DME Happenings

• THIS IS WRITTEN NOTIFICATION OF MEDICARE CHANGES •

November 2011 | Issue No. 33

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

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In This Issue...

NORIDIAN® Administrative Services LLC

CMS CENTERS for MEDICARE & MEDICAID SERVICES

DOCUMENTATION

DRUGS/BIOLOGICALS

EDUCATIONAL

ENROLLMENT

ENTERAL NUTRITION

FORMS

FRAUD & ABUSE

GLUCOSE MONITORS

ICD-10

MEDICARE SECONDARY PAYER

MODIFIERS

NEBULIZERS

ORTHOTICS AND PROSTHETICS

OXYGEN

PAP DEVICES

PECOS

REFUNDS/OVERPAYMENTS

REMITTANCE ADVICES

SKILLED NURSING FACILITY

SUPPORT SURFACES

TENS

THERAPEUTIC SHOES

VERSION 5010

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 8 pm CT Monday – Friday
Supplier Contact Center	1-866-243-7272	8:30 am to 5:30 pm CT Monday – Friday
Beneficiary Customer Service	1-800-633-4227	24 hours a day/7 days a week
Telephone Reopenings	1-888-826-5708	8 am – 4 pm CT

Website: www.noridianmedicare.com/dme

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

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

Mailing Addresses	
Claims, Redetermination Requests, Correspondence and Medical Review Documentation Noridian Administrative Services PO Box 6727 Fargo ND 58108-6727	**Benefit Protection** Noridian Administrative Services Benefit Protection-DME PO Box 6736 Fargo ND 58108-6736
Administrative Simplification Compliance Act Exception Requests Noridian Administrative Services PO Box 6737 Fargo ND 58108-6737	**Qualified Independent Contractor** C2C Solutions Inc. Attn: DME QIC PO Box 44013 Jacksonville FL 32202-4103
Electronic Funds Transfer Forms / Overpayment Redeterminations/DME RAC Redeterminations Noridian Administrative Services PO Box 6728 Fargo ND 58108-6728	**DME RAC Overpayments** Noridian Administrative Services PO Box 6759 Fargo ND 58108-6759

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

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

2011 Supplier Contact Center and Telephone Reopenings Holiday and Training Closures

Supplier Contact Center

The NAS Customer Service team (1-866-243-7272) will be closed for the entire day (8:30 a.m. through 5:30 p.m. CT) on nine days in 2011 in recognition of holidays. Additionally, the Customer Service team will be closed two days each month 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
Veterans Day* Training	November 11	8:30 a.m. – 12:00 p.m. CT
Thanksgiving	November 24 and 25	Entire Day Closed 8:30 a.m. – 5:30 p.m. CT
Off-the-Phone Training*	December 16	8:30 a.m. – 12:00 p.m. CT
Christmas	December 23 and 26	Entire Day Closed 8:30 a.m. – 5:30 p.m. CT
Martin Luther King Day* Training	January 17	8:30 a.m. – 12:00 p.m. CT
Off-the-Phone Training*	January 27	8:30 a.m. – 12:00 p.m. CT
Off-the-Phone Training*	February 10	8:30 a.m. – 12:00 p.m. CT
President's Day* Training	February 20	8:30 a.m. – 12:00 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
Veterans Day* Training	November 11	8:00 a.m. – 12:30 p.m. CT
Thanksgiving	November 24 and 25	Entire Day Closed 8:00 a.m. – 4:00 p.m. CT
Off-the-Phone Training*	December 16	8:00 a.m. – 12:30 p.m. CT
Christmas Eve Observed	December 23	Entire Day Closed 8:00 a.m. – 4:00 p.m. CT
Christmas	December 26	Entire Day Closed 8:00 a.m. – 4:00 p.m. CT

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

Additional Fields for Additional Documentation Request Letters

MLN Matters® Number: MM7254 Revised
Related Change Request (CR) #: 7254
Related CR Release Date: September 15, 2011
Related CR Transmittal #: R958OTN
Effective Date: January 1, 2012, except April 1, 2012 for suppliers billing DME MACs
Implementation Date: January 3, 2012, except April 2, 2012 for DME MACs

Note: This article was revised on September 30, 2011, to clarify the description of the content in the ADR. All other information remains the same.

Provider Types Affected

This article is for physicians, providers, and suppliers who must respond to ADRs from 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

CR 7254, from which this article is taken, makes changes to the Medicare systems that allow A/B MACs and DME MACs to include, on Additional Documentation Request (ADR) letters, information about the Electronic Submission of Medical Documentation (esMD) pilot.

Background

CR7254, from which this article is taken, announces several changes to the Medicare systems that enable Medicare Review Contractors, participating in the esMD pilot, to include on ADR letters additional information necessary for Electronic Submission of Medical Documentation (esMD).

Specifically, these will allow MACs to include in each ADR:

- A statement about how providers can get more information about submitting medical documentation via the esMD mechanism
- A documentation case ID number that may facilitate tracking of submitted documents.

Additional Information

You can find the official instruction, CR7254, issued to your A/B MAC or DME MAC by visiting http://www.cms.gov/Transmittals/downloads/R958OTN.pdf on the Centers for Medicare & Medicaid Services (CMS) website.

You can learn more about the esMD pilot by going to http://www.cms.gov/ESMD/ on the CMS website. In addition, MLN Matters® article SE1110 provides more details on the esMD initiative. That article is at http://www.cms.gov/MLNMattersArticles/downloads/SE1110.pdf on the CMS website.

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

Contractor Entities at a Glance: Who May Contact You about Specific CMS Activities

MLN Matters® Number: SE1123

Provider Types Affected

All physicians, providers, and suppliers who submit claims to Medicare contractors (as defined in this article) for services and supplies provided to Medicare beneficiaries are affected.

What You Need to Know

The Centers for Medicare & Medicaid Services (CMS) has received calls from providers about the various entities that may contact them with questions and requests for medical records, documentation, or other information. CMS recognizes that shifts in contracting entities due to recent Medicare Contracting Reform may be confusing. CMS

has prepared this Special Edition article to describe the current Medicare contracting environment. In addition, this article will list the entities responsible for activities in the Medicare Program, as well as with some Medicaid claims, and explain the reasons why they may contact you. CMS has also prepared a quick reference table titled, "Contractor Entities at a Glance: Who May Contact You about Specific Centers for Medicare & Medicaid Services (CMS) Activities," that you may provide to your office staff for easy reference. The table is available at http://www.cms.gov/MLNProducts/downloads/ContractorEntityGuide_ICN906983.pdf on the CMS website.

CMS understands that several of these entities may contact you concurrently. You may question whether the efforts of these entities are coordinated and whether the burden placed upon providers can be reduced. CMS constantly strives to reduce the burden on providers. However, as this article explains, certain functions are performed by different entities by design. Sometimes different entities are involved because different skill sets are needed. For example, reviewing a provider enrollment application for correctness requires different skills than reviewing medical records to determine correct diagnosis and procedure coding. Also, sometimes certain functions must be performed by different entities to protect providers and the Medicare Program. For example, appeals of claims decisions should be heard, at least at certain levels, by an entity that is separate and distinct from the entity that made the claims decision. Therefore, while CMS strives to coordinate efforts of these entities, there may be times when providers are contacted by several of the entities concurrently.

Background

Listed below are general categories of the current entities that CMS uses under the Medicare and Medicaid programs to handle claims processing and other functions. Some of the entities are new to these programs as part of Medicare Contracting Reform. This article and the table mentioned above display the new entities in **bold type**. The table also provides websites that are available should you need further information. Finally, we explain how CMS coordinates the work of these entities so that phone calls and letters requesting medical records, documentation, or other information related to a beneficiary's claims are minimized.

Claims Processing Contractors

CMS contracts with entities to process claims submitted by physicians, hospitals, and other health care providers/suppliers, and to make payment in accordance with Medicare regulations and policies. These entities, called carriers, Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), **and Medicare Administrative Contractors (MACs)**, are also referred to as Medicare claims processing contractors. These entities are the entry point for participating in the Medicare program as they process provider enrollment applications.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) mandated that the Secretary of the Department of Health and Human Services (DHHS) replace the current contracting authority under Title XVIII of the Social Security Act (SSA) with the new **MAC** authority.

MACs will be the central point in CMS' national Fee-For-Service (FFS) program.

- Carrier and FI workloads have or will be transitioned to **10 Part A/ B MAC** jurisdictions.
- Regional Home Health Intermediary (RHHI) workloads are being transitioned to **4 HH MAC** jurisdictions.
- Durable Medical Equipment (DME) workloads have been transitioned to **4 DME MAC** jurisdictions.

You may access the most current Medicare Contracting Reform information to determine the effect of these changes on your practice and to view the list of current **MACs** for each jurisdiction at http://www.cms.gov/MedicareContractingReform on the CMS website. **MACs** may contact you for a variety of reasons, such as:

- Resolving issues regarding your initial and renewal enrollment applications;
- Providing education and guidance on procedures for billing Medicare;
- Resolving issues regarding claims you submit;
- Requesting medical records related to the claims you submit for medical review;
- Paying you for approved claims and/or explaining why some claims are not processed or are denied; and
- Recovering overpayments on claims previously processed.

Program Integrity Contractors

CMS contracts with Program Safeguard Contractors (PSCs) and **Zone Program Integrity Contractors (ZPICs),** who are responsible for identifying cases of suspected fraud and taking appropriate actions. As a result of Medicare

FYI CONT'D

Contracting Reform, seven **ZPICs** were created based on the MAC jurisdictions. Eventually, PSCs will no longer exist and ZPICs will perform all benefit integrity work. ZPICs were created to perform program integrity for Medicare Parts A, B, C (Medicare Advantage or MA), D (Prescription Drugs, including MA-Drug Plans), Durable Medical Equipment (DME), Home Health and Hospice, and Medicare-Medicaid data matches, also referred to as Medi-Medi. Since these seven **ZPICs** focus on these different aspects of the Medicare Program, it is possible that providers could hear from more than one **ZPIC**, depending on the aspects of that **ZPIC's** review and/or the nature of the services for which the provider bills Medicare.

CMS also contracts with **Recovery Auditors** to identify and correct underpayments and overpayments. There are 4 **Recovery Auditors. Recovery Auditors** responsibilities include working with providers to detect and correct Medicare improper payments. **Recovery Auditors** conduct reviews of claims in the following ways:

- Automated (no medical records are needed);
- Semi-Automated (medical records are supplied at the discretion of the provider to support a claim identified by data analysis as an improper payment); and
- Complex (medical record is required).

FFS Recovery Auditors contact providers to request additional documentation in support of potential improper payments. If an improper payment is determined, the **FFS Recovery Auditor** will send a review results letter, providing the decision and the accompanying reviewer rationale. A Demand letter is issued to you by the FFS Recovery Auditor or the MAC once the claim is adjusted. The **FFS Recovery Auditor** will offer you an opportunity to discuss the improper payment determination with the **FFS Recovery Auditor** (this is outside the normal appeal process).

The **Tax Relief and Health Care Act of 2006 (TRHCA)** authorizes the Recovery Audit program for Part A and Part B Medicare services.

The **Affordable Care Act** expands the **Recovery Audit** program to Medicaid and Medicare Part C (Medicare Advantage or MA) and Part D (prescription drugs).

- Medicaid Recovery Auditors are responsible for identifying and recovering Medicaid overpayments and identifying underpayments.
- MA Recovery Auditors will ensure that MA plans have an anti-fraud plan in effect and review the effectiveness of each anti-fraud plan.
- Prescription Drug Plan (PDP) Recovery Auditors will ensure that each PDP under part D has an anti-fraud plan in effect and review the effectiveness of each anti-fraud plan.

CMS also reviews Medicare FFS claims nationally to identify improper payments, as required by the Improper Payment Information Act (IPIA) and the Improper Payments Elimination and Recovery Act (IPERA). This is accomplished through the **Comprehensive Error Rate Testing (CERT)** program. If a provider's claim is randomly chosen, the CERT program will contact the provider to obtain medical records that support the claim and will conduct a review of the medical records to determine if the claim was paid correctly. If an improper payment is identified by the CERT program, your MAC will notify you and make the appropriate payment adjustment. Normal appeal rights apply to CERT-initiated denials and are handled through the routine appeal process.

CMS also reviews Medicaid and Children's Health Insurance Program (CHIP) claims to identify improper payments, as required by the IPIA and the IPERA. This is accomplished through the **Payment Error Rate Measurement (PERM)** program.

CMS reviews a sample of claims in one-third of the states each year to develop a national estimate of improper payments. PERM conducts two types of reviews on these claims:

- Medical review (medical record is required)
- Data processing reviews (this is a validation that the payment was processed correctly in a state's system)

If a provider's claim is randomly chosen, the PERM program will contact the provider to obtain medical records that support the claim and will conduct a review of the medical records to determine if the claim was paid correctly.

Medicaid Integrity Contractors (MICs) are entities that contract with CMS to conduct audit-related activities for the Medicaid programs. There will be five **MIC** jurisdictions performing three primary functions:

- Review MICs, which analyze Medicaid claims data to investigate suspected/potential provider fraud, waste, or abuse;
- Audit MICs, which audit provider claims and identify overpayments; and
- Education MICs, which provide education to providers and others on payment integrity and quality-of-care issues.

Program Integrity contractors may contact you to resolve problems they identify in your claims or to request medical records for claims under review.

Specialty Medical Review Contractors

In an effort to continue the prevention and reduction of improper payments, CMS has contracted with a Specialty Medical Review Contractor to conduct medical review studies of Part A and B claims. Studies are conducted as fact-finding undertakings to allow CMS to better understand trends in billing behavior that may lead to improper payments. These studies occur on a quarterly basis and vary in topic. Claims chosen for review are selected randomly.

The Specialty Medical Review Contractor may contact you to request medical records for claims under review.

Also, CMS contracts with the Medicare Coordination of Benefits Contractor (COBC), a single entity, to provide a centralized COB operation. Responsibilities of the COBC include all activities that support the collection, management, and reporting of other insurance coverage of Medicare beneficiaries. The COBC may contact you to identify Medicare Secondary Payer (MSP) situations quickly and accurately.

There is also a Medicare Secondary Payer Recovery Contractor (MSPRC) that performs post-payment recovery of funds paid where Medicare should not have been the primary payer. The MSPRC may contact you for information related to MSP recoveries and can issue demand letters to require payment recovery.

The last specialty contractor is the National Supplier Clearinghouse (NSC), which handles enrollment activities related to Durable Medical Equipment suppliers. The NSC may contact you about your enrollment information.

Appeals Contractors and Entities

CMS contracts with entities to conduct appeals of claims determinations. These include FIs, carriers, RHHIs, and **MACs, who conduct first level appeals. Qualified Independent Contractors (QICs)** conduct reconsiderations, the second level of appeals. There are:

- Two Part A QICs,
- Two Part B QICs,
- One DME QIC,
- One Part C QIC for MA, and
- One Part D QIC for Medicare Prescriptions Drug Plans (PDPs) and MA Drug Plans.

Other appeals-related entities include the Administrative Law Judges (ALJs) within the HHS Office of Medicare Hearings and Appeals and the Medicare Appeals Council within the HHS Departmental Appeals Board conduct the next two levels of appeal. The ALJ will send you a notice of hearing to all parties to the appeal, indicating the time and place of the hearing. The ALJ will generally issue a decision or dismissal within 90 days of receipt of a valid appeal request. The Medicare Appeals Council will generally issue a decision or dismissal within 90 days of receipt of a valid appeals request.

ALJs in the Civil Remedies Division within the HHS Departmental Appeals Board also conduct hearings on provider and supplier enrollment issues, and hearings on civil money penalties and sanctions imposed against providers and suppliers by CMS and the HHS Office of the Inspector General. For appeals of enrollment issues, the ALJ will generally issue a decision within 180 days of receipt of your request. For other types of appeals, the ALJ will issue a decision as soon as practical after the close of the hearing.

The Provider Reimbursement Review Board (PRRB) is an independent panel to which a certified Medicare provider of services may appeal if it is dissatisfied with a final determination of its fiscal intermediary or the Centers for Medicare & Medicaid Services (CMS). The Medicare Geographic Classification Review Board (MGCRB) decides on requests of Prospective Payment System (PPS) hospitals for reclassification to another area (Urban or in some cases Rural) for the purposes of receiving a higher wage index.

The PRRB and the MGCRB provide appeals avenues for providers on specific matters, including cost report disputes.

When you, or a beneficiary (or an appointed representative), appeal claims decisions, any of these appeals entities may request more information from you (or your representative).

Quality Improvement Contractors

Quality Improvement Organizations (QIOs) provide quality of care review services and conduct quality improvement projects. CMS contracts with one QIO in each state, as well as the District of Columbia, Puerto Rico, and the U.S. Virgin Islands. QIOs are private, mostly not-for-profit organizations, staffed by professionals, mostly doctors and other health care professionals, responsible for the review of services provided to beneficiaries enrolled in MA plans and in FFS Medicare, including:

- Conducting expedited Medicare coverage determinations of inpatient hospital discharges and provider service terminations;
- Reviewing beneficiary complaints about quality of care, including working with the provider and reviewing medical records as part of the complaint-resolution process;
- Working with providers to accomplish national quality improvement goals;
- Implementing improvements in the quality of care;
- Contacting providers to provide technical assistance and encouraging partnerships to achieve quality goals;
- Providing technical assistance with many of the CMS Value-Based Purchasing Programs; and
- Performing provider-requested higher-weighted Diagnosis Related Group reviews.

CWF System Availability and Impact on Supplier Inquiries

This article describes the information available in the national system, known as the Common Working File (CWF), the hours it is available, and the types of inquiries in which the NAS Interactive Voice Response (IVR) system and Endeavor online portal rely on the CWF to complete supplier inquiries.

The CWF is comprised of nine localized databases called Hosts. Hosts maintain total Medicare claim history and entitlement information for the beneficiaries in their jurisdiction as updated daily by Medicare contractors and other applicable entities (i.e., Social Security Administration). Each beneficiary is assigned to only one CWF Host site based on where the beneficiary signs up for their SSA benefits. For example, if a beneficiary signs up for their SSA benefits in Portland, Oregon, the Great Western CWF Host will retain the beneficiary Medicare claims and eligibility information. Beneficiaries who permanently move or travel from the state in which they registered for SSA benefits may have their records located within a CWF Host that differs from the state in which their Medicare services are provided.

NAS uses the CWF to assist with "same or similar" equipment, oxygen rental months, Skilled Nursing Facility and Home Health consolidated billing, Health Maintenance Organization, primary insurance company identification, and other inquiries. When CWF is unavailable, the Customer Service Representatives, IVR, and Endeavor are unable to assist with these inquiry types.

The identified hours of operation for the nine CWF Host regions are as follows. While the CWF system may be operational or available outside of the timeframes identified below, there are no consistent guarantees for such availability due to routine system maintenance or historical claim purges. When the CWF Host is unavailable for a historical claim purge, suppliers may be notified by their contractor of a CWF "Dark Day."

Northeast	Keystone	Mid-Atlantic	Southeast	South
5am–5pm CT M–F 5am–11am CT Sat	5am–5pm CT M–F 5am–11am CT Sat	5am–5pm CT M–F 5am–11am CT Sat	5am–5pm CT M–F 5am–11am CT Sat	5am–5pm CT M–F 5am–11am CT Sat
Connecticut Maine Massachusetts New Hampshire New York Rhode Island Vermont	Delaware New Jersey Pennsylvania	Indiana Maryland Ohio Virginia West Virginia	Alabama Kentucky Mississippi North Carolina South Carolina Tennessee	Florida Georgia

Great Lakes	Southwest	Pacific	Great Western	
6am-6pm CT M-F 6am-12pm Sat	6am-6pm CT M-F 6am-12pm Sat	8am-8pm CT M-F 8am-2pm Sat	8am-8pm CT M-F 8am-2pm Sat	
Illinois Michigan Minnesota Wisconsin	Arkansas Colorado Louisiana New Mexico Oklahoma Texas	Arizona California Hawaii Nevada	Alaska Idaho Iowa Kansas Missouri Montana Nebraska North Dakota Oregon South Dakota Utah Washington Wyoming	

Additional information regarding the CWF may found in the CMS Internet Only Manual, Publication 100-4, Chapter 27, https://www.cms.gov/manuals/downloads/clm104c27.pdf.

