DME Happenings

• THIS IS WRITTEN NOTIFICATION OF MEDICARE CHANGES •

May 2011 | Issue No. 31

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

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

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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: www.noridianmedicare.com/dme

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

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

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
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
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
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 4 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 4 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 4 p.m. CT
Independence Day Observed	July 4	Entire Day Closed – 8 a.m. through 4 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 4 p.m. CT
Off-the-Phone Training*	September 16	8 a.m. – 12:30 p.m. CT
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Christmas Day Observed	December 26	Entire Day Closed – 8 a.m. through 4 p.m. CT

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

Automatic Mailing/Delivery of DMEPOS Reminder

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

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

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

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

Beneficiaries Call 1-800-MEDICARE

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

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

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

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

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

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

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

CMS Issued Proposed Rule on Medicare Shared Savings Program Created by Affordable Care Act

The U.S. Department of Health and Human Services (HHS) today released proposed new rules to help doctors, hospitals, and other health care providers better coordinate care for Medicare patients through Accountable Care Organizations (ACOs). ACOs create incentives for health care providers to work together to treat an individual patient across care settings – including doctor's offices, hospitals, and long-term care facilities. The Medicare Shared Savings Program will reward ACOs that lower health care costs while meeting performance standards on quality of care and putting patients first. Patient and provider participation in an ACO is purely voluntary.

CMS has worked closely with other federal agencies, including the Department of Health and Human Services Office of Inspector General (OIG), the Department of Justice (DOJ), the Federal Trade Commission (FTC), and Internal Revenue Service (IRS) to ensure that providers and suppliers have the clear and practical guidance they need to form ACOs without running afoul of the fraud and abuse, antitrust, and tax laws. Concurrently with the publication of this

proposed rule, the following documents have been issued: a joint CMS and OIG notice and solicitation of public comments on potential waivers of certain fraud and abuse laws in connection with the Medicare Shared Savings Program; a joint FTC and DOJ proposed antitrust policy statement; and an IRS notice requesting comments regarding the need for additional tax guidance for tax-exempt organizations, including tax-exempt hospitals, participating in the Medicare Shared Savings Program.

The proposed rule and joint CMS/OIG notice are posted at: http://www.ofr.gov/inspection.aspx

For more information, read the fact sheet at http://www.healthcare.gov/news/factsheets/accountablecare03312011a.html.

Comments on the proposed rule will be accepted until June 6, 2011 at http://www.regulations.gov. CMS will respond to all comments in a final rule to be issued later this year.

The CMS dedicated website for providers of services and suppliers is http://www.cms.gov/sharedsavingsprogram.

The Proposed Antitrust Policy Statement is posted at: http://www.ftc.gov/opp/aco

The IRS Guidance and Solicitation of Comments will be posted at: http://www.irs.gov/pub/irs-drop/n-11-20.pdf

DME SPR Advice and Check Print Transition Changes

On Monday, April 18, 2011, Noridian will transition the printing of DME Standard Paper Remittances (SPRs) and SPRs with checks to a new print facility.

The SPRs with checks may or may not include a coversheet depending on the length of the SPR. The SPRs with a coversheet will have the check at the bottom of the page. The Noridian return address and the provider address will be printed on the top third of the coversheet. The coversheet will enable the use of double-window envelopes, thus allowing cost savings.

The supplier checks will be blue in color. While some formatting changes have been made to the SPRs and checks, there should not be an impact to suppliers.

Effective on/after April 18, 2011

Fax Numbers Changed Effective April 11, 2011

Beginning Monday, April 11, 2011, suppliers must use new fax numbers when sending NAS DME Jurisdiction D information and supporting documentation for reopenings, redeterminations, refunds, and other NAS departments. Suppliers should be aware the new fax numbers are caller-paid and are not toll-free numbers. Documentation faxed to the old number will be forwarded to the correct department for a minimal timeframe (i.e., two weeks). After that time, the intended faxed content sent to the outdated fax number is not transmitted to a functioning fax number and is therefore not received by NAS. Please take appropriate action to share the changed fax numbers with your staff.

NAS DME JD Department	New Fax Effective 4/11/2011	Old Fax Number Disabled 4/12/2011
Reopenings and Redeterminations	1-701-277-7886	1-888-408-7405
Administrative Simplification Compliance Act (ASCA)	1-701-277-7882	1-888-523-8449
Refunds to Medicare	1-701-277-7894	1-888-529-3666
Immediate Offsets	1-701-277-7894	1-888-529-3666
MSP Inquiries and Refunds	1-701-277-7892	1-888-408-7405
DME RAC Offsets	1-701-277-7896	1-866-640-9459
DME RAC Redeterminations	1-701-277-7886	1-888-408-7405
Medical Review Medical Documentation	1-701-277-7888	1-866-465-0213
CERT Medical Documentation	1-701-277-7890	1-877-436-4479

Suppliers have the opportunity to use postal mail if preferred. The mailing addresses are available at https://www.noridianmedicare.com/dme/contact/contact.html.

Home Health and Hospice Face-to-Face Encounter Requirements

Effective April 1, 2011, the Centers for Medicare & Medicaid Services (CMS) expects home health agencies and hospices have fully established internal processes to comply with the face-to-face encounter requirements mandated by the Affordable Care Act (ACA) for purposes of certification of a patient's eligibility for Medicare home health services and of recertification for Medicare hospice services.

Section 6407 of the ACA established a face-to-face encounter requirement for certification of eligibility for Medicare home health services, by requiring the certifying physician to document that he or she, or a non-physician practitioner working with the physician, has seen the patient. The encounter must occur within the 90 days prior to the start of care, or within the 30 days after the start of care. Documentation of such an encounter must be present on certifications for patients with starts of care on or after January 1, 2011.

Similarly, section 3132(b) of the ACA requires a hospice physician or nurse practitioner to have a face-to-face encounter with a hospice patient prior to the patient's 180th-day recertification, and each subsequent recertification. The encounter must occur no more than 30 calendar days prior to the start of the hospice patient's third benefit period. The provision applies to recertifications on and after January 1, 2011.

On December 23, 2010, due to concerns that some providers needed additional time to establish operational protocols necessary to comply with face-to-face encounter requirements mandated by the Affordable Care Act (ACA) for purposes of certification of a patient's eligibility for Medicare home health services and of recertification for Medicare hospice services, CMS announced that it will expect full compliance with the requirements, beginning with the second quarter of CY2011.

Throughout the first quarter of 2011, CMS has continued outreach efforts to educate providers, physicians, and other stakeholders affected by these new requirements. CMS has posted guidance materials including a MLN Matters article, questions and answers documents, training slides, and manual instructions which are available via CMS' Home Health Agency Center and Hospice webpages. CMS' Office of External Affairs and Regional Offices contacted state and local associations for physicians and home health agencies and advocacy groups to ensure awareness about the face-to-face encounter laws, and to distribute the educational materials.

CMS will continue to address industry questions concerning the new requirements, and will update information on our website at http://www.cms.gov/center/hha.asp and http://www.cms.gov/center/hospice.asp.

IVR and Endeavor Saturday Availability 2011 Dates

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

April – June 2011	July – September 2011	October – December 2011
April 30	July 9	October 8
May 7	July 16	October 15
May 14	July 23	October 22
May 21	July 30	October 29
May 28	August 6	November 5
June 4	August 13	November 12
June 11	August 20	November 19
June 18	August 27	November 26
June 25	September 3	December 3
	September 10	December 10
	September 17	December 17
	September 24	

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

Noridian Administrative Services Again Receives Medicare Contract for Durable Medical Equipment Claims Administration

Noridian Administrative Services (NAS) has received a government contract to administer Medicare claims from suppliers of durable medical equipment (DME), prosthetics and orthotic supplies. NAS is the incumbent contractor for the DME contract known as Jurisdiction D, which includes 17 states and three U.S. island territories. The contract, which takes effect on March 1, 2011, was awarded by the Centers for Medicare & Medicaid Services (CMS) on February 16, 2011. The contract's award value of approximately $86.2 million includes the base year plus four one-year options to renew.

Since 2006, NAS has provided DME claims administration for Jurisdiction D, which includes Alaska, American Samoa, Arizona, California, Guam, Hawaii, Idaho, Iowa, Kansas, Missouri, Montana, Nebraska, Nevada, North Dakota, Northern Mariana Islands, Oregon, South Dakota, Utah, Washington and Wyoming. From the start of the contract in late 2006 through 2010, NAS processed more than 65 million DME Medicare claims, with benefit payouts in excess of $8.7 billion.

"We appreciate that CMS has again awarded the DME contract for Jurisdiction D to NAS," said NAS President and CEO Mike Hamerlik. "We believe the decision was based on confidence in our abilities, overall cost value and the outstanding customer service our dedicated team provided over the course of the prior contract."

"Over the past five years, we have shown CMS that we deliver strong performance and innovative approaches," said Emy Stenerson, vice president of NAS DME Operations. "To be re-awarded the contract is confirmation of the great day-to-day work done by our staff."

NAS is one of four regional DME contractors serving the Medicare program. The NAS DME operations are headquartered in Fargo, with some DME operations in Grand Forks, N.D. The contract's workload includes claims processing, contact center services, written correspondence on Medicare inquiries, supplier outreach and education, appeals and medical review for claims requiring assessment.

A subsidiary of Noridian Mutual Insurance Company, Noridian Administrative Services, LLC, is a regional claims contractor for the federal government's Medicare program and provides Part A, Part B and DME claims processing. In 2010, NAS distributed $19.6 billion as payment for more than 78 million claims for services rendered to Medicare beneficiaries in its 18-state service area.

Physician Documentation Responsibilities

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

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

Quarterly Provider Updates

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

- Inform providers about new developments in the Medicare program;
- Assist providers in understanding CMS programs ad complying with Medicare regulations and instructions;
- Ensure that providers have time to react and prepare for new requirements;

- Announce new or changing Medicare requirements on a predictable schedule; and
- Communicate the specific days that CMS business will be published in the Federal Register.

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

Refunds to Medicare

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

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

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

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

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

Reporting Gross Payments on IRS Form-1099

The reporting requirements of section 6041A states that any service-recipient engaged in a trade or business that pays in the course of such trade or business during any calendar year remuneration for such services in the aggregate of $600 or more, must file an information return. The $600 or more paid by a Federal executive agency to a corporation is also subject to the information reporting requirements per section 6041A(d)(3). However, contracts between Federal agencies and corporations that qualify as classified or confidential (i.e., for national security reasons) are exempt under Internal Revenue Code sections 6050M (e) and 6050M.

CMS, HHS C.F.R 42 400.202 – Definitions Specific to Medicare
"Services means medical care or services and items, such as medical diagnosis and treatment, drugs and biological, supplies, appliances, and equipment, medical social services, and use of hospital, CAH, or SNF facilities."

Internal Revenue Service (IRS) – Special Rules
Payments reportable to corporations: Payments by federal agencies to corporations are not exempt from the filing requirements. Internal Revenue Code section 6041A(d)(3) provides that payments made for services performed by a corporation are subject to information reporting requirements when the remuneration has been paid to the corporation by a federal executive agency.

IRS Specific Instructions for Form-1099-MISC
States in part – File IRS Form 1099-MISC, Miscellaneous Income, for each person to whom you have paid during the year:

At least $600 in rents, services (including parts and materials), prizes and awards, other income payments, medical and health care payments.

Treasury Regulations, Subchapter A, Section 1.6041-1
(f) Amount to be reported when fees, expenses or commissions are deducted – (1) In general, the amount to be reported as paid to a payee is the amount includible in the gross income of the payee (which in many cases will be the gross amount of the payment or payments before fees, commissions, expenses, or other amounts owed by the payee to another person have been deducted), whether the payment is made jointly or separately to the payee and another person.

(h) When payment deemed made. For purposes of a return of information, an amount is deemed to have been paid when it is credited or set apart to a person without any substantial limitation or restriction as to the time or manner of payment or condition upon which payment is to be made, and is made available to him so that it may be drawn at any time, and its receipt brought within his own control and disposition.

Example: Company X submitted Medicare claims of $1,000 for payment. The claims were processed and approved for payment, however there is a prior year amount due the program of $300. The $300 amount is offset against the $1,000 due the provider, and a payment of $700 is authorized. Since the provider received benefit of $1,000 ($700 in cash and $300 reduction of a liability to CMS) the amount of payment that is required to be reported to the IRS on IRS Form-1099 is $1,000.

If the Shared Systems reports $1,000 as paid by CMS on the IRS Form-1099, no system changes are required in reference to the "Netting" issue. If the Shared System reports $700 on the IRS Form-1099, this is considered "Netting" and system changes must be made to comply with the reporting of "Gross" payments.

These reporting requirements are not intended to be a cash payment system or a cash reconciliation system. The reporting requirements follow the rules of accrual accounting.

This CR does emphasize our concern of CMS compliance with reporting of "Gross" payments; however it is not our intent to limit the review of the systems to this issue in reference to CMS's compliance to all IRS Reporting Rules and Regulations.

Note: The necessary changes to correct the netting/grossing issues have been made to the HIGLAS System under a separate HCR.

Source: Transmittal 498, Change Request 6466 dated May 29, 2009

Reprocessing Claims Affected by Affordable Care Act and 2010 Medicare Physician Fee Schedule Changes

This message is for physicians, other practitioners, ambulance suppliers, inpatient/outpatient hospitals, long term care hospitals, inpatient rehabilitation facilities, home health agencies, and any other provider type affected by the post-effective date implementation of select provisions of the Affordable Care Act and the 2010 Medicare physician fee schedule.

On March 23, 2010, President Obama signed into law the Affordable Care Act. Various provisions of the new law were effective April 1, 2010, or earlier and, therefore, were implemented some time after their effective date. In addition, corrections to the 2010 Medicare Physician Fee Schedule (MPFS) were implemented at the same time as the Affordable Care Act revisions to the MPFS, with an effective date retroactive to January 1, 2010.

Due to the retroactive effective dates of these provisions and the MPFS corrections, a large volume of Medicare fee-for-service claims will be reprocessed. Given this large workload, the Centers for Medicare & Medicaid Services (CMS) is taking steps to ensure that new claims coming into the Medicare program are processed timely and accurately, even as the retroactive adjustments are being made. CMS *will begin* to reprocess these claims over the next several weeks. We expect that this reprocessing effort will take some time and will vary depending upon the claim-type, the volume, and each individual Medicare claims administration contractor.

In the majority of cases, you will not have to request adjustments because your Medicare claims administration contractor will automatically reprocess your claims. Please do not resubmit claims because they will be denied as duplicate claims and slow the retroactive adjustment process. However, any claim that contains services with submitted charges lower than the revised 2010 fee schedule amount (MPFS and ambulance fee schedule) cannot be automatically reprocessed at the higher rates. In such cases, you will need to request a manual reopening/adjustment from your Medicare contractor. While there is normally a one-year time limit for physicians and other providers and suppliers to request the reopening of claims, we believe that these circumstances fall under the "good cause" criteria described in the Claims Processing Manual, Publication 100-04, Chapter 34, Section 10.11 (http://www.cms.gov/manuals/downloads/clm104c34.pdf). CMS is, therefore, extending the time period to request adjustment of these claims, as necessary.

Medicare claims administration contactors will follow the normal process for handling any applicable underpayments or overpayments that occur while reprocessing your claims. Underpayments will be included in your next regularly scheduled remittance after the adjustment. Overpayments resulting from institutional provider (e.g., hospitals, inpatient rehabilitation facilities, etc.) claim adjustments will be offset immediately, regardless of the amount, unless there are insufficient funds to make the offset. When these overpayments cannot be offset, the amounts will accumulate until a $25 threshold is reached. At that time, a demand letter will be sent to the institutional provider. When a claim adjustment for a non-institutional provider (e.g., physician, other practitioner, supplier, etc.) results in an overpayment, the Medicare contractor will send a request for repayment. If this overpayment is less than $10, your contractor will

not request repayment until the total amount owed accrues to at least $10. See the Financial Management Manual, Publication 100-06, Chapter 4, Section 70.16 or Section 90.2 (http://www.cms.gov/manuals/downloads/fin106c04.pdf) for more information.

The CMS wants to remind physicians, practitioners, suppliers, and other providers, impacted by the retroactive increases in payment rates for claims affected by the Affordable Care Act and 2010 MPFS changes, of the Office of Inspector General policy related to waiving beneficiary cost-sharing amounts attributable to retroactive increases in payment rates resulting from the operation of new Federal statutes or regulations. The policy may be found at the following link:

http://oig.hhs.gov/fraud/docs/alertsandbulletins/Retroactive_Beneficiary_Cost-Sharing_Liability.pdf

Please contact your Medicare claims administration contractor with any questions about this information.

Sixth Annual Administration of CMS 2011 MCPSS

In case you've forgotten or haven't heard, the Centers for Medicare & Medicaid Services (CMS) has launched its annual Medicare Contractor Provider Satisfaction Survey (MCPSS). This is a friendly reminder to encourage selected providers to take the survey. The 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. As a result of past survey responses, Medicare FFS Contractors have implemented changes to improve their communication processes and education & training of their staff.

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 including but not limited to the Business Office manager, Revenue Cycle Director or Medicare Biller.

If you have received a survey letter, then 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.

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.

If you've already completed and submitted your survey, we thank you for your feedback.

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
14	Fraud and Abuse	Added states	04/13/11
2	National Provider Identifier	Changed NPPES web address	04/12/11
2	Do Not Forward	Removed "Declined" from table	04/12/11
2	Re-enrollment	Changed to Revalidation	04/12/11
2	Accreditation/Surety Bond/ Electronic Funds Transfer	Moved sections below NSC Process for Becoming a DME Supplier	04/12/11
3	Orders	Moved "Nurse Practitioners or Clinical Nurse Specialist Rules Concerning Orders and CMNs" and "Physician Assistant Rules Concerning Orders and CMNs"	04/12/11

FYI CONT'D

3	Comprehensive Error Rate Testing	Updated web address	04/12/11
4	Transmission of CMN	Removed font modifications	04/12/11
4	CMNs as Orders and Claim Submission	Removed last two paragraphs regarding providing the CMN upon request	04/12/11
5	Capped Rental Items	Added elimination of lump sum payment for standard power wheelchairs	04/12/11
6	CMS-1500 Claim Form	Removed NAS web page as reference for ASCA and claim form instructions; removed Keys to Successful Claim Filing reference	04/12/11
8	Introduction	Removed Claim Status Inquiry information	04/12/11
8	Benefits	Removed Claim Status Inquiry information	04/12/11
11	Medicare Secondary Payer	Moved types of insurances to beginning of chapter	04/12/11
13	Reopenings and Appeals	Updated fax numbers	04/12/11
14	Fraud and Abuse	Added ZPIC	04/12/11
15	Overpayments and Refunds	Updated fax numbers	04/12/11
15	Refund Process	Added this section	04/12/11
15	Voluntary Refunds	Added this section	04/12/11
15	Extended Repayment Schedule	Removed sentence stating forms are sent with letter. These forms are available on the Forms page of our website.	04/12/11
15	RAC Overpayments	Changed appeal form to DME Redetermination Request form and changed fax number	04/12/11
15	Offset Requests	Changed fax number	04/12/11
17	Internal Control Numbers	Changed to Claim Control Numbers	04/12/11
Appendix	Resources	Updated NAS fax numbers	04/12/11
Appendix	Additional DME Contacts	Changed PDAC fax number	04/04/11
15	Extended Repayment Plan	Changed to Extended Repayment Schedule	03/16/11
13	Reopenings	Removed KX modifier from examples	02/17/11
10	Guidelines	Removed five-year period	02/15/11
16	Modifiers	Added CS modifier and added clarification to GZ modifier	02/14/11

APPEALS

"Medicare Appeals Process: Five Levels to Protect Providers, Physicians, and Other Suppliers" Revised

The revised brochure titled "The Medicare Appeals Process: Five Levels to Protect Providers, Physicians, and Other Suppliers" (revised January 2011) is now available in downloadable format from the Medicare Learning Network® at http://www.CMS.gov/MLNProducts/downloads/MedicareAppealsProcess.pdf. This brochure is designed to provide an overview of the Medicare Part-A and Part-B administrative appeals process available to providers, physicians, and other suppliers who provide services and supplies to Medicare beneficiaries, as well as details on where to obtain more information about this appeals process.

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.

Top Ten Redeterminations: July – December 2010

The purpose of this article is to assist suppliers with solutions to the top ten redeterminations NAS Appeals staff received from July – December 2010. These redeterminations include medical necessity, same or similar, certificate of medical necessity needed, duplicate items, and more.

1. Maximum Amount Paid (MA18, MA01)

This is the maximum approved amount for this item.

The maximum payment has been allowed for this service. To minimize these types of claim errors when additional money should be allowed, ensure the proper units, date span, place of service, etc., is correct on the initial claim.

2. Medical Necessity (MA13, MA67)

These are noncovered services because this is not deemed a "medical necessity" by the payer.

For any item to be covered by Medicare, it must be eligible for a defined Medicare benefit category, be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, and meet all other applicable Medicare statutory and regulatory requirements.

Also, 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 a policy without first receiving the completed order, the item will be denied as not medically necessary.

Suppliers are encouraged to consult the Local Coverage Determination (LCD) and related Policy Article for medical policy coverage criteria. Suppliers are also encouraged to subscribe to the NAS DME electronic mailing list to receive updates regarding LCDs and policy articles.

3. Certification of Medical Necessity Needed (MA13, MA01)

No Certification of Medical Necessity was received for this equipment.

Suppliers should be knowledgeable regarding the medical policies for items requiring a Certificate of Medical Necessity (CMN) or a DME Information Form (DIF). Ensure the CMN or DIF is submitted with the correct information on the initial claim submission.

Another suggestion is to submit the initial claim and wait at least five days to submit consecutive months. This will ensure the initial claim has processed and the CMN entered the system for proper processing of additional claims.

The policies and related articles will aid in completing the CMNs and DIFs and inform the supplier on the appropriate time to submit the CMN and DIF to the DME MACs.

All CMNs and DIFs are located on the DME website under the Forms section. Additional information regarding CMN requirements can be found in the Internet Only Manual (IOM) Publication 100-4, Chapter 20, Section 100.2 and Chapter 4 of the Supplier Manual found in the Publications section of our website.

4. Same/Similar (MA18, MA13, MA01)

Either you or another supplier is already furnishing the same or similar equipment to this patient.

In order to avoid a denial for same or similar equipment the supplier should begin speaking with the patient regarding same/similar items. The patient should know if they have used or owned a same or similar item in the past. To ensure the patient understands how items are grouped, NAS suggests explaining what items may be considered "similar". Additional information can be found in Chapter 3 of the Supplier Manual and a Same or Similar Reference Chart is located under the Claims section of our website. Same and similar information can be obtained on the Interactive Voice Response (IVR) system and through Endeavor. In addition, suppliers may use the Suggested Intake Form available on our website.

5. Recertification of Medical Necessity Needed (MA13, MA01)

No recertification or revision of medical necessity was received for this equipment.

Ensure the recertification and/or revision is sent electronically with the claim when the claim requires this information.

Refer to the individual LCD and related Policy Articles for proper claims submission. Additional information regarding CMN requirements can be found in the IOM Publication 100-4, Chapter 20, Section 100.2 and Chapter 4 of the Supplier Manual.

6. Frequency (MA13, MA01)

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.

Frequency guidelines are outlined in the applicable LCD and related Policy Articles. Tips to reduce the number of claims denying for this issue include:

- Ensure the dates are spanned, if applicable.
- Ensure the number of units is correct. If more units are necessary, proper documentation will need to be on file to support the increased units.
- Suppliers should review the documentation section of each individual medical policy to verify the utilization guidelines and the documentation requirements needed when billing for quantities of supplies greater than those described in the policy.

The policies can be accessed from the Coverage/MR Section of our website by going to the section titled Local Coverage Determinations.

For a guide of what type of documentation is needed, refer to the Documentation Guide for DME Redeterminations. Additional information can also be found in Chapter 3 of the Supplier Manual on our website.

7. Noncovered Charges (MA13, MA01)

Noncovered charges.

This service is not covered by Medicare. These denials are not based on policy criteria and are usually statutorily excluded items.

8. Medicare Cannot Pay for Supplies or Accessories Used With Equipment For Which Payment Has Been Denied (MA13, MA67)

Medicare Cannot Pay for Supplies or Accessories Used With Equipment for Which Payment Has Been Denied

The most common type of service where this denial is seen is Parenteral/Enteral Nutrition. When the nutrition is denied for needing a DIF, the accessories are also denied. To minimize these types of denials send the DIF electronically attached to the initial claim or when calorie changes occur.

9. Billing over months covered (MA18, MA13, MA67)

Billing exceeds the rental months covered/approved by the payer.

A common type of service where this denial is seen frequently is Oxygen and Oxygen Equipment when a new capped rental is needed due to a break in service or if the reasonable useful lifetime has been met. To minimize these types of denials send the CMN electronically attached to the initial claim.

10. Prescription Not On File (MA18, MA13, MA01)

Payment adjustment because this service was not prescribed by a physician, not prescribed prior to delivery, the prescription is incomplete, or the prescription is not current.

Ensure the prescriptions are current and the CMN or DIF is submitted with the correct information on the original submitted claim.

Top Ten Reopenings: July – December 2010

The purpose of this article is to assist suppliers with solutions to the Top Ten reopenings NAS Appeals staff received from July – December 2010. Some of these reopenings include medical necessity, frequency, Certificate of Medical Necessity (CMN) recertification, and same or similar.

