Coverage for Hizentra (J1559) effective 04/04/2010, coverage for Gamunex (J1561) effective 10/13/2010) to subcutaneous immune globulin section
HCPCS CODES AND MODIFIERS: (effective 01/01/2011 except as noted)
Revised: GA modifier verbiage
Added: J1559
Added: J1561 (effective 10/13/2010)
Added: JB modifier
Deleted: J9110, J9375, and J9380
ICD-9 CODES THAT SUPPORT MEDICAL NECESSITY:
Added: J1559, J1561
DOCUMENTATION REQUIREMENTS: (effective 01/01/2011)
Added: JB modifier

Glucose Monitors
LCD
Revision Effective Date: 02/04/2011
INDICATIONS AND LIMITATIONS OF COVERAGE:
Revised: Preamble language
Deleted: Least costly alternative language for codes E2100 and E2101
Deleted: Least costly alternative language for codes E0620 and A4257
Note: this is NOT a release of the draft Glucose Monitors policy that was recently out for comment. This is a revision to the existing policy.

Hospital Beds
LCD
Revision Effective Date: 02/04/2011
INDICATIONS AND LIMITATIONS OF COVERAGE:
DELETED: Least costly alternative language
HCPCS CODES AND MODIFIERS:
Revised: GA modifier

Knee Orthosis
LCD
Revision Effective Date: 02/04/2011
INDICATIONS AND LIMITATIONS OF COVERAGE:
Deleted: Least costly alternative for multiple HCPCS codes
HCPCS CODES AND MODIFIERS:
Added: Code L4002
Revised: GA modifier
ICD-9 COES THAT SUPPORT MEDICAL NECESSITY:
Added: ICD-9 code 844.8 for codes L1830, L1832, L1834, and L1843-L1846

Policy Article
Revision Effective Date: 02/04/2011
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: Preamble language
CODING GUIDELINES:
Added: Code L4002 to correct coding tables
Added: Instructions for L4002

Manual Wheelchairs
LCD
Revision Effective Date: 02/04/2011
INDICATIONS AND LIMITATIONS OF COVERAGE:
Deleted; Least costly alternative language for K0002 – K0007
HCPCS CODES AND MODIFIERS:
Revised: GA modifier

Nebulizers
LCD
Revision Effective Date: 02/04/2011
INDICATIONS AND LIMITATIONS OF COVERAGE:
Added: Coverage for treprostinil inhalation solution
Revised: Coverage of E0574, E0575
Deleted: References to code E0571
HCPCS CODES AND MODIFIERS (Effective 1/1/2011):
Added: J7686
Revised: J7013
Revised: GA modifier
Deleted: E0571
ICD-9 CODES THAT SUPPORT MEDICAL NECESSITY:
Added: A7013, A7014, A7016, E0574, J7686 to pulmonary hypertension ICD-9 code
Deleted: Code E0574 from COPD code set
Deleted: Code E0571

Policy Article
Revision Effective Date: 02/04/2011
NONMEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: Preamble language
Added: Noncoverage statement for nebulizer used to administer aztreonam lysine and related accessories
CODING GUIDELINES:
Added: Coding information for nebulizer used to administer aztreonam lysine inhalation solution and related accessories.
Added: Coding verification review for E0574 ultrasonic nebulizers (Effective for DOS on or after 4/1/2011)
Added: Code E0571 invalid for DME MAC submission
Revised: Definition of E0570 to include battery-powered aerosol compressors

COVERAGE CONT'D

Patient Lifts
LCD
Revision Effective Date: 02/04/2011
INDICATIONS AND LIMITATIONS OF COVERAGE:
Removed: Least costly alternative language for E0636, E0135, and E0136.
HCPCS CODES AND MODIFIERS:
Revised: GA modifier

Pneumatic Compression Devices
LCD
Revision Effective Date: 02/04/2011
INDICATIONS AND LIMITATIONS OF COVERAGE:
Deleted: Least Costly Alternative for HCPCPS code E0652

Positive Airway Pressure Devices
LCD
Revision Effective Date: 02/04/2011
INDICATIONS AND LIMITATIONS OF COVERAGE:
Deleted: Least costly alternative language for codes E0470 and E0471
HCPCS CODES AND MODIFIERS:
Revised: GA modifier
DOCUMENTATION REQUIREMENTS:
Revised: Requirements for documenting ineffective therapy on E0601

Power Mobility Devices
LCD
Revision Effective Date: 02/04/2011
INDICATIONS AND LIMITATIONS OF COVERAGE:
Revised: Coverage criteria relating to patient weight for POVs and PWCs
Deleted: Least costly alternative language for multiple codes.
Moved: Denial information on Group 2 POVs, Group 2 PWCs with Seat Elevators, and Group 4 PWCs to the Policy Article
HCPCS CODES AND MODIFIERS:
Revised: GA modifier

Policy Article
Revision Effective Date: 02/04/2011
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: Preamble language
Added: Noncoverage statement for Group 2 POVs, Group 2 PWCs with Seat Elevators, and Group 4 PWCs

Respiratory Assist Devices
LCD
Revision Effective Date: 02/04/2011
INDICATIONS AND LIMITATIONS OF COVERAGE:
Deleted: Least costly alternative language for E0471
HCPCS CODES AND MODIFIERS:
Revised: GA modifier

Seat Lift Mechanisms
LCD
Revision Effective Date: 02/04/2011
INDICATIONS AND LIMITATIONS OF COVERAGE:
Deleted: Least costly alternative language for E0627.

Surgical Dressings
LCD
Revision Effective Date: 02/04/2011
INDICATIONS AND LIMITATIONS OF COVERAGE:
Deleted: Least costly alternative for HCPCS codes A6228-A6230
HCPCS CODES: (effective 1/01/2011)
Revised: A6011, A6248, A6260-A6262

Tracheostomy Supplies
LCD
Revision Effective Date: 02/04/2011
INDICATIONS AND LIMITATIONS OF COVERAGE:
Deleted: Least Costly Alternative for A4625

Therapeutic Shoes
LCD
Revision Effective Date: 02/04/2011
INDICATIONS AND LIMITATIONS OF COVERAGE:
Revised: Denial statements for custom fabricated shoes
DOCUMENTATION REQUIREMENTS:
Added: Statement about timing of detailed written order. (Effective 1/1/2011)
Added: Clarification about documentation that must be in the certifying physician's records.
Added: Documentation required at the time of selecting the shoes/inserts. (Effective 7/1/2010)
Added: Documentation required at the time of delivery. (Effective 7/1/2010)

Urological Supplies
LCD
Revision Effective Date: 02/04/2011
INDICATIONS AND LIMITATIONS OF COVERAGE:
Deleted: Least costly alternative language for multiple codes
Revised: Coverage of A4336
Added: A5105 to list of codes used with A5131
ICD-9 CODES THAT SUPPORT MEDICAL NECESSITY
Added: 625.6 for HCPCS A4336

Policy Article
Revision Effective Date: 02/04/2011
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: Preamble language
CODING GUIDELINES:
Revised: A4253 definition
Revised: Bundling table instructions
Deleted: A4353 from table

Walkers
LCD
Revision Effective Date: 02/04/2011
INDICATIONS AND LIMITATIONS OF COVERAGE:
Deleted: Least costly alternative language for heavy-duty walkers, E0147 walkers, and walkers with an enclosed frame or trunk support.
HCPCS CODES AND MODIFIERS:
Revised: GA modifier

COVERAGE CONT'D

Wheelchair Options and Accessories
LCD
Revision Effective Date: 02/04/2011
INDICATIONS AND LIMITATIONS OF COVERAGE:
Deleted: Least costly alternative language for dual mode battery chargers
HCPCS CODES AND MODIFIERS:
Revised: GA modifier

Policy Article
Revision Effective Date: 01/01/2011
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: Introductory statement concerning content of Policy Articles.
CODING GUIDELINES:
Revised: Instructions for use of the RT and LT modifiers when unit of service is "pair".
Clarified: Billing instructions for expandable controllers (E2377, E2376), electronic harnesses (E2313), and special features of joysticks.
Added: Statement that E1028 is not separately billable with a wheelchair tray and added E0950 to bundling table

Wheelchair Seating
LCD
Revision Effective Date: 02/04/2011
INDICATIONS AND LIMITATIONS OF COVERAGE:
Revised: Denial statements for general use cushions used with power wheelchairs with sling/solid seats/backs, for skin protection, positioning and combination seat cushions, for positioning back cushions, and for custom fabricated cushions.
HCPCS CODES AND MODIFIERS: (effective 01/01/2011)
Added: E2622 - E2625
Revised: GA
Deleted: K0734 – K0737
ICD-9 CODES THAT SUPPORT MEDICAL NECESSITY:
Replaced: K0734-K0737 with E2622-E2625
DOCUMENTATION REQUIREMENTS:
Replaced: K0734-K0737 with E2622-E2625

Policy Article
Revision Effective Date: 01/01/2011
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: Introductory statement concerning content of Policy Articles.
CODING GUIDELINES:
Replaced: K0734-K0737 with E2622-E2625

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.

Heating Pads and Heat Lamps – Draft Medical Policy Finalized

The draft Local Coverage Determination and Policy Article for Heating Pads and Heat Lamps has been finalized. The medical policy is effective for claims with dates of service on or after April 1, 2011.

Products that are currently coded E0210, E0215, E0217, or E0249 by the Pricing, Data Analysis and Coding (PDAC) contractor and are listed in the DME Coding System (DMECS) Product Classification List on the PDAC web site will be end-dated on March 31, 2011. Although Coding Verification Review by the PDAC is not required for suppliers to bill these products, manufacturers who want their product(s) listed in DMECS after April 1, 2011, will need to submit a new application.

The PDAC coding verification review application required for these products is the *DME and Supplies* application. This application is located on the PDAC website: https://www.dmepdac.com/review/apps_check.html. If you have questions, please 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/.

Home Dialysis and Epoetin – Medical Policies Retired

Effective for claims with dates of service on or after January 1, 2011, Method II home dialysis is no longer an option. All claims for home dialysis and related epoetin use will be submitted to the Medicare Part A/B contractors. Therefore, the DME MAC Local Coverage Determinations and Policy Articles for Home Dialysis Supplies and Equipment and for Epoetin will be retired with an ending date of December 31, 2010.

DRUGS/BIOLOGICALS

Immunosuppressive Drugs Coverage Requirements

During recent claim reviews for Immunosuppressive Drugs, the Durable Medical Equipment Medicare Administrative Contractors (DME MAC) noted that suppliers are appending the KX modifier inappropriately. Specifically, suppliers are using the KX modifier when a beneficiary received their transplant prior to Medicare Part A enrollment. According to the Immunosuppressive Drugs Policy Article, coverage of immunosuppressive drugs requires that, in part:

- The patient was enrolled in Medicare Part A at the time of the transplant; and
- The patient is enrolled in Medicare Part B at the time that the drugs are dispensed.

Immunosuppressive drugs provided to Medicare beneficiaries whose transplant occurred prior to their enrollment in Medicare Part A should not be billed to the DME MAC. For those patients, the drugs may be eligible for coverage under Medicare Part D.

In order to use the KX modifier on a claim line for immunosuppressive drugs, the supplier must have documentation on file to support that the coverage requirements are met. As noted in the local coverage determination (LCD) for Immunosuppressive Drugs Documentation Section:

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 must not be added to the claim.

Suppliers should refer to the Immunosuppressive Drugs LCD and related Policy Article for additional coverage, coding and documentation requirements.

Oral Anti-Emetic Drugs – Coverage Reminder

Recently the Durable Medical Equipment Medicare Administrative Contractors (DME MACs) have received questions regarding the coverage requirements in the Oral Antiemetic Drugs (Replacement for Intravenous Drugs) local coverage determination (LCD) and related policy article. Coverage of oral antiemetic drugs is a specific Medicare benefit category found in the Social Security Act, Title XVIII, Section 1861(s)(2)(T) with further instructions for coverage in the Medicare Claims Processing Manual (CMS Internet-Only Publication 100-4, Chapter 17, Section 80.2).

Questions recently raised relate to the requirement that the oral antiemetic must be initiated within two (2) hours of the administration of the chemotherapeutic agent. This means that the first dose of the oral antiemetic drug or drugs (if part of a multi-drug regimen), must be administered to the beneficiary within 2 hours of initiation of the cancer chemotherapeutic regimen. This *does not* mean that the pharmacy must dispense the drug or fill a prescription within 2 hours of administration of the drug(s). In addition, the amount dispensed must not exceed the maximum dosing time period limitation of 24 or 48 hours as described in the Healthcare Common Procedure Coding System (HCPCS) code descriptor for each drug.

Suppliers should refer to the local coverage determination and related policy article for Oral Antiemetic Drugs (Replacement for Intravenous Drugs) for additional coverage, coding and documentation requirements.

Revised January 2011 ASP Files Now Available

The Centers for Medicare & Medicaid Services (CMS) has posted a revised January 2011 Average Sales Price (ASP) Pricing file, which is available for download at: http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/ (see left menu for year-specific links).

Pharmacy Billing for Drugs Provided "Incident to" Physician's Service

MLN Matters® Number: MM7109
Related Change Request (CR) #: 7109
Related CR Release Date: December 10, 2010
Related CR Transmittal #: R2115CP
Effective Date: March 14, 2011
Implementation Date: March 14, 2011

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

Provider Action Needed
This article is based on Change Request (CR) 7109 which clarifies the Centers for Medicare & Medicaid Services (CMS) policy with respect to restrictions on pharmacies billing for drugs provided "incident to" a physician's service. CR 7109 also clarifies the CMS policy for the local determination of payment limits for drugs that are not nationally determined.

Background
Pharmacies may bill Medicare for certain classes of drugs including:

- Immunosuppressive drugs,
- Oral anti-emetic drugs,
- Oral anti-cancer drugs, and
- Drugs administered through any piece of Durable Medicare Equipment (DME).

Claims for these drugs are generally submitted to the DME MAC, and the DME MAC makes payment for these drugs (when deemed to be covered and reasonable and necessary) to the pharmacy. One exception is that claims for drugs administered through implanted durable medical equipment such as an implanted infusion pump are submitted to the A/B MAC or local carrier. All bills submitted to the DME MAC must be submitted on an assigned basis by the pharmacy. (Medicare Claims Processing Manual (Chapter 17, Section 50.B; see http://www.cms.gov/manuals/downloads/clm104c17.pdf on the CMS website).

Pharmacies, suppliers, and providers may not bill Medicare for drugs purchased directly by beneficiaries for administration "incident to" a physician service. Medicare will deny such claims. (See the Medicare Claims

Processing Manual, Chapter 17, Section 50.B at http://www.cms.gov/manuals/downloads/clm104c17.pdf on the CMS website.) Pharmacies also may not bill for drugs purchased by a physician for administration to a Medicare beneficiary. These drugs are being furnished "incident to" the physician's service and as such must be billed by the physician. (See Medicare Benefit Policy Manual, Chapter 15, Section 50.3; at http://www.cms.gov/manuals/Downloads/bp102c15.pdf on the CMS website).

The payment limits for drugs and biologicals that are not included in 1) the average sales price (ASP) Medicare Part B Drug Pricing File or 2) the Not Otherwise Classified (NOC) Pricing File are based on the published Wholesale Acquisition Cost (WAC) or invoice pricing except under 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.

Additional Information
The official instruction, CR 7109, issued to your carriers, DME MACs, FIs, A/B MACs, and/or RHHIs regarding this change may be viewed at http://www.cms.gov/Transmittals/downloads/R2115CP.pdf on the CMS website.

Widespread Prepayment Review for Immunosuppressive Drugs - Edit Effectiveness for 1st Quarter

The Jurisdiction D DME MAC Medical Review Department is conducting a widespread complex review of HCPCS codes J7507, J7517, J7518 and J7520 and the first quarter edit effectiveness results from August 2010 through November 2010 are as follows:

The results of the review of the claims identified 2,660 claims of which 1,897 were denied. This resulted in an overall error rate of 68%. Due to this high error rate NAS will continue with the widespread complex review.

The following are the top reasons for denial:

A. No valid written order
   a. No written order submitted with the documentation
   b. Insufficient or incomplete order
B. No Proof Of Delivery
   a. No proof of delivery submitted with the documentation
   b. Invalid proof of delivery
C. No Part A coverage for transplant
D. Requested documentation was not provided within the allotted time frame as referenced in the Medicare guidelines

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

A. 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.

   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.

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

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

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

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

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

April 2011 Quarterly ASP Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files

MLN Matters® Number: MM7298
Related C**hange Request (CR) #: 7298**
Related CR Release Date: January 21, 2011
Related CR Transmittal #: R2135CP
Effective Date: April 1, 2011
Implementation Date: April 4, 2011

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

Provider Action Needed
This article is based on Change Request (CR) 7298 which instructs your Medicare contractors to download and implement the April 2011 Average Sales Price (ASP) Medicare Part B drug pricing file for Medicare Part B drugs and, if released by the Centers for Medicare & Medicaid Services (CMS), also to download and implement the revised January 2011, October 2010, July 2010, and April 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 April 4, 2011, with dates of service April 1, 2011, through June 30, 2011. See the Background and Additional Information Sections of this article for further details regarding these changes.

Background
Section 1847A of The Medicare Modernization Act of 2003 (Section 303(c); see http://www.cms.gov/MMAUpdate/downloads/PL108-173summary.pdf on the CMS website) revised the payment methodology for Part B covered drugs and biologicals that are not paid on a cost or prospective payment basis.

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

Files	Effective for Dates of Service
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
July 2010 ASP and ASP NOC files	July 1, 2010, through September 30, 2010
April 2010 ASP and ASP NOC files	April 1, 2010, through June 30, 2010

Additional Information
The official instruction, CR7298, issued to your carriers, DME MACs, FIs, A/B MACs, and RHHIs regarding this change may be viewed at http://www.cms.gov/transmittals/downloads/R2135CP.pdf on the CMS website.

EDUCATION

Education Efforts are Driven by Supplier Feedback

As we begin the new year, NAS wants to continue to engage with you and hear your feedback on how we can best serve you. A summary of the NAS DME Jurisdiction D Education efforts are highlighted within this article.

Last year, due to your requests and feedback, NAS for Jurisdiction D conducted 164 educational events, educating a total of 29,223 suppliers including:

a. 8 Ask the Contractor Teleconference (ACT) events
b. 128 web-based workshops
c. 5 association events
d. 14 face-to-face workshops
e. 3 tradeshow events
f. 6 face-to-face training events during tradeshows

In an effort to help new suppliers understand how to bill Medicare NAS began mailing "Welcome" materials to newly enrolled suppliers with a goal to assist suppliers to avoid billing errors.

To help you train within your office and on your schedule, we added more self-service technology to our website, on the Training/Events webpage. There have been 16 tutorials launched in addition to the publication of 3 View & Listen 'on-demand' workshop recordings.

Based on supplier feedback, there have been changes to the Web-based workshops offered. During 2010, web-based workshops were offered in the morning and afternoon to accommodate all time zones. Advertisement regarding these events was accomplished through promotional articles that were consistently posted to the What's New section of our website and sent through the email listserv. To supplement these web-based workshops, we have added "Question and Answer" documents to the Training/Events webpage for the applicable workshop topic based on attendee questions posed during the events. New workshop topics were also developed and offered, which included four different orthotic and prosthetic topics.

NAS values the feedback received from our suppliers and we look forward to continuing to serve as your DME MAC for Jurisdiction D. NAS strives to offer the best customer service, education, and efficient claims processing for our supplier community.

NAS has Added More CEUs

NAS has added additional web-based workshops that provide Continuing Education Units (CEUs) approved by the American Academy of Professional Coders (AAPC). Below is a listing of all web-based workshops offering CEUs. NAS does not require CEUs from our supplier community; however, these web-based workshops and CEUs are offered by NAS for free as an opportunity for those suppliers/staff that need CEUs as part of their Certified Professional Coder education.

- Enteral Nutrition*
- Glucose Monitors and Testing Supplies*
- Hospital Beds and Accessories*
- Pressure Reducing Support Surfaces Group II*
- Nebulizers*
- Positive Airway Pressure Devices*
- Respiratory Assist Devices*
- Therapeutic Shoes for Persons with Diabetes*
- Putting the Pieces of DME Together Part 1: Background Knowledge*
- Putting the Pieces of DME Together Part 2: Documentation*
- Putting the Pieces of DME Together Part 3: Claims and Appeals*
- Documentation Prior to DME Claims Submission*
- Power Mobility Devices*
- Manual Wheelchair Bases*
- Wheelchair Options, Accessories, and Seating*
- Oxygen and Oxygen Equipment*

Please check the Training and Events page for scheduled events.

*This program has the prior approval of the American Academy of Professional Coders (AAPC) for 1 continuing education hour. Granting of prior approval in no way constitutes endorsement by the AAPC of the program content or the program sponsor

Ask the Contractor Teleconference Questions and Answers - November 10, 2010

Comprehensive Error Rate Testing (CERT)
On a national level, the most common documentation errors found by the CERT contractor have been indentified for policy groups with the highest error rates. Most recently the oxygen and glucose monitor policy groups were studied. The top three documentation errors for oxygen included: missing a copy of the qualifying blood gas study to support the study resulted dated on the Certificate of Medical Necessity (CMN); missing clinical records to support the following medical management oversight medical necessity and/or continued use; or missing patient evaluation, such as a 30 day evaluation prior to initial CMN and/or a 90 day re-evaluation prior to recertification of the CMN.

The top three documentation errors for glucose monitors included: missing clinical documentation supporting that the beneficiary is testing at the frequency prescribed; missing clinical records to support medical treating physician's management oversight; or the order is expired or it's invalid or missing one or more of the required elements. National data analysis will continue in an effort to identify common documentation errors for additional policy groups.

For additional CERT information, please refer to the CERT section of our website, https://www.noridianmedicare.com/dme/coverage/cert.html. Look for upcoming modifications and new resources added to our website and a WebEx presentation on the overall CERT process.

Endeavor - Online Claim Status and Eligibility Supplier Portal
Suppliers are encouraged to register for Endeavor. Endeavor offers free online access to patient eligibility, claim status inquiries, and claim-specific remittance advices. The hours of availability for eligibility inquiries are 24 hours a day, seven days a week; however, the source of the eligibility is maintained by the CMS and may be unavailable based on CMS scheduled system maintenance. Endeavor offers claims status and remittance advices inquiries to be completed between 6 a.m. and 6 p.m. CT, Monday through Friday and 7 a.m. to 3 p.m. CT on Saturday and Sunday. Suppliers, billers and third parties may register for Endeavor.

Each person accessing the Endeavor system must register with their own user identification. User IDs cannot be used by more than one person. To register, a supplier can go to the claims section of our website, https://www.noridianmedicare.com/dme/claims/endeavor.html. Many suppliers are already taking advantage of this tool.

Website Satisfaction Survey
NAS encourages suppliers to complete the r andomly distributed Website Satisfaction Survey that displays for people when they are navigating the www.noridianmedicare.com/dme website. Enhancements to the NAS DME website are made based on comments received through this survey. Suppliers should let NAS know what they like about the website, along with ideas for improvement. NAS appreciates and values supplier's thoughts and opinions.

Medtrade Conference and Training Events - November 2010
NAS is attending the fall Medtrade in Atlanta, Georgia on November 16th through the 18th. NAS will host a Positive Airway Pressure (PAP) device update session which focuses on documentation requirements on November 16th. Additionally, a national CERT task force meeting will be hosted the same day. All four DME MAC jurisdictions will present Medicare updates on November 17. The Competitive Bidding Implementation Contractor (CBIC) and the National Supplier Clearinghouse (NSC) will each conduct a session November 18.

Interactive Voice Response (IVR) System 1-877-320-0390
As of Friday, October 22, the IVR no longer requires the reentry of the supplier's national provider identifier (NPI), provider transaction access number (PTAN) and last five digits of the tax identification number (TIN) combination when navigating through multiple menu options. The IVR will now carry the NPI, PTAN and TIN combination obtained with the first inquiry throughout all the menu options the supplier navigates, eliminating the need to reenter this information. The menu options, which previously allowed suppliers to change their NPI, PTAN and TIN combination after each inquiry will continue to do so. Those options are same and similar, claims, duplicate remittance and the three financial sub-menu options, checks, payment floor and overpayment. If the supplier elects to change their NPI, PTAN and TIN combination, the newly entered combination will be the one carried forward to the next menu option.

Q1. My question is regarding the Medicare Provider Enrollment, Chain and Ownership System (PECOS) and the CMS open door forum event, held October 14 that referenced a July implementation date compared to a January, 2011 implementation date. Confirm when the PECOS front-end claim rejections will be implemented that replaces the current "warning" edit messages.
A1. CMS had hosted Open Door Forum calls in which the PECOS front-end rejections (also known as phase two) would be implemented. NAS must follow the Change Request process regarding how to process and/or reject claims. The latest direction NAS received from CMS as of the date of the ACT event was Change Request 6421, which indicates the implementation date in which claims would be front-end rejected January 3, 2011. However, on November 24, CMS issued a Technical Direction Letter which indicated,

> "The automated edits will not be turned on effective January 3, 2011. We (CMS) are working diligently to resolve enrollment backlogs and other system issues and will provide ample advanced notice to the provider and beneficiary communities before we (CMS) begin any automatic nonpayment actions."

As additional information is received from CMS, NAS will publish that to the What's New section of our website, include it within the Tuesday/Friday electronic newsletter and reference it within the PECOS "upcoming changes" webpage, https://www.noridianmedicare.com/dme/news/pecos.html.

Q2. If a supplier obtains an order from a nurse practitioner or physician's assistant and verifies their NPI in the National Plan and Provider Enumeration System (NPPES), is that sufficient?
A2. No. A nurse practitioner or clinical nurse specialist may give the dispensing order and sign the written order in the following situations:

- They are treating the beneficiary for the condition for which the item is needed;
- They are practicing independently of a physician;
- They bill Medicare for other covered services using their own provider number; and
- They are permitted to do all of the above in the State in which the services are rendered.

Physician assistants may provide the dispensing order and write and sign the written order if they satisfy all the following requirements:

- They meet the definition of physician assistant as found in Section 1861(aa)(5)(A) of the Act;
- They are treating the beneficiary for the condition for which the item is needed;
- They are practicing under the supervision of a Doctor of Medicine or Doctor of Osteopathy;
- They have their own NPI; and
- They are permitted to perform services in accordance with State law.

Q3. Is it acceptable to have an order signed by a physician, other than the treating physician, that works in the same office as them?
A3. As long as the physician who has signed the order is covering for the patient's treating physician and he indicates that on the order, or is actually ordering the item, it is acceptable.

Q4. What is the permitted timeframe for follow-up notes from a physician for their management oversight? For example, an August 15 audit is being conducted. What time period is CERT looking for those follow-up notes?
A4. The CERT is generally looking for a timeline that may be one year prior to the dispensing of an item or up to six months after. NAS cannot speak specifically for the CERT, but that is generally what they are looking for; a fairly decent proximity to the date of service.

Q5. A supplier has an oxygen patient that transferred from another supplier. The new supplier completes a revised CMN and has a pick-up ticket. Should the new supplier also get a copy of the SAT tests?
A5. Yes. NAS recommends getting a copy of the test results. Suppliers are reminded that in an audit they may be asked to provide a copy of the actual test report and/or information from the medical record to verify that coverage criteria have been met.

Q6. A patient does not qualify by Medicare requirements for an item (i.e., bariatric hospital bed). The secondary insurance (i.e., Medicaid) notified the supplier they will cover the item but require a Medicare denial before they authorize the item. Can the supplier bill Medicare for the denial with a notation on the claim that the item has not been dispensed and it is being billed solely for denial purposes for the secondary insurance (Medicaid)?
A6. It would not be appropriate to bill Medicare for an item that has not been provided to the beneficiary. However, if the patient does qualify for a hospital bed and an upgrade is requested, the supplier could dispense and bill the bed in which the patient has qualified. There is upgrade modifiers a supplier could use to identify the patient wants something that differs from the coverage criteria requirements for which they had qualified. Read the following article for billing instructions for upgrades:
DME Upgrades, ABNS, and Claims Modifiers.

Q7. How long does a supplier need to keep original documents on file for Medicare once the documents have been scanned and are electronically available?
A7. CMS published MLN Matters Special Edition 1022, which indicates, "The Medicare program does not have requirements for the media formats for medical records. However, the medical record needs to be in its original form or in a legally reproduced form, which may be electronic, so that medical records may be reviewed and audited by authorized entities. Providers must have a medical record system that insures that the record may be accessed and retrieved promptly." NAS is currently in contact with CMS regarding multiple Internet Only Manual chapters containing different record retention timelines depending on the type of record. When that CMS resource is published that clearly defines the timeline for record retention, NAS will publish that to our website, quarterly bulletin and electronic mailing list.

Q8. If a patient does not meet their positive airway pressure (PAP) device requirements for adherence to therapy in the first 90 days, but they are close to meeting it, for example by 150 days, what are the options to get coverage for that missing time period? Is there an appeal process available as patients have expressed to their physicians and suppliers that they want an appeal to describe their individual situation as to why they did not meet the criteria.
A8. If the beneficiary does not qualify in the first 90 days, the only way to get them qualified after that point is to have a new face-to-face re-examination with the treating physician to determine the etiology of the failure to respond to the PAP therapy. The patient would have to have a new facility-based sleep test and they would have to go through the qualification period again. If the beneficiary was in a nursing home or a skilled nursing facility, those days could be excluded.

Q9. A supplier set their own return policy, and does not allow returns unless the product is faulty. The supplier will replace the product if it does not fit until the patient has an item that is a proper fit. Even though the supplier has that policy, the supplier is charged back from Medicare because the beneficiary will call and say they did not want that product and has returned it. The product is not a substandard product. Instead, it is a situation in which after two weeks, the patient does not want the item although a doctor provided a prescription and the patient originally wanted the item.
A9. Supplier standard number 15 states, "A supplier must accept returns of substandard (less than full quality for the particular item) or unsuitable items (inappropriate for the beneficiary at the time it was fitted and rented or sold) from beneficiaries." Possibly the patient considers the item unsuitable at the time that it was delivered. The product is not necessarily substandard, but is not suitable for the time that the beneficiary received it. If it is due to a patient changing their mind, it would make sense for the supplier to speak to their own legal counsel. There are special guidelines for custom made items. If the supplier customizes an item for a beneficiary and then the beneficiary returns the item or decides they do not want the item, if the item was customized for that beneficiary, the supplier is allowed to bill for the customized item. See the Medicare Benefit Policy Manual, Chapter 15, Section 20.3 for more information.

Q10. Can both an order and medical necessity certifying statement be on the same form for diabetic shoes and inserts?
A10. A certifying statement from the physician who is managing the patient's diabetic condition is required. There are specific elements that need to be on this statement. The prescribing and certifying physician are generally not the same. The detailed written order should be a different document than the certifying physician statement.

Q11. A doctor writes a prescription for oxygen after doing a finger pulse test in the office and then the patient has an outside pulse suction imagery test done by qualified personnel. Technically, the physician is saying the patient has to be seen by an outside qualified source to conduct the oximetry test. The results of the pulse suction imagery test indicate the patient does need oxygen. Does the patient have to return to the doctor's office before the oxygen can be delivered?
A11. There are two entities that can perform testing for oxygen patients; the physician or a qualified provider of laboratory services. Therefore, the doctor is qualified to conduct a pulse oximetry test. As long as the physician is documenting the results in the medical record and the records are available upon request, then that would be a certified test.

Q12. If the patient goes to a lab for an oximetry test ordered by a doctor, does the patient need to return to the doctor to obtain a prescription to receive oxygen?
A12. Not as long as the patient saw the physician 30 days prior to the initial date on the CMN and the test was performed by a qualified provider of laboratory services.

Q13. On the continuous positive airway pressure (CPAP) device download, the requirement is 70 percent compliance for a 30 day download. Does it have to be 30 consecutive days? An example was within 30 days; the patient wore the mask 29 nights, did not wear the mask one night, and overall, resulted in the patient being 70 percent compliant.
A13. According to the PAP Devices for the Treatment of Obstructive Sleep Apnea (Formerly CPAP) Local Coverage Determination (LCD) L171, "Adherence to therapy is defined as use of PAP greater than or equal to (=) 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." As long as there is a 30 days consecutive period, it meets the criteria.

Q14: In the Power Mobility Device (PMD) LCD, what medical necessity information is required that differentiates between providing a Group 1 (K0813-K0816) and Group 2 (K0820-K0829) no power option power wheelchair?
A14: The coverage criteria for a Group 1 or Group 2 no power option power wheelchair is the same (listed below). The beneficiary's medical records must support the coverage criteria to meet the medical necessity. The actual chair that is dispensed to the beneficiary should be the best fit for the patient's weight and appropriate to complete the patient's mobility related activities of daily living (MRADL) within the home.

Criteria:

A.. All of the basic coverage criteria A-C are met; and

B. The patient does not meet coverage criterion D, E or F for a POV; and

C. Either criterion J or K is met; and

D. Criteria L, M, N and O are met; and

E. Any coverage criteria pertaining to the specific wheelchair type (see below) are met.

Basic coverage criteria A-C is:

A. The patient has a mobility limitation that significantly impairs his/her ability to participate in one or more mobility-related activities of daily living (MRADLs) such as toileting, feeding, dressing, grooming, and bathing in customary locations in the home. A mobility limitation is one that:

- Prevents the patient from accomplishing an MRADL entirely, or
- Places the patient at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to perform an MRADL; or
- Prevents the patient from completing an MRADL within a reasonable time frame.

B. The patient's mobility limitation cannot be sufficiently and safely resolved by the use of an appropriately fitted cane or walker.

C. The patient does not have sufficient upper extremity function to self-propel an optimally-configured manual wheelchair in the home to perform MRADLs during a typical day.

- Limitations of strength, endurance, range of motion, or coordination, presence of pain, or deformity or absence of one or both upper extremities are relevant to the assessment of upper extremity function.
- An optimally-configured manual wheelchair is one with an appropriate wheelbase, device weight, seating options, and other appropriate nonpowered accessories.

Criteria J-O is:

J. The patient has the mental and physical capabilities to safely operate the power wheelchair that is provided; or

K. If the patient is unable to safely operate the power wheelchair, the patient has a caregiver who is unable to adequately propel an optimally configured manual wheelchair, but is available, willing and able to safely operate the power wheelchair that is provided; and

L. The patient's weight is less than or equal to the weight capacity of the power wheelchair that is provided.

M. The patient's home provides adequate access between rooms, maneuvering space and surfaces for the operation of the power wheelchair that is provided.

N. Use of a power wheelchair will significantly improve the patient's ability to participate in MRADLs and the patient will use it in the home. For patients with severe cognitive and/or physical impairments, participation in MRADLs may require the assistance of a caregiver.