The other systems used by the NAS IVR and Endeavor for supplier inquiries are the CMS HIPAA Eligibility Transaction System (HETS) and ViPS Medicare System (VMS).

- HETS provides beneficiary eligibility coverage information for the IVR and Endeavor twenty-four hours a day, seven days a week. There is maintenance occurring on many Saturdays as determined by CMS.
- VMS provides claim-specific, financial, remittance advice, order/referring physician related information between the hours of 6 a.m. to 8 p.m. CT Monday through Friday and between the hours of 7am and 3pm CT on predetermined Saturdays.

Customer Service Representatives are available to assist suppliers with complex inquiries that cannot be answered by the IVR or Endeavor between the hours of 8:30 a.m. and 5:30 p.m. CT Monday through Friday.

NAS hopes this CWF informational article assists suppliers in understanding the dependencies our IVR and Endeavor self-service tools have on systems maintained by other entities.

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."

Oxygen Rental Month Counts Now Available on Interactive Voice Response System

Effective August 5, 2011, suppliers can obtain the total number of months paid on rented oxygen equipment from the Jurisdiction D Interactive Voice Response (IVR) System (1- 877-320-0390). Below are instructions on utilizing this new feature.

Accessing the Monthly Paid Oxygen Rental Option

Monthly Paid Oxygen Rental Count will be a sub-option of the main menu option Same or Similar HCPCS Lookup. From the Main Menu select Same or Similar HCPCS Lookup. The IVR will then request the supplier National Provider Identifier (NPI), Provider Transaction Access Number (PTAN), and the last five digits of the Tax Identification Number (TIN). Once this information has been successfully obtained, the IVR will provide the option of performing a Same or Similar HCPCS Lookup or Monthly Paid Oxygen Rental Lookup. Select the Monthly Paid Oxygen Rental Lookup by saying "Oxygen Rental" or pressing the number "2" key on the telephone keypad.

When requested, key or speak the following information:

- Beneficiary Medicare Number
- Beneficiary Name
- Beneficiary Date of Birth
- HCPCS Code
- Modifier - Since oxygen is always rented, the only modifier used should be RR.

Successful Request

If the request is successful, the IVR will return the number of months paid on equipment that is either the same or similar to the oxygen code entered. If there is a date of death on file for the beneficiary, no information will be returned. In these instances suppliers will need to call the Contact Center for assistance.

Note: It may take up to two minutes for the IVR to return information as it must search the beneficiary's entire Medicare record. In an instance where the inquiry exceeds the two minutes of search time, the IVR will refer the caller to the Contact Center for assistance.

Failed Request

If the request is unsuccessful, verify the beneficiary's Medicare number, name, and date of birth.

Navigation

Once the monthly paid oxygen rental information has played, key or speak one of the options below to continue.

- 1-Repeat That
- 4-Change the HCPCS Code
- 5-Change the Medicare Number
- 6-Change the PTAN
- 7-Change the NPI
- 8-Return to Main Menu

Maintenance and Servicing

Paid claims for the maintenance and servicing of capped oxygen equipment may be included in the total oxygen rental months returned in instances where claims for maintenance and servicing of the equipment have posted to the national file.

Hours of Availability

Although the majority of features available on the IVR are available from 6 a.m. to 8 p.m. CT, the IVR does depend on the Common Working File (CWF) to provide some aspects of the oxygen rental month as well as the 'same or similar' IVR inquiry feature. The CWF is not available after 4 p.m. CT for a small number of beneficiaries (mainly with Medicare numbers originating in east coast states).

We hope suppliers find this enhancement to the IVR self service inquiry feature beneficial.

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

Predictive Modeling Analysis of Medicare Claims

MLN Matters® Number: SE1133

Provider Types Affected

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

What Providers Need to Know

As of June 30, 2011, the Centers for Medicare & Medicaid Services (CMS), has implemented a predictive analytics system that will analyze all Medicare FFS claims to detect potentially fraudulent activity.

The predictive analytics system uses algorithms and models to examine Medicare claims in real time to flag suspicious billing. This article briefly explains the predictive modeling system, its purpose, and how CMS is incorporating the system into its claims payment process.

Background

Section 4241 of the Small Business Jobs Act of 2010 (SBJA) mandated that the CMS implement a predictive analytics system to analyze Medicare claims to detect patterns that present a high risk of fraudulent activity. Signed by the President in Fall 2010, the SBJA enables CMS to employ real-time, pre-payment claims analysis to identify emerging trends of potentially fraudulent activity. This new process is similar to the pre-payment analysis already done by the financial and credit card industries. The entire text of the SBJA is available at http://www.gpo.gov/fdsys/pkg/BILLS-111hr5297enr/pdf/BILLS-111hr5297enr.pdf on the Internet.

Real Time Claims Streaming to Build Profiles and Create Risk Scores

As of June 30, 2011, CMS is streaming all Medicare FFS claims through its predictive modeling technology. As each claim streams through the predictive modeling system, the system builds profiles of providers, networks, billing patterns, and beneficiary utilization. These profiles enable CMS to create risk scores to estimate the likelihood of fraud and flag potentially fraudulent claims and billing patterns.

Risk scores enable CMS to quickly identify unusual billing activity and flag claims for more thorough review prior to releasing payment. The system automatically prioritizes claims, providers, beneficiaries, and networks that are generating the most alerts and highest risk scores. CMS is leveraging the benefits of its new high-tech system to complement, not replace, the expertise of its experienced analysts:

- Analysts review prioritized cases by closely reviewing claims histories, conducting interviews, and performing site visits as necessary.
- If an analyst finds only innocuous billing, the outcome is recorded directly into the predictive modeling system and the payment is released as usual. This feedback loop refines the predictive models and algorithms to better target truly fraudulent behavior.
- Analysts who find evidence or indicators of fraud will work with the CMS Center for Program Integrity, MACs, and Zone Program Integrity Contractors to enact targeted payment denials, and in cases of egregious fraud, revoke Medicare billing privileges. Program integrity entities may also, as appropriate, coordinate with law enforcement officials to investigate cases for criminal or civil penalties.

Effect of Risk Scores on Claims Payment

Risk scores alone do not initiate administrative action and serve only to alert CMS to the necessity of more careful review of claims activity. While providers will be unable to appeal risk scores, CMS's new technology will in no way alter a provider or supplier's existing rights to appeal administrative actions or overpayment recovery efforts.

Currently, CMS is not denying claims solely based on the alerts generated by predictive models. CMS is focused on developing and refining models that identify unusual behavior without disrupting its claims processing for Medicare providers.

Working closely with clinical experts across the country and of every provider specialty, CMS is developing and refining algorithms that reflect the complexities of medical treatment and billing. The new technology will ultimately benefit the program's many honest providers and suppliers by enabling the agency to prioritize the highest-risk cases

for investigation and review. Prioritizing the alerts will minimize the disruption to providers who may occasionally exhibit unusual but honest billing.

CMS's predictive modeling technology also enables automated cross-checks of provider, beneficiary, and claim information against historical trends and external databases. Automating checks that were previously performed manually will help CMS to more quickly identify and resolve any issues that may delay payment to providers and suppliers. Even as CMS implements a more thorough claims screening process, the Agency remains dedicated to ensuring prompt payment for the providers. Prompt payment of claims is a statutory requirement; only in exceptional and urgent circumstances will CMS leverage its authority to waive prompt payment to conduct further investigation or review.

Quarterly Provider Updates

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

- Inform providers about new developments in the Medicare program;
- Assist providers in understanding CMS programs ad complying with Medicare regulations and instructions;
- Ensure that providers have time to react and prepare for new requirements;
- Announce new or changing Medicare requirements on a predictable schedule; and
- Communicate the specific days that CMS business will be published in the Federal Register.

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

Sources for "Jurisdiction D Happenings" Articles

The purpose of "Jurisdiction D Happenings" is to educate NAS' Durable Medical Equipment supplier community. The educational articles can be advice written by NAS staff or directives from CMS. Whenever NAS publishes material from CMS, we will do our best to retain the wording given to us; however, due to limited space in our bulletins, we will occasionally edit this material. NAS includes "Source" following CMS derived articles to allow for those interested in the original material to research it at CMS's website, http://www.cms.gov/manuals. CMS Change Requests and the date issued will be referenced within the "Source" portion of applicable articles.

CMS has implemented a series of educational articles within the Medicare Leaning Network (MLN), titled "MLN Matters", which will continue to be published in NAS bulletins. The Medicare Learning Network is a brand name for official CMS national provider education products designed to promote national consistency of Medicare provider information developed for CMS initiatives.

Supplier Manual Updates

The following table outlines updates to the DME MAC Jurisdiction D Online Supplier Manual. The content is ordered with the most current changes appearing on top.

Chapter	Subheading	Supplier Manual Update	Change Date
Appendix	Resources	Added ASCA fax number	10/17/11
2	EFT	All suppliers are required to receive EFT payments	09/26/11
8	Communications Software	Removed: "Asynchronous and File Transfer Protocol via Dial Up" and added "using a Network Service Vendor (NSV)"	09/26/11
11	Workers Compensation	Added Workers' Compensation Medicare Set-Aside Arrangements (WCMSAs)	09/26/11
13	Redeterminations	Added guidelines for writing a letter to NAS	09/26/11

FYI CONT'D

Chapter	Subheading	Supplier Manual Update	Change Date
13	Administrative Law Judge	Updated ALJ offices, addresses, and states	09/26/11
15	Recoupment Process	Removed: and sends a second refund request letter to the provider	09/26/11
15	Recoupment Process	Changed: if no response to second letter to 'if no payment is received by the 41st day'	09/26/11
15	Recoupment Process	Changed: third letter to 'Intent to Refer letter'	09/26/11
15	Recoupment Process	Changed: telephone call to 'Intent to Refer letter'	09/26/11
15	Offset Requests	Added: "Do not use a Refunds to Medicare…titled "Submitting Offset Requests" at…"	09/26/11
15	Overpayments Redeterminations	Added entire section	09/26/11
15	Extended Repayment Schedule	Added: "Once a debt has been…cannot be handled at NAS."	09/26/11
Appendix	Contacting NAS and Inquiries	Added oxygen rental month count to IVR options	09/26/11
Appendix	Contacting NAS and Inquiries	Changed IVR hours of availability to 6 a.m. – 8 p.m. CT	09/26/11
Appendix	Contacting NAS and Inquiries	Changed Endeavor hours of availability to 6 a.m. – 8 p.m. CT Monday – Friday	09/26/11
Appendix	Resources	Changed Supplier Contact Center hours of availability to 8:30 a.m. – 5:30 p.m. CT	09/26/11
Appendix	Resources	Added oxygen rental month count to IVR options	09/26/11
3	Written Order Prior to Delivery	Removed K0734–K0737, Added E2622–E2625	08/18/11
3	Proof of Delivery	Updated refill contact information	08/15/11

Telephone Reopenings: What Can and Cannot be Requested

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

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

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

What may I request as a telephone reopening?	The following is a list of clerical errors and omissions that may be completed as a telephone reopening. This list is not all-inclusive:
	• Diagnosis changes/additions
	• Date of service changes
	• HCPCS code changes
	• Certificate of Medical Necessity (CMN)/DME Information Form (DIF) updates (*with the exception of parenteral and enteral nutrition and oxygen Break In Service (BIS) which must be sent in as a written reopening or redetermination*)
	• Certain modifier changes/additions (not all inclusive list):
	  • KH – DMEPOS item, initial claim, purchase or first month
	  • KI – DMEPOS item, second or third month rental
	  • KJ – DMEPOS item, parenteral enteral nutrition (PEN) pump or capped rental, months four to fifteen
	  • RR – Rental
	• Surgical dressing (when number of services are within the policy – if the request is to allow over the policy amount, these must go to written redeterminations)
	• Wheelchairs – HCPCS K0004 and lower
	NOTE: If any of the above changes, upon research, are determined to be too complex, the requester will be notified that the request needs to be sent in writing, with the appropriate documentation, as a redetermination.

What is not accepted as a telephone reopening?	The following will not be accepted as a telephone reopening. These items must be submitted along with all supporting documentation as a redetermination. • Any item billed over the allowance listed in the medical policy – documentation is required to support amount billed • Parenteral and enteral DIF issues • Oxygen BIS • Wheelchairs/power mobility devices – HCPCS K0005 and higher • Recoupment/reduction of payment – complete Refunds to Medicare form • Medicare Secondary Payer (MSP) – send inquiry to MSP department • Timely denials – claims submitted within appropriate time frame • Late files – reopening and/or redetermination requests submitted within the appropriate time frame • Requests that require documentation • Advance Beneficiary Notice of Noncoverage (ABN) issues • A1–A9 modifiers • GA modifier • GY modifier • GZ modifier • KX modifier • HCPCS codes J1559, J1561, J1562 • Liability issues • Repairs to equipment • Miscellaneous codes • Labor codes **NOTE**: Claims with remittance message MA130 can never be submitted as a reopening. Claims with message MA130 are considered unprocessable and do not have reopening or redetermination rights. The claim is missing information that is needed for processing the claim or the claim information is invalid. These claims must be resubmitted with a new corrected claim.
What do I do when I have a large amount of the same correction?	In the event that a supplier has more than 50 of the same correction, that is able to completed as a reopening, NAS encourages the supplier to notify the telephone representative. The telephone representative will gather the required information and provide the supplier with direction on what is needed and how to submit the request.
Where can I find more information on telephone reopenings?	Suppliers can utilize NAS website at https://www.noridianmedicare.com/dme, specifically Supplier Manual, Chapter 13: https://www.noridianmedicare.com/dme/news/manual/chapter13.html Appeals page: https://www.noridianmedicare.com/dme/appeals/
Additional Assistance Available	**Suppliers can email questions and concerns regarding reopenings and redeterminations** to dmeredeterminations@noridian.com, excluding any Protected Health Information (PHI) information.

BILLING

Chiropractors Not Eligible to Order and Refer

In recent announcements and materials, CMS incorrectly included chiropractors in the list of physician and practitioner types that may order and refer items or services to Medicare beneficiaries. In accordance with section 1877(a)(1) and (5)(A), and section 1861(r)(5) of the Social Security Act, and 42 CFR 410.21(b)(1) and (2), doctors of chiropractic medicine are not eligible to order and refer. Medicare coverage extends only to treatment by means of manual manipulation of the spine to correct a subluxation; all other services furnished or ordered by chiropractors are not covered.

CMS is in the process of revising documents (including change requests) to reflect this correction.

CEDI

Healthcare Provider Taxonomy Codes October 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 Washington Publishing Company (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 WPC. To view the October 2011 changes, visit the WPC Web site 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.

Reminder: 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 9-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 4-digit extension will cause front end rejections.

Quick Reference Full 9 Digit ZIP Code Required:

2010AA Billing Provider
2310C Service Facility Claim Level
2420C Service Facility Line Level

Note: All other ZIP Codes may be sent in the 5 or 9 digit format.

CEDI CONT'D

The Billing Provider Address (2010AA loop for ANSI claims) will require a physical location address to be reported in 5010A1 claim files. Post Office (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.

COMPETITIVE BIDDING

Are You Licensed for DMEPOS Competitive Bidding?

The Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program Round 2 and national mail-order competitions are coming soon! If you plan to bid, take action now to make sure you have all required licensures for the competitive bidding areas and product categories for which you plan to bid. You must have current versions of all required licenses on file with the National Supplier Clearinghouse (NSC) at the time of bidding or we can reject your bid.

The NSC has recently updated its DMEPOS licensure database. This database contains the licensure requirements for each state and territory and can assist you in verifying that you meet current licensure requirements. The updated database contains a search tool that is more interactive and is arranged by product specialty rather than supplier type. The database also contains contact information for licensing agencies in each state and territory.

Licensure requirements vary from state to state and locality to locality. The NSC licensure directory provides a good starting point to help you identify the licenses you need. State licensure requirements change periodically and have many exceptions, so the NSC's database serves only as a guide. It remains your responsibility to ensure you are in compliance with the most current state and federal laws and regulations.

The new and improved NSC licensure database can found on the NSC website at http://www.PalmettoGBA.com/NSC (select the "Licensure Database" in the Self Service Tools section of the homepage). You can verify the licenses you currently have on file with the NSC via the internet-based Provider Enrollment, Chain, and Ownership System (PECOS) at https://PECOS.CMS.hhs.gov/pecos/login.do.

For more information about the Competitive Bidding Program, including a factsheet about the licensure requirements for bidding suppliers, please visit the Competitive Bidding Implementation Contractor website at http://www.dmecompetitivebid.com.

DMEPOS Competitive Bidding Program Expansion Announce

MLN Matters® Number: SE1127

Provider Types Affected

This article is for suppliers of DMEPOS that wish to participate in the upcoming Round 2 of the Medicare DMEPOS Competitive Bidding Program and/or the National Mail-Order Competition for Diabetic Testing Supplies that will occur at the same time as Round 2.

What You Need to Know

This article provides important information from the Centers for Medicare & Medicaid Services (CMS) regarding the next phase (Round 2 and National Mail-Order) of Medicare's Competitive Bidding Program for DMEPOS. If you are interested in bidding, prepare now – don't wait!

The Round 2 product categories are:

- Oxygen, oxygen equipment, and supplies;
- Standard (Power and Manual) wheelchairs, scooters, and related accessories;
- Enteral nutrients, equipment, and supplies;
- Continuous Positive Airway Pressure (CPAP) devices and Respiratory Assist Devices (RADs) and related supplies and accessories;
- Hospital beds and related accessories;
- Walkers and related accessories;
- Negative Pressure Wound Therapy pumps and related supplies and accessories; and
- Support surfaces (Group 2 mattresses and overlays).

CMS will also be conducting a national mail-order competition for diabetic testing supplies at the same time as the Round 2 competition. The national mail-order competition will include all parts of the United States, including the 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, and American Samoa.

A list of the specific items in each product category is available on the Competitive Bidding Implementation Contractor (CBIC) website, http://www.dmecompetitivebid.com, and the specific ZIP codes in each Round 2 competitive bidding

area (CBA) are also available on the CBIC website.

Update Your Contact Information: The following contact information in your enrollment file at the National Supplier Clearinghouse (NSC) must be up to date before you register to bid. If your file is not current, you may experience delays and/or be unable to register and bid. DMEPOS suppliers should review and update the following:

- The name, Social Security number, and date of birth for all authorized official(s) (if you have only one authorized official listed on your enrollment file, consider adding one or more authorized officials to help with registration and bidding) and
- The correspondence address.

DMEPOS suppliers can update their enrollment via the internet-based Provider Enrollment, Chain and Ownership System (PECOS) or by using the 7/11/2011 version of the CMS-855S enrollment form. Suppliers not currently using PECOS can learn more about this system by accessing the PECOS website at http://www.cms.gov/MEDICAREPROVIDERSUPENROLL/ or reviewing the PECOS fact sheet at http://www.cms.gov/MLNProducts/downloads/MedEnroll_PECOS_DMEPOS_FactSheet_ICN904283.pdf on the CMS website.

Information and instructions on how to submit a change of information via the hardcopy CMS-855S enrollment form may be found on the NSC website at http://www.palmettogba.com/nsc and by following this path: Supplier Enrollment/Change of Information/Change of Information Guide.