Maximum Amount Paid (MA18, MA01)

1. This is the maximum approved amount for this item.

The maximum payment has been allowed for this service. To minimize these types of claim errors, when additional money should be allowed, review the claim before submitting it. Ensure the units, date span, place of service, etc., is correct on the initial claim submission.

2. Medical Necessity (MA13, MA67)

These are noncovered services because this is not deemed a "medical necessity" by the payer.

For any item to be covered by Medicare, it must be eligible for a defined Medicare benefit category, be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, and meet all other applicable Medicare statutory and regulatory requirements.

Also, 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 a policy without first receiving the completed order, the item will be denied as not medically necessary.

Suppliers are encouraged to consult the Local Coverage Determination (LCD) and related Policy Article for medical policy coverage criteria. Suppliers are also encouraged to subscribe to the NAS DME electronic mailing list to receive updates regarding LCDs and policy articles.

3. Noncovered Charges (MA13, MA01)

Noncovered charges.

This service is not covered by Medicare. These denials are not based on policy criteria and are usually statutorily excluded items.

4. Prescription Not On File (MA18, MA13, MA01)

Payment adjustment because this service was not prescribed by a physician, not prescribed prior to delivery, the prescription is incomplete, or the prescription is not current.

Ensure the prescriptions are current and the CMN or DME Information Form (DIF) is submitted with the correct information on the original submitted claim.

5. Recertification of Medical Necessity Needed (MA13, MA01)

No recertification or revision of medical necessity was received for this equipment.

Ensure the recertification and/or revision is sent electronically with the claim when the claim requires this information.

Refer to the individual LCD and related Policy Articles for proper claims submission.

6. Frequency (MA13, MA01)

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.

Frequency guidelines are outlined in the applicable LCD and related Policy Articles. Tips to reduce the number of claims denying for this issue include:

Ensure the dates are spanned, if applicable.

Ensure the number of units is correct. If more units are necessary, proper documentation will need to be on file to support the increased units.

Suppliers should review the documentation section of each individual medical policy to verify the utilization guidelines and the documentation requirements needed when billing for quantities of supplies greater than those described in the policy.

The policies can be accessed from the Coverage/MR Section of our website by going to the section titled Local Coverage Determinations.

For a guide of what type of documentation is needed, refer to the Documentation Guide for DME Redeterminations. Additional information can also be found in Chapter 3 of the Supplier Manual on our website.

7. Same/Similar (MA18, MA13, MA01)

Either you or another supplier is already furnishing the same or similar equipment to this patient.

In order to avoid a denial for same or similar equipment the supplier should begin speaking with the patient regarding same/similar items. The patient should know if they have used or owned a same or similar item in the past. To ensure the patient understands how items are grouped, NAS suggests explaining what items may be considered "similar".

For example, walkers and wheelchairs are both considered mobility and therefore, would be considered similar equipment. A great tool to use is the Same or Similar Reference Chart located under the Claims section of our website. Same and similar information can be obtained on the Interactive Voice Response (IVR) system. In addition, suppliers may use the Suggested Intake Form available on our website. Additional information can be found in Chapter 3 of the Supplier Manual found in the Publications section of our website.

8. Billing Over Months Covered (MA18, MA13, MA67)

Billing exceeds the rental months covered/approved by the payer.

A common type of service where this denial is seen frequently is Oxygen and Oxygen Equipment when a new capped rental is needed due to a break in service or if the reasonable useful lifetime has been met. To minimize these types of denials send the CMN electronically attached to the initial claim.

9. Certification of Medical Necessity Needed (MA13, MA01)

No Certification of Medical Necessity was received for this equipment.

Suppliers should be knowledgeable regarding the medical policies for items requiring a CMNs or a DME Information Form (DIF). Ensure the CMN or DIF is submitted with the correct information on the initial claim submission. Another suggestion is to submit the initial claim and wait at least five days to submit consecutive months. This will ensure the initial claim has processed and the CMN entered the system for proper processing of additional claims.

The policies and related articles will aid in completing the CMNs and DIFs and inform the supplier on the appropriate time to submit the CMN and DIF to the DME MACs.

All CMNs and DIFs are located on the DME website under the Forms section. Additional information regarding CMN requirements can be found in the Internet Only Manual (IOM), Publication 100-4, Chapter 20, Section 100.2 and Chapter 4 of the Supplier Manual.

10. Procedure Code Invalid on Date of Service (MA13, MA01)

Procedure code was invalid on the date of service.

In order to avoid a denial for procedure code invalid on date of services, the supplier should insure the claim is filed correctly. Items to double check for accuracy on claims before submitting to Medicare is the appropriate date of service and HCPCS code being used for the item provided.

BILLING

Billing Reminders for Replacement of Accessories

The purpose of this article is to ensure that suppliers are billing the RB modifier and a detailed description when they are replacing an accessory for a main piece of equipment.

When billing a replacement accessory for the main piece of equipment, suppliers must bill the RB modifier (replacement of a part of DME, orthotic or prosthetic item furnished as part of a repair) and provide a detailed explanation as to why the accessory is being replaced. This information is to be placed in Item 19 on the CMS-1500 claim form or in the NTE segment, 2400 loop for electronic claims. Effective for claims received on or after April 1, 2011, if the RB modifier and description are not given, claims will be rejected as incorrect coding.

Claim Status Category Code and Claim Status Code Update

MLN Matters® Number: MM7348
Related Change Request (CR) #: 7348
Related CR Release Date: March 18, 2011
Related CR Transmittal #: R2177CP
Effective Date: July 1, 2011
Implementation Date: July 5, 2011

Provider Types Affected
All physicians, providers, and suppliers submitting claims to Medicare contractors (Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), carriers, A/B Medicare Administrative Contractors (MACs), Durable Medical Equipment MACs (DME MACs) and the DME Common Electronic Data Interchange (CEDI) contractor for Medicare beneficiaries are affected.

What You Need to Know
This article, based on CR7348, 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 will be updated during the June 2011 meeting of the national Code Maintenance Committee and code changes approved at that meeting will be posted at http://www.wpc-edi.com/content/view/180/223/ on or about July 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 July 5, 2011.

Background
The Health Insurance Portability and Accountability Act (HIPPA) requires all health care benefit payers to use only Claim Status Category Codes and Claim Status Codes approved by the national Code Maintenance Committee in the X12 276/277 Health Care Claim Status Request and Response format adopted as the standard for national use (004010X093A1 and 005010X212). The Centers for Medicare & Medicaid Services (CMS) has also adopted as the CMS standard for contractor use the X12 277 Health Care Claim Acknowledgement (005010X214) as the X12 5010 required method to acknowledge the inbound 837 (Institutional or Professional) claim format. These codes explain the status of submitted claims. Proprietary codes may not be used in the X12 276/277 to report claim status.

Additional Information
The official instruction, CR7348 issued to your Medicare contractor regarding this change may be viewed at http://www.cms.gov/Transmittals/downloads/R2177CP.pdf on the CMS website.

Enforcement of Payment Requirements for Beneficiary-Owned Capped Rental DME

MLN Matters® Number: SE1103 Revised

Note: This article was revised on March 18, 2011, to show that the oxygen equipment requirements were significantly changed on January 1, 2009, as a result of CR6297. Those changes were added to pages 3-5. All other information is the same.

Provider Types Affected
This article is for suppliers submitting claims to Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for services provided to Medicare beneficiaries for capped rental DME equipment.

Provider Action Needed
This article is primarily informational and summarizes the findings of the Office of the Inspector General (OIG) report of August of 2010 titled, "A Review of Claims for Capped Rental Durable Medical Equipment." The article contains references to Medicare policy documents that the Center for Medicare & Medicaid Services (CMS) has available to guide suppliers in proper billing of capped rental DME claims, including repairs and maintenance. Suppliers need to be aware of the report findings and proper billing procedures to avoid impact on claims payments. The OIG report provides the details about the findings and it is available at http://oig.hhs.gov/oei/reports/oei-07-08-00550.pdf on the Internet. In addition to the procedures for proper billing, be sure to follow all proper documentation requirements to assure that the documentation adequately supports your claims for payment.

Background
The DME items covered by Medicare are medical equipment that often requires maintenance and repairs, and Medicare pays DME suppliers for that maintenance and those repairs in certain circumstances. Capped rental DME is a specific category of DME for which Medicare pays a fee schedule amount that is capped after 13 consecutive months of rental to a beneficiary.

Section 5101 of the Deficit Reduction Act of 2005 (DRA) revised the payment rules for capped rental DME so that ownership of the equipment would transfer to the beneficiaries after 13 continuous months of rental. During the audit conducted by the OIG's office, approximately 500 claims were reviewed and 34 beneficiary interviews were conducted. The finding of the claims reviews and beneficiary interviews was that claims for repairs of beneficiary-owned capped rental DME were improperly paid. Consequently the OIG recommended strategies to reduce improper payments and strengthen program integrity.

Key Points
DME is medical equipment that can withstand repeated use, serves a medical purpose, is not useful in the absence of an illness or injury, and is appropriate for home use. The following are the summarized findings listed in the OIG report:

- From 2006 to 2008, suppliers erroneously billed Medicare for routine maintenance and servicing of capped rental DME with rental periods after implementation of the DRA.
- From 2006 to 2008, suppliers erroneously billed Medicare for repairs for beneficiary-rented capped rental DME.
- In 2007, Medicare allowed payment for some repair claims of beneficiary-owned capped rental DME that failed to meet payment requirements. OIG review of supplier records indicate that 27 percent of allowed repair claims for beneficiary-owned capped rental DME in 2007 lacked medical necessity, service, or delivery documentation, or represented repairs to DME still under manufacturer or supplier warranties.
- In 2007, Medicare allowed payment for repair claims for capped rental DME that were questionable because of missing information and high dollar allowed amounts for repairs relative to replacement costs.
- Supplier practices adversely affected some beneficiaries with high-cost repairs. Beneficiaries with high-cost allowed repairs reported that some suppliers failed to properly customize Power Mobility Devices (PMD), rendering the PMDs useless to them, and that other suppliers did not offer loaner equipment when repairing PMDs, leaving some beneficiaries immobile. Some beneficiaries reported difficulties in contacting suppliers, and record reviews indicated that suppliers charged some beneficiaries service fees for repairs of capped rental DME. Finally, other beneficiaries reported that suppliers failed to provide instructions about the proper use of their equipment and information about repair charges.

Several payment policy changes have been implemented to improve the accuracy of payment for beneficiary-owned capped rental items.

- Capped Rental Items – The DRA required changes to payments for maintenance and servicing of capped rental items so that Medicare payment is no longer made at every 6 months for maintenance and servicing. Instead, once the beneficiary owns the capped rental item, Medicare will cover reasonable and necessary repairs and servicing, provided the repairs are not to items still covered (parts and/or labor) by the manufacturer's warranty. These changes are discussed in Change Request (CR) 5461, issued by CMS on February 2, 2007. That CR is available at http://www.cms.gov/Transmittals/downloads/R1177CP.pdf on the CMS website. A companion MLN Matters® article, MM5461 is also available at http://www.cms.gov/MLNMattersArticles/downloads/MM5461.pdf on the same site.
- Oxygen and Oxygen Equipment – The Medicare Improvements for Patients and Providers Act (MIPPA) as of January 1, 2009, eliminated the requirement for suppliers to transfer title to oxygen equipment. Instead, the supplier who furnished the stationary and/or portable oxygen equipment during the 36-month rental period is required to continue furnishing the stationary and/or portable equipment following the 36-month rental period for any period of medical need for the remainder of the equipment's reasonable useful lifetime (5 years). This requirement includes situations where there is a temporary break in need or break in use of the equipment of any duration after the 36-month rental cap. In such situations, the supplier remains responsible for furnishing the oxygen equipment after the break in need for the remainder of the reasonable useful lifetime during which the medical need for oxygen and oxygen equipment continues. A new rental period can begin if the equipment is replaced because it is lost, stolen, irreparably damaged, or is replaced after the reasonable useful lifetime expires.
- Effective for certain oxygen equipment (i.e., oxygen concentrators and oxygen transfilling equipment) but not for other gaseous or liquid oxygen equipment (stationary or portable), a maintenance and servicing fee can be billed with the "MS" modifier and is paid every 6 months, beginning 6 months after the 36th paid rental month or end of the period the item is no longer covered under the supplier's or manufacturer's warranty, whichever is later. The maintenance and servicing fee will be updated on an annual basis through program instructions based on the covered item update for DME. The payment covers all maintenance and servicing through the following 6 months that is needed in order to keep the oxygen equipment in good working order. A single payment ($65.93 for dates of service January 1, 2011, through December 31, 2011), is made per beneficiary regardless of the number of pieces of equipment serviced (stationary concentrator, portable concentrator, and/or transfilling equipment), regardless

of when the maintenance and servicing is performed during each 6-month period, and regardless of how often the equipment must be maintained and serviced. The supplier is required to make at least one maintenance and servicing visit to inspect the equipment and provide any maintenance and servicing needed at the time of the visit during the first month of each 6-month period. These changes are discussed in Change Request (CR) 7248, issued by CMS on January 24, 2011.

- As discussed in CR6297, excerpted from MLN Matters® article MM6297): the monthly payment amount for oxygen and oxygen equipment covers equipment, contents, supplies and accessories. The supplier who received payment for furnishing the oxygen and oxygen equipment during the 36-month rental period is responsible for continuing to furnish any accessories and supplies necessary for the effective use of the equipment for any period of medical need following the 36-month rental cap for the remainder of the reasonable useful lifetime of the equipment. Therefore, separate payment shall not be made for replacement of supplies and accessories for use with oxygen equipment that are furnished on or after January 1, 2009. This applies to any supply or accessory billed under a miscellaneous HCPCS code, any codes added to the HCPCS in the future, or under the following current HCPCS codes:

HCPCS Code	Descriptor
A4608	Transtracheal oxygen catheter, each
A4615	Cannula, nasal
A4616	Tubing (oxygen), per foot
A4617	Mouth piece
A4619	Face tent
A4620	Variable concentration mask
A7525	Tracheostomy mask, each
E0555	Humidifier, durable, glass or autoclavable plastic bottle type, for use with regulator or flowmeter
E0560	Humidifier, durable for supplemental humidification during IPPB treatment or oxygen delivery
E0580	Nebulizer, durable, glass or autoclavable plastic, bottle type, for use with regulator or flowmeter
E1353	Regulator
E1354	Wheeled cart for portable cylinder or concentrator (Added to HCPCS effective January 1, 2009)
E1355	Stand/Rack
E1356	Battery pack/cartridge for portable concentrator (Added to HCPCS effective January 1, 2009)
E1357	Battery charger for portable concentrator (Added to HCPCS effective January 1, 2009)
E1358	DC Power adapter for portable concentrator (Added to HCPCS effective January 1, 2009)

CMS will continue to improve its claims processing edits to improve the accuracy of payments for capped rental DME.

Additional Information
The entire OIG report, "A Review of Claims for Capped Rental Durable Medical Equipment," referenced in this SE1103 is available at http://oig.hhs.gov/oei/reports/oei-07-08-00550.pdf on the Internet.

CR6297 is available at http://www.cms.gov/Transmittals/downloads/R421OTN.pdf and the related article, MM6297 is at http://www.cms.gov/MLNMattersArticles/downloads/MM6297.pdf on the CMS website.

Reminder: 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 them.

In general, the start date for determining the 1-year timely filing period is the date of service or "From" date on the claim. For institutional claims that include span dates of service (i.e., a "From" and "Through" date on the claim), the "Through" date on the claim is used for determining the date of service for claims filing timeliness. For claims submitted by physicians and other suppliers that include span dates of service, the line item "From" date is used for determining the date of service for claims filing timeliness.

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.
- MM7270 – "Changes to the Time Limits for Filing Medicare Fee-for-Service Claims – http://www.cms.gov/MLNMattersArticles/downloads/MM7270.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 and under "Related Links Inside CMS."

CEDI

CEDI Enrollment Form Reminder

CEDI maintains the enrollment forms for electronic transactions to Medicare for all four DME MAC Jurisdictions. To enroll in one or multiple Jurisdictions, you will only need to submit one set of forms and CEDI will process them for all four DME MAC Jurisdictions. The enrollment forms are located on the CEDI Website at http://www.ngscedi.com. These forms are completed and submitted electronically online, then printed, signed, dated, and faxed to the CEDI Enrollment Department to be processed. CEDI has Instructional Guides listed with each enrollment form to assist in completing the forms and when each form would be required.

If you have any questions, please contact the CEDI Help Desk at ngs.cedihelpdesk@wellpoint.com or at 866-311-9184.

Gateway Transition – Reduction of Capacity for Current National Government Services CEDI Gateway Dial-up Users

Common Electronic Data Interchange (CEDI) Trading Partners may begin to experience a busy signal when attempting to connect to the CEDI Gateway using a direct dial-up connection option. The capacity for direct dial-up connection options to the CEDI Gateway will be reduced again on **Sunday, March 27, 2011**. The reduction is due to the Network Service Vendor migration project, which mandates that all providers who currently utilize dial-up and Point-to-Point Protocol (PPP) File Transfer Protocol (FTP) must switch to a Network Service Vendor (NSV) for their secured connection.

CEDI Trading Partners who have not migrated to a Network Service Vendor may experience a busy signal with their dial-up service as a result of this reduction. We encourage all trading partners to move to a Network Service Vendor solution as quickly as possible to avoid this situation.

As a Reminder
As of May 1, 2011, these direct connections and protocols to the National Government Services CEDI Gateway will no longer be supported by National Government Services.

The National Government Services approved NSVs are listed below and can also be found on the CEDI website http://www.ngscedi.com under Telecommunications.

CEDI CONT'D

Ability (VisionShare)
Website: http://www.abilitynetwork.com
Phone: 888-895-2649
E-mail: sales@abilitynetwork.com

ClaimShuttle
Website: http://www.claimshuttle.com
Phone: 602-439-2525
E-mail: info@claimshuttle.com

Cortex EDI, Inc.
Website: https://www.cortexedi.com
Customer Service: 800-485-5977

ECC Technologies
Website: http://www.ecctec.com
Phone: 585-377-1850

IVANS
Website: http://www.ivans.com
Phone: 800-548-2690

McKesson CareBridge
Website: http://www.carebridge.net
Phone: 888-663-6250

MedXpress
Website: http://www.medxpressclaims.com
Phone: 877-624-3250

Nebo Systems, Inc.
Website: http://www.nebo.com
Phone: 630-916-8818

Please contact the National Government Services CEDI Help Desk at ngs.cedihelpdesk@wellpoint.com or 866-311-9184 if you have any additional questions regarding this initiative.

Healthcare Provider Taxonomy Codes April 2011 Update

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

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

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

The taxonomy code is not required for processing Medicare claims. However, if a taxonomy code is submitted, it must be valid according to the HPTC code set. The HPTC code set is named in the 837 professional implementation guide, thus CEDI must validate the inbound taxonomy codes against this HPTC maintained code source.

The HPTC list is available from the Washington Publishing Company (WPC). To view the April 2011 changes, visit the WPC Website at: http://www.wpc-edi.com/codes/taxonomy, then select "New Codes" for a listing of new HPTCs or "Modifications" for a listing of modified HPTCs.

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

Important Testing Information for 5010A1

This email update contains important information for our Common Electronic Data Interchange (CEDI) customers (suppliers, Trading Partners, billing services, clearinghouses and vendors). Although the email update is long, it is important you read through all of the information provided. It is important for suppliers and Trading Partners to be aware of all aspects of the transition to 5010A1 and D.0 even if you won't 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 begin testing for the X12 837 and 835 transactions of the 5010A1 version on Friday, April 1, 2011 as well as continue testing for the 276/277 5010 transaction.

Vendors that pass the testing process can begin to move their customers into production.

The timeline for implementation:

- **January 2011** – Vendors and those who do their own programming (also referred to as in-house programmers) began testing the base versions of the X12 transactions.
- **January 2011 – December 2011** – Vendors/in house programmers began testing NCPDP D.0. Once testing has passed they may begin moving their NCPDP D.0 customers into production.
- **April 2011** – Vendors and in-house programmers may begin testing the 5010 Errata or A1 versions of the X12 837 and 835 transactions.
- **April – December 2011** – Once vendors have passed testing of the X12 5010A1 versions, 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 for the 837 and 835 transactions. The 276/277 transaction will only be used in the base 5010 format.
- **April – December 2011** – Once in-house programmers have passed testing of the X12 A1 versions, they may move into production.
- **January 1, 2012** – ONLY 837 and 835 5010A1, 276/277 5010, 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 (for X12 format):

- Ability to support 5010A1 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 5010A1 against production 835 4010A1
- Test 276/277 in 5010 format

Production Criteria:

- 100 percent compliant with Level 1 (translator edits)
- 95 percent 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 5010A1 835 electronic remittance advice, it will be produced from the DME MACs production environment in parallel with the current production 4010A1 ERA.

CEDI CONT'D

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.

Note: The 276/277 transactions will use only the base version of the 5010 format.

As part of the transition to 5010A1, the following reports will be returned:

- TRN will continue to be sent by CEDI for 5010A1 as it is today for 4010A1
- TA1 will be sent by CEDI for 5010A1 837 and 5010 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 5010A1 837 and 5010 276 transactions
- 277CA for X12 837 transactions
- 277 claim status response for X12 version 5010 276 transactions as it is today for 4010A1
- 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 5010A1

- 997 for X12 837 and 276 transactions
- CEDI GenResponse for X12 837 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.

Version D.0: Version NCPDP D.0 began testing January 2011. If you still need to test for this transaction, please contact the CEDI Help Desk at ngs.cedihelpdesk@wellpoint.com with your vendor information.

As part of the transition to D.0, the following reports will be returned:

- TRN will continue to be sent by CEDI for D.0 as it is today for 5.1
- NCPDP Transmission Response Report for version D.0

The following reports will no longer be sent for D.0

- CEDI NCPDP Error Report for NCPDP version 5.1 transactions
- CEDI Submission Summary Report NCPDP version 5.1 transactions

Report Format Changes: The current CEDI NCPDP error report and Submission Summary Report are both being replaced by the NCPDP Transmission Response, and like the 277CA, will need to be translated into a readable format by vendors for their customers.

Additional Information: CEDI has created a page on our website dedicated to the upcoming transition to the 5010A1 and D.0 formats. Go to the CEDI Website 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 Websites to purchase the guides.

Companion Documents for the 5010 and D.0 transactions and are available on the CEDI Website under Technical Specifications. These documents are intended to be used as a reference in addition to the Technical Reports (TR3), NCPDP standard implementation guides, and other reference documents.

Reasons CEDI Enrollment Forms are Returned

CEDI will return enrollment forms with invalid or missing information. All returned forms must be re-entered electronically on the CEDI website at http://www.ngscedi.com/forms/formsindex.htm and the forms must then be printed, signed and faxed to CEDI. Any forms re-submitted by fax without completion of the electronic forms on the CEDI website will not be processed and will be returned.

The top reasons for enrollment paperwork to be returned are:

- The supplier's PTAN/NSC number submitted on the form(s) is invalid
- The entire two page hard copy of the EDI Enrollment Agreement was not received
- The supplier's name and address do not match the National Supplier Clearinghouse (NSC) database. The form(s) must contain the supplier's name and address as is enrolled with Medicare.
- The signee is not authorized to sign on behalf of the supplier. For questions about the authorized signer, contact the NSC at 866-238-9652.
- The authorized signature and/or date is missing
- The NPI and PTAN match has been terminated on the NPPES crosswalk. Verify the supplier's information listed on the NPPES website matches the information at the NSC. If you have questions about these matches please contact NPPES at 800-465-3203 or the NSC at 866-238-9652.
- The NPI is not on the NPPES crosswalk. Please visit the NPPES website https://nppes.cms.hhs.gov/NPPES/Welcome.do to verify the supplier's information. The NSC/PTAN number must be indicated under Issuer as the "MEDICARE NSC".
- The hard copy fax was not received by CEDI Enrollment within 10 days of submission of the online application
- The Trading Partner (Submitter) ID is missing or invalid
- The Third Party Supplier Authorization Form is required

To ensure that paperwork does not get returned, review it carefully before faxing it to the CEDI Enrollment department.

Please contact the CEDI Help Desk at ngs.cedihelpdesk@wellpoint.com or at 866-311-9184 for more information. Questions can also be sent to cedienrollment@wellpoint.com.

ZIP Codes and Address Information for 5010A1

The information provided below is for claim files being sent in the version 5010A1 format. For more information about when you will be transitioning to this format, please contact your software vendor, billing service, or clearinghouse.

In the version 5010A1 format, a change has been made to include the full nine-digit ZIP Code for the Billing Provider (2010AA loop for ANSI claims). It will also be required for any Service Facility locations (2310C loop and 2420C loop for ANSI claims) if they are required to be sent. Providing all zeros in the four-digit extension will cause front end rejections.

The Billing Provider Address (2010AA loop for ANSI claims) will require a physical location address to be reported in 5010A1 claim files. P.O. Box and lockbox addresses cannot be reported as a billing provider address. If you would like to send a P.O. Box or lockbox address, it must be reported as a Pay-to Address (2010AB loop for ANSI claims). The Pay-To Provider address is only needed if it is different than the one being used for the Billing Provider. Providers should work with their software vendors to ensure that the correct addresses are captured and sent in the correct locations when they make the transition to sending the 5010A1 format.

Questions regarding these changes should be directed to your software vendor, billing service, or clearinghouse. Be sure to ask when you will be making the transition to the 5010A1 format for claim submission.

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.