O. The patient has not expressed an unwillingness to use a power wheelchair in the home.

Q15. In regards to the Wheelchair Options/Accessories Article A19846, which include coding guidelines that reflects, "There is no separate billing for angle adjustable footplates with Group 1 or 2 PWCs. Angle adjustable footplates may be billed separately with Group 3, 4 and 5 PWCs." The Article also indicates, "The adjustable angle footplates (K0040) are separately billable with Groups 3, 4 and 5 PWCs." Suppliers are receiving contractual obligation (CO97) denials which indicate, "The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated." This denial is inconsistent with the article guidelines and the denials are being overturned and paid on appeal. What remedy is available to relieve suppliers from doing appeals?
A15. This was an internal issue that has been corrected. The examples that were faxed to NAS all had been adjusted and paid correctly through a mass adjustment.

Q16. How should a supplier correctly file a Medicare claim for glasses provided to a patient after cataract surgery when the patient is in a hospital Part A stay?
A16. If the patient is in a hospital Part A stay when the supplier is delivering the glasses, the glasses will not be covered by the DME MAC. The patient has to be in their home or in a home environment to be covered. If the beneficiary is in a skilled nursing facility (SNF) that is being covered by Medicare Part A, then the supplier would have to look to that facility for reimbursement as glasses are not excluded in the consolidated billing under perspective payment. If the beneficiary is outside that Part A stay and the patient is considered in place of service 31 or 32, the supplier can bill the glasses to the DME MAC.

Q17. When a patient changes from commercial insurance to Medicare and the patient is receiving continuous glucose monitoring products, how should suppliers submit these claims? Does each claim need to progress through the appeal (redetermination) level?
A17. Continuous glucose monitoring is considered precautionary and therefore, it is noncovered as a Medicare benefit. A denied claim has appeal rights if the supplier and/or beneficiary choose to pursue that next step in claims processing.

Q18. Where do I find more information regarding becoming a grandfathered non-contract supplier for the competitive bidding program?
A18. A non-contract supplier electing to become grandfathered must send written notification of their decision to CMS by November 17, 2010. The Competitive Bidding Implementation Contractor (CBIC), Palmetto GBA gives directions for notifying CMS on their website: http://www.dmecompetitivebid.com. You can also contact their Customer Service at 1-877-577-5331.

Q19. On the CMS 484 CMN - Oxygen form, Question 2 states, "Was the test in Question 1 performed (1) with the patient in a chronic stable state as an outpatient, (2) within two days prior to discharge from an inpatient facility to home, or (3) under other circumstances?" What "other circumstances" can qualify that CMN?
A19. The Oxygen and Oxygen Equipment LCD L11457 states, "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." There are no other circumstances that would be covered by Medicare. If the answer to Question 2 is '3: under other circumstances', the claim will be automatically denied.

Q20. During the August 25, 2010, General ACT, a question regarding the type of documentation needed for a seat for a walker was posed. The following answer was provided, "The patient must meet coverage criteria for the walker. There also needs to be an order for the seat with documentation in the medical records describing the reason for the seat, such as knee buckling." Does a supplier need to submit two separate diagnosis codes to qualify a patient for walker with a seat?
A20. The medical records (i.e., chart notes) need to have the reason well documented to support why the seat is necessary, not the submission of two separate diagnosis on a claim. A supplier needs to have the supporting medical records that indicate why the patient needs the seat.

Q21. How can a supplier receive a more detailed explanation as to why the CERT contractor determined a claim was overpaid during the original processing by Medicare and now denied and the money needs to be returned to Medicare? The recoupment letter received from NAS for the CERT reviewed claim does not provide the detail necessary to help the supplier determine what was found to be lacking, which would have assisted the supplier determine if an appeal should be pursued.
A21. Unfortunately, the CERT contractor does not send specific information regarding the processing of each claim reviewed to the supplier. The details of the claims are made available by the CERT contractor to NAS. Suppliers are able to call the NAS Supplier Contact Center (1-866-243-7272) with their assigned claim's CERT identification number (CID). The customer service representative will refer supplier's CID inquiry to be researched and then the supplier will receive a telephone call from our internal staff who works on CERT findings in order to provide a more detailed explanation based on the information shared by the CERT contractor with NAS. After the supplier receives the NAS return phone call with the CERT details shared, the supplier can choose to submit a DME MAC Redetermination Request form if they disagree with the findings.

Q22. The PAP Devices for the Treatment of Obstructive Sleep Apnea LCD L171 requires a diagnostic study. Is there clarification available regarding titration study requirements?
A22. The policy indicates there is an option for the study; it can be "either during a facility-based titration or in the home setting." The titration is not necessarily in the sleep study.

Q23. When Medicare conducts prepayment claim reviews, does NAS staff review a specific claim date of service and take back payments on other dates of service if the reviewed claims' documentation is deemed not payable ? There is concern suppliers are not necessarily providing every medical record, every prescription change, etc., going back through time, but are instead submitting the documentation for the single claim in question.
A23. Yes, if the medical review nurses find that an item being reviewed is not medically necessary (i.e., a rental item), NAS will consider prior payments for the item paid in error and will begin the process to collect those payments. When NAS conducts a review, we have the right to look at prior claims. Suppliers are encouraged, when their claim is reviewed, to provide all of the documentation from the beginning with the order, medical notes, etc, to demonstrate why the item was medically necessary. Suppliers have appeal rights on the reviewed claim as well as those claims that have been recouped/overpaid and taken back by NAS.

Q24. If Medicare purchased the enteral pump after the 15th rental month, when may the beneficiary chose to receive a new pump?
A24. After 15 rental months have been paid, the option to purchase is no longer available. Per the Claims Processing Manual, Chapter 20, Section 30.7.1, "The supplier that collects the last month of rental (i.e., 15th month) is responsible for ensuring that the patient has a pump for the duration of medical necessity and for maintenance and servicing (M/S) of pump during the duration of therapy."

Q25. Is a CMS-R-131 Advance Beneficiary Notice of Noncoverage (ABN) form required for each item or can multiple items, such as a deluxe frame, be included within the same ABN?
A25. As long as the items are related, like frames and tint or wheelchair and leg rests, yes, a single ABN could be properly executed.

Q26. What happens if a supplier has an enteral patient transferred to them by a different supplier for the rental of a pump; however, the original supplier only billed for three months of the multiple years for which they saw the patient?
A26. Examples were requested and not received.

Q27. If Medicare paid for a power wheelchair to an original supplier, but a new supplier now services the chair for the patient, does the new supplier have to have all supporting documentation from the original provider or will a script from the physician be sufficient?
A27. Medicare will only cover repairs for items that are reasonable and necessary. In order for Medicare to determine whether it is reasonable and necessary, the new supplier would need to provide all the supporting documentation

upon request. This would be required in order to submit the KX modifier for payment as well. If the original supplier is no longer in business, the new supplier would need to establish a business practice decision for this situation.

Q28. Why would Noridian ask for more documentation on a diabetic claim when a favorable Administrative Law Judge (ALJ) decision was already made on the claim?
A28. A fax was requested and received. It was researched and the supplier was contacted with the information. The claim involved two separate diabetic codes on two separate claims.

Q29. Does Medicare require a form, other than the ABN, which would be completed that describes to the patient in more detail the difference between a deluxe frame versus a Medicare covered frame?
A29. The ABN, when properly executed, allows the beneficiary to make an informed consumer decision. It is mandatory to use this form in order to shift liability from the supplier to the beneficiary in cases where the items are expected to deny as not reasonable and necessary. This form also serves as a voluntary Notice of Exclusion of Medicare Benefits (NEMB) when used for items that will always deny patient responsibility, such as deluxe frames. No other form is necessary or required.

Q30. Are there any penalties for physicians that choose not to register and/or enroll in PECOS?
A30. This question has been posed to CMS during their own open door calls. At this point the physicians are being reimbursed for their office calls and their services. However, when these physicians are referring their patients for lab work, x-rays or durable medical equipment, the ordered services will not be paid and the patients that physician is treating are going to be negatively impacted. When the physician is registered in PECOS, claims can be resubmitted as the PECOS entry date does not have to coordinate with the submitted claim's date of service. At this point, NAS has received no additional guidance from CMS in regards to penalizing physicians for not registering/enrolling in PECOS. At this point, if suppliers have concerns or frustrations, they would need to work with CMS local or regional offices. The CMS website does announce open door meetings (conference calls) in which this topic is discussed.

NAS' IVR (1-877-320-0390) offers a feature that allows suppliers to enter the ordering/referring physician's name and NPI to learn if that physician is registered in PECOS. It is updated nightly and was developed to supplement the CMS "Ordering/Referring Report."

Q31. How can a supplier support maintenance and service for oxygen equipment if the anniversary date falls on a holiday or weekend?
A31. Maintenance and servicing of oxygen equipment needs to occur during the first month, six months following the 36 months cap of the rental. As long as the maintenance and servicing occurs during that first month, six months following a 36 month cap, there should not be a problem as it does not have to follow solely on the anniversary date.

Q32. For shoes and inserts for persons with diabetes, can a nurse practitioner complete the chart notes as long as they are reviewed and signed by the certifying physician who completes the certification statement? Is an electronic signature acceptable or is an original signature required?
A32. This is acceptable as long as the certification statement is signed by an MD or DO and the medical records are available upon request and support the certification statement.

Q33. A supplier has verified the DME information forms (DIFs) they submitted electronically have loaded into the system; however, claims are being denied and customer service representatives indicate the DIF is on file but has not 'attached' to the claim. Why is the DIF not processing with the claim as submitted?
A33. Examples were requested and not received.

Q34. If a doctor is not registered in PECOS and a supplier has a patient who comes to their office with a prescription to receive an item, can the supplier have the patient sign an ABN that indicates the doctor is not registered in PECOS and, therefore, is responsible for the item?
A34. No. An ABN does not cover PECOS registration. CMS did receive a suggestion to consider an ABN as an option but, to date, that suggestion has been declined. The claim will receive a front-end claim rejection as unprocessable when Phase 2 of Change Request 6421 is implemented. The claim is not being denied. Instead, suppliers will be notified that their claim cannot be processed. Suppliers have one year from the date of service to get that claim through the system. As a note, unprocessable rejections do not count as a claim submission.

Fact Sheets: DMEPOS Competitive Bidding Procedures for Upgrades, Oxygen Therapy Supplies, Positive Airway Pressure Devices and Cardiac Pacemakers

"DMEPOS Competitive Bidding Procedures for Upgrades" Fact Sheet
The "Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Billing Procedures for Upgrades" Fact Sheet is now available to download, free of charge, from the Medicare Learning Network®.

Once the DMEPOS Competitive Bidding Program becomes effective on Saturday, January 1, 2011, beneficiaries with Original Medicare who obtain competitively bid items in competitive bidding areas (CBAs) must obtain these items from a contract supplier for Medicare to pay, unless an exception applies. This fact sheet contains helpful information on Competitive Bidding Program rules that apply when a beneficiary wants to obtain an upgrade – that is, an item or a component of an item that exceeds the beneficiary's medical need. It includes information on which DMEPOS suppliers can provide the item, how the item will be paid, beneficiary liability, and Advance Beneficiary Notice (ABN) requirements.

To view the fact sheet, please visit the DMEPOS Competitive Bidding Educational Resources page at http://www.cms.gov/DMEPOSCompetitiveBid/04_Educational_Resources.asp. Scroll to "Downloads" and select "DMEPOS Competitive Bidding Fact Sheets."

Three New Fact Sheets on Oxygen Therapy Supplies, Positive Airway Pressure Devices, and Cardiac Pacemakers
The Medicare Learning Network® has developed three new fact sheets to provide education on common Comprehensive Error Rate Testing (CERT) errors related to oxygen therapy supplies, positive airway pressure (PAP) devices, and cardiac pacemakers. These educational products are available in downloadable format at the URLs listed below:

- "Oxygen Therapy Supplies: Complying with Documentation & Coverage Requirements" – includes a checklist of the documentation needed to support claims submitted to Medicare for oxygen therapy supplies. For more details, visit http://www.cms.gov/MLNProducts/downloads/OxgnThrpy_DocCvg_FactSheet_ICN904883.pdf.
- "Cardiac Pacemakers" – provides a list of common errors identified through the CERT Review Process and the covered indications for dual-chamber pacemakers. For more details, visit http://www.cms.gov/MLNProducts/downloads/CERT_Pmaker_FactSheet_ICN905144.pdf.
- "Positive Airway Pressure (PAP) Devices: Complying with Documentation & Coverage Requirements" – includes a checklist of the documentation needed to support claims submitted to Medicare for PAP devices. For more details, visit http://www.cms.gov/MLNProducts/downloads/PAP_DocCvg_FactSheet_ICN905064.pdf.

For additional resources that educate Fee-For-Service providers about common billing errors and other improper activities identified through CMS's claim review programs, including CERT, please visit the MLN Provider Compliance web page at http://www.cms.gov/MLNProducts/45_ProviderCompliance.asp.

Note: If you have problems accessing any hyperlink in this message, please copy and paste the URL into your Internet browser.

Medicare Claim Review Programs: MUE, CCI, CERT, RAC Booklet Revised

The Medicare Learning Network® has revised the "Medicare Claim Review Programs: MUE, CCI, CERT, RAC" booklet, which is designed to provide education on the different CMS claim-review programs and assist providers in reducing payment errors – in particular, coverage and coding errors. It includes FAQs, resources, and an overview of the various programs, including Medical Review (MR), Recovery Audit Contractor (RAC), and the Comprehensive Error Rate Testing (CERT) Program. This product is suggested for all Medicare Fee-For-Service providers and is available in downloadable format at http://www.cms.gov/MLNProducts/downloads/MCRP_Booklet.pdf. Additionally, please visit the MLN Provider Compliance web page at http://www.cms.gov/MLNProducts/45_ProviderCompliance.asp for additional resources designed to educate FFS providers about the common billing errors and other improper activities identified through these programs.

New CMS Web Page Available for MLN Provider Compliance Educational Products

In an effort to inform Medicare Fee-For-Service (FFS) providers about how to avoid common billing errors and other improper activities when dealing with the Medicare Program, the Medicare Learning Network® has developed the MLN Provider Compliance web page. This page contains MLN products and MLN Matters articles that educate FFS providers about common billing errors and other improper activities identified through CMS' various claim review programs. The web page is now available at http://www.cms.gov/MLNProducts/45_ProviderCompliance.asp and will be updated as new products and articles are developed and existing products and articles are revised.

Inpatient Hospital Web Guide & DMEPOS Competitive Bidding Program Repairs and Replacements Fact Sheets

From the Medicare Learning Network: "Suite of Products and Resources for Inpatient Hospitals" Web Guide
A new Educational Web Guide is now available from The Medicare Learning Network®. The "Suite of Products and Resources for Inpatient Hospitals" provides Medicare Part-A providers with an understanding of the various PPS rates and classification criterion for reimbursement to acute inpatient hospitals, home health agencies, hospice, hospital outpatient, inpatient psychiatric facilities, inpatient rehabilitation facilities, long-term care hospitals, and skilled nursing facilities. It also provides Part-A business office management professionals with accurate, timely, and easy-to-understand billing and coding products as well as information to help understand and streamline claims submissions. This product is suggested for all Part-A Medicare Fee-For-Service inpatient hospital providers and is available in downloadable format at http://www.cms.gov/MLNEdWebGuide/45_MLN_Suite_of_Products_and_Resources_for_Inpatient_Hospitals.asp.

From the Medicare Learning Network: "DMEPOS Competitive Bidding Program Repairs and Replacements" Fact Sheet
Once the DMEPOS (Durable Medical Equipment, Prosthetics, Orthotics, and Supplies) Competitive Bidding Program becomes effective on Sat Jan 1, 2011, beneficiaries with Original Medicare who obtain competitively bid items in competitive bidding areas (CBAs) must obtain these items from a contract supplier for Medicare to pay, unless an exception applies. One exception occurs when an item of DMEPOS that a beneficiary already owns needs to be repaired.

The "DMEPOS Competitive Bidding Program Repairs and Replacements" Fact Sheet contains helpful information on Competitive Bidding Program rules that apply when an item of DMEPOS that is owned by a beneficiary needs to be repaired or requires replacement parts. It includes information on which items and services non-contract suppliers may provide, and which Healthcare Common Procedure Coding System (HCPCS) codes can be considered replacement parts associated with repair of base equipment. To view the fact sheet, please visit the DMEPOS Competitive Bidding Educational Resources page at http://www.cms.gov/DMEPOSCompetitiveBid/04_Educational_Resources.asp, scroll down to "Downloads," and select "DMEPOS Competitive Bidding Fact Sheets."

Get Accurate Solutions Now to Your Medicare Claim Questions

You can find plenty of answers to your Medicare questions. Find the accurate ones from the Medicare Learning Network® (MLN).

As a billing or coding professional, you need Medicare information at your fingertips. That is why CMS experts developed the "Medicare Learning Network® Suite of Products and Resources for Billing and Coding Professionals" just for you. The Suite contains easy-to-understand, accessible, and free Medicare Program information.

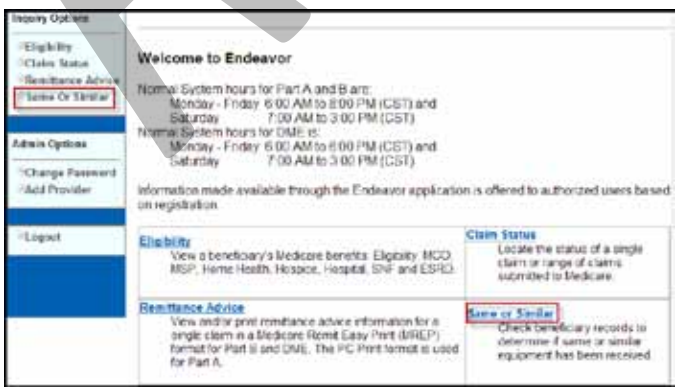
To access a detailed listing of all of the products you need to correctly submit claims the first time, visit the MLN Educational Web Guides web page at http://www.cms.gov/MLNEdWebGuide and, on the left hand side of the page, click on the "Medicare Learning Network Suite of Products and Resources for Billing and Coding Professionals."

Equip yourself today with critical reimbursement solutions from the official source for Medicare Fee-For-Service Provider information.

Same or Similar Now Available on Endeavor

Jurisdiction D suppliers may now access same or similar through Endeavor. This option is automatically provided to suppliers who currently have access to claim status.

Inquiry
Once logged in to Endeavor choose the "Same or Similar" option from the left side or middle of the main menu.



The following information must then be entered:

- National Provider Identifier (NPI) from list of approved NPIs
- Beneficiary Medicare number, first name, last name, and date of birth
- Date of service
  - Date may be current date or within the previous five years
- HCPCS code and modifier (if applicable)
  - When entering the HCPCS code, be sure to include RR or NU modifier, if applicable. If the modifier is not entered, the error message will state that the item is not tracked for same or similar. To determine if the RR or NU is required in Endeavor, see the fee schedule on our website at https://www.noridianmedicare.com/dme/fees/dmepos.html. If the HCPCS code shows the RR or NU modifier in the "Mod" column, it is required in Endeavor.

Reminders

- Same or similar is only available for the HCPCS codes provided in the Same or Similar Reference Chart, located on the Claims page of our website.
- Same or similar is not available for HCPCS codes beginning with G, J, L, Q, or V.

Response

The following information will be provided if all information is entered correctly and same or similar guidelines apply:

- Submitted HCPCS code
- Approved HCPCS code: Same or similar code on file)
- Initial Date on File:
- Recertification Date (if applicable):
- Last Day Item Billed:
- Name of Supplier: Supplier who provided the item
- Phone Number: Phone number of supplier who provided the item

Not Registered for Endeavor?
Go to https://www.noridianmedicare.com/dme/claims/endeavor.html to read an overview, the User Manual, and tips on using Endeavor. Then, click "here" under Login and/or Register.

- If registering as a new user, be sure to request access to claim status in the registration to obtain access to Same or Similar.
- Each person accessing Endeavor must register for their own User ID.

Questions
Questions regarding Endeavor may be emailed to dmeendeavor@noridian.com.

Internet-based PECOS for DMEPOS Suppliers

DMEPOS suppliers can use Internet-based Provider Enrollment, Chain and Ownership System (PECOS) to enroll, make a change in their enrollment record, view their Medicare enrollment information on file with Medicare and check on the status of a Medicare enrollment application via the Internet.

Using Internet-based PECOS
Before you begin to use Internet-based PECOS, you:

- Should review the document titled, 'Internet-based PECOS -- Getting Started Guide for Suppliers of DMEPOS' to obtain access to Internet-based PECOS
- Must obtain and designate a unique National Provider Identifier for each business/practice location that you are enrolling or have enrolled with the National Supplier Clearinghouse (NSC). Note: There is an exception for sole proprietorships.
- Enter the 'legal business name' for the supplier of DMEPOS as it shown on the IRS documentation and on the National Plan and Provider Enumeration System (NPPES). Both PECOS and NPPES require the submission of the 'legal business name'.

Finalizing Submission and Responding to Development Request
After submitting an enrollment application via Internet-based PECOS, you:

- Must print, sign and date (blue ink recommend) the certification statement(s) and mail the certification statement(s) and supporting documentation to the NSC within seven days. The NSC will not begin to process your enrollment application until it receives a signed and dated certification statement.
- May be asked to make corrections or submit additional documents by the NSC. In order for your application to be processed, you must submit this information promptly.

Pending paper enrollment application: If a DMEPOS supplier has a pending paper enrollment application, the supplier should not submit an Internet-based PECOS enrollment application for the same enrollment or change of information.

More Information
For more information about Internet-based PECOS, including contact information for the External User Services (EUS) help desk, go to CMS' website and select the 'Internet-based PECOS' tab on the left side of screen. The EUS help desk provides assistance to providers and suppliers if they encounter an application navigation or systems problem with Internet-based PECOS.

Clarification FAQs for Supplier Enrollment Standards

CMS recently released frequently asked questions (FAQs) clarifying the newly revised and additional supplier enrollment standards that were effective September 27, 2010. For more detailed information, please review the full listing of Supplier Enrollment Standards which can be found at 42 CFR 424.57 (c). View the FAQs on the National Supplier Clearinghouse website.

Additional Guidance on Implementing System Edits for Certain DMEPOS

MLN Matters® Number: MM7073
Related Change Request (CR) #: 7073
Related CR Release Date: November 12, 2010
Related CR Transmittal #: R808OTN
Effective Date: July 1, 2011
Implementation Date: July 5, 2011

Provider Types Affected
Suppliers who submit claims to Medicare DME Medicare Administrative Contractors (DME MACs) for DMEPOS services provided to Medicare beneficiaries.

Provider Action Needed
This article is based on Change Request (CR) 7073. The Centers for Medicare & Medicaid Services (CMS) is issuing CR7073 to provide further guidance to suppliers of DMEPOS, regarding licensing, accreditation, or other mandatory quality requirements that may apply. DMEPOS suppliers should be aware that if they are not identified by the National Supplier Clearing House-Medicare Administrative Contractor (NSC-MAC) as being accredited to supply the specific product/service AND they are not exempt from accreditation, their claims will be denied automatically by Medicare.

Background
Section 302 of the Medicare Modernization Act of 2003 (MMA) added a new paragraph 1834(a)(20) to the Social Security Act (the Act). This paragraph requires the Secretary of the Department of Health and Human Services to establish and implement quality standards for suppliers of DMEPOS. All suppliers that furnish such items or services set out at subparagraph 1834(a)(20)(D) as the Secretary determines appropriate must comply with the quality standards in order to receive Medicare Part B payments and to retain a Medicare supplier number to be able to bill Medicare. Pursuant to subparagraph 1834(a)(20)(D) of the Act, the covered items and services are defined in Section 1834(a)(13), Section 1834(h)(4) and Section 1842(s)(2) of the Act. The covered items include:

- DME;
- Medical supplies;
- Home dialysis supplies and equipment;
- Therapeutic shoes;
- Parenteral and enteral nutrient, equipment and supplies;
- Transfusion medicine; and
- Prosthetic devices, prosthetics, and orthotics.

ENROLLMENT CONT'D

Section 154(b) of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) added a new subparagraph (F) to Section 1834(a)(20) of the Act. In implementing quality standards under this paragraph the Secretary will require suppliers furnishing items and services directly, or as a subcontractor for another entity, to have submitted evidence of accreditation by an accreditation organization designated by the Secretary. This subparagraph states that eligible professionals and other persons (defined below) are exempt from meeting the accreditation deadline unless CMS determines that the quality standards are specifically designed to apply to such professionals and persons. The eligible professionals who are exempt from meeting the September 30, 2009, accreditation deadline (as defined in Section 1848(k)(3)(B)) include the following practitioners:

- Physicians (as defined in Section 1861(r) of the Act);
- Physical Therapists;
- Occupational Therapists;
- Qualified Speech-Language Pathologists;
- Physician Assistants;
- Nurse Practitioners;
- Clinical Nurse Specialists;
- Certified Registered Nurse Anesthetists;
- Certified Nurse-Midwives;
- Clinical Social Workers;
- Clinical Psychologists;
- Registered Dietitians; and
- Nutritional Professionals.

Additionally, MIPPA allows the Secretary to specify "other persons" that are exempt from meeting the accreditation deadline unless CMS determines that the quality standards are specifically designed to apply to such other persons. At this time, "such other persons" are specifically defined as the following practitioners:

- Orthotists;
- Prosthetists;
- Opticians; and
- Audiologists, and
- Pharmacies (. that have an NSC-MAC approved "Attestation for Exemption from Accreditation for a Medicare Enrolled Pharmacy. (see the NSC-MAC website at Palmettogba.com or the CMS website) (In accordance with Section 3109(a) of the Patent Protection and Affordable Care Act.)

Key Points
All supplier types (except those listed above) who furnish items and services requiring accreditation, directly or as a subcontractor for another entity, must have submitted evidence of accreditation by an accreditation organization designated by the Secretary on or after October 1, 2009.

Edits for the Healthcare Common Procedure Coding System (HCPCS) codes in the product categories designated by MIPPA as requiring accreditation will be in effect. Effective for claims with dates of service on or after July 5, 2011, this Medicare systems edit will automatically deny claims for these codes unless:

1. The DMEPOS supplier has been identified as accredited for the timeframe that covers the date of service on the claim; or
2. The DMEPOS supplier is currently exempt from meeting the accreditation requirements.

When claims are denied, DME MACs will use the following messages:

- Remark Code N211 – "Alert: You may not appeal this decision" and
- Claim Adjustment Reason Code B7 – "This provider was not certified/eligible to be paid for this procedure/service on this date of service. **Note**: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present."

Note: Products and services requiring accreditation found on CMS 855S, Section 2D next to the NSC-MAC product codes along with HCPCS codes may be found in Attachment B in CR 7073. Their corresponding HCPCS codes may be found in Attachment C. The web address of CR 7073 can be found in the next section of this article.

Additional Information
The official instruction (CR7073) issued to your Medicare DME MAC is available at http://www.cms.gov/Transmittals/downloads/R808OTN.pdf on the CMS website.

To review the CR6566, the initial article listing HCPCS codes, you may go to http://www.cms.gov/MLNMattersArticles/downloads/MM6566.pdf on the CMS website.

For additional information about the NSC-MAC and Recent Regulatory Revisions Pertinent to Suppliers of DMEPOS MM6282 is available at http://www.cms.gov/mlnmattersarticles/downloads/MM6282.pdf on the CMS website.

Pharmacy Attestation Information

As of January 1, 2011, pharmacies that meet all of the criteria may file an accreditation exemption statement which enables them to be enrolled in Medicare to supply durable medical equipment, orthotics, prosthetics and supplies (DMEPOS) which require accreditation, without having an accreditation. Pharmacies must complete and submit the attached attestation statement to the National Supplier Clearinghouse. Full exemption criteria along with the attestation statement are available here: webattestationstatement.pdf (PDF, 88 KB)

Source: National Supplier Clearinghouse

Physicians and Non-Physician Practitioners Excluded from Deactivation in Medicare Due to Inactivity with Medicare

MLN Matters® Number: SE1034

Provider Types Affected
Physicians and non-physician practitioners (NPPs) who need to enroll in the Medicare Program for the sole purpose of ordering and referring items and services for Medicare beneficiaries are excluded from the process that would deactivate them after 12 consecutive months of non-billing.

Provider Action Needed
This article is for certain physicians and NPPs who have the unique enrollment scenarios of enrolling for the sole purpose of ordering and referring items and services for Medicare beneficiaries. These physicians and NPPs do not and will not send claims to a Medicare contractor for the services they furnish and shall be excluded from the 12-month non-billing deactivation process. The supplier types affected are listed in the *Background* section of this article.

Background
The Centers for Medicare & Medicaid Services (CMS) instructs Medicare contractors to deactivate the records of physicians and NPPs who have had no activity in submitting claims to Medicare contractors for 12 consecutive months. However, CMS excludes certain physicians and NPPs from this deactivation process and has instructed Medicare contractors accordingly. The supplier types that are excluded from deactivation for non-billing include the following physicians and NPPs who are employees of Department of Veterans Affairs (DVA), Department of Defense (DOD), or Public Health Service (PHS) and employees of Medicare enrolled Federally Qualified Health Center (FQHC), Critical Access Hospital (CAH), and Rural Health Clinic (RHCs):

- Doctor of medicine or osteopathy;
- Doctor of dental medicine;
- Doctor of dental surgery;
- Doctor of podiatric medicine;
- Doctor of optometry;
- Doctor of chiropractic medicine;
- Physician Assistant;
- Certified Clinical Nurse Specialist;
- Nurse Practitioner;
- Clinical psychologist;
- Certified Nurse Midwife; and
- Clinical social worker.

In addition, the following supplier types, regardless of their employment, are excluded from the deactivation process:

- Pediatric Medicine physicians (specialty 37); and
- Oral surgery (dentist only, specialty 19)

New Affordable Care Act Rules to Fight Healthcare Fraud

On Monday, January 24, 2011, HHS announced new rules authorized by the Affordable Care Act which will help stop healthcare fraud. "Thanks to the new law, CMS now has additional resources to help detect fraud and stop criminals from getting into the system in the first place," CMS Administrator Donald Berwick, MD, said. "The Affordable Care Act's new authorities allow us to develop sophisticated, new systems of monitoring and oversight to not only help us crack down on fraudulent activity scamming these programs, but also help us to prevent the loss of taxpayer dollars across the board for millions of American healthcare consumers."

Specifically, the final rule:

- Creates a rigorous screening process for providers and suppliers enrolling Medicare, Medicaid, and CHIP to keep fraudulent providers out of those programs. Types of providers and suppliers that have been identified in the past as posing a higher risk of fraud (for example, durable medical equipment suppliers) will be subject to a more thorough screening process.
- Requires new enrollment process for Medicaid and CHIP providers. Under the Affordable Care Act, states will have to screen providers who order and refer to Medicaid beneficiaries to determine if they have a history of defrauding the government. Providers that have been kicked out of Medicare or another state's Medicaid or CHIP will be barred from all Medicaid and CHIP programs.
- Temporarily stops enrollment of new providers and suppliers. Medicare and state agencies will be on the lookout for trends that may indicate healthcare fraud – including using advanced predictive modeling software, such as that used to detect credit-card fraud. If a trend is identified in a category of providers or geographic area, the program can temporarily stop enrollment as long as that will not impact access to care for patients.
- Temporarily stops payments to providers and suppliers in cases of suspected fraud. Under the new rules, if there has been a credible fraud allegation, payments can be suspended while an action or investigation is underway.

For more information:

- The full text of the press release issued on Mon Jan 24 is available at http://www.HHS.gov/news/press/2011pres/01/20110124a.html.
- A copy of the regulation is available in the Federal Register at http://www.ofr.gov/inspection.aspx or http://www.archives.gov/federal-register/news.html.
- A factsheet on the new rules can be found at http://www.HealthCare.gov/news/factsheets.

New Tools to Prevent and Fight Fraud

As part of the Obama Administration's ongoing efforts to prevent and fight fraud in our nation's health care system, US Department of Health & Human Services Secretary Sebelius and Attorney General Eric Holder today announced that the

FRAUD & ABUSE CONT'D

Centers for Medicare & Medicaid Services (CMS) would be acquiring new state-of-the-art fraud fighting analytic tools to prevent wasteful and fraudulent payments in Medicare, Medicaid and the Children's Health Insurance Program.

Sebelius and Holder made the announcement at the University of Massachusetts, Boston at the fourth regional health care fraud prevention summit. The Attorney General and the HHS Secretary have crisscrossed the country this year bringing together a wide array of federal, state, and local partners, beneficiaries, and providers to discuss innovative ways to eliminate fraud within the US health care system.

As part of that summit, CMS will issue a solicitation for state-of-the-art fraud fighting analytic tools to help the agency predict and prevent potentially wasteful, abusive, or fraudulent payments before they occur. These tools will integrate many of the Agency's pilot programs into the National Fraud Prevention Program and complement the work of the joint HHS and Department of Justice Health Care Fraud Prevention and Enforcement Action Team (HEAT).

The recently-enacted Affordable Care Act provides additional tools and resources to fight fraud in the health care system by providing an additional $350 million over the next ten years through the Health Care Fraud and Abuse Control Account. The Act toughens sentencing for criminal activity, enhances screenings and enrollment requirements, encourages increased sharing of data across government, expands overpayment recovery efforts, and provides greater oversight of private insurance abuses. For information on the 2009 Health Care Fraud and Abuse Control Program Report, please visit http://www.justice.gov/dag/pubdoc/hcfacreport2009.pdf.

To read the entire HHS Release issued on Thursday, December 16, 2010, please visit http://www.hhs.gov/news/press/2010pres/12/20101216a.html.

GLUCOSE MONITORS

Glucose Testing Supplies: Complying with Documentation & Coverage Requirements Fact Sheet

The Medicare Learning Network® (MLN) would like to remind you that it has developed a "Glucose Testing Supplies: Complying with Documentation & Coverage Requirements" fact sheet to provide education on common Comprehensive Error Rate Testing (CERT) Program errors related to glucose testing supplies, which is currently one of the highest sources of CERT error rates. This fact sheet includes a checklist of the documentation needed to support claims submitted to Medicare for glucose testing supplies and is currently available in downloadable format at http://www.cms.gov/MLNProducts/downloads/GlucSup_DocCvge_FactSheet_ICN905104.pdf. Please visit the MLN Provider Compliance web page at http://www.cms.gov/MLNProducts/45_ProviderCompliance.asp for additional resources that educate Fee-For-Service providers about common billing errors and other improper activities identified through CMS' claim review programs, including CERT.