Get Licensed: Contracts are only awarded to suppliers that have all required state licenses at the time the bid is submitted. Therefore, before you submit a bid for a product category in a CBA, you must have all required state licenses for that product category on file with the NSC. Every location must be licensed in each state in which it provides services. If you have only one location and are bidding in a CBA that includes more than one state, you must have all required licenses for every state in that CBA. If you have more than one location and are bidding in a CBA that includes more than one state, your company must have all required licenses for the product category for every state in that CBA. **It is VERY IMPORTANT that current versions of all required licenses are in your enrollment file with the NSC BEFORE you bid**. If any required licenses are expired or missing from your enrollment file, CMS can reject your bid. Suppliers bidding in the National Mail-Order Competition must have the applicable licenses for all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, and American Samoa.

Get Accredited: Suppliers must be accredited for all items in a product category in order to submit a bid for that product category. If you are interested in bidding for a product category and are not currently accredited for that product category, take action NOW to get accredited for that product category. Your accreditation organization will need to report any accreditation updates to the NSC. CMS cannot contract with suppliers that are not accredited by a CMS-approved accreditation organization.

Current Round 2 and National Mail-Order Schedule

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

Summer 2011

- CMS begins pre-bidding supplier awareness program;

Fall 2011

- CMS announces bidding schedule;
- CMS begins bidder education program; and
- Bidder registration period to obtain user ID and passwords begins

Winter 2012

- Bidding begins.

Additional Information

The Competitive Bidding Implementation Contractor (CBIC) is the official information source for bidders. Stay informed - visit the CBIC website at http://www.dmecompetitivebid.com/ to subscribe to e-mail updates and for the latest information.

For more information on the DMEPOS competitive bidding program, visit http://www.cms.gov/dmeposcompetitivebid/ on the CMS website.

Information on the DMEPOS accreditation requirements along with a list of the accreditation organizations and those professionals and other persons exempted from accreditation may be found at http://www.cms.gov/MedicareProviderSupEnroll/01_Overview.asp on the CMS website.

The press release about the expanded competitive bidding program may be found at http://www.cms.gov/apps/media/press_releases.asp on the CMS website.

To view the Fact Sheet titled: Next Steps For Expansion Of The Medicare Durable Medical Equipment, Prosthetics, Orthotics, And Supplies go to http://www.cms.gov/apps/media/fact_sheets.asp on the CMS website.

Get Ready for DMEPOS Competitive Bidding

The Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program Round 2 and the National Mail-Order Competitions are Coming Soon!!

Fall 2011

- CMS announces bidding schedule
- CMS begins bidder education program
- Bidder registration period to obtain user ID and passwords begins

Winter 2012

- Bidding begins

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

Update Your Contact Information: The following contact information in your enrollment file at the National Supplier Clearinghouse (NSC) must be up to date before you register to bid. If your file is not current, you may experience delays and/or be unable to register and bid. DMEPOS suppliers should review and update:

The name, Social Security number, and date of birth for all authorized official(s) (if you have only one authorized official listed on your enrollment file, consider adding one or more authorized officials to help with registration and bidding); and

The correspondence address.

DMEPOS suppliers can update their enrollment via the internet-based Provider Enrollment, Chain and Ownership System (PECOS) or by using the 7/11/2011 version of the CMS-855S enrollment form. Suppliers not currently using PECOS can learn more about this system by accessing the PECOS website (http://www.cms.gov/MEDICAREPROVIDERSUPENROLL) or reviewing the PECOS fact sheet at the following link: (http://www.cms.gov/MLNProducts/downloads/MedEnroll_PECOS_DMEPOS_FactSheet_ICN904283.pdf). Information and instructions on how to submit a change of information via the hardcopy CMS-855S enrollment form may be found on the NSC Web site (http://www.palmettogba.com/nsc) and by following this path: Supplier Enrollment/Change of Information/Change of Information Guide.

Get Licensed: Contracts are only awarded to suppliers that have all required state licenses at the time the bid is submitted. Therefore, before you submit a bid for a product category in a CBA, you must have all required state licenses for that product category on file with the NSC. Every location must be licensed in each state in which it provides services. If you have only one location and are bidding in a CBA that includes more than one state, you must have all required licenses for every state in that CBA. If you have more than one location and are bidding in a CBA that includes more than one state, your company must have all required licenses for the product category for every state in that CBA. It is VERY IMPORTANT that you make sure that current versions of all required licenses are in your enrollment file with the NSC BEFORE you bid. If any required licenses are expired or missing from your enrollment file, we can reject your bid. Suppliers bidding in the national mail-order competition must have the applicable licenses for all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, and American Samoa.

Get Accredited: Suppliers must be accredited for all items in a product category in order to submit a bid for that product category. If you are interested in bidding for a product category and are not currently accredited for that product category, take action NOW to get accredited for that product category. Your accreditation organization will need to report any accreditation updates to the NSC. CMS cannot contract with suppliers that are not accredited by a CMS-approved accreditation organization.

COMPETITIVE BIDDING CONT'D

Further information on the DMEPOS accreditation requirements along with a list of the accreditation organizations and those professionals and other persons exempted from accreditation may be found at the CMS website: http://www.cms.gov/MedicareProviderSupEnroll/01_Overview.asp.

The Competitive Bidding Implementation Contractor (CBIC) is the official information source for bidders. Stay informed - visit the CBIC web site at http://www.dmecompetitivebid.com to subscribe to e-mail updates and for the latest information on the DMEPOS competitive bidding program.

DOCUMENTATION

Additional Documentation Request Procedures

When a Medicare claim requires additional information, the DME MAC will send an Additional Documentation Request (ADR) letter requesting information to support the claim being billed. These are not denial letters. The claims referenced in the letter are pending in the claims processing system, waiting for a response to the ADR.

A supplier may receive several letters asking the same questions, if several claims require the same information. Each letter with its response must be returned so it can be matched to the corresponding claim. Be sure to provide all documentation requested and/or respond to each question asked.

Responses to development letters should be returned promptly to avoid processing delays and must be submitted within the timeframe documented in the letter to avoid claim denials.

Here are some helpful hints when responding to ADR letters:

- Return a copy of the letter as the first page of the faxed or mailed response and attach the requested documentation.
- Make sure all documentation requested is returned along with the letter.
- Make sure the documentation is legible, signed by the author, and a clear copy is sent.
- Make sure the documentation is current and pertains to the codes being billed.
- Do not highlight information. Highlighting shades the information when a document is faxed or imaged, making it difficult to read.
- Make sure documentation is being sent to the correct contractor.
- Only send documentation once per ADR letter. Documentation can be returned via mail or fax at 701-277-7880.
- A redetermination request form is only required if a supplier wants to submit additional documentation after the claim has been processed.

Additionally:

- Make sure you are billing with the appropriate modifier. For example, a non-insulin dependent beneficiary needs to be billed with modifier KS.

Medicare Pilot Project for Electronic Submission of Medical Documentation (esMD)

MLN Matters® Number: SE1110 Revised

Note: This article was revised on October 14, 2011, to correct the contractor for DME MAC C on page 5. It had incorrectly listed Palmetto GBA. The correct contractor is CGS Administrators, LLC. All other information remains the same.

Provider Types Affected

This Special Edition (SE) affects all Medicare Fee-For-Service (FFS) providers who submit medical documentation to Medicare review contractors.

Provider Action Needed

Each year, the Medicare Fee-For-Service (FFS) Program makes billions of dollars in estimated improper payments. The Centers for Medicare & Medicaid Services (CMS) employs several types of Medicare review contractors to measure, prevent, identify, and correct these improper payments. Review contractors find the improper payments by requesting

medical documentation from each provider who submitted a questionable claim. The review contractor then manually reviews the claims against the submitted medical documentation to verify the providers' compliance with Medicare's rules.

Currently, review contractors request medical documentation by sending a paper letter to the provider. The provider has two options for submitting the requested records: 1) mail paper, or 2) send a fax.

Medicare's Electronic Submission of Medical Documentation (esMD) pilot project gives some providers a new mechanism for submitting medical documentation to review contractors. A list of review contractors that will accept esMD transactions can be found at http://go.usa.gov/kr4 on the Internet.

The esMD pilot will begin in September of 2011.

The primary intent of esMD is to reduce provider costs and cycle time by minimizing and eventually eliminating paper processing and mailing of medical documentation to review contractors. A secondary goal of esMD is to reduce costs and time at review contractors.

In order to send medical documentation electronically to review contractors, Medicare providers, including physicians, hospitals, and suppliers, must obtain access to a CONNECT-compatible gateway.

Certain larger providers, such as hospital chains, may choose to build their own gateway.

Many providers may choose to obtain gateway services by entering into a contract or other arrangement with a Health Information Handler (HIH) that offers esMD gateway services.

A list of HIHs that offer esMD services as of September 2011 can be found in the "Key Points" section of this article. An updated listing of the HIHs that have been approved by CMS to offer esMD services can also be found at http://go.usa.gov/krg on the Internet.

CMS does not set the price that an HIH may charge a provider for esMD services. Providers who believe it may be more efficient to respond to documentation requests electronically are encouraged to contact one or more of the HIHs to determine if esMD services are available at a reasonable price.

You should know that esMD is completely voluntary. You may continue to mail or fax documentation to your review contractor.

The initial esMD system accepts Portable Document Format (PDF) files, which means that even those providers who have paper records may utilize esMD services as long as there is a mechanism to scan the paper records into PDF files. Some HIHs may offer scanning services in addition to their esMD services.

Key Points

The following are tentative schedules of when HIHs will be ready to offer esMD services and when Review Contractors will be ready to accept esMD:

HIH/Web Address	Scheduled Readiness*
HealthPort (http://www.healthport.com)	September 2011
IVANS (http://www.ivans.com)	September 2011
MRO (http://www.mrocorp.com)	September 2011
NaviNet (http://www.navinet.net)	September 2011
RISARC (http://www.risarc.com)	September 2011
eSolutions (http://www.ecorpnet.com)	November 2011
Cobius (http://www.cobius.com)	November 2011
IOD, Inc. (http://www.iodincorporated.com)	November 2011
Proficient Health (http://www.proficienthealth.com)	November 2011
Craneware (http://www.craneware.com)	November 2011
MDClick (http://www.mdclick.com)	November 2011
Medical Electronic Attachment (http://www.mea-fast.com)	November 2011

DOCUMENTATION CONT'D

HIH/Web Address	Scheduled Readiness*
EHR Doctors (http://www.ehrdoctors.com)	November 2011
ApeniMED (http://www.Apenimed.com)	November 2011
HealthIT+ (http://www.healthitplus.com)	November 2011
ECC Technologies (http://www.ecctec.com)	January 2012
Stratice Healthcare (http://straticehealthcare.com)	January 2012
AT&T (http://www.att.com/healthcare)	January 2012
CureMD (http://www.curemd.com)	January 2012
MediConnect (http://www.mediconnect.net)	January 2012
MediCopy (http://www.medicopy.net)	January 2012
Cal eConnect (http://www.caleconnect.org)	January 2012
LMRP Manager (http://www.racmanager.com)	January 2012
SSI (http://www.thessigroup.com/)	January 2012
Verisma Systems (http://www.verismasystems.com)	January 2012
Zydoc (http://www.zydoc.com)	January 2012
Ivertex (http://www.ivertex.com)	April 2012

Medicare review contractors include the Recovery Auditors (RACs), Medicare Administrative Contractors (MACs), the Comprehensive Error Rate Testing (CERT) contractor, the Program Error Rate Measurement (PERM) contractor, and Zone Program Integrity (ZPIC) contractors.

The following shows when some of these contractors will be accepting esMD transactions:

Review Contractors	Scheduled Readiness*
RAC A - Diversified Collection Services (DCS)	September 2011
RAC B - CGI Technologies and Solutions	September 2011
MAC J1 and J11 - Palmetto GBA	September 2011
MAC J3 - Noridian Administrative Services	September 2011
MAC J4 - Trailblazer Health Enterprises	September 2011
MAC J5 - Wisconsin Physicians Services Health Insurance Corporation	September 2011
MAC J9 - First Coast Service Options	September 2011
MAC J12 - Highmark Medicare Services	September 2011
MAC J14 – NHIC	September 2011
DME MAC A – NHIC	September 2011
DME MAC D - Noridian Administrative Services, LLC	September 2011
CERT – Livanta	September 2011
PERM - A+ Government Solutions	September 2011
MAC J10 - Cahaba Government Benefit Administrators	November 2011
MAC J13 - National Government Services	November 2011
DME MAC B – NGS	November 2011
ZPIC 1 - Safeguard Services LLC	November 2011
ZPIC 7 - Safeguard Services LLC	November 2011
RAC D – HealthDataInsights	November 2011

Review Contractors	Scheduled Readiness*
MAC J15 - CIGNA Government Services, LLC	January 2012
DME MAC C - CGS Administrators, LLC	January 2012

These are anticipated dates and subject to change. Please check the esMD website (**http://www.cms.gov/ESMD**) for more information.

Note: CMS expects that the Region C and D Recovery Auditors and remaining MACs will begin accepting esMD transactions within the next 12 months.

Additional Information

For more information, visit the esMD webpage at http://www.cms.gov/esmd on the CMS website. You might also try the Twitter Link, which is @CMSGov (Look for #CMS_esMD).

For more information on the Medicare Recovery Audit program, see the MLN Matters® article SE1024 at http://www.cms.gov/MLNMattersArticles/downloads/SE1024.pdf on the CMS website. You may contact your Recovery Auditor for questions you have of them. Their contact information is at http://www.cms.gov/RAC/Downloads/RACcontactinfo.pdf on the CMS website.

Proof of Delivery and Delivery Methods

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

Provider Types Affected

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

What You Need to Know

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

Additional Information

The official instruction, CR 7410 issued to your DME MAC regarding this change may be viewed at http://www.cms.gov/Transmittals/downloads/R389PI.pdf on the CMS website.

DRUGS/BIOLOGICALS

Gammagard Liquid® (J1569) Added as Covered Subcutaneous Immune Globulin

Gammagard Liquid® (J1569) is added to the External Infusion Pump LCD as covered subcutaneous immune globulin effective for dates of service on or after July 22, 2011. The existing HCPCS code for Gammagard Liquid® must be used:

> J1569 – INJECTION, IMMUNE GLOBULIN, (GAMMAGARD LIQUID), INTRAVENOUS, NONLYOPHILIZED, (E.G. LIQUID), 500 MG

For J1569 and associated infusion pump (E0779) claims where the route of administration is subcutaneous, a JB modifier must be added to each HCPCS code. For other methods of administration, no modifier should be added.

One (1) unit of service (UOS) is 500mg. Gammagard liquid is distributed in multiple package sizes from one (1)-gram (1000mg) to thirty (30)-grams (30,000mg). Suppliers must choose the package size that is appropriate for the dosage being administered to minimize waste. For example:

> 1500mg is prescribed (3 UOS). Gammagard liquid is available in 1-gram (2UOS) and 2.5-gram (5 UOS) sizes. Two 1-gram vials (4 UOS) must be used rather than one 2.5-gram vial (5 UOS).

Excess wastage due to non-optimal vial sizes will be denied as not reasonable and necessary.

As a reminder, below are the coverage criteria from the External Infusion Pump LCD:

"Subcutaneous immune globulin (J1559, J1561, J1562) is covered only if criteria 1 and 2 are met:

- The subcutaneous immune globulin preparation is a pooled plasma derivative which is approved for the treatment of primary immune deficiency disease; and
- The patient has a diagnosis of primary immune deficiency disease (ICD-9 codes 279.04, 279.05, 279.06, 279.12, 279.2).

Coverage of subcutaneous immune globulin applies only to those products that are specifically labeled as subcutaneous administration products. Intravenous immune globulin products are not covered under this LCD.

Only an E0779 infusion pump is covered for the administration of subcutaneous immune globulin. If a different pump is used, it will be denied as not reasonable and necessary."

Gammagard Liquid will be added in a future revision of the LCD.

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

October 2011 ASP Files Now Available

CMS has posted the October 2011 Average Sales Price (ASP) and Not Otherwise Classified (NOC) pricing files and crosswalks. The ASP pricing files and crosswalks for July 2011, April 2011, January 2011, and October 2010 have also been updated. All are available for download at: http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/ (see left menu for year-specific links).

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

MLN Matters® Number: MM7397 Revised
Related Change Request (CR) #: 7397
Related CR Release Date: August 5, 2011
Related CR Transmittal #: R2312CP
Effective Date: January 1, 2012
Implementation Date: January 1, 2012

Note: This article was revised on September 26, 2011, to reflect the revised CR7397 issued on September 23. The effective and implementation dates were changed. Also, the CR release date, transmittal number, and the Web address for accessing CR7397 were revised. All other information remains the same.

Provider Types Affected

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

What You Should Know

This article is based on Change Request (CR) 7397, which clarifies policy with respect to restrictions on pharmacy billing for drugs provided "incident to" a physician service. The CR also clarifies policy for the local determination of payment limits for drugs that are not nationally determined. This article notes that CR 7397 rescinds and fully replaces CR 7109. Please be sure your staffs are aware of this update.

Background

Pharmacies billing drugs

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

Claims for these drugs are generally submitted to the Durable Medical Equipment Medicare Administrative Contractor (DME MAC). The carrier or A/B MAC will reject these claims as they need to be sent to the DME MAC.

In the rare situation where a pharmacy dispenses a drug that will be administered through implanted DME and a physician's service will not be utilized to fill the pump with the drug, the claim is submitted to the A/B MAC or carrier.

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

When drugs may not be billed by pharmacies to Medicare Part B

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

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

Payment limits

The payment limits for drugs and biologicals that are not included in the average sales price (ASP) Medicare Part B Drug Pricing File or Not Otherwise Classified (NOC) Pricing File are based on the published Wholesale Acquisition Cost (WAC) or invoice pricing, except under the Outpatient Prospective Payment System (OPPS) where the payment allowance limit is 95 percent of the published average wholesale price (AWP). In determining the payment limit based on WAC, the payment limit is 106 percent of the lesser of the lowest-priced brand or median generic WAC. Medicare contractors will not search their files to either retract payment for claims already paid or to retroactively pay claims, but will adjust claims brought to their attention.

Additional Information

The official instruction, CR 7397 issued to your Medicare contractor regarding this issue may be viewed at http://www.cms.gov/Transmittals/downloads/R2312CP.pdf on the Centers for Medicare & Medicaid Services (CMS) website.

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

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

Widespread Prepayment Review for Immunosuppressive Drugs - Edit Effectiveness for 4th Quarter

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

The results of the review of the claims identified 3,031 claims of which 2,233 were denied. This resulted in an overall error rate of 71%. This is a decrease from 74% during the third quarter of this review. Due to the high error rate, NAS will continue with the widespread complex review for the above mentioned immunosuppressive drugs with future reporting on each HCPCS code individually.

The following are the top reasons for denial:

- Requested documentation was not provided within the allotted time frame as referenced in the Medicare guidelines
- No valid written order
  a. No written order submitted with the documentation
  b. Insufficient or incomplete order
- No Proof Of Delivery
  a. No proof of delivery submitted with the documentation
  b. Invalid proof of delivery
- No office notes/medical records provided to support the KX modifier

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

- 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.
- 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.
- 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.
- KX and GY Modifiers
  The KX modifier must be added to the claim line(s) for the immunosuppressive drug(s) only if:
  a. The supplier obtains from the ordering physician the date of the organ transplant, and
  b. The beneficiary was enrolled in Medicare Part A at the time of the organ transplant (whether or not Medicare paid for the transplant), and
  c. The transplant date precedes the date of service on the claim.