CMS Staff to Conduct Follow-up Calls for CERT Program

The Centers for Medicare and Medicaid Services (CMS) will be conducting follow-up calls to providers for the Comprehensive Error Rate Testing (CERT) program. Our staff may contact you to obtain all necessary medical record documentation for claims reviewed under the CERT program. Although you may have already received letters and telephone calls from the CERT contractor, these additional efforts by CMS to obtain adequate documentation may change your claim's status from "improper payment" to "proper payment." This will allow us to calculate a more accurate Medicare FFS error rate, while also reducing the amount of improper payments.

COMPETITIVE BIDDING

CBIC Website - New Look Coming Soon

The Competitive Bidding Implementation Contactor (CBIC) website, http://www.dmecompetitivebid.com, will have a new look and feel. What does this mean for you? It means less scrolling and clicking to access information. It also means new features that allow you to find information faster, such as an interactive map with details about each competitive bidding area (CBA), and functions that allow you to bookmark, e-mail, save and print pages.

Look for the changes to take effect early next week. In the meantime, be sure to continue visiting the CBIC website for accurate, up-to-date information for bidders and contract suppliers about the Medicare DMEPOS Competitive Bidding Program.

COMPETITIVE BIDDING CONT'D

DMEPOS Competitive Bidding Program Focuses on Providing Access to High-Quality Products and Services for People with Medicare

The Centers for Medicare & Medicaid Services (CMS) launched the first phase of the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program on Saturday, January 1, 2011, in nine different areas of the country.

Through supplier competition, the program set new, lower payment rates for certain medical equipment and supplies, such as oxygen equipment, certain power wheelchairs and mail order diabetic supplies. CMS estimates that Medicare and beneficiaries will pay 32-percent less on average for these equipment and supplies. In most cases, Medicare beneficiaries who obtain these items in the nine competitive bidding areas will need to get them from the Medicare suppliers that were awarded contracts in order to have the items covered under Medicare. More than four million Medicare beneficiaries living in the nine competitive bidding areas can save money through this new program, while continuing to have access to quality medical equipment from accredited suppliers they can trust.

We are pleased to report that implementation of the program is going very smoothly. We continue to deploy a wide array of resources across all of the competitive bidding areas to address any concerns that may arise, including local State Health Insurance and Assistance Program (SHIP) offices, specially-trained customer service representatives at 1-800-MEDICARE, and caseworkers in Medicare's regional offices who all stand ready to assist beneficiaries who may have questions about the program. In addition, there is a complaint and inquiry process for beneficiaries, caregivers, doctors, referral agents, and suppliers to use for reporting concerns about a contract supplier or other competitive bidding implementation issues. This process is designed to ensure that all complaints are correctly routed, investigated, resolved, tracked, and reported.

To read the entire CMS Press Release issued on this topic on Wed Feb 16, visit http://www.CMS.gov/apps/media/press_releases.asp. Read more about how the Affordable Care Act improves Medicare at http://www.Healthcare.gov/law/provisions/rebate/index.html. And for additional information about the Medicare DMEPOS Competitive Bidding Program, please visit http://www.CMS.gov/DMEPOSCompetitiveBid.

COVERAGE

LCD and Policy Article Revisions - Summary for February 17, 2011

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

Oral Appliances for Obstructive Sleep Apnea
LCD
Revision Effective Date: 01/03/2011
INDICATIONS AND LIMITATIONS OF COVERAGE:
Corrected: Clerical error in the coverage criterion for Severe OSA (Was listed as criterion C. Should have been B 3.)

Suction Pumps
LCD
Revision Effective Date: 03/01/2011
INDICATIONS AND LIMITATIONS OF COVERAGE:
Replaced: A4624 with A4628 in reference to re-use of catheter

Wheelchair Options/Accessories
Policy Article
Revision Effective Date: 03/01/2011
CODING GUIDELINES:

Clarified: Billing instructions for Power Wheelchairs for armrests versus separate billing for detachable adjustable height armrests (K0017 and K0018)

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

LCD and Policy Article Revisions - Summary for March 3, 2011

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

Automatic External Defibrillators
LCD
Revision Effective Date: 01/01/2011
INDICATIONS AND LIMITATIONS OF COVERAGE:
Revised: Preamble language
HCPCS CODES AND MODIFIERS:
Added: KF modifier
Revised: GA modifier

Policy Article
Revision Effective Date: 01/01/2011
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: Preamble statement
CODING GUIDELINES:
Added: KF modifier use information

Cold Therapy
LCD
Revision Effective Date: 01/01/2011
INDICATIONS AND LIMITATIONS OF COVERAGE:
Revised: Preamble language
HCPCS CODES AND MODIFIERS:
Added: Code A9273

Policy Article
Revision Effective Date: 01/01/2011
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: Preamble language

High frequency Chest Wall Oscillation Devices
LCD
Revision Effective Date: 01/01/2011
INDICATIONS AND LIMITATIONS OF COVERAGE:
Revised: Preamble language
HCPCS CODES AND MODIFIERS:
Revised: GA modifier

Policy Article
Revision Effective Date: 01/01/2011
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: Preamble language

Intravenous Immune globulin
LCD
Revision History Effective Date: 01/01/2011
INDICATIONS AND LIMITATIONS OF COVERAGE AND MEDICAL NECESSITY:
Revised: Preamble
Revised: "Medical necessity" changed to "reasonable and necessary"
HCPCS CODES:
Added: J1599
DOCUMENTATION REQUIREMENTS:
Added: J1599
Revised: Information required for NOC codes

COVERAGE CONT'D

Policy Article
Revision Effective Date: 01/01/2011
NONMEDICAL NECESSITY COVERGE AND PAYMENT RULES:
Added: Preamble
Added: Benefit category statement

Lower Limb Prosthesis
LCD
Revision Effective Date: 01/01/2011
INDICATIONS AND LIMITATIONS OF COVERAGE:
Added: Functional level requirement for L5961
Changed: Functional level for L5978
HCPCS CODES:
Added: L5961

Policy Article
Revision Effective Date: 01/01/2011
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: Preamble language
Added: Benefit Category Statement

Mechanical In-exsufflation Devices
LCD
Revision Effective Date: 01/01/2011
INDICATIONS AND LIMITATIONS OF COVERAGE:
Revised: Preamble
Replaced: "medically necessary" with "reasonable and necessary"

HCPCS CODES AND MODIFIERS:
Added: A7020
ICD-9 CODES THAT SUPPORT MEDICAL NECESSITY:

Added: ICD-9 351.29

Policy Article
Revision Effective Date: 01/01/2011
NONMEDICAL MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: Preamble
Added: Benefit category statement

CODING GUIDELINES:
Added: Bundling statement for A7020

Negative Pressure Wound Therapy Pumps
LCD
Revision Effective Date: 01/01/2011
INDICATIONS AND LIMITATIONS OF COVERAGE AND MEDICAL NECESSITY:
Revised: Preamble
Revised: "medically necessary" replaced with "reasonable and necessary"

HCPCS CODES AND MODIFIERS
Revised: GA narrative
DOCUMENTATION REQUIREMENTS:
Revised: "medically necessary" replaced with "reasonable and necessary"

Policy Article
Revision Effective Date: 01/01/2011
NONMEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: Preamble
Added Benefit category statement

COVERAGE CONT'D

Oral Antiemetic Drugs (Replacement for Intravenous Antiemetics)
LCD
Revision Effective Date: 01/01/2011
INDICATIONS AND LIMITATIONS OF COVERAGE:
Revised: Preamble language
HCPCS CODES AND MODIFIERS:
Revised: GA modifier

Policy Article
Revision Effective Date: 01/01/2011
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: Preamble language

Ostomy Supplies
LCD
Revision Effective Date: 01/01/2011
INDICATIONS AND LIMITATIONS OF COVERAGE:
Revised: Preamble language
HCPCS CODES AND MODIFIERS:
Revised: A4399, A4407, A4408

Policy Article
Revision Effective Date: 01/01/2011
NON-MEDICAL NECESSITY AND PAYMENT RULES:
Added: Preamble language

Oxygen and Oxygen Supplies
LCD
Revision Effective Date: 01/01/2011
INDICATIONS AND LIMITATIONS OF COVERAGE:
Added: Noncoverage statement for E0446
Added: Clinical trial coverage for cluster headaches (CR7235)
Revised: Clarified sleep testing qualification using results that drop from baseline.
HCPCS CODES AND MODIFIERS:
Added: E0446

Policy Article
Revision Effective Date: 01/01/2011
NONMDEICAL NECESSITY COVERAGE AND PAUMENT RULES:
Added: Preamble and coverage benefit statement
CODING GUIDELINES:
Added: Coding instructions for equipment used in a cluster headache clinical trial (CR7235)
BILLING INSTRUCTIONS:
Clarified: Monthly billing for contents

Pressure Reducing Support Surfaces – Group 1
LCD
Revision Effective Date: 01/01/2011
INDICATIONS AND LIMITATIONS OF COVERAGE:
Revised: Preamble language
HCPCS CODES AND MODIFIERS:
Revised: GA modifier

Policy Article
Revision Effective Date: 01/01/2011
NONMEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: Preamble language

COVERAGE CONT'D

Pressure Reducing Support Surfaces – Group 2
LCD
Revision Effective Date: 01/01/2011
INDICATIONS AND LIMITATIONS OF COVERAGE:
Revised: Preamble language
HCPCS CODES AND MODIFIERS:
Revised: GA modifier

Policy Article
Revision Effective Date: 01/01/2011
NONMEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: Preamble language
CODING GUIDELINES (Effective 01/01/2007):
Removed: Reference to E0180 as a possible code for a powered overlay

Pressure Reducing Support Surfaces – Group 3
LCD
Revision Effective Date: 01/01/2011
INDICATIONS AND LIMITATIONS OF COVERAGE:
Revised: Preamble language
HCPCS CODES AND MODIFIERS:
Revised: GA modifier

Policy Article
Revision Effective Date: 01/01/2011
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: Preamble language

Refractive Lenses
LCD
Revision Effective Date: 01/01/2011
INDICATIONS AND LIMITATIONS OF COVERAGE:
Revised: Preamble language
HCPCS CODES AND MODIFIERS:
Revised: GA modifier

Policy Article
Revision Effective Date: 01/01/2011
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: Preamble language

Speech Generating Devices
LCD
Revision Effective Date: 01/01/2011
INDICATIONS AND LIMITATIONS OF COVERAGE:
Revised: Preamble language
HCPCS CODES AND MODIFIERS:
Revised: GA modifier

Policy Article
Revision Effective Date: 01/01/2011
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: Preamble language

Transcutaneous Electrical Nerve Stimulators
LCD
Revision Effective Date: 01/01/2011
INDICATIONS AND LIMITATIONS OF COVERAGE AND MEDICAL NECESSITY:
Added: Preamble
Revised: "medically necessary" replaced with "reasonable and necessary"
HCPCS CODES AND MODIFIERS:
Revised: GA modifier narrative
DOCUMENTATION REQUIREMENTS:
Revised: "medically necessary" replaced with "reasonable and necessary"

Policy Article
Revision Effective Date: 01/01/2011
NONMEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: Preamble
Added: Benefit category statement

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

LCD and Policy Article Revisions – Summary for April 21, 2011

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

Lower Limb Prosthesis
LCD
Revision Effective Date: 01/01/2011 (April publication)
DOCUMENTATION REQUIREMENTS:
Clarified: Instruction for submitting prosthetic claim for billed code for hip (L5961)

Policy Article
Revision Effective Date: 01/01/2011
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Updated: List of prostheses included in the payment to a SNF

Nebulizers
Policy Article
Revision Effective Date: 02/04/2011
NONMEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: Preamble language
Revised: Correct coding instructions for code G0333

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.

CPM DEVICES

CPM Coverage Time Limit Following Total Knee Replacement – RAC Identified Issue

Continuous Passive Motion (CPM) coverage is limited by Medicare to a 3-week period following a total knee replacement. Claims paid for CPM devices for dates of service more than 3 weeks after a total knee replacement are an overpayment error. This article is a result of findings from the Recovery Audit Contractor (RAC), HealthDataInsights, as published as "New Issues Approved by CMS."

CPM DEVICES CONT'D

Resources pertaining to this RAC identified issue:

- RAC "New Issues Approved by CMS": https://racinfo.healthdatainsights.com/Public1/NewIssues.aspx
- CMS Internet Only Manual Publication 100-3, National Coverage Determinations Manual, Chapter 1, Part 4, Section 280.1, http://www.cms.gov/manuals/downloads/ncd103c1_Part4.pdf
- CMS Internet Only Manual Publication 100-4, Claims Processing Manual, Chapter 20, Section 30.2.1, http://www.cms.gov/manuals/downloads/clm104c20.pdf, as cited below:

"The CPM devices (HCPCS code E0935) are classified as items requiring frequent and substantial servicing and are covered as DME as follows (see the Medicare National Coverage Determinations Manual.):

> Continuous passive motion devices are covered for patients who have received a total knee replacement. To qualify for coverage, use of the device must commence within 2 days following surgery. In addition, coverage is limited to that portion of the 3 week period following surgery during which the device is used in the patient's home.

Contractors make payment for each day that the device is used in the patient's home. No payment can be made for the device when the device is not used in the patient's home or once the 21 day period has elapsed. Since it is possible for a patient to receive CPM services in their home on the date that they are discharged from the hospital, this date counts as the first day of the three week limited coverage period."

Additional information previously published by NAS regarding CPM is provided as follows:

- https://www.noridianmedicare.com/dme/news/docs/2010/03_mar/act_q_and_a_021710.html
- https://www.noridianmedicare.com/dme/news/docs/2008/03_mar/cpm_coding_guidelines.html

DRUGS/BIOLOGICALS

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

The manufacturer of capecitabine has notified the Food and Drug Administration (FDA) that there is a national shortage of the 500 mg. dosage form of the drug. To accommodate this temporary shortage, the FDA has approved the sale of the European 500 mg. capecitabine formulation in the United States. Pharmacy access to the European formulation is anticipated shortly.

Currently there is no national drug code (NDC) number assigned to the European formulation of 500 mg. Capecitabine. Until an NDC number can be assigned, suppliers are instructed to follow the instructions in the Coding Guidelines Section of the Oral Anticancer Drugs Policy Article and use the miscellaneous code J8999. The new NDC number will be posted on the Pricing, Data Analysis, and Coding Contractor website when it becomes available. At that time, suppliers may use it for claim submission and discontinue use of J8999.

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

Faslodex (J9395) Claims Processing Issue – Provider Action Needed

The Centers for Medicare & Medicaid Services has identified a Medicare claims processing issue with Healthcare Common Procedure Coding System (HCPCS) J9395 (Fulvestrant, 25 mg) (Faslodex) that began January 1, 2011. Payment for Faslodex is currently limited to a 250 mg dose but should be 500 mg, effective January 1, 2011, based on U.S. Food and Drug Administration (FDA) approved prescribing information. This will be corrected on April 1, 2011.

Provider Action
Providers may delay submission of their claims for a dosage greater than 250 mg until April 1, 2011, when the fix is in place to properly pay these claims. Alternatively, in this instance only, providers may submit their claims prior to April 1, 2011 by reporting J9395 on two lines of a claim utilizing modifier 59 with the code on one claim line, reporting ten units of service on each line, and be paid for the 500 mg dose of Faslodex.

If providers have had claims denied due to this issue, they may resubmit their claims using the alternative identified above or request a reopening after April 1, 2011."

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

MLN Matters® Number: MM7357
Related Change Request (CR) #: 7357
Related CR Release Date: March 25, 2011
Related CR Transmittal #: R2182CP
Effective Date: July 1, 2011
Implementation Date: July 5, 2011

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

Provider Action Needed
This article is based on Change Request (CR) 7357, which instructs Medicare contractors to download and implement the July 2011 Average Sales Price (ASP) drug pricing file for Medicare Part B drugs; and, if released by the Centers for Medicare & Medicaid Services (CMS), the revised April 2011, January 2011, October 2010, and July 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 July 1, 2011, with dates of service July 1, 2011, through September 30, 2011. Contractors will not search and adjust claims that have already been processed unless brought to their attention. Please ensure that your staffs are aware of this quarterly update.

Background
The ASP methodology is based on quarterly data submitted to CMS by manufacturers. CMS supplies Medicare contractors with the ASP and Not Otherwise Classified (NOC) drug pricing files for Medicare Part B drugs on a quarterly basis. Payment allowance limits under the Outpatient Prospective Payment System (OPPS) are incorporated into the Outpatient Code Editor (OCE) through separate instructions.

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

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

Additional Information
If you have questions, please contact your Medicare MAC, carrier, or FI at their toll-free number, which may be found at http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip on the CMS website. The official instruction (CR 7357) issued to your Medicare MAC, carrier, and FI may be found at http://www.cms.gov/transmittals/downloads/R2182CP.pdf on the CMS website.

Quarterly HCPCS Drug/Biological Code Changes – April 2011 Update

MLN Matters® Number: MM7299 Revised
Related Change Request (CR) #: 7299
Related CR Release Date: February 4, 2011
Related CR Transmittal #: R2147CP
Effective Date: April 1, 2011
Implementation Date: April 4, 2011

Note: This article was revised on February 22, 2011, to show the correct status indicator of "X" for HCPCS code Q2040. All other information is the same.

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

What You Need to Know
Change Request (CR) 7299 announces that effective for claims with dates of service on or after April 1, 2011, HCPCS code Q2040 (Injection, Incobotulinumtoxin A, 1 Unit) will be payable by Medicare. Specifically, your contractors will accept Q2040 as a valid HCPCS code for dates of service on or after April 1, 2011, using Type of Service (TOS) 1, 9, and Medicare Physician Fee Schedule Database (MPFSDB) Status Indicator "X" (Statutorily Excluded from Physician Fee Schedule). You should make sure that your billing staffs are aware of this HCPCS code change.

Additional Information
You can find the official instruction, CR7299, issued to your carrier, FI, RHHI, A/B MAC, or DME MAC by visiting http://www.cms.gov/Transmittals/downloads/R2147CP.pdf on the Centers for Medicare & Medicaid Services (CMS) website.

Revised April 2011 ASP Files Now Available

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

Updated October 2010 and January 2011 ASP Files Now Available

CMS has posted revised October 2010 and January 2011 Average Sales Price (ASP) Pricing files, which are available for download at: http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/ (see left menu for year-specific links).

Widespread Prepayment Review for Immunosuppressive Drugs Edit Effectiveness for 2nd Quarter

The Jurisdiction D DME MAC Medical Review Department is conducting a widespread complex review of HCPCS codes J7507, J7517, J7518 and J7520 and the second quarter edit effectiveness results from November 2010 through February 2011 are as follows:

The results of the review of the claims identified 4,634 claims of which 3,689 were denied. This resulted in an overall error rate of 79%. This is an increase from 68% during the first quarter of this review. Due to the increasing high error rate, NAS will continue with the widespread complex review.

The following are the top reasons for denial:

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

B. No valid written order

   a. No written order submitted with the documentation

   b. Insufficient or incomplete order

C. No Proof Of Delivery

   a. No proof of delivery submitted with the documentation

   b. Invalid proof of delivery

D. No Part A coverage for transplant

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

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

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

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

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.

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.

As a reminder, the Local Coverage Determination (LCD) for Immunosuppressive Drugs (L68) states in part:

Prescription drugs used in immunosuppressive therapy are covered if all of the following criteria (I-V) are met:

I. Immunosuppressive drugs are prescribed following either:

A. Kidney (V42.0), heart (V42.1), liver (V42.7), bone marrow (V42.81)/stem cell (V42.82), lung (V42.6), or heart/lung (V42.1 and V42.6) transplant; or

B. Whole organ pancreas (V42.83) transplant performed concurrent with or subsequent to a kidney transplant (V42.0) because of diabetic nephropathy (performed on or after July 1, 1999); or

C. Intestinal transplant (V42.84) (performed on or after April 1, 2001); or

D. Pancreatic islet cell transplant (V42.89) or partial pancreatic tissue transplantation (V42.89) performed on or after October 1, 2004 that is conducted as part of a National Institutes of Health (NIH)-sponsored clinical trial; or

E. Pancreas transplants alone (performed on or after April 26, 2006) that meet the following criteria:

1. The transplant is performed in a facility that is Medicare-approved for kidney transplantation; and

2. Patient must have a diagnosis of type I diabetes; and:

a. Must be beta cell autoantibody positive; or

b. Must demonstrate insulinopenia, (fasting C-peptide level that is less than or equal to 110% of the lower limit of normal of the laboratory's measurement method). A fasting glucose must be obtained when performing a fasting C-peptide determination. Fasting C-peptide levels are considered valid when a concurrently obtained fasting glucose is < 225 mg/dl; and

3. Must have a history of labile (brittle or medically-uncontrollable) insulin-dependent diabetes mellitus resulting in documented recurrent, severe, acutely life-threatening metabolic complications requiring

hospitalizations(s). Complications may include frequent hypoglycemia where the patient is unaware, recurring severe ketoacidosis, or recurring severe hypoglycemic attacks; and

4. Must have been under the care of an endocrinologist and have clinical documentation denoting optimal and intensive management was provided for at least 12 months, having received the most medically-recognized advanced insulin formulations and delivery systems; and
5. Must demonstrate being able to emotionally and mentally understand the significant risks associated with surgery and be able to effectively manage the lifelong need for immunosuppression; and
6. Must otherwise be a suitable candidate for transplantation; and

II. The transplant met Medicare coverage criteria in effect at the time (e.g., approved facility for kidney, heart, intestinal, liver, lung, or heart/lung transplant; national and/or local medical necessity criteria; etc.); and

III. The patient was enrolled in Medicare Part A at the time of the transplant; and

IV. The patient is enrolled in Medicare Part B at the time that the drugs are dispensed; and

V. The drugs are furnished on or after the date of discharge from the hospital following a covered organ transplant.

If criteria I-V are not met, the drug(s) will be denied as noncovered.

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.

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

EDUCATIONAL

Ask the Contractor Teleconferences

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

Upcoming 2011 ACTs: 3 p.m. CT

- June 14 – Oxygen
- July 7 – General
- August 24 – Glucose
- October 12 – Orthotics and Prosthetics

Conference Information

- Telephone Number: 1-800-230-1074
- International Number (American Samoa, Guam or the Northern Mariana Islands): 1-612-288-0337

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

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

CMS Offers Educational Tools on HIPAA EDI Standards, Remittance Advices, and Email Subscriptions

"HIPAA EDI Standards" Web-Based Training Revised

The Medicare Learning Network® is now offering the revised "HIPAA EDI Standards" web-based training (revised January 2011) for CE credit. The goal of this activity is to provide information to physicians, suppliers, and healthcare professionals regarding electronic billing and other healthcare electronic transactions such as the Administrative Simplification provisions of HIPAA, electronic transaction standards and code sets required by HIPAA, and an overview of the steps involved in the Medicare electronic data interchange process. To take this training, visit http://www.CMS.gov/MLNProducts and click on "Web-Based Training Modules" under "Related Links Inside CMS."

"Understanding the Remittance Advice: A Guide for Medicare Providers, Physicians, Suppliers and Billers" Publication Revised

The publication titled "Understanding the Remittance Advice: A Guide for Medicare Providers, Physicians, Suppliers and Billers" (revised October 2010) is designed to educate institutional and professional providers who bill Medicare with general remittance advice (RA) information. It includes instructions to help you interpret the RA received from Medicare and reconcile it against submitted claims and provides guidance on how to read Electronic Remittance Advices (ERAs) and Standard Paper Remittance Advices (SPRs), as well as information on balancing an RA. This publication may be downloaded from http://www.CMS.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf.

"CMS Email Subscription Service" Publication Available in Print

The educational tool titled "CMS Email Subscription Service" (revised October 2010), which provides education on the various CMS Fee-For-Service (FFS) electronic mailing lists, is now available in print format from the Medicare Learning Network® (MLN). To place your order, visit http://www.CMS.gov/MLNGenInfo, scroll down to "Related Links Inside CMS," and select "MLN Product Ordering Page."

Index to Articles Published from October 2006 to Current Now Available

NAS has created a categorized index to the articles published by CMS and NAS as the DME Medicare Administrative Contractor for Jurisdiction D beginning with articles dated October 2006. The articles are categorized by topic and include the title, the CMS MLN Matters source if applicable, the DME Happenings bulletin issue number, the bulletin page number, and the date the article was first posted to the "What's New / Latest Updates" section of our website.

This index had been first published and included as part of the "DMEPOS Jurisdiction D Supplier Training Manual" and mailed to each active supplier within Jurisdiction D during January and February 2011. The index is scheduled to be updated on a quarterly basis as additional DME Happenings bulletins are published.

NAS Jurisdiction D DME Happenings: Index to Articles

Category	Title	Issue	Page	MLN Matters	Date Posted
1099 Form					
	Support Income Tax Reporting	11	6	5816	2/6/2008
	DME MACs Issuing 1099s for 2007	11	6		2/4/2008
1500 Claim Form					
	Updated Form CMS-1500 Information	28	54	6929	6/3/2010
	Update to Medicare Learning Network Educational Product: CMS Form 1500 Web-Based Training Course	16	9		9/12/2008
	Item 24J Reminder	7	34		8/22/2007
	CMS-1500 Tutorial Now Available on NAS Web Site	5	8		5/17/2007
	Q & As from March 2007 CMS-1500 Claim Form Workshops	5	12		5/2/2007
	Item 11 Submission for Paper Claims	5	46		6/5/2007
	Improper Reporting on NPI, Supplier Number and UPIN on Revised CMS-1500 Claim Form	4	20		Archived
	Revisions to Incomplete or Invalid Claims Instructions Necessary to Implement the Revised CMS-1500 (Version 8/05) - Revised	4	22	5391	Archived

This resource was developed in response to supplier comments received through the website satisfaction survey as well as the Medicare Contractor Provider Satisfaction Survey (MCPSS). Suppliers are encouraged to share their thoughts regarding this new resource by completing the Website Satisfaction Survey that is randomly displayed or by completing the MCPSS. NAS appreciates and value your thoughts and will continue improving the material on our website based on supplier feedback.