A4253 - Probe Review Summary

NAS initiated a widespread complex prepayment targeted review on August 18, 2010, for HCPCS code A4253 (Blood glucose test or reagent strips for home blood glucose monitor, per 50 strips) as a result of the widespread prepayment probe review error ratio of 77%.

As of November 18, 2010, 4300 claims were captured for review and additional documentation was requested. Of these claims:

- 914 claims were paid in full
- 3386 claims were denied resulting in a 72% error rate

The following is a brief summary of main reasons for denials:

- 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
- Basic coverage criteria as listed in Local Coverage Determination (LCD) (L196) was not met

As a reminder, to be eligible for coverage of home blood glucose monitor and related accessories and supplies, the patient must meet the criteria as noted in LCD L196 and Policy Article A33673, which can be found on our website: https://www.noridianmedicare.com/dme/coverage/lcd.html.

It is important for suppliers to be familiar with the documentation requirements outlined in the Glucose Monitor LCD and Policy Article. Please ensure when submitting additional documentation, that all supporting medical necessity documentation is provided. Supplier responses should also be submitted timely.

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

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

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

Due to the high error rate found with this review, this service specific targeted review will continue.

Glucose Monitor Supplies – Use of Upgrade Modifiers

An upgrade is defined as an item that goes beyond what is medically necessary under Medicare's coverage requirements. An item can be considered an upgrade even if the physician has signed an order for it. For glucose monitor supplies, if the **quantity** of test strips and lancets that is provided exceeds the standard amount specified in the LCD and if the supplier does not have information indicating that all of the criteria for coverage of the excess quantities have been met (i.e., criteria [a]–[f] in the Glucose Monitors Local Coverage Determination), that quantity can be considered an upgrade.

General information about the use of upgrade modifiers is found in the Jurisdiction D Supplier Manual, Chapter 6. Applying this to test strips and lancets, if a supplier wants to collect from the beneficiary for the excess quantity of supplies, a properly completed ABN must be obtained. If an ABN is obtained, on one claim line the supplier bills the appropriate HCPCS code with a GA modifier and bills the units of service that describe the quantity of supplies that were **provided**. On the next claim line, the supplier bills the same HCPCS code with a GK modifier and bills the units of service that describe the standard quantity of supplies that are **covered** based on the LCD. (**Note: The codes must be billed in this specific order on the same claim**.) In this situation, the claim line with the GA modifier will be denied as not medically necessary with a "patient responsibility" (PR) message and the claim line with the GK modifier will continue through the usual claims processing. The beneficiary liability will be the sum of (a) the difference between the submitted charge for the GA claim line and the submitted charge for the GK claim line and (b) the deductible and co-insurance that relate to the allowed charge for the GK claim line. (Note: When using the upgrade modifiers, the submitted charge for the upgrade [GA modifier line] – i.e., the quantity of supplies that were provided – may not exceed the Medicare fee schedule allowance for the items.)

If a supplier wants to provide the excess quantity of supplies without any additional charge to the beneficiary, then no ABN is obtained. The supplier bills the HCPCS code with a GL modifier and bills the units of service that describe the quantity of supplies that are **covered** based on the LCD. The quantity of supplies that is provided is not billed.

When using an upgrade modifier for excess quantities of test strips, suppliers are not required to include on the claim the brand name of the product(s) or an explanation for why it is considered an upgrade.

Codes with a GK or GL modifier will continue through the usual claims processing. For test strips and lancets, if the units of service on the GK/GL claim line are within the policy guidelines, then that claim line will not hit an edit which is focused on individual claims lines with excess units of service. If no other edits hit the claim line, payment will be made based on the units of service billed for the code with the GK or GL modifier.

Example
The physician orders testing twice per day for a non-insulin treated patient. The supplier provides 4 vials of test strips (50 in each) and 2 boxes of lancets (100 in each) as a three month supply. The supplier is unable to confirm that there is documentation in the patient's medical record that justifies the need for twice per day testing and/or documentation (e.g., beneficiary log) that the beneficiary is testing at that frequency.

If the supplier wants to collect payment for the excess quantity of supplies from the beneficiary and obtains a properly completed ABN, the claim is billed as:

Line 1 – A4253NUKSGA, 4 UOS, 90 day date span
Line 2 – A4253NUKSGK, 2 UOS, 90 day date span
Line 3 – A4259NUKSGA, 2 UOS, 90 day date span
Line 4 – A4259NUKSGK, 1 UOS, 90 day date span

If the supplier does not want to collect payment for the excess quantity from the beneficiary, no ABN is obtained and the supplier bills:

Line 1 – A4253NUKSGL, 2 UOS, 90 day date span
Line 2 – A4259NUKSGL, 1 UOS, 90 day date span

Refer to the Glucose Monitors Local Coverage Determination and Policy Article for additional information on coverage criteria, coding guidelines, and documentation requirements.

Draft Glucose Monitors Local Coverage Determination Withdrawn

The DME MACs released a draft revision of the Glucose Monitors LCD for comment on September 23, 2010. The comment period ended November 8, 2010. Based upon the comments received this proposed revision has been withdrawn.

HCPCS CODES

HCPCS Code Update – 2011 – Revised

The following list identifies changes to level II Healthcare Common Procedure Coding System (HCPCS) codes for 2011. Please refer to Change Requests 7300, 7064 and 7121 published on the Centers for Medicare and Medicaid (CMS) website.

Added Codes/Added Modifiers: New codes and modifiers are effective for dates of service on or after January 1, 2011.

Discontinued Codes/Deleted Modifiers: Codes or modifiers that are discontinued/deleted will continue to be valid for claims with dates of service on or before December 31, 2010, regardless of the date of claim submission. If there is a direct crosswalk for a discontinued/deleted code or modifier, it is listed in the table. The crosswalked codes are also "added" codes effective for dates of service on or after January 1, 2011.

Narrative Changes/Revised Modifiers: A description change for an existing code or modifier is effective for dates of service on or after January 1, 2011.

HCPCS CODES CONT'D

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

Ankle-Foot/Knee-Ankle-Foot Orthoses

Added Code

Code	Narrative
L4631	ANKLE FOOT ORTHOSIS, WALKING BOOT TYPE, VARUS/VALGUS CORRECTION, ROCKER BOTTOM, ANTERIOR TIBIAL SHELL, SOFT INTERFACE, CUSTOM ARCH SUPPORT, PLASTIC OR OTHER MATERIAL, INCLUDES STRAPS AND CLOSURES, CUSTOM FABRICATED

Enteral Nutrition

Narrative Changes

Code	Old Narrative	New Narrative
B4034	ENTERAL FEEDING SUPPLY KIT; SYRINGE FED, PER DAY	ENTERAL FEEDING SUPPLY KIT; SYRINGE FED, PER DAY, INCLUDES BUT NOT LIMITED TO FEEDING/ FLUSHING SYRINGE, ADMINISTRATION SET TUBING, DRESSINGS, TAPE
B4035	ENTERAL FEEDING SUPPLY KIT; PUMP FED, PER DAY	ENTERAL FEEDING SUPPLY KIT; PUMP FED, PER DAY, INCLUDES BUT NOT LIMITED TO FEEDING/ FLUSHING SYRINGE, ADMINISTRATION SET TUBING, DRESSINGS, TAPE
B4036	ENTERAL FEEDING SUPPLY KIT; GRAVITY FED, PER DAY	ENTERAL FEEDING SUPPLY KIT; GRAVITY FED, PER DAY, INCLUDES BUT NOT LIMITED TO FEEDING/ FLUSHING SYRINGE, ADMINISTRATION SET TUBING, DRESSINGS, TAPE

External Infusion Pumps

Added Code

Code	Narrative
J1559	INJECTION, IMMUNE GLOBULIN (HIZENTRA), 100 MG

Discontinued Code

Code	Narrative	Crosswalk to Code
J9110	INJECTION, CYTARABINE, 500 MG	J9100
J9375	VINCRISTINE SULFATE, 2 MG	J9370
J9380	VINCRISTINE SULFATE, 5 MG	J9370

Home Dialysis Supplies and Equipment

INVALID FOR SUBMISSION TO DME MAC

Code	Narrative
A4651	CALIBRATED MICROCAPILLARY TUBE, EACH
A4652	MICROCAPILLARY TUBE SEALANT
A4653	PERITONEAL DIALYSIS CATHETER ANCHORING DEVICE, BELT, EACH
A4671	DISPOSABLE CYCLER SET USED WITH CYCLER DIALYSIS MACHINE, EACH
A4672	DRAINAGE EXTENSION LINE, STERILE, FOR DIALYSIS, EACH
A4673	EXTENSION LINE WITH EASY LOCK CONNECTORS, USED WITH DIALYSIS
A4674	CHEMICALS/ANTISEPTICS SOLUTION USED TO CLEAN/STERILIZE DIALYSIS EQUIPMENT, PER 8 OZ
A4680	ACTIVATED CARBON FILTER FOR HEMODIALYSIS, EACH
A4690	DIALYZER (ARTIFICIAL KIDNEYS), ALL TYPES, ALL SIZES, FOR HEMODIALYSIS, EACH
A4706	BICARBONATE CONCENTRATE, SOLUTION, FOR HEMODIALYSIS, PER GALLON
A4707	BICARBONATE CONCENTRATE, POWDER, FOR HEMODIALYSIS, PER PACKET
A4708	ACETATE CONCENTRATE SOLUTION, FOR HEMODIALYSIS, PER GALLON
A4709	ACID CONCENTRATE, SOLUTION, FOR HEMODIALYSIS, PER GALLON
A4714	TREATED WATER (DEIONIZED, DISTILLED, OR REVERSE OSMOSIS) FOR PERITONEAL DIALYSIS, PER GALLON
A4719	"Y SET" TUBING FOR PERITONEAL DIALYSIS
A4720	DIALYSATE SOLUTION, ANY CONCENTRATION OF DEXTROSE, FLUID VOLUME GREATER THAN 249CC, BUT LESS THAN OR EQUAL TO 999CC, FOR PERITONEAL DIALYSIS

HCPCS CODES CONT'D

A4721	DIALYSATE SOLUTION, ANY CONCENTRATION OF DEXTROSE, FLUID VOLUME GREATER THAN 999CC BUT LESS THAN OR EQUAL TO 1999CC, FOR PERITONEAL DIALYSIS
A4722	DIALYSATE SOLUTION, ANY CONCENTRATION OF DEXTROSE, FLUID VOLUME GREATER THAN 1999CC BUT LESS THAN OR EQUAL TO 2999CC, FOR PERITONEAL DIALYSIS
A4723	DIALYSATE SOLUTION, ANY CONCENTRATION OF DEXTROSE, FLUID VOLUME GREATER THAN 2999CC BUT LESS THAN OR EQUAL TO 3999CC, FOR PERITONEAL DIALYSIS
A4724	DIALYSATE SOLUTION, ANY CONCENTRATION OF DEXTROSE, FLUID VOLUME GREATER THAN 3999CC BUT LESS THAN OR EQUAL TO 4999CC, FOR PERITONEAL DIALYSIS
A4725	DIALYSATE SOLUTION, ANY CONCENTRATION OF DEXTROSE, FLUID VOLUME GREATER THAN 4999CC BUT LESS THAN OR EQUAL TO 5999CC, FOR PERITONEAL DIALYSIS
A4726	DIALYSATE SOLUTION, ANY CONCENTRATION OF DEXTROSE, FLUID VOLUME GREATER THAN 5999CC, FOR PERITONEAL DIALYSIS
A4728	DIALYSATE SOLUTION, NON-DEXTROSE CONTAINING, 500 ML
A4730	FISTULA CANNULATION SET FOR HEMODIALYSIS, EACH
A4736	TOPICAL ANESTHETIC, FOR DIALYSIS, PER GRAM
A4737	INJECTABLE ANESTHETIC, FOR DIALYSIS, PER 10 ML
A4740	SHUNT ACCESSORY, FOR HEMODIALYSIS, ANY TYPE, EACH
A4750	BLOOD TUBING, ARTERIAL OR VENOUS, FOR HEMODIALYSIS, EACH
A4755	BLOOD TUBING, ARTERIAL AND VENOUS COMBINED, FOR HEMODIALYSIS, EACH
A4760	DIALYSATE SOLUTION TEST KIT, FOR PERITONEAL DIALYSIS, ANY TYPE, EACH
A4765	DIALYSATE CONCENTRATE, POWDER, ADDITIVE FOR PERITONEAL DIALYSIS, PER PACKET
A4766	DIALYSATE CONCENTRATE, SOLUTION, ADDITIVE FOR PERITONEAL DIALYSIS, PER 10 ML
A4770	BLOOD COLLECTION TUBE, VACUUM, FOR DIALYSIS, PER 50
A4771	SERUM CLOTTING TIME TUBE, FOR DIALYSIS, PER 50
A4772	BLOOD GLUCOSE TEST STRIPS, FOR DIALYSIS, PER 50
A4773	OCCULT BLOOD TEST STRIPS, FOR DIALYSIS, PER 50
A4774	AMMONIA TEST STRIPS, FOR DIALYSIS, PER 50
A4802	PROTAMINE SULFATE, FOR HEMODIALYSIS, PER 50 MG
A4860	DISPOSABLE CATHETER TIPS FOR PERITONEAL DIALYSIS, PER 10
A4870	PLUMBING AND/OR ELECTRICAL WORK FOR HOME HEMODIALYSIS EQUIPMENT
A4890	CONTRACTS, REPAIR AND MAINTENANCE, FOR HEMODIALYSIS EQUIPMENT
A4911	DRAIN BAG/BOTTLE, FOR DIALYSIS, EACH
A4913	MISCELLANEOUS DIALYSIS SUPPLIES, NOT OTHERWISE SPECIFIED
A4918	VENOUS PRESSURE CLAMP, FOR HEMODIALYSIS, EACH
A4928	SURGICAL MASK, PER 20
A4929	TOURNIQUET FOR DIALYSIS, EACH
E1500	CENTRIFUGE, FOR DIALYSIS
E1510	KIDNEY, DIALYSATE DELIVERY SYST. KIDNEY MACHINE, PUMP RECIRCULATING, AIR REMOVAL SYST, FLOWRATE METER, POWER OFF, HEATER AND TEMPERATURE CONTROL WITH ALARM, I.V.POLES, PRESSURE GAUGE, CONCENTRATE CONTAINER
E1520	HEPARIN INFUSION PUMP FOR HEMODIALYSIS
E1530	AIR BUBBLE DETECTOR FOR HEMODIALYSIS, EACH, REPLACEMENT
E1540	PRESSURE ALARM FOR HEMODIALYSIS, EACH, REPLACEMENT
E1550	BATH CONDUCTIVITY METER FOR HEMODIALYSIS, EACH
E1560	BLOOD LEAK DETECTOR FOR HEMODIALYSIS, EACH, REPLACEMENT
E1570	ADJUSTABLE CHAIR, FOR ESRD PATIENTS
E1575	TRANSDUCER PROTECTORS/FLUID BARRIERS, FOR HEMODIALYSIS, ANY SIZE, PER 10

HCPCS CODES CONT'D

E1580	UNIPUNCTURE CONTROL SYSTEM FOR HEMODIALYSIS
E1590	HEMODIALYSIS MACHINE
E1592	AUTOMATIC INTERMITTENT PERITONEAL DIALYSIS SYSTEM
E1594	CYCLER DIALYSIS MACHINE FOR PERITONEAL DIALYSIS
E1600	DELIVERY AND/OR INSTALLATION CHARGES FOR HEMODIALYSIS EQUIPMENT
E1610	REVERSE OSMOSIS WATER PURIFICATION SYSTEM, FOR HEMODIALYSIS
E1615	DEIONIZER WATER PURIFICATION SYSTEM, FOR HEMODIALYSIS
E1620	BLOOD PUMP FOR HEMODIALYSIS, REPLACEMENT
E1625	WATER SOFTENING SYSTEM, FOR HEMODIALYSIS
E1630	RECIPROCATING PERITONEAL DIALYSIS SYSTEM
E1632	WEARABLE ARTIFICIAL KIDNEY, EACH
E1634	PERITONEAL DIALYSIS CLAMPS, EACH
E1635	COMPACT (PORTABLE) TRAVEL HEMODIALYZER SYSTEM
E1636	SORBENT CARTRIDGES, FOR HEMODIALYSIS, PER 10
E1637	HEMOSTATS, EACH
E1699	DIALYSIS EQUIPMENT, NOT OTHERWISE SPECIFIED

Intravenous Immune Globulin

Added Code

Code	Narrative
J1599	INJECTION, IMMUNE GLOBULIN, INTRAVENOUS, NON-LYOPHILIZED (E.G. LIQUID), NOT OTHERWISE SPECIFIED, 500 MG

Lower Limb Prostheses

Added Code

Code	Narrative
L5961	ADDITION, ENDOSKELETAL SYSTEM, POLYCENTRIC HIP JOINT, PNEUMATIC OR HYDRAULIC CONTROL, ROTATION CONTROL, WITH OR WITHOUT FLEXION AND/OR EXTENSION CONTROL

Mechanical In-Exsufflation Devices

Added Code

Code	Narrative
A7020	INTERFACE FOR COUGH STIMULATING DEVICE, INCLUDES ALL COMPONENTS, REPLACEMENT ONLY

Miscellaneous

Added Code

Code	Narrative
A4566	SHOULDER SLING OR VEST DESIGN, ABDUCTION RESTRAINER, WITH OR WITHOUT SWATHE CONTROL, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT (Note: Noncovered; No benefit category)
A9273	HOT WATER BOTTLE, ICE CAP OR COLLAR, HEAT AND/OR COLD WRAP, ANY TYPE (Note: Noncovered; No benefit category)
E1831	STATIC PROGRESSIVE STRETCH TOE DEVICE, EXTENSION AND/OR FLEXION, WITH OR WITHOUT RANGE OF MOTION ADJUSTMENT, INCLUDES ALL COMPONENTS AND ACCESSORIES
L3674	SHOULDER ORTHOSIS, ABDUCTION POSITIONING (AIRPLANE DESIGN), THORACIC COMPONENT AND SUPPORT BAR, WITH OR WITHOUT NONTORSION JOINT/TURNBUCKLE, MAY INCLUDE SOFT INTERFACE, STRAPS, CUSTOM FABRICATED, INCLUDES FITTING AND ADJUSTMENT

Narrative Changes

Code	Old Narrative	New Narrative
L3671	SHOULDER ORTHOSIS, SHOULDER CAP DESIGN, WITHOUT JOINTS, MAY INCLUDE SOFT INTERFACE, STRAPS, CUSTOM FABRICATED, INCLUDES FITTING AND ADJUSTMENT	SHOULDER ORTHOSIS, SHOULDER JOINT DESIGN, WITHOUT JOINTS, MAY INCLUDE SOFT INTERFACE, STRAPS, CUSTOM FABRICATED, INCLUDES FITTING AND ADJUSTMENT
L3677	SHOULDER ORTHOSIS, HARD PLASTIC, SHOULDER STABILIZER, PRE-FABRICATED, INCLUDES FITTING AND ADJUSTMENT	SHOULDER ORTHOSIS, SHOULDER JOINT DESIGN, WITHOUT JOINTS, MAY INCLUDE SOFT INTERFACE, STRAPS, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT

HCPCS CODES CONT'D

Discontinued Code

Code	Narrative	Crosswalk to Code
E0220	HOT WATER BOTTLE	A9273
E0230	ICE CAP OR COLLAR	A9273
E0238	NON-ELECTRIC HEAT PAD, MOIST	A9273
L3672	SHOULDER ORTHOSIS, ABDUCTION POSITIONING (AIRPLANE DESIGN), THORACIC COMPONENT AND SUPPORT BAR, WITHOUT JOINTS, MAY INLCUDE SOFT INTERFACE, STRAPS, CUSTOM FABRICATED, INCLUDES FITTING AND ADJUSTMENT	L3674
L3673	SHOULDER ORTHOSIS, ABDUCTION POSITIONING (AIRPLANE DESIGN), THORACIC COMPONENT AND SUPPORT BAR, INCLUDES NONTORSION JOINT/ TURNBUCKLE, MAY INCLUDE SOFT INTERFACE, STRAPS, CUSTOM FABRICATED, INCLUDES FITTING AND ADJUSTMENT	L3674

Nebulizers

Added Code

Code	Narrative
J7686	TREPROSTINIL, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, UNIT DOSE FORM, 1.74 MG

Narrative Changes

Code	Old Narrative	New Narrative
A7013	FILTER, DISPOSABLE, USED WITH AEROSOL COMPRESSOR	FILTER, DISPOSABLE, USED WITH AEROSOL COMPRESSOR OR ULTRASONIC GENERATOR

Ostomy Supplies

Narrative Changes

Code	Old Narrative	New Narrative
A4399	OSTOMY IRRIGATION SUPPLY; CONE/CATHETER, INCLUDING BRUSH	OSTOMY IRRIGATION SUPPLY; CONE/ CATHETER, WITH OR WITHOUT BRUSH

Oxygen

Added Code

Code	Narrative
E0446	TOPICAL OXYGEN DELIVERY SYSTEM, NOT OTHERWISE SPECIFIED, INCLUDES ALL SUPPLIES AND ACCESSORIES (Note: Denied as not medically necessary; National Coverage Determination 20.29[C])

Surgical Dressings

Narrative Changes

Code	Old Narrative	New Narrative
A6011	COLLAGEN BASED WOUND FILLER, GEL/PASTE, STERILE, PER GRAM OF COLLAGEN	COLLAGEN BASED WOUND FILLER, GEL/PASTE, PER GRAM OF COLLAGEN
A6248	HYDROGEL DRESSING, WOUND FILLER, GEL, STERILE, PER FLUID OUNCE	HYDROGEL DRESSING, WOUND FILLER, GEL, PER FLUID OUNCE
A6260	WOUND CLEANSERS, STERILE, ANY TYPE, ANY SIZE	WOUND CLEANSERS, ANY TYPE, ANY SIZE
A6261	WOUND FILLER, GEL/PASTE, STERILE, PER FLUID OUNCE, NOT OTHERWISE SPECIFIED	WOUND FILLER, GEL/PASTE, PER FLUID OUNCE, NOT OTHERWISE SPECIFIED
A6262	WOUND FILLER, DRY FORM, STERILE, PER GRAM, NOT OTHERWISE SPECIFIED	WOUND FILLER, DRY FORM, PER GRAM, NOT OTHERWISE SPECIFIED

Urological Supplies

Narrative Changes

Code	Old Narrative	New Narrative
A5112	URINARY LEG BAG; LATEX	URINARY DRAINAGE BAG, LEG OR ABDOMEN, LATEX, WITH OR WITHOUT TUBE, WITH STRAPS, EACH

HCPCS CODES CONT'D

Wheelchair Seating

Added Code

Code	Narrative
E2622	SKIN PROTECTION WHEELCHAIR SEAT CUSHION, ADJUSTABLE, WIDTH LESS THAN 22 INCHES, ANY DEPTH
E2623	SKIN PROTECTION WHEELCHAIR SEAT CUSHION, ADJUSTABLE, WIDTH 22 INCHES OR GREATER, ANY DEPTH
E2624	SKIN PROTECTION AND POSITIONING WHEELCHAIR SEAT CUSHION, ADJUSTABLE, WIDTH LESS THAN 22 INCHES, ANY DEPTH
E2625	SKIN PROTECTION AND POSITIONING WHEELCHAIR SEAT CUSHION, ADJUSTABLE, WIDTH 22 INCHES OR GREATER, ANY DEPTH

Discontinued Code

Code	Narrative	Crosswalk to Code
K0734	SKIN PROTECTION WHEELCHAIR SEAT CUSHION, ADJUSTABLE, WIDTH LESS THAN 22 INCHES, ANY DEPTH	E2622
K0735	SKIN PROTECTION WHEELCHAIR SEAT CUSHION, ADJUSTABLE, WIDTH 22 INCHES OR GREATER, ANY DEPTH	E2623
K0736	SKIN PROTECTION AND POSITIONING WHEELCHAIR SEAT CUSHION, ADJUSTABLE, WIDTH LESS THAN 22 INCHES, ANY DEPTH	E2624
K0737	SKIN PROTECTION AND POSITIONING WHEELCHAIR SEAT CUSHION, ADJUSTABLE, WIDTH 22 INCHES OR GREATER, ANY DEPTH	E2625

Modifiers

Added Code

Code	Narrative
AY	ITEM OR SERVICE FURNISHED TO AN ESRD PATIENT THAT IS NOT FOR THE TREATMENT OF ESRD
CS	ITEM OR SERVICE RELATED, IN WHOLE OR IN PART, TO AN ILLNESS, INJURY, OR CONDITION THAT WAS CAUSED BY OR EXACERBATED BY THE EFFECTS, DIRECT OR INDIRECT, OF THE 2010 OIL SPILL IN THE GULF OF MEXICO, INCLUDING BUT NOT LIMITED TO SUBSEQUENT CLEAN-UP ACTIVITIES NOTE: This modifier was effective as of April 20, 2010.
GU	WAIVER OF LIABILITY STATEMENT ISSUED AS REQUIRED BY PAYER POLICY, ROUTINE NOTICE
NB	NEBULIZER SYSTEM, ANY TYPE, FDA-CLEARED FOR USE WITH SPECIFIC DRUG

Narrative Changes

Code	Old Narrative	New Narrative
GA	WAIVER OF LIABILITY STATEMENT ON FILE	WAIVER OF LIABILITY STATEMENT ISSUED AS REQUIRED BY PAYER POLICY, INDIVIDUAL CASE

HCPCS Collection Instrument

CMS would like to inform you that the Healthcare Common Procedure Coding System (HCPCS) collection instrument has been published in the Federal Register Notice for a 60-day comment period as part of the Paperwork Reduction Act (PRA) process. You can access this publication at http://edocket.access.gpo.gov/2010/pdf/2010-31071.pdf. To obtain copies of the supporting statement and any related forms for the HCPCS collection, access CMS' website at http://www.cms.gov/PaperworkReductionActof1995. If you have comments regarding the proposed revision of this paperwork collection please follow the instructions in the Federal Register Notice. To be assured consideration, comments and recommendations must be submitted by February 8, 2011.

Please note that while the form includes our proposed changes for 2013, the form is inadvertently dated 2012. CMS will correct the date prior to the 30-day comment period.

Home Health Face-to-Face Encounter: A New Home Health Certification Requirement

A new Medicare home health law goes into effect on January 1st that affirms the role of the physician as the person who orders home health care based on personal examination of the patient. Effective in January, a physician who certifies a patient as eligible for Medicare home health services must see the patient. The law also allows the requirement to be satisfied if a non-physician practitioner (NPP) sees the patient, when the NPP is working for or in collaboration with the physician.

As part of the certification form itself, or as an addendum to it, the physician must document that the physician or NPP saw the patient, and document how the patient's clinical condition supports a homebound status and need for skilled services. The face-to-face encounter must occur within the 90 days prior to the start of home health care, or within the 30 days after the start of care.

While the long-standing requirement for physicians to order and certify the need for home health remains unchanged, this new requirement assures that the physician's order is based on current knowledge of the patient's condition. In situations when a physician orders home health care for the patient based on a new condition that was not evident during a recent visit, the certifying physician or NPP must see the patient within 30 days after admission.

The new requirement includes several features to accommodate physician practice. In addition to allowing NPPs to conduct the face-to-face encounter, Medicare allow a physician who attended to the patient but does not follow patient in the community, such as a hospitalist, to certify the need for home health care based on their face to face contact with the patient in the hospital and establish and sign the plan of care. Medicare will also allow such physicians to certify the need for home health care based on their face to face contact with the patient, initiate the orders for home health services, and "hand off" the patient to his or her community-based physician to review and sign off on the plan of care. Finally, in rural areas, the law allows the face-to-face encounter to occur via telehealth, in an approved originating site.

Medicare home health plays a vital role in allowing patients to receive care at home as an alternative to extended hospital or nursing home care. Additional guidance has been made available via a Special Edition article on our Medicare Learning Network website at: http://www.cms.gov/MLNMattersArticles/downloads/SE1038.pdf. Questions and answers regarding this requirement will be available shortly thereafter on the CMS website. We will post a link to those questions in the Spotlights sections at: http://www.cms.gov/center/hha.asp. Finally, we expect a video training module describing this new requirement to be released within the next few weeks.

Note: If you have problems accessing any hyperlink in this message, please copy and paste the URL into your Internet browser.

Home Health Face-to-Face Encounter - A New Home Health Certification Requirement

MLN Matters® Number: SE1038

Provider Types Affected
This article is for physicians certifying Medicare patients' need/eligibility for home health benefits, home health agencies (HHAs), and beneficiaries.

What You Need to Know
As a condition for payment, the Affordable Care Act mandates that prior to certifying a patient's eligibility for the home health benefit, the certifying physician must document that he or she, or an allowed non-physician practitioner (NPP) has had a face-to-face encounter with the patient. Documentation regarding these encounters must be present on certifications for patients with starts of care on and after January 1, 2011. See the remainder of this article for details.

Background
Since the inception of the benefit, the Social Security Act has required physicians to order and certify the need for Medicare home health services. This new mandate assures that the physician's order is based on current knowledge of the patient's condition.

As a condition for payment, the Affordable Care Act mandates that prior to certifying a patient's eligibility for the home health benefit, the certifying physician must document that he or she, or an allowed NPP has had a face-to-face encounter with the patient.

The Affordable Care Act describes NPPs who may perform this face-to-face patient encounter as a nurse practitioner or clinical nurse specialist (as those terms are defined in section 1861(aa)(5)of the Social Security Act), who is working in collaboration with the physician in accordance with State law, or a certified nurse-midwife (as defined in section 1861(gg) of the Social Security Act, as authorized by State law), or a physician assistant (as defined in section 1861(aa)(5)of the Social Security Act), under the supervision of the physician.

Home Health Prospective Payment System (HHPPS) Final Rule Implementation Provisions
The Centers for Medicare & Medicaid Services (CMS) implemented this provision of the Affordable Care Act via the HHPPS Calendar Year (CY) 2011 rulemaking. In that rule, CMS finalized the following:

- Documentation regarding these face-to-face encounters must be present on certifications for patients with starts of care on and after January 1, 2011.
- As part of the certification form itself, or as an addendum to it, the physician must document when the physician or allowed NPP saw the patient, and document how the patient's clinical condition as seen during that encounter supports the patient's homebound status and need for skilled services.
- The face-to-face encounter must occur within the 90 days prior to the start of home health care, or within the 30 days after the start of care.

HOME HEALTH CONT'D

- In situations when a physician orders home health care for the patient based on a new condition that was not evident during a visit within the 90 days prior to start of care, the certifying physician or NPP must see the patient within 30 days after admission. Specifically:
  - If the certifying physician or NPP had not seen the patient in the 90 days prior to the start of care, a visit within 30 days of start of care would be required.
  - If a patient saw the certifying physician or NPP within the 90 days prior to start of care, another encounter would be needed if the patient's condition had changed to the extent that accepted standards of practice would preclude the physician from ordering services without the physician or an NPP first examining the patient.

The Affordable Care Act and the final rule include several features to accommodate physician practice:

- In addition to allowing NPPs to conduct the face-to-face encounter, Medicare allows a physician who attended to the patient in an acute or post-acute setting, but does not follow patient in the community (such as a hospitalist) to certify the need for home health care based on their contact with the patient, and establish and sign the plan of care. The acute/post-acute physician would then "hand off" the patient's care to his or her community-based physician.
- Medicare will also allow physicians who attended to the patient in an acute or post-acute setting to certify the need for home health care based on their contact with the patient, initiate the orders for home health services, and "hand off" the patient to his or her community-based physician to review and sign off on the plan of care.
- The law allows the face-to-face encounter to occur via telehealth, in rural areas, in an approved originating site.

Plan of Care (POC) and Certification Clarifications
Long-standing regulations have described the distinct content requirements for the POC and certification. The Affordable Care Act requires the face-to-face encounter and corresponding documentation as a certification requirement. Providers have the flexibility to implement the content requirements for both the POC and certification in a manner that best makes sense for them.

Prior to CY 2011, CMS manual guidance required the same physician to sign the certification and the POC. Beginning in CY 2011, CMS will allow additional flexibility associated with the POC when a patient is admitted to home health from an acute or post-acute setting. For such patients, CMS will allow physicians who attend to the patient in acute and post-acute settings to certify the need for home health care based on their face to face contact with the patient (which includes documentation of the face-to-face encounter), initiate the orders (POC) for home health services, and "hand off" the patient to his or her community-based physician to review and sign off on the plan of care. As described in the final HHPPS regulation, CMS continues to expect that, in most cases, the same physician will certify and establish and sign the POC. But the flexibility exists for HH post-acute patients if needed.

Certain non-physician practitioners can play an important role in the face to face encounter. For example, an allowed non-physician practitioner who attends to a patient in an acute setting or emergency room can collaborate with and inform the community certifying physician regarding his/her contact with the patient. The community physician could document the encounter and certify based on this information.

Additional Information
Medicare home health plays a vital role in allowing patients to receive care at home as an alternative to extended hospital or nursing home care. Questions and answers regarding this requirement will be available the via Medicare's home health agency website, http://www.cms.gov/center/hha.asp on the CMS website.

HOSPICE

Hospice Face-to-Face Encounter Requirement

Section 3131(b) of the Affordable Care Act of 2010 requires a hospice physician or nurse practitioner (NP) to have a face-to-face encounter with every hospice patient prior to the patient's 180th- day recertification, and each subsequent recertification. The provision applies to recertifications on and after January 1, 2011.

In the Home Health Prospective Payment System Rate Update for Calendar Year (CY) 2011, the Centers for Medicare & Medicaid Services (CMS) finalized its implementation approach for this hospice provision. The final rule, codified at 42 C.F.R. 418.22(a)(4) (75 Fed. Reg. 70463, November 17, 2010) states that the encounter must occur no more than 30 calendar days prior to the start of the hospice patient's third benefit period. The regulation requires that the hospice physician or nurse practitioner attest that the encounter occurred, and the recertifying physician must include a narrative which describes how the clinical findings of the encounter support the patient's terminal prognosis of 6 months or less. Both the narrative and the attestation must be part of, or an addendum to, the recertification.

Although many hospices are aware of and are able to comply with this policy, CMS is concerned that some hospices may need additional time to establish operational protocols necessary to comply with this new law. As such, CMS expects that during the first quarter of CY 2011, hospices will establish internal processes to ensure compliance. Beginning with the second quarter of CY 2011, hospices will have fully established such internal processes and CMS will expect appropriate documentation of the encounter.

CMS will address industry questions concerning the new requirement on our website at http://www.cms.gov/center/hospice.asp. We will also use other channels we have to communicate with providers to ensure information is widely distributed.