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

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

outlined in the Immunosuppressive Drugs Local Coverage Determination (LCD) L68 and Policy Article A25366. Suppliers can also review the Immunosuppressive Drugs documentation checklist on the NAS website at https://www.noridianmedicare.com/dme/coverage/checklists.html

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

EDUCATIONAL

MLN Learning Network Updates

"Medicare Enrollment Guidelines for Ordering/Referring Providers" Fact Sheet Revised
The publication titled "Medicare Enrollment Guidelines for Ordering/Referring Providers," which is available from the Medicare Learning Network® at http://www.CMS.gov/MLNProducts/downloads/MedEnroll_OrderReferProv_FactSheet_ICN906223.pdf, was revised to remove "Doctors of Chiropractic Medicine" from the list of providers who are eligible to order/refer, as indicated in technical direction that CMS issued on Friday, August 12. CMS will re-issue the related policies as soon as possible. This fact sheet is designed to provide education on the Medicare enrollment requirements for eligible ordering/referring providers. It includes information on the three basic requirements for ordering and referring and who may order and refer for Medicare Part A Home Health Agency, Part B, and DMEPOS beneficiary services.

- **"Contractor Entities At A Glance" Educational Tool Released**
  The Medicare Learning Network® (MLN) has released a new product titled "Contractor Entities At A Glance: Who May Contact You About Specific Centers for Medicare & Medicaid Services (CMS) Activities" to provide education about the definitions and responsibilities of entities involved in various claims adjudication activities. This educational tool, which is available in downloadable format at http://www.CMS.gov/MLNProducts/downloads/ContractorEntityGuide_ICN906983.pdf, includes a chart that outlines each entity by type, definitions, responsibilities, and reasons for contacting providers. This product will be available in hard copy format from the MLN® at a later date.
- **Advance Beneficiary Notice of Noncoverage (ABN) Booklet**
  Revised—Advance Beneficiary Notice of Noncoverage (ABN) Part A and Part B http://cms.meridianksi.com/kc/pfs/pfs_lnkfrm_fl.asp?lgnfrm=reqprod&function=pfs, Booklet, 006266, hard copy. This booklet is designed to provide education on the ABN. It includes information on when an ABN should be used and how it should be completed.
- **"The Medicare Overpayment Collection Process" Fact Sheet Revised**
  "The Medicare Overpayment Collection Process" fact sheet, which includes the definition of a physician or supplier overpayment and information about the overpayment collection process, has been revised and is now available in downloadable format at http://www.CMS.gov/MLNProducts/downloads/OverpaymentBrochure508-09.pdf.
- **Medicare Learning Network Catalog of Products Updated**
  The Medicare Learning Network® Catalog of Products has been updated and is available as a free interactive downloadable document at http://www.CMS.gov/MLNProducts/downloads/MLNCatalog.pdf. The catalog lists all MLN products available to the Medicare Fee-For-Service provider community. In the catalog, click on the title of a product to go directly to a downloadable copy or, if the product is available in hard copy, click on "Hard Copy" next to "Formats Available," to link to the MLN Product Ordering Page.
- **"Medicare Quarterly Provider Compliance Newsletter" Now Available**
  The July 2011 issue of the "Medicare Quarterly Provider Compliance Newsletter" is now available in downloadable format from the Medicare Learning Network® at http://www.CMS.gov/MLNProducts/downloads/MedQtrlyComp_Newsletter_ICN903687.pdf. This educational tool is issued on a quarterly basis and designed to provide education on how to avoid common billing errors and other erroneous activities when dealing with the Medicare Program. In this issue, several Recovery Audit findings that affect inpatient hospitals and DMEPOS suppliers are presented. Please visit http://www.CMS.gov/MLNProducts/downloads/MedQtrlyCompNL_Archive.pdf to download, print, and search newsletters from previous quarters.
- **New Fast Fact Posted on MLN Provider Compliance Webpage**
  A new fast fact has been posted to the MLN Provider Compliance webpage, which contains educational FFS

provider materials to help you understand – and avoid – common billing errors and other improper activities identified through claim review programs. You can review quick tips on relevant provider compliance issues and corrective actions directly from this webpage; bookmark the page and check back often as a new "fast fact" is added each month!

- **"Introduction to the Medicare Program" Booklet Available in Hard Copy**
  The MLNs "Introduction to the Medicare Program" booklet is now available in print format. This booklet is designed to provide education on the Medicare Program and includes information about the four parts of the Medicare Program, other health insurance plans, and organizations of interest to providers and beneficiaries. To place your order, visit http://www.CMS.gov/MLNGenInfo, scroll to "Related Links Inside CMS," and select "MLN Product Ordering Page."
- **From the MLN: New Fast Fact Posted on MLN Provider Compliance Webpage**
  A new fast fact has been posted to the MLN Provider Compliance webpage, which contains educational Fee-For-Service provider materials to help you understand – and avoid – common billing errors and other improper activities identified through claim review programs. You can review quick tips on relevant provider compliance issues and corrective actions directly from this webpage. Please bookmark this page and check back often as a new "fast fact" is added each month!
- **From the MLN: Sign Up For the MLN Matters Listserv**
  Looking for the latest new and revised MLN Matters articles? Subscribe to the MLN Matters mailing list! For more information about MLN Matters and how to register for this service, visit http://www.CMS.gov/MLNMattersArticles/downloads/What_Is_MLNMatters.pdf and start receiving updates!
- **Get Connected with the Medicare Learning Network**
  Want to stay informed about the latest new and revised MLN products and services? Subscribe to the MLN Educational Products electronic mailing list! For more information about the MLN and how to register for this service, visit http://www.CMS.gov/MLNProducts/downloads/MLNProducts_listserv.pdf and start receiving updates.
- **"Medicare Claim Submission Guidelines" Fact Sheet Now Available**
  The new "Medicare Claim Submission Guidelines" fact sheet is now available in downloadable format. It includes information about applying for a National Provider Identifier and enrolling in the Medicare Program, filing Medicare claims, and private contracts with Medicare beneficiaries.
- **New Podcast Released on Avoiding Medicare Billing Errors**
  The MLN has released the next in a series of podcasts designed to provide education on how to avoid common billing errors and other improper activities when dealing with the Medicare Program. "Positive Airway Pressure (PAP) Devices: Complying with Documentation & Coverage Requirements" discusses the documentation and coverage requirements needed to submit Medicare claims for PAP devices.

  Please visit the MLN Multimedia webpage to download this and other podcasts from the MLN. We also encourage you to visit the MLN Provider Compliance webpage for the latest educational products designed to help Medicare Fee-For-Service Providers understand – and avoid – common billing errors and other improper activities identified through claim review programs. Stay tuned for future podcasts from the MLN!
- **The New Medicare Secondary Payer Provisions Web-Based-Training Course Has Been Released**
  The Medicare Secondary Payer Provisions Web-Based-Training Course (WBT) is designed to provide general education on when Medicare may or may not pay first. It includes an overview of the MSP Provisions, common payment situations, Medicare conditional payments, and the role of the Coordination of Benefits Contractor. To access the WBT, please visit the MLN® overview page at http://www.CMS.gov/MLNGenInfo and click on "Web-Based Training (WBT) Courses" in the "Related Links Inside CMS" section.
- **"Advance Beneficiary Notice of Noncoverage Part A and Part B" Booklet (ICN 006266) Available in Downloadable and Hardcopy Format**
  The "Advance Beneficiary Notice of Noncoverage (ABN) Part A and Part B" booklet (ICN 006266) is designed to provide education on the Advanced Beneficiary Notice (ABN). It includes information on when an ABN should be used and how it should be completed.

ENROLLMENT

All Medicare Provider and Supplier Payments EFT

Existing regulations at 42 CFR 424.510(e)(1)(2) require that at the time of enrollment, enrollment change request or revalidation, providers and suppliers that expect to receive payment from Medicare for services provided must also agree to receive Medicare payments through electronic funds transfer (EFT). Section 1104 of the Affordable Care Act of 2010 (ACA) further expands Section 1862 (a) of the Social Security Act by mandating federal payments to providers and suppliers only by electronic means. As part of CMS's revalidation efforts, all suppliers and providers who are not currently receiving EFT payments will be identified, and required to submit the CMS 588 EFT form with the Provider Enrollment Revalidation application.

Announcing Release of Revised and New CMS-855 Medicare Provider-Supplier Enrollment Applications

The US Office of Management and Budget recently approved changes to the Medicare Provider-Supplier Enrollment Applications (CMS-855) in order to update them from the 2008 versions, as well as the new CMS-855O application form used for the sole purpose of enrolling to order and refer items and/or services to Medicare beneficiaries. The revised and new forms are now available on the CMS Provider-Supplier website at http://www.CMS.gov/CMSForms/CMSForms/list.asp?filtertype=dual&filtertype=keyword&keyword=855.

Providers and suppliers enrolling for the sole purpose to order and refer are required to begin using the new CMS-855O form immediately. Providers and suppliers using the other CMS-855 forms to enroll in Medicare are encouraged to begin using the revised forms, though may continue to use the old forms through October 2011.

Further Details on the Revalidation of Provider Enrollment Information

MLN Matters® Number: SE1126 Revised

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

Provider Types Affected

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

Provider Action Needed

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

All providers and suppliers enrolled with Medicare prior to March 25, 2011, must revalidate their enrollment information, but only after receiving notification from their MAC.

Special Note: The Medicare provider enrollment revalidation effort does not change other aspects of the enrollment process. Providers should continue to submit routine changes – address updates, reassignments, additions to practices, changes in authorized officials, information updates, etc – as they always have. If you also receive a request for revalidation from the MAC, respond separately to that request.

When you receive notification from your MAC to revalidate:

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

Background

Section 6401 (a) of the Affordable Care Act established a requirement for all enrolled providers and suppliers to

revalidate their enrollment information under new enrollment screening criteria. This revalidation effort applies to those providers and suppliers that were enrolled prior to March 25, 2011. **Newly enrolled providers and suppliers that submitted their enrollment applications to CMS on or after March 25, 2011, are generally not impacted**. CMS has reevaluated the revalidation requirement in the Affordable Care Act, and believes it affords the flexibility to extend the revalidation period for another 2 years. This will allow for a smoother process for providers and contractors. Revalidation notices will now be sent through March of 2015. **IMPORTANT**: This does not affect those providers which have already received a revalidation notice. If you have received a revalidation notice from your contractor respond to the request by completing the application either through internet-based PECOS or by completing the appropriate 855 application form. **Therefore, between now and 2015, MACs will send out revalidation notices on an intermittent, but regular basis to begin the revalidation process for each** -provider and supplier. **Providers and suppliers must submit the revalidation application only after being asked by their MAC to do so**. Please note that 42 CFR 424.515(d) provides CMS the authority to conduct these off-cycle revalidations. The first set of revalidation notices went to providers who are billing, but are not currently in PECOS. To identify these providers, contractors searched their local systems and if a Provider Transaction Access Number (PTAN) for a physician was not in PECOS, a revalidation request for that physician was sent. CMS asks all providers who receive a request for revalidation to respond to that request.

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

Note: CMS has structured the revalidation processes to reduce the burden on the providers by implementing innovative technologies and streamlining the enrollment and revalidation processes. CMS will continue to provide updates as progress is made on these efforts.

The most efficient way to submit your revalidation information is by using the Internet-based PECOS.

To revalidate via the Internet-based PECOS, go to https://pecos.cms.hhs.gov on the CMS website. PECOS allows you to review information currently on file, update and submit your revalidation via the Internet. Once submitted, YOU MUST print, sign, date, and mail the certification statement along with all required supporting documentation to the appropriate MAC IMMEDIATELY. Section 6401(a) of the Affordable Care Act also requires the Secretary to impose a fee on each "institutional provider of medical or other items or services and suppliers." The application fee is $505 for Calendar Year (CY) 2011. CMS has defined "institutional provider" to mean any provider or supplier that submits a paper Medicare enrollment application using the CMS-855A, CMS-855B (except physician and non-physician practitioner organizations), or CMS-855S forms or associated Internet-based PECOS enrollment application.

All institutional providers (i.e., all providers except physicians, non-physicians practitioners, physician group practices and non-physician practitioner group practices) and suppliers who respond to a revalidation request must submit an enrollment fee (reference 42 CFR 424.514) with their revalidation. In mid September, CMS revised the revalidation letter that contractors sent to providers to clarify who must pay the fee. You may submit your fee by ACH debit, or credit card. Revalidations are processed only when fees have cleared. To pay your application fee, go to https://pecos.cms.hhs.gov/pecos/feePaymentWelcome.do and submit payment as directed. A confirmation screen will display indicating that payment was successfully made. This confirmation screen is your receipt and you should print it for your records. CMS strongly recommends that you mail this receipt to the Medicare contractor along with the Certification Statement for the enrollment application. CMS will notify the Medicare contractor that the application fee has been paid. Upon receipt of the revalidation request, providers and suppliers have 60 days from the date of the letter to submit complete enrollment forms. **Failure to submit the enrollment forms as requested may result in the deactivation of your Medicare billing privileges**.

Additional Information

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

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

The MLN® fact sheet titled "The Basics of Internet-based Provider Enrollment, Chain and Ownership System

(PECOS) for Provider and Supplier Organizations" is designed to provide education to provider and supplier organizations on how to use Internet-based PECOS to enroll in the Medicare Program and can be found at http://www.cms.gov/MLNProducts/downloads/MedEnroll_PECOS_ProviderSup_FactSheet_ICN903767.pdf on the CMS website.

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

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

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

Implementation of Pay.gov Application Fee Collection Process through PECOS

MLN Matters® Number: SE1130

Provider Types Affected

This Medicare Learning Network (MLN) Matters® Special Edition Article is intended for all providers and suppliers, (except physicians and non-physician practitioners who are not required to pay an application fee), who are initially enrolling in Medicare, adding a practice location, or revalidating their enrollment information, and do so by submitting one of the following paper Medicare enrollment applications or the associated Internet-based Provider Enrollment, Chain and Ownership System (PECOS) enrollment applications:

- CMS 855A--Medicare Enrollment Application for Institutional Providers;
- CMS 855B--Medicare Enrollment Application for Clinics, Group Practices; and Certain Other Suppliers; and
- CMS 855S--Medicare Enrollment Application for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Suppliers.

Currently, providers or suppliers use Pay.gov to make Medicare application fee payments electronically. This article announces a change to this website address to access Pay.gov on the Internet.

The changes outlined below have no effect on the Pay.gov payment collection process. Provider and suppliers will continue to make payment for the application fees to Pay.gov on the Internet. CMS is simply revising the way providers access Pay.gov to improve the efficiency of the application fee payment, collection, and accounting process.

Use the following address to make your application fee payments: https://pecos.cms.hhs.gov/pecos/feePaymentWelcome.do on the CMS website. Please update any bookmarks you and your staffs may have in place to the new address.

Background

In February 2011, CMS published a final rule, CMS-6028-FC, with provisions related to the submission of application fees as part of the provider enrollment process. An application fee and/or hardship exception must be submitted with any application received from institutional providers initially enrolling in Medicare, adding a practice location, or revalidating their enrollment on or after March 25, 2011.

Changes for Making Medicare Application Payments

Internet based PECOS On-Line Application Submitters: For those who submit applications online via the PECOS website (also referred to as PECOS Provider Interface (or PECOS PI)), you will no longer have to separately access Pay.gov **first** to make your application fee payments. Instead, as you proceed through the Internet based PECOS application process, if a fee is required, you will be prompted to submit a payment. You will be automatically transferred from the Internet based PECOS application site to the Pay.gov website where you will make your payment by ACH credit and debit card. Once your payment transaction is complete, you will be automatically returned to the PECOS website to complete the remaining part of your application. PECOS will track the collection transaction from Pay.gov and will update payment status, allowing your application to be processed.

855 Paper Application Submitters: For providers who continue to use the 855 paper enrollment application, you will now access Pay.gov using the following URL: https://pecos.cms.hhs.gov/pecos/feePaymentWelcome.do on the CMS website. Complete the Medicare Application Fee form and click the 'PAY NOW' button. You will be redirected to enter and submit payment collection information. At the conclusion of the collection process, you will receive a receipt

indicating the status of your payment. Please print a copy for your records. We strongly recommend that you attach this receipt to the completed CMS-855 application submitted to your Medicare contractor.

Paper Application Submitters-Interim Procedures: Through December 31, 2011, CMS will continue to route providers and suppliers, who access Pay.gov directly using the Pay.gov form set up process, to the correct URL, https://pecos.cms.hhs.gov/pecos/feePaymentWelcome.do, on the CMS website.

After December 31, 2011, to access https://pecos.cms.hhs.gov/pecos/feePaymentWelcome.do on the CMS website. Pay.gov, you will be required use the URL.

Additional Information

More information about the enrollment process, the required fees, and the hardship exceptions process can be found in the MLN Matters® Article MM7350, available at http://www.cms.gov/MLNMattersArticles/downloads/MM7350.pdf on the CMS website. More information on revalidation can be found in SE1126, which is available at http://www.cms.gov/MLNMattersArticles/downloads/SE1126.pdf on the CMS website.

Medicare Providers Must Begin to Revalidate Enrollment by March 2013

All providers and suppliers who enrolled in the Medicare program prior to Friday, March 25, 2011, will be required to revalidate their enrollment under new risk screening criteria required by the Affordable Care Act (section 6401a). (Providers/suppliers who enrolled on or after Friday, March 25, 2011 have already been subject to this screening, and need not revalidate at this time.)

In the continued effort to reduce fraud, waste, and abuse, CMS implemented new screening criteria to the Medicare provider/supplier enrollment process beginning in March 2011. Newly-enrolling and revalidating providers and suppliers are placed in one of three screening categories – limited, moderate, or high – each representing the level of risk to the Medicare program for the particular category of provider/supplier, and determining the degree of screening to be performed by the Medicare Administrative Contractor (MAC) processing the enrollment application.

Between now and March 2013, MACs will be sending notices to individual providers/suppliers; please begin the revalidation process as soon as you hear from your MAC. Upon receipt of the revalidation request, providers and suppliers have 60 days from the date of the letter to submit complete enrollment forms. Failure to submit the enrollment forms as requested may result in the deactivation of your Medicare billing privileges. The easiest and quickest way to revalidate your enrollment information is by using Internet-based PECOS (Provider Enrollment, Chain, and Ownership System), at https://pecos.CMS.hhs.gov.

Section 6401a of the Affordable Care Act requires institutional providers and suppliers to pay an application fee when enrolling or revalidating ("institutional provider" includes any provider or supplier that submits a paper Medicare enrollment application using the CMS-855A; CMS-855B, not including physician and non-physician practitioner organizations; CMS-855S; or associated Internet-based PECOS enrollment applications); these fees may be paid via www.Pay.gov.

In order to reduce the burden on the provider, CMS is working to develop innovative technologies and streamlined enrollment processes – including Internet-based PECOS. Updates will continue to be shared with the provider community as these efforts progress.

For more information about provider revalidation, review the Medicare Learning Network's Special Edition Article #SE1126, titled "Further Details on the Revalidation of Provider Enrollment Information."

Medicare's Provider Enrollment Revalidation Process and Improvements to Internet-Based PECOS

Over the coming months and years, CMS Medicare Administrative Contractors will ask providers to submit a complete and up-to-date enrollment application. You will be able to submit your application via paper (CMS-855 form) or electronically through the internet-based PECOS (Provider Enrollment, Chain, and Ownership System). CMS urges you to use internet-based PECOS for responding to the request for revalidation – and for most other updates that may need to be made to your provider enrollment records.

Between now and April 2012, CMS will continue to improve internet-based PECOS to make it easier for you to update your information and submit your revalidation application. We have already streamlined the application process with fewer screens and new helpful prompts to let you know if information is incomplete. Once enrolled in PECOS, you

ENROLLMENT CONT'D

can review your existing information online, make changes, and submit the revalidated application without having to complete the entire application. You are also able to pay the application fee (if applicable) during the online submission process.