"Medicare Contractor Provider Satisfaction Survey" Fact Sheet

New from the Medicare Learning Network: The "Medicare Contractor Provider Satisfaction Survey" fact sheet provides information on the Medicare Contractor Provider Satisfaction Survey (MCPSS), which offers Medicare FFS providers and suppliers the opportunity to provide feedback on interactions with Medicare contractors. The product is available in downloadable format and can be viewed at http://www.CMS.gov/MLNProducts/Downloads/MCPSS_FactSheet.pdf.

Medicare Learning Network: Products Catalog and NPI Booklet

From the MLN: Medicare Learning Network Products Catalog Now Available
The March 2011 version of the Medicare Learning Network® Products Catalog is now available! The MLN Products Catalog is a free interactive downloadable document that lists all MLN products by media format. To access the catalog, visit http://www.CMS.gov/MLNGenInfo and select the "MLN Products Catalog" in the Downloads section. Once you have opened the catalog, you may either click on the title of a product or the type of "Formats Available."

From the MLN: "The National Provider Identifier: What You Need to Know" Booklet Revised
Revised! "The National Provider Identifier (NPI): What You Need to Know" (revised February 2011) is now available in downloadable format. This booklet was created to help you become more familiar with the NPI (established by final rule on Jan 23, 2004). Covered entities under HIPAA are required by regulation to use NPIs to identify healthcare providers in HIPAA standard transactions. This publication may be downloaded from http://www.CMS.gov/MLNProducts/downloads/NPIBooklet.pdf.

Medicare Learning Network: Quality Standards, Accreditation, and Pharmacies

CMS provides three new fact sheets for suppliers regarding quality standards, the basics of accreditation, and information for pharmacies.

New "DMEPOS Quality Standards" Fact Sheet
The new publication titled "Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Quality Standards" is now available in downloadable format from the Medicare Learning Network(r) at http://www.CMS.gov/MLNProducts/downloads/DMEPOS_Qual_Stand_Booklet_ICN905709.pdf. This fact sheet is designed to provide education on DMEPOS quality standards for Medicare deemed Accreditation Organizations (AOs) for DMEPOS suppliers. A hard copy version of this fact sheet will be available at a later date.

New "The Basics of DMEPOS Accreditation" Fact Sheet
A new publication titled "The Basics of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Accreditation" is now available in downloadable format from the Medicare Learning Network(r) at http://www.cms.gov/MLNProducts/downloads/DMEPOS_Basics_FactSheet_ICN905710.pdf. This fact sheet is designed to provide education on the DMEPOS accreditation requirements, the types of providers who are exempt, and the process for becoming accredited. A hard copy version of this fact sheet will be available at a later date.

New "DMEPOS New Information for Pharmacies" Booklet
A new publication titled "Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) New Information for Pharmacies" is now available in downloadable format from the Medicare Learning Network(r) at http://www.cms.gov/MLNProducts/downloads/DMEPOS_Pharm_FactSheet_ICN905711.pdf. This booklet is designed to provide education for new pharmacies on how to obtain a DMEPOS accreditation exemption. In order to supply DMEPOS, pharmacies must be accredited by a CMS-approved independent national Accreditation Organization (AO) or must obtain an accreditation exemption. A hard copy version of this fact sheet will be available at a later date.

MLN Opinion Page and Revised Factsheet on Dual Eligible's

Medicare Learning Network (MLN) Opinion Page
The Medicare Learning Network® (MLN) is interested in what you have to say. Regardless of whether you have an MLN account or not, you can evaluate the MLN products, services, and activities that you have participated in, received, or downloaded.

If you don't have an MLN account or don't want to log in, don't worry: the MLN offers a new anonymous evaluation function that allows you to complete an evaluation without logging in. Visit the MLN Opinion Page (http://www.CMS.gov/MLNProducts/85_Opinion.asp) and click on 'MLN Opinion Page' in the 'Related Links Inside CMS' section at the bottom of the page. Click on the underlined title of the product, service, or activity you want to evaluate and click on the 'Take the anonymous evaluation for this product' link that will appear on the right-hand side. A new window will open containing the product evaluation.

Your feedback is important to us and we use your suggestions to help us improve our educational products, services, and activities and to develop products, services, and activities that better meet your educational needs. If you have any suggestions related to MLN product topics or formats, please send them to MLN@cms.hhs.gov.

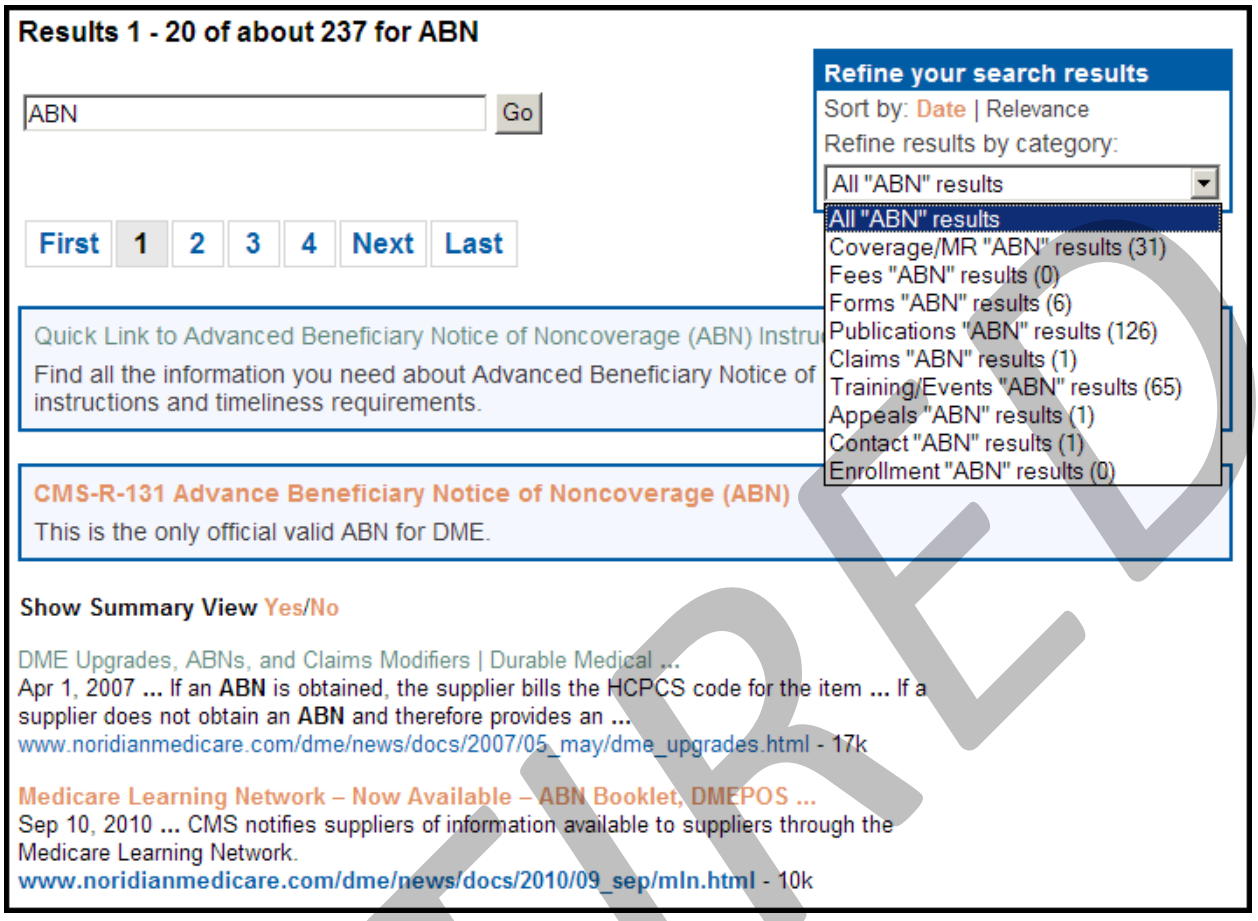
"Medicaid Coverage of Medicare Beneficiaries (Dual Eligible's) At a Glance" Factsheet Revised
The revised publication titled "Medicaid Coverage of Medicare Beneficiaries (Dual Eligible's) At a Glance" (revised December 2011) is now available from the Medicare Learning Network at http://www.CMS.gov/MLNProducts/downloads/Medicare_Beneficiaries_Dual_Eligibles_At_a_Glance.pdf.

Search Engine Result Page Navigation Options Improved

Suppliers will notice improved options in viewing search results from our https://www.noridianmedicare.com/dme website. These results, based on direct supplier feedback and survey responses, include the ability to:

1. Navigate between the first and last pages containing search results
2. Refine search by date or relevance is now in a more noticeable location
3. Note: The default is to sort results by "Relevance" so only the "Date" sort option is offered as a link. When someone elects to sort the results by selecting the Date link, the Relevance sort option is then offered as a link.
4. Refine search results by category and see how many search results for any given search term(s) is located within a specified website category (i.e. fee schedules, training and events)
5. Display an advertisement which provides a link to the most applicable resource or time-sensitive events pertaining to the searched term
6. Minimize the narrative summary that accompanies the title and link for each search result
7. Modify the searched term within the search box and select 'Go' to submit a new query

EDUCATIONAL CONT'D



Suppliers are encouraged to share their thoughts regarding this new resource by completing the Website Satisfaction Survey that is randomly displayed or by completing the Medicare Contractor Provider Satisfaction Survey. NAS appreciates and values your thoughts and will continue improving the material on our website based on supplier feedback.

Training Manual Mailed to Active NAS DME Jurisdiction D Suppliers February 2011

In response to supplier feedback received and analysis conducted, each active NAS DME Jurisdiction D supplier is being mailed a "Supplier Training Manual" in February 2011. Suppliers should know this is a one-time mailing and it is a supplier's choice if they choose to maintain the manual based on resources received at educational events, electronic mailings, and updates to the https://www.noridianmedicare.com/dme website. The training manual includes:

1. Contact information for multiple contractors
2. Interactive Voice Recognition (IVR) System user guide and At-a-Glance guide
3. Electronic claim submission information
4. Documentation information (intake forms, Certificates of Medical Necessity, DME Information Forms)
5. Advanced Beneficiary Notice of Noncoverage form and instructions
6. 2011 tentative education schedule of workshops and related events
7. Endeavor; explanation of the free, supplier portal offering online eligibility, claim status, same/similar, and claim-specific remittance advice
8. Index to Articles published in the DME Happenings bulletins between October 2006 and December 2010
9. 1500 claim form instructions
10. Forms; including Medicare Secondary Payer Inquiry and Refunds, Overpayment Refunds, and Redetermination Request
11. Acronym listing
12. Reviews; including Comprehensive Error Rate Testing, Recovery Audit Contractor, and NAS Medical Reviews

Replication of the contents within the Training Manual is permitted by suppliers for the purpose of training staff within their office. This training manual is not to be confused with the 16 chapter supplier manual accessible from our website which is maintained quarterly for suppliers to reference, print, and share with staff. NAS hopes suppliers use this as a foundation of Medicare knowledge.

Updates from Medicare Learning Network – Billing Tools and Protected Health Information

New Information for Compliance Officers and Billing and Coding Professionals

As part of ongoing efforts by CMS to keep Medicare Fee-For-Service providers aware of new and improved products, CMS encourages you to visit the Provider Compliance MLN web page, where you will find FFS provider materials to help you understand – and avoid – common billing errors and other improper activities identified through claim review programs. Be sure to pay particular attention to the listing of Provider Compliance National Educational Products, from which you can quickly link to each available product. Also take a moment to review the first two issues of the Medicare Quarterly Provider Compliance Newsletter (Volume 1, Issue 1 and Volume 1, Issue 2). And like all MLN products, our downloadable compliance materials are available at no cost.

"Medical Privacy of Protected Health Information" Factsheet Revised

The revised publication titled "Medical Privacy of Protected Health Information" (revised January 2011) is now available from the **Medicare Learning Network®** at http://www.CMS.gov/MLNproducts/downloads/SE0726FactSheet.pdf. This factsheet contains resources and information regarding the HIPAA Privacy Rule and how this applies to customary healthcare practices and other information on the HHS HIPAA webpage.

Updates from Medicare Learning Network: Signature Requirements and Interactive Guide CD-ROM

New "Signature Requirements" Fact Sheet

A new publication titled "Signature Requirements" is now available in downloadable format from the Medicare Learning Network® at http://www.CMS.gov/MLNProducts/downloads/Signature_Requirements_Fact_Sheet_ICN905364.pdf. This fact sheet is designed to provide education on Signature Requirements to healthcare providers, and includes information on the documentation needed to support a claim submitted to Medicare for medical services.

EDUCATIONAL CONT'D

New "Interactive Guide to the Medicare Learning Network" CD-ROM
The Medicare Learning Network® has released a new CD-ROM titled "The Interactive Guide to the Medicare Learning Network." This CD-ROM allows for a two-way flow of information between FFS providers and the MLN. Providers and other healthcare professionals can link directly from the products described on the CD-ROM to the MLN webpages and the MLN Catalog of Products. Once there, users can then confidently download and print copies of the most up-to-date and accurate MLN products. To order the CD-ROM through the MLN Product Ordering System, visit http://www.CMS.gov/MLNProducts.

ENROLLMENT

Expansion of DME Supplier Standards

MLN Matters® Number: SE1032

Provider Types Affected
Suppliers of Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) submitting claims to Medicare DME Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries are impacted by this Special Edition (SE) 1032.

Provider Action Needed
This article alerts suppliers that the Centers for Medicare & Medicaid Services (CMS) expanded the enrollment standards that DMEPOS suppliers must meet in order to establish and/or maintain billing privileges in the Medicare Program. CMS issued these revisions to ensure that only legitimate DMEPOS suppliers participate in the Medicare program and are providing DMEPOS items to Medicare beneficiaries. Be certain your billing staffs are aware of these changes.

Background
On August 27, 2010 CMS published a final rule titled, *Medicare Program; Establishing Additional Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Supplier Enrollment Safeguards* (CMS-6036-F) in the Federal Register. This final rule, effective September 27, 2010, may be reviewed at http://edocket.access.gpo.gov/2010/pdf/2010-21354.pdf on the Internet. This final rule clarifies, expands, and adds to the existing enrollment requirements that DMEPOS suppliers must meet to establish and maintain billing privileges in the Medicare program.

Key Points of SE1032
The *Medicare Program; Establishing Additional Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Supplier Enrollment Safeguards* rule does the following:

- Requires DMEPOS suppliers to obtain oxygen from a State-licensed oxygen supplier (applicable only to those suppliers in States that require oxygen licensure (Section 424.57(c)(27));
- Requires DMEPOS suppliers to maintain ordering and referring documentation consistent with the provisions found in Section 424.516(f) (§424.57(c)(28)). (DMEPOS supplier will be required to maintain written order from a physician or eligible professional.);
- Prohibits DMEPOS suppliers from sharing a practice location with certain other Medicare providers and suppliers (Section 424.57(c)(29));
- Requires DMEPOS suppliers to remain open to the public for at least 30 hours a week, except physician, licensed non-physician practitioners furnishing services to his or her own patient(s) as part of his or her professional service, or a DMEPOS supplier working with custom made orthotics and prosthetics (Section 424.57(c)(30)); and
- Requires DMEPOS suppliers to notify the National Supplier Clearinghouse (NSC) of an adverse legal action, change of location, or change of ownership (including authorized and delegated officials) within 30 days. Failure to notify the NSC of these changes will result in overpayments from the date of the reportable event (Section 424.57(e));
- Revises supplier standard 1 (Section 424.57(c)(1)) requiring suppliers meet all state licensure and regulatory requirements. If a State requires licensure to furnish certain items or services, a DMEPOS supplier must be licensed to provide the item or service, and must employ the licensed professional on a full-time or part time basis unless the State permits contracting for licensed services. A supplier may contract with an individual or other entity to provide licensed services unless State law expressly prohibits such an arrangement.

- Revises supplier standard 7 (Section 424.57(c)(7)) to ensure that the DMEPOS supplier maintains a physical facility on an appropriate site. The appropriate site must meet the following:
  - Except for State-licensed orthotic and prosthetic personnel providing custom fabricated orthotics or prosthetics in private practice, maintain a practice location that is at least 200 square feet;
  - Is in a location that is accessible to the public, Medicare beneficiaries, CMS, the NSC and its agents. The location must not be in a gated community or other area where access is restricted;
  - Is accessible and staffed during posted hours of operation;
  - Maintains a permanent visible sign in plain view and posts hours of operation; and
  - Is in a location that contains space for storing businesses records, including the supplier's delivery, maintenance and beneficiary communication records.
- Revises supplier standard 9 (Section 424.57(c)(9)) to limit the use of cell phones, beeper numbers, and pagers as a primary business telephone number. In addition, the exclusive use of answering machines and answering services as the primary telephone number by a DMEPOS supplier during posted business hours is prohibited.

Additional Information
Remember, your Medicare contractor is available to assist you in providing services to Medicare beneficiaries and in being reimbursed in a timely manner for those services.

If you have questions related to enrollment or accrediting standards issues, please contact the NSC at (866) 238-9652 from 9 a.m. until 5 p.m. EST to reach a customer service representative. Medicare's surety bond requirements are summarized in detail in article MM6392 at http://www.cms.gov/MLNMattersArticles/downloads/MM6392.pdf on the CMS website.

More information regarding accreditation can be found at the provider/supplier accreditation page located at http://www.cms.gov/MedicareProviderSupEnroll/07_DMEPOSAccreditation.asp on the CMS website.

For more information explaining the revised requirements for pharmacies as a result of Section 3109 (a) of the Patient Protection and Affordable Care Act you may review MM7021 at http://www.cms.gov/MLNMattersArticles/downloads/MM7021.pdf on the CMS website.

Also, extensive information, including a number of Frequently Asked Questions with answers, is available on the NSC website at http://www.palmettogba.com/nsc on the Internet.

How Institutional Providers Will Pay Medicare Enrollment Application Fee Beginning March 25, 2011

Section 6401(a) of the Affordable Care Act (ACA) requires the secretary to impose a fee on each 'institutional provider of medical or other items or services and suppliers.' The fee is to be used by the secretary to cover the cost of program integrity efforts including the cost of screening associated with provider enrollment processes, including those under section 1866(j) and section 1128J of the Social Security Act. The application fee is $505 for CY2011. Based upon provisions of the ACA, this fee will vary from year-to-year based on adjustments made pursuant to the Consumer Price Index - All Urban Consumers (CPI-U). The application fee is to be imposed on institutional providers that are newly-enrolling, re-enrolling/re-validating or adding a new practice location for applications received on and after Friday, March 25, 2011. CMS has defined 'institutional provider' to mean any provider or supplier that submits a paper Medicare enrollment application using the CMS-855A, CMS-855B (except physician and non-physician practitioner organizations), or CMS-855S forms or associated Internet-based PECOS enrollment application.

Institutional providers applying to participate in the Medicare program must first submit a completed CMS-855 application. An enrollment application can be submitted in one of two ways:

1. Electronically, using Internet-based PECOS: Once you have completed and submitted your enrollment application using Internet-based PECOS, you should then promptly pay the application fee through www.Pay.gov. Once you are on Pay.gov, type 'CMS' in the search box under 'Find Public Forms' and click the 'GO' button. Click on the 'CMS Medicare Application Fee' link. Complete the form and submit payment as directed. You will get a confirmation screen indicating that payment was successfully made. This confirmation screen is your receipt and should be printed for your records. We strongly recommend that this receipt be mailed to the Medicare contractor

along with the Certification Statement for the enrollment application. CMS will notify the Medicare contractor that the application fee has been paid. The Medicare contractor will process the provider enrollment application in the order in which it was received. Normal processing time frames apply to your provider enrollment application.

2. Complete the paper Medicare enrollment application (CMS-855): Once you have completed filling out the CMS-855 paper application, you should promptly pay the application fee through www.Pay.gov. Once you are on Pay.gov, type 'CMS' in the search box under 'Find Public Forms' and click the 'GO' button. Click on the 'CMS Medicare Application Fee' link. Complete the form and submit payment as directed. You will get a confirmation screen indicating your payment was successful. This confirmation screen is your receipt and should be printed for your records. We strongly recommend that this receipt be mailed to the Medicare contractor along with the completed CMS-855 application. CMS also notifies the Medicare contractor that your application fee has been paid. The Medicare Contractor will process your provider enrollment application in the order in which it was received. Normal processing timeframes apply to your provider enrollment application.

Pay.gov is operated by the US Department of the Treasury and is a Web-based application that allows you to make online payments to government agencies by electronic check, credit card or debit from your checking or savings account. Pay.gov accepts Visa, MasterCard, American Express and Discover. Do not mail application fee payments. Pay.gov cannot accept payments by mail or phone. Please note that all fees must be paid via Pay.gov and that paper checks will not be accepted. Users need not worry about submitting the incorrect amount; CMS has pre-populated the field for the correct payment amount for the specific calendar year. Users may not make multiple payments in one transaction and must make separate payments for each application.

CMS has reviewed the security of Pay.gov and is confident in the measures used to protect its users. Pay.gov uses 128-bit SSL encryption to protect your transaction information while you're logged in to Pay.gov. In addition, any account numbers you set up in your profile are encrypted before being stored in our database. When you access your profile, any account numbers you have entered will be masked on-screen; each account number in your profile will be displayed as a group of asterisks followed by the last four digits of the account number.

Your Medicare application is processed by the Medicare contractor via the Provider Enrollment, Chain, and Ownership System (PECOS). The application fee, which is paid electronically by check, debit card or credit card, is processed through Pay.gov. Therefore, if you have problems submitting your application fee, you should use the Help Tools available on the Pay.gov site for questions specific to the payment processing. Other questions regarding payment policies and procedures may be sent to the Medicare provider and supplier enrollment e-mail account at Dpse_admin@cms.hhs.gov.

For more information, please refer to the regulation published to the Federal Register (PDF, 636 KB). For additional clarification, look out for an official MLN Matters Article that will be released on the subject in the near future.

Implementation of Provider Screening and Risk Based Categories for Provider/Supplier Enrollment

It is the continuing goal of the Centers for Medicare & Medicaid Services (CMS) to reduce fraud, waste, and abuse through all available avenues. The Affordable Care Act requires CMS to determine the level of screening to be conducted during provider and supplier enrollment based on the level of risk posed to the Medicare system. With the enactment of the Affordable Care Act, we have the increased ability to focus our efforts on prevention, rather than simply acting after the fact. The use of risk categories and associated screening levels will help ensure that only legitimate providers and suppliers are enrolled in Medicare, Medicaid, and CHIP, and that only legitimate claims are paid.

Effective Friday, March 25, 2011, newly-enrolling and revalidating providers and suppliers will be placed in one of three screening categories – limited, moderate, or high. These categories represent the level of risk for fraud, waste, and abuse to the Medicare program for the particular category of provider/supplier, and determine the degree of screening to be performed by the Medicare Administrative Contractor (MAC) processing the enrollment application.

- Providers/suppliers in the "limited" screening category will include:
  - Physicians
  - Non-physician practitioners other than physical therapists
  - Medical groups or clinics
  - Ambulatory surgical centers

ENROLLMENT CONT'D

- Competitive Acquisition Program / Part B Vendors
- End-Stage Renal Disease facilities
- Federally-Qualified Health Centers
- Histocompatibility laboratories
- Hospitals (including Critical Access Hospitals, Department of Veterans Affairs hospitals, and other federally-owned hospital facilities)
- Health programs operated by an Indian Health Program (as defined in section 4(12) of the Indian Health Care Improvement Act) or an urban Indian organization (as defined in section 4(29) of the Indian Health Care Improvement Act) that receives funding from the Indian Health Service pursuant to Title V of the Indian Health Care Improvement Act
- Mammography screening centers
- Mass immunization roster billers
- Organ procurement organizations
- Pharmacies that are newly enrolling or revalidating via the CMS-855B application
- Radiation Therapy Centers
- Religious non-medical health care institutions
- Rural Health Clinics
- Skilled Nursing Facilities

- Providers in the "moderate" screening category will include:
  - Ambulance service suppliers
  - Community Mental Health Centers (CMHCs)
  - Comprehensive Outpatient Rehabilitation Facilities (CORFs)
  - Hospice organizations
  - Independent clinical laboratories
  - Independent Diagnostic Testing Facilities (IDTFs)
  - Physical therapists enrolling as individuals or as group practices
  - Portable x-ray suppliers (PXRS)
  - Revalidating Home Health Agencies (HHAs)
  - Revalidating DMEPOS suppliers
- Providers in the "high" screening category will include:
  - Newly-enrolling DMEPOS suppliers
  - Newly-enrolling HHAs
  - Providers and suppliers reassigned from the "limited" or "moderate" categories due to triggering events. Triggering events include the following instances:
    - imposition of a payment suspension within the previous 10 years;
    - a provider or supplier has been terminated or is otherwise precluded from billing Medicaid;
    - exclusion by the OIG;

- a provider or supplier has had billing privileges revoked by a Medicare contractor within the previous 10 years and such provider/supplier is attempting to establish additional Medicare billing privileges by enrolling as a new provider or supplier or establish billing privileges for a new practice location;
- a provider or supplier has been excluded from any federal health care program;
- a provider or supplier has been subject to any final adverse action (as defined in 42 CFR 424.502) within the past 10 years; or
- instances in which CMS lifts a temporary moratorium for a particular provider or supplier type and a provider or supplier that was prevented from enrolling based on the moratorium, applies for enrollment as a Medicare provider or supplier at any time within 6 months from the date the moratorium was lifted.