INDIAN HEALTH SERVICES

Implementation of Section 2902 of Affordable Care Act for Indian Health Service

MLN Matters® Number: MM6908
Related Change Request (CR) #: 6908
Related CR Release Date: October 28, 2010
Related CR Transmittal #: R2075CP
Effective Date: January 1, 2010
Implementation Date: January 28, 2011

Provider Types Affected
This article is for IHS providers receiving payment under the AIR payment methodology for Part B hospital outpatient services.

Provider Action Needed
This article is based on Change Request (CR) 6908 which clarifies billing for return visits to IHS providers under the AIR payment methodology. See the Background and Additional Information Sections of this article for further details regarding this clarification.

CR 6908 also implements Section 2902 of The Affordable Care Act, which extends indefinitely Section 630 of The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), retroactive to January 1, 2010. MLN Matters® article SE0930 contains more details on this extension of Section 630 of the MMA. The article is available at http://www.cms.gov/MLNMattersArticles/downloads/SE0930.pdf on the Centers for Medicare & Medicaid Services (CMS) website.

Background
CR 6908 updates the Medicare Claims Processing Manual (Chapter 19, Section100.5.1) to clarify that, while at least one face-to-face encounter with a physician (or non-physician practitioner) is required for an initial visit to count as a billable AIR encounter, the same is not always true of return visits to obtain follow-up care ordered by the physician (or non-physician practitioner) during the initial visit.

CR 6908 further states that it is appropriate for a return encounter to be billed on the date the procedure or test is furnished and for the provider to receive an additional AIR payment (even if the beneficiary did not interact with a physician or non-physician practitioner during the return visit) if:

- A physician (or non-physician practitioner) orders a specific procedure or test which cannot be furnished until a later date after the date of the initial visit with the physician (or non-physician practitioner); and
- The procedures or tests are medically necessary.

Examples of medically necessary reasons for return visits would include a requirement that:

The beneficiary fast for 12 hours prior to an ordered test; or

1. A chest X-ray be provided two weeks following the initiation of antibiotic treatment for pneumonia.
2. Also, a return visit would be considered medically necessary if a beneficiary must return on another day for a medically necessary test ordered during an initial visit because the test cannot be performed on the day it is ordered due to provider or patient constraints that cannot be overcome.

Additional Information
The official instruction, CR 6908, issued to your carrier, DME MAC and/or A/B MAC regarding this change may be viewed at http://www.cms.gov/Transmittals/downloads/R2075CP.pdf on the CMS website.

MEDICAL REVIEW

Face Validity Assessment of ABN for Complex Medical Record Review

MLN Matters® Number: MM6988
Related Change Request (CR) #: 6988
Related CR Release Date: December 10, 2010
Related CR Transmittal #: R361PI
Effective Date: January 12, 2011
Implementation Date: January 12, 2011

Provider Types Affected
All providers submitting claims to Medicare contractors (Carriers, Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), Part A/B Medicare Administrative Contractors (A/B MACs) and Durable Medical Equipment (DME) MACs) for services provided to Medicare beneficiaries are affected.

Provider Action Needed
This article is based on Change Request (CR) 6988. This CR advises contractors about the addition of Section 3.15, ABN and Complex Medical Record Review, to Chapter 3 of the Medicare Program Integrity Manual (PIM). This addition directs contractors to request, as part of the Additional Documentation Requests (ADRs), required ABNs when performing a complex medical record review on all claims. Please ensure that your staffs are aware of this change.

Background
Requesting required ABNs on all claims undergoing complex medical record reviews and conducting face validity assessments of mandatory ABNs will assist in ensuring that liability is assigned appropriately in accordance with the Limitation on Liability Provisions of section 1879 of the Social Security Act.

The instructions in the Medicare Claims Processing Manual Chapter 30 Section 50.6.3 address how to complete an ABN. In CR 6563, Healthcare Common Procedure Coding System (HCPCS) level 2 modifiers have been updated in order to

distinguish between voluntary and required uses of liability notices. The MLN Matters® article related to CR 6563 may be viewed at http://www.cms.gov/MLNMattersArticles/downloads/MM6563.pdf on the Centers for Medicare & Medicaid Services (CMS) website.

Additional Information
The official instruction, CR 6988, issued to your Medicare carrier and/or MAC regarding this change may be viewed at http://www.cms.gov/Transmittals/downloads/R361PI.pdf on the CMS website.

MEDICARE SECONDARY PAYER

CWF Unsolicited Response Adjustments for Certain Claims Denied Due to Open MSP GHP Record

MLN Matters® Number: MM6625 Revised
Related Change Request (CR) #: 6625
Related CR Release Date: December 3, 2010
Related CR Transmittal #: R2112CP
Effective Date: April 1, 2011
Implementation Date: July 5, 2011

Note: This article was revised on December 6, 2010, to reflect a revision to CR 6625. The implementation date has been changed to July 5, 2011. The CR release date, transmittal number, and the Web address for accessing CR 6625 has been revised. All other information is the same.

Provider Types Affected
Physicians, providers, and suppliers who bill Medicare contractors (fiscal intermediaries (FI), Regional Home Health Intermediaries (RHHI), carriers, Medicare Administrative Contractors (A/B MAC), or Durable Medical Equipment Contractors (DME MAC) for services provided, or supplied, to Medicare beneficiaries.

What You Need to Know
CR 6625, from which this article is taken, instructs Medicare contractors (FIs, RHHIs, carriers, A/B MACS, and DME MACs) and shared system maintainers (SSM) to implement (effective April 1, 2011) an automated process to reopen Group Health Plan (GHP) Medicare Secondary Payer (MSP) claims when related MSP data is deleted or terminated after claims were processed subject to the beneficiary record on Medicare's database. Make sure that your billing staffs are aware of these new Medicare contractor instructions. Please see the Background section, below, for more details.

Background
MSP GHP claims were not automatically reprocessed in situations where Medicare became the primary payer after an MSP GHP record had been deleted or when an MSP GHP record was terminated after claims were processed subject to MSP data in Medicare files. It was the responsibility of the beneficiary, provider, physician or other suppliers to contact the Medicare contractor and request that the denied claims be reprocessed when reprocessing was warranted. However, this process places a burden on the beneficiary, physician, or other supplier and CR 6625 eliminates this burden. As a result of CR 6625, Medicare will implement an automated process to:

1. Reopen certain MSP claims when certain MSP records are deleted, or
2. Under some circumstances when certain MSP records are terminated and claims are denied due to MSP or Medicare made a secondary payment before the termination date is accreted.

Basically, where Medicare learns, retroactively, that Medicare Secondary Payer data for a beneficiary is no longer applicable, Medicare will require its systems to search claims history for claims with dates of service within 180 days of a MSP GHP deletion date or the date the MSP GHP termination was applied, which were processed for secondary payment or were denied (rejected for Part A only claims). If claims were processed, the Medicare contractors will reprocess them in view of the more current MSP GHP information and make any claims adjustments that are appropriate. If providers, physicians or other suppliers believe some claim adjustments were missed please contact your Medicare contractor regarding those missing adjustments.

Additional Information
You can find the official instruction, CR6625, issued to your FI, RHHI, carrier, A/B MAC, or DME MAC by visiting http://www.cms.gov/Transmittals/downloads/R2112CP.pdf on the Centers for Medicare & Medicaid Services (CMS) website.

MOBIITY DEVICES

Power Mobility Devices – Detailed Product Descriptions – Implications of Fee Schedule and Payment Policy Changes

In order for a power mobility device (PMD) and related options and accessories to be covered, a detailed product description (DPD) signed and dated by the ordering physician must be obtained by the supplier prior to delivery. Two of the required elements of the DPD are the supplier's submitted charge and the Medicare fee schedule allowance. Medicare fee schedule allowances typically change with a new calendar year and may be revised at other times. If the supplier's submitted charge and fee schedule allowance are correct at the time that the DPD is signed by the physician but change prior to delivery of the PMD, the supplier is not required to obtain a new DPD. Also, if the DPD was completed in 2010 based on the submitted charge and fee schedule allowance for a purchased PMD, a new DPD is not required if the PMD is delivered in 2011 and billed as a rental. (Refer to Power Mobility Devices LCD for additional information relating to DPDs.)

Widespread Prepayment Review for K0823 Power Wheelchair Edit Effectiveness for the 2nd Quarter

The Jurisdiction D DME MAC Medical Review Department is conducting a widespread complex review of HCPCS code K0823 and the second quarter edit effectiveness results from September 2010 through November 2010 are as follows:

The results of the review of the claims identified 253 claims of which 232 were denied. This resulted in an overall error rate of 92%.

The following are the top reasons for denial:

- Insufficient medical records submitted to justify the medical necessity for the wheelchair and required documentation not submitted in full or was not complete
  - Medical records did not include the basic policy coverage criteria A-C
  - No evidence of a face-to-face examination
  - No home assessment completed
- No valid written order
  - No written order submitted with the documentation
  - No dispensing order submitted, only a detailed product description (DPD) that was completed by the supplier
  - Name of ordering physician was not legibly identified

Although the error rate remains high, NAS will discontinue the review due to upcoming changes in payment for this item. NAS will continue to monitor the billing patterns of this and all power mobility devices to determine if further review is necessary.

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

BASIC COVERAGE CRITERIA:

All of the following basic criteria (A-C) must be met for a power mobility device (K0800-K0898) or a push-rim activated power assist device (E0986) to be covered.

A. The patient has a mobility limitation that significantly impairs his/her ability to participate in one or more mobility-related activities of daily living (MRADLs) such as toileting, feeding, dressing, grooming, and bathing in customary locations in the home. A mobility limitation is one that:
   - Prevents the patient from accomplishing an MRADL entirely, or
   - Places the patient at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to perform an MRADL; or
   - Prevents the patient from completing an MRADL within a reasonable time frame.

B. The patient's mobility limitation cannot be sufficiently and safely resolved by the use of an appropriately fitted cane or walker.

C. The patient does not have sufficient upper extremity function to self-propel an optimally-configured manual wheelchair in the home to perform MRADLs during a typical day.
   - Limitations of strength, endurance, range of motion, or coordination, presence of pain, or deformity or absence of one or both upper extremities are relevant to the assessment of upper extremity function.
   - An optimally-configured manual wheelchair is one with an appropriate wheelbase, device weight, seating options, and other appropriate nonpowered accessories.

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in Power Mobility Devices Local Coverage Determination (LCD) L23598 and Policy Article A41127. Suppliers can review the Group 1 Power wheelchairs (K0813-K0816) and Group 2 Power wheelchairs (K0820-K0829) documentation checklist on the NAS website at https://www.noridianmedicare.com/dme/news/power_mobility_devices.html.

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

Power Wheelchair Rental – Frequently Asked Questions – UPDATED January 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.

12. **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.**

    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 items, 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.

Elimination of Lump Sum Purchase Payment for Standard Power Wheelchairs Furnished On or After January 1, 2011

MLN Matters® Number: MM7116
Related Change Request (CR) #: 7116
Related CR Release Date: October 15, 2010
Related CR Transmittal #: R786OTN
Effective Date: January 1, 2011
Implementation Date: January 3, 2011

Provider Types Affected
This article is for suppliers billing Durable Medical Equipment Medicare Administrative Contractors (DME MACs) or Regional Home Health Intermediaries (RHHIs) for the lump sum purchase for standard power wheelchairs.

What You Need to Know
This article is based on Change Request (CR) 7116 which informs Medicare DME MACS and RHHIs that Section 3136 of the Affordable Care Act eliminates the lump sum purchase payment for standard power wheelchairs, effective for items furnished on or after January 1, 2011. This elimination of the lump sum purchase payment applies to Health Care Common Procedural Coding System (HCPCS) codes K0813 through K0831 and code K0898 submitted with the NU or UE modifier for items furnished on or after January 1, 2011. (Note: This change will not apply to standard power wheelchairs furnished to beneficiaries in the nine competitive bidding areas (CBAs) of Round 1 Rebid of the durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program with dates of service January 1, 2011 thru December 31, 2013.) See the Background and Additional Information Sections of this article for further details regarding these changes.

Background
Power wheelchairs are included in the capped rental DME payment category and suppliers have been required to offer beneficiaries the option of receiving power wheelchairs on either a lump sum purchase basis or monthly rental basis. Claims for purchase of DME are submitted with the HCPCS modifier NU (purchase of new equipment) or UE (purchase of used equipment) while claims for rental of durable medical equipment are submitted with the HCPCS modifier RR. Beginning with items initially rented on or after January 1, 2006, suppliers have been required to transfer the equipment title for rented power wheelchairs to the beneficiary after the 13th month of continuous use.

Previous instructions on payment for power wheelchairs were released in Transmittal 918, Change Request (CR) 5010, dated April 28, 2006, and Transmittal 1037, CR 5255, dated August 25, 2006. MLN Matters® articles related to these transmittals are available at http://www.cms.gov/MLNMatersArticles/downloads/MM5010.pdf and http://www.cms.gov/MLNMattersArticles/downloads/MM5255.pdf, respectively.

Effective for items furnished on or after January 1, 2011, section 3136 of the Affordable Care Act eliminates the lump sum purchase payment for standard power wheelchairs. Suppliers must furnish these items on a monthly rental basis like other capped rental DME other than power wheelchairs. This elimination of lump sum purchase payment applies to standard power wheelchairs classified under the HCPCS codes for Group 1 power wheelchairs or Group 2 power wheelchairs without additional power options. The current HCPCS codes identifying standard power wheelchairs include codes K0813 thru K0831 and code K0898 for miscellaneous standard power wheelchairs. Claims with dates of service on or after January 1, 2011, for these HCPCS codes with modifier NU or UE will be denied since the statute prohibits payment on a purchase basis for these items. These codes are described in the following table.

HCPCS Code	Description
K0813	POWER WHEELCHAIR, GROUP 1 STANDARD, PORTABLE, SLING/SOLID SEAT AND BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
K0814	POWER WHEELCHAIR, GROUP 1 STANDARD, PORTABLE, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
K0815	POWER WHEELCHAIR, GROUP 1 STANDARD, SLING/SOLID SEAT AND BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
K0816	POWER WHEELCHAIR, GROUP 1 STANDARD, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
K0820	POWER WHEELCHAIR, GROUP 2 STANDARD, PORTABLE, SLING/ SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
K0821	POWER WHEELCHAIR, GROUP 2 STANDARD, PORTABLE, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
K0822	POWER WHEELCHAIR, GROUP 2 STANDARD, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
K0823	POWER WHEELCHAIR, GROUP 2 STANDARD, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS

MOBIITY DEVICES CONT'D

K0824	POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS
K0825	POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS
K0826	POWER WHEELCHAIR, GROUP 2 VERY HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS
K0827	POWER WHEELCHAIR, GROUP 2 VERY HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS
K0828	POWER WHEELCHAIR, GROUP 2 EXTRA HEAVY DUTY, SLING/SOLID SEAT/ BACK, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE
K0829	POWER WHEELCHAIR, GROUP 2 EXTRA HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE
K0830	POWER WHEELCHAIR, GROUP 2 STANDARD, SEAT ELEVATOR, SLING/ SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 126 TO 300 POUNDS
K0831	POWER WHEELCHAIR, GROUP 2 STANDARD, SEAT ELEVATOR, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 126 TO 300 POUNDS
K0898	POWER WHEELCHAIR, NOT OTHERWISE CLASSIFIED

Payment can continue to be made on a lump sum purchase basis or monthly rental basis for complex rehabilitative power wheelchairs. Complex rehabilitative power wheelchairs include Group 2 power wheelchairs with additional power options and Group 3 and higher power wheelchairs (HCPCS codes K0835 through K0843 and K0848 through K0864 as defined in Attachment B of CR 7116, which is available at http://www.cms.gov/Transmittals/downloads/R786OTN.pdf on the Centers for Medicare & Medicaid Services (CMS) website.

In addition, this change will not apply to standard power wheelchairs furnished to beneficiaries in the nine competitive bidding areas (CBAs) of Round 1 Rebid of the durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program with dates of service January 1, 2011 thru December 31, 2013. The lump sum purchase payment method remains available for claims with dates of service January 1, 2011 thru December 31, 2013 for standard power wheelchairs furnished to beneficiaries residing in these nine CBAs.

Also, Section 3136 of Affordable Care Act changes the monthly fee schedule amounts for rental of standard and complex rehabilitative power wheelchairs furnished on or after January 1, 2011. Instructions for the revised fee schedule amounts are in the CY 2011 annual update for the DMEPOS fee schedule.

Additional Information
The official instruction, CR 7116, issued to your DME MAC or RHHI regarding this change may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R786OTN.pdf on the CMS website.

MODIFIERS

Use of Upgrade Modifiers – Revised

An upgrade is defined as an item that goes beyond what is medically necessary under Medicare's coverage requirements. An item can be considered an upgrade even if the physician has signed an order for it. When suppliers know that an item will not be paid in full because it does not meet the coverage criteria stated in the LCD, the supplier can still obtain partial payment at the time of initial determination if the claim is billed using one of the upgrade modifiers, GK or GL. The descriptions of the modifiers are:

GK – Reasonable and necessary item/service associated with a GA or GZ modifier

GL – Medically unnecessary upgrade provided instead of non-upgraded item, no charge, no ABN

If a supplier wants to collect from the beneficiary for the upgraded item provided, a properly completed ABN must be obtained. If an ABN is obtained, on one claim line the supplier bills with a GA modifier the HCPCS code that describes the item that was **provided**. On the next claim line, the supplier bills with a GK modifier the HCPCS code that describes the item that is **covered** based on the LCD. (**Note: The codes must be billed in this specific order on the claim**.) In this situation, the claim line with the GA modifier will be denied as not medically necessary with a "patient responsibility" (PR) message and the claim line with the GK modifier will continue through the usual claims processing. The beneficiary liability will be the sum of (a) the difference between the submitted charge for the GA claim line and the submitted charge for the GK claim line and (b) the deductible and co-insurance that relate to the allowed charge for the GK claim line. **The supplier may charge their "usual and customary" fee for the upgraded item that is provided**.

If a supplier wants to provide the upgraded item without any additional charge to the beneficiary, then no ABN is obtained. If it is the supplier's decision to provide the upgraded item at no additional charge to the beneficiary or if physician ordered the upgraded item and the supplier decides to provide it at no additional charge to the beneficiary, the supplier bills with a GL modifier the HCPCS code that describes the item that is **covered** based on the LCD. In this situation, the supplier does not bill the HCPCS code that describes the item that was **provided**.

If the request for the upgraded item is from the beneficiary and the supplier decides to provide it at no additional charge,

no ABN is obtained. On one claim line the supplier bills with a GZ modifier the HCPCS code that describes the item that was **provided**. On the next claim line, the supplier bills with a GK modifier the HCPCS code that describes the item that is **covered** based on the LCD. (**Note: The codes must be billed in this specific order on the claim**.)

DME Upgrades - ABN and Claims Modifiers

	ABN Required	Required Modifier(s)	DMAC Payment	Beneficiary Pays for Upgrade
1) Physician orders upgrade:				
a) Supplier provides upgrade free of charge to beneficiary	No	GL	R&N item only (GL line)	No
b) Supplier bills beneficiary for upgrade	Yes	GA/GK	R&N item only (GK line)	Yes
2) Patient requests upgrade:				
a) Supplier provides upgrade free of charge to beneficiary	No	GZ/GK	R&N item only (GK line)	No
b) Supplier bills beneficiary for upgrade	Yes	GA/GK	R&N item only (GK line)	Yes
3) Supplier provides upgrade for supplier convenience:				
a) Supplier provides upgrade free of charge to beneficiary	No	GL	R&N item only (GL line)	No
Table Footnotes: GK or GL is added to HCPCS code for item that meets Medicare coverage requirements. When GK is used, GA or GZ is added to HCPCS code for item that is provided. R&N = Reasonable and necessary				

Suppliers are reminded that if there is a requirement in a specific policy to use a KX modifier to indicate that an item meets coverage criteria, then it is used in addition to the GK or GL modifier. Codes with a GK or GL modifier will continue through the usual claims processing. Other edits may cause the GK/GL claim line to be denied. However, if no other edits are involved, payment will be made based on the fee schedule for the code with the GK or GL modifier.

Resubmitting Claims with Upgrade Modifiers

For certain items that were previously subject to least costly alternative (LCA) payment policy, suppliers will now receive a not reasonable and necessary denial. For these items only, suppliers have the option of resubmitting the claim using the upgrade modifiers and the code for the covered medically necessary item rather than exercising the option of Appeals. For example, a supplier submits a claim after February 4, 2011, for code E0265 (fully electric hospital bed) and the claim is denied as not reasonable and necessary. That claim may be resubmitted with code E0265 and the appropriate modifiers on Line 1 and code E0260 and the appropriate modifiers on Line 2. Resubmitting the claim in this fashion will not result in a conflict with the original code E0265 claim and subsequent duplicate claim denial.

These resubmission instructions apply *only* to items previously subject to LCA payment policy that now receive not reasonable and necessary denials. Other items receiving reasonable and necessary denials must follow the usual redeterminations process.

For additional information on LCA elimination, refer to the article entitled *Local Coverage Determinations – Elimination of Least Costly Alternative* published December 16, 2010, on the NAS web site at https://www.noridianmedicare.com/dme/news/docs/2010/12_dec/lcd_elimination_of_least_costly_alternative.html.

Resubmitting Claims with Upgrade Modifiers

Recently the Durable Medical Equipment Medicare Administrative Contractors (DME MAC) issued bulletin articles regarding the use of upgrade modifiers in conjunction with HCPCS codes subject to the elimination of least costly alternative (LCA). For certain items that were previously subject to LCA, suppliers will now receive a not reasonable and necessary denial. The article indicated that further instructions would be forthcoming concerning the options that a supplier has if a claim for an item previously subject to LCA is submitted without upgrade modifiers, is subsequently denied as not reasonable and necessary and the supplier decides that it would like to utilize the upgrade modifiers.

For items that were previously subject to LCA, suppliers have the option of resubmitting the claim using the upgrade modifiers and the code for the covered medically necessary item rather than exercising the option of Appeals. For example, a supplier submits a claim after February 4, 2011 for code E0265 (fully electric hospital bed) and the claim is denied as not reasonable and necessary. That claim may be resubmitted with code E0265 and the appropriate modifiers on Line 1 and code E0260 and the appropriate modifiers on Line 2. Resubmitting the claim in this fashion will not result in a conflict with the original code E0265 claim and subsequent duplicate claim denial.

These resubmission instructions apply only to items previously subject to LCA payment policy that now receive not reasonable and necessary denials. Other items receiving reasonable and necessary denials must follow the usual redeterminations process.

For additional information on the use of upgrade modifiers, see the bulletin article entitled *Use of Upgrade Modifiers* published on the Noridian Administrative Services listserv and web site on December 16, 2010.

Correction – New Modifier CS – Effective Date April 10, 2010

Modifier "CS" is a new modifier that was created to identify items or services related to the treatment of illnesses, injuries, or conditions caused or exacerbated, directly or indirectly, by the 2010 oil spill in the Gulf of Mexico. As noted in Transmittal 2021 (CR 7087), contractors will accept modifier CS on all claims for such items or services for dates of service on or after April 10, 2010. The Calendar Year (CY) 2011 Healthcare Common Procedure Codes System (HCPCS) file erroneously listed modifier CS with an effective date of January 1, 2011.

If you have questions, please 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/.

National Modifier and Condition Code to Identify Items or Services Related to 2010 Oil Spill in Gulf of Mexico

MLN Matters® Number: MM7087
Related Change Request (CR) #: 7087
Related CR Release Date: August 6, 2010
Related CR Transmittal #: R2021CP
Effective Date: April 20, 2010
Implementation Date: January 3, 2011

Provider Types Affected
This article is for physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs), and/or Part A/B Medicare Administrative Contractors (MACs)) for services provided to Medicare beneficiaries related, in whole or in part, to the 2010 oil spill in the Gulf of Mexico.

Provider Action Needed
This article is based on Change Request (CR) 7087 which identifies a new modifier and a new condition code that must be used to identify items or services related to the 2010 oil spill in the Gulf of Mexico. Be sure your billing staff is aware of these changes. You should begin to place the modifier or condition code on claims submitted as of January 3, 2011.

Background
As a result of the oil spill in the Gulf of Mexico, the Centers for Medicare & Medicaid Services (CMS) plans to monitor the potential health and cost impacts of the oil spill on Medicare beneficiaries, in both the short and long-term. In order to ensure that such health care services and costs are properly identified, CMS is requiring that every Medicare Fee-For-Service claim be specifically identified if it is for an item or service furnished to a Medicare beneficiary, where the provision of such item or service is related, in whole or in part, to an illness, injury, or condition that was caused by or exacerbated by the effects, direct or indirect, of the 2010 oil spill in the Gulf of Mexico (hereafter referred to as the "Gulf oil spill") and/or circumstances related to such oil spill, including but not limited to subsequent clean-up activities.

Claims from physicians, other practitioners, and suppliers must be annotated with the modifier "CS" for each line item where the item or service is so related. Similarly, claims from institutional billers must be annotated with a condition code of "BP" when the entire claim is so related or with the "CS" modifier for each relevant line item when only certain line items are so related. The modifier and condition code are to be used for claims with dates of service on or after April 20, 2010.

The long description of the CS modifier is as follows: "Item or service related, in whole or in part, to an illness, injury, or condition that was caused by or exacerbated by the effects, direct or indirect, of the 2010 oil spill in the Gulf of Mexico, including but not limited to subsequent clean-up activities."

The short description of the CS modifier is: "Gulf Oil Spill Related".

The title of the BP condition code is "Gulf oil spill related" and its definition is as follows: "This code identifies claims where the provision of all services on the claim are related, in whole or in part, to an illness, injury, or condition that was caused by or exacerbated by the effects, direct or indirect, of the 2010 oil spill in the Gulf of Mexico and/or circumstances related to such spill, including but not limited to subsequent clean-up activities."

Note: CMS requests provider, physician and supplier assistance in identifying previously processed claims related to an illness, injury or condition caused or exacerbated either directly or indirectly by the 2010 Gulf oil spill. CMS encourages providers, physicians and suppliers to contact their Medicare contractor to identify services or claims – submitted and processed prior to the creation of the Gulf oil spill modifier and condition code – that should have the CS modifier and/or the BP condition code appended.

Additional Information
The official instruction (CR7087) issued to your Medicare MAC, carrier and/or FI is available at http://www.cms.gov/Transmittals/downloads/R2021CP.pdf on the CMS website.

NEBULIZERS

Treprostinil Inhalation Solution (Tyvaso®) – Coverage

Effective for dates of service on or after January 1, 2011, least costly alternative payment policy will no longer be applied to the nebulizer used to administer treprostinil inhalation solution. This information will be added to the next revision of the Nebulizers policy.

For additional coverage, coding, and documentation requirements, suppliers should refer to the Nebulizer LCD and related Policy Article on the DME MAC web sites. Additional information specific to the coverage and coding of treprostinil was also published in August 2010 in an article titled *Treprostinil Inhalation Solution (Tyvaso®) – Coverage and Coding*.

HCPCS Code E0571 - Invalid

Effective for dates of service on or after February 4, 2011, Healthcare Common Procedure Coding System (HCPCS) code E0571 (Aerosol compressor, battery powered, for use with small volume nebulizer) will be invalid for claim submission to the Durable Medical Equipment Medicare Administrative Contractors (DME MACs). Suppliers providing battery-powered aerosol compressors should bill existing HCPCS code E0570 (Nebulizer, with compressor).

Refer to the Nebulizers local coverage determination (LCD) for additional coverage, coding and documentation requirements.

Products previously coded E0571 by the Pricing, Data Analysis and Coding (PDAC) contractor will be end dated on February 3, 2011, and will be listed with E0570 with an effective date of February 4, 2011. These products will be listed on the Product Classification List which is located on DME Coding System (DMECS). DMECS is located on the PDAC website, www.dmepdac.com.

Widespread Prepayment Review for Nebulizers - Edit Effectiveness for 1st Quarter

The Jurisdiction D DME MAC Medical Review Department is conducting a widespread complex review of HCPCS codes J7626 and J7605. The first quarter edit effectiveness results from September 2010 through December 2010 are as follows:

The result of this review identified 2,076 claims of which 1,053 were denied. This resulted in an overall error rate of 50%. Due to this high error rate, NAS will continue with the widespread complex review.

The following are the top reasons for denial:

A. No valid written order
   - No written order submitted with the documentation
   - Insufficient or incomplete order

B. No beneficiary evidence of exhaustion

C. No medical documentation to support medical necessity

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

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

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

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

   The order for any drug must clearly specify the type of solution to be dispensed to the patient and the administration instructions for that solution. The type of solution is described by a combination of: (a) the name of the drug and the concentration of the drug in the dispensed solution and the volume of solution in each container, or (b) the name of the drug and the number of milligrams/grams of drug in the dispensed solution and the volume of solution in that container.

B. The pharmacist is responsible for assessing how much inhalation solution a patient is actually using. Considering this information, the pharmacist is responsible for assuring that the patient has used almost all of his/her supply on hand prior to dispensing a new supply. As referenced in the Program Integrity Manual (Internet-Only Manual, CMS Pub. 100-8, Chapter 4.26.1) "Contact with the beneficiary or designee regarding refills should take place no sooner than approximately 7 days prior to the delivery/shipping date. For subsequent deliveries of refills, the supplier should deliver the DMEPOS product no sooner than approximately 5 days prior to the end of usage for the current product."

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

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Nebulizers Local Coverage Determination (LCD) L11488 and Policy Article A24942. Suppliers can also review the Nebulizer documentation checklist on the NAS website at https://www.noridianmedicare.com/dme/coverage/checklists.html.

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

NPI

Provider Education for Handling NPI Issues Related to Deceased Providers Who Had NPI

MLN Matters® Number: MM6984
Related Change Request (CR) #: 6984
Related CR Release Date: November 5, 2010
Related CR Transmittal #: R799OTN
Effective Date: Claims processed on or after April 4, 2011
Implementation Date: April 4, 2011

Provider Types Affected
This article is relevant for claims of physicians, non-physician practitioners, and other providers/suppliers who are deceased and for whom claims are submitted to Medicare contractors (carriers, Durable Medical Equipment Medicare Administrative Contractors (DME MACs) and Part A/B MACs) for services provided to Medicare beneficiaries.

What You Need to Know
This article is based on change request (CR) 6984 and explains how claims should be submitted by representatives of deceased providers who had obtained an NPI prior to death. A claim submitted after May 23, 2007, for a deceased provider who had an NPI will be rejected by Medicare because the provider's NPI was deactivated in the Medicare claims processing system due to the provider's death. When a deceased provider's claim is rejected by a Medicare contractor because of the absence of an NPI, the claim submitter is expected to contact the Medicare contractor to discuss payment of the claim and the provider's death.

The Medicare contractor will ask the representative of the provider's estate to submit the claim in paper format and will instruct the representative that Item 19 of the Form CMS-1500 claim must be annotated to state that the provider is deceased.

Additional Information
The official instruction, CR6984, issued to your Medicare contractor regarding this change, may be viewed at http://www.cms.gov/Transmittals/downloads/R799OTN.pdf on the CMS website.

ORTHOTICS/PROSTHETICS

Modification to HCPCS Code Set

The Centers for Medicare & Medicaid Services (CMS) has released a modification to the Healthcare Common Procedure Coding System (HCPCS) code set. CMS has reinstated codes **L3660** "SHOULDER ORTHOSIS, FIGURE OF EIGHT DESIGN ABDUCTION RESTRAINER, CANVAS AND WEBBING, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT"; **L3670** "SHOULDER ORTHOSIS, ACROMIO/CLAVICULAR (CANVAS AND WEBBING TYPE), PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT"; and **L3675** "SHOULDER ORTHOSIS, VEST TYPE ABDUCTION RESTRAINER, CANVAS WEBBING TYPE OR EQUAL, PREFABRICATED INCLUDES FITTING AND ADJUSTMENT" with the original language. In making this change, the CY 2011 HCPCS Annual Tape will no longer reflect a termination date of 12/31/10 for these codes. This change has been posted to the 2011 HCPCS Corrections document located on the HCPCS web page at http://www.cms.hhs.gov/HCPCSReleaseCodeSets/ANHCPCS/list.asp.

OXYGEN

CERT Errors for Oxygen

The Comprehensive Error Rate Testing (CERT) contractor has been identifying a significant number of errors on claims for oxygen with the most recent error rate at 71.17%. Oxygen is the highest source of errors for Jurisdiction D. Most of the errors are due to insufficient documentation to support the medical necessity for the billed items. Based on reports received by NAS, the documentation that the CERT contractor is looking for includes:

- Copy of the qualifying blood gas study to support the results noted on the Certificate of Medical Necessity (CMN)
- Clinical records documenting the patient has severe lung disease or hypoxia related symptoms that are expected to improve with oxygen
- Clinical records showing medical management/oversight
- Clinical records showing continued need
- Patient evaluation
  - Within 30 days of initial CMN and/or
  - Within 90 days of recertification

When suppliers receive a request from the CERT contractor on an oxygen claim, it is important to assure that all of these documents are included in the response. If any of these documents is not provided, it will likely result in a request for overpayment on the claim.

Widespread Prepayment Review for Oxygen and Oxygen Equipment Edit Effectiveness for the 2nd Quarter

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

The results of the review of the claims identified 865 claims of which 573 were denied. This resulted in an overall error rate of 67%. This is an increase from 54% during the first quarter of this review. Due to this high error rate NAS will continue with the widespread complex review.

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

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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.

The following are the top four reasons for denial:

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

B. No qualifying blood gas study submitted

C. POD signed after dated of service

D. Invalid Certificate of Medical Necessity (CMN)

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

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

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

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

Group I criteria include any of the following:

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

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

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.

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. Many claims were denied for an invalid CMN. The CMN contained a qualifying blood gas study result. The medical record submitted did not contain the correlating study entered on the CMN, thus making the CMN invalid.

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.

Home Oxygen Use to Treat Cluster Headache

MLN Matters® Number: MM7235
Related Change Request (CR) #: 7235
Related CR Release Date: January 14, 2011
Related CR Transmittal #: R130NCD
Effective Date: January 4, 2011
Implementation Date: February 15, 2011

Provider Types Affected
This article is for suppliers that bill Medicare Durable Medical Equipment Medicare Administrative Contractors (DME MAC) for home use of oxygen services.

What You Need to Know
CR7235, from which this article is taken, announces that (effective for claims with dates of service on and after January 4, 2011) Medicare will allow for the coverage of home use of oxygen to treat Medicare beneficiaries diagnosed with Cluster Headaches (CH) when these beneficiaries are enrolled in clinical studies that are approved by the Centers for Medicare & Medicaid Services (CMS) for the purpose of gaining further evidence.