Soon internet-based PECOS will be improved to:

- Allow you to view all application data on a single screen, reducing data entry and duplication of data
- Allow you to easily manage and search your enrollment applications, as well as upload multiple applications at one time
- Simplify the registration process for Authorized Representatives
- Eliminate separate mailing of most documents through digital document upload for support documents

Use internet-based PECOS – it's faster, safe, and secure. To log on, visit https://PECOS.CMS.hhs.gov.

NSC Launches New Licensure Database

The National Supplier Clearinghouse (NSC) has launched a new supplier licensure database to help DMEPOS suppliers determine the licensure needed for Medicare enrollment. The database is more interactive, including licensure verification and hyperlinks to additional information. The search tool is arranged by product speciality rather than supplier type as with previous versions.

As a reminder licensure requirements vary from state to state. Therefore the database serves only as a guide. It remains the responsibility of the supplier to ensure they are compliant with all state and federal laws and regulations. The streamlined NSC Licensure Database will clarify what licenses are required to properly enroll for Medicare billing privileges.

Source: National Supplier Clearinghouse

ENTERAL NUTRITION

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

MLN Matters® Number: MM7498
Related Change Request (CR) #: 7498
Related CR Release Date: August 12, 2011
Related CR Transmittal #: R948OTN
Effective Date: January 1, 2011
Implementation Date: January 3, 2012

Provider Types Affected

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

Provider Action Needed

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

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

ENTERAL NUTRITION CONT'D

Key Points

- Claims will be paid when submitted by a National Competitive Bidding (NCB) contract or non-contract supplier for the maintenance and servicing of enteral nutrition pumps, provided the supplier furnished the pump to the beneficiary in the 15th month of continuous rental and provided that, in the case of a non-contractor supplier, the 15th month of rental occurred before the start of the competitive bidding round (January 1, 2011).
- Claims will be denied if submitted by non-contract suppliers for maintenance and servicing if the supplier did not provide the item in the 15th month of the rental period or if the 15th month occurred on or after the start of the competitive bidding round.
- For denied claims, DME MACs will supply the following messages on the remittance advice:
  - 96 – Non-covered charge(s).
  - M115 – This item is denied when provided to this patient by a non-contract or non-demonstration supplier.
  - M114 – This service was processed in accordance with rules and guidelines under the DMEPOS Competitive Bidding Program or other demonstration project. For more information regarding this project, contact your local contractor.
  - N211 – Alert: You may not appeal this decision.
  - MA13 – Alert: You may be subject to penalties if you bill the patient for amounts not reported with the PR (patient responsibility) group code.
  - Group Code CO.
- Suppliers will be paid the Medicare payment amount for maintenance and servicing of enteral nutrition equipment equal to a percentage of the fee schedule for the purchase or rental of the enteral equipment, as applicable.
- For maintenance and servicing claims submitted by a non-contract supplier, Medicare Contractors will pay 50 percent of the fee schedule amount for a single month's rental of enteral nutrition equipment.
- For maintenance and servicing claims submitted by contract suppliers, Medicare Contractors will pay 5 percent of the single payment amount for the purchase of enteral nutrition equipment.
- Payments are allowed for maintenance and servicing of enteral nutrition equipment furnished by contract or non-contract suppliers until the earlier of either a determination is made by the beneficiary's physician that the equipment is no longer medically necessary or the end of the Reasonable Useful Lifetime (RUL) of the equipment.
- DMEPOS Competitive Bidding Program claims submitted by non-contract suppliers for maintenance and servicing of enteral nutrition equipment with dates of service between January 1, 2011, and December 31, 2011, and which were previously denied, will be reprocessed by your Medicare contractor if the supplier submitting the adjustment received payment for the 15th month of equipment rental prior to the start of the competitive bidding round.

Additional Information

The official instruction, CR7498 issued to your DME/ MAC regarding this change may be viewed at http://www.cms.gov/Transmittals/downloads/R948OTN.pdf on the CMS website.

FORMS

ABN Form: Revised Version Mandatory Use Delayed until January 1, 2012

The latest version of the Advance Beneficiary Notice of Noncoverage (ABN) (release date of 3/2011 printed in lower left hand corner) is now available for immediate use. In order for suppliers to have time to transition to using the new ABN form, mandatory use of this version begins has been delayed until January 1, 2012. All ABNs with the release date of 3/2008 that are issued on or after January 1, 2012, will be considered invalid if used for new DMEPOS. The form is considered by CMS to be an Office of Management and Budget (OMB) form and therefore must be replaced every three years. Additional information regarding the ABN is accessible on the CMS website, http://www.cms.gov/BNI/02_ABN.asp.

EDI Enrollment Form Reminder

As a Reminder: If a DME supplier receives a new Provider Transaction Access Number (PTAN)/National Supplier Clearinghouse (NSC) supplier number, you must notify Common Electronic Data Interchange (CEDI) Enrollment of the new PTAN/NSC number and its associated NPI. The DME supplier must complete the EDI Enrollment Form to register all PTAN/NSC numbers with CEDI. If the DME supplier uses a billing service or clearinghouse, the Supplier Authorization Form will also need to be completed.

All enrollment forms must be completed and submitted on-line. After completing the form(s) online, you must print the form(s), sign and date, and then fax all pages to CEDI at 315-442-4299.

FRAUD & ABUSE

Information You Need: CMS Fraud Prevention Initiative

If you help people with Medicare, Medicaid and the Children's Health Insurance Program (CHIP), you should know about an expanded federal government effort to reduce fraud and other improper payments in these health care programs to help ensure their long-term viability.

Significant progress in the fight against health care fraud has already been made as shown by the federal government's recovery of a record $4 billion last year from people who attempted to defraud seniors and taxpayers. The Affordable Care Act provides additional resources and tools to enable the Centers for Medicare & Medicaid Services (CMS) to expand efforts to prevent and fight fraud, waste and abuse. The CMS Fraud Prevention Initiative aims to ensure that correct payments are made to legitimate providers for covered appropriate and reasonable services in all federal health care programs.

Fraud prevention efforts focus on moving CMS beyond its former "pay and chase" recovery operations to a more proactive "prevention and detection" model that will help prevent fraud and abuse before payment is made. A good example is the recent CMS announcement that for the first time, through the use of innovative predictive modeling technology similar to that used by credit card companies, the agency will have the ability to use risk scoring techniques to flag high risk claims and providers for additional review and take action to stop payments and remove providers from the program when necessary.

Yet, as important as these aggressive new initiatives are, the first and best line of defense against fraud remains the health care consumer. You can help by making sure that Medicare beneficiaries have the information they need to identify and report suspected fraud. This information is available in the CMS Fraud Prevention Toolkit on the web at https://www.cms.gov/Partnerships/04_FraudPreventionToolkit.asp.

The web site contains materials to help you inform Medicare beneficiaries about how to protect themselves from becoming a victim of fraud and how to report it. Thanks in advance for your assistance.

GLUCOSE MONITORS

CMS to Release Comparative Billing Report on Ordering Durable Medical Equipment: Diabetic Supplies

On Monday, August 29th, CMS will release a national provider Comparative Billing Report (CBR) focused on Ordering Durable Medical Equipment: Diabetic Supplies. This will be the first release of 5000 CBRs with two additional releases to follow (the second release of 5000 CBRs is targeted for Wednesday, September 7th; the third for Thursday, September 15th).

CBRs produced by Safeguard Services under contract with CMS contain actual data-driven tables and graphs with an explanation of findings that compare a provider's billing and payment patterns to those of their peers located in the state and across the nation. CMS has received feedback from a number of providers that this kind of data is very helpful to them and encouraged us to produce more CBRs.

CBRs convey billing information that can be used as an educational tool by providers in complying with Medicare billing rules and improve the level of care they furnish to their Medicare patients. These reports are not available to anyone but the providers who receive them. To ensure privacy, CMS presents only summary billing information; no patient- or case-specific data is included.

For more information and to review a sample of the Ordering Durable Medical Equipment: Diabetic Supplies CBR, please visit www.CBRservices.com or call the SafeGuard Services Provider Help Desk, CBR Support Team at 530-896-7080.

Glucose Monitor and Testing Supplies Ask the Contractor Q&A – August 30, 2011

Resources for glucose monitor and testing supplies are available in the Local Coverage Determination (LCD), Policy Article and on the glucose specific webpage.

Prior to taking questions, NAS provided updates on the system hours changing to 6 a.m. – 8 p.m. CT for the Interactive Voice Recognition (IVR) System and Endeavor supplier claim-related inquiries, the supplier contact center change in hours to 8:30 a.m. to 5:30 p.m., the email listserv as well as Endeavor.

Note: Answers to these questions are accurate as of the posted date.

Questions received prior to the call:

Q1: Aside from narrative on patient's notes (used for refill orders) and copies of blood sugar testing logs, what other proof do we need to prove the patient was contacted, refills were authorized, and utilization of supplies were verified?

A1: Suppliers should have contemporaneous written record of a phone conversation with the beneficiary or a form signed by the beneficiary that they have nearly exhausted their current supply on hand. A retrospective statement by the supplier or beneficiary is not sufficient. This needs to take place no sooner than 14 days prior to delivery/shipping date. This should include the beneficiary's name, a description of each item that is being requested, the date of the refill request and the quantity of each item that the beneficiary still has remaining.

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

Questions and answers taken during the call:

Q1: Do we have to document the quantity of supplies (i.e., amount of days) the patient still has on hand prior to the refill?

A1: Yes. We need to know how much the patient has on hand so we know the supplies are needed.

Q2: If we receive a fax from an assisted living facility stating the patient is almost out of supplies and also has the testing log attached verifying how many times the patient tested, would that be sufficient? We can verify the patient is within the 10 days expected end of usage since we sent them a 30 day supply and have the fax 25 days into the usage with a testing log for 25 days.

A2: From the fax, you can verify when the expected end of usage would occur, but you would not know the actual quantity left. You would use the estimate you had to calculate that you were reaching out to the patient no sooner than 14 days prior to the expected delivery/shipping date, but you would need information from the patient or their caregiver to determine you were not sending the supplies earlier than 10 days prior to the actual end of usage.

Follow-up: If the fax said the patient had five days worth of supplies left on hand, would that be sufficient?

A: Yes, that shows there was less than the required 10 days on hand.

Q3: Some nursing homes call us to let us know the patient is due for supplies. I can tell by my records they should be at their end of usage by the next day. Do I still need to know from the nursing home exactly how many they have left?

A3: If you are initiating the contact, you must have record that showed you expected there were no more than 14 days until the next expected delivery/shipping date. To be able to ship or deliver, you need to document the quantity remaining was not greater than a 10 day supply.

Q4: A lot of physicians document risk factors such as hyperlipidemia and think it is sufficient to prove medical necessity for patients to test above utilization guidelines even though they do not reference any other symptoms specific to diabetes, such as hypoglycemia and hyperglycemia. When reviewing medical records, does NAS consider those risk factors? I know the policy says there needs to be a specific narrative but physicians do not understand what kind of narrative is sufficient. Can you be more detailed about what kind of narrative is required?

A4: When hyperlipidemia is the only thing documented, it does not tell you the cause is from a glucose problem. The policy clearly states there needs to be a record showing the utilization of test strips. There is educational material on the website that can help the physician understand the requirements including Physician Documentation Requirements, Patient Documentation Form – Insulin Using and Patient Documentation Form – Non-Insulin Using. NAS also collaborates with Medicare Part B to conduct workshops for physicians and suppliers to attend. Currently, this has only been offered to Washington and Oregon but may be looked at for other states in the future.

Q5: What should I do when a physician's office refuses to send medical records to us when we are required to respond to a Medicare request?

A5: A medical records documentation letter has been written by Dr. Whitten, the Jurisdiction D Medical Director, that shows it is the physician's responsibility to be able to help support the need and also that it is not a violation of Health Insurance Portability and Accountability Act (HIPAA).

Q6: We have several patients who receive phone calls from random companies asking them if they want a free glucometer and solicit their business. Some of these patients are elderly and are easily confused and just do not understand what is happening so they unknowingly give out their Medicare and billing information. In turn it throws a wrench into their regular supply orders. Is there anything that can protect us from receiving duplicate denials because of the mail order companies other than an Advance Beneficiary Notice of Noncoverage (ABN)?

A6: If the patient does not know why they are receiving diabetic supplies from a company, it is recommended that the beneficiary call 1-800-HHS-TIPS. That is the contact information for inappropriate behavior. There are also state consumer protection agencies set up to protect people, especially the elderly, from being preyed upon that can be contacted.

Follow-up: If we supply an order to the patient and it overlaps with the date of this illegitimate order, is there a way to fight the denial? I know the patient would have to appeal it but how would we go about that? Just go through the regular appeals process?

A: If the patient states they did not order the supplies, documentation would be requested from the illegitimate supplier at the redeterminations level to see if they have full documentation in order to receive payment. If they do not, recoupment of monies will take place. It is also recommended to have the beneficiary call the illegitimate supplier to cancel any supplies moving forward.

Q7: If we know a patient is not going to be covered, we only bill Medicare for what is normally allowed. The patient then wants to purchase additional testing supplies out of their own pocket. Is an ABN required for this every time? If so, will that throw a wrench into subsequent orders if they insist on Medicare being billed for those?

A7: This could be considered an upgrade. An article titled Glucose Monitor Supplies – Use of Upgrade Modifiers – Revised is posted to the website. Be sure to follow the guidelines as outlined in the article.

Follow-up: Do we still need an ABN? If option one is checked on the ABN, how will it deny?

Yes, if you want to charge the beneficiary the difference you will need to obtain an ABN. When the claim is billed, the appropriate amount will deny as long as you are billing it correctly with the full charge on the first line and the allowed charge on the second line.

Follow-up: That won't affect the future orders?

A: No, you still need to follow all the refill requirement guidelines but would not be calling the patient until later because they have plenty of supplies on hand.

Widespread Prepayment Review for Diabetic Supplies - Edit Effectiveness for 4th 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 fourth quarter edit effectiveness results from May 2011 through August 2011 are as follows:

The results of the review of the claims identified 5,489 claims of which 4,172 were denied. This resulted in an overall error rate of 69%. This is a decrease from 75% during the third quarter of this review. Due to the high error rate, NAS will continue with the widespread complex review for the above mentioned diabetic supplies with the focus and future reporting on claims billing for over utilization per policy.

The following are the top reasons for denial:

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

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

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Glucose Monitors Local Coverage Determination (LCD) L196 and Policy Article A33673. Suppliers can also review the Glucose Monitors and Supplies documentation checklist on the NAS website at https://www.noridianmedicare.com/dme/coverage/checklists.html

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

Medicare FFS Claims Processing Guidance for Implementing ICD-10

MLN Matters® Number: MM7492
Related Change Request (CR) #: 7492
Related CR Release Date: August 19, 2011
Related CR Transmittal #: R950OTN
Effective Date: October 1, 2013
Implementation Date: January 1, 2012

Provider Types Affected

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

Provider Action Needed

For dates of service on and after October 1, 2013, entities covered under the Health Insurance Portability and Accountability Act (HIPAA) are required to use the ICD-10 code sets in standard transactions adopted under HIPAA. The HIPAA standard health care claim transactions are among those for which ICD-10 codes must be used for dates of service on and after October 1, 2013. Make sure your billing and coding staffs are aware of these changes.

Key Points of CR7492

- **General Reporting of ICD-10**
  As with ICD-9 codes today, providers and suppliers are still required to report all characters of a valid ICD-10 code on claims. ICD-10 diagnosis codes have different rules regarding specificity and providers/suppliers are required to submit the most specific diagnosis codes based upon the information that is available at the time. Please refer to http://www.cms.hhs.gov/ICD10 for more information on the format of ICD-10 codes. In addition, ICD-10 Procedure Codes (PCs) will only be utilized by inpatient hospital claims as is currently the case with ICD-9 procedure codes.
- **General Claims Submissions Information**
  ICD-9 codes will no longer be accepted on claims (including electronic and paper) with FROM dates of service (on professional and supplier claims) or dates of discharge/through dates (on institutional claims) on or after October 1, 2013. Institutional claims containing ICD-9 codes for services on or after October 1, 2013, will be Returned to Provider (RTP). Likewise, professional and supplier claims containing ICD-9 codes for dates of services on or after October 1, 2013, will also be returned as unprocessable. You will be required to re-submit these claims with the appropriate ICD-10 code. A claim cannot contain both ICD-9 codes and ICD-10 codes. Medicare will RTP/return as unprocessable all claims that are billed with both ICD-9 and ICD-10 diagnosis codes on the same claim. For dates of service prior to October 1, 2013, submit claims with the appropriate ICD-9 diagnosis code. For dates of service on or after October 1, 2013, submit with the appropriate ICD-10 diagnosis code. Likewise, Medicare will also RTP/return as unprocessable all claims that are billed with both ICD-9 and ICD-10 procedure codeson the same claim. For claims with dates of service prior to October 1, 2013, submit with the appropriate ICD-9 procedure code. For claims with dates of service on or after October 1, 2013, submit with the appropriate ICD-10 procedure code. Remember that ICD-10 codes may only be used for services provided on or after October 1, 2013. Institutional claims containing ICD-10 codes for services prior to October 1, 2013, will be Returned to Provider (RTP). Likewise, professional and supplier claims containing ICD-10 codes for services prior to October 1, 2013, will be returned as unprocessable. Please submit these claims with the appropriate ICD-9 code.
- **Claims that Span the ICD-10 Implementation Date**
  The Centers for Medicare & Medicaid Services (CMS) has identified potential claims processing issues for institutional, professional, and supplier claims that span the implementation date; that is, where ICD-9 codes are effective for the portion of theservices that were rendered on September 30, 2013, and earlier and where ICD-10 codes are effective for the portion of the services that were rendered October 1, 2013, and later. In some cases, depending upon the policies associated with those services, there cannot be a break in service or time (i.e., anesthesia) although the new ICD-10 code set must be used effective October 1, 2013. The following tables provide further guidance to providers for claims that span the periods where ICD-9 and ICD-10 codes may both be applicable.