The enrollment screening procedures will vary depending upon the categories described above. Screening procedures for the "limited" screening category will largely be the same as those currently in use; screening procedures for the "moderate" screening category will include all current screening measures, as well as a site visit; screening procedures for the "high" screening category will include all current screening measures, as well as a site visit and, at a future date a fingerprint-based criminal background check.

CMS will continuously evaluate whether we need to change the assignment of categories of providers and suppliers to the various risk categories. If CMS assigns certain groups of providers and/or suppliers to a different category, this change will be proposed in the Federal Register. However, CMS will not publish a notice or a proposed rule in the Federal Register that would include instances in which an individual provider/supplier is reassigned based upon meeting one or more of the triggering events.

For more information, please refer to the regulation published to the Federal Register at http://www.GPO.gov/fdsys/pkg/FR-2011-02-02/pdf/2011-1686.pdf. And for additional clarification, look out for an official MLN Matters Article that will be released on the subject in the near future.

NSC Revalidation Process for DMEPOS Suppliers

CMS requires that all DMEPOS suppliers with Medicare billing privileges re-enroll with the Medicare program every three years through the National Supplier Clearinghouse (NSC). Suppliers will be prompted to revalidate, formerly re-enroll, for billing privileges using the Internet-based PECOS system. Don't wait. Register now to use Internet-Based PECOS in preparation for the receipt of the letter instructing suppliers when revalidation is necessary.

Upon receipt of the revalidation letter, suppliers are required to go online and respond to the request within 30 days. If the NSC does not receive the completed revalidation packet, the supplier's billing privileges are subject to normal filing rules including revocation or inactivation.

To learn more about Internet-based PECOS or to register, visit the CMS website at http://www.cms.gov/MedicareProviderSupEnroll. For more information, contact NSC Customer Service during regular operating hours, Monday through Friday, 9 a.m. to 5 p.m. ET at 1-866-238-9652.

NSC Update: Implementation of Supplier Enrollment Provisions

The National Supplier Clearinghouse (NSC) has published information on a final rule regarding screening categories, an application fee of $505 in 2011 as part of the enrollment process, suspension of payment based on credible allegations of fraud, and authority to impose a temporary moratorium on enrollment of new Medicare suppliers of a particular type in a geographic area. Additional information regarding this guidance and CMS Change Request 7350 can be accessed at http://www.cms.gov/MLNMattersArticles/downloads/MM7350.pdf. Suppliers are to work directly with NSC Customer Service (1-866-238-9652) with any questions regarding this information.

GLUCOSE MONITORS

Glucose Monitors and Related Supplies Resulting in CERT Error Rate of 87 Percent

The Comprehensive Error Rate Testing (CERT) contractor has been identifying a significant number of errors on claims for glucose monitors and related supplies with the most recent error rate at 87.27%. This product category is the third 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:

- Clinical documentation supporting the beneficiary is testing at the frequency prescribed
- Clinical records showing medical management/oversight of the patient's diabetes
- Written orders containing the required elements:
  - Item to be dispensed
  - Frequency of testing (as needed is not acceptable)
  - Physician signature
  - Signature date
  - Start date (only needed if different from signature date)

When suppliers receive a request from the CERT contractor on a glucose monitor or related supplies 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 Diabetic Supplies Edit Effectiveness for 2nd Quarter

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

The results of the review of the claims identified 11,415 claims of which 8,929 were denied. This resulted in an overall error rate of 73%. This is a decrease from 77% during the first quarter of this review. However, because the error rate remains high, NAS will continue with the widespread complex review.

The following are the top reasons for denial:

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

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

To be eligible for coverage of home blood glucose monitor and related accessories and supplies, the patient must meet the criteria as noted in Local Coverage Determination (LCD) L196 and Policy Article A33673, 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.

GLUCOSE MONITORS CONT'D

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

HCPCS CODES

HCPCS Code Set Update

CMS is pleased to announce the scheduled release of modifications to the Healthcare Common Procedure Coding System (HCPCS) code set. These changes have been posted to the HCPCS web page at http://www.cms.gov/HCPCSReleaseCodeSets/02_HCPCS_Quarterly_Update.asp. Changes are effective on the date indicated on the update.

MOBILITY DEVICES

Mobility DME Paid After Patient Lift Paid – RAC Identified Issue

When coverage is provided for the Multi-Positional Patient Transfer System, E1035 or E1036, payment will be discontinued for any other mobility assistive equipment, including but not limited to: canes, crutches, walkers, rollabout chairs, transfer chairs, manual wheelchairs, power-operated vehicles, or power wheelchairs. 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
- CMS Internet Only Manual Publication 100-3, Chapter 1, Part 4, Section 280.1, http://www.cms.gov/manuals/downloads/ncd103c1_Part4.pdf
- Local Coverage Determination (LCD) L11577 Patient Lifts, https://www.noridianmedicare.com/dme/coverage/docs/lcds/current_lcds/patient_lifts.htm

Power Mobility Device Face-to-Face Examination Checklist

MLN Matters® Number: SE1112

Provider Types Affected

This Special Edition (SE) MLN Matters® article is intended for physicians or treating practitioners who prescribe a Power Mobility Device (PMD) for Medicare beneficiaries. (In addition to a physician; a physician assistant, nurse practitioner, or clinical nurse specialist may order a PMD.) The article should also be of interest to Durable Medical Equipment (DME) suppliers who submit claims to DME Medicare Administrative Contractors (DME MACs) for such equipment.

What You Need to Know

The Centers for Medicare & Medicaid Services (CMS) is issuing this article as solely an educational guide to improve compliance with documentation requirements for the face-to-face examination that occurs prior to the physician or treating practitioner ordering a PMD for their Medicare patients. The article presents a checklist, which is a tool that providers may wish to use for this examination, in addition to some helpful tips to help providers and suppliers avoid denial of their PMD claims. The use of this guide is not mandatory and does not ensure Medicare payment for a PMD, even if signed and dated.

Background
Power wheelchairs and power operated vehicles (also known POVs or scooters) are collectively classified as Power Mobility Devices (PMDs) and are covered under the Medicare Part B benefit. CMS defines a PMD as a covered item of DME that includes a power wheelchair or a POV that a beneficiary uses in the home. Effective May 5, 2005, CMS revised national coverage policy to create a new class of DME identified as Mobility Assistive Equipment (MAE), which includes a continuum of technology from canes to power wheelchairs.

In addition to the prescription for the PMD, the physician or treating practitioner must provide the supplier with supporting documentation consisting of portions of the medical record essential for supporting the medical necessity for the PMD in the beneficiary's home. In order to document the need for a PMD there are a few specific statutory requirements that must be met before the prescription is written:

1. An in-person visit between the ordering physician and the beneficiary must occur. This visit must document the decision to prescribe a PMD.
2. A medical evaluation must be performed by the ordering physician. The evaluation must clearly document the patient's functional status with attention to conditions affecting the beneficiary's mobility and their ability to perform activities of daily living within the home. This may be done all or in part by the ordering physician. If all or some of the medical examination is completed by another medical professional, the ordering physician must sign off on the report and incorporate it into their records.
3. Items 1 and 2 together are referred to as the face-to-face exam. Only after the face-to-face examination is completed may the prescribing physician write the prescription for a PMD. This prescription has seven required elements and is referred to as the seven-element order which must be entered on the prescription only by the physician.
4. The records of the face-to-face examination and the seven-element order must be forwarded to the PMD supplier within 45 days of the completion of the face-to-face examination
5. CMS' National Coverage Determination requires consideration as to what other items of mobility assistive equipment (MAE), e.g., canes, walkers, manual wheelchair, etc., might be used to resolve the beneficiaries mobility deficits. Information addressing MAE alternatives must be included in the face-to-face medical evaluation.

CMS offers a checklist that providers may wish to use in the examination and documentation process and can be found in the 'Attachment' section at the end of this article. The checklist contains the information that is essential for Medicare to determine the medical necessity of the PMD. Please note, the checklist contained in this article is a guide and does not replace the underlying medical records. The checklist outlines the information that is essential for Medicare to have in determining whether payment should be made for a PMD. It is provided for educational purposes and serves to help providers understand the types of information which Medicare believes is critical for providers to document the patient's medical need in the home and that the device can be used safely.

The evaluation should be tailored to the individual patient's conditions. The medical history should contain a well-documented description of your patient's functional abilities and limitations on a typical day. It should contain as much objective data as possible. The physical examination should be focused on the body systems that are responsible for the patient's ambulatory difficulty or impact on the patient's ambulatory ability.

Tips to Avoid Denial of PMD Claims
Medical records should contain enough information to support the coverage for a PMD. Currently, audits show medical records commonly lack documentation that justifies the need for payment.

The medical record must contain sufficient information to show that the coverage criteria for a PMD are met. This information must be directly related to the patient's use of a PMD. Key items to be addressed are:

- Why does the patient require the use of a PMD in the home to safely and effectively accomplish Activities of Daily Living (ADLs)?
  - Examples of ADLs include but are not limited to bathing, grooming, dressing, toileting.
  - What are important medical history factors that demonstrate the patient's mobility limitations?

- Do the physical examination findings support the patient's claimed functional status (mobility level)?
  - Physical Examination (PE): The information provided in the PE must support the pertinent history above. The information must not be recorded in vague and subjective terms (e.g. weak, breathless, tired, etc), but instead must provide quantifiable, objective measures or tests of the abnormal characteristic (e.g. range of motion; manual muscle test scores; heart rate/respiratory rate/pulse oximetry). Each medical record is expected to be individualized to the unique characteristics of the patient. Included in all exams must be a detailed description of the patient's observed ability or inability to transfer and/or walk. Examples of other patient physical findings that would commonly be relevant to describe medical need for and ability to use a PMD include:
    - Height and weight ;
    - Limb abnormalities;
    - Strength, tone, coordination, reflexes, balance;
    - Heart rate, blood pressure, respiratory rate (at rest and with exertion)
    - Joint swelling, range of motion, erythema, subluxation;
    - Description of limb loss; and
    - Cardiopulmonary exam
- If the patient is thought to require a PMD due to respiratory illness or injury:
  - Does the patient use home oxygen? If yes, what is the frequency, duration, delivery system, and flow rate denoted? How far does the patient report that she/he can walk or self-propel a manual wheelchair before becoming short of breath (with best oxygenation provided)? Describe the ADLs that make him/her short of breath in the home (with best oxygenation provided) and the interventions that palliate them. How have these signs/symptoms changed over time?
- If the patient is thought to require a PMD due to cardiovascular illness or injury:
  - Specifically, describe any clinically significant increased heart rate, palpitations, or ischemic pain that occurs or worsens when the patient attempts or performs ADLs within the home (with best oxygenation provided)? What palliates these signs/symptoms? How far does the patient report that she/he can walk or self-propel a manual wheelchair before experiencing these signs/symptoms? How have these signs/symptoms changed over time?
- If the patient is thought to require a PMD due to neuromusculoskeletal illness or injury or malformed body member:
  - Describe the patient's impairments. For example, does the patient exhibit joint/bone signs/symptoms, changes in strength, coordination or tone? How do these signs/symptoms relate to the patient's functional state and the ability to perform ADLs in specific? How far does the patient report that she/he can walk or self-propel a manual wheelchair before these signs/symptoms interrupt that activity? How have these signs/symptoms changed over time?

Illustrative Example of Medical Record Documentation

This entry may result in a claim DENIED:
Mr. Smith is a male, age 72, with Chronic Obstructive Pulmonary Disease (COPD) who over the last few weeks has been having more Shortness of Breath (SOB). He states he is unable to walk for me today because he is too tired. Therefore he needs a PMD.

Instead consider an entry with this level of detail and support:
Mr. Smith is a 72 yo male with COPD, worsening gradually over the past year despite compliant use of XYZ meds, nebulizers and rescue inhalers. PFT's (attached) demonstrate the decline in lung function over the last 12 months. Now with the constant use of 2-3L NC O2 at home for the last month, he still can no longer walk to the bathroom, about 30 feet from his bed without significant SOB and overall discomfort. The kitchen is further from his bed. He says his bed/bath doorways and halls are wide enough for a scooter that will bring him to his toilet, sink and kitchen, all of which are on the same floor.

VS 138/84, Ht rate 88 RR 16 at rest on 3L NC

Vision- sufficient to read newspaper with glasses on

Cognition- OX3. Able to answer my questions without difficulty.

Ht XX Wt YY

Ambulation – Sit to stand was done without difficulty. Patient attempted to ambulate 50' in hallway, but needed to stop and rest 2 x's before he could accomplish. HR at first stop point (about 25') was 115 and RR was 32. Patient became slightly diaphoretic.

Lung exam – Hyperresonant percussion and distant breath sounds throughout. Occ wheezes.

Neuro- Hand grips of normal strength bilat. Patient able to maintain sit balance when laterally poked.

Steps carefully around objects in the room.

Alternative MAE equipment – Pt has attempted to use cane, walker or manual wheelchair unsuccessfully due to extreme fatigue with slight exertion described above.

Assessment – Pt seems good candidate for a scooter to carry him the necessary distances in his home to use toilet/sink and kitchen facilities. Home seems amenable to this device.

Accurate and complete documentation in the physician records regarding the face-to-face examination is extremely important to ensure the patient receives an appropriate PMD.

ATTACHMENT – Sample Checklist for the PMD Examination

Please note, this checklist is not mandatory and does not replace the underlying medical records.

The medical record for the patient includes the following history:

_____ Signs/Symptoms that limit ambulation;

_____ Diagnoses that are responsible for these signs/symptoms;

_____ Medications or other treatment for these signs/symptoms;

_____ Progression of ambulation difficulty over time;

_____ Other diagnoses that may relate to ambulatory problems;

_____ How far the patient can ambulate without stopping and with what assistive device, such as a cane or walker;

_____ Pace of ambulation;

_____ History of falls, including frequency, circumstances leading to falls, what ambulatory assistance (cane, walker, wheelchair) is currently used and why it is not sufficient;

_____ What has changed in the patient's condition that now requires the use of a power mobility device;

_____ Reason for inability to use a manual wheelchair; such as assessment of upper body strength;

_____ Why does the patient need a power wheelchair rather than each level of mobility assistive equipment (a cane, walker, optimally configured manual wheelchair, scooter)? What are the reasons that the patient should not or could not use a cane, walker, optimally configured manual wheelchair or power operated vehicle (scooter) in the home to satisfy their needs?; and

_____ Description of the home setting, including the ability to perform activities of daily living in the home, as well as the ability to utilize the PMD in the home.

The physical examination is relevant to the patient's mobility needs and the medical record for the patient contains:

_____ Weight and Height

_____ Musculoskeletal examination

- Arm and leg strength and range of motion;

_____ Neurological examination

- Gait
- Balance and coordination
- If the patient is capable of walking, the report should include a documented observation of ambulation (with use of cane or walker as appropriate)

Power Mobility Devices ACT Questions and Answers – February 17, 2011

Prior to taking questions, NAS provided the following updates:

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

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

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

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

Suppliers, billers and third parties may register for Endeavor.

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

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

Fee Schedule for Power Driven Wheelchairs MM7248
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. (K0841 example 585.67 / .15 = 3904.46)

Common Medical Review Concerns for PMD
The beneficiary must have a face-to-face MOBILITY exam that should be tailored to the individual patient's conditions. This exam should paint a picture of the patient's functional abilities and limitations on a typical day. It should contain as much objective data as possible. i.e., how many feet is the patient able to ambulate, using what type of device, vs. pt. can only walk a short distance.

Suppliers are reminded they must receive, within 45 days after completion of the face-to-face examination, an order from the treating physician that must contain all of the following elements:

1. Beneficiary's name
2. Description of the item that is ordered. This may be general – e.g., "power operated vehicle", "power wheelchair", or "power mobility device"– or may be more specific
3. Date of the face-to-face examination
4. Pertinent diagnoses/conditions that relate to the need for the POV or power wheelchair
5. Length of need
6. Physician's signature
7. Date of physician signature

A date stamp or equivalent must be used to document receipt date.

Questions received prior to the call:

Q1. How should providers show proof that the patient still needs/uses the PWC? Are providers required to call patients on a monthly basis to ask them if they still need and are using the PWC?

A1. Suppliers are encouraged to incorporate business practices to verify the item they are receiving rental payments for continues to be reasonable and necessary and used by the beneficiary.

Q2. When a patient owned PWC requires a repair, what are the correct codes and modifiers when billing for labor and repair replacement parts? When should K0108 codes be used?

A2. Common repairs have standardized labor time units that should be submitted with HCPCS code K0739. Refer to the "Repair Labor Billing Payment Policy" posted to the What's New section of the NAS website on 2/25/09. Claims for repairs must include narrative information itemizing each repair and the time taken for each repair. Items being replaced as part of a repair that have a specific HCPCS code should be used with the RB modifier. Replacement parts for wheelchairs that do not have a specific HCPCS code and are not included in another code should be coded as K0108 (other accessories). A description of the item must be included in the narrative section of the claim when using K0108.

Q3. For Group 2 Single Power Options and above, the PMD LCD requires a Specialty Exam. If this Specialty Exam is conducted after a fully documented face-to-face mobility exam, what date is included on the seven element order as the date of the face-to-face exam?

A3. The specialty evaluation that is required for patients who receive a Group 2 Single Power Option or Multiple Power Options PWC, any Group 3 or Group 4 PWC, or a push-rim activated power assist device is in addition to the requirement for the face-to-face examination. If this exam is conducted after a fully documented face-to-face mobility exam, the date on the seven element order would be the date of the face-to-face mobility exam and not the specialty exam.

Q4. If a supplier repairs a PWC but did not initially provide that chair, is the supplier who repaired the chair required to provide documentation to support medical necessity of the PWC upon review?

A4. Medicare pays for repairs to medically necessary equipment that the beneficiary owns. Medicare must verify the chair is medically necessary in order to allow repairs.

Q5. Do mobility related activities of daily living include more than toileting, bathing, preparing meals, dressing, grooming, and feeding in customary places within the home? Could MRADLs include having your meals, doing laundry, or getting to the front door on a different floor if there were a fire or other emergency, fall into this category?

A5. Yes. There is not an all inclusive list of MRADLs.

Questions and answers taken during the call:

Q6. I understand that servicing is not reimbursed during the capped rental period, but for batteries that don't have a reasonable useful lifetime (five years), can they be replaced during the capped rental period if out of warranty since they are inexpensive and routinely purchased items or are suppliers expected to replace for free like other service and repairs?

A6. This question has been posed to the DME MAC Medical Directors, who are currently requesting direction from the CMS to clarify how to handle Inexpensive and Routinely Purchased items that are part of a capped rental item. There are other items besides batteries that fall into this same circumstance. Per Supplier Standard #5, beneficiaries may rent or purchase IRP items.

Q7. I had a question about product descriptions with the new rental rules. If something happens with a piece of equipment, it's not working properly or the patient is not happy with it, and we replace it for the rest of the rental period, does it have to continue to exactly match the product description?

A7. Yes, but 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.

Q8. Going back to the batteries, once a power wheelchair is capped and the batteries need to be replaced, say two or three years later, they usually come in a set; you have to have two batteries to run the chair. I read somewhere that Medicare only allows one battery at a time to be replaced. Is that true?

A8. Up to two batteries (E2361, E2363, E2365, E2371, K0733) at any one time are allowed if required for a power wheelchair. However the usual maximum frequency of replacement for a lithium-based battery (E2397) is one every 3 years. Only one lithium-based battery is allowed at any one time.

Q9. How does a supplier bill for extras when the patient wants to pay for upgrades? Is there a certain procedure we need to follow?

A9. Yes. A "What's New" article was posted on January 26, 2011 titled Use of Upgrade Modifiers with complete instructions. Claim examples can also be found in the WebEx presentation called DME Modifiers.

Q10. Is an ABN obtained at the beginning of a capped rental period good for only 12 months and do we need to obtain a new one before the 13th month?

A10. That is correct. An ABN is only valid for one year (12 months), so you would have to get another ABN for the remaining rental month.

Q11. My company won the bid for a competitive bid area (CBA). A customer called regarding repairs to a wheelchair that we did not provide. If we provide that repair service for this chair do we need to have proof of medical necessity? 1-800-Medicare told her we would provide the service, but we don't have any medical documentation, and the chair was a cash purchase that did not go through insurance. Should we execute an ABN and submit the charges with a GA modifier if medical documentation does not exist?

A11. Correct. In order for Medicare to cover the repairs there must be documentation to support medical necessity. If policy coverage criteria are not met, a properly executed ABN is recommended.

Q12. A few patients are bringing in power wheelchairs that were purchased a year or two ago that require a lot of repairs. The manufacturer has discontinued this model and the parts we need to repair the chair are no longer available. Is this a reason to start a new capped rental period or are the patients out of luck?

A12. Most manufacturers have interchangeable parts. Medicare will only start a new capped rental for the same item if it is lost, stolen, irreparably damaged due to a specific incident, or if the item reaches its reasonable useful lifetime (5 years). Suppliers are expected to provide DME that will last for the entire RUL. A provision added as part of the Deficit Reduction Act rulemaking requires the supplier of a capped rental item (the one that was paid the 13th rental payment) to replace the capped rental equipment free of charge if it will not or does not last for the entire RUL. If the company that provided the chair went out of business, the beneficiary may discuss recourse through 1-800-Medicare.

Q13. When we get an ABN for equipment that is not medically necessary and add the GA modifier we include a narrative of patient owned equipment, and the date it was purchased. Sometimes we get a Patient Responsibility (PR) denial and other times we do not. Is there more we need to place in the narrative to get a PR denial?

A13. An example was request, but not received. In addition to patient owned equipment a brief description of why the item is not medically necessary should be included. A GA modifier does not guarantee a PR denial. Coding and billing guidelines all need to be followed.

Q14. Regarding question 12, if the manufacturer stopped making replacement parts, wouldn't that be considered irreplaceable?

A14. No. Medicare will only pay for a new chair if it is lost, stolen or irreparably damaged due to a specific incident such as a flood, fire, or natural disaster. Suppliers may want to consider purchasing their equipment from a different manufacturer.

Q15. When repairing a chair, sometimes replacement parts are required. If a HCPCS code does not exist for an item we use K0108. Is there a specific modifier that we have to use with those K0108 codes at the time of repairs?

A15. Suppliers should only use K0108 if there is not a specific code for the item or part being provided. An example was requested but not received.

Q16. How long should suppliers keep documentation/medical records for an initial rental? I just received an audit for a rental that was delivered in January 2003. It was signed by Benefit Protection Analyst, DME Benefit Protection Unit.

A16. The Program Integrity Manual, publication 100-8, chapter 5, section 5.8 states:

"Documentation **must** be maintained in the supplier's files for seven (7) years"

CMS Special Edition 1022 states:

"CMS requires Medicare managed care program providers to retain records for 10 years"

Q17. On the detailed product description for a K0823, which is a Group 2 capped rental power chair, the listed allowable is $545.69, so we would divide that by 0.15 to get the actual payment amount. Correct?

A17. No. A Group 2 no power option PWC cannot be purchased effective January 1, 2011. You should include the supplier's rental charge and the Medicare rental fee schedule allowance of $545.69. If the beneficiary chooses the purchase option for a complex rehab PWC, Group 2 single power option and above, then yes, you would take the listed allowable and divide by 0.15 for the actual purchase price.

Q18. I was on a similar teleconference several months ago and the Medical Director who was on the call said something about a committee researching a more reasonable guideline for the documentation required for PWCs. I'm wondering if anything ever happened with that.

A18. The Medical Directors are always looking for ways they can make requirements clearer and better for suppliers and ordering physicians to understand. There is currently no specific new guideline in place for documentation. The Program Integrity Manual, publication 100-8, chapter 5, section 5.8 states:

"The supplier should also obtain as much documentation from the patient's medical record as they determine they need to assure themselves that coverage criteria for an item have been met. If the information in the patient's medical record does not adequately support the medical necessity for the item, the supplier is liable for the dollar amount involved unless a properly executed ABN of possible denial has been obtained."

Follow up questions: I watch Medicare audits carefully. I don't know the exact number, it was like 95% or 97% of PWC were denied. Does Medicare really think that 97% of suppliers are trying to pull a fast one or does anybody acknowledge that maybe it's because it's impossible to get the paperwork required? Is there anything that we as providers can do or any suggestions? Do we need to go to the congressional level? Medicare is saying that you must follow rules, but the rules are very subjective. It feels like we're just chasing and guessing what a reviewer in a year is going to decide is important about a particular case even though we feel that we've addressed everything that relates to this policy and all the medical necessity issues. Follow up answer: Federal regulations require that documentation be available that gives objective evidence of medical necessity. CMS is aware of the challenges that suppliers encounter. They have commented as such to NAS as a contractor, they have initiated different task forces to reach out to the physician community; we have actually partnered with the Part A and Part B education staff to begin conducting outreach to their physicians regarding the DME policies and requirements relating to medical records. NAS does respect what you're indicating. CMS does have efforts that they're pursuing as well. We do acknowledge the position suppliers are in. It is a challenge. Suppliers are dependent on the physicians to provide clear documentation so their patients can get the equipment necessary and the suppliers can receive payment for the items and services provided. Working together and communicating with your referral sources is paramount. NAS Education will continue to reach out to Part B contractors to work collaboratively to education physicians on documentation requirements. Suppliers may continue to work with associations and lobbying groups to express opinion to law makers.