Background
Medicare has a National Coverage Determination (NCD) on the home use of oxygen stating that its use is reasonable and necessary for patients with significant hypoxemia, as evidenced by a blood gas study or a measurement of arterial oxygen saturation. (Please refer to the "Medicare NCD Manual, Chapter 1, Part 4 ((Sections 200 – 310.1) Coverage Determinations), Section 240.2 (Home Use of Oxygen), which you can find at http://www.cms.gov/manuals/downloads/ncd103c1_Part4.pdf on the CMS website.

In March 2006, an internally generated NCD led to coverage of beneficiaries who were participating in clinical studies that did not qualify for coverage based on the initial criteria for hypoxemia established in the earlier NCD. (Please refer to MLN Matters® article MM4389 -- MMA - Coverage for Home Use of Oxygen Included in Clinical Trials, released on May 26, 2006 which you can find at http://www.cms.gov/MLNMattersArticles/downloads/MM4389.pdf on the CMS website.) This expansion in coverage requires that beneficiaries be enrolled subjects in National Heart, Lung, and Blood Institute-sponsored clinical trials; and the current national policy states that the home use of oxygen is reasonable and necessary for only those patients diagnosed with significant hypoxemia in conjunction with certain health conditions.

Effective for claims with dates of service on and after January 4, 2011, Medicare will allow for coverage of home use of oxygen to treat Medicare beneficiaries diagnosed with CH when beneficiaries are enrolled in clinical studies that are approved by CMS for the purpose of gaining further evidence. Medicare will allow for coverage of beneficiaries with CH participating in an approved prospective clinical study comparing normobaric 100% oxygen with at least one clinically appropriate comparator for the treatment of CH. The clinical study must address whether home use of oxygen improves Medicare beneficiaries' health outcomes and is subject to the criteria as outlined in the NCD Manual, chapter 1, section 240.2.2.

DME MACs will use existing clinical trial coding conventions to help identify on a claim that the Home use of Oxygen for CH was provided pursuant to a Medicare-approved clinical study under Coverage with Evidence Development (CED). Your claims for these services must contain:

- The ICD-9-CM diagnosis codes for CH (339.00, cluster headache syndrome unspecified, 339.01, cluster headache episodic, and 339.02, cluster headache, chronic);
- HCPCS code E1399 (durable medical equipment, miscellaneous);
- Place of Service (POS) 12 (home);
- The 8-digit clinical trial number is optional;
- The Clinical Trial ICD-9-CM diagnosis code of V70.7 (Examination of participant in clinical trial); and
- The Clinical Trial Procedure Code Modifier Q0 (Investigational clinical service provided in a clinical research study that is in an approved clinical research study).

Currently, there are no clinical trials approved or pending approval for the home use of oxygen for CH. Certificates of Medical Necessity (CMNs) are not required in the context of this clinical trial setting. This is a Part B DME benefit only.

Should your DME MAC deny your claims for home use of oxygen for the treatment of CH (effective for dates of service on and after January 4, 2011) that do not conform to all of the above coding requirements, they will use following messages:

- Claim Adjustment Reason Code (CARC) 50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present;
- Remittance Advice Remark Code (RARC) N386 - This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at

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http://www.cms.hhs.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD; and

- Group Code - Patient Responsibility (PR) if ABN/HINN given, otherwise Contractual Obligation (CO).

Additional Information The official instruction, CR 7235, issued to your DME/MAC regarding this change may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R130NCD.pdf on the CMS website.

ENTERAL NUTRITION

Specialty Enteral Formulas

Effective with dates of service on or after February 4, 2011, claims submitted to the DME MACs for HCPCS Codes B4149, B4153–B4157, B4161, and B4162 will no longer be subjected to least costly alternative payment policy and downcoded to B4150 or B4152 (semi-synthetic intact protein/protein isolate formulas). For dates of service on or after February 4, 2011, claims for HCPCS Codes B4149, B4153–B4157, B4161, and B4162 will be denied as not reasonable and necessary unless the coverage criteria for specialty nutrients is met. Suppliers also have the option of using the upgrade modifiers as noted in the recent DME MAC publication on Use of Upgrade Modifiers.

Refer to LCD for Enteral Nutrition for additional coverage, coding and documentation requirements.

Parenteral Nutrition – Least Costly Medically Appropriate Alternative Eliminated

CMS has instructed contractors that they may no longer make partial payment for claims based on a "least costly alternative" (LCA) determination. In December 2010, the DME MACs released revisions to LCDs containing LCA provisions. The Parenteral Nutrition LCD was not included in that release.

It was discovered that the Parenteral Nutrition LCD might be considered as having an LCA provision. The Parenteral Nutrition LCD contains the following statement:

> "Special parenteral formulas (B5000–B5200) are rarely medically necessary. If the medical necessity for these formulas is not substantiated, payment will be made for the medically appropriate formula."

While this passage does not explicitly say "paid at LCA", in most cases the medically appropriate formula is a standard nutrient solution which is less costly. Therefore, it was felt that it would be appropriate to revise the passage. The revised section states:

> "The medical necessity for special parenteral formulas (B5000–B5200) must be justified in each patient. If a special parenteral nutrition formula is provided and if the medical record does not document why that item is reasonable and necessary, it will be denied as not reasonable and necessary."

A revised LCD will be released via our list-serves. The revised LCD will be effective for dates of service on or after 2/4/2011.

Enteral Nutrition Ask the Contractor Teleconference Questions and Answers – October 20, 2010

Prior to taking questions, NAS provided the following updates:

Endeavor – Online Eligibility and Claim Status
Suppliers are encouraged to register for Endeavor, which offers free, online access to patient eligibility, claims status, and remittance advices. Eligibility inquires can be conducted 24 hours a day, 7 days a week while claim status and remittance advices inquiries can be conducted from 6 a.m. to 6 p.m. Monday through Friday CT, and from 7 a.m. to 3 p.m. CT on Saturdays and Sundays. Suppliers, billers, and third parties, may register for Endeavor.

Each person accessing Endeavor must register for their own user ID. These user IDs cannot be used by more than one person. To register, go to the claims page of our website, https://www.noridianmedicare.com/dme/claims/endeavor.html.

Website Satisfaction Survey
NAS encourages suppliers to complete their randomly distributed Website Satisfaction survey that pops up when navigating the website, https://www.noridianmedicare.com/dme. Enhancements to the NAS DME website are made based on the comments from this survey. Suppliers should let NAS know what they like about our website, along with ideas for improvement. NAS appreciates and values suppliers' thoughts and opinions.

PECOS: Provider Enrollment, Chain and Ownership System
Edits to deny claims for referring/ordering physicians and nonphysician practitioners who are not enrolled in PECOS will be front-end rejected January 3, 2011. Although enrolled in Medicare, some physicians and nonphysician practitioners who are eligible to order items do not have current enrollment records in PECOS. Suppliers are encouraged to verify with their referral sources their legal name, national provider identifier, or National Provider Identifier (NPI), and that the physician or nonphysician practitioner is not being excluded from the Medicare program. Additional information regarding Phase 2 of the CMS Change Request 6421, expansion of the current scope of editing for ordering, referring providers for the DMEPOS suppliers is available on our website, https://www.noridianmedicare.com/dme/news/pecos.html.

Interactive Voice Recognition (IVR) Features Available (1-877-320-0390)
In March 2010, the NAS IVR was enhanced to offer a feature that allows suppliers to research ordering and referring physician information to help avoid receiving PECOS error messages which may turn into front-end claim rejections if

the ordering/referring entities are not enrolled in PECOS by January 3, 2011. Suppliers can enter the NPI, the first name, and the last name of the referring physician to determine if that physician is or is not enrolled in the Medicare provider enrollment change in ownership system. https://www.noridianmedicare.com/dme/news/docs/2010/03_mar/pie_available_through_ivr.html.

Overpayments, also known as offsets, inquiries became available from the NAS IVR in March 2010. Suppliers enter their 14-digit financial control number, as it appears on the remittance advice, to obtain the name of the beneficiary, the dates of service, the amount of the overpayment, and how many overpaid claims are involved, and provide the details for each overpayment. https://www.noridianmedicare.com/dme/news/docs/2010/03_mar/overpayment_information_available_through_ivr.html.

Face-To-Face Workshops in California

NAS is pleased to announce the outreach and education team will be conducting free, face-to-face workshops in Irvine, California on November 2, 3, and 4 as well as in Riverside, California January 18, 19, and 20. The workshop topics are: glucose monitors, enteral nutrition, positive airway pressure devices or PAPs, oxygen, and wheelchairs. The workshops will include information on medical necessity guidelines, documentation requirements, coding and more. Additional information and registration can be accessed from the NAS website, https://www.noridianmedicare.com/dme/train/workshops/face_to_face.html.

Medtrade Conference – November 2010

The NAS education and medical review staff will be attending the Medtrade conference in Atlanta, Georgia, on November 16, 17, and 18. The DME MAC contractors will be located in booth number 1861. Educational sessions include, a DME MAC National Comprehensive Error Rate Testing (CERT) Taskforce seminar, a NAS PAP documentation session, a Common Electronic Data Interchange (CEDI) session, a DME MAC Medicare update session, a Competitive Bid session, and an update session from the National Supplier Clearinghouse.

Questions and Answers Taken During the ACT Event

Q1. If a doctor, in his initial order, signs over management of a patient to a supplier for one year, are the supplier's dieticians allowed to make changes and record the orders that they make as changes done by them, or do the changes have to be sent to the physician for his signature? In this situation, the supplier does have signed orders yet they are trialing a patient on a different formula before changing them permanently. Can the trial occur without the physician signature order?

A1. The physician must make any changes in a patient's order. If a supplier employs a dietician, that dietician needs to communicate patient changes to the physician, and the physician is the one who needs to order and change any nutrition requirements that the beneficiary requires. No, the trial cannot occur without the physician's order and signature. When a supplier is billing Medicare for a service, Medicare needs a valid order from a valid ordering entity such as a physician, nurse practitioner, clinical nurse specialist, physician assistant, who is not employed by the supplier.

Q2. When a supplier is doing the medical review for some of their patients who are receiving enteral nutrition due to cancer (i.e., cancer of the throat), the documentation is received from the physician and it appears the patient is qualified (i.e., patient unable to swallow) and therefore, covered. However, the length of need is not always written clearly within the documentation or is "indefinite". Are guidelines or recommendations to assist suppliers with this situation available?

A2. The most important thing to understand is that the enteral nutrition falls under our prosthetic device category, and the definition of that benefit category is that the patient has a permanent, nonfunctioning condition (gastrointestinal tract is nonfunctioning). It is the physician's responsibility to determine and document within the medical record whether the patient has a permanent condition or not. Suppliers need to review the documentation for indications of a permanent, nonfunctioning organ. Suppliers are encouraged to have a thorough intake process, and when the supplier is contacted by the ordering physician to order the enteral nutrition, ask questions. What kind of condition does the patient have? Does the patient have a functioning gastrointestinal tract and if so, is it a permanent condition? Does the physician see the patient getting better within two months? Suppliers are encouraged to have a copy of the Local Coverage Determination (LCD) readily available or provide the physician the website address for the LCD L11568 and the Policy Article A25361 so they can review what the criteria is for Medicare.

If the physician is unable to tell a supplier what the patient's need is, then it probably does not meet Medicare's criteria. It needs to be clear that it is a permanent, nonfunction. Otherwise there is not a need for the item(s).

Q3. When a supplier asks the doctor if there is a permanent need, if the doctor is providing the supplier the correct answers or what the doctor believes the length of need would be, how does a supplier get him to put that in his documentation? A supplier cannot take notes and include that in the documentation received, correct? It must be in the medical record to be covered, correct?

A3. That is correct, the medical records, the information that's used for medical review to determine whether they meet the coverage criteria or not would be the medical record from the physician's office or from whoever is ordering the enteral nutrition. The supplier needs to strongly encourage the doctor during the intake process and ensure the supplier asks the doctor if the discussed information is well documented in the patient's medical record. Yes, in order to be covered, it does need to be documented in the medical record. NAS offers resources on our website, https://www.noridianmedicare.com/dme/coverage/, to assist supplier's work with the ordering physicians; for example, https://www.noridianmedicare.com/dme/news/docs/2008/03_mar/physician_letter.pdf.

Q4. A supplier has completed the orders for the physician and created templates for each method of administration that lists every item that the supplier could possibly send with the quantities that the supplier wants to send to the patient. Is this required for an order, or can a supplier bill the 'kit' code such as HCPCS B4035 and/or B4034?

A4. Anything that is separately billed to Medicare needs to be listed on the detailed written order. Each kit may have different items that are necessary depending on the patient's

needs. Suppliers need to make sure they are indicating that a kit is being provided to the patient is important. A detailed template, as described in the question, is a good idea as long as the supplier is completing the template based on a verbal order from the physician from the point of initial contact. The supplier cannot initiate the order. The physician must initiate the order but the supplier completes the details in the template described.

Q5. A supplier has many patients that live in facilities such as a skilled nursing facility or a residential home. What type of documentation needs to be maintained to reflect that the supplies sent by the supplier are actually being used for the correct patient? Is the facility or the supplier obligated to maintain this documentation?
A5. If the patient resides in a facility, the facility may maintain a usage report with the Medicare beneficiary's name that would be able to support that the beneficiary is using the actual enteral that the supplier has sent/ dispensed. Suppliers need to make sure that there is a type of proof of delivery as well (i.e., delivery ticket which has been signed).

Q6. Is it true that a supplier is only allowed to deliver one month's supply of enteral nutrition?
A6. Yes, that is correct. One perspective payment for one month may be delivered. A supplier is allowed to bill up to 30 days or one month's supply. But if a supplier needs to bill for prior months (i.e., a delay in billing), suppliers can bill for more than one month on a claim. Billing for current months, suppliers can only deliver one month at a time.

Q7. A supplier's patient resides at home and enteral was provided for an entire month; i.e., October 1 through 31. Later, the supplier is notified by the family that the patient was hospitalized for a portion of the month; i.e., the 10 to the 15, and that the patient's enteral formula was taken to the hospital which will cause the patient to not have enough enteral nutrition for the remainder of the month. Normally suppliers instruct patients not to take the formula with them to the hospital and to contact the supplier before going to the hospital. Should the supplier send an Advance Beneficiary Notice of Noncoverage (ABN) at that time because the patient will have a shortage of formula because they actually took the formula that they were not supposed to to the facility?
A7. When the beneficiary is inpatient, the facility is responsible to provide the patient with their enteral supply needs. Patients should not be bringing the enteral from home while the patient is admitted for an inpatient Medicare Part A stay. It would not be appropriate to execute an ABN when another Medicare entity is responsible for the billing, which would be the inpatient stay. Medicare would not expect an ABN to be executed to make the beneficiary responsible. In the example, the five days would not have been used, so the supplier would bill Medicare for a smaller quantity the next month, and that would have to be sorted out between the beneficiary and the hospital.

Q8. Sometimes patients who are receiving a high volume of enteral nutrition will not use all that has been ordered. The patient will be slightly noncompliant causing them to have excess formula that would last a couple weeks into the next month. Is it correct to bill Medicare for the supplies if we note in our system that the patient has an overstock due to noncompliance?
A8. Yes, it is appropriate to bill Medicare because a supplier would not dispense additional enteral nutrition until the patient's supply is approximately five days out. However; the supplies are one unit a day and the supplier should enter a note within the narrative section of the claim being submitted that the patient still has the enteral need, but they do not have additional supplies.

Q9. When a group of physicians handle the care of patients in a nursing facility, those physicians normally are assigned different floors of the nursing home. The doctors are basically all involved with the care of the patients. On the dispensing and the detailed written order (DWO), the nursing home enters the doctor who normally is assigned to the patient on the order. At times, doctor 'A' could be on vacation so doctor 'B' signs orders. In this vacation situation, which doctor should be listed on the dispensing order and DWO?
A9. This situation is a group of physicians that are assisting; a treating physician can be more than one physician. Suppliers need to be certain the DWO corresponds with the physician that gave the verbal order. Sometimes by the time the DWO is completed, that physician may not be available to sign. The physician, who signed the dispensing order, is the physician that needs to be put on the detailed written order, although it could be signed "Doctor A by Doctor B". If it's signed by somebody else, that needs to be indicated that they're signing that on behalf of the physician on the verbal order otherwise they will not match.

It is not unusual to have physicians cross-covering one for another. One may have given the verbal order, and then another may validate that verbal order. However, when they validate that verbal order, if the physician is cross-covering for doctor 'A' and doctor 'A' gave a verbal order, and it is written that way, then the cross-covering doctor signs that "for doctor 'A' by "cross-covering doctor name." This allows both names to be listed and the cross-covering doctor is validating the verbal order from doctor 'A'. Without this "signing for" approach, this could lead to "I didn't give the verbal order". One may sign for the other's verbal order. This would be a valid verbal order, but the name of the person who gave the verbal order would be the one in whose name the order is actually being generated even though it is a different physician who has cross-signed that. Both under Medicare would need to be valid Medicare physicians, but the order is coming from the one who gave the verbal order on which basis the claim was filled, the supply was provided.

Q10. Supplies are billed as one unit per day. A supplier determines what items go into the supply kits; however, if a patient who resides at home has an excess of items, i.e., feeding bags or syringes, should the supplier delay their next delivery of supplies? What guidelines exist that may describe supply kit delivery as to whether they are syringes or the feeding bags which may cause a delay in delivery? There is concern with efficiency and added cost for multiple deliveries for one Medicare beneficiary for a billing month.

A10. When a supplier is preparing to send out supplies, the supplier should make sure that the patient has already exhausted all their supplies on hand. The supplier would then estimate as close as possible, what the patient will need for that entire month. The supplier will prepare a kit for each day that that beneficiary needs those supplies and bill one unit for each day. If the beneficiary does not need a separate kit every day, the supplier determines what that beneficiary's needs are; which is not necessarily determined by what the supplier wants to put in that kit. If the patient needs all items normally in their kit for 30 days, but the patient has an excess of syringes left over, then the supplier still provides sufficient supplies for one unit of service per day but they would provide fewer syringes in what was delivered for the month. All other supplies would be sufficient to accommodate the beneficiary for that month. In this situation, the supplier would make one delivery for that month. The supplier would adjust the quantity when they are delivering the supplies(s) because the beneficiary has certain supplies left over in excess and compute out what the units of service needed for the month would be.

Q11. When a supplier receives the patient's records to determine if the patient qualifies for the benefit, there are patients who are experiencing an issue such as pancreatitis or a malignant tumor involved with the pancreas. The doctor has said that the patient is Nothing Per Orem (NPO; nothing by mouth), and the doctor does not want the patient eating by mouth at all because of this issue that the patient is having with their pancreas. This causes a lack of understanding as to how the patient may or may not qualify for the benefits according to the enteral nutrition guidelines.

A11. First, if the condition is considered permanent. Issues such as acute pancreatitis would typically not be permanent. This may be long-term, but typically is not a permanent circumstance. The physician needs to tell the supplier if it is permanent based on the patient's condition. The patient could have a malignant tumor at the head of the pancreas that is causing an acute pancreatitis because it is causing some blockage. It still may or may not be permanent. The supplier needs to clearly communicate to the physician that Medicare, due to the nature of the benefit, can only cover enteral nutrition when there is a permanent impairment. The supplier would need to have documentation from the physician that the pathology was permanent or the condition was permanent.

Q12. When patients are discharged, the supplier receives discharge orders from the hospital that are signed by the doctor, but the details were not in order and not everything that the supplier needs for the detailed written order are apparent even though a signed dispensing order is received. When the detailed written order is submitted to the hospital, the hospital physicians do not want to sign it but instead those physicians want it all to be directed to the primary care physician.

A12. If the attending physician is ordering something, that attending physician needs to follow through and sign the detailed written order. That physician cannot verbally order items and have a different physician do the details or it will negate the delivery of the product. The option to sign on behalf as previously discussed during these ACT minutes would be permitted.

Q13. When a patient has a primary private insurance and Medicare is the secondary insurance, does the supplier always have to generate a DME Information Form (DIF) when the supplier is billing Medicare as the secondary insurance?

A13. Yes. Even if Medicare is the secondary insurance, you still have to follow all the guidelines.

Q14. How long is a DIF good? Is it six months or until something changes?

A14. Currently the DIF does have a length of need field listed on the form itself and the supplier needs to complete that field based on what the detailed written order reflects is the length of need. When that date/length expires, the supplier needs to develop a revised DIF based on the current detailed written order. Medicare has been notified of some confusion in the supplier community regarding the situation; however, an order is only valid for the length of need specified in the detailed written order the supplier receives.

Q15. An Alzheimer's patient refused to open their mouth and was not taking anything orally, even though there was no permanent dysfunction. The patient was not qualified for enteral nutrition based on the LCD. Is there any way an Alzheimer's related dysphasia, even though it's not really dysphasia, could qualify for the benefit or do they always have to go to a Skilled Nursing Facility (SNF)?

A15. Unfortunately, because of the way the benefit category is written, there has to be a permanent condition, nonfunctioning issue. A psychiatric reason or something of that nature would not meet the benefit criteria. The Alzheimer's related dysphasia would not qualify for the benefit.

Q16. During a recent web-based workshop, NAS stated that the medical documentation has to be signed by the physician. Suppliers receive a lot of medication documentation from different databases at the hospital, so the documents are all electronically signed by the physician. Is the electronic signature sufficient?

A16. Yes, an electronic signature is acceptable as long as it indicates that it is an electronic signature and is dated.

Q17. When a patient is taking formula to the facility while hospitalized, what can a supplier do? Some patients insist on taking their specific formula to the hospital because the hospital does not have that specific brand of formula or there have been many issues with tolerance and the patient refuses to use the hospital formula. The patient takes their formula to the hospital and informs the supplier after the fact. After discharge, at the end of the month, the patient will not have enough home formula. Based on this call, suppliers cannot execute an ABN and make the beneficiary pay for their shortage of formula; however, where is the beneficiary supposed to get this formula that is not available at retail stores to make up their shortage? What does Medicare recommend the suppliers do; should suppliers tell the patient to contact their physician and see if the patient can take another formula that they can purchase from the retail store? If the patient chooses or asks to purchase extra formula from the supplier, must the supplier say no?
A17. The supplier bills Medicare for the entire month on the 'from' date. When the supplier follows up with the beneficiary seven days out, the supplier verifies what quantity they have left, if they still need additional supplies, or if they were in an inpatient facility. At that point in time, the supplier provides the beneficiary with the amount of supplies that they need. The supplier cannot bill the patient for the supplies that they took to the hospital. It is important that the patient has a conversation with the facility to let the facility know what type of formula they need.

Medicare does not want to be providing twice for the same circumstance. If a supplier was executing an ABN for option 2 (do not bill Medicare) indicating the enteral nutrition would be paid for in the hospital; however, the beneficiary is specifically deciding they only want a certain brand, the criteria of an independent transaction with an ABN would be fulfilled but it should occur rarely and it should be very clear that the beneficiary had ample notice and was not providing something that the hospital would otherwise provide and that they understood the noncoverage and they still elected to purchase their own enteral nutrition.

Q18. If the order is only good as long as the prescription is written, when a patient has a lifetime need for enteral services, i.e., an ALS patient, how does the state of California requirements that a prescription can only be written for a 12-month period apply? Does the supplier have to submit DIFs with a 12-month period and submit a recert or a new initial DIF every year? Would the submission be a revised or recertification based on the length of need being the only extension/change?
A18. The supplier needs to follow their state guidelines and get a new order after the length of need expires; every year based on the state requirements posed in this question. But the supplier's DIF, which is for Medicare purposes, is going to have the length of need that is indicated on your initial order. Medicare handles this situation from a systematic standpoint as a recertification. If it is submitted as a revised DIF, our system will process it as a recertification. The LCD guidelines do not explain the entire length of need expiring issue because this is intended for permanent conditions. Either a recertification or a revision will be accepted.

Q19. When a supplier has patients who, month after month, do not want the supplies the way that their physician has ordered them, what documentation does the supplier have to have to make sure that they are protected? Does the supplier ask the beneficiary if they are using the item(s) and are in compliance, or does the supplier inform the doctor that the patient is not using the item(s) the way that they had been ordered?
A19. NAS recommends having a conversation with the physician who is ordering the supplies and the physician can then follow up with their patient, see their patient, and adjust the patient's needs. In a few different Medicare LCDs, it is expected that the supplier have a conversation with the physician on atypical utilization patterns. Additionally, the supplier does need to speak with the beneficiary regarding their actual utilization every month before submitting and dispensing more supplies. Suppliers need to bill only for what is actually being used as well as provide the information to the physician so they can adjust and have a discussion with the patient.

Q20. Large teaching hospitals have limited/no correlation between the attending physician and the primary care physician. When the hospital doctor's discharge order and the attending physician detail order cannot be received or signed, what can the supplier do?
A20. When the physician is contacting the supplier for the order, if the supplier can identify that the order is from an inpatient or attending physician, the supplier can ask that physician if they will be the person signing the detailed written order or if they are working with the patient's primary care physician; in which case the primary care physician will sign for the ordering physician. Ask if it would be more appropriate to get that order from their primary care physician. It is important that the supplier take these protective measures for appropriate documentation. Possibly, the supplier could contact the primary care physician to describe the order that is being placed and promote the two physicians work together.

Q21. If the doctor's initial order indicates the supplier is allowed to manage the patient, and the supplier's dietitian(s) makes changes to the formula based on lab results or tolerance levels, the doctor must sign that change of orders, correct? Every time a change is made, does the doctor have to sign a written order?
A21. It is a requirement that if the order changes, the supplier needs to obtain a new order, and a dietitian, even if they weren't in a facility, cannot sign or cannot order enteral. If the dietician is changing the codes that end up being billed and results in a different order from Medicare's point of view, then the change does need to come from the physician. A brand change that does not change the caloric quantity delivered would not require the change; however, when changing what is actually being delivered to the patient does require the doctor to sign and submit a written change in order.

Q22. A supplier has a lot of patients that come in with the swallow evaluation showing that the patient refuses oral/by mouth trials or is uncooperative, etc., resulting in the patient only taking in four ounces, and then will not take any more. In the discharge summary, the therapist signs the documentation indicating the patient has severe oral pharyngeal dysphasia. Does that qualify the patient even though the evaluation necessarily did not?
A22. No, the situation described would not qualify the patient.

ENTERAL NUTRITION CONT'D

Q23. What is the definition of permanent?
A23. Medicare defines a permanent condition of a condition lasting at least three months.

Q24. For competitive bidding and enteral products, if a supplier wins a bid, and that supplier takes over patients from another provider, does the competitive bid supplier have to do the patient's intake process all over again to make sure the patient qualifies?
A24. It is recommended that suppliers conduct their own intake process to ensure their new patients qualify. The supplier will want to have the DIF reflect their supplier information and use this as a time to ensure documentation is available and appropriate.

Q25. What happens if a supplier who receives a new patient as a result of competitive bid determines some of the patients will not qualify based on the documentation they receive? What does the supplier do with the patients if they have been receiving enteral and they should not have been getting paid by Medicare?
A25. This is a supplier's business practice decision as to what they should do; however, if the supplier knows the patient(s) does not qualify for the benefit, and the patient still wants the supplier to provide it, the supplier may want to consider properly executing an ABN.

Q26. A supplier has a patient that has the diagnosis of dysphasia and the patient has a puree diet or mechanical soft diet order, but it does not exactly specify how much the patient is in-taking or the type of diet. How does a supplier provide nutrition if the patient has a swallow evaluation that states the patient has oral pharyngeal dysphasia, but the patient is on a mechanical soft diet? When would Medicare cover the benefit if the patient is in-taking a mechanical soft diet and there is no indication as to how much it is or how much the patient is actually in-taking when they do take the soft diet?
A26. If the patient has oral pharyngeal dysphasia, which can be a variable severity and still be able to take in some quantities, the patient may or may not, independent of that, qualify for the Medicare benefit. They are all three different situations. If the patient has an intake of a mechanically soft diet, and there is nothing to indicate that is limited in some way, then the patient would not meet the Medicare benefit. If the patient is able to be on a mechanical soft diet, the conditions of the benefit are not met. The patient can have an ability to take in food; somebody even with a total esophagectomy who has no esophagus can still partake of a child birthday cake once in a while and take in some food. They end up spitting it out, or they have a pouch or something that will collect it. But they must meet the benefit to be eligible for the benefit.

Q27. There are dietitians who will claim that if a patient is on some type of diet, it does not necessarily have to be documented how much the patient is in-taking because the diet is for oral gratification. A patient who has a diagnosis of dysphasia based on a swallow evaluation has a diet order reflecting mechanical soft diet but does not always reflect the purpose is for oral gratification. The patients with the same oral gratification diet are in-taking sandwiches as a snack, and there are no documents to prove that the patients in-taking the sandwiches other than a nurse telling me this. How would a supplier disprove that the patient does not have dysphasia to either the patient, the beneficiary itself, or to a facility?
A27. If the question has been asked from a physician's order point of view of caloric intake, for instance, for a patient to control diabetes or something of that nature, and it is only for oral gratification, and how much does that have to be documented, that has nothing to do with the Medicare enteral nutrition issues being discussing. That is an issue between the dieticians and the nursing facility or whoever is following that patient and the physician. They may want to pursue that, and they may need it to be able to follow the patient's needs, for instance, for diabetic control, but that has nothing to do with the issues being discussed. It needs to be clear from the medical record that the patient meets the criteria for the benefit to start with to be billing Medicare. Now beyond that, if the supplier understands that the patient does not meet the criteria, then it would not be appropriate to bill Medicare for the benefit. If there are instructions there that the patient is not supposed to take in beyond the soft puree diet, for example, and they are doing that, that is something the supplier would have to work out with the patient, the facility, and the provider. This coordination effort would not alter the basics that the need for oral intake by enteral parenteral would still need to be there, as defined in the LCD. If the patient is meeting their caloric needs by oral intake, then something is being misrepresented. Yes, that definitely could be the case if it is for oral gratification, which means by definition it is a small quantity for the patient's comfort and gratification for something that they want to do.

Q28. According to Medicare standards, is there something that does qualify a patient as a small diet, i.e., four ounces is considered small, and nothing above that?
A28. No, a small diet has not been defined. Gratification and maintaining a patient's strength on their oral diet is not going to meet the enteral nutrition qualifications. Patients might be able to take a larger amount some time and not another. Medicare has not defined it in terms of either the weight or the volume. But instead, if the patient is able to maintain strength and weight on the diet that the patient is taking, then the patient does not have a need for a prosthesis to substitute for that intake mechanism.

PECOS

No Date Set for Expanded Ordering/ Referring Provider Claim Edits

Due to recent inquiries, the Centers for Medicare & Medicaid Services (CMS) is clarifying its policy regarding expanded ordering/referring provider claim edits. CMS has not yet decided when it will begin to reject claims if an ordering/referring provider does not have a record in the Provider Enrollment, Chain, and Ownership System (PECOS). CMS will give providers ample notice before claim rejections begin. Recent revisions to Change Requests (CRs) #6417 and #6421 require Medicare Administrative Contractors to delay rejecting claims until receiving further direction from CMS.

NORIDIAN® Administrative Services LLC

Medicare

January 2011

Regarding: Enrollment in Medicare Provider Enrollment, Chain and Ownership System (**PECOS**)

Dear Colleague:

Providers of laboratory and radiologic services and suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) are partners in caring for your patient(s). They will not receive payment from Medicare for the items or services ordered **if you do not have a current enrollment in the Medicare Provider Enrollment, Chain and Ownership System (PECOS)**. This may also result in your patient not receiving the service or item needed, or potentially being held financially responsible and **may result in your office being swamped with calls as others seek this information**. Please help avoid these difficulties by **confirming now that you are enrolled in PECOS** if you have not already done so, or updating your Medicare enrollment if you have not done so since November 2003.

For any service or item to be covered by Medicare, it must be ordered by a physician or a practitioner who a) is eligible to order such items, b) is **enrolled in PECOS**, and c) for DMEPOS items, must be indicated in PECOS as specialty eligible to order DMEPOS items for Medicare beneficiaries, reference (SSA section 186(r) and 1842 (b)(18)(c)). The providers who can order/refer DMEPOS include:

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

Physicians and nonphysician practitioners who are enrolled in the Medicare Program who have not updated their enrollment application (completing Internet-based PECOS or the CMS-855I) since 2003 or have not reported their National Provider Identifier (NPI) to their designated contractor/local carrier, but plan on ordering these services or items are **required** to submit a Medicare enrollment application. Those with questions concerning the enrollment process should contact their designated Medicare contractor/local carrier in advance of submitting the CMS-855I. **Please complete this now to avoid future frustrations for your office and other colleagues!** For additional information regarding the Medicare enrollment process, including Internet-based PECOS, go to http://www.cms.hhs.gov/MedicareProviderSupEnroll on the CMS Web site.

Sincerely,
Richard W. Whitten, MD, FACP
Medical Director, Jurisdiction D DME MAC

CMS CENTERS for MEDICARE & MEDICAID SERVICES

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

Expansion of Current Scope of Editing for Ordering/Referring

MLN Matters® Number: MM6417 Revised
Related Change Request (CR) #: 6417
Related CR Release Date: December 16, 2010
Related CR Transmittal #: R825OTN
Effective Dates: Phase 1: October 5, 2009
Implementation Dates: Phase 1: October 5, 2009, Phase 2: July 5, 2011(Placeholder)

Note: This article was revised on December 17, 2010, to reflect the changes in the release of a revised CR 6417 on December 16, 2010. The CR was revised to show that implementation date for Phase 2 is being delayed and will not begin on January 3, 2011. A placeholder date of July 5, 2011 has been stated in the revised CR 6417. This placeholder date is being issued to give the Centers for Medicare & Medicaid Services more flexibility to determine the appropriate date for nonpayment of claims that fail the ordering/referring provider edits.

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

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

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

The providers who can order/refer are:

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

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

Key Points

- **During Phase 1 (October 5, 2009- July 5, 2011** (Placeholder date)): If the billed item or service requires an ordering/referring provider and the ordering/referring provider is not in the claim, the claim will not be paid. It will be rejected. If the ordering/referring provider is on the claim, Medicare will verify that the ordering/referring provider is in PECOS and is eligible to order/refer in Medicare. If the ordering/referring provider is not in PECOS the carrier or Part B MAC will search its claims system for the ordering/referring provider. If the ordering/referring provider is not in PECOS and is not in the claims system, the claim will continue to process and the Part B provider or supplier will receive a warning message on the Remittance Advice. If the ordering/referring provider is in PECOS or the claims system but is not of the specialty to order or refer, the claim will continue to process and the Part B provider or supplier will receive a warning message on the Remittance Advice.
- **During Phase 2** (July 5, 2011 (Placeholder) and thereafter): If the billed item or service requires an ordering/referring provider and the ordering/referring provider is not in the claim, the claim will not be paid. It will be rejected. If the ordering/referring provider is on the claim, Medicare will verify that the ordering/referring provider is in PECOS and eligible to order and refer. Effective July 5, 2011, if the ordering/referring provider is not in PECOS, the carrier or Part B MAC will search its claims system for the ordering/referring provider. If the ordering/referring provider is not in PECOS and is not in the claims system, the claim will not be paid. It will be rejected. If the ordering/referring provider is in PECOS or the claims system but is not of the specialty to order or refer, the claim will not be paid. It will be rejected.