Table A – Institutional Providers

Bill Type(s)	Facility Type/Services	Claims Processing Requirement	Use FROM or THROUGH Date
11X	Inpatient Hospitals *(incl. TERFHA hospitals, Prospective Payment System (PPS) hospitals, Long Term Care Hospitals (LTCHs), Critical Access Hospitals (CAHs)*	If the hospital claim has a discharge and/ or through date on or after 10/1/13, then the entire claim is billed using ICD-10.	THROUGH
12X	Inpatient Part B Hospital Services	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM
13X	Outpatient Hospital	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM
14X	Non-patient Laboratory Services	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM
18X	Swing Beds	If the [Swing bed or SNF] claim has a discharge and/or through date on or after 10/1/13, then the entire claim is billed using ICD-10.	THROUGH
21X	Skilled Nursing (Inpatient Part A)	If the [Swing bed or SNF] claim has a discharge and/or through date on or after 10/1/13, then the entire claim is billed using ICD-10.	THROUGH
22X	Skilled Nursing Facilities (Inpatient Part B)	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM
23X	Skilled Nursing Facilities (Outpatient)	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM
32X	Home Health (Inpatient Part B)	Allow HHAs to use the payment group code derived from ICD-9 codes on claims which span 10/1/2013, but require those claims to be submitted using ICD-10 codes.	THROUGH

ICD-10 CONT'D

Bill Type(s)	Facility Type/Services	Claims Processing Requirement	Use FROM or THROUGH Date
3X2	Home Health – Request for Anticipated Payment (RAPs)*	* NOTE - RAPs can report either an ICD-9 code or an ICD-10 code based on the one (1) date reported. Since these dates will be equal to each other, there is no requirement needed. The corresponding final claim, however, will need to use an ICD-10 code if the HH episode spans beyond 10/1/2013.	*See Note
34X	Home Health – (Outpatient)	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM
71X	Rural Health Clinics	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM
72X	End Stage Renal Disease (ESRD)	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM
73X	Federally Qualified Health Clinics (*prior to 4/1/10*)	N/A – Always ICD-9 code set.	N/A
74X	Outpatient Therapy	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM
75X	Comprehensive Outpatient Rehab facilities	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM
76X	Community Mental Health Clinics	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM

Bill Type(s)	Facility Type/Services	Claims Processing Requirement	Use FROM or THROUGH Date
77X	Federally Qualified Health Clinics (*effective 4/4/10*)	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM
81X	Hospice- Hospital	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM
82X	Hospice – Non hospital	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM
83X	Hospice – Hospital Based	N/A	N/A
85X	Critical Access Hospital	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM

Table B - Special Outpatient Claims Processing Circumstances

Scenario	Claims Processing Requirement	Use FROM or THROUGH Date
3-day /1-day Payment Window	Since all outpatient services (with a few exceptions) are required to be bundled on the inpatient bill if rendered within three (3) days of an inpatient stay; if the inpatient hospital discharge is on or after 10/1/2013, the claim must be billed with ICD-10 for those bundled outpatient services.	THROUGH

Table C – Professional Claims

Type of Claim	Claims Processing Requirement	Use FROM or THROUGH Date
All anesthesia claims	Anesthesia procedures that begin on 9/30/13 but end on 10/1/13 are to be billed with ICD-9 diagnosis codes and use 9/30/13 as both the FROM and THROUGH date.	FROM

Table D –Supplier Claims

Supplier Type	Claims Processing Requirement	Use FROM or THROUGH/TO Date
DMEPOS	Billing for certain items or supplies (such as capped rentals or monthly supplies) may span the ICD-10 compliance date of 10/1/13 (i.e., the FROM date of service occurs prior to 10/1/13 and the TO date of service occurs after 10/1/13).	FRO

ICD-10 CONT'D

Additional Information

The official instruction, CR7492 issued to your carrier, FI, RHHI, or MAC regarding this change may be viewed at http://www.cms.gov/Transmittals/downloads/R950OTN.pdf on the CMS website.

New Podcasts Available from Four Popular CMS ICD-10 National Provider Calls

Limited on time? CMS has created podcasts from four popular National Provider Calls on ICD-10. These podcasts are perfect for use in the office, on the go in your car, or on your portable media player or smart phone. Listen to all of the podcasts from a call or just the ones that fit your needs.

- "CMS ICD-10 Conversion Activities" – Wednesday, May 18, 2011
- "Preparing for ICD-10 Implementation in 2011" – Wednesday, January 12, 2011
- "Basic Introduction to ICD-10-CM" – Tuesday, March 23, 2010
- "ICD-10-CM/PCS Implementation and General Equivalence Mappings (Crosswalks)" – Tuesday, May 19, 2009

To access these podcasts, select the links above or visit the CMS Sponsored ICD-10 Teleconferences webpage at http://www.CMS.gov/ICD10/Tel10/list.asp; select a call date from the list of previous National Provider Calls to access related presentation materials, audio recordings, and written transcripts.

MEDICARE SECONDARY PAYER

Delay in Implementation of Automated MSP Adjustments

On Friday, July 1, 2011, CMS implemented change request (CR) 6625 that created a systematic process in which Medicare automatically reopens/adjusts certain Medicare Secondary Payer (MSP) claims when a beneficiary's MSP claims record was deleted or an end date was applied to an open beneficiary MSP record. This automated process no longer required physicians, providers, and suppliers to contact their Medicare contractors to adjust or reprocess these types of MSP claims. CMS informed physicians, providers, and suppliers of these changes through a listserv message.

Due to systems issues currently affecting CR 6625, CMS directed its A/B Medicare Administrative Contractors, Durable Medical Equipment Medicare Administrative Contractors, and legacy contractors (FIs and Carriers) to immediately suspend all actions on this CR. This means that our Medicare contractors are unable to automatically reopen/adjust claims when Medicare takes action to delete or terminate a previously existing MSP record. Physicians, providers, and suppliers must revert to the pre-July 1 process and contact their Medicare contractor to request re-openings/adjustments of claims that were previously considered MSP. Therefore, if you have claims that were processed since July 1 that need to be reopened/ adjusted due to Medicare now being the primary payer, you should contact your local Medicare contractor to request that action.

CMS will alert physicians, providers, and suppliers once the current issues tied to the implementation of CR 6625 have been resolved.

MODIFIERS

KB and 99 Modifiers-More than Four Modifiers

Effective November 1, 2011, if modifiers KB or 99 are used incorrectly, i.e., used with three or fewer modifiers, claims will be rejected as unprocessable and suppliers will need to resubmit.

When a supplier uses more than four modifiers, the KB or 99 must be added as the fourth modifier to the HCPCS code. On paper claims, the remainder of the modifiers must be listed in Item 19 with an indicator as to which line the modifiers apply. On electronic claims, the remainder should be entered in the NTE segment, the 2400 loop. It is only appropriate to use the modifier KB or 99 when there is a need to use more than four modifiers on the claim line.

KB Beneficiary requested upgrade for ABN, more than four modifiers identified on claim.

99 Modifier overflow

The KB modifier only applies to beneficiary upgraded claims for DMEPOS where the supplier obtained an Advance Beneficiary Notice of Noncoverage (ABN) and there are more than four modifiers on the claim line. The 99 modifier is used in any other situation when a claim line has more than four modifiers.

NEBULIZERS

Reminder - Ultrasonic/Electronic Aerosol Generator With Small Volume Nebulizer – Coding Verification Review Requirement

Recently it was brought to the attention of the Durable Medical Equipment Medicare Administrative Contractors (DME MAC) that suppliers and pharmacies are billing code E0574 (ULTRASONIC/ELECTRONIC AEROSOL GENERATOR WITH SMALL VOLUME NEBULIZER). The article published by the DME MACs on November 4, 2010, titled "Ultrasonic/Electronic Aerosol Generator with Small Volume Nebulizer – Coding Verification Review Requirement" (see https://www.dmepdac.com/resources/articles/2010/11_04_10.html) required:

Effective for claims with dates of service on or after April 1, 2011, the only products which may be billed to Medicare using code E0574 (Ultrasonic/Electronic Aerosol Generator With Small Volume Nebulizer) are those for which a written coding verification has been made by the Pricing, Data Analysis, and Coding (PDAC) contractor and that are listed in the Product Classification Matrix of the DME Coding System (DMECS) maintained on the PDAC website, https://www.dmepdac.com/dmecsapp/do/search.

Code E0574 and related accessories are reasonable and necessary to administer treprostinil inhalation solution (J7686) only. To date only one ultrasonic nebulizer has been approved to use code E0574 – Optineb-ir Model ON-100/7 (NebuTec, GmbH). There are no other nebulizers that are authorized to bill the DME MACs using code E0574. Suppliers billing for ultrasonic nebulizers not listed in the Product Classification Matrix of the DME Coding System (DMECS) must contact the PDAC for proper coding instructions.

With the exception of the Optineb-ir®, no other ultrasonic nebulizers have received approval to use code E0574 through the coding verification review process. Suppliers of ultrasonic nebulizers other than the Optineb-ir® who have incorrectly coded these items and had paid claims for E0574 with dates of service on or after April 1, 2011, should submit a voluntary refund. In addition, voluntary refunds should be submitted for paid claims for inhalation medications used in conjunction with an E0574 nebulizer.

The PDAC coding verification application required for these products is the DME and Supplies application. This application is located on the PDAC website here: https://www.dmepdac.com/review/apps_check.html. If you have questions please contact the PDAC Contact Center at (877) 735-1326 during the hours of 8:30 a.m. to 4:00 p.m. CT, Monday through Friday, or e-mail the PDAC by completing the DME PDAC Contact Form located on the PDAC website here: www.dmepdac.com. Once products are coded by the PDAC, they will be listed in the Product Classification Matrix on DMECS.

Widespread Prepayment Review for Nebulizers Edit Effectiveness for the 3rd Quarter

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

The results of the review of the claims identified 4,262 claims of which 2,889 were denied. This resulted in an overall error rate of 67%. This is an increase from 50% during the first quarter and 56% during the second 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:

- No valid written order
  a. No written order submitted with the documentation
  b. Insufficient or incomplete order
- No beneficiary evidence of exhaustion
- No medical documentation to support medical necessity
- Requested documentation was not provided within the allotted time frame as referenced in the Medicare guidelines

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

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

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

  The order for any drug must clearly specify the type of solution to be dispensed to the patient and the administration instructions for that solution. The type of solution is described by a combination of: (a) the name of the drug and the concentration of the drug in the dispensed solution and the volume of solution in each container, or (b) the name of the drug and the number of milligrams/grams of drug in the dispensed solution and the volume of solution in that container.
- The pharmacist is responsible for assessing how much inhalation solution a patient is actually using. Considering this information, the pharmacist is responsible for assuring that the patient has used almost all of his/her supply on hand prior to dispensing a new supply. As referenced in the Program Integrity Manual (Internet-Only Manual, CMS Pub. 100-8, Chapter 4.26.1) "Contact with the beneficiary or designee regarding refills should take place no sooner than approximately 7 days prior to the delivery/shipping date. For subsequent deliveries of refills, the supplier should deliver the DMEPOS product no sooner than approximately 5 days prior to the end of usage for the current product."
- Section 1833(e) of the Social Security Act precludes payment to any provider of services unless "there has been furnished such information as may be necessary in order to determine the amounts due such provider." It is expected that the patient's medical records will reflect the need for the care provided. The patient's medical records include the physician's office records, hospital records, nursing home records, home health agency records, records from other healthcare professionals and test reports. This documentation must be available upon request.
- A large number of suppliers failed to respond to our request for records.Suppliers are in violation of Supplier Standard #28 when, upon request, they fail to provide requested documentation to a Medicare contractor. Medicare regulations (42 C.F.R §424.516[f]) stipulate that a supplier is required to maintain documentation for seven years from the date of service and, upon the request of CMS or a Medicare contractor, provide access to that documentation. Therefore, the consequences of failure to provide records may not only be a claim denial but also referral to the NSC.

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

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

Charcot Restraint Orthotic Walker - CROW Boot – Coding Update

A new Healthcare Common Procedure Coding System (HCPCS) code been established for the Charcot Restraint Orthotic Walker (CROW), effective for claims with dates of service on or after January 1, 2011.

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

The information in this coding article supersedes and replaces instructions in the previous coding article for the Charcot Restraint Orthotic Walker published by the PDAC on August 19, 2009, https://www.dmepdac.com/resources/articles/2009/08_19_09.html. The Charcot Restraint Orthotic Walker, also referred to as CROW boot or walker, was developed for patients with severe deformity of the foot and ankle due to a sensory neuropathic arthropathy, most commonly caused by diabetes. The device is a bi-valved copolymer full foot enclosure, totally encapsulated around the ankle and foot with a rocker bottom sole built into the device. The orthosis is custom fabricated to a positive model made from an impression of the patient's affected limb. It is fully lined and uses a custom foot insert. Appropriate modifications are performed to the impression, which permits for equal weight distribution through the limb and provides support of the ankle joint, tibia, and fibula. The CROW boot can be modified to accommodate changes by flaring, adding padding, and trimming where and when appropriate.

No other codes may be billed for a CROW boot. There is no separate billing for any modifications, fitting, or adjustments.

When these products are used solely to treat edema or ulcers, or to prevent an ulcer of the lower extremity, suppliers should code them based on the patient's condition. HCPCS code A9283 (Foot pressure off loading/ supportive device, any type, each) was developed to describe various devices used for the treatment of edema or for a lower extremity ulcer or for the prevention of ulcers. If the CROW boot is used for these conditions and the patient does not have Charcot arthropathy, then it should be coded A9283.

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

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

NORIDIAN® Administrative Services LLC

Medicare

August 2011

Documentation of Artificial Limbs

Dear Physician,

The Durable Medical Equipment Medical Administrative Contractors (DME MAC) have jurisdiction for processing claims from prosthetists for artificial limbs. In the event of an audit, the Medicare contractor may request medical records to demonstrate that the prosthetic arm or leg was reasonable and necessary. Since the prosthetist is a supplier, the prosthetist's records must be corroborated by the information in your patient's medical record. It is the treating physician's records, not the prosthetist's, which are used to justify payment.

The patient's functional capabilities are crucial to establishing the medical necessity for a prosthetic device. Many prosthetic components are restricted to specific functional levels; therefore, it is critical that physicians thoroughly document the functional capabilities of their patients, both before and after amputation. Clinical assessments of a patient's rehabilitation potential must be based on the following classification levels:

> **Level 0:** Does not have the ability or potential to ambulate or transfer safely with or without assistance and a prosthesis does not enhance their quality of life or mobility.
>
> **Level 1:** Has the ability or potential to use a prosthesis for transfers or ambulation on level surfaces at fixed cadence. Typical of the limited and unlimited household ambulator.
>
> **Level 2**: Has the ability or potential for ambulation with the ability to traverse low level environmental barriers such as curbs, stairs or uneven surfaces. Typical of the limited community ambulator.
>
> **Level 3:** Has the ability or potential for ambulation with variable cadence. Typical of the community ambulator who has the ability to traverse most environmental barriers and may have vocational, therapeutic, or exercise activity that demands prosthetic utilization beyond simple locomotion.
>
> **Level 4**: Has the ability or potential for prosthetic ambulation that exceeds basic ambulation skills, exhibiting high impact, stress, or energy levels. Typical of the prosthetic demands of the child, active adult, or athlete.

The records must document the patient's current functional capabilities and his/her expected functional potential, including an explanation for the difference. Note that it is recognized, within the functional classification hierarchy, that bilateral amputees often cannot be strictly bound by functional level classifications.

The physician's assessment of a patient's physical and cognitive capabilities typically includes:

- History of the present condition(s) and past medical history that is relevant to functional deficits
- Symptoms limiting ambulation or dexterity
- Diagnoses causing these symptoms
- Other co-morbidities relating to ambulatory problems or impacting the use of a new prosthesis
- What ambulatory assistance (cane, walker, wheelchair, caregiver) is currently used (either in addition to the prosthesis or prior to amputation)
- Description of activities of daily living and how impacted by deficit(s)
- Physical examination that is relevant to functional deficits
- Weight and height, including any recent weight loss/gain

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- Cardiopulmonary examination
- Musculoskeletal examination
  - Arm and leg strength and range of motion
- Neurological examination
  - Gait
  - Balance and coordination

The assessment points above are not all-inclusive and physicians should tailor their history and examination to the individual patient's condition, clearly describing the pre and post-amputation capabilities of the patient. The history should paint a picture 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 or upper extremity difficulties or impact on the patient's functional ability.

Note that when physicians are unable to provide the requested documentation to the supplier, the suppliers receive denials for the items billed which could result in your patient being financially responsible for all or part of the charges for the items/service received. If a supplier contacts your office to request additional clinical documentation, please partner with the supplier to establish what clinical records are needed to support that the service/item you ordered is medically necessary.

Section 1842(p)(4) of the Social Security Act mandates that:

> ***[i]n case of an item or service…ordered by a physician or a practitioner…but furnished by another entity, if the Secretary (or fiscal agent of the Secretary) requires the entity furnishing the item or service to provide diagnostic or other medical information in order for payment to be made to the entity, the physician or practitioner shall provide that information to the entity at the time that the item or service is ordered by the physician or practitioner.***

Providing medical records to the supplier is not a violation of the HIPAA Privacy Rule. Thank you for your cooperation in future documentation requests.

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

Widespread Prepayment Review for Oxygen and Oxygen Equipment - Edit Effectiveness for 5th Quarter

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

The results of the review of the claims 3,123 identified claims of which 1,989 were denied. This resulted in an overall error rate of 61%. This is an increase from 50% during the fourth quarter of this review. However, because the error rate remains high, NAS will continue with the widespread complex review for the above mentioned oxygen equipment with future reporting on each HCPCS code individually.

The following are the top four reasons for denial:

- Requested documentation was not provided within the allotted time frame as referenced in the Medicare guidelines
- No office visit notes to determine medical necessity within 30 days of certification or 90 days within recertification were submitted
- No/invalid qualifying blood gas study submitted
- No documentation to support diagnosis
- No documentation to support alternative treatment has been tried/considered

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

- 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.
- 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.
- In this policy, the term blood gas study includes both an oximetry test and an arterial blood gas test.
  Group I criteria include any of the following:

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

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

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

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

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

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

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

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

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

PAP DEVICES

Widespread Prepayment Probe Review Results for Continuous Positive Airway Pressure Devices (E0601)

The DME MAC Jurisdiction D has completed the widespread prepayment review of claims for Continuous Positive Airway Pressure Devices (E0601) for the first month of billing (KH modifier). This review was initiated based on the results of Comprehensive Error Rate Testing (CERT) review analysis.

A total of 100 claims were developed for additional documentation. Responses to the Additional Documentation Request (ADR) were not received for 17 of the claims. Of the 83 claims for which responses were received, 49 claims were allowed and 34 were denied. The error rate, calculated by taking the total denied allowance amount (dollar amount of allowable charges for services determined to be billed in error) and dividing it by the total allowance amount of services medically reviewed, was 51%. Based on the results of this prepayment review, DME MAC D will close this review for Continuous Positive Airway Pressure Devices.

The following are the top reasons for denial:

- 27% of denied claims did not have documentation supporting a face-to-face evaluation prior to the sleep test to assess for obstructive sleep apnea. (criteria A of LCD L171)
- 23% of claims were denied as requested documentation was not provided within the allotted time frame as referenced in the Medicare guidelines
- 19% of denied claims were denied for invalid physician orders
  a. No written or verbal order received
  b. Order not dated
  c. Date of physician signature was after the date of service with no verbal/dispensing order provided
  d. There were incomplete or missing elements
- 7% of denied claims did not have a Medicare-covered sleep test that met criteria 1 or 2 per LCD L171.

Explanation and information regarding the denial reasons are as follows:

- There were a number of claims that were submitted without an initial face-to-face evaluation or the documentation provided did not contain information regarding symptoms of suspected obstructive sleep apnea.

  In regards to the initial face-to-face clinical evaluation prior to the sleep test to assess for obstructive sleep apnea (criteria A) per LCD L171:

  Physicians shall document the face-to-face clinical evaluations and re-evaluations in a detailed narrative note in their charts in the format that they use for other entries. For the initial evaluation, the report would commonly document pertinent information about the following elements, but may include other details. Each element would not have to be addressed in every evaluation.

  History: signs and symptoms of sleep disordered breathing including, snoring, daytime sleepiness, observed apneas, choking or gasping during sleep, morning headaches; duration of symptoms, validate sleep hygiene inventory such as the Epworth Sleepiness Scale

  Physical Exam: focused cardiopulmonary and upper airway system evaluation, neck circumference, body mass index (BMI)
- A 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.

PAP DEVICES CONT'D

- A number of claims did not provide a valid order for the billed items.

  The supplier for all durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) is required to keep on file a physician prescription (order). The treating physician must sign and date the order. A supplier must have an order from the treating physician before dispensing any DMEPOS item to a beneficiary.

  It's important to remember that if an item is dispensed based on a verbal order and a written order is provided afterwards, both orders must be retained. It is not adequate to only have a written order after dispensing an item. There must be documentation to show the verbal order was received prior to dispensing the item.

  The elements required on all written orders are:

  - Beneficiary name; and
  - Detailed description of item (either a narrative description or a brand name/model number); and
  - All options and accessories that will be billed separately or which require an upgraded code; and
  - Signature of the treating physician and the date the order is signed; and
  - Initial date of need or start date.