Lastly, suppliers have the option of the appeals process if you don't think the decision that was made was correct. Suppliers are actually out there working with the beneficiary. When documentation comes to NAS Medical Review, it is only in the form of paper. Make sure the documentation you receive presents the same picture that you the supplier are seeing.

Q19. I want to clarify the question about the fee schedule for the DPD. It sounded like you said that the DPD Medicare allowable should show the allowable at the purchase price rather than the rental. So the DPD should show the $3,600-$3,700 for a K0823 rather than the $545.69? Did I understand that correctly?

A19. The DPD should show the rental allowance, not the purchase price. Purchases would only apply to complex rehab chairs.

Q20. Is it acceptable to have something other than a date stamp to confirm when the supplier received the 7-element order, signed and dated detailed product description, and report of face-to-face exam? Can a supplier circle and initial the electronic fax date or can a supplier hand write and initial the date received?

A20. According to the Power Mobility Devices Local Coverage Determination L23598, "The order that the supplier must receive within 45 days after completion of the face-to-face examination (see Policy Article) must contain all of the following elements…A date stamp or equivalent must be used to document receipt date." Therefore, the NAS Medical Review staff do permit the identified date of the fax or a hand-written date to be acceptable as the document receipt date.

Q21. A physician completed the mobility face-to-face examination but was unable to complete the 7-element order within 45 days due to personal reasons. The 7-element order was signed 50 days later. Could that be considered the end of the face-to-face?

A21. No. The LCD and Policy Article are very specific. The supplier must receive the 7-element order within 45 days of completion of the face-to-face examination.

Q22. If the physician did not complete the 7-element order until after 45 days, will Medicare cover another evaluation?

A22. The DME MAC does not process the claim for the evaluation. The supplier or beneficiary would need to contact the Medicare Part B contractor.

Q23. After the physician completes the mobility face-to-face examination he/she may want the patient to see a physical or occupational therapist. It may take three weeks to get an appointment. Does the 45 days start from the date of the face-to-face with the physician or from the date the doctor signs the therapist's evaluation?

A23. The date the physician signs the therapist's evaluation and concurs or disagrees with the findings is the date the 45 days starts; however the physician may decide to see the patient after the therapist evaluation and in that case the 45 days start after that additional examination.

Q24. For Group 2 single power option chairs and above a specialty evaluation is required. Does the 45 days start counting the day of the specialty evaluation which is performed after the face-to-face evaluation?

A24. The face-to-face examination and specialty examination are two separate requirements. Complex rehab PWC (Group 2 single power option and above) require a specialty examination. However the physician may also request the beneficiary receive a specialty examination as part of the face-to-face mobility examination. If the physician is requesting the specialty examination as part of the face-to-face requirement, the 45 days begins after the specialty examination is completed. If the physician completely documents a face-to-face mobility examination and completes the 7-element order and it is determined after the 7-element order that a specialty examination is required for specific options, the specialty examination may occur after the 7-element order and the 45 days would not start after the specialty examination.

Q25. A patient is initially set up with a Group 2 no power option PWC and a general use cushion. During the capped rental period, the patient develops sores and requires a skin protection cushion. Is a new detailed product description required?

A25. Yes.

Q26. Could an ABN be given for "same or similar" equipment if the beneficiary had a walker and is now getting a wheelchair or should "same or similar" only be considered from one walker to another walker within five years?

A26. A walker is not "same or similar" to a wheelchair. If a beneficiary began with a walker and their condition progressed to the point they needed a wheelchair, the medical documentation should fully document that changing medical need. If the documentation does not support the wheelchair, a properly executed ABN is recommended. Providing both a walker and a wheelchair at the same time is rarely allowed. Medical documentation should reflect exactly when they use the walker and when they're using the manual wheelchair. There is a separate LCD for walkers and there is a separate LCD for a manual wheelchair. The manual wheelchair LCD clearly states:

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

Q27. The patient received a power scooter in 2009. The patient's disease is progressing and they now need a power wheelchair. What do we need to submit or what do we need to do to show that their condition has deteriorated?

A27. All the requirements for a new PWC must be met (i.e., FTF exam, 7-element order, etc.).

Q28. We would like to verify the allowed amounts for PWCs. The capped rental period took effect January 1, 2011, but is the allowable on the CMS website still from 2010?

A28. The CMS website has multiple years listed including 2011. The allowable that is shown on the fee schedule for 2011 PWCs is 15% of the allowed purchase price, which is paid during months 1-3 of the rental period. That amount is reduced to 6% of the allowed purchase price for months 4-13.

Q29. If a patient goes to a doctor for a mobility examination and the doctor is not comfortable doing the entire examination, they may refer the patient to a physician therapist. The PT does the majority of the mobility examination. The doctor signs, dates, and indicates agreement or disagreement with the PT's report. That date is the end of the face-to-face examination and the date indicated on the seven element order, correct?

A29. Correct.

Follow up question: After the face-to-face, PT evaluation, and 7-element order are received, we realize the patient needs specialized seating and a specialty examination to address the seating. This was not discussed in the previous PT evaluation and is addressed separately from the mobility examination. This second evaluation is not considered part of the face-to-face exam correct? The doctor may still sign that evaluation, but the 7-element order date does not need to be changed, correct?
Follow up answer. Correct.

Q30. When I fax in an ADMC request for a patient who has ALS are those patients given any special consideration because of their disease? Normally ADMCs take up to 30 days. Are ADMCs for ALS patients given a quicker turnaround time?

A30. ADMCs are processed first received, first processed. Nothing stands out to indicate the condition nor are ADMCs organized by the patient's condition.

Q31. There are two ways to look up a fee schedule. One is the fee schedule look up tool, which is not been updated for about six months. I think the most recent information is second quarter 2010. So my understanding is you just shouldn't use that one if you want current fee schedules. Go to the DMEPOS fees and download the Excel or the PDF file to find the most current fee schedule information on the NAS site. I just wanted to share that.

A31. The NAS fee schedule look up tool was outdated and we apologize for the inconvenience. We are grateful that we did have the alternative files on our website to obtain the correct fee schedules, and at this point we are 90% complete with the updates required for that application. Another option is to go to the Pricing, Data Analysis and Coding (PDAC) contractor's site at https://www.dmepdac.com and select the DMECS tab and then select the Search for Codes or Fees tab.
Update: The fee schedule look-up tool was updated on our website on March 1, 2011 for all fees.

Q32. I just want to confirm what I should include in the narrative section of my claim for patient-owned equipment when we're billing for a PR denial.

A32. List the reason for the PR denial as listed in the "because" section of the ABN if one was executed and you are using the GA modifier. It would be helpful to have a narrative stating "beneficiary owned equipment and the date or purchase and the HCPCS code of the base equipment when billing for repairs or replacement parts.

Q33. To deliver a PWC we need the 7-element order, chart notes and other medical documentation, and we need the product description. Which of those three do we have to have in hand within 45 days of the face-to-face?

A33. The supplier must receive a written report of the face-to-face examination within 45 days after completion. The 7-element order must be received within 45 days after completion of the face-to-face mobility examination. The detailed product description must be signed and dated by the ordering physician prior to delivering the POV or PWC.

Results for Widespread Prepayment Review for K0823 Power Wheelchair

The Jurisdiction D DME MAC Medical Review Department has conducted a widespread complex review of HCPCS code K0823. The results are as follows:

A total of 648 claims were reviewed of which 576 were denied. This resulted in an overall error rate of 90%.

The following are the top reasons for denial:

- Failure to respond to request for records.
  Suppliers are in violation of Supplier Standard #28 when, upon request, they fail to provide requested documentation to a Medicare contractor. Medicare regulations (42 C.F.R §424.516[f]) stipulate that a supplier is required to maintain documentation for seven years from the date of service and, upon the request of CMS or a Medicare contractor, provide access to that documentation. Therefore, the consequences of failure to provide records may not only be a claim denial but also referral to the NSC.
- Medical records were insufficient and did not meet LCD L23598 criteria
  - Medical records did not include the coverage criteria A-C
  - No face-to-face mobility examination present
  - Incomplete or missing elements of the face-to-face examination
  - No home assessment completed

  The report of the face-to-face examination (see Policy Article A41127) should provide information relating to the following questions.

For POVs and PWCs	What is this patient's mobility limitation and how does it interfere with the performance of activities of daily living?
For POVs and PWCs	Why can't a cane or walker meet this patient's mobility needs in the home?
For POVs and PWCs	Why can't a manual wheelchair meet this patient's mobility needs in the home?
For POVs	Does this patient have the physical and mental abilities to transfer into a POV and to operate it safely in the home?
For PWCs	Why can't a POV (scooter) meet this patient's mobility needs in the home?
For PWCs	Does this patient have the physical and mental abilities to operate a power wheelchair safely in the home?

The evaluation should be tailored to the individual patient's conditions. The history should paint a picture of the patient's functional abilities and limitations on a typical day. It should contain as much objective data as possible. The physical examination should be focused on the body systems that are responsible for the patient's ambulatory difficulty or impact on the patient's ambulatory ability. Physicians shall document the examination in a detailed narrative note in their charts in the format that they use for other entries. The note must clearly indicate that a major reason for the visit was a mobility examination.

Many suppliers have created forms which have not been approved by CMS which they send to physicians and ask them to complete. Even if the physician completes this type of form and puts it in his/her chart, this supplier-generated form is not a substitute for the comprehensive medical record as noted above. Suppliers are encouraged to help educate physicians on the type of information that is needed to document a patient's mobility needs.

- No valid written order
  - No written order submitted with the documentation
  - Order not properly completed or missing/incomplete elements

The order that the supplier must receive within 45 days after completion of the face-to-face examination (see Policy Article A41127) must contain all of the following elements:

1. Beneficiary's name
2. Description of the item that is ordered. This may be general – e.g., "power operated vehicle", "power wheelchair", or "power mobility device"– or may be more specific
3. Date of the face-to-face examination
4. Pertinent diagnoses/conditions that relate to the need for the POV or power wheelchair
5. Length of need
6. Physician's signature
7. Date of physician signature

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

BASIC COVERAGE CRITERIA:

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

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

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

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

Please review our resources to assist you in preventing the above errors.

- Power Mobility Devices - 7-Element Order, posted 11/05/09
- LCD L23598, Policy Article A41127
- Article: Documentation Requirements for K0823 Power Wheelchair Claims, posted 06/08/09
- Power Wheelchairs and Power Operated Vehicles – Documentation Requirements, Dear Physician Letter, posted September 2010
- The Durable Medical Directors, DMD, response to the Texas and Florida Academy F2F form, posted 12/31/2009

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

Upgrades to Group 2 POVs (K0806-K0808) and Group 4 PWCs (K0868-K0886)

Recent revisions to the Power Mobility LCD eliminating Least Costly Medically Necessary Alternative classified the denials for Group 2 POVs (K0806-K0808) and Group 4 PWCs (K0868-K0886) as statutorily non-covered. This determination caused the unintended consequence of making these items ineligible for the Advanced Beneficiary Notice (ABN) upgrade process. The LCD and Policy Article are being revised to indicate that Group 2 POVs (K0806-K0808) and Group 4 PWCs (K0868-K0886) are considered durable medical equipment but are not reasonable and necessary. This change will be effective for dates of service on or after June 1, 2011.

In addition to capabilities that allow Group 2 POVs (K0806-K0808) and Group 4 PWCs (K0868-K0886) to be used in the home, they also have certain performance characteristics that are not reasonable and necessary for use in the home such as (not all-inclusive):

- robust frames
- motors with increased torque/power
- suspensions with enhanced vibration-dampening or obstacle climbing capabilities

The revised Power Mobility Devices LCD and related policy article will reflect that claims for Group 2 POVs (K0806-K0808) and Group 4 PWCs (K0868-K0886) will be denied as not reasonable and necessary. As a result, Group 2 POVs (K0806-K0808) and Group 4 PWCs (K0868-K0886) are eligible for the ABN upgrade provisions as set out in the recently published bulletin article on the use of upgrade modifiers as a result of changes due to elimination of least costly alternative.

Refer to the LCD, Policy Article, and Supplier Manual for additional information on upgrades and Power Mobility devices.

The Power Mobility Devices LCD and Policy Article revisions will be published in the near future.

Wheelchair Seating, Mutually Exclusive Codes – RAC Identified Issue

According to Local Coverage Determination (LCD) L15670 and Policy Article A17265, certain wheelchair seating additions are not medically necessary when used with certain power wheelchairs, power operated vehicles, rollabout or transport chairs. 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
- LCD L15670 Wheelchair Seating, https://www.noridianmedicare.com/dme/coverage/docs/lcds/current_lcds/wheelchair_seating.htm
- Policy Article A17265 Wheelchair Seating, https://www.noridianmedicare.com/dme/coverage/docs/lcds/current_articles/wheelchair_seating.htm

A web-based workshop on the topic of "Wheelchair Options, Accessories, and Seating" is scheduled for Thursday, March 10, 2011 at 2 p.m. CT. Details regarding this event are available at: https://www.noridianmedicare.com/dme/news/docs/2011/01_jan/wheelchair_options_accessories_and_seating_workshop.html.

MODIFIERS

Auto Denial of Claims Submitted With GZ Modifier

MLN Matters® Number: MM7228
Related Change Request (CR) #: 7228
Related CR Release Date: February 4, 2011
Related CR Transmittal #: R366PI and R2148CP
Effective Date: July 1, 2011
Implementation Date: July 5, 2011

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

What You Need to Know
The Health and Human Services Office of General Counsel (OGC) has provided guidance that Medicare contractors that process both institutional and professional claims have discretion to automatically deny claims billed with the GZ modifier. The GZ modifier indicates that an Advance Beneficiary Notice (ABN) was not issued to the beneficiary and signifies that the provider expects denial due to a lack of medical necessity based on an informed knowledge of Medicare policy. Medicare Contractors will automatically deny claim line(s) items submitted with a GZ modifier, effective for dates of service on or after July 1, 2011. Further, your Medicare contractor will not perform complex medical review on any claim line item(s) submitted with the GZ modifier. In addition, line items denied due to the presence of the GZ modifier will reflect a Claim Adjustment Reason Code of 50 (These services are non-covered services because this is not deemed a "medical necessity" by the payer.) and a Group Code of CO (Contractual Obligation) to show provider/supplier liability.

Additional Information
The official instruction, Change Request (CR) 7228, was issued to your carrier, FI, A/B MAC, and DME/MAC via two transmittals. The first transmittal modifies the Medicare Claims Processing Manual and it is at http://www.cms.gov/Transmittals/downloads/R2148CP.pdf on the Centers for Medicare & Medicaid Services (CMS) website. The second transmittal modifies the Medicare Program Integrity Manual and it is at http://www.cms.gov/Transmittals/downloads/R366PI.pdf on the same site.

NEBULIZERS

CERT Errors for Nebulizers and Related Medications

The Comprehensive Error Rate Testing (CERT) contractor has identified a significant number of errors on claims for nebulizers and related medications with the most recent error rate at 55.17%. Nebulizers and related medications are the eighth 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 from the CERT contractor, the most common documentation that is lacking includes:

- Completed order
- Clinical records supporting the medical need for a nebulizer and use of the medication
- Clinical records showing medical management/oversight of the patient's respiratory condition that requires a nebulizer

When suppliers receive a request from the CERT contractor on a nebulizer or related medications 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 result in a request for overpayment on the claim.

For additional information and resources, please visit the newly-updated CERT page of our website at: https://www.noridianmedicare.com/dme/coverage/cert.html.

Clarification - 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).

Since code E0571 is a capped rental item and for dates of service prior to February 4, 2011, is subject to least costly alternative (LCA) payment policy, claims for code E0571 will continue to have LCA applied until the 13 month capped rental payment period is completed. New initial claims for E0571 on or after February 4, 2011, will be rejected as invalid coding.

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

Note that 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.

Nebulizer Drugs – Billing Reminder

During a recent review of nebulizer medication claims it was noted that some suppliers made errors in claim submission. Suppliers were using the micrograms or milligrams of the inhalation drug as the units of service rather than the units of service associated with the Healthcare Common Procedure Coding System (HCPCS) codes. This error results in billing for amounts of medication that significantly exceed the usual maximum utilization amounts listed in the local coverage determination (LCD). When billing for nebulizer medications, suppliers must use the units of service related to the HCPCS code being billed. For reference, the usual maximum utilization stated in the LCD for Nebulizers:

Inhalation Drugs and Solutions	HCPCS Billing Unit of Service	Maximum Milligrams/Month
Acetylcysteine	Per 1 gram	74 grams/month
Albuterol	Per 1 mg	465 mg/month (See below for exception)
Albuterol/Ipratropium combination	1 unit dose vial	186 units/month
Arformoterol	1 unit dose vial	930 micrograms/month – 62 units/month
Budesonide	1 unit dose vial	62 units/month
Cromolyn sodium	Per 10 mg	2480 mg/month – 248 units/month
Dornase alpha	Per 1 mg	78 mg/month
Formoterol	1 unit dose vial	1240 micrograms/month – 62 units/month
Ipratropium bromide	Per 1 mg	93 mg/month
Levalbuterol	Per 0.5 mg	232.5 mg/month – 465 units/month (See below for exception)
Metaproterenol	Per 10 mg	2800 mg/month – 280 units/month (See below for exception)
Pentamidine	Per 300 mg	300 mg/month
Treprostinil	Per 1.74 mg	31 units/month
Sterile saline or water, 10ml/unit (A4216, A4218)	Per 10 ml	56 units/month
Distilled water, sterile water, or sterile saline in large volume nebulizer (A7018)	Per 1 liter	18 liters/month

Suppliers should refer to the LCD and related policy article for additional information on the proper coding, coverage and documentation requirements for these items.

Nebulizer Drugs Units of Service

The Durable Medical Equipment Medicare Administrative Contractors (DME MACs) are aware of trends in billing discrepancies for nebulizer drugs. This article serves as a tool to assist DMEPOS suppliers to correctly calculate the units of service (UOS) for nebulizer drugs when billing.

Drug Name	HCPCS	Unit of Service (UOS)	Maximum/month	Maximum UOS/month
Acetylcysteine	J7608	per 1 gram	74 grams/month	74
Albuterol	J7611, J7613	per 1 mg	465 mg/month**	465
Albuterol/Ipratropium combination	J7620	up to 2.5 mg albuterol and 0.5 mg of ipratropium – 3.0mg total – 1 vial	558 mg total/month – 186 vials**	186
Arformoterol	J7605	15 mcg	930 mcg/month	62
Budesonide	J7626	up to 0.5 mg – 1 vial	31 mg/month	62
Cromolyn sodium	J7631	per 10 mg	2480 mg/month	248
Dornase alpha	J7639	per 1 mg	78 mg/month	78
Formoterol	J7606	20 mcg	1240 mcg/month	62
Ipratropium bromide	J7644	per 1 mg	93 mg/month	93
Levalbuterol	J7612, J7614	per 0.5 mg	232.5 mg/month **	465
Metaproterenol	J7669	per 10 mg	2800 mg/month **	280
Pentamidine	J2545	per 300 mg	300 mg/month	1
Treprostinil	J7686	1.74 mg – 1 ampule/vial	31 ampules/vials month	31
Sterile saline or water	A4216, A4218	10 ml – 1 unit	560 ml/month	56
Distilled water, sterile water, or sterile saline in large volume nebulizer	A4217, A7018	500 ml	18,000 ml – 18 liters/month	36

**When albuterol, levalbuterol, or metaproterenol are prescribed as rescue/supplemental medication for patients who are taking formoterol or arformoterol, the maximum milligrams/month that are reasonably billed are:

Drug Name	HCPCS	Unit of Service (UOS)	Maximum milligrams/ month	Maximum UOS/month
Albuterol	J7611, J7613	1 mg	78 mg/month	78
Albuterol/Ipratropium combination	J7620	up to 2.5 mg albuterol and 0.5 mg of ipratropium – 3.0 mg total – 1 vial	93 mg/month – 31 vials	31
Levalbuterol	J7612, J7614	0.5 mg	39 mg/month	78
Metaproterenol	J7669	Per 10 mg	470 mg/month	47

The billing unit of service for inhalation drug codes varies. Suppliers must be sure that they use the correct billing unit of the code when calculating the number of units of service to enter on the claim. Listed below are examples of some of the more common errors identified when billing for nebulizer drugs:

- Code J7620 is used for an FDA-approved combination of albuterol and ipratropium which contains 3.0 mg of albuterol sulfate, which is 2.5 mg of albuterol base and 0.5 mg of ipratropium bromide in each unit dose vial. For these products, 1 unit of service of J7620 equals 1 unit dose vial.

NEBULIZERS CONT'D

- For code J7626 and J7627 (budesonide, unit dose) bill one unit of service for each vial dispensed, regardless of whether a 0.25 mg vial or a 0.5 mg vial is dispensed. If the vial dispensed is a 1.0 mg vial suppliers must bill 2 units of service for each vial dispensed.

For additional information, suppliers should refer to the Nebulizers Local Coverage Determination (LCD) and Policy Article (PA).

NEGATIVE PRESSURE WOUND THERAPY

Negative Pressure Wound Therapy - LCD Documentation

Suppliers of Negative Pressure Wound Therapy (NPWT) claims are reminded that there are stringent documentation requirements in the local coverage determination (LCD). Elements of the LCD that require information from the medical record to justify coverage include:

- Complete description of the wound
- Description of prior care for the wound
- Complications with surgically-created wounds
- Monthly monitoring of wound healing progress
- Need for more than four months therapy
- Need for a quantity of supplies that exceeds the expected amounts outlined in the LCD

Suppliers should review the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD for a complete discussion of coverage criteria.

As noted in the "Documentation Requirements" section, the following types of information may be requested in the event of a claim review:

Documentation of the history, previous treatment regimens (if applicable), and current wound management for which an NPWT pump is being billed must be present in the patient's medical record and be available for review if requested by the DMERC. This documentation must include such elements as length of sessions of use, dressing types and frequency of change, and changes in wound conditions, including precise measurements, quantity of exudates, presence of granulation and necrotic tissue and concurrent measures being addressed relevant to wound therapy (debridement, nutritional concerns, support surfaces in use, positioning, incontinence control, etc.).

Documentation of wound evaluation and treatment, recorded in the patient's medical record, must indicate regular evaluation and treatment of the patient's wounds, as detailed in the Indications and Limitations of Coverage Section. Documentation of quantitative measurements of wound characteristics including wound length and width (surface area), and depth, and amount of wound exudate (drainage), indicating progress of healing must be entered at least monthly. ***The supplier of the NPWT equipment and supplies must obtain from the treating clinician, an assessment of wound healing progress, based upon the wound measurement as documented in the patient's medical record, in order to determine whether the equipment and supplies continue to qualify for Medicare coverage.*** *(The supplier need not view the medical records in order to bill for continued use of NPWT. Whether the supplier ascertains that wound healing is occurring from month to month via verbal or written communication is left to the discretion of the supplier. However, the patient's medical records may be requested by the DMERC in order to corroborate that wound healing is/was occurring as represented on the supplier's claims for reimbursement.)* [Emphasis added]

Suppliers should note the highlighted statement from the Documentation Section requiring frequent contact with the treating clinician to assess the continued need for therapy.

Suppliers should refer to the Supplier Manual, LCD and Policy Article for additional information on NPWT and other general documentation requirements.

ORAL APPLIANCES

Fee Schedule Amount Established for Oral Appliances for Diagnosis of Obstructive Sleep Apnea

NAS has established a fee schedule amount for HCPCS code E0486 (Oral device/appliance used to reduce upper airway collapsibility, adjustable or non-adjustable, custom fabricated, includes fitting and adjustment). Effective April 1, 2011, E0486 has a fee schedule amount of $1,175.39 for services provided in 2009 and 2010. The fee schedule amount for services in 2011 is $1,290.63.

As a DME MAC, we established a fee schedule amount based on the following gap filling criteria outlined by CMS:

- Contractors gather enough pricing information or processes enough claims to enable them to gap-fill a base fee.
- After the contractor has processed a minimum number of claims using an interim payment method, they must gap-fill base fees using the average allowed amount for the claims they have paid. A minimum number of claims required for establishing a fee are claims from at least four suppliers who have at least three charges each.

OAOSA – Clerical Revision

The Oral Appliances Used for Treatment of Obstructive Sleep Apnea (OAOSA) LCD effective on 01/01/2011 contained a clerical error in the numbering of the coverage criteria. That section has been revised to read,

a. The patient has a Medicare-covered sleep test that meets one of the following criteria (1 - 3):

1. The apnea-hypopnea index (AHI) or Respiratory Disturbance Index (RDI) is greater than or equal to 15 events per hour with a minimum of 30 events; or,

2. The AHI or RDI is greater than or equal to 5 and less than or equal to 14 events per hour with a minimum of 10 events and documentation of:

c. Excessive daytime sleepiness, impaired cognition, mood disorders, or insomnia; or,

d. Hypertension, ischemic heart disease, or history of stroke., or

5. If the AHI>30 or the RDI>30 and meets either of the following(a or b):

a. the patient is not able to tolerate a positive airway pressure (PAP) device or

b. the treating physician determines that the use of a PAP device is contraindicated.

Item 3 was incorrectly listed as “C” in the original publication.

Refer to the policy for additional information.

ORTHOTICS/PROSTHETICS

Additional HCPCS Codes Payable under Replacement Part, Accessories, and Supplies Pricing Logic

MLN Matters® Number: MM7261
Related Change Request (CR) #:7261
Related CR Release Date: January 28, 2011
Related CR Transmittal #: R846OTN
Effective Date: January 1, 2011
Implementation Date: July 5, 2011

Provider Types Affected
This article is for suppliers billing Medicare Carriers and Medicare Administrative Contractors (A/B MACs) for certain Durable Medical Equipment (DME) products provided to Medicare beneficiaries.