- In **both phases**, Medicare will verify the NPI and the name of the ordering/referring provider reported in the claim against PECOS or, if the ordering/referring provider is not in PECOS, against the claims system. In paper claims, be sure not to use periods or commas within the name of the ordering/referring provider. Hyphenated names are permissible.
- Providers who order or refer may want to verify their enrollment in PECOS. They may do so by accessing Internet-based PECOS at https://pecos.cms.hhs.gov/pecos/login.do on the CMS website. Before using Internet-based PECOS, providers should read the educational material about Internet-based PECOS that is available at http://www.cms.gov/MedicareProviderSupEnroll/04_InternetbasedPECOS.asp on the CMS website. Once at that site, scroll to the downloads section of that page and click on the materials that apply to you and your practice.

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

Additional Information
You can find the official instruction, CR6417, issued to your carrier or B MAC by visiting http://www.cms.gov/Transmittals/downloads/R825OTN.pdf on the CMS website.

Expansion of Current Scope of Editing for Ordering/Referring Providers for DMEPOS Claims

MLN Matters Number: MM6421 Revised
Related Change Request (CR) #: 6421
Related CR Release Date: December 16, 2010
Related CR Transmittal #: R823OTN
Effective Dates: Phase 1 – October 1, 2009
Implementation Date: Phase 1 – October 5, 2009
Phase 2 – To be announced

Note: This article was revised on January 12, 2011, to clarify that the Centers for Medicare & Medicaid Services has not yet decided when it will begin to reject claims if an ordering/referring provider does not have a PECOS record. CMS will give providers ample notice before claim rejections begin. Recent revisions to CR 6421 required DME MACs to delay rejecting claims until receiving further direction from CMS. Some language in this article was also revised to be more aligned with language in the Change Request.

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

Provider Action Needed
This article is based on change request (CR) 6421, which requires Medicare implementation of system edits to assure that DMEPOS suppliers bill for items or services only when those items or services are ordered or referred by physician and non-physician practitioners who are eligible to order/refer such services. Physician and non-physician practitioners must be enrolled in the Medicare Provider Enrollment, Chain and Ownership System (PECOS) and of the type/specialty eligible to order/refer services for Medicare beneficiaries. Be sure billing staff are aware of these changes that will impact DMEPOS claims received and processed on or after October 5, 2009.

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

The providers who can order/refer are:

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

Claims that are the result of an order or a referral must contain the National Provider Identifier (NPI) and the name of the ordering/referring provider and the ordering/referring provider must be in PECOS with one of the above specialties.

Key Points

- **During Phase 1 (October 5, 2009- until further notice)**: When a claim is received, Medicare will determine if the ordering/referring provider is required for the billed service. If the ordering/referring provider is not on the claim, the claim will continue to process. If the ordering/referring provider is on the claim, Medicare will verify that the ordering/referring provider is in PECOS and is eligible to order/refer. If the ordering/referring provider is not in PECOS or is in PECOS but is not of the type/specialty to order or refer, the claim will also continue to process.

1. If the DMEPOS supplier claim is an ANSI X12N 837P standard electronic claim, the DMEPOS supplier will receive a warning message on the Common Electronic Data Interchange (CEDI) GenResponse Report.
2. If the DMEPOS supplier claim is a paper CMS-1500 claim, the DMEPOS supplier will not receive a warning and will not know that the claim did not pass these edits.

- **During Phase 2 (Start Date to Be Announced):** If the ordering/referring provider is not on the claim, the claim will not be paid. If the ordering/referring provider is on the claim, Medicare will verify that the ordering/referring provider is in PECOS and eligible to order and refer. If the ordering/referring provider is not in PECOS or is in PECOS but is not of the specialty to order or refer, the claim will not be paid. It will be rejected.
  1. If the DMEPOS supplier claim is an ANSI X12N 837P standard electronic claim, the DMEPOS supplier will receive a rejection message on the CEDI GenResponse Report.
  2. If the DMEPOS supplier claim is a paper CMS-1500 claim, the DMEPOS supplier will see the rejection indicated on the Remittance Advice.
- In **both phases**, Medicare will verify the NPI and the name of the ordering/referring provider reported on the ANSI X12N 837P standard electronic claim against PECOS.
- When furnishing names on the paper claims, be sure not to use periods or commas within the name. Hyphenated names are permissible.
- Providers who order and refer may want to verify their enrollment or pending enrollment in PECOS. You may do so by:
  - Using Internet-based PECOS to look for your PECOS enrollment record. (You will need to first set up your access to Internet-based PECOS.) For more information, regarding PECOS enrollment go to http://www.cms.gov/MedicareProviderSupEnroll/Downloads/Instructionsforviewingpractitionerstatus.pdf on the CMS website. If no record is displayed, you do not have an enrollment record in PECOS.
  - Checking the Ordering Referring Report at http://www.cms.gov/MedicareProviderSupEnroll/06_MedicareOrderingandReferring.asp#TopOfPage on the CMS website.
  - **I don't have an enrollment record. What should I do?** Internet-based PECOS is the fastest and most efficient way to submit your enrollment application. For instructions, see "Basics of Internet-based PECOS for Physicians and Non-Physician Practitioners" at http://www.cms.gov/MLNProducts/downloads/MedEnroll_PECOS_PhysNonPhys_FactSheet_ICN903764.pdf on the CMS website.

Additional Information
The official instruction, CR6421, issued to your Medicare DME MAC regarding this change, may be viewed at http://www.cms.gov/Transmittals/downloads/R823OTN.pdf on the CMS website.

Edits on Ordering/Referring Providers (Change Requests 6417, 6421, and 6696)

MLN Matters Number: SE1011 Revised

Note: This article was revised on November 26, 2010 to include the following statement: The Centers for Medicare & Medicaid Services (CMS) previously announced that, beginning January 3, 2011, if certain Part B billed items and services require an ordering/referring provider and the ordering/referring provider is not in the claim, is not of a profession that is permitted to order/refer, or does not have an enrollment record in the Medicare Provider Enrollment, Chain and Ownership System (PECOS), the claim will not be paid. The automated edits will not be turned on effective January 3, 2011. We are working diligently to resolve enrollment backlogs and other system issues and will provide ample advanced notice to the provider and beneficiary communities before we begin any automatic nonpayment actions.

Provider Types Affected
Physicians, non-physician practitioners (including residents, fellows, and also those who are employed by the Department of Veterans Affairs (DVA) or the Public Health Service (PHS)) who order or refer items or services for Medicare beneficiaries, Part B providers and suppliers who submit claims to carriers, Part B Medicare Administrative Contractors (MACs), and DME MACs for items or services that they furnished as the result of an order or a referral should be aware of this information.

Provider Action Needed
If you order or refer items or services for Medicare beneficiaries and you do not have an enrollment record in the Provider Enrollment, Chain and Ownership System (PECOS), you need to submit an enrollment application to Medicare. You can do this using Internet-based PECOS or by completing the paper enrollment application (CMS-855I). If you reassign your Medicare benefits to a group or clinic, you will also need to complete the CMS-855R.

What Providers Need to Know
Phase 1: Beginning October 5, 2009, if the billed Part B service requires an ordering/referring provider and the ordering/referring provider is not reported on the claim, the claim will not be paid. If the ordering/referring provider is reported on the claim but does not have a current enrollment record in PECOS or is not of a specialty that is eligible to order and refer, the claim will be paid and the billing provider will receive an informational message in the remittance indicating that the claim failed the ordering/referring provider edits.

Phase 2: Beginning January 3, 2011 (See statement on page one delaying implementation of phase 2.), Medicare will reject Part B claims that fail the Ordering/Referring Provider

edits. Physicians and others who are eligible to order and refer items or services need to establish their Medicare enrollment records in PECOS and must be of a specialty that is eligible to order and refer.

Enrolled physicians and non-physician practitioners who do not have enrollment records in PECOS and who submit enrollment applications in order to get their enrollment information into PECOS should not experience any disruption in Medicare payments, as a result of submitting enrollment applications.

Enrollment applications must be processed in accordance with existing Medicare instructions. It is possible that it could take 45-60 days, sometimes longer, for Medicare enrollment contractors to process enrollment applications. All enrollment applications, including those submitted over the web, require verification of the information reported. Sometimes, Medicare enrollment contractors may request additional information in order to process the enrollment application.

Waiting too late to begin this process could mean that your enrollment application will not be able to be processed prior to the implementation date of Phase 2 of the Ordering/ Referring Provider edits, which is January 3, 2011.

Background

The Centers for Medicare & Medicaid Services (CMS) has implemented edits on Ordering and Referring Providers when they are required to be identified in Part B claims from Medicare providers or suppliers who furnished items or services as a result of orders or referrals.

- Below are examples of some of these types of claims:
  - Claims from laboratories for ordered tests;
  - Claims from imaging centers for ordered imaging procedures;
  - Claims from suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) for ordered DMEPOS; and
  - Claims from specialists or specialty groups for referred services.
- Only physicians and certain types of non-physician practitioners are eligible to order or refer items or services for Medicare beneficiaries. They are as follows:
  - Physician (doctor of medicine or osteopathy, doctor of dental medicine, doctor of dental surgery, doctor of podiatric medicine, doctor of optometry, doctor of chiropractic medicine),
  - Physician Assistant,
  - Certified Clinical Nurse Specialist,
  - Nurse Practitioner,
  - Clinical Psychologist,
  - Certified Nurse Midwife, and
  - Clinical Social Worker.

Questions and Answers Relating to the Edits

1. **What will the edits do?**
   The edits will determine if the Ordering/Referring Provider (when required to be identified in a Part B claim) (1) has a current Medicare enrollment record (i.e., the enrollment record is in PECOS and it contains the National Provider Identifier (NPI)), and (2) is of a type that is eligible to order or refer for Medicare beneficiaries (see list above).
2. **Why did Medicare implement these edits?**
   These edits help protect Medicare beneficiaries and the integrity of the Medicare program.
3. **How and when will these edits be implemented?**
   These edits are being implemented in two phases:
   - **Phase 1** began on October 5, 2009, and is scheduled to end on January 2, 2011. In Phase 1, if the Ordering/ Referring Provider does not pass the edits, the claim will be processed and paid (assuming there are no other problems with the claim) but the Billing Provider (the provider who furnished the item or service that was ordered or referred) will receive an informational message* from Medicare in the Remittance Advice†.

     The informational message will indicate that the identification of the Ordering/Referring provider is missing, incomplete, or invalid, or that the Ordering/ Referring Provider is not eligible to order or refer. The informational message on an adjustment claim that does not pass the edits will indicate that the claim/service lacks information that is needed for adjudication.

     Note: if the billed service requires an ordering/ referring provider and the ordering/referring provider is not on the claim, the claim will not be paid.
   - **Phase 2** is scheduled to begin on January 3, 2011, and will continue thereafter. In Phase 2, if the Ordering/ Referring Provider does not pass the edits, the claim will be rejected. This means that the Billing Provider will not be paid for the items or services that were furnished based on the order or referral.

CMS has taken actions to reduce the number of informational messages.

In December 2009, CMS added the NPIs to more than 200,000 PECOS enrollment records of physicians and non-physician practitioners who are eligible to order and refer but who had not updated their PECOS enrollment records with their NPIs.‡

On January 28, 2010, CMS made available to the public, via the Downloads section of the "Ordering Referring Report" page on the Medicare provider/supplier enrollment website, a file containing the NPIs and the names of physicians and non-physician practitioners who have current enrollment records in PECOS and are of a type/specialty that is eligible to order and refer. The file, called the Ordering Referring Report, lists, in alphabetical order based on last name, the NPI and the name (last name, first name) of the physician or non-physician practitioner. To keep the available information up to date, CMS will replace the Report on a periodic basis.

PECOS CONT'D

At any given time, only one Report (the most current) will be available for downloading. To learn more about the Report, and to download it, go to http://www.cms.gov/MedicareProviderSupEnroll; click on "Ordering Referring Report" (on the left). Information about the Report will be displayed.

Effect of Edits on Providers

A. I order and refer. How will I know if I need to take any sort of action with respect to these two edits?

In order for the claim from the Billing Provider (the provider who furnished the item or service) to be paid by Medicare for furnishing the item or service that you ordered or referred, you - the Ordering/Referring Provider - need to ensure that:

1. **You have a current Medicare enrollment record (that is, your enrollment record is in PECOS and it includes your NPI).**
   - If you enrolled in Medicare after 2003, your enrollment record is in PECOS and CMS may have added your NPI to it.
   - If you enrolled in Medicare prior to 2003 but submitted an update(s) to your enrollment information since 2003, your enrollment record is in PECOS and CMS may have added your NPI to it.
   - If you enrolled in Medicare prior to 2003 and have not submitted an update to your Medicare enrollment information in 6 or more years, you do not have an enrollment record in PECOS. **You need to take action to establish one. See the last bullet in this section.**
   - If you are not sure, you may: (1) check the Ordering Referring Report mentioned above, and if you are on that report, you have a current enrollment record in Medicare (that is, your enrollment record is in PECOS and it contains your NPI); (2) contact your designated Medicare enrollment contractor and ask if you have an enrollment record in PECOS that contains the NPI; or (3) use Internet-based PECOS to look for your PECOS enrollment record (if no record is displayed, you do not have an enrollment record in PECOS). If you choose (3), please read the information on the Medicare provider/supplier enrollment web page about Internet-based PECOS before you begin.
   - **If you do not have an enrollment record in PECOS:**
     - You need to submit an enrollment application to Medicare in one of two ways:
       a. **Use Internet-based PECOS** to submit your enrollment application over the Internet to your designated Medicare enrollment contractor. You will have to print, sign, and date the Certification Statement and mail the Certification Statement, and any required supporting paper documentation, to your designated Medicare enrollment contractor. The designated enrollment contractor cannot begin working on your application until it has received the signed and dated Certification Statement. If you will be using Internet-based PECOS, please visit the Medicare provider/supplier enrollment web page to learn more about the web-based system before you attempt to use it. Go to http://www.cms.gov/MedicareProviderSupEnroll, click on "Internet-based PECOS" on the left-hand side, and read the information that has been posted there. Download and read the documents in the Downloads Section on that page that relate to physicians and non-physician practitioners. A link to Internet-based PECOS is included on that web page.

Note for physicians/non-physician practitioners who reassign all their Medicare benefits to a group/clinic: If you reassign all of your Medicare benefits to a group/clinic, the group/clinic must have an enrollment record in PECOS in order for you to enroll via the web. You should check with the officials of the group/clinic or with your designated Medicare enrollment contractor if you are not sure if the group/clinic has an enrollment record in PECOS. If the group/clinic does not have an enrollment record in PECOS, you will not be able to use the web to submit your enrollment application to Medicare. You will need to submit a paper application, as described in the bullet below.

b. Obtain a paper enrollment application (CMS-855I), fill it out, sign and date it, and mail it, along with any required supporting paper documentation, to your designated Medicare enrollment contractor. If you reassign all your Medicare benefits to a group/clinic, you will also need to fill out, sign and date the CMS-855R, obtain the signature/date signed of the group's Authorized Official, and mail the CMS-855R, along with the CMS-855I, to the designated Medicare enrollment contractor. Enrollment applications are available for downloading from the CMS forms page (http://www.cms.gov/cmsforms) or by contacting your designated Medicare enrollment contractor.

Note about physicians/non-physician practitioners who have opted-out of Medicare but who order and refer: Physicians and non-physician practitioners who have opted out of Medicare may order items or services for Medicare beneficiaries. Their opt-out information must be current (an affi**davit must be completed every 2 years, and the NPI is required on** the affidavit). Opt-out practitioners whose affidavits are current should have enrollment records in PECOS that contain their NPIs.

2. **You are of a type/specialty that can order or refer items or services for Medicare beneficiaries. When you enrolled in Medicare, you indicated your Medicare specialty. Any physician specialty** and **only** the non-physician practitioner specialties listed above in this Article are eligible to order or refer in the Medicare program.

B. I bill Medicare for items and services that were ordered or referred. How can I be sure that my claims for these items and services will pass the Ordering/Referring Provider edits?

As the Billing Provider, you need to ensure that your Medicare claims for items or services that you furnished based on orders or referrals will pass the two edits on the Ordering/Referring Provider so that you will not receive informational messages in Phase 1 and so that your claims will be paid in Phase 2.

You need to use due diligence to ensure that the physicians and non-physician practitioners from whom you accept orders and referrals have current Medicare enrollment records (i.e., they have enrollment records in PECOS that contain their NPIs) and are of a type/specialty that is eligible to order or refer in the Medicare program. If you are not sure that the physician or non-physician practitioner who is ordering or referring items or services meets those criteria, it is recommended that you check the Ordering Referring Report described earlier in this article. Ensure you are correctly spelling the Ordering/Referring Provider's name. If you furnished items or services from an order or referral from someone on the Ordering Referring Report, your claim should pass the Ordering/Referring Provider edits. Keep in mind that this Ordering Referring Report will be replaced about once a month to ensure it is as current as practicable. It is possible, therefore, that you may receive an order or a referral from a physician or non-physician practitioner who is not listed in the Ordering Referring Report but who may be listed on the next Report. You may resubmit a claim that did not initially pass the Ordering/Referring Provider edits.

Make sure your claims are properly completed. Do not use "nicknames" on the claim, as their use could cause the claim to fail the edits (e.g., Bob Jones instead of Robert Jones will cause the claim to fail the edit, as the edit will look for R, not B, as the first letter of the first name). Do not enter a credential (e.g., "Dr.") in a name field. On paper claims (CMS-1500), in item 17, you should enter the Ordering/Referring Provider's first name first, and last name second (e.g., John Smith). Ensure that the name and the NPI you enter for the Ordering/Referring Provider belong to a physician or non-physician practitioner and not to an organization, such as a group practice that employs the physician or non-physician practitioner who generated the order or referral. Make sure that the qualifier in the electronic claim (X12N 837P 4010A1) 2310A NM102 loop is a 1 (person). Organizations (qualifier 2) cannot order and refer. If there are additional questions about the informational messages, Billing Providers should contact their local carrier, A/B MAC, or DME MAC.

Billing Providers should be aware that claims that are rejected because they failed the Ordering/Referring Provider edits are not denials of payment by Medicare that would expose the Medicare beneficiary to liability. Therefore, **an Advance Beneficiary Notice is not appropriate**.

Additional Guidance

1. **Orders or referrals by interns or residents.** Interns are not eligible to enroll in Medicare because they do not have medical licenses. Unless a resident (with a medical license) has an enrollment record in PECOS, he/she may not be identified in a Medicare claim as the Ordering/Referring Provider. The teaching, admitting, or supervising physician is considered the Ordering/Referring Provider when interns and residents order and refer, and that physician's name and NPI would be reported on the claim as the Ordering/Referring Provider.
2. Orders or referrals by physicians and non-physician practitioners who are of a type/specialty that is eligible to order and refer who work for the Department of Veterans Affairs (DVA), the Public Health Service (PHS), or the Department of Defense(DoD)/Tricare. These physicians and non-physician practitioners will need to enroll in Medicare in order to continue to order or refer items or services for Medicare beneficiaries. They may do so by filling out the paper CMS-855I or they may use Internet-based PECOS. They must include a covering note with the paper application or with the paper Certification Statement that is generated when submitting a web-based application that states that they are enrolling in Medicare only to order and refer. They will not be submitting claims to Medicare for services they furnish to Medicare beneficiaries.
3. **Orders or referrals by dentists**. Most dental services are not covered by Medicare; therefore, most dentists do not enroll in Medicare. Dentists are a specialty that is eligible to order and refer items or services for Medicare beneficiaries (e.g., to send specimens to a laboratory for testing). To do so, they must be enrolled in Medicare. They may enroll by filling out the paper CMS-855I or they may use Internet-based PECOS. They must include a covering note with the paper application or with the paper Certification Statement that is generated when submitting a web-based application that states that they are enrolling in Medicare only to order and refer. They will not be submitting claims to Medicare for services they furnish to Medicare beneficiaries.

Additional Information

You may want to review the following related CRs:

- CR 6417 at http://www.cms.gov/Transmittals/downloads/R642OTN.pdf on the CMS website;
- CR 6421 at http://www.cms.gov/Transmittals/downloads/R643OTN.pdf on the CMS website; and
- CR 6696 at http://www.cms.gov/Transmittals/downloads/R328PI.pdf on the CMS website.

* The informational messages vary depending on the claims processing system.

† DMEPOS suppliers who submit paper claims will not receive an informational message on the Remittance Advice.

‡ NPIs were added only when the matching criteria verified the NPI.

Outpatient Therapy Cap Values for CY 2011

MLN Matters® Number: MM7107
Related Change Request (CR) #: 7107
Related CR Release Date: October 22, 2010
Related CR Transmittal #: R2073CP
Effective Date: January 1, 2011
Implementation Date: January 3, 2011

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

Provider Action Needed
This article is based on Change Request (CR) 7107, which describes the Centers for Medicare & Medicaid Services (CMS) policy for outpatient therapy caps for Calendar Year (CY) 2011. No change to the exceptions process is anticipated, if it should be extended into 2011. Be sure billing staff is aware of the updates.

Background
The Balanced Budget Act of 1997 set therapy caps, which change annually, for Part B Medicare patients. The Deficit Reduction Act of 2005 allowed CMS to establish a process for exceptions to therapy caps for medically necessary services. The Affordable Care Act extended exceptions to therapy caps through December 31, 2010.

Therapy caps for 2011 will be $1870. The exceptions process will continue unchanged for the time frame directed by the Congress.

Note that the limitations apply to outpatient services and do not apply to Skilled Nursing Facility (SNF) residents in a covered Part A stay, including swing beds. Rehabilitation services are included within the global Part A per diem payment that the SNF receives under the prospective payment system (PPS) for the covered stay. Also, limitations do not apply to any therapy services billed under the Home Health PPS, inpatient hospitals or the outpatient department of hospitals, including critical access hospitals.

Additional Information
The official instruction, CR 7170, issued to your FI, carrier, A/B MAC, or RHHI regarding this change may be viewed at http://www.cms.gov/Transmittals/downloads/R2073CP.pdf on the CMS website.

Additional information concerning outpatient therapy services may be found at http://www.cms.hhs.gov/therapyservices on the CMS website.

Reasonable Charge Update for 2011 for Splints, Casts, and Certain Intraocular Lenses

MLN Matters® Number: MM7225
Related Change Request (CR) #: 7225
Related CR Release Date: November 19, 2010
Related CR Transmittal #: R2100CP
Effective Date: January 1, 2011
Implementation Date: January 3, 2011

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

Provider Action Needed
Change Request (CR) 7225, from which this article is taken, instructs your carriers, FIs, and MACs how to calculate reasonable charges for the payment of claims for splints, casts, and intraocular lenses furnished in calendar year 2011. Make sure your billing staff is aware of these changes.

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

Beginning January 1, 2011, reasonable charges will no longer be calculated for payment of home dialysis supplies and equipment for Method II End Stage Renal Disease (ESRD) patients. Section 153 of Medicare Improvements for Patients and Providers Act (MIPPA) amended section 1881(b) of the Act to require the implementation of an ESRD bundled payment system effective January 1, 2011. The ESRD prospective payment will provide an all-inclusive single payment to ESRD facilities (i.e. hospital-based providers of services and renal dialysis facilities) that will cover all the resources used in providing outpatient dialysis treatment, including dialysis supplies and equipment that are currently separately payable to Method II DME suppliers.

CR 7225 provides instructions regarding the calculation of reasonable charges for payment of claims for splints, casts, and intraocular lenses furnished in calendar year 2011. Payment on a reasonable charge basis is required for these items by regulations contained in 42 CFR 405.501. The Inflation Indexed Charge (IIC) is calculated using the lowest of the reasonable charge screens from the previous year updated by an inflation adjustment factor or the percentage

change in the Consumer Price Index (CPI) for all urban consumers (United States city average) or CPI-U for the 12-month period ending with June of 2010. The 2011 payment limits for splints and casts will be based on the 2010 limits that were announced in CR 6691 last year, increased by 1.1 percent, the percentage change in the CPI-U for the 12-month period ending June 30, 2010. The IIC update factor for 2011 is 1.1 percent.

A list of the 2011 payment limits for splints and casts are as follows:

Code	Payment Limit
A4565	$7.84
Q4001	$44.60
Q4002	$168.58
Q4003	$32.04
Q4004	$110.92
Q4005	$11.81
Q4006	$26.62
Q4007	$5.92
Q4008	$13.31
Q4009	$7.89
Q4010	$17.75
Q4011	$3.94
Q4012	$8.88
Q4013	$14.36
Q4014	$24.21
Q4015	$7.18
Q4016	$12.10
Q4017	$8.30
Q4018	$13.23
Q4019	$4.16
Q4020	$6.62
Q4021	$6.14
Q4022	$11.08
Q4023	$3.09
Q4024	$5.54
Q4025	$34.44
Q4026	$107.54
Q4027	$17.23
Q4028	$53.78
Q4029	$26.34
Q4030	$69.33
Q4031	$13.17
Q4032	$34.66
Q4033	$24.57
Q4034	$61.10
Q4035	$12.28
Q4036	$30.56
Q4037	$14.99
Q4038	$37.55
Q4039	$7.51
Q4040	$18.76
Q4041	$18.22
Q4042	$31.11
Q4043	$9.12
Q4044	$15.56
Q4045	$10.58
Q4046	$17.02
Q4047	$5.28
Q4048	$8.51
Q4049	$1.93

Additional Information
The official instruction, CR 7225 issued to your carrier, FI, A/B MAC, and DME/MAC regarding this change may be viewed at http://www.cms.gov/Transmittals/downloads/R2100CP.pdf on the CMS website.

2011 Update for DMEPOS Fee Schedule

MLN Matters® Number: MM7248 Revised
Related Change Request (CR) #:7248
Related CR Release Date: January 24, 2011
Related CR Transmittal #: R2142CP
Effective Date: January 1, 2011
Implementation Date: January 3, 2011

Note: This article was revised on January 25, 2011, to make the following changes (**in bold**): On page 4, codes L3660, L3670 and L3675 were removed from the list of codes deleted from the HCPCS file; On page 5, the purchase fee schedule calculation for complex rehabilitation power wheelchairs was added to the Power-Driven Wheelchairs section; and On page 6, the language was clarified under the CY 2011 Fee Schedule Update Factor section. The transmittal number, CR date and link for viewing the CR was also changed. All other information remains the same.

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, based on Change Request (CR) 7248, advises you of the CY 2011 annual update for the Medicare DMEPOS fee schedule. The instructions include information on the data files, update factors, and other information related to the update of the DMEPOS fee schedule. The annual update process for the DMEPOS fee schedule is documented in the Medicare Claims Processing Manual, Chapter 23, Section 60 at http://www.cms.gov/manuals/downloads/clm104c23.pdf on the Centers for Medicare & Medicaid Services (CMS) website. Key points about these changes are summarized in the Background section below. These changes are effective for DMEPOS provided on or after January 1, 2011. Be sure your billing staffs are aware of these changes.

Background and Key Points of CR7248

The DMEPOS fee schedule file is available for State Medicaid Agencies, managed care organizations, and other interested parties at http://www.cms.hhs.gov/DMEPOSFeeSched/ on the CMS website.

2011 Update to Labor Payment Rates

2011 Fees for Healthcare Common Procedure Coding System (HCPCS) labor payment codes K0739, L4205, L7520 are increased by 1.1 percent effective for dates of service on or after January 1, 2011 through December 31, 2011, and those rates are as follows:

STATE	K0739	L4205	L7520	STATE	K0739	L4205	L7520
AK	25.55	29.11	34.25	NC	13.56	20.21	27.44
AL	13.56	20.21	27.44	ND	16.90	29.05	34.25
AR	13.56	20.21	27.44	NE	13.56	20.19	38.26
AZ	16.77	20.19	33.76	NH	14.56	20.19	27.44
CA	20.81	33.19	38.68	NJ	18.30	20.19	27.44
CO	13.56	20.21	27.44	NM	13.56	20.21	27.44
CT	22.65	20.67	27.44	NV	21.61	20.19	37.40
DC	13.56	20.19	27.44	NY	24.98	20.21	27.44
DE	24.98	20.19	27.44	OH	13.56	20.19	27.44
FL	13.56	20.21	27.44	OK	13.56	20.21	27.44
GA	13.56	20.21	27.44	OR	13.56	20.19	39.46
HI	16.77	29.11	34.25	PA	14.56	20.79	27.44
IA	13.56	20.19	32.85	PR	13.56	20.21	27.44
ID	13.56	20.19	27.44	RI	16.17	20.81	27.44
IL	13.56	20.19	27.44	SC	13.56	20.21	27.44
IN	13.56	20.19	27.44	SD	15.15	20.19	36.68
KS	13.56	20.19	34.25	TN	13.56	20.21	27.44
KY	13.56	25.88	35.09	TX	13.56	20.21	27.44
LA	13.56	20.21	27.44	UT	13.60	20.19	42.73
MA	22.65	20.19	27.44	VA	13.56	20.19	27.44
MD	13.56	20.19	27.44	VI	13.56	20.21	27.44
ME	22.65	20.19	27.44	VT	14.56	20.19	27.44
MI	13.56	20.19	27.44	WA	21.61	29.62	35.18
MN	13.56	20.19	27.44	WI	13.56	20.19	27.44
MO	13.56	20.19	27.44	WV	13.56	20.19	27.44
MS	13.56	20.21	27.44	WY	18.91	26.94	38.26
MT	13.56	20.19	34.25	MT	13.56	20.19	34.25

HCPCS Code Updates

The following new codes are effective as of January 1, 2011:

- A4566, A9273, and EO446 all of which have no assigned payment category;
- A7020,E2622, E2623, E2624, and E2625 in the inexpensive/routinely purchased (DME) payment category:
- E1831 in the capped rental payment category (DME);
- L3674, L4631, L5961, L8693, Q0478, and Q0479, in the prosthetics/orthotics payment category.

The fee schedule amounts for the above new codes will be established as part of the July 2011 DMEPOS Fee Schedule Update, when applicable. The DME MACs will establish local fee schedule amounts to pay claims for the new codes, where applicable, from January 1, 2011 through June 30, 2011. The new codes are not to be used for billing purposes until they are effective on January 1, 2011.

The following codes are being deleted from the HCPCS effective January 1, 2011, and are therefore being removed from the DMEPOS fee schedule files:

- **E0220, E0230, and E0238**
- **K0734, K0735, K0736, and K0737**
- **L3672 and L3673.**

For gap-filling purposes, the 2010 deflation factors by payment category are listed as follows:

Factor	Category
0.502	Oxygen
0.506	Capped Rental
0.507	Prosthetics and Orthotics
0.643	Surgical Dressings
0.700	Parenteral and Enteral Nutrition

Specific Coding and Pricing Issues

Therapeutic shoes and insert fee schedule amounts were implemented as part of the January 2005 Fee Schedule Update as described in Change Request 3574 (Transmittal

369) which may be reviewed at http://www.cms.gov/transmittals/Downloads/R369CP.pdf on the CMS website. The payment amounts for shoe modification codes A5503 through A5507 were established in a manner that prevented a net increase in expenditures when substituting these items for therapeutic shoe insert codes (A5512 or A5513). The fees for codes A5512 and A5513 were weighted based on the approximate total allowed services for each code for items furnished during the second quarter of calendar year 2004.

As part of this update, CMS is revising the weighted average insert fees used to establish the fee schedule amounts for the shoe modification codes with more current allowed service data for each insert code as follows:

- Fees for A5512 and A5513 will be weighted based on the approximate total allowed services for each code for items furnished during the Calendar Year 2009;
- The fee schedules for codes A5503 through A5507 are being revised effective January 1, 2011, to reflect this change.

Power-Driven Wheelchairs
In accordance with Section 3136(a)(1) of The Affordable Care Act of 2010, effective for claims with dates of service on or after January 1, 2011, payment for power-driven wheelchairs under the DMEPOS fee schedule for power-driven wheelchairs furnished on or after January 1, 2011, is revised to pay 15 percent (instead of 10 percent) of the purchase price for the first three months under the monthly rental method and 6 percent (instead of 7.5 percent) for each of the remaining rental months 4 through 13. The purchase fee schedule amount for complex rehabilitation power wheelchairs is equal to the rental fee (for months 1-3) divided by 0.15. The current HCPCS codes identifying power-driven wheelchairs are listed in Attachment B of CR 7248. This attachment identifies those codes where payment, when applicable, should be made at 15 percent of the purchase price for months 1 through 3 and 6 percent of the purchase price for months 4 through13.

These changes do not apply to rented power-driven wheelchairs for which the date of service for the initial rental month is prior to January 1, 2011. For these items, payment for rental claims with dates of service on or after January 1, 2011, will continue to be based on 10 percent of the purchase price for rental months 2 and 3 and 7.5 percent of the purchase price for rental months 4 through 13.

Also, Section 3136(c)(2) of The Affordable Care Act specifies that these changes do not apply to power-driven wheelchairs furnished pursuant to contracts entered into prior to January 1, 2011, as part of Round 1 of the Medicare DMEPOS Competitive Bidding Program. MLN Matters® article MM7181 at http://www.cms.gov/MLNMattersArticles/downloads/MM7181.pdf discusses these changes.

For power-driven wheelchairs furnished on a rental basis with dates of service prior to January 1, 2006, for which the beneficiary did not elect the purchase option in month 10 and continues to use, contractors shall continue to pay the maintenance and servicing payment amount at 10% of the purchase price. In these instances, suppliers should continue to use the following HCPCS codes, with the MS modifier, for billing maintenance and servicing, as appropriate:

- K0010 Standard- Weight Frame Motorized/Power Wheelchair
- K0011 Standard- Weight Frame Motorized/Power Wheelchair with Programmable Control Parameters for Speed Adjustment, Tremor Dampening, Acceleration Control and Braking
- K0012 Lightweight Portable Motorized/Power Wheelchair
- K0014 Other Motorized/Power Wheelchair Base

The rental fee schedule payment amounts for codes K0010, K0011 and K0012 will continue to reflect 10 percent of the wheelchair's purchase price.