- Documentation provided did not support a qualifying sleep test per Medicare coverage guidelines.

  The patient must have had a Medicare-covered sleep test that meets either of the following criteria (1 or 2):

  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.

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Positive Airway Pressure (PAP) Devices for the Treatment of Obstructive Sleep Apnea Local Coverage Determination(LCD) L171 and Policy Article A19827. Suppliers can also review the PAP devices resources and publications on the NAS website at https://www.noridianmedicare.com/dme/news/pap_devices.html%3f.

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

Edits on Ordering/Referring Providers in Medicare Part B Claims

MLN Matters Number: SE1011 Revised

Note: This article was revised on August 15, 2011, to delete doctors of chiropractic medicine from the list of providers on page 3 who are eligible to order and refer items or services for Medicare beneficiaries. This article was revised on November 26, 2010 to include the following statement: The Centers for Medicare & Medicaid Services (CMS) previously announced that, beginning January 3, 2011, if certain Part B billed items and services require an ordering/referring provider and the ordering/referring provider is not in the claim, is not of a profession that is permitted to order/refer, or does not have an enrollment record in the Medicare Provider Enrollment, Chain and Ownership System (PECOS), the claim will not be paid. The automated edits will not be turned on effective January 3, 2011.

Provider Types Affected

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

Provider Action Needed

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

What Providers Need to Know

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

Phase 2: Beginning January 3, 2011 (See statement on page one delaying implementation of phase 2.), Medicare will reject Part B claims that fail the Ordering/Referring Provider edits. Physicians and others who are eligible to order and refer items or services need to establish their Medicare enrollment records in PECOS and must be of a specialty that is eligible to order and refer.

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

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

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

Background

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

- Below are examples of some of these types of claims:
  - Claims from laboratories for ordered tests;
  - Claims from imaging centers for ordered imaging procedures;
  - Claims from suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) for ordered

DMEPOS; and

- Claims from specialists or specialty groups for referred services.

- Only physicians and certain types of non-physician practitioners are eligible to order or refer items or services for Medicare beneficiaries. They are as follows:
  - Physician (doctor of medicine or osteopathy, doctor of dental medicine, doctor of dental surgery, doctor of podiatric medicine, doctor of optometry),
  - Physician Assistant,
  - Certified Clinical Nurse Specialist,
  - Nurse Practitioner,
  - Clinical Psychologist,
  - Certified Nurse Midwife, and
  - Clinical Social Worker.

Questions and Answers Relating to the Edits

1. *What will the edits do?*
   The edits will determine if the Ordering/Referring Provider (when required to be identified in a Part B claim) (1) has a current Medicare enrollment record (i.e., the enrollment record is in PECOS and it contains the National Provider Identifier (NPI)), and (2) is of a type that is eligible to order or refer for Medicare beneficiaries (see list above).

2. *Why did Medicare implement these edits?*
   These edits help protect Medicare beneficiaries and the integrity of the Medicare program.

3. *How and when will these edits be implemented?*
   These edits are being implemented in two phases:

   - **Phase 1** began on October 5, 2009, and is scheduled to end on January 2, 2011. In Phase 1, if the Ordering/Referring Provider does not pass the edits, the claim will be processed and paid (assuming there are no other problems with the claim) but the Billing Provider (the provider who furnished the item or service that was ordered or referred) will receive an informational message1 from Medicare in the Remittance Advice2.

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

     Note: if the billed service requires an ordering/referring provider and the ordering/referring provider is not on the claim, the claim will not be paid.

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

CMS has taken actions to reduce the number of informational messages. In December 2009, CMS added the NPIs to more than 200,000 PECOS enrollment records of physicians and non-physician practitioners who are eligible to order and refer but who had not updated their PECOS enrollment records with their NPIs.3

On January 28, 2010, CMS made available to the public, via the Downloads section of the "Ordering Referring Report" page on the Medicare provider/supplier enrollment website, a file containing the NPIs and the names of physicians and non-physician practitioners who have current enrollment records in PECOS and are of a type/specialty that is eligible to order and refer. The file, called the Ordering Referring Report, lists, in alphabetical order based on last name, the NPI and the name (last name, first name) of the physician or non-physician practitioner. To keep the available information up to date, CMS will replace the Report on a periodic basis. At any given time, only one Report (the most current) will be available for downloading. To learn more about the Report, and to download it, go to http://www.cms.gov/MedicareProviderSupEnroll; click on "Ordering Referring Report" (on the left). Information about the Report will be displayed.

1 The informational messages vary depending on the claims processing system.

2 DMEPOS suppliers who submit paper claims will not receive an informational message on the Remittance Advice.

3 NPIs were added only when the matching criteria verified the NPI.

Effect of Edits on Providers

A. I order and refer. How will I know if I need to take any sort of action with respect to these two edits?

In order for the claim from the Billing Provider (the provider who furnished the item or service) to be paid by Medicare for furnishing the item or service that you ordered or referred, you—the **Ordering/Referring Provider—need to ensure that**:

1. You have a current Medicare enrollment record (that is, your enrollment record is in PECOS and it includes your NPI).
   - If you enrolled in Medicare after 2003, your enrollment record is in PECOS and CMS may have added your NPI to it.
   - If you enrolled in Medicare prior to 2003 but submitted an update(s) to your enrollment information since 2003, your enrollment record is in PECOS and CMS may have added your NPI to it.
   - If you enrolled in Medicare prior to 2003 and have not submitted an update to your Medicare enrollment information in 6 or more years, you do not have an enrollment record in PECOS. **You need to take action to establish one. See the last bullet in this section.**
   - If you are not sure, you may: (1) check the Ordering Referring Report mentioned above, and if you are on that report, you have a current enrollment record in Medicare (that is, your enrollment record is in PECOS and it contains your NPI); (2) contact your designated Medicare enrollment contractor and ask if you have an enrollment record in PECOS that contains the NPI; or (3) use Internet-based PECOS to look for your PECOS enrollment record (if no record is displayed, you do not have an enrollment record in PECOS). If you choose (3), please read the information on the Medicare provider/supplier enrollment web page about Internet-based PECOS before you begin.
   - **If you do not have an enrollment record in PECOS**:
     - You need to submit an enrollment application to Medicare in one of two ways:
       a. **Use Internet-based PECOS** to submit your enrollment application over the Internet to your designated Medicare enrollment contractor. You will have to print, sign, and date the Certification Statement and mail the Certification Statement, and any required supporting paper documentation, to your designated Medicare enrollment contractor. The designated enrollment contractor cannot begin working on your application until it has received the signed and dated Certification Statement. If you will be using Internet-based PECOS, please visit the Medicare provider/supplier enrollment web page to learn more about the web-based system before you attempt to use it. Go to http://www.cms.gov/MedicareProviderSupEnroll, click on "Internet-based PECOS" on the left-hand side, and read the information that has been posted there. Download and read the documents in the Downloads Section on that page that relate to physicians and non-physician practitioners. A link to Internet-based PECOS is included on that web page.

Note for physicians/non-physician practitioners who reassign all their Medicare benefits to a group/clinic: If you reassign all of your Medicare benefits to a group/clinic, the group/clinic must have an enrollment record in PECOS in order for you to enroll via the web. You should check with the officials of the group/clinic or with your designated Medicare enrollment contractor if you are not sure if the group/clinic has an enrollment record in PECOS. If the group/clinic does not have an enrollment record in PECOS, you will not be able to use the web to submit your enrollment application to Medicare. You will need to submit a paper application, as described in the bullet below.

b. **Obtain a paper enrollment application (CMS-855I)**, fill it out, sign and date it, and mail it, along with any required supporting paper documentation, to your designated Medicare enrollment contractor. If you reassign all your Medicare benefits to a group/clinic, you will also need to fill out, sign and date the CMS-855R, obtain the signature/date signed of the group's Authorized Official, and mail the CMS-855R, along with the CMS-855I, to the designated Medicare enrollment contractor. Enrollment applications are available for downloading from the CMS forms page (http://www.cms.gov/cmsforms) or by contacting your designated Medicare enrollment contractor.

Note about physicians/non-physician practitioners who have opted-out of Medicare but who order and refer: Physicians and non-physician practitioners who have opted out of Medicare may order items or services for Medicare beneficiaries. Their opt-out information must be current (an affidavit must be completed every 2 years, and the NPI is required on the affidavit). Opt-out practitioners whose affidavits are current should have enrollment records in PECOS that contain their NPIs.

2. You are of a type/specialty that can order or refer items or services for Medicare beneficiaries. When you enrolled in Medicare, you indicated your Medicare specialty. Any physician specialty and only the non-physician practitioner specialties listed above in this Article are eligible to order or refer in the Medicare program.

B. I bill Medicare for items and services that were ordered or referred. How can I be sure that my claims for these items and services will pass the Ordering/Referring Provider edits?

As the Billing Provider, you need to ensure that your Medicare claims for items or services that you furnished based on orders or referrals will pass the two edits on the Ordering/Referring Provider so that you will not receive informational messages in Phase 1 and so that your claims will be paid in Phase 2.

You need to use due diligence to ensure that the physicians and non-physician practitioners from whom you accept orders and referrals have current Medicare enrollment records (i.e., they have enrollment records in PECOS that contain their NPIs) and are of a type/specialty that is eligible to order or refer in the Medicare program. If you are not sure that the physician or non-physician practitioner who is ordering or referring items or services meets those criteria, it is recommended that you check the Ordering Referring Report described earlier in this article. Ensure you are correctly spelling the Ordering/Referring Provider's name. If you furnished items or services from an order or referral from someone on the Ordering Referring Report, your claim should pass the Ordering/Referring Provider edits. Keep in mind that this Ordering Referring Report will be replaced about once a month to ensure it is as current as practicable. It is possible, therefore, that you may receive an order or a referral from a physician or non-physician practitioner who is not listed in the Ordering Referring Report but who may be listed on the next Report. You may resubmit a claim that did not initially pass the Ordering/Referring Provider edits.

Make sure your claims are properly completed. Do not use "nicknames" on the claim, as their use could cause the claim to fail the edits (e.g., Bob Jones instead of Robert Jones will cause the claim to fail the edit, as the edit will look for R, not B, as the first letter of the first name). Do not enter a credential (e.g., "Dr.") in a name field. On paper claims (CMS-1500), in item 17, you should enter the Ordering/Referring Provider's first name first, and last name second (e.g., John Smith). Ensure that the name and the NPI you enter for the Ordering/Referring Provider belong to a physician or non-physician practitioner and not to an organization, such as a group practice that employs the physician or non-physician practitioner who generated the order or referral. Make sure that the qualifier in the electronic claim (X12N 837P 4010A1) 2310A NM102 loop is a 1 (person). Organizations (qualifier 2) cannot order and refer. If there are additional questions about the informational messages, Billing Providers should contact their local carrier, A/B MAC, or DME MAC.

Billing Providers should be aware that claims that are rejected because they failed the Ordering/Referring Provider edits are not denials of payment by Medicare that would expose the Medicare beneficiary to liability. Therefore, **an Advance Beneficiary Notice is not appropriate**.

Additional Guidance

1. **Orders or referrals by interns or residents**. Interns are not eligible to enroll in Medicare because they do not have medical licenses. Unless a resident (with a medical license) has an enrollment record in PECOS, he/she may not be identified in a Medicare claim as the Ordering/Referring Provider. The teaching, admitting, or supervising physician is considered the Ordering/Referring Provider when interns and residents order and refer, and that physician's name and NPI would be reported on the claim as the Ordering/Referring Provider.

2. **Orders or referrals by physicians and non-physician practitioners who are of a type/specialty that is eligible to order and refer who work for the Department of Veterans Affairs (DVA), the Public Health Service (PHS), or the Department of Defense(DoD)/Tricare**. These physicians and non-physician practitioners will need to enroll in Medicare in order to continue to order or refer items or services for Medicare beneficiaries. They may do so by filling out the paper CMS-855I or they may use Internet-based PECOS. They must include a covering note with the paper application or with the paper Certification Statement that is generated when submitting a web-based application that states that they are enrolling in Medicare only to order and refer. They will not be submitting claims to Medicare for services they furnish to Medicare beneficiaries.

3. **Orders or referrals by dentists**. Most dental services are not covered by Medicare; therefore, most dentists do not enroll in Medicare. Dentists are a specialty that is eligible to order and refer items or services for Medicare beneficiaries (e.g., to send specimens to a laboratory for testing). To do so, they must be enrolled in Medicare. They may enroll by filling out the paper CMS-855I or they may use Internet-based PECOS. They must include a covering note with the paper application or with the paper Certification Statement that is generated when submitting a web-based application that states that they are enrolling in Medicare only to order and refer. They will not be submitting claims to Medicare for services they furnish to Medicare beneficiaries.

Additional Information

You may want to review the following related CRs:

- CR 6417 at http://www.cms.gov/Transmittals/downloads/R825OTN.pdf on the CMS website;
- CR 6421 at http://www.cms.gov/Transmittals/downloads/R823OTN.pdf on the CMS website; and
- CR 6696 at http://www.cms.gov/Transmittals/downloads/R328PI.pdf on the CMS website.

Expansion of Current Scope of Editing for Ordering/Referring Providers for Claims Processed by Medicare Carriers and Part B MACs

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

Note: This article was revised on August 15, 2011, to delete chiropractors from the list of providers on page 2 who may order and/or refer. All other information remains the same. In the near future, CR6417 will be revised to remove chiropractors from that CR's list of providers who may order and/or refer. Also remember that the Centers for Medicare & Medicaid Services has not yet decided when it will begin to reject claims if an ordering/referring provider does not have a PECOS record. CMS will give providers ample notice before claim rejections begin. Please note, the implementation and effective dates in this article are different than what is in the related CR. The "To Be Announced" implementation and effective dates in this article are the correct dates.

Provider Types Affected

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

Provider Action Needed

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

Background

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

PECOS CONT'D

The providers who can order/refer are:

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

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

Key Points

- **During Phase 1 (October 5, 2009- until further notice)**: When a claim is received, the MultiCarrier System (MCS) will determine if the ordering/referring provider is required for the billed service. If the ordering/referring provider is not on the national PECOS file and is not on the contractor's master provider file, or if the ordering/referring provider is on the contractor's master provider file but is not of the specialty eligible to order or refer, the claim will continue to process but a message will be included on the remittance advice notifying the billing provider that the claims may not be paid in the future if the ordering/referring provider is not enrolled in Medicare or if the ordering/referring provider is not of the specialty eligible to order or refer.
- **During Phase 2 (Start Date to Be Announced)**: If the billed service requires an ordering/referring provider and the ordering/referring provider is not on the claim, the claim will not be paid. If the ordering/referring provider is on the claim, MCS will verify that the ordering/referring provider is on the national PECOS file. If the ordering/referring provider is not on the national PECOS file, MCS will search the contractor's master provider file for the ordering/referring provider. If the ordering/referring provider is not on the national PECOS file and is not on the contractor's master provider file, or if the ordering/referring provider is on the contractor's master provider file but is not of the specialty eligible to order or refer, the claim will not be paid.
- In **both phases**, Medicare will verify the NPI and the name of the ordering/referring provider reported in the claim against PECOS or, if the ordering/referring provider is not in PECOS, against the claims system. In paper claims, be sure not to use periods or commas within the name of the ordering/referring provider. Hyphenated names are permissible.
- Providers who order and refer may want to verify their enrollment or pending enrollment in PECOS. You may do so by:
  - Using Internet-based PECOS to look for your PECOS enrollment record. (You will need to first set up your access to Internet-based PECOS.) For more information, regarding PECOS enrollment go to http://www.cms.gov/MedicareProviderSupEnroll/Downloads/Instructionsforviewingpractitionerstatus.pdf on the CMS website. If no record is displayed, you do not have an enrollment record in PECOS.
  - Checking the Ordering Referring Report at http://www.cms.gov/MedicareProviderSupEnroll/06_MedicareOrderingandReferring.asp#TopOfPage on the CMS website.
- **I don't have an enrollment record. What should I do?** Internet-based PECOS is the fastest and most efficient way to submit your enrollment application. For instructions, see "Basics of Internet-based PECOS for Physicians and Non-Physician Practitioners" at http://www.cms.gov/MLNProducts/downloads/MedEnroll_PECOS_PhysNonPhys_FactSheet_ICN903764.pdf on the CMS website.

Please Note: The changes being implemented with CR 6417 do not alter any existing regulatory restrictions that may exist with respect to the types of items or services for which some of the provider types listed above can order or refer

or any claims edits that may be in place with respect to those restrictions. Please refer to the Background Section, above, for more details.

Additional Information

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

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

MLN Matters Number: MM6421 Revised
Related Change Request (CR) #: 6421
Related CR Release Date: October 14, 2011
Related CR Transmittal #: R963OTN
Effective Dates: Phase 1 – October 1, 2009
Implementation Date: Phase 1 – October 5, 2009 Phase 2 – To be announced

Note: This article was to reflect a revised CR6421. The CR was revised to delete chiropractors from the list of providers on page 2 who may order and/or refer. As a result, the CR release date transmittal number and Web address for accessing the CR were revised. Also remember that the Centers for Medicare & Medicaid Services has not yet decided when it will begin to reject claims if an ordering/referring provider does not have a PECOS record. CMS will give providers ample notice before claim rejections begin. Please note, the implementation and effective dates in this article are different than what is in the related CR. The "To Be Announced" implementation and effective dates in this article are the correct dates.

Provider Types Affected

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

Provider Action Needed

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

Background

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

The providers who can order/refer are:

- Doctor of Medicine or Osteopathy;
- Dental Medicine;
- Dental Surgery;
- Podiatric Medicine;
- Optometry;
- Physician Assistant;
- Certified Clinical Nurse Specialist;

PECOS CONT'D

- Nurse Practitioner;
- Clinical Psychologist;
- Certified Nurse Midwife; and
- Clinical Social Worker.

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

Key Points

- **During Phase 1 (October 5, 2009- until further notice)**: When a claim is received, Medicare will determine if the ordering/referring provider is required for the billed service. If the ordering/referring provider is not on the claim, the claim will continue to process. If the ordering/referring provider is on the claim, Medicare will verify that the ordering/referring provider is in PECOS and is eligible to order/refer, If the ordering/referring provider is not in PECOS or is in PECOS but is not of the type/specialty to order or refer, the claim will also continue to process.
  1. If the DMEPOS supplier claim is an ANSI X12N 837P standard electronic claim, the DMEPOS supplier will receive a warning message on the Common Electronic Data Interchange (CEDI) GenResponse Report.
  2. If the DMEPOS supplier claim is a paper CMS-1500 claim, the DMEPOS supplier will not receive a warning and will not know that the claim did not pass these edits.
- **During Phase 2 (Start Date to Be Announced)**: If the ordering/referring provider is not on the claim, the claim will not be paid. If the ordering/referring provider is on the claim, Medicare will verify that the ordering/referring provider is in PECOS and eligible to order and refer. **If the ordering/referring provider is not in PECOS or is in PECOS but is not of the specialty to order or refer, the claim will not be paid. It will be rejected**.
  1. If the DMEPOS supplier claim is an ANSI X12N 837P standard electronic claim, the DMEPOS supplier will receive a rejection message on the CEDI GenResponse Report.
  2. If the DMEPOS supplier claim is a paper CMS-1500 claim, the DMEPOS supplier will see the rejection indicated on the Remittance Advice.
- In **both phases**, Medicare will verify the NPI and the name of the ordering/referring provider reported on the ANSI X12N 837P standard electronic claim against PECOS.
- When furnishing names on the paper claims, be sure not to use periods or commas within the name. Hyphenated names are permissible.
- Providers who order and refer may want to verify their enrollment or pending enrollment in PECOS. You may do so by:
  - Using Internet-based PECOS to look for your PECOS enrollment record. (You will need to first set up your access to Internet-based PECOS.) For more information, regarding PECOS enrollment go to http://www.cms.gov/MedicareProviderSupEnroll/Downloads/Instructionsforviewingpractitionerstatus.pdf on the CMS website. If no record is displayed, you do not have an enrollment record in PECOS.
  - Checking the Ordering Referring Report at http://www.cms.gov/MedicareProviderSupEnroll/06_MedicareOrderingandReferring.asp#TopOfPage on the CMS website.
- **I don't have an enrollment record. What should I do?** Internet-based PECOS is the fastest and most efficient way to submit your enrollment application. For instructions, see "Basics of Internet-based PECOS for Physicians and Non-Physician Practitioners" at http://www.cms.gov/MLNProducts/downloads/MedEnroll_PECOS_PhysNonPhys_FactSheet_ICN903764.pdf on the CMS website.