Provider Action Needed
The Centers for Medicare & Medicaid Services (CMS) issued CR7261 in order to provide three additional HCPCS codes for replacement parts, accessories, and supplies for implanted prosthetic devices, which become effective January 1, 2011. These three HCPCS codes are separately billable to the A/B MACs and carriers under the guidelines established by CR5917 and CR6573. The *Key Points* section of this article lists the three additional HCPCS codes. Make certain billing staffs are aware of this change.

Key Points of CR7261
Beginning January 1, 2011, suppliers that are enrolled with the National Supplier Clearinghouse (NSC) as a DMEPOS supplier may bill Medicare Carriers or A/B MACs for:

- HCPCS codes L8693 (Auditory Osseointegrated Device Abutment, Any Length, Replacement Only);
- Q0478 (Power Adapter 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).

Medicare contractors will process claims containing such codes, according to the instructions in CR5917 and CR6573.

These Medicare contractors will reprocess any claims containing the three HCPCS codes listed directly above submitted by DMEPOS suppliers with dates of service on or after January 1, 2011, through the implementation date of this CR, according to the guidelines established in CR5917 and CR6573.

When claims containing these codes are submitted to the DME MACs, they will be denied.

Additional Information
The official instruction, CR7261, issued to your Medicare A/B MAC and carrier regarding this change may be viewed at http://www.cms.gov/transmittals/downloads/R846OTN.pdf on the CMS website.

CMS published MLN Matters® article MM6573, related to CR6573, which may be reviewed at http://www.cms.gov/mlnmattersarticles/downloads/MM6573.pdf on the CMS website.

CMS published MLN Matters® article MM5917, related to CR5917, which may be reviewed at http://www.cms.gov/MLNMattersArticles/downloads/MM5917.pdf on the CMS website.

AFO and KAFO Custom Fabricated versus Prefabricated Codes – RAC Identified Issue

HCPCS codes for Ankle Foot Orthotic and Knee Ankle Foot additions that include the descriptors "For Custom Fabricated Orthosis Only" or "Molded to Patient Model" may not be billed with HCPCS codes for prefabricated base orthotics. These addition codes, when paid for on the same date of service and for the same extremity as the prefabricated base orthotic codes, are overpayments. 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
- CMS Internet Only Manual Publication 100-2, Chapter 15, Medicare Benefit Policy Manual, Section 130, http://www.cms.gov/manuals/Downloads/bp102c15.pdf
- Local Coverage Determination (LCD) L142 Ankle-Foot/Knee-Ankle-Foot Orthosis, https://www.noridianmedicare.com/dme/coverage/docs/lcds/current_lcds/ankle-foot_knee-ankle-foot_orthosis.htm
- Policy Article A19800, https://www.noridianmedicare.com/dme/coverage/docs/lcds/current_articles/ankle-foot_knee-ankle-foot_orthosis.htm

Watch for future training events on this topic. Notification will be distributed through website postings within the "What's New" section of our website as well as the email newsletter.

Implementation of New RUL Policy for Stationary and Portable Oxygen Equipment

MLN Matters® Number: MM7213
Related Change Request (CR): 7213
Related CR Release Date: April 8, 2011
Related CR Transmittal #: R871OTN
Effective Date: May 8, 2011
Implementation Date: May 8, 2011

Provider Types Affected
This article is for suppliers billing Durable Medical Equipment Medicare Administrative Contractors (DME MACs) and/or Regional Home Health Intermediaries (RHHIs) for portable and stationary oxygen equipment for Medicare beneficiaries.

Provider Action Needed
Change Request (CR) 7213 implements changes to address situations in which a beneficiary has both portable and stationary oxygen equipment and the RUL for one piece of equipment expires before the RUL for the other piece of equipment has been reached.

Background
CR 7213 results in systems changes to establish new RUL policies for instances where the beneficiary has both portable and stationary oxygen equipment and the RUL for one piece of equipment expires before the RUL for the other piece of equipment has been reached. In most cases, a beneficiary who requires both stationary and portable oxygen will have developed the need for both stationary and portable oxygen at the same time, will have received their stationary and portable oxygen equipment at the same time, and will be in a situation where the RUL for the stationary oxygen equipment ends at the same time that the RUL for the portable oxygen equipment ends. At the end of the RUL, the beneficiary can elect to obtain new oxygen equipment.

Payment for portable oxygen equipment under Medicare is made as an add-on to the monthly payment amount for oxygen and oxygen equipment, which includes payment for stationary equipment, stationary oxygen contents, and portable oxygen contents. As a general rule, the same supplier that furnishes the stationary oxygen equipment to a beneficiary and receives the monthly payment for oxygen and oxygen equipment should also be furnishing the portable oxygen equipment to that beneficiary since a component of the payment for portable oxygen (portable oxygen contents) is included in the monthly payment amount for oxygen and oxygen equipment. A supplier of either stationary oxygen equipment or portable oxygen equipment that has furnished the equipment for 36 months of continuous use must continue to furnish the oxygen equipment to the beneficiary for the remainder of the RUL. Under the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) competitive bidding program, this responsibility does not transfer to a contract supplier if the supplier is not awarded a contract. When the RUL for oxygen equipment ends and the beneficiary elects to obtain replacement oxygen equipment, the replacement equipment must be furnished by a contract supplier and cannot be furnished by a non-contract supplier.

At the start of a competitive bidding program, a supplier that is not awarded a contract for furnishing oxygen and oxygen equipment under the program may elect to continue or may be required to continue furnishing oxygen and oxygen equipment to beneficiaries they are currently serving:

1. They may elect to be a grandfathered supplier for oxygen and oxygen equipment that has not yet reached the 36-month rental cap for all of their current customers who are Medicare beneficiaries residing in a DMEPOS Competitive Bidding Area (CBA); or
2. They are required to continue furnishing oxygen and oxygen equipment for which they received the 36th rental payment prior to the start of the program for the remainder of the RUL established for the equipment.

Note: These new RUL policies outlined below apply to oxygen and oxygen equipment furnished to Medicare beneficiaries in general and are not restricted to oxygen and oxygen equipment furnished to beneficiaries residing in CBAs.

Key Points of CR7213
The following rules apply in situations where the beneficiary is using both stationary and portable oxygen equipment with different RUL end dates.

- When the RUL of a beneficiary's portable oxygen equipment differs from the RUL of the beneficiary's stationary oxygen equipment, the RUL of the stationary oxygen equipment shall govern the application of RUL-based rules and processes for both types, stationary and portable, of oxygen equipment.
- Until such time, as the end date of the RUL of the stationary oxygen equipment is reached, the supplier must continue to furnish both the portable and stationary oxygen equipment.
    - If the end date of the RUL of the portable oxygen equipment **precedes** the end date of the RUL of the stationary oxygen equipment, the end date of the RUL of the portable oxygen equipment is adjusted **(extended)** to coincide with the end date of the RUL of the stationary oxygen equipment.
    - If the end date of the RUL of the portable oxygen equipment **follows** the end date of the RUL of the stationary oxygen equipment, the end date of the RUL of the portable oxygen equipment is adjusted **(shortened)** to coincide with the end date of the RUL of the stationary oxygen equipment.
- When the end date of the RUL of the stationary oxygen equipment occurs, the beneficiary may elect to obtain replacement of both the stationary and the portable oxygen equipment.
- If the beneficiary elects to obtain replacement of the stationary and the portable oxygen equipment, both types of oxygen equipment must be replaced at the same time.
- When the stationary and the portable oxygen equipment are replaced, a new 36-month rental period and new RUL is started for both the replacement stationary oxygen equipment and the replacement portable oxygen equipment.
- Beginning January 1, 2011, a beneficiary who resides in a DMEPOS CBA may obtain replacement of both the stationary and portable oxygen systems only from a contract supplier having a competitive bidding contract for the CBA in which the beneficiary permanently resides.
- A grandfathered supplier for oxygen and other grandfathered equipment as of January 1, 2011, who has continued to furnish such equipment that has not yet reached the 36-month rental cap, does not qualify to furnish replacement equipment once the end date of the RUL of the stationary equipment is reached, if the beneficiary resides in the CBA when the end of the RUL has been reached (unless the status of the grandfathered supplier has changed to a contract supplier for the current round of the DMEPOS competitive bidding program).

Additional Information
For complete details regarding this CR please see the official instruction (CR 7213) issued to your Medicare RHHI or DME MAC. That instruction may be viewed by going to http://www.cms.gov/Transmittals/downloads/R871OTN.pdf on the CMS website.

National DME MAC CERT Taskforce Oxygen ACT Transcript, Audio, and Revised Pre-Submitted Q&A Now Available

To reduce common Comprehensive Error Rate Testing (CERT) errors, DME MAC Jurisdictions A, B, C and D have collaborated to form the DME MAC CERT Education Taskforce. The task force conducted a national Ask the Contractor Teleconference (ACT) specific to the oxygen policy. Members of the DME MAC CERT Education Taskforce and knowledgeable CMS policy experts answered supplier questions on oxygen and oxygen equipment posed February 3, 2011.

The transcript from the call is now available along with the audio version. Revised pre-submitted questions and answers have also been posted. These items are available on the Ask the Contractor Teleconference web page: https://www.noridianmedicare.com/dme/train/act/act_schedule.html

Oxygen ACT February 3 Attendees: Complete Survey and Offer Guidance

CMS and each DME contractor hosted a national Oxygen Ask the Contractor Teleconference on February 3, 2011. Prior to the ACT event, over 60 questions were collected from suppliers and the answers were published to each contractor's website. These questions and answers addressed coverage, testing, Certificate of Medical Necessity, and documentation. This ACT event was conducted as a collaborative effort to address the most common national Comprehensive Error Rate Testing (CERT) errors and to offer consistent education from all four DME MAC jurisdictions. By completing the survey, suppliers will provide guidance to each DME MAC that will be considered as future events are planned. The survey is accessible at: https://www.surveymonkey.com/s/NY8PZTH. Thank you in advance.

Widespread Prepayment Review for Oxygen and Oxygen Equipment Edit Effectiveness for 3rd Quarter

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

The results of the review of the claims 892 identified claims of which 597 were denied. This resulted in an overall error rate of 66%. This is an increase from 54% during the first quarter and a decrease from 67% in the second quarter of this review. However, because the error rate remains high, 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:

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:

1. Requested documentation was not provided within the allotted time frame as referenced in the Medicare guidelines
2. No office visit notes to determine medical necessity within 30 days of certification or 90 days within recertification were submitted
3. No qualifying blood gas study submitted
4. POD signed after dated of service
5. Invalid Certificate of Medical Necessity (CMN)

OXYGEN CONT'D

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

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

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

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

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

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

Group I criteria include any of the following:

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

2. An arterial PO 2 at or below 55 mm Hg, or an arterial oxygen saturation at or below 88 percent, for at least 5 minutes taken during sleep for a patient who demonstrates an arterial PO 2 at or above 56 mm Hg or an arterial oxygen saturation at or above 89 percent while awake, or

3. A decrease in arterial PO 2more than 10 mm Hg, or a decrease in arterial oxygen saturation more than 5 percent, for at least 5 minutes taken during sleep associated with symptoms (e.g., impairment of cognitive processes and [nocturnal restlessness or insomnia]) or signs (e.g., cor pulmonale, "P" pulmonale on EKG, documented pulmonary hypertension and erythrocytosis) reasonably attributable to hypoxemia, or

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

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

5. Dependent edema suggesting congestive heart failure, or

6. Pulmonary hypertension or cor pulmonale, determined by measurement of pulmonary artery pressure, gated blood pool scan, echocardiogram, or "P" pulmonale on EKG (P wave greater than 3 mm in standard leads II, III, or AVF), or

7. Erythrocythemia with a hematocrit greater than 56 percent.

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

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

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

OXYGEN CONT'D

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

E. 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/docs/checklists/oxygen_and_oxygen_equipment.pdf.

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

PAP DEVICES

HCPCS E0601 - Notification of Prepayment Review

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

In order to evaluate compliance with Medicare coverage and coding rules, all suppliers billing Jurisdiction D for HCPCS code E0601 are subject to this review. Suppliers of the selected claims will receive an *Additional Documentation Request* (ADR) letter asking for specific information to determine if the item billed complies with the existing reasonable and necessary criteria. Failure to supply the requested information within **30 days** of the date on the letter will result in the claim being denied as not medically necessary. The ADR letter will provide instruction for submitting documentation.

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Positive Airway Pressure (PAP) Devices for the Treatment of Obstructive Sleep Apnea Local Coverage Determination (LCD) L171 and Policy Article A19827.

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

Positive Airway Pressure Devices – Interpreting Physician Credentials

Recently questions have arisen regarding how suppliers should verify the credentials of the physician interpreting sleep tests when requested during the course of a contractor's claim review. As noted in the local coverage determination (LCD) for Positive Airway Pressures (PAP) Devices:

For PAP devices with initial dates of service on or after November 1, 2008, all HSTs (Type II, III, IV, Other) must be interpreted by a physician who holds either:

1. Current certification in Sleep Medicine by the American Board of Sleep Medicine (ABSM); or
2. Current subspecialty certification in Sleep Medicine by a member board of the American Board of Medical Specialties (ABMS); or
3. Completed residency or fellowship training by an ABMS member board and has completed all the requirements for subspecialty certification in sleep medicine except the examination itself and only until the time of reporting of the first examination for which the physician is eligible; or
4. Active staff membership of a sleep center or laboratory accredited by the American Academy of Sleep Medicine (AASM) or The Joint Commission (formerly the Joint Commission on Accreditation of Healthcare Organizations – JCAHO).

For PAP devices with coverage based on a facility-based polysomnogram (Type I) performed on or after January 1, 2010, the interpreting physician must meet one of the requirements listed above (1-4) for credentialing.

There are multiple methods for confirming the interpreting physician's credentials. One method is to request a copy of the board certificate or other documentation provided by the certifying entity directly from the physician. Alternatively, there are several websites that have credential verification information. Suppliers may provide screen prints from one of these sites with information about the interpreting physician's credentialing status. The following list contains examples (not all-inclusive) of websites and organizations that maintain this information:

1. For physicians affiliated with an American Academy of Sleep Medicine (AASM)-accredited sleep lab - http://www.sleepcenters.org
2. Board certification entities:
   a. American Board of Sleep Medicine (ABSM) (for those certified prior to 2007) - Certification by ABSM was not time-limited (i.e., lifetime certification) so ABSM still maintains a site with credentials verification information at http://www.absm.org.
   b. American Board of Medical Specialties (ABMS) – ABMS member boards took over administration of the certifying examination in sleep medicine from ABSM in 2007. The ABMS site - http://www.absm.org – also has a credentials verification look-up function.
   c. ABMS member board sites. Each member board of ABMS that is involved in physician training in sleep medicine and administration of a specialty examination in sleep medicine has credentials verification. Those specific ABMS member sites are listed below:

American Board of Family Medicine
2228 Young Drive
Lexington, KY 40505-4294
Phone: 859-269-5626 or 888-995-5700
Fax: 859-335-7501 or 859-335-7509
Website: https://www.theabfm.org/cert/caq.aspx#caq4

American Board of Internal Medicine
510 Walnut Street
Suite 1700
Philadelphia, PA 19106-3699
Phone: 215-446-3500 or 1-800-441-2246
Fax: 215-446-3633
Website: http://www.abim.org/certification/policies/imss/sleep.aspx

American Board of Pediatrics
111 Silver Cedar Court
Chapel Hill, NC 27514
Phone: 919-929-0461
Fax: 919-929-9255
Website: http://www.abp.org

American Board of Psychiatry and Neurology
500 Lake Cook Road, Suite 335
Deerfield, IL 60015
Phone: 847-945-7900
Fax:847-945-1146
Website: http://www.abpn.com/cert_subspecialties.htm

American Board of Otolaryngology
5615 Kirby Drive
Suite 600
Houston, Texas 77005
Phone: 713-850-0399
Fax: 713-850-1104
Website: http://www.aboto.org

Additional Guidance on Implementing System Edits for Certain DMEPOS

MLN Matters® Number: MM7073 Rescinded
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

Note: This article was replaced by article MM7333 on March 15, 2011. The replacement article is available at http://www.cms/gov/MLNMattersArticles/downloads/MM7333.pdf on the Centers for Medicare & Medicaid Services website.

Guidance on Implementing System Edits for Certain DMEPOS

MLN Matters® Number: MM7333
Related Change Request (CR) #:7333
Related CR Release Date: March 4, 2011
Related CR Transmittal #: R865OTN
Effective Date: July 1, 2011
Implementation Date: July 5, 2011

Provider Types Affected
This article is for suppliers who submit claims to Medicare Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) services provided to Medicare beneficiaries.

Provider Action Needed
This article is based on Change Request (CR) 7333. The Centers for Medicare & Medicaid Services (CMS) issued CR7333 to rescind and replace CR7073 dated November 12, 2010. CR7333 provides 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 accredited to supply the specific product/service AND they are not exempt from accreditation, their claims will be automatically denied by Medicare. Also be aware that Attachments B and C of CR7333 are updated to include additional Healthcare Common Procedures Coding System (HCPCS) codes. All other information remains the same as that included in CR7073.

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.

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 Social Security Act. In implementing quality standards under this paragraph the Secretary will require suppliers furnishing items and services directly on or after October 1, 2009, 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 Social Security 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;
- Audiologists, and
- Pharmacies (Those that have an NSC-MAC approved "Attestation for Exemption from Accreditation for a Medicare Enrolled Pharmacy." (See the NSC-MAC website at http://palmettogba.com or the CMS website) (In accordance with Section 3109(a) of the Patent P rotection 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 HCPCS codes in the product categories designated by MIPPA as requiring accreditation will be in effect. This Medicare system edit will auto-deny claims paid for these codes on claims with dates of service on or after July 5, 2011 unless:

1. The DMEPOS supplier has been identified as accredited and verified on their CMS-855S;
2. Or the DMEPOS supplier is currently exempt from meeting the accreditation requirements as listed in Attachment A of this change request; and
3. Medicare system edits will begin this process by phasing in a limited number of product categories and HCPCS codes, as listed in Attachments B and C of this change request. The web address for Attachments B and C is part of the official instruction and may be found in the Additional Information section of this CR7333.

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."

PECOS CONT'D

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 CR7333. Their corresponding HCPCS codes may be found in Attachment C. The web address of CR7333 can be found in the Additional Information section of this article.

Additional Information
The official instruction, CR7333 issued to your DME/MAC regarding this change may be viewed at http://www.cms.gov/Transmittals/downloads/R865OTN.pdf on the CMS website.

Internet-Based PECOS Even More User-Friendly

Healthcare providers who use or plan to use the Provider Enrollment, Chain, and Ownership System (PECOS) to file and track their Medicare enrollment record and specialty status have even more reason to enjoy the convenience of internet-based PECOS. The internet-based system received a series of enhancements during the month of January, including:

- An improved submission process, including simpler directions for signing up and a clearer process for follow-up;
- A tracking bar for the application process, indicating progress through the system; and
- A new application status module on the website for checking whether enrollment applications have been:
  - received by the MAC (Medicare Administrative Contractor),
  - reviewed by the MAC,
  - returned for additional information, or
  - approved or rejected; and

Additionally, providers now have 15 days to submit signed paperwork required to complete the enrollment process.

To access internet-based PECOS, visit https://pecos.CMS.hhs.gov/pecos/login.do. To learn more about Medicare enrollment for providers and suppliers, visit http://www.CMS.gov/MedicareProviderSupEnroll; additional informative factsheets from the Medicare Learning Network about internet-based PECOS are available for physicians and non-physician practitioners, provider and supplier organizations, and DMEPOS suppliers.

No Date Set for Expanded Ordering/Referring Provider Claim Edits

It has come to CMS' attention that there was an editorial oversight in the Office of Inspector General (OIG) Compendium of Unimplemented Recommendations (March 2011 Edition). The OIG report states that the CMS will delay the implementation of Phase 2 of Change Request (CR) 6417 and CR until Tuesday, July 5, 2011. This is incorrect.

CMS has not yet determined when it will begin to apply the ordering/referring provider claim edit to ordering/referring providers that do not have a record in the Provider Enrollment, Chain, and Ownership System (PECOS). As previously stated, CMS will give providers ample notice before the ordering/referring provider claim edit is applied. Recent revisions to CRs #6417 and #6421 require MACs to delay rejecting claims until receiving further direction from CMS.

PRESSURE REDUCING SUPPORT SURFACES

HCPCS E0277 - Notification of Prepayment Review

NAS Jurisdiction D DME MAC Medical Review will be initiating a widespread prepayment probe review of claims for HCPCS code E0277 (Powered pressure-reducing air mattress). Widespread reviews are used to determine the extent of potential problem areas across multiple suppliers. This review is being initiated based on the results of Comprehensive Error Rate Testing (CERT) and Office of Inspector General (OIG) review analysis.

In order to evaluate compliance with Medicare coverage and coding rules, all suppliers billing Jurisdiction D for HCPCS code E0277 are subject to this review. Suppliers of the selected claims will receive an *Additional Documentation Request* (ADR) letter asking for specific information to determine if the item billed complies with the existing reasonable and necessary criteria. Failure to supply the requested information within **30 days** of the date on the letter will result in the claim being denied as not medically necessary. The ADR letter will provide instruction for submitting documentation.

PRESSURE REDUCING SUPPORT SURFACES CONT'D

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Pressure Reducing Support Surfaces – Group 2 Local Coverage Determination (LCD) L11579 and Policy Article A35422.

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

REFUNDS AND OVERPAYMENTS

Extended Repayment Schedule

As of March 21, 2011, NAS will no longer include a copy of the two-page Extended Repayment Schedule documentation list with each overpayment letter mailed.

Suppliers who wish to apply for an Extended Repayment Schedule may print the documentation list from the Forms page of our website at https://www.noridianmedicare.com/dme/forms/refunds_overpayments_forms.html.

There are two versions of the documentation list, one for sole proprietors and one for other ownership arrangements. Please be sure to use the correct one.

Instructions for requesting an Extended Repayment Schedule are found at https://www.noridianmedicare.com/dme/forms/requesting_an_extended_repayment_schedule.html.

REMITTANCE ADVICE

MREP Version 2.8 Now Available

Version 2.8 of the MREP software is available for download at http://www.cms.gov/AccesstoDataApplication/02_MedicareRemitEasyPrint.asp on the CMS website.

There are two new Medicare Secondary Payer (MSP)/Non-MSP Claims Reports. The MSP Claims Report identifies the X12 835V4010A1 and v5010 claims, within a remittance, that were processed by Medicare as secondary. The Non-MSP Claims Report identifies the X12 835V4010A1 and V5010 claims, within a remittance that were processed by Medicare as primary.

Since changes are being made to the MREP software, the updated Claim Adjustment Reason Codes/Remittance Advice Remark Codes file is included with version 2.8 of the MREP software. However, the separate Codes.ini file is provided when version 2.8 of the MREP software is distributed.

SAME OR SIMILAR

Same or Similar Denials

Same or similar denials occur when the patient's history indicates they have already received a piece of equipment which is the same or similar to the equipment being billed. An example of a scenario which would cause a same or similar denial is billing an E0196 (gel pressure mattress) when an E0277 (powered pressure-reducing air mattress) is already on file in the patient's history.

To determine whether same or similar items have previously been provided, suppliers must obtain all possible information from the patient as part of their intake process. This information may include the following:

- Patient's correct Health Insurance Claim number;
- Whether the patient has employer insurance or is enrolled in a Health Maintenance Organization (HMO);
- If the patient currently has or had an identical or similar item in the past;
- When the patient received the item and whether or not the item has been lost, stolen, or returned;
- Where the item will be used; and
- Certificate of Medical Necessity (CMN) or DME Information Form (DIF), if required.

SAME OR SIMILAR CONT'D

NAS has created a Suggested Intake Form to help ensure all appropriate information is obtained. Suppliers can customize their own intake form to meet their needs as well.

In addition to a thorough intake, the supplier should call the Interactive Voice Response (IVR) System or use Endeavor to verify the patient has not had a same or similar item in the past. These systems are able to access the beneficiary's local and national file to determine if they have received same or similar equipment. The IVR can be reached at 1-877-320-0390. For Endeavor go to https://www.noridianmedicare.com/dme/claims/endeavor.html to read more.

A modifier is required when using the IVR and Endeavor for same or similar inquiries. Failure to use the appropriate modifier when checking same or similar may result in inaccurate or incomplete same or similar information being returned. Suppliers attempted to retrieve same or similar information through Endeavor without the appropriate modifier 1,199 times in February. To determine what modifier is appropriate when requesting same or similar, first determine which payment category is assigned to the equipment being checked.

Below is a list of the applicable payment categories and the modifier(s) which would be appropriate to use when checking for equipment within that category.

Capped Rental Item - RR or NU
Inexpensive and Routinely Purchased DME - RR or NU
Oxygen and Oxygen Equipment - RR
Parentral/Enteral Nutrients - none
Parentral/Enteral Pumps - RR

Be aware that same and similar is not tracked on all HCPCS codes. Suppliers attempted to access same or similar information for items that are not tracked through Endeavor 106 times in February. Diabetic supplies, diabetic shoes, orthotics, prosthetics, lenses and frames are some of the items which are not able to be verified. For a complete list of the HCPCS codes that are tracked for same or similar purposes and which codes are considered similar to one another, refer to the Same or Similar Reference Chart. For complete instructions on using the IVR and Endeavor, see the IVR User Guide and the Endeavor User Manual.