CY 2011 Fee Schedule Update Factor
The DMEPOS fee schedule amounts are to be updated for 2011 by the percentage increase in the Consumer Price Index (CPI) for all urban consumers (United States city average) or CPI-U for the 12-month period ending with June of 2010. Also beginning with CY 2011, Section 3401 of The Affordable Care Act requires that the increase in the CPI-U be adjusted by changes in the economy-wide productivity equal to the 10-year moving average of changes in annual economy-wide private non-farm business Multi-Factor Productivity (MFP). The amendment specifies the application of the MFP may result in an update "being less than 0.0 for a year, and may result in payment rates being less than such payment rates for the preceding year". For CY 2011, the MFP adjustment is 1.2 percent and the CPI-U percentage increase is 1.1 percent. Therefore, the 1.1 percent increase in the CPI-U is reduced by the 1.2 percent increase in the MFP, resulting in a net reduction of 0.1 percent for the MFP-adjusted update factor. In other words, the MFP-adjusted update factor of -0.1 percent is applied to the applicable CY 2010 DMEPOS fee schedule amounts.

2011 National Monthly Payment Amounts for Stationary Oxygen Equipment
CMS will also implement the 2011 national monthly payment rates for stationary oxygen equipment (HCPCS codes E0424, E0439, E1390 and E1391), effective for claims with dates of service on or after January 1, 2011. The fee schedule file is being revised to include the new national 2011 monthly payment rate of $173.31 for stationary oxygen equipment. The payment rates are being adjusted on an annual basis, as necessary, to ensure budget neutrality of the addition of the new Oxygen Generating Portable Equipment (OGPE) class. The revised 2011 monthly payment rate of $173.31 includes the -0.1 percent MFP-adjusted update factor. The budget neutrality adjustment and the MFP-adjusted covered item update factor for 2011 caused the 2010 rate to change from $173.17 to $173.31.

When updating the stationary oxygen equipment fees, corresponding updates are made to the fee schedule amounts for HCPCS codes E1405 and E1406 for oxygen and water

vapor enriching systems. Since 1989, the fees for codes E1405 and E1406 have been established based on a combination of the Medicare payment amounts for stationary oxygen equipment and nebulizer codes E0585 and E0570, respectively.

2011 Maintenance and Service Payment Amount for Certain Oxygen Equipment
Payment for maintenance and servicing of certain oxygen equipment can occur every 6 months beginning 6 months after the end of the 36th month of continuous use or end of the supplier's or manufacturer's warranty, whichever is later for either HCPCS code E1390, E1391, E0433 or K0738, billed with the "MS" modifier. Payment cannot occur more than once per beneficiary, regardless of the combination of oxygen concentrator equipment and/or transfilling equipment used by the beneficiary, for any 6-month period.

The 2010 maintenance and servicing fee for certain oxygen equipment was based on 10 percent of the average price of an oxygen concentrator which resulted in a payment of $66 for CY 2010. For CY 2011 and subsequent years, the maintenance and servicing fee is adjusted by the covered item update for DME as set forth in Section 1834(a)(14) of the Social Security Act. The 2010 maintenance and servicing fee is adjusted by the -0.1 percent MFP-adjusted covered item update factor to yield a CY 2011 maintenance and servicing fee of $65.93 for oxygen concentrators and transfilling equipment.

Specific Billing Issues
Effective January 1, 2011, the payment category for code E0575 (Nebulizer, Ultrasonic, Large Volume) is being revised to move the nebulizer from the DME payment category for frequent and substantial servicing to the DME payment category for capped rental items. The first claim received for each beneficiary for this code with a date of service on or after January 1, 2011 will be counted as the first rental month in the cap rental period.

Code A7020 (Interface for Cough Stimulating Device, Includes All Components, Replacement Only) is added to the HCPCS file effective January 1, 2011. Items coded under this code are accessories used with the capped rental Durable Medical Equipment cough stimulating device coded at E0482. Section 110.3, Chapter 15 of the Medicare Benefit Policy Manual at http://www.cms.gov/Manuals/downloads/bp102c15.pdf provides that reimbursement may be made for replacement of essential accessories such as hoses, tubes, mouthpieces for necessary Durable Medical Equipment only if the beneficiary owns or is purchasing the equipment. Therefore, separate payment will not be made for the replacement of accessories described by code A7020 until after the 13-month rental cap has been reached for capped rental code E0482.

The following new codes are being added to the HCPCS file, effective January 1, 2011, to describe replacement accessories for Ventricular Assist Devices (VADs):

- Q0478 (Power Adaptor for Use with Electric or Electric/Pneumatic Ventricular Assist Device, Vehicle Type); and
- Q0479 (Power Module for Use with Electric/Pneumatic Ventricular Assist Device, Replacement Only).

Similar to the other VAD supplies and accessories coded at Q0480 thru Q0496, Q0497 thru Q0502, Q0504 and Q0505, CMS has determined the reasonable useful lifetime for codes Q0478 and Q0479 to be one year. CMS is establishing edits to deny claims before the lifetime of these items has expired. Suppliers and providers will need to add HCPCS modifier RA to claims for codes Q0478 and Q0479 in cases where the battery is being replaced because it was lost, stolen, or irreparably damaged.

Additionally, code Q0489 (Power Pack Base for Use With Electric/Pneumatic Ventricular Assist Device, Replacement Only) should not be used to bill separately for a VAD replacement power module or a battery charger in instances where the power module and battery charger are not integral and are furnished as separate components.

Additional Information
The official instruction, CR7248, issued to your carrier, FI, RHHI, A/B MAC, and DME/MAC regarding this change may be viewed at http://www.cms.gov/Transmittals/downloads/R2142CP.pdf on the CMS website.

Emergency Update to CY 2011 Medicare Physician Fee Schedule Database

MLN Matters® Number: MM7300
Related Change Request (CR) #:7300
Related CR Release Date: December 29, 2010
Related CR Transmittal #: R828OTN
Effective Date: January 1, 2011
Implementation Date: January 3, 2011

Provider Types Affected
This article is for physicians and providers submitting claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), Durable Medical Equipment Medicare Administrative Contractors (DME/MACs) and/or Part A/B Medicare Administrative Contractors (A/B MACs)) for professional services provided to Medicare beneficiaries that are paid under the Medicare Physician Fee Schedule (MPFS).

Provider Action Needed
This article is based on Change Request (CR) 7300, which amends payment files that were issued to Medicare contractors based on the 2011 MPFS Final Rule. This CR also reinstates three Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) HCPCS L-codes, as described below. Be sure your billing staff is aware of these changes.

Background
Payment files were issued based upon the Calendar Year (CY) 2011 MPFS Final Rule, issued on November 2, 2010, and published in the "Federal Register" on November 29, 2010. CR 7300 amends those payment files to include MPFS policy and payment indicator revisions described in the CY 2011 MPFS Final Rule Correction Notice, issued in December 30, 2010, (http://www.ofr.gov/(X(1)S(zj23h5e5vs3xn5y2yjsecx03))/inspection.aspx?AspxAutoDetectCookieSupport=1) to be published in the "Federal Register" on January 11, 2011, as well as relevant statutory changes applicable January 1, 2011. Therefore, new MPFS payment files have been created and are available. CR 7300 also reinstates three DMEPOS Healthcare Common Procedure Coding System (HCPCS) L-codes. Following is a summary of the changes as they impact providers:

Medicare Physician Fee Schedule Revisions and Updates
Some physician work, Practice Expense (PE) and Malpractice (MP) Relative Value Units (RVUs) published in the CY 2011 MPFS Final Rule have been revised to align their values with the CY 2011 MPFS Final Rule policies. These changes are discussed in the CY 2011 MPFS Final Rule Correction Notice and revised RVU values will be found in Addendum B and Addendum C of the CY 2011 MPFS Final Rule Correction Notice. In addition to RVU revisions, changes have been made to some HCPCS code payment indicators in order to reflect the appropriate payment policy. Procedure status indicator changes will also be reflected in Addendum B and Addendum C of the CY 2011 MPFS Final Rule Correction Notice. Other payment indicator changes will be included, along with the RVU and procedure status indicator changes, in the CY 2011 MPFS Final Rule Correction Notice public use data files located at http://www.cms.gov/PhysicianFeeSched/PFSRVF/list.asp on the Centers for Medicare & Medicaid Services (CMS) website. Changes to the physician work RVUs and payment indicators can be found in the Attachment to CR 7300, which is available at http://www.cms.gov/Transmittals/downloads/R828OTN.pdf on the CMS website.

Due to these revisions, the conversion factor (CF) associated with the CY 2011 MPFS Final Rule has been revised. This CF will be published in the CY 2011 MPFS Final Rule Correction Notice. Legislative changes subsequent to issuance of the CY 2011 MPFS Final Rule have led to the further revision of the values published in the CY 2011 MPFS Final Rule Correction Notice, including a change to the conversion factor. As such, the MPFS database (MPFSDB) has been revised to include MPFS policy and payment indicator revisions described above, as well as relevant statutory changes applicable January 1, 2011. A new MPFSDB reflecting payment policy as of January 1, 2011, has been created and made available.

A summary of the recent statutory provisions included in the revised MPFS payment files is as follows.

1. **Physician Payment and Therapy Relief Act of 2010**

On November 30, 2010, President Obama signed into law the Physician Payment and Therapy Relief Act of 2010. As a result of the Physician Payment and Therapy Relief Act of 2010 a new reduced therapy fee schedule amount (20 percent reduction on the PE component of payment) will be added to the MPFS payment file. Per this Act, CMS will apply the CY 2011 MPFS Final Rule policy of a 25 percent Multiple Procedure Payment Reduction (MPPR) on the PE component of payment for therapy services furnished in the hospital outpatient department and other facility settings that are paid under Section 1834(k) of the Social Security Act, and a 20 percent therapy MPPR will apply to therapy services furnished in clinicians' offices and other settings that are paid under section 1848 of the Social Secrutiy Act. This change is detailed in recently released CR7050. CMS published MLN Matters® article 7050, related to CR 7050, which may be reviewed at http://www.cms.gov/MLNMattersArticles/downloads/MM7050.pdf on the CMS website. This Act also made the therapy MPPR not budget neutral under the Physician Fee Schedule (PFS) and, therefore, the redistribution to the PE RVUs for other services that would otherwise have occurred will not take place. The revised RVUs, in accordance with this new statutory requirement, are included in the revised CY 2011 MPFS payment files.

2. **Medicare and Medicaid Extenders Act (MMEA) of 2010**

On December 15, 2010, President Obama signed into law the Medicare and Medicaid Extenders Act (MMEA) of 2010. This new legislation contains a number of Medicare provisions which change or extend current Medicare Fee-For-Service program policies. A summary of MPFS-related provisions follows.

- **Physician Payment Update**

Section 101 of the MMEA averts the negative update that would otherwise have taken effect on January 1, 2011, in accordance with the CY 2011 MPFS Final Rule. The MMEA provides for a zero percent update to the MPFS for claims with dates of service January 1, 2011, through December 31, 2011. While the MPFS update will be zero percent, other changes to the RVUs (e.g., miss valued code initiative and rescaling of the RVUs to match the revised Medicare Economic Index weights) are budget neutral. To make those changes budget neutral, CMS must make an adjustment to the conversion factor so the conversion factor will not be unchanged in CY 2011 from CY 2010. The revised conversion factor to be used for physician payment as of January 1, 2011, is $33.9764.

The calculation of the CY 2011 conversion factor is illustrated in the following table.

December 2010 Conversion Factor		$36.8729
MMEA "Zero Percent Update"	0.0 percent (1.000)	
CY 2011 RVU Budget Neutrality Adjustment	0.4 percent (1.0043)	
CY 2011 Rescaling to Match MEI Weights Budget Neutrality Adjustment	-8.3 percent (0.9175)	
CY 2011 Conversion Factor		$33.9764

The revised CY 2011 MPFS payment files will reflect this conversion factor.

- **Extension of Medicare Physician Work Geographic Adjustment Floor**

Current law requires the payment rates under the MPFS to be adjusted geographically for three factors to reflect differences in the cost of provider resources needed to furnish MPFS services: physician work, practice expense, and malpractice expense. Section 3102 of the Affordable Care Act extended the 1.0 floor on the physician work Geographic Practice Cost Index (GPCI) for services furnished though December 31, 2010. Section 103 of the MMEA extends the existing 1.0 floor on the physician work GPCI for services furnished through December 31, 2011. Updated CY 2011 GPCIs can also be found in the attachment to CR 7300 as noted previously.

- **Extension of MPFS Mental Health Add-On**

Section 138 of the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 increased the Medicare payment amount for specific "Psychiatry" services by 5 percent, effective for dates of service July 1, 2008, through December 31, 2009. Section 3107 of the Affordable Care Act extended this provision retroactive to January 1, 2010, through December 31, 2010. Section 107 of the Medicare & Medicaid Extenders Act (MMEA) extends the five percent increase in payments for these mental health services, through December 31, 2011. This five percent increase will be reflected in the revised CY 2011 MPFS payment files. A list of Psychiatry HCPCS codes that represent the specified services subject to this payment policy can also be found in the attachment to CR 7300.

- **Extension of Exceptions Process for Medicare Therapy Caps**

Under the Temporary Extension Act of 2010, the outpatient therapy caps exception process expired for therapy services on April 1, 2010. Section 3103 of the Affordable Care Act continued the exceptions process through December 31, 2010. Section 104 of the MMEA extends the exceptions process for outpatient therapy caps through December 31, 2011. **Outpatient therapy service providers may continue to submit claims with the KX modifier, when an exception is appropriate**, for services furnished on or after January 1, 2011, through December 31, 2011.

The therapy caps are determined on a calendar year basis, so all patients begin a new cap year on January 1, 2011. For physical therapy and speech language pathology services combined, the limit on incurred expenses is $1,870. For occupational therapy services, the limit is $1,870. Deductible and coinsurance amounts applied to therapy services count toward the amount accrued before a cap is reached.

- **Extension of Moratorium That Allowed Independent Laboratories to Bill for the Technical Component (TC) of Physician Pathology Services Furnished to Hospital Patients**

Under previous law, a statutory moratorium allowed independent laboratories to bill a carrier or a MAC for the TC of physician pathology services furnished to hospital patients. This moratorium expired on December 31, 2009. Section 3104 of the Affordable Care Act extended the payment to independent laboratories for the TC of certain physician pathology services furnished to hospital patients retroactive to January 1, 2010, through December 31, 2010. The MMEA restores the moratorium through CY 2011. Therefore, independent laboratories may continue to submit claims to Medicare for the TC of physician pathology services furnished to patients of a hospital, regardless of the beneficiary's hospitalization status (inpatient or outpatient) on the date that the service was performed. This policy is effective for claims with dates of service on or after January 1, 2011, through December 31, 2011.

Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Updates

The following HCPCS codes will not be discontinued as of December 31, 2010:

- L3660 SHOULDER ORTHOSIS, FIGURE OF EIGHT DESIGN ABDUCTION RESTRAINER, CANVAS AND WEBBING, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT (SD: Abduct restrainer canvas &web);
- L3670 SHOULDER ORTHOSIS, ACROMIO/ CLAVICULAR (CANVAS AND WEBBING TYPE), PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT (SD: Acromio/clavicular canvas & web); and
- L3675 SHOULDER ORTHOSIS, VEST TYPE ABDUCTION RESTRAINER, CANVAS WEBBING TYPE OR EQUAL, and PREFABRICATED INCLUDES FITTING AND ADJUSTMENT (SD: Canvas vest SO).

PRICING/REIMBURSEMENT CONT'D

These three "L" codes will continue to stay active codes for January 1, 2011. Instruction for billing and payment will remain the same for these three "L" codes. Medicare contractors will pay for codes L3660, L3670, and L3675 with dates of service on or after January 1, 2011, using the following 2011 DMEPOS fee schedule amounts:

	JURIS	CATG	L3660	L3670	L3675
AL	D	PO	$85.06	$118.57	$145.25
AR	D	PO	$85.06	$97.17	$145.24
AZ	D	PO	$100.69	$124.79	$141.00
CA	D	PO	$100.69	$124.79	$141.00
CO	D	PO	$111.02	$93.60	$146.04
CT	D	PO	$113.42	$93.60	$141.00
DC	D	PO	$85.06	$112.42	$141.00
DE	D	PO	$85.06	$112.42	$141.00
FL	D	PO	$85.06	$118.57	$145.25
GA	D	PO	$85.06	$118.57	$145.25
IA	D	PO	$106.53	$124.79	$143.74
ID	D	PO	$85.06	$97.28	$141.00
IL	D	PO	$85.06	$93.60	$144.48
IN	D	PO	$85.06	$93.60	$144.48
KS	D	PO	$106.53	$124.79	$143.74
KY	D	PO	$85.06	$118.57	$145.25
LA	D	PO	$85.06	$97.17	$145.24
MA	D	PO	$113.42	$93.60	$141.00
MD	D	PO	$85.06	$112.42	$141.00
ME	D	PO	$113.42	$93.60	$141.00
MI	D	PO	$85.06	$93.60	$144.48
MN	D	PO	$85.06	$93.60	$144.48
MO	D	PO	$106.53	$124.79	$143.74
MS	D	PO	$85.06	$118.57	$145.25
MT	D	PO	$111.02	$93.60	$146.04
NC	D	PO	$85.06	$118.57	$145.25
ND	D	PO	$111.02	$93.60	$146.04
NE	D	PO	$106.53	$124.79	$143.74
NH	D	PO	$113.42	$93.60	$141.00
NJ	D	PO	$87.06	$110.96	$141.00
NM	D	PO	$85.06	$97.17	$145.24
NV	D	PO	$100.69	$124.79	$141.00
NY	D	PO	$87.06	$110.96	$141.00
OH	D	PO	$85.06	$93.60	$144.48
OK	D	PO	$85.06	$97.17	$145.24
OR	D	PO	$85.06	$97.28	$141.00
PA	D	PO	$85.06	$112.42	$141.00
RI	D	PO	$113.42	$93.60	$141.00
SC	D	PO	$85.06	$118.57	$145.25
SD	D	PO	$111.02	$93.60	$146.04
TN	D	PO	$85.06	$118.57	$145.25
TX	D	PO	$85.06	$97.17	$145.24
UT	D	PO	$111.02	$93.60	$146.04
VA	D	PO	$85.06	$112.42	$141.00
VT	D	PO	$113.42	$93.60	$141.00
WA	D	PO	$85.06	$97.28	$141.00
WI	D	PO	$85.06	$93.60	$144.48
WV	D	PO	$85.06	$112.42	$141.00
WY	D	PO	$111.02	$93.60	$146.04
AK	D	PO	$100.22	$148.35	$141.00
HI	D	PO	$107.12	$158.62	$141.00
PR	D	PO	$82.83	$105.08	$169.21
VI	D	PO	$87.06	$110.96	$169.21

In accordance with the statutory Section 1834(a)(14) of the Social Security Act, the above fee schedule amounts were updated for CY 2011 by applying the CY 2011 -0.1 percent update factor to the CY 2010 fee schedule amounts. The CY 2011 payment amounts for codes L3660, L3670, and L3675 will be posted as a public use file at: http://www.cms.gov/DMEPOSFeeSched/LSDMEPOSFEE/list.asp on the CMS website.

Additional Information

The official instruction, CR7300, issued to your carrier, FI, RHHI, DME MAC, and A/B MAC regarding this change may be viewed at http://www.cms.gov/Transmittals/downloads/R828OTN.pdf on the CMS website.

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-02 Medicare Benefit Policy	Centers for Medicare & Medicaid Services (CMS)
Transmittal 136	Date: JANUARY 28, 2011
	Change Request 7312

SUBJECT: Clarification of Existing Policy Regarding Items and Services Included Under the End Stage Renal Disease (ESRD) Composite Payment Rate

I. SUMMARY OF CHANGES: This change request provides clarification to the existing policy regarding items and services included under the End Stage Renal Disease composite rate located in Pub. 100-02, Medicare Benefit Policy Manual, chapter 11, section 30.

EFFECTIVE DATE: January 1, 2011
IMPLEMENTATION DATE: February 25, 2011

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

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

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	11/30/Composite Rate for Outpatient Maintenance Dialysis

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

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

IV. ATTACHMENTS:

Business Requirements
Manual Instruction
Unless otherwise specified, the effective date is the date of service.

Attachment - Business Requirements

Pub. 100-02	Transmittal: 136	Date: January 28, 2011	Change Request: 7312

SUBJECT: Clarification of Existing Policy Regarding Items and Services Included Under the End Stage Renal Disease (ESRD) Composite Payment Rate

Effective Date: January 1, 2011

Implementation Date: February 25, 2011

I. GENERAL INFORMATION

A. Background: CMS has received numerous inquiries about whether or not certain types of protective catheter coverings are considered to be an ESRD-related service and, as such, included under the ESRD composite rate. In response to these questions, this change request provides clarification to the existing policy regarding items and services included under the ESRD composite rate for dialysis patients, located in Pub 100-02, Medicare Benefit Policy Manual, chapter 11, section 30. As dressings or protective catheter coverings may be used to protect the dialysis access site, these supplies are considered ESRD-related and are included in the ESRD composite rate for all dialysis patients regardless of the method of dialysis, or where they receive dialysis treatment, and, therefore are not separately billable. All dressings and protective catheter coverings are also included in the ESRD Prospective Payment System (PPS) bundled payment amount, effective January 1, 2011.

B. Policy: ESRD facilities and Monthly Capitated Payment (MCP) physicians and practitioners may determine that it is medically required for a dialysis patient to use dressings or protective access coverings, including catheter coverings, on their access site. All medically required dressings or protective access coverings used during or after dialysis to protect a dialysis patient's access site, including for example, coverings used for day-to-day activities such as bathing, are considered to be ESRD-related items. To the extent that dressings and protective access coverings, including catheter coverings, are determined to be medically required, an ESRD facility can provide them. Medicare payment for ESRD-related items and services are included in the ESRD composite payment rate, and are therefore included in the ESRD PPS, for all dialysis patients regardless of the method of dialysis or where they receive dialysis treatments.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7312.1	Medicare contractors shall ensure that their policies acknowledge that all dressings and/or protective access coverings are included in the ESRD composite rate and ESRD PPS bundled base rate and therefore are not separately payable.	X	X	X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7312.2	Contractors shall post this entire instruction, or a direct link to this instruction, on their Web site and include information about it in a listserv message within 1 week of the release of this instruction. In addition, the entire instruction must be included in your next regularly scheduled bulletin. Contractors are free to supplement it with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X	X	X							

IV. SUPPORTING INFORMATION

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

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

Pre-Implementation Contact(s): DME suppliers: Susan.Webster@cms.hhs.gov or (410) 786-3384. ESRD facility claim inquires: Wendy.Tucker@cms.hhs.gov or (410) 786-3004. ESRD payment policy: Michelle.Cruse@cms.hhs.gov or (410) 786-7540.

Post-Implementation Contact(s): Contact your Contracting Officer's Technical Representative (COTR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers*:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: *For Medicare Administrative Contractors (MACs)*, include the following statement:

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

30 - Composite Rate for Outpatient Maintenance Dialysis

(Rev. 136, Issued: 01-28-11, Effective: 01-01-11, Implementation: 02-25-11)

The composite payment rate system is a prospective system for the payment of outpatient maintenance dialysis services furnished to Medicare beneficiaries. All maintenance dialysis treatments furnished to Medicare beneficiaries in an approved ESRD facility are covered by this system. Further, the composite rate system is one of two methods by which Medicare pays for maintenance dialysis performed in a beneficiary's home. (For a description of the other method, see §50)

The facility's composite payment rate is a comprehensive payment for all modes of infacility and Method I home dialysis. Most items and services related to the treatment of the patient's end-stage renal disease are covered under the composite rate payment. The cost of an item or service is included under the composite rate unless specifically excluded. Therefore, the determination as to whether an item or service is covered under the composite rate payment does not depend on the frequency that dialysis patients require the item or service or the number of patients who require it. The composite rate is payment for the complete dialysis treatment except for physicians' professional services, separately billable laboratory services, and separately billable drugs. This payment is subject to the normal Part B deductible and coinsurance requirements.

Under the composite rate, a dialysis facility must furnish all of the necessary dialysis services, equipment, and supplies. If it fails to furnish (either directly under arrangement or under an agreement with another approved ESRD facility) any part of the items and services covered under the rate, then the facility cannot be paid any amount for the part of the items and services that the facility does furnish.

A certified hospital-based outpatient dialysis facility that is not the patient's usual facility can provide and must bill Medicare directly for routine maintenance services. The certified hospital-based dialysis facility cannot bill the patient's usual facility for payment and have the patient's usual facility bill Medicare.

Other ESRD Items and Services

Items and services included under the composite rate must be furnished by the facility, either directly or under arrangements to all of its dialysis patients. Examples of such items and services are:

- Bicarbonate dialysate;
- Cardiac monitoring;
- Catheter changes (Ideal Loop);
- Suture removal;

- Dressing changes *(all dressings or protective access coverings, including catheter coverings, used to conceal a dialysis patient's access site, for any purpose, including allowing dialysis patients to bathe or shower as well as perform other day-to-day activities, are included in the composite rate)*;
- Crash cart usage for cardiac arrest;
- Declotting of shunt performed by facility staff in the dialysis unit;
- All oxygen and its administration furnished in the dialysis unit;
- Staff time to administer blood;
- Staff time used to administer separately billable parenteral items; and
- Staff time used to collect specimens for all laboratory tests.

Sometimes outpatient dialysis related services (e.g., declotting of shunts, suture removal, injecting separately billable ESRD related drugs) are furnished in a department of the hospital other than the dialysis unit (e.g., the emergency room (ER)). These services may be paid in addition to the composite payment rate only if the services could not be furnished in a dialysis facility or the dialysis unit of the hospital, due to the absence of specialized equipment or staff found only in the other department. In the case of emergency services furnished in the hospital ER, the services are paid separately subject to the additional requirement that there is a sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention in the ER could reasonably be expected to result in either:

- Placing the patient's health in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Since the above noted situations rarely occur, they require clinical documentation to validate they were met; otherwise, they would be denied services.

RECOVERY AUDIT CONTRACTOR

PAP and RAD – Excessive Units Billed Causing Overpayments – RAC Identified Issues

In the Positive Airway Assist (PAP) and Respiratory Assist Devices (RAD) Local Coverage Determinations (LCDs), there is a common table that represents the usual maximum amount of accessories expected to be medically necessary. Quantities of supplies greater than those described in the policy as the usual maximum amounts will be denied as not medically necessary. This article is a result of findings from the Recovery Audit Contractor (RAC), HealthDataInsights, as published as "New Issues Approved by CMS."

Resources pertaining to this RAC identified issue:

- RAC "New Issues Approved by CMS": https://racinfo.healthdatainsights.com/Public1/NewIssues.aspx
- NAS' published RAC information: https://www.noridianmedicare.com/dme/claims/recoupment/rac.html
- PAP resources and publications including links to the PAP LCD, Policy Article, documentation checklists, frequently asked questions, and previously published articles: https://www.noridianmedicare.com/dme/news/pap_devices.html
- RAD LCD: https://www.noridianmedicare.com/dme/coverage/docs/lcds/current_lcds/respiratory_assist_devices.htm
- RAD Policy Article: https://www.noridianmedicare.com/dme/coverage/docs/lcds/current_articles/respiratory_assist_devices.htm

Suppliers should stay attuned to atypical utilization patterns of their clients. A beneficiary or their caregiver must specifically request refills of PAP accessories before they are dispensed. The supplier must not automatically dispense a quantity of supplies on a predetermined regular basis, even if the beneficiary has "authorized" this in advance.

REMITTANCE ADVICES

Timely Filing Claim Denials – CO-29

Claims for services furnished on or after January 1, 2010, must be filed within one calendar year after the date of service. The following codes are displayed on the remittance advice when items have been denied for untimely filing:

- Remark Code - N211 – You may not appeal this decision.
- Reason Code 29 – The time limit for filing has expired.
- Group Code – Contractual Obligation (CO)

For more information on timely filing guidelines, see Important Information on Timely Claims Filing Requirement.

CO-107: Accessories Denied Due to No Qualifying Equipment

When a claim is submitted and the related service is not identified on the claim, the claim may be denied with the Contractual Obligation (CO) message 107, the related or qualifying claim/service was not identified on this claim.

Examples of these types of denials are below:

Policy	Reason
Enteral and Parenteral Nutrition	Medicare does not pay for pump and supplies if nutrition is not billed within the same month.
Positive Airway Pressure Device (PAP)	Medicare does not pay for supplies or accessories when the main piece of equipment is denied.
Nebulizers	Medicare does not pay for supplies and accessories when the main piece of equipment is denied.

The *Medicare National Coverage Determinations Manual*, Chapter 1, Section 180.2, states:

> If the coverage requirements for enteral or parenteral nutritional therapy are met under the prosthetic device benefit provision, related supplies, equipment and nutrients are also covered under the conditions in the following paragraphs and the Medicare Benefit Policy Manual, Chapter 15, "Covered Medical and Other Health Services," Section120.

Solutions to Common Reopenings and Redeterminations on our website states:

> Supplies and accessories will not be paid if the qualifying equipment, to which these supplies and accessories correspond to, is not paid. Ensure the qualifying equipment is submitted correctly based on the policy, if applicable. If the beneficiary owns the equipment or is getting this from another entity, ensure this documentation is submitted with the initial claim. If this is sent to redeterminations, the proper documentation must be submitted with the request.

Reason Code MA04 – Missing/ Illegible MSP Information

If Medicare is unable to read the Explanation of Benefits (EOB) or if the legend identifying the primary insurance denial codes is not included, NAS is unable to process the claim to coordinate benefits.

Do you know how to avoid these denials with Reason Code MA04?

"Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible."

Below are hints on how to avoid these denials.

Situation	Solution
Beneficiary has a valid, active MSP record on the Common Working File (CWF) and no EOB information was submitted with the claim.	Use the Interactive Voice Response (IVR) system or Endeavor to check MSP status prior to submitting a claim or after receiving a denial with Reason Code MA04. Suppliers should submit the claim to the primary payer first. Suppliers may then submit the claim to Medicare with the primary insurance information. After a denial, suppliers may resubmit the claim with the EOB or fax the MSP Inquiry & Refunds form with a copy of the EOB to 1-888-535-5114 to request consideration for secondary payment on the claim.
Beneficiary has an active MSP record on CWF, but the primary coverage has been terminated or was entered in CWF in error and CWF has not been updated.	Use the IVR or Endeavor to check MSP status. If the beneficiary indicates that the primary coverage is terminated or that the record is incorrect, the supplier or the beneficiary may contact the Coordination of Benefits Contractor (COBC) to correct the record. After the CWF record is corrected, suppliers may submit the claim. After a denial, suppliers may resubmit the claim or fax the MSP Inquiry & Refunds form to 1-888-535-5114 (with a comment that CWF has been updated) to request consideration for primary payment on the claim.
Beneficiary has a valid, active MSP record on CWF but incorrect, invalid, illegible, or unrelated EOB information was submitted with the claim.	Suppliers may either resubmit the claim with the corrected primary insurance information or fax the MSP Inquiry & Refunds form with a legible copy of the EOB to 1-888-535-5114 to request consideration for secondary payment on the claim.

For instructions on completing the MSP Inquiry & Refunds form, see the article titled MSP Inquiry & Refunds Form – Instructions for Completion.

Additional Resources

- Supplier Manual, Chapter 11
- CMS – Medicare Second Payer and You
- MSP Fact Sheet

Overutilization Denial - Reason Code 150, Remark Code N115

This article discusses supplies that are billed for over the policy allowed amount. These items deny with remark code N115 (This decision was based on a Local Coverage Determination) and reason code 150 (Payment denied/ reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, this dosage, or this day's supply.) on the remittance advice. The liability of the claim is dependent on the Advance Beneficiary Notice of Noncoverage (ABN).

To avoid such denials, ensure that you are following Medicare guidelines for usage. Supplies having utilization guidelines in Local Coverage Determinations (LCDs) include, but are not limited to:

- Glucose Monitors - LCD L196
- Home Dialysis Supplies and Equipment - LCD L11487
- Nebulizer Supplies – LCD L11488
- Ostomy Supplies – LCD L11491
- Positive Airway Pressure (PAP) Device Supplies - LCD L171
- Surgical Dressings - LCD L11460
- Urological Supplies - LCD L11581

For example, if the LCD states one unit per month is allowed and the supplier is billing over that amount, a narrative describing the justification of the additional units may reduce denials for overutilization.

For information regarding ABNs, refer to the Jurisdiction D Supplier Manual, Chapter 3.

Instructions for PLB Code Reporting on Remittance Advice, a Crosswalk between HIGLAS PLB Codes and ASC X12 Transaction 835 PLB Codes, and RAC Recoupment Reporting on Remittance Advice for DMEPOS Claims

MLN Matters® Number: MM7068
Related Change Request (CR) #:7068
Related CR Release Date: November 12, 2010
Related CR Transmittal #: R812OTN
Effective Date: April 1, 2011
Implementation Date: April 4, 2011; July 5, 2011 for Institutional providers and DME Suppliers

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 (DME MACs) for Medicare beneficiaries are affected.

Provider Action Needed
Change Request (CR) 7068 provides instructions to Medicare Carriers, MACs, FIs, and RHHIs about using and reporting PLB codes on the Remittance Advice (RA). It also includes instruction for DME MACs for reporting RAC recoupment when there is a time difference between the creation of the Accounts Receivable and actual recoupment of money.

The attachment in CR 7068 provides a list of PLB codes to be reported on the 835 as well as the paper remittance advice and a crosswalk between the HIGLAS PLB codes and the ASC X12 Transaction 835 PLB codes to ensure that PLB code reporting on the RA is consistent and uniform across the board.

Background
In the Tax Relief and Health Care Act of 2006, Congress required a permanent and national Recovery Audit Contractors (RAC) program to be in place by January 1, 2010. The goal of the recovery audit program is to identify improper payments made on claims of health care services provided to Medicare beneficiaries. The RACs review claims on a post-payment basis, and can go back 3 years from the date the claim was paid. To minimize provider burden, the maximum look back date is October 1, 2007.

Section 935 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Publication. L.108-173) which amended Title XVIII of the Social Security Act (the Act) has added a new paragraph (f) to §1893 of the Act, the Medicare Integrity Program. The statute requires Medicare to change how certain overpayments are recouped. These new changes to recoupment and interest are tied to the Medicare fee-for-service claims appeal process and structure.

Recoupment under the provisions of Section 935 of the MMA can begin no earlier than the 41st day (see CR6183 – Transmittal 141, issued September 12, 2008), and can happen only when a valid request for a redetermination has not been received within that period of time.

Under the scenario just described, the RA has to report the actual recoupment in two steps:

Step I: Reversal and Correction to report the new payment and negate the original payment (actual recoupment of money does not happen here)

Step II: Report the actual recoupment.

In a previous CR (Transmittal 659, CR6870), Medicare Carriers, FIs and A/B MACs were instructed to provide enough detail in the RA to enable providers to track and update their records to reconcile Medicare payments. The Front Matter 1.10.2.17 – Claim Overpayment Recovery – in ASC X12N/005010X221 provides a step-by-step process, regarding how to report in the RA when funds are not recouped immediately, and a manual reporting (demand letter) is also done. CR7068 instructs DME MACs how to report on the RA when an overpayment is identified and also when Medicare actually recoups the overpayment in a future RA.

RAC Recoupment Reporting – DME Claims Only

Step I: Claim Level:

The original claim payment is taken back and the new payment is established (Reversal and Correction).

Provider Level:

PLB03-1 – PLB reason code FB (Forward Balance)

PLB 03-2 shows the detail:

PLB-03-2

1-2: 00

3-19: Adjustment CCN#

20-30: HIC#

PLB04 shows the adjustment amount to offset the net adjustment amount shown at the service level. If the service level net adjustment amount is positive, the PLB amount would be negative and vice versa.

Step II: Claim Level:

No additional information at this step

Provider Level:

PLB03-1 – PLB reason code WO (Overpayment Recovery)

PLB 03-2 shows the detail:

PLB-03-2

1-2: 00

3-19: Adjustment CCN#

20-30: HIC#

PLB04 shows the actual amount being recouped

A demand letter is also sent to the provider when the Accounts Receivable (A/R) is created – Step I. This document contains a control number for tracking purpose that is also reported on the RA.

CMS has decided to follow the same reporting protocol for all other recoupments in addition to the 935 RAC recoupment mentioned above.

Note: CR 7068 instructions, regarding recoupment, apply to both 004010A1 and 005010 versions of ASC X12 Transaction 835 and Standard Paper Remittance (SPR). In some very special cases the HIC # may have to be truncated to be compliant with the 004010A1 Implementation Guide.

PLB Code Reporting
The RA reports payments and adjustments to payments at 3 levels: a) service, b) claim, and c) provider.

The adjustments at the service and the claim level are reported using 3 sets of codes:

- Group Codes,
- Claim Adjustment Reason Codes (CARCs), and
- Remittance Advice Remark Codes (RARCs).

Provider level adjustments are reported using the PLB codes. The PLB code list is an internal code list that can be changed only when there is a change in the version.

REMITTANCE ADVICES CONT'D

In Version 004010A1, the following PLB codes are available for use: 50, 51, 72, 90, AM, AP, B2, B3, BD, BN, C5, CR, CS, CT, CV, CW, DM, E3, FB, FC, GO, IP, IR, IS, J1, L3, L6, LE, LS, OA, OB, PI, PL, RA, RE, SL, TL, WO, WU, AND ZZ. In version 005010, two new codes – AH and HM – have been added, and code ZZ has been deleted. The other change in Version 005010 is the way situational field PLB03-2 for reference identification is used.

Field	Version 00401A1	Version 005010
PLB03-1		AH – additional code HM – additional code ZZ – deleted code
PLB03-2	Max: 30 **Position 1-2:** Medicare intermediaries must enter the applicable Medicare code **Position 3-19:** Financial control number or the provider level adjustment. number or other pertinent identifier **Position 20-30:** Health Insurance Claim (HIC) Number	Max: 50 Required when a control, account or tracking number applies to this adjustment as reported in field PLB03-1 No Medicare specific codes.

HIGLAS uses additional PLB codes from the X12 Standard that are not in the Implementation Guide (IG) or Technical Report (TR) 3. **Medicare must use only those codes that are included in the IG/TR3 to report on the 835.**

HIGLAS PLB Codes and ASC X12 Crosswalk
Currently CMS is transitioning to HIGLAS, and some contractors are still not under HIGLAS. CR 7068 applies to both HIGLAS and Non-HIGLAS contractors with the goal of uniform and consistent reporting on the 835 across the board. Secondly, CMS is also in the process of implementing version 005010/005010A1. Attachment – 835 PLB Code Mapping is applicable to Version 004010A1 as well as 005010A1.

The PLB codes to report on the 835 and HIGLAS and HIPAA PLB Crosswalk may be found in the attachment in CR 7068.

Additional Information
For complete details regarding this Change Request (CR) please see the official instruction (Transmittal 812/CR 7068) issued to your Medicare contractor at http://www.cms.gov/transmittals/downloads/R812OTN.pdf on the CMS website.

You may also want to review the following MLN Matters® articles:

- *Limitation on Recoupment (935) for Provider, Physicians and Suppliers Overpayments* at http://www.cms.gov/MLNMattersArticles/downloads/MM6183.pdf, and
- *Reporting of Recoupment for Overpayment on the Remittance Advice (RA)* at http://www.cms.gov/MLNMattersArticles/downloads/MM6870.pdf on the CMS website.

MREP Enhancement

MLN Matters® Number: MM7218
Related Change Request (CR) #: 7218
Related CR Release Date: November 12, 2010
Related CR Transmittal #: R811OTN
Effective Date: July 1, 2011
Implementation Date: July 5, 2011

Provider Types Affected
This article is for physicians, providers, and suppliers submitting claims to Medicare contractors (carriers and/or Part A/B Medicare Administrative Contractors (MACs)) for services provided to Medicare beneficiaries.

What You Need to Know
The MREP software is made available to Medicare providers who may want to use the software to print their electronic remittance advice records without having to purchase software on their own. The latest enhancement to the MREP software is that, effective July 1, 2011, the software is being modified to be compatible with Microsoft Windows 7 (32 or 64 bit), Vista (32 or 64 bit), and XP (32 or 64 bit) operating systems. If you wanted to use the MREP software, but have not done so because it was not compatible with your computer's operating system, this enhancement may make MREP a viable option for you.

Background
The Centers for Medicare and Medicaid Services (CMS) recently learned that the current version of MREP is not compatible with anything other than Microsoft XP (32 bit) operating system. Change Request (CR) 7218 will make the MREP software compatible with Microsoft Windows 7 (32 or 64 bit), Vista (32 or 64 bit), and XP (32 or 64 bit), operating systems. CMS expects that making the software compatible with multiple operating systems will make it more acceptable to users and providers/suppliers for printing their Electronic Remittance Advice (ERA) records.

Additional Information
The official instruction, CR 7218 issued to your carrier or A/B MAC regarding this change may be viewed at http://www.cms.gov/Transmittals/downloads/R811OTN.pdf on the CMS website.

To learn more about this software, visit http://www.cms.gov/AccesstoDataApplication/02_MedicareRemitEasyPrint.asp on the CMS website.

TIMELY FILING

Important Information on Timely Claims Filing Requirement

The Centers for Medicare & Medicaid Services (CMS) would like to remind Medicare Fee-For-Service physicians, providers and suppliers submitting claims to Medicare for payment, as a result of the Patient Protection and Affordable Care Act (PPACA), effective immediately, all claims for services furnished on or after Jan 1, 2010, must be filed with your Medicare contractor no later than one calendar year (12 months) from the date of service – or Medicare will deny those claims.

TIMELY FILING CONT'D

If you have Medicare Fee-For-Service claims with service dates from October 1, 2009, through December 31, 2009, those claims **MUST** be filed by December 31, 2010, or Medicare will deny those claims. Claims with service dates from January 1, 2009, to October 1, 2009, keep their original December 31, 2010 deadline for filing.

Claims for services that require reporting a line item date of service, the line item date will be used to determine the date of service. For other claims, the claim statement's "From" date is used to determine the date of service.

For additional information about the new maximum period for claims submission filing dates, contact your Medicare contractor, or review the MLN Matters articles listed below related to this subject:

- **MM6960** – "Systems Changes Necessary to Implement the Patient Protection and Affordable Care Act (PPACA) Section 6404 - Maximum Period for Submission of Medicare Claims Reduced to Not More Than 12 Months" – http://www.cms.gov/MLNMattersArticles/downloads/MM6960.pdf on the CMS website.
- **MM7080** – "Timely Claims Filing: Additional Instructions" – http://www.cms.gov/MLNMattersArticles/downloads/MM7080.pdf on the CMS website.

You can also listen to a podcast on this subject by visiting http://www.cms.gov/CMSFeeds/02_listofpodcasts.asp on the CMS website.

Timely Filing Requirements for Medicare Fee-For-Service Claims

Due to the change in the timely filing limits for Medicare fee-for-service claims, if you need a claim receipt date prior to January 1, 2011, you must have your claims submitted to Common Electronic Data Interchange (CEDI) no later than 3 p.m. eastern time (ET) on Thursday, December 30, 2010.

Because Friday, December 31, 2010, is a holiday for CEDI and DME MACs, electronic submitters must know the following:

- Claims submitted to CEDI **before** 3 p.m. ET on December 30, 2010, will receive a date of receipt of December 30, 2010.
- Claims submitted to CEDI **after** 3 p.m. ET on December 30, 2010, and before 5 p.m. (ET) on January 3, 2011, will receive a date of receipt of January 3, 2011.

On March 23, 2010, President Obama signed into law the *Patient Protection and Affordable Care Act* (PPACA), which amended the time period for filing Medicare fee-for-service (FFS) claims as one of many provisions aimed at curbing fraud, waste, and abuse in the Medicare Program.

The time period for filing Medicare FFS claims is specified in Sections 1814(a), 1835(a)(1), and 1842(b)(3) of the Social Security Act and in the Code of Federal Regulations (CFR), 42 CFR Section 424.44. Section 6404 of the PPACA amended the timely filing requirements to reduce the maximum time period for submission of all Medicare FFS claims to one calendar year after the date of service.

As a result of the PPACA, the timely filing limits for submitting claims for Medicare fee-for-service (FFS) reimbursement have changed.

- Claims with dates of service prior to 10/01/2008 are past timely filing for Medicare.
- Claims with dates of service 10/01/2008–12/31/2009 must be submitted to Medicare by 12/31/2010.
- Claims with dates of service 01/01/2010 and after have to be submitted to Medicare within one year after the date of service.

Section 6404 of the PPACA also permits the secretary to make certain exceptions to the one-year filing deadline. At this time, no exceptions have been established. However, proposals for exceptions will be specified in future proposed rulemaking.

Please be on the alert for more information pertaining to the *Patient Protection and Affordable Care Act*.

Changes to Time Limits for Filing Medicare Fee-For-Service Claims

MLN Matters® Number: MM7270
Related Change Request (CR) #: 7270
Related CR Release Date: January 21, 2011
Related CR Transmittal #: R2140CP
Effective Date: January 1, 2010
Implementation Date: February 22, 2011

Provider Types Affected
This article is for all providers and suppliers submitting Part A and/or Part B claims to Medicare contractors (Carriers, Durable Medical Equipment Medicare Administrative Contractors (DME MACs), Fiscal Intermediaries (FIs), A/B Medicare Administrative Contractors (A/B MACs), and/or Regional Home Health Intermediaries (RHHIs)) for services furnished to Medicare beneficiaries.

Provider Action Needed
This article is based on Change Request (CR) 7270, regarding changes to the time limits for filing Medicare Fee-For-Service (FFS) claims.

Section 6404 of the Affordable Care Act reduced the maximum period for submission of all Medicare Fee-For-Service claims to no more than 12 months, or one calendar year, after the date of service. As a result of the passage of this legislation, the Centers for Medicare & Medicaid Services (CMS) is updating the Medicare Claims Processing Manual (Chapter 1) pertaining to the time limits for filing Medicare claims.

CR 7270 also establishes exceptions, if certain conditions are met, to the time limit for filing Medicare claims. (See the Background and Additional Information Sections of this article, for further details regarding these changes.)

TIMELY FILING CONT'D

Background
The Social Security Act (Sections 1814(a)(1), 1835(a)(1), and 1842(b)(3)(B)) as well as the Medicare regulations at 42 CFR §424.44 (see http://edocket.access.gpo.gov/cfr_2009/octqtr/pdf/42cfr424.44.pdf on the Internet), specify the time limits for filing Medicare Fee-For-Service (Part A and Part B) claims.

Prior to the passage of the Affordable Care Act on **March 23, 2010**, a provider or supplier had from 15 to 27 months (depending on the date of service) to file a timely claim.

- For services furnished **in the first 9 months of a calendar year**, claims had to be submitted to the appropriate Medicare contractor by **December 31 of the following year**.
- For services furnished **in the last 3 months of a calendar year**, claims had to be submitted to the appropriate Medicare contractor by **December 31 of the second following year**.

The Affordable Care Act (Section 6404) reduced the maximum period for submission of all Medicare Fee-For-Service claims to no more than 12 months (one calendar year) after the date services were furnished. This time limit policy for claims submission became effective for services furnished on or after January 1, 2010. In addition, claims for services furnished prior to January 1, 2010, had to be submitted no later than December 31, 2010. The Affordable Care Act (Section 6404) also mandated that CMS may specify exceptions to the one calendar year time limit for filing Medicare claims.

CR 7270 instructs that claims for services furnished:

- Prior to January 1, 2010, must be submitted no later than December 31, 2010.
- On or after January 1, 2010, the time limit for filing all Medicare Fee-For-Service claims (Part A and Part B claims) is 12 months, or one calendar year from the date services were furnished.

Exceptions Allowing Extension of Time Limit
Medicare will allow for the following exceptions to the one calendar year time limit for filing Fee-For-Service claims:

- **Administrative Error**: This is where the failure to meet the filing deadline was caused by error or misrepresentation of an employee, the Medicare contractor, or agent of the Department that was performing Medicare functions and acting within the scope of its authority. In these cases, Medicare will extend the timely filing limit through the last day of the sixth month following the month in which the beneficiary, provider, or supplier received notice that an error or misrepresentation was corrected.
- **Retroactive Medicare Entitlement**: This is where a beneficiary receives notification of Medicare entitlement retroactive to or before the date the service was furnished. For example, at the time services were furnished the beneficiary was not entitled to Medicare. However, after the timely filing period has expired, the beneficiary receives notification of Medicare entitlement effective retroactive to or before the date of the furnished service In these cases, Medicare will extend the timely filing limit through the last day of the sixth month following the month in which the beneficiary, provider, or supplier received notification of Medicare entitlement retroactive to or before the date of the furnished service.
- **Retroactive Medicare Entitlement Involving State Medicaid Agencies**: This is where a State Medicaid Agency recoups payment from a provider or supplier six months or more after the date the service was furnished to a dually eligible beneficiary. For example, at the time the service was furnished the beneficiary was only entitled to Medicaid and not to Medicare. Subsequently, the beneficiary receives notification of Medicare entitlement effective retroactive to or before the date of the furnished service. The State Medicaid Agency recoups its money from the provider or supplier and the provider or supplier cannot submit the claim to Medicare, because the timely filing limit has expired. In these cases, Medicare will extend the timely filing limit through the last day of the sixth month following the month in which a State Medicaid Agency recovered Medicaid payment from a provider or supplier.
- **Retroactive Disenrollment from a Medicare Advantage (MA) Plan or Program of All-inclusive Care of the Elderly (PACE) Provider Organization**: This is where a beneficiary was enrolled in an MA plan or PACE provider organization, but later was disenrolled from the MA plan or PACE provider organization retroactive to or before the date the service was furnished, and the MA plan or PACE provider organization recoups its payment from a provider or supplier six months or more after the date the service was furnished. In these cases, Medicare will extend the timely filing limit through the last day of the sixth month following the month in which the MA plan or PACE provider organization recovered its payment from a provider or supplier.

Additional Information
The official instruction, CR 7270, issued to your Carriers, DME MACs, FIs, A/B MACs, and RHHIs regarding this change may be viewed at http://www.cms.gov/transmittals/downloads/R2140CP.pdf on the CMS website. Attached to CR 7270 are the revised Manual instructions, which provide complete details on the timely filing requirements, including the exceptions process.

http://www.cms.gov/transmittals/downloads/R2140CP.pdf

http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip

http://www.cms.gov/MLNProducts/Downloads/Flu_Products.pdfhttp://www.cms.gov/AdultImmunizations

VERSION 5010/ICD-10

HIPAA 5010 & D.0 Implementation Calendar and Important Reminders

During the transition to HIPAA Versions 5010 and D.0, CMS will periodically remind you of important items and dates that may be of specific interest to the Medicare Fee-for-Service (FFS) provider/supplier community. Please see below to learn about current, upcoming, and past events that have taken placed during this implementation process.

VERSION 5010/ICD-10 CONT'D

Important 5010/D.0 Implementation Reminders

1. Announcement - January 1, 2011 marked the beginning of the 501/D.0 transition year!
2. Readiness Assessment - Have you done the following to be ready for 5010/D.0?
3. Readiness Assessment - What do you need to have in place to test with your MAC?
4. Reminder - 5010/D.0 Errata requirements and testing schedule can be found here
5. Reminder - Contact your MAC for their testing schedule

5010/D.0 Implementation Calendar

Current Items:

January 2010

1st Beginning of Transition Year

11th HIMSS 5010 Industry Readiness Update*

19th 5010 National Call – Errata/Companion Guides

25th - 27th 4th WEDI 5010 and ICD-10 Implementation Forums – Advancing Down the Implementation Highway: Moving Forward with Testing to Attain Implementation*

Upcoming Items:

February 2011

20th - 24th HIMSS 11th Annual Conference & Exhibition*

March 2011

30th 5010 National Call – Provider Testing and Readiness

April 2011

TBD MAC Hosted Outreach and Education Session - Are You Ready to Test?

May 2011

2nd - 5th 20th Annual WEDI National Conference*

25th 5010 National Call – Topic TBD

June 2011

TBD National MAC Testing Day (for Vendors, Clearinghouses, and Billing Services, etc)

July 2011

TBD MAC Hosted Outreach and Education Session - Troubleshooting with your MAC

August 2011

31st 5010 National Call – MAC Panel

TBD National MAC Testing Day (For Providers)

October 2011

TBD MAC Hosted Outreach and Education Session (last push for implementation)

24th - 27th WEDI 2011 Fall Conference*

December 2011

31st End of the transition year, and the beginning of 5010 production environment!

Past Items:

June 2010

15th 5010 National Call – ICD-10/5010 National Provider Call

30th 5010 National Call – 837 Institutional Claim Transaction

July 2010

28th 5010 National Call – 276/277 Claim Status Inquiry & Response Transaction Set

August 2010

25th 5010 National Call – 835 Remittance Advice Transaction

September 2010

27th 5010 National Call – Acknowledgement Transactions (TA1, 999, 277CA)

October 2010

13th 5010/D.0 Errata requirements and testing schedule released

27th 5010 National Call – NCPDP Version D.0 Transaction

November 2010

4th Version 5010 Resource Card published

8th WEDI 2010 Fall Conference*

17th 5010 National Call – Coordination of Benefits (COB)

December 2010

8th 5010 National Call – MAC Outreach and Education Activities and Transaction-Specific Testing Protocols

For older National Call information, please visit the 5010 National Calls section of our Versions 5010 & D.0 website.

* Information about events in which CMS Medicare FFS staff participates may be applicable to the healthcare industry at large, though it is geared toward the Medicare FFS audience.

CMS Is Here to Help in Transitions to Version 5010 and ICD-10

Have questions about the Version 5010 and ICD-10 transition? CMS is here to help!

We have resources for providers, vendors, and payers to prepare for the transition. Fact sheets available for educating staff and others about the transition include:

- The ICD-10 Transition: An Introduction
- ICD-10 Basics for Medical Practices

- Talking to Your Vendors About ICD-10 and Version 5010: Tips for Medical Practices
- Talking to Your Customers About ICD-10 and Version 5010: Tips for Software Vendors

Compliance timelines, materials from CMS-sponsored calls and conferences, and links to resources are available at http://www.cms.gov/icd10. Check back often for the latest information and updates.

Keep Up to Date on Version 5010 and ICD-10
Please visit http://www.cms.gov/icd10 for the latest news and to sign up for Version 5010 and ICD-10 e-mail updates!

Version 5010 and ICD-10 are coming. Will you be ready?

Important Testing Information for 5010 and D.0

This article contains important information for our CEDI customers (suppliers, Trading Partners, billing services, clearinghouses and vendors). It is important you read through all of the information provided. All suppliers and Trading Partners must be aware of all aspects of the transition to 5010 and D.0 even if you may not be participating in the testing process.

If you have any questions, please contact the CEDI Help Desk at ngs.cedihelpdesk@wellpoint.com or at 866-311-9184.

Medicare will be implementing the new versions of the X12 and NCPDP formats in order to be compliant with HIPAA.

The X12 transactions are the 837 claims, 835 electronic remittance, 276 claim status request and 277 claim status response and will move to the 5010A1 versions.

For NCPDP, claims transactions will move to the version D.0 Telecommunications Standard.

Transactions Affected by the Errata Version	Base Version	Errata Version
837 Health Care Claim: Professional	005010X222	005010X222A1
835 Health Care Claim Payment/Advice	005010X221	005010X221A1
276/277 Status Inquiry and Response	005010X212	N/A
999 Implementation Acknowledgment For Health Care Insurance	005010X231	005010X231A1
277CA Claim Acknowledgement	005010X214	N/A
National Council for Prescription Drug Programs (NCPDP) Version D.0 of the Telecom Standard	D.0	D.0 April 2009

CEDI has created a page on our web site dedicated to the upcoming transition to the 5010 and D.0 formats. Go to the CEDI web site at http://www.ngscedi.com and select "5010 and D.0 Implementation Information". There is an FAQ as well as links to the CMS 5010 and D.0 web page and to the X12 and NCPDP web sites to purchase the guides.

We are working with CMS to create the Companion Documents for the 5010 and D.0 transactions and will release those as soon as they are completed.

The timeline for implementing 5010 and D.0 is:

- **January 2011** – Vendors and those who do their own programming (also referred to as in-house programmers) may begin testing the base versions of the X12 transactions and NCPDP D.0.
- **April 2011** – Vendors and in-house programmers may begin testing the 5010 Errata or A1 versions of the X12 transactions.
- **April – December 2011** – Once vendors have passed testing of the X12 5010A1 versions and/or the NCPDP D.0, they may begin moving their customers into production.
- **April – December 2011** – Trading Partners will only be able to move into production for the A1 version of 5010 but will be able to test the base version prior to April 2011.
- **April – December 2011** – Once in-house programmers have passed testing of the X12 A1 versions and/or the NCPDP D.0, they may move into production.
- **January 1, 2012 – Only** 5010A1 and D.0 transactions will be allowed.

Only vendors and in-house programmers are required to test the claims transactions. Vendors may choose to test the other transactions including the 276/277 and 835 transactions. Vendors and in-house programmers should already have a test Trading Partner ID setup with CEDI. This ID will start with "V089". If you are a vendor or in-house programmer and you aren't sure if you have a test Trading Partner ID or if you need to request one, please contact the CEDI Help Desk at ngs.cedihelpdesk@wellpoint.com.

Software Vendor Testing

- Ability to support 5010 test and 4010A1 production;
- Test all claim types supported by clients;
- Test MSP claims;
- Test receipt and translation of 999 acknowledgement to text report;
- Test receipt and translation of 277 Claims Acknowledgement to text report
- Compare 835 5010 against production 835 4010A1
- Test 276/277

Production Criteria

- 100% compliant with Level 1 (translator edits)
- 95% compliant with Level II (business/Medicare edits)
- Vendors will work with their CEDI Trading Partner customers to determine when the Trading Partners are ready to move to production

835 Electronic Remittance Advice Testing: If a Trading Partner elects to test the 5010 835 electronic remittance advice, it will be produced from the DME MACs production environment in parallel with the current production 4010A1 ERA.

276/277 Claim Status Request/Response Testing: The 276 transaction can be sent as a test file to produce the CEDI 277 created response showing any front end errors on the 276. However, 276 files sent with a "Test" indicator will not be forwarded to the DME MAC to produce the 277 Claim Status Response. CEDI recommends testing of the 276/277 be done by sending a small 5010 276 file (no more than 5 requests) with a "Production" indicator. If the 5010 276 passes the CEDI front end edits, it will be forwarded to the DME MAC to produce the 277 Response transaction. The production 277 will then be returned for the Trading Partner to review.

As part of the transition to 5010 and D.0, the following reports will be returned:

- TRN will continue to be sent by CEDI for 5010 and D.0 as it is today for 4010A1 and 5.1
- TA1 will be sent by CEDI for 5010 837 and 276 transactions only when requested by sending the indicator to receive the TA1 within the 837 and 276 (ISA14; 0 = No 1 = Yes)
- 999 for X12 5010 837 and 276 transactions
- 277CA for X12 837 transactions
- 277 claim status response for X12 version 5010 276 transactions as it is today for 4010A1
- NCPDP Transmission Response Report for version D.0
- DME MAC Front End Report with accepted claims received and CMN rejections for 5010A1 claims as it is today for X12 4010A1 submissions

The following reports will no longer be sent for 5010 and D.0

- 997 for X12 837 and 276 transactions
- CEDI GenResponse for X12 837 transactions
- CEDI NCPDP Error Report for NCPDP version 5.1 transactions
- CEDI Submission Summary Report NCPDP version 5.1 transactions

Report Format Changes

The 277CA will be replacing the CEDI GenResponse report and is an X12 formatted transaction. It will be necessary for software vendors to support the 277CA for their customers and we are expecting vendors will create a tool to translate the 277CA into a readable format. CEDI will not provide support to Trading Partners in how to read a 277CA.

The current CEDI NCPDP error report will be replaced by the NCPDP Transmission Response Report, and like the 277CA, will need to be translated into a readable format by vendors for their customers.

Source: Common Electronic Data Interchange (CEDI)

2011 Versions of ICD-10-CM Crosswalks Now Available

CMS has posted the 2011 versions of the ICD-10-CM and ICD-10-PCS crosswalks, formally referred to as the General Equivalence Mappings (GEMs), on the ICD-10 website at http://www.cms.gov/ICD10. See the links on this page for 2011 ICD-10-CM and GEMs and 2011 ICD-10-PCS and GEMs.

These updated files complete the requirements of Section 10109(c) of the Affordable Care Act of 2010. The Affordable Care Act required the Secretary of Health and Human Services to task the ICD-9-CM Coordination and Maintenance Committee to convene a meeting before January 1, 2011, to receive stakeholder input regarding the crosswalks between ICD-9-CM and ICD-10 for the purpose of making appropriate revisions to said crosswalks. Section 10109(c) further requires that these revisions to the crosswalks be posted to the CMS website, and treated as a code set for which the Secretary has adopted a standard.

In addition, CMS also has posted a document, ICD-10 GEMs 2011 Version Update, Update Summary. This document describes the number of comments we received, the type of changes recommended, the types of changes made based on the comments, and the types of comments not accepted and reasons why some comments were not accepted.

Written Transcript and Audio Recording for "Preparing for ICD-10 Implementation in 2011" January Teleconference

The Centers for Medicare & Medicaid Services (CMS) hosted a national provider teleconference on "Preparing for ICD-10 Implementation in 2011" on January 12, 2011. The written transcript and audio recording are now available at http://www.cms.gov/ICD10/Tel10/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS1242831&intNumPerPage=10. To access these file, scroll down the web page to the "Downloads" section and select the appropriate file.

Revision Request for ASC X12 005010 TR3

On January 1, 2012, all HIPAA1 covered entities are required to use the adopted ASC X12 Version 5010 (Version 5010) standard for electronic health care transactions, known as the ASC X12 Type 3 Technical Reports (TR3) or implementation guides.

Even though Version 5010 has not yet been implemented, the work of the standards organization is ongoing. At this time, ASC X12 is giving stakeholders an opportunity to review and comment on the Version 5010 implementation guide so that modifications can be made for the next version - 6020. Stakeholder input and consensus is critical, to ensure that the standards meet the needs of all who use them, and to

increase the use of electronic commerce in health care. We encourage all interested parties and stakeholders to submit recommendations for improvements to X12.

Revision requests and recommendations should be submitted through the Designated Standard Maintenance Organization (DSMO) website, http://www.hipaa-dsmo.org. **The deadline to submit revision requests for the ASC X12 005010 TR3 is February 4, 2011**. It is imperative to have all comments submitted by this deadline for them to be considered in the development of Version 6020. Please share this notification with others in your own association or network as soon as possible.

While we encourage stakeholders to respond to X12's request and participate in the standards process to the fullest extent feasible, this notification is **not an indication of our intent to adopt Version 6020 at this time**. New versions of standards must complete the Standard Development Organization' (SDO) balloting processing, be considered and recommended by the National Committee on Vital and Health Statistics (NCVHS), and then adopted through the notice and public comment rulemaking process before they can be adopted as HIPAA standards.

For more information, please visit:

- http://www.x12.org/TR3ChangeRequest
- http://www.hipaa-dsmo.org

Implementation of PWK Segment for X12N Version 5010

MLN Matters® Number: MM7041 Revised
Related Change Request (CR) #: 7041
Related CR Release Date: November 10, 2010
Related CR Transmittal #: R806OTN
Effective Date for Providers: July 1, 2011
Implementation Date: July 5, 2011

Note: This article was revised on November 12, 2010, to reflect a revised CR 7041 issued on November 10, 2010. The effective and implementation dates have been changed. In addition, the CR transmittal number, release date, and the Web address for accessing CR 7041 were 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, and fiscal intermediaries (FIs) including regional home health intermediaries).

Provider Action Needed
This article is based on Change Request (CR) 7041 which announces the implementation of the PWK (paperwork) segment for X12N Version 5010. Be sure your billing staff is aware of these changes.

Background
Since 2003, the Centers for Medicare & Medicaid Services (CMS) has believed that a complete Health Insurance Portability & Accountability Act of 1996 (HIPAA) implementation involves implementing the PWK (paperwork) segment. The PWK is a segment within the 837 Professional and Institutional electronic transactions. The PWK segment provides the "linkage" between electronic claims and additional documentation which is needed for claims adjudication. Although the PWK segment allows for an electronic submission of the additional documentation, this preliminary implementation will only allow for submission of additional documentation via mail and fax.

The implementation of a dedicated PWK process, involving OCR/imaging technology, allows providers to continue using cost effective electronic data interchange (EDI) technology as well as providing cost savings for the Medicare program. Medicare contractors will be responsible for imaging, storage, and retrieval of the additional documentation for their claims examiners. Having the documentation available to claims examiners eliminates the need for costly automated development.

Key Points for Medicare Billers

- Your Medicare contractor will implement the appropriate PWK fax/mail cover sheet for their line of business which must be used by trading partners when mailing or faxing additional documentation which is indicated in the PWK segment. Sample versions of the fax/mail cover sheets are attached to CR 7041, which is available at http://www.cms.gov/Transmittals/downloads/R763OTN.pdf on the CMS website.
- Your Medicare contractor will provide the cover sheet to their trading partners via hardcopy and/or electronic download.
- Submitters must send the additional documentation AFTER the claim has been electronically submitted with the PWK segment.
- Submitters will need to accurately and completely record data on the fax/mail cover sheet that relates the faxed/mailed data to the PWK Loop on the claim.
- Medicare contractors will manually return PWK data submissions (cover sheet and attached data) which are incomplete or incorrectly filled out.
- Medicare contractors will allow seven calendar "waiting" days (from the date of receipt) for additional information to be faxed or ten calendar "waiting" days for additional information to be mailed.
- Submitters must send ALL relevant PWK data at the same time for the same claim.
- If the additional documentation is not received within the seven calendar waiting days (fax) or ten calendar waiting days for mailed submissions, your contractor will begin normal processing procedures on your claim.
- Medicare will not crossover PWK data to the Coordination of Benefits contractor.

Additional Information
The official instruction (CR 7041) issued to your Medicare MAC and/or FI/carrier is available at http://www.cms.gov/Transmittals/downloads/R806OTN.pdf on the CMS website.

Implementation of Errata Version 5010 of HIPAA Transactions

MLN Matters® Number: MM7202
Related Change Request (CR) #:7202
Related CR Release Date: November 10, 2010
Related CR Transmittal #: R2090CP
Effective Date: April 1, 2011
Implementation Date: April 4, 2011

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

Provider Action Needed
The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 7202 to alert and update providers about the Administrative Simplification provisions of HIPAA Regulations that the Secretary of the Department of Health and Human Services (DHHS) is required to adopt regarding standard electronic transactions and code sets. Currently, CMS is in the process of implementing an ERRATA version of 5010 of the HIPAA transactions as well as the updates to the 837I, 837P and 835 flat files. Be sure that you will be compliant with this next HIPAA standard by January 1, 2012.

Background
The Secretary of DHHS has adopted ASC X12 version 5010 and NCPDP version D.0 as the next HIPAA standard for HIPAA covered transactions. The final rule was published on January 16, 2009. Some of the important dates in the implementation process are:

- Effective Date of the regulation: March 17, 2009;
- Level I compliance by December 31, 2010;
- Level II Compliance by December 31, 2011; and
- All covered entities have to be fully compliant on January 1, 2012

To review the explanation of these levels you may go to an earlier MLN Matters® article, MM6975 on the *Additional Instruction for Implementation of Health Insurance Portability and Accountability Act of 1996 (HIPAA) Version 5010 for Transaction 835 - Health Care Claim Payment/Advice and Updated Standard Paper Remit (SPR)* at http://www.cms.gov/MLNMattersArticles/downloads/MM6975.pdf on the CMS website.

Key Points of CR7202
CMS is working with your Medicare contractors to implement the new HIPAA standard (version 5010) correctly and:

- CMS expects that external testing will start on January 2011, but no sender/receiver will be migrated to 5010A1 production before April 2011;
- During the transition period January 2011 - March, 2011, Medicare contractors will be ready to receive/send transactions in version 4010A1 as well as test in version 5010. From April 2011 to December 2011, contractors will be ready to receive/send transactions in version 4010A1 as well as test and receive/send all transactions in version 5010 or the appropriate errata versions; and
- All Medicare claims processing systems will use appropriate X12 based Flat File layouts for transactions 837I, 837P, and 835, as attached to CR7202. (To review the file descriptions, go to http://www.cms.gov/Transmittals/downloads/R2090CP.pdf on the CMS website.)
- Over the past year, there has been discussion about modifications needed to implement 5010 correctly. As a result, X12N released the ERRATA modifications, and they were adopted by DHHS. CMS will implement the changes that impact Medicare and update the relevant flat files even if specific modifications do not impact Medicare.
- The ERRATA are basically modifications to some of the TR3s. For Medicare the following TR3 name changes will be required per:
  - 005010X279A1 270/271 Health Care Eligibility Benefit Inquiry and Response (A separate CR will be issued for the 270/271);
  - 005010X221A1 835 Health Care Claim Payment/Advice;
  - 005010X222A1 837 Health Care Claim: Professional;
  - 005010X223A2 837 Health Care Claim: Institutional; and
  - 005010X231A1 999 Implementation Acknowledgment for Health Care Insurance.

Additional Information
The official instruction, CR 7202 issued to your carrier, A/B MAC, and RHHI regarding this change may be viewed at http://www.cms.gov/Transmittals/downloads/R2090CP.pdf on the CMS website.