DME suppliers are expected to be familiar with DME coverage policies and any additional pertinent information that may have an impact on medical necessity determinations. In order to be protected under the limitation of liability provision, a supplier must provide a proper Advance Beneficiary Notice of Noncoverage (ABN) for each item that is likely to be denied as not medically necessary.

A supplier may request a redetermination on same or similar denials with ANSI code CO-150. Examples of additional documentation to submit include a CMN or DIF, physician order, signed pick up and/or delivery ticket, a detailed outline of events, and any changes in medical need. Suppliers are liable for CO-150 denials unless an ABN has been properly executed. This includes same or similar denials.

If there is no indication that same or similar equipment has been previously obtained, the supplier would have no reason to provide an ABN. If the beneficiary or the beneficiary's authorized representative is unable to respond fully on the issue of "same or similar equipment," the supplier may issue an ABN. When the beneficiary intends to use a piece of equipment as a backup, i.e., an extra wheelchair to keep in the car the supplier should always obtain a signed ABN. A signed ABN is indicated on the claim form with a GA modifier. Please submit a copy of the ABN with each appeal request.

SIGNATURES

Signature on Requisition for Clinical Diagnostic Laboratory Tests

In the Monday, 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 non-physician practitioner's (NPP) signature on requisitions for clinical diagnostic laboratory tests paid under the clinical laboratory fee schedule effective Saturday, 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.)

On Monday, December 20, 2010, CMS informed its contractors of concerns that some physicians, NPPs, and clinical diagnostic laboratories are not aware of or do not understand this policy. As such, CMS indicated that it will focus in the first quarter of 2011 on developing educational and outreach materials to educate those affected by this policy. CMS indicated that once the first quarter educational campaign is fully underway, it will expect requisitions to be signed.

SIGNATURES CONT'D

After further input from community, CMS has decided to focus for the remainder of 2011 on changing the regulation that requires signatures on laboratory requisitions because of concerns that physicians, NPPs, and clinical diagnostic laboratories are having difficulty complying with this policy.

TENS

HCPCS E0731 - Notification of Prepayment Review

NAS Jurisdiction D DME MAC Medical Review will be initiating a widespread prepayment probe review of claims for HCPCS code E0731 (Form-fitting conductive garment for delivery of TENS or NMES). Widespread reviews are used to determine the extent of potential problem areas across multiple suppliers. This review is being initiated based on contractor identified billing concerns.

In order to evaluate compliance with Medicare coverage and coding rules, all suppliers billing Jurisdiction D for HCPCS code E0731 are subject to this review. Suppliers of the selected claims will receive an *Additional Documentation Request* (ADR) letter asking for specific information to determine if the item billed complies with the existing reasonable and necessary criteria. Failure to supply the requested information within **30 days** of the date on the letter will result in the claim being denied as not medically necessary. The ADR letter will provide instruction for submitting documentation.

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

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

THERAPEUTIC SHOES

HCPCS A5500 and A5512 - Notification of Prepayment Review

NAS Jurisdiction D DME MAC Medical Review will be initiating a widespread prepayment probe review of claims for HCPCS codes A5500 (For diabetics only, fitting including follow-up, custom preparation and supply of off-the-shelf depth-inlay shoe manufactured to accommodate multidensity insert (s) per shoe) and A5512 (Multiple density inserts, direct formed, molded to foot prefabricated).Widespread reviews are used to determine the extent of potential problem areas across multiple suppliers. This review is being initiated based on the results of Comprehensive Error Rate Testing (CERT) review analysis.

In order to evaluate compliance with Medicare coverage and coding rules, all suppliers billing Jurisdiction D for HCPCS codes A5500 and A5512 are subject to this review. Suppliers of the selected claims will receive an *Additional Documentation Request* (ADR) letter asking for specific information to determine if the item billed complies with the existing reasonable and necessary criteria. Failure to supply the requested information within **30 days** of the date on the letter will result in the claim being denied as not medically necessary. The ADR letter will provide instruction for submitting documentation.

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Therapeutic Shoes for Persons with Diabetes Local Coverage Determination (LCD) L157 and Policy Article A37076.

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

THERAPEUTIC SHOES CONT'D

Therapeutic Footwear Utilization – RAC Identified Issue

The LCD and Policy Article for Therapeutic Shoes for Diabetics limit the use of shoes and inserts as follows: For patients meeting these criteria, coverage is limited to one of the following within one calendar year (January – December): One pair of custom molded shoes (A5501) (which includes inserts provided with these shoes) and 2 additional pairs of inserts; or one pair of depth shoes (A5500) and 3 pairs of inserts. 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
- CMS Internet Only Manual Publication 100-2, Chapter 15, Benefits Policy Manual, Section 140, http://www.cms.gov/manuals/Downloads/bp102c15.pdf
- LCD L157 Therapeutic Shoes for Persons with Diabetes, https://www.noridianmedicare.com/dme/coverage/docs/lcds/current_lcds/therapeutic_shoes_for_persons_with_diabetes.htm
- Policy Article A37076 Therapeutic Shoes for Persons with Diabetes, https://www.noridianmedicare.com/dme/coverage/docs/lcds/current_articles/therapeutic_shoes_for_persons_with_diabetes.htm

NAS has created a self-paced tutorial for suppliers and their staff to receive training regarding Therapeutic Shoes for Persons with Diabetes, https://www.noridianmedicare.com/dme/train/.

UROLOGICAL SUPPLIES

Correct Coding Instructions: A4358 Urinary Collection Bag

A4358 (URINARY DRAINAGE BAG, LEG OR ABDOMEN, VINYL, WITH OR WITHOUT TUBE, WITH STRAPS, EACH) is a urinary collection bag that includes straps which hold the bag securely to the body.

Manufacturers of urinary collection bags have notified the Pricing, Data Analysis and Coding (PDAC) Contractor that some collection bags do not contain straps. While manufacturers may offer these products without straps, Durable Medical Equipment, Prothestics, Orthotics and Supplies (DMEPOS) suppliers are reminded they MUST supply straps with the urinary drainage bag to the Medicare beneficiary.

Suppliers are reminded that A4358 includes both the drainage bag and straps. If the drainage bag from a particular manufacturer does not contain a leg strap, suppliers must provide a leg strap but should not bill using the miscellaneous code A4335 (INCONTINENCE SUPPLY; MISCELLANEOUS) and A5113 (LEG STRAP; LATEX, REPLACEMENT ONLY, PER SET) or A5114 (LEG STRAP; FOAM OR FABRIC, REPLACEMENT ONLY, PER SET).

Refer to the Local Coverage Determination (LCD) and Policy Article for Urological Supplies for coverage and HCPCS coding requirements.

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

Urological Supplies – A4353 Correct Coding Clarification Policy Revision

The Coding Guidelines section of the Urological Supplies Policy Article has been revised to clarify the correct coding for use of HCPCS code A4353 (Urinary intermittent catheter with insertion supplies). The revised passage states:

> "A urinary intermittent catheter with insertion supplies (A4353) is a kit which includes a catheter and all supplies necessary for sterile insertion (see below). Code A4353 may be used if either 1 or 2 is supplied:
>
> **1.** A sterile intermittent urinary catheter plus a separately packaged sterile kit of insertion/collection supplies; or
>
> **2.** A single sterile package containing both a catheter and all insertion/collection supplies.

UROLOGICAL SUPPLIES CONT'D

The insertion kit (A4353) contains a catheter (may be packaged separately from the other components), lubricant, gloves, antiseptic solution, applicators, a drape, and a collection tray/bag in a sterile package intended for single use. The collection tray/bag is a separate item included as part of the kit; therefore, materials that serve as non-sterile packaging to contain all of the items in the kit do not meet this requirement. Except as noted in 1 above, code A4353 must not be billed if individual insertion kit components are provided as separate items. When providing a sterile kit, the individual components must not be separately billed."

Suppliers are reminded that payment for code A4353 includes both the catheter and all insertion supplies. Separate billing for the catheter and/or any insertion supplies is incorrect.

The Local Coverage Determination (LCD) section on Intermittent Catheterization also has been revised to be consistent with the Coding Guideline above. The revised material in the LCD states:

> Refer to Coding Guidelines section of the related Policy Article for contents of the kit (A4353). A4353 should not be used for billing if the components are packaged separately rather than together as a kit. Separately provided components do not provide the equivalent degree of sterility achieved with an A4353. If separate components are provided instead of a kit (A4353) they will be denied as not reasonable and necessary.

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

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

VERSION 5010/ICD-10

Have You Started External Testing of Version 5010?

All HIPAA covered entities that submit transactions electronically are required to upgrade from Version 4010/4010A to Version 5010 transaction standards by January 1, 2012.

Testing should be conducted both internally and with external business partners in preparation for the January 1, 2012, compliance deadline. Internal testing of Version 5010 should have been completed by December 31, 2010. Now is the time to begin external testing.

Testing transactions using Version 5010 standards will assure that you are able to send and receive compliant transactions effectively. And testing early will allow you to identify any potential issues, and address them in advance.

Stay ahead of the Version 5010 and ICD-10 transitions! Know the deadlines and mark your calendars:

January 1, 2011 - Begin external testing of Version 5010 for electronic claims

- CMS begins accepting Version 5010 claims
- Version 4010 claims continue to be accepted

December 31, 2011 - External testing of Version 5010 for electronic claims must be complete to achieve Level II Version 5010 compliance

January 1, 2012 - All electronic claims must use Version 5010; Version 4010 claims are no longer accepted

October 1, 2013 - Claims for services provided on or after this date must use ICD-10 codes for medical diagnosis and inpatient procedures; CPT codes will continue to be used for outpatient services

CMS has resources that can help you with the Version 5010 and ICD-10 transitions at http://www.cms.gov/icd10.

Version 5010 and ICD-10 are coming. Will you be ready?

Important Reminders about HIPAA 5010 & D.0 Implementation

MLN Matters® Number: SE1106

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

Provider Action Needed
The implementation of HIPAA 5010 and D.0 presents substantial changes in the content of the data that you submit with your claims as well as the data available to you in response to your electronic inquiries. The implementation requires changes to the software, systems, and perhaps procedures that you use for billing Medicare and other payers. It is important for new providers enrolling in Medicare to know that Electronic Data Interchange (EDI) transactions are the normal mode of business for Medicare claims, claim status, and remittance advice.

Medicare requires the use of electronic claims (except for certain rare exceptions) in order for providers to receive Medicare payment. Effective January 1, 2012, you must be ready to submit your claims electronically using the Accredited Standards Committee (ASC) X12 Version 5010 and National Council for Prescription Drug Programs (NCPDP) Version D.0 standards. This also is a prerequisite for implementing the new ICD-10 codes. This Special Edition MLN Matters® Article is being provided by the Centers for Medicare & Medicaid Services (CMS) to assist you and keep you apprised of progress on Medicare's implementation of the ASC X12 Version 5010 and NCPDP Version D.0 standards. Remember that the HIPAA standards, including the ASC X12 Version 5010 and Version D.0 standards are national standards and apply to your transactions with all payers, not just with Fee-for-Service (FFS) Medicare. Therefore, you must be prepared to implement these transactions with regard to your non-FFS Medicare business as well. Medicare began Level II transitioning to the new formats on January 1, 2011, and will be ending the exchange of current formats on January 1, 2012. While the new claim format accommodates the ICD-10 codes, ICD-10 codes will not be accepted as part of the 5010 project. Separate MLN Matters® articles will address the ICD-10 implementation.

In preparing for the implementation of these new ASC X12 and NCPDP standards, providers should also consider the requirements for implementing the ICD-10 code set as well. You are encouraged to prepare for the implementation of these standards or speak with your billing vendor, software vendor, or clearinghouse to inquire about their readiness plans for these standards.

The Health Insurance Portability and Accountability Act (HIPAA) requires the Secretary of the Department of Health and Human Services (HHS) to adopt standards that covered entities (health plans, health care clearinghouses, and certain health care providers) must use when they electronically conduct certain health care administrative transactions, such as claims, remittance, eligibility, claims status requests and responses, and others.

It is important that new providers enrolling in Medicare know that EDI transactions are the normal mode of business for Medicare claims, claim status, and remittance advice.

More information about Medicare's EDI requirements can be found in the "Medicare Claims Processing Manual," Chapter 24 – "General EDI and EDI Support Requirements, Electronic Claims and Coordination of Benefits Requirements, Mandatory Electronic Filing of Medicare Claims," at http://www.cms.gov/manuals/downloads/clm104c24.pdf on the CMS website. Electronic billing and EDI transaction information can be found at http://www.cms.gov/ElectronicBillingEDITrans/ on the CMS website. This section contains information on:

- EDI transaction and corresponding paper claims requirements;
- Links to those chapters of the "Medicare Claims Processing Manual" that contain further information on these types of transactions;
- The Administrative Simplification Compliance Act (ASCA) requirement that claims be sent to Medicare electronically as a condition for payment;
- How you can obtain access to Medicare systems to submit or receive claim or beneficiary eligibility data electronically; and
- EDI support furnished by Medicare contractors.

VERSION 5010/ICD-10 CONT'D

Current versions of the transaction standards (ASC X12 Version 4010/4010A1 for health care transactions, and the NCPDP Version 5.1 for pharmacy transactions) are widely recognized as lacking certain functionality that the health care industry needs. Therefore, on January 16, 2009, HHS announced a final rule that replaced the current Version 4010/4010A and NCPDP Version 5.1 with Version 5010 and Version D.0, respectively. The final rule (CMS-0009-F) titled, "Health Insurance Reform; Modifications to the Health Insurance Portability and Accountability Act (HIPAA) Electronic Transaction Standards," can be found at http://edocket.access.gpo.gov/2009/pdf/E9-740.pdf on the US Government Printing Office (GSP) website.

Subsequently, CMS is performing activities to convert from processing the ASC X12 Version 4010A1 to HIPAA ASC X12 Version 5010, and the NCPDP Version 5.1 to NCPDP Version D.0.

HHS is permitting the dual use of existing standards (4010A1 and 5.1) and the new standards (5010 and D.0) from the March 17, 2009, effective date of the regulation until January 1, 2012, the fully compliant (Level I and Level II Compliance) date to facilitate testing subject to trading partner agreement.

- **Level I compliance** means "that a covered entity can demonstrably create and receive compliant transactions, resulting from the compliance of all design/build activities and internal testing."
- **Level II compliance** means "that a covered entity has completed end-to-end testing with each of its trading partners, and is able to operate in production mode with the new versions of the standards."

The CMS Medicare Fee-for-Service implementation schedule is:

- **Level I** April 1, 2010, through December 31, 2010;
- **Level II** January 1, 2011, through December 31, 2011; and

Fully compliant on January 1, 2012.

CMS has prepared a comparison of the current ASC X12 HIPAA EDI standards (Version 4010/4010A1) with Version 5010, and NCPDP EDI standards Version 5.1 with Version D.0. For more information see http://www.cms.gov/ElectronicBillingEDITrans/18_5010D0.asp on the CMS website.

CMS has made the side-by-side comparison documents available to interested parties without guarantee and without cost. The documents are available for download in both Microsoft Excel and PDF formats.

The comparisons were performed for Medicare Fee-for-Service business use and while they may serve other uses, CMS does not offer to maintain for purposes other than Medicare Fee-for-Service. Maintenance will be performed without notification, as needed to support Medicare Fee-for-Service.

Readiness Assessment 1– Have you done the following to be ready for 5010/D.0?
Are you ready for 5010/D.0? Testing with external trading partners began in January of 2011. Testing with version 5010A1 Errata will begin in April 2011. Please don't wait until April to begin testing because compliance with the Errata must be achieved by the original regulation compliance date of January 1, 2012.

Visit http://www.cms.gov/Versions5010andD0/downloads/readiness_1.pdf to see a summary of information that is important for your readiness assessment.

Do not wait to begin testing with your MAC because the MACs may not be able to accommodate large volumes of trading partners seeking production status all at once. Be sure to start testing Version 5010 and D.0 as early as possible in 2011. Be prepared.

To download readiness checklists and a resource card with helpful web links go to http://www.cms.gov/Versions5010andD0/40_Educational_Resources.asp on the CMS website.

Readiness Assessment 2 – What do you need to have in place to test with your MAC?
Providers/trading partners should make it a priority to test early during calendar year 2011 with their MACs for the implementation of Versions 5010 and D.0 transactions so as not to impact future Medicare claim processing.

- Trading partner testing for the 5010 base version began with MACs on January 1, 2011.
- Testing with the 5010 errata version (5010A1) will be available for testing in April 2011.
- Successful testing with your MAC is required prior to being placed into production.

Prior to testing, trading partners should ensure their billing service, clearinghouse, or software vendor:

- Has passed testing requirements for each transaction (testing with each Medicare contractor or a certification system that the Medicare contractor has accepted); and
- Is using the same program/software to generate the transaction for all of their clients.

Details about Medicare testing requirements and protocols and the 5010 National Call presentation on Provider Outreach and Education – Transition Year Activities can be found at http://www.cms.gov/Versions5010andD0/downloads/OE_National_Presentation_12-8-10.pdf on the CMS website.

Trading partners are encouraged to review the following:

- Version 5010 and D.0. transaction resources can be found at http://www.cms.gov/Versions5010andD0/ on the CMS website;
- Educational Resources (i.e., Medicare Learning Network® (MLN) articles, fact sheets, readiness checklists, brochures, quick reference charts and guides, frequently asked questions, and transcripts from previous national provider calls) can be found at http://www.cms.gov/Versions5010andD0/40_Educational_Resources.asp on the CMS website; and
- The dedicated HIPAA 5010/D.0 Project web page, which includes technical documents and communications at national conferences, can be found at http://www.cms.gov/ElectronicBillingEDITrans/18_5010D0.asp on the CMS website.

Errata Requirements and Testing Schedule
HIPAA Version 5010 has new Errata, which can be found at http://www.cms.gov/Versions5010andD0/downloads/Errata_Req_and_Testing.pdf on the CMS website. According to the published regulation (Federal Register, Vol. 74, No. 11, 3296-3328, January 16, 2009; RIN 0938-AM50 of 45 CFR Part 162), testing with external trading partners must begin in January of 2011. Compliance with theErrata must be achieved by the original regulation compliance date of January 1, 2012.

Medicare FFS will implement the errata versions of the affected 5010 transactions to meet HIPAA compliance requirements, and Medicare FFS contractors will be ready to test the 5010 Errata versions in April 2011.

Transactions not impacted by the errata can be tested starting January 2011 without regard to the published errata schedule. Trading Partners should contact their local Medicare FFS contractor for specific testing schedules. To find a Medicare FFS contractor in your state, please refer to the "Downloads" section at http://www.cms.gov/ElectronicBillingEDITrans/ on the CMS website.

CMS 5010 Provider Outreach and Education Materials
CMS has developed extensive information and educational resources pertaining to the topics listed below. This information is available on the CMS website:

- Version 5010- the new version of the X12 standards for HIPAA transactions;
- Version D.0 – the new version of the National Council for Prescription Drug Program (NCPDP) standards for pharmacy and supplier transactions;
- Version 3.0 – a new NCPDP standard for Medicaid pharmacy subrogation.

The information posted at http://www.cms.gov/Versions5010andD0/01_overview.asp on the CMS website may be applicable to the healthcare industry at large, or may be specifically Medicare-related information. The "Overview" web page is designed to distinguish the Medicare-related information from the industry related.

Please note there are separate resource pages for D.0 and 3.0 for tools and information specific to these pharmacy-related standards. The highlights and overview of these pages are as follows:

- **Federal Regulation & Notices**
  (http://www.cms.gov/Versions5010andD0/20_Federal_Regulation_and_Notices.asp)
  This web page contains general information related to federal regulations and notices and contains the following link to the Final Rule for X12 5010, D.0 and 3.0 document. See http://edocket.access.gpo.gov/2009/pdf/E9-740.pdf on the GPO website.

- **CMS Communications**
  (http://www.cms.gov/Versions5010andD0/30_CMS_Communications.asp)
  This CMS Communications web page includes Versions 5010 & D.0 implementation information and the following downloads:
  - 5010 Implementation Calendar [PDF, 325KB]; see http://www.cms.gov/Versions5010andD0/Downloads/5010ImplementationCalendar.pdf on the CMS website.
  - Readiness Assessment - What do you need to have in place to test with your MAC? [PDF, 241KB]; see http://www.cms.gov/Versions5010andD0/Downloads/Readiness_2.pdf on the CMS website.
- **Educational Resources**
  (http://www.cms.gov/Versions5010andD0/40_Educational_Resources.asp)
  The Educational Resources web page includes information designed to increase national awareness and assist in the implementation of Versions 5010, D.0 and 3.0. Products that target a specific population, such as Medicare FFS, are clearly identified. Otherwise, products and information may be appropriate for the healthcare industry at large. This Web page includes the following downloads:
  - Version 5010 Resource Card [PDF, 243KB] (see http://www.cms.gov/MLNProducts/downloads/5010EDI_RefCard_ICN904284.pdf);
  - Preparing for Electronic Data Interchange (EDI) Standards: The Transition to Versions 5010 and D.0 Fact Sheet [PDF, 1208KB] (see http://www.cms.gov/Versions5010andD0/Downloads/w5010TransitionFctSht.pdf);
  - Checklist for Level I Testing Activities [PDF, 324 KB] (see http://www.cms.gov/Versions5010andD0/Downloads/w5010PrepChklst.pdf);
  - Provider Action Checklist for a Smooth Transition [PDF, 333KB] (see http://www.cms.gov/Versions5010andD0/Downloads/w5010PvdrActionChklst.pdf); and
  - Versions 5010 and D.0 MLN Matters® Articles [PDF, 31KB] (see http://www.cms.gov/Versions5010andD0/Downloads/Versions_5010_and_D0_MLN_Matters_Articles.pdf on the CMS website).
- **5010 National Calls**
  (http://www.cms.gov/Versions5010andD0/V50/)
  Throughout the implementation of Version 5010, CMS has been hosting a variety of national education calls that inform the provider community of the steps that they need to take in order to be ready for implementation. These calls also give participants an opportunity to ask questions of CMS subject matter experts. The 5010 web page contains the list of past calls with links to Web pages where you can download the past call presentations, transcripts, and audio files.

Additional Information
A Special Edition MLN Matters® article on the ICD-10 code set can be found at http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0832.pdf on the CMS website.

CMS is also using the Open Door Forums and listservs to keep providers informed of its implementation progress and will also use these vehicles to assist providers in preparing for the new standards. Information on the Open Door Forums can be found at http://www.cms.hhs.gov/OpenDoorForums/ on the CMS website. Information about listservs (email updates) can be found at http://www.cms.hhs.gov/AboutWebsite/EmailUpdates/ on the CMS website.

Modifications to Implementation of Paperwork Segment for X12N Version 5010

MLN Matters® Number: MM7306
Related Change Request (CR) #: 7306
Related CR Release Date: January 28, 2011
Related CR Transmittal #: R849OTN
Effective Date: July 1, 2011
Implementation Date: July 5, 2011

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

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

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

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

Be sure your staffs are informed of this change.

Additional Information
The official instruction, CR7306, issued to your FI, carrier, A/B MAC, and DME/MAC regarding this change, may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R849OTN.pdf on the CMS website.

New FAQs About ICD-10 Implementation

The Centers for Medicare & Medicaid Services (CMS) has posted two new frequently asked questions (FAQs) about ICD-10 national provider teleconferences and the partial code freeze.

To access these FAQs, please visit the CMS ICD-10 web page at http://www.cms.gov/ICD10, select the Medicare Fee-for-Service Provider Resources link on the left side of the page, scroll down the page to the "Related Links Inside CMS" section, and select "ICD-10 FAQs".

Please check the ICD-10 FAQ section regularly for newly posted or updated ICD-10 FAQs.

Sign Up for CMS ICD-10 Industry Update Messages

Did you know that the Centers for Medicare & Medicaid Services (CMS) has an e-mail update specific to ICD-10 that you can sign up for?

The CMS ICD-10 Industry E-mail Update provides subscribers with timely information about the upcoming Version 5010 and ICD-10 transitions. Each message is delivered directly to your e-mail inbox, supplying helpful reminders, information on new resources, and other ICD-10 and Version 5010 news. Recent messages have covered important topics, such as:

- The partial code freeze prior to ICD-10 implementation,
- External testing of Version 5010 transaction standards, and
- The General Equivalence Mappings (GEMs).

To sign up for the ICD-10 Industry E-mail Updates, or to view previous e-mail updates, visit http://www.CMS.gov/ICD10/02d_CMS_ICD-10_Industry_Email_Updates.asp. To keep up to date on Version 5010 and ICD-10, and for the latest news and resources, be sure to keep current with http://www.CMS.gov/ICD10.

Version 5010 and ICD-10 are coming. Will you be ready?

Version 5010 Transaction Standards Deadline Approaching. Are You Ready?

There are less than **10 months** until all HIPAA-covered entities need to transition from Version 4010/4010A1 to Version 5010 electronic transaction standards. With the **January 1, 2012**, deadline quickly approaching, have you taken the necessary steps to get ready?

Unlike the current Version 4010/4010A1, Version 5010 accommodates the ICD-10 codes and must be in place first before the changeover to ICD-10 on October 1, 2013. Version 5010 has the ability to tell your practice management or other system that you are using an ICD-10 versus an ICD-9 code.

A key step in preparing your office for this upgrade is testing transactions in the new Version 5010 format. If you have not already done so, you should begin external Version 5010 testing now.

Testing transactions using Version 5010 standards will assure that you are able to send and receive compliant transactions effectively. Testing will also allow you to identify any potential issues and address them in advance of the January 1, 2012, compliance date.

Keep Up to Date on Version 5010 and ICD-10.
CMS has resources to help you prepare. Visit http://www.cms.gov/ICD10 and click on "Version 5010."