Additional Information

The official instruction, CR6421, issued to your Medicare DME MAC regarding this change, may be viewed at http://www.cms.gov/Transmittals/downloads/R963OTN.pdf on the CMS website.

Refunds to Medicare

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

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

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

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

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

Updated Refunds to Medicare Form

As of August 22, 2011, the Refunds to Medicare form located at https://www.noridianmedicare.com/dme/forms/docs/ref_med_dme.pdf will be updated.

The update is designed to provide suppliers with reminders on how to use the form.

The Refunds to Medicare form is not designed to be used to request offset AFTER the claim has been adjusted and the overpayment letter mailed to the supplier. If you have already received an overpayment letter requesting repayment, please fax a copy of the first page of the overpayment letter with the word "offset" written on it to NAS.

- If the overpayment letter was mailed from NAS, please send the offset request to 701-277-7894.
- If the overpayment letter was mailed from the Recovery Audit Contractor (RAC), HealthDataInsights(HDI), please fax the offset request to 701-277-7896.

If the overpayment is the result of a change to the beneficiary's Certificate of Medical Necessity (CMN) for the item or service, a revised CMN must be on file with NAS. Claims must be processed according to the CMN on file. If there is any doubt as to whether the correct CMN is currently on file, please include the revised CMN with the Refund to Medicare form.

More information on completing the Refund to Medicare form can be found at https://www.noridianmedicare.com/dme/forms/docs/refunds_to_medicare_form_instructions.pdf

CARC, RARC, and MREP and PC Print Update

MLN Matters® Number: MM7514
Related Change Request (CR) #: 7514
Related CR Release Date: September 15, 2011
Related CR Transmittal #: R2304CP
Effective Date: October 1, 2011
Implementation Date: October 3, 2011

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 7514, from which this article is taken, announces the latest update of Claim Adjustment Reason Codes (CARC) and Remittance Advice Remark Codes (RARCs) that are effective on October 1, 2011, for Medicare. It also instructs certain Medicare contractors to update Medicare Remit Easy Print (MREP) and PC Print software. Be sure your billing staffs are aware of these changes.

Background

The reason and remark code sets must be used to report payment adjustments in remittance advice transactions. The reason codes are also used in some Coordination-of-Benefits (COB) transactions. A national code maintenance committee maintains the Healthcare Claim Adjustment Reason Codes (CARCs). The CARC list is updated three times a year in early March, July, and November. The Centers for Medicare & Medicaid Services (CMS) maintains the Remittance Advice Remark Code (RARC) list, which is used by all payers. The RARC list is also updated three times a year in early March, July, and November.

Both code lists are posted on the Washington Publishing Company (WPC) website, available at http://www.wpc-edi.com/Codes on the Internet.

The lists at the end of this article summarize the latest changes to these code lists, as announced in CR7514.

Additional Information

If you use the MREP and/or PC Print software, be sure to obtain an updated copy once it is available.

The official instruction, CR7514, issued to your FI, RHHI, carrier, A/B MAC, and DME MAC regarding this change, may be viewed at http://www.cms.gov/Transmittals/downloads/R2304CP.pdf on the CMS website.

CR 7514 Changes
New Codes – CARC

Code	Current Narrative	Effective Date
237	Legislated/Regulatory Penalty. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	6/5/2011

Modified Codes – CARC
None

Deactivated Codes – CARC
None

New Codes – RARC

Code	Current Narrative	Medicare Initiated
N544	Alert: Although this was paid, you have billed with a referring/ordering provider that does not match our system record. Unless corrected, this will not be paid in the future.	Yes

Code	Current Narrative	Medicare Initiated
N545	Payment reduced based on status as an unsuccessful eprescriber per the Electronic Prescribing (eRx) Incentive Program.	Yes
N546	Payment represents a previous reduction based on the Electronic Prescribing (eRx) Incentive Program.	Yes

Modified Codes – RARC
None

Deactivated Codes – RARC
None

Claim Status Category and Claim Status Codes Update

MLN Matters® Number: MM7585
Related Change Request (CR) #: 7585
Related CR Release Date: September 30, 2011
Related CR Transmittal #: R2314CP
Effective Date: January 1, 2012
Implementation Date: January 3, 2012

Provider Types Affected

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

Provider Action Needed

This article, based on Change Request (CR) 7585, explains that the Claim Status and Claim Status Category Codes for use by Medicare contractors with the Health Care Claim Status Request and Response ASC X12N 276/277 and the Health Care Claim Acknowledgement ASC X12N 277 are updated three times per year at the Committee meeting. These meetings are held in the January/February time frame, again in June and finally in late September or early October, in conjunction with the Accredited Standards Committee (ASC) X12 meetings.

The Committee has decided to allow the industry 6 months for implementation of newly added or changed codes. Medicare contractors will begin using the current codes posted at http://www.wpc-edi.com/codes on the Internet, on or about November 1, 2011. Included in the code lists are specific details, including the date when a code was added, changed, or deleted. All providers are reminded to ensure that their billing staffs are aware of the updated codes and the timeframe for implementations.

Background

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

Additional Informatio

The official instruction, CR7585, issued to your Medicare contractors (FI, RHHI, A/B MAC, DME MAC and carrier) regarding this change, may be viewed at http://www.cms.gov/Transmittals/downloads/R2314CP.pdf on the CMS website.

FCNs on Remittance Advices Appropriately Displaying as of 09/09/2011

As of September 9, 2011, the Financial Control Numbers (FCNs) on remittance advices issued by NAS DME Jurisdiction D are displaying the accurate information. Due to CMS Change Request 7068, the remittance advices issued between July 15 and September 8, 2011 contained invalid information regarding the FCN. The number reported on those remits did not permit the overpayment option of the NAS Interactive Voice Response (IVR) system to function correctly.

Information regarding this remittance advice issue was previously published July 21, 2011; https://www.noridianmedicare.com/dme/news/docs/2011/07_jul/remittance_advice_change_to_financial_control_number_impacting_ivr.html. NAS understands the impact this issue had and we appreciate your patience as the remittance advice changes were made to display the FCNs accurately.

MREP for Version 5010A1

In July 2011, Medicare Remit Easy Print (MREP) software users were notified that version 3.1 was available. Suppliers using the MREP software to print their electronic remittance advice (ERA) will need to upgrade to version 3.1 if they have not already done so. Version 3.1 will translate both the 4010A1 and 5010A1 versions of the ERA file.

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

Once suppliers have downloaded MREP version 3.1, they can request to be setup to receive 5010A1 835 test files or 5010A1 835 production files. Suppliers who use the MREP software are not required to test the 5010A1 835.

- To receive 5010A1 835 ERA test files, complete and submit the Supplier Submitter Action Request form.
- To receive 5010A1 835 ERA production files, complete the 5010/D.0 Production Migration form.
- If you are already receiving the 5010A1 835 file, you will not need to complete any additional forms.

Both forms are located on the CEDI website at http://www.ngscedi.com.

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

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

MREP Software Codes Update

The latest Claim Adjustment Reason Codes and Remittance Advice Remark Codes are available in the Codes.ini file for the Medicare Remit Easy Print (MREP) software. You can access this file in the Zipped folder for "Medicare Remit Easy Print - Version 3.1" at http://www.cms.gov/AccesstoDataApplication/02_MedicareRemitEasyPrint.asp on the CMS website.

Reporting of Recoupment for Overpayment on Remittance Advice with Patient Control Number

MLN Matters® Number: MM7499
Related Change Request (CR) #: CR 7499
Related CR Release Date: August 5, 2011
Related CR Transmittal #: R940OTN
Effective Date: January 1, 2012
Implementation Date: April 2, 2012

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 7499 which instructs Medicare's claims processing systems maintainers to replace the Health Insurance Claim (HIC) number being sent on the ASC X12 Transaction 835) with the Patient Control Number received on the original claim, whenever the electronic remittance advice (ERA) is reporting the recovery of an overpayment.

Background

The Centers for Medicare & Medicaid Services (CMS) generates Health Insurance Portability and Accountability Act (HIPAA) compliant remittance advice that includes enough information to providers so that manual intervention is not needed on a regular basis. CMS changed reporting of recoupment for overpayment on the ERA) as a response to provider request per CR6870 and CR7068. The MLN Matters article corresponding to CR6870 can be reviewed at http://www.cms.gov/MLNMattersArticles/downloads/MM6870.pdf and CR7068 can be reviewed at http://www.cms.gov/transmittals/downloads/R812OTN.pdf on the CMS website.

It has been brought to the attention of CMS that providing the Patient Control Number as received on the original claim rather than the Health Insurance Claim (HIC) number would:

- Enhance provider ability to automate payment posting, and
- Reduce the need for additional communication (via telephone calls, etc.) that would subsequently reduce the costs for providers as well as Medicare.

CR7499 instructs the shared systems to replace the HIC number being sent on the ERA with the Patient Control Number, received on the original claim. The ERA will continue to report the HIC number if the Patient Control Number is not available. This would appear in positions 20-39 of PLB 03-2. A demand letter is also sent to the provider when the Accounts Receivable (A/R) is created. This document contains a claim control number for tracking purposes that is also reported in positions 1-19 of PLB 03-2 on the ERA.

Note: Instructions in CR7499 apply to the 005010A1 version of ASC X12 Transaction 835 only and do not apply to the Standard Paper Remit or the 004010A1 version of ASC X12 Transaction 835.

Additional Information

The official instruction, CR7499, issued to your carrier, FI, A/B MAC, DME MAC, or RHHI regarding this change may be viewed at http://www.cms.gov/Transmittals/downloads/R940OTN.pdf on the CMS website.

SKILLED NURSING FACILITIES

2012 Annual Update of HCPCS Codes for SNF Consolidated Billing Update

MLN Matters® Number: MM7552
Related Change Request (CR) #: CR 7552
Related CR Release Date: August 26, 2011
Related CR Transmittal #: R2286CP
Effective Date: January 1, 2012
Implementation Date: January 3, 2012

Provider Types Affected

Physicians, other providers, and suppliers submitting claims to Medicare contractors (carriers, Durable Medical Equipment Medicare Administrative Contractors (DME MACs), Fiscal Intermediaries (FIs), and/or A/B Medicare Administrative Contractors (A/B MACs)) for services provided to Medicare beneficiaries who are in a Part A covered Skilled Nursing Facility (SNF) stay.

What You Need to Know

This article is based on Change Request (CR) 7552 which provides the 2012 annual update of Healthcare Common Procedure Coding System (HCPCS) Codes for Skilled Nursing Facility Consolidated Billing (SNF CB) and how the updates affect edits in Medicare claims processing systems.

By the first week in December 2011:

- Physicians and other providers/suppliers who bill carriers, DME MACs, or A/B MACs are advised that new code files (entitled 2012 Carrier/A/B MAC Update) will be posted at http://www.cms.hhs.gov/SNFConsolidatedBilling/ on the Centers for Medicare & Medicaid Services (CMS) website; and
- Providers who bill Fiscal Intermediaries or A/B MACs are advised that new Excel and PDF files (entitled 2011 FI/A/B MAC Update) will be posted to http://www.cms.hhs.gov/SNFConsolidatedBilling/ on the CMS website.

It is **important and necessary** for the provider community to view the "General Explanation of the Major Categories" PDF file located at the bottom of each year's FI/A/B MAC update in order to understand the Major Categories, including additional exclusions not driven by HCPCS codes.

Background

Medicare's claims processing systems currently have edits in place for claims received for beneficiaries in a Part A covered SNF stay as well as for beneficiaries in a non-covered stay. Changes to HCPCS codes and Medicare Physician Fee Schedule designations are used to revise these edits to allow carriers, A/B MACs, DME MACs, and FIs to make appropriate payments in accordance with policy for Skilled Nursing Facility Consolidated Billing (SNF CB) contained in the "Medicare Claims Processing Manual" (Chapter 6, Section 110.4.1 for carriers and Chapter 6, Section 20.6 for FIs) which is available at http://www.cms.gov/manuals/downloads/clm104c06.pdf on the CMS website.

Please note that these edits only allow services that are excluded from CB to be separately paid by Medicare contractors.

Additional Information

You can find the official instruction, CR7552, issued to your carrier, FI, A/B MAC, or DME MAC by visiting http://www.cms.gov/Transmittals/downloads/R2286CP.pdf on the CMS website.

Results of Widespread Prepayment Review for Group 2 Pressure Reducing Support Surfaces

The DME MAC Jurisdiction D has completed the widespread prepayment review of claims for Pressure Reducing Support Surfaces (E0277). This review was initiated based on the results of Comprehensive Error Rate Testing (CERT) review analysis.

A total of 100 claims were developed for additional documentation. Responses to the Additional Documentation Request (ADR) were not received for 29 of the claims. Of the 71 claims for which responses were received, 18 claims were allowed and 53 were denied. The error rate, calculated by taking the total denied allowance amount (dollar amount of allowable charges for services determined to be billed in error) and dividing it by the total allowance amount of services medically reviewed, was 82%. Although the error rate remains high, NAS will discontinue the widespread prepayment review however, NAS will continue to monitor billing patterns for Pressure Reducing Support Surfaces to determine if further review is necessary.

The following are the top reasons for denial:

- No documentation of a comprehensive ulcer treatment plan
- Criteria 1, 2 and 3 were not met
- Criteria 5 and 6 not met
- Criteria 4 not met
- Requested documentation was not provided within the allotted time frame as referenced in the Medicare guidelines.

Explanation and information regarding the denial reasons are as follows:

- Claims were submitted with no documentation of a comprehensive ulcer treatment plan or the documentation provided did not contain:
  a. Education of the patient and caregiver on the prevention and/or management of pressure ulcers
  b. Regular assessment by a nurse, physician, or other licensed healthcare practitioner (usually at least weekly for a patient with a stage III or IV ulcer).
  c. Appropriate turning and positioning
  d. Appropriate wound care (for a stage II, II, or IV ulcer).
  e. Appropriate management of moisture/incontinence.
  f. Nutritional assessment and intervention consistent with the overall plan of care.
- The documentation submitted did not meet Criteria 1,2 and 3:
  a. Criterion 1: The patient has multiple stage II pressure ulcers located on the trunk or pelvis (ICD-9 707.02-707.05), and
  b. Criterion 2: Patient has been on a comprehensive ulcer treatment program for at least the past month which has included the use of an appropriate group 1 support surface, and
  c. Criterion 3: The ulcers have worsened or remained the same over the past month
- The documentation submitted did not meet Criteria 5 and 6.
  a. Criterion 5: The patient had a recent myocutaneous flap or skin graft for the pressure ulcer on the trunk or pelvis (surgery within the past 60 days),and
  b. Criterion 6: The patient has been on a group 2 or 3 support surface immediately prior to a recent discharge from a hospital or nursing facility (discharge within the past 30 days).
- The documentation submitted did not meet Criteria 4.
  a. Criterion 4: The patient has large or multiple stage III or IV pressure ulcer(s) on the trunk or pelvis (ICD-9 707.02-707.05)
- A number of suppliers failed to respond to our request for records
  a. 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.

Note: A Group 2 support surface is covered if the patient meets:

- Criterion 1,and 2 and 3, or
- Criterion 4, or
- Criterion 5 and 6.

It is important for suppliers to be familiar with the documentation requirements as outlined in the Pressure Reducing Support Surfaces-Group 2 Local Coverage Determination (LCD11579) and Policy Article A35422.

Supplier Documentation checklist [PDF] may be used as an internal guide to help the supplier gather the appropriate documentation.

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

TENS

Results of Widespread Prepayment Review of TENS Garments

The DME MAC Jurisdiction D has completed the widespread prepayment review of claims for TENS garments (E0731). This review was initiated based on the results of Comprehensive Error Rate Testing (CERT) review analysis.

A total of 98 claims were developed for additional documentation. Responses to the Additional Documentation Request (ADR) were not received for 24 of the claims. Of the 74 claims for which responses were received, all 74 were denied. The error rate, calculated by taking the total denied allowance amount (dollar amount of allowable charges for services determined to be billed in error) and dividing it by the total allowance amount of services medically reviewed, was 100%. Although the error rate remains high, NAS will discontinue the widespread prepayment review however, NAS will continue to monitor the billing patterns for TENS garments to determine if further review is necessary.

The following are the top reasons for denial:

1. Documentation did not support coverage of a garment purchase
2. No written order
3. Documentation did not support the usage and/or frequency of the garment
4. Medical records were not submitted
5. Proof of delivery was invalid or not submitted
6. Brand name and/or model number were not submitted
7. Requested documentation was not provided within the allotted time frame as referenced in the Medicare guidelines

Explanation and information regarding the denial reasons are as follows:

1. Per LCD L11495, a conductive garment used with a TENS unit is rarely reasonable and necessary, but may be covered if all the following conditions are met:
   - It has been prescribed by a physician for use in delivering covered TENS treatment; and
   - One of the medical indications outlined below is met:
     - The patient cannot manage without the conductive garment because there is such a large area or so many sites to be stimulated and the stimulation would have to be delivered so frequently that it is not feasible to use conventional electrodes, adhesive tapes, and lead wires; or
     - The patient cannot manage without the conductive garment for the treatment of chronic intractable pain because the areas or sites to be stimulated are inaccessible with the use of conventional electrodes, adhesive

tapes, and lead wires; or

- The patient has a documented medical condition, such as skin problems, that preclude the application of conventional electrodes, adhesive tapes, and lead wires; or
- The patient requires electrical stimulation beneath a cast to treat chronic intractable pain.

- Suppliers cannot generate an order without it first being initiated by a qualified ordering professional. Per chapter 5 of the PIM (Medicare Program Integrity Manual), suppliers may dispense most items of DMEPOS based on a verbal order or preliminary written order from the treating physician. This order must include: A description of the item, the beneficiary's name, the physician's name and the start date of the order. Suppliers must maintain the preliminary written order or written documentation of the verbal order and this documentation must be available upon request. Chapter 5 of the PIM also requires a detailed written order prior to delivery for the TENS unit. PerLCD L11495, an order for each item billed must be signed and dated by the treating physician, kept on file by the supplier, and made available upon request.
- Per LCD L11495, the physician's records must document reevaluation of the patient at the end of the trial period, must indicate how often the patient used the TENS unit, the typical duration of use each time, and the results.
- Per LCD L11495, the medical record must document the location of the pain, the duration of time the patient has had the pain and the presumed etiology of the pain. The pain must have been present for at least three months. Other appropriate treatment modalities must have been tried and failed, and the medical record must document what treatment modalities have been used.
- Per chapter 4, section 4.26–4.26.2 of the PIM, there are three methods of delivery: Delivering directly to the beneficiary or authorized representative, utilizing a shipping service, or delivery to a nursing facility on behalf of the beneficiary. 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 supplies shall be the date of service on the claim. If the supplier utilizes a shipping service or mail order, an example of proof of delivery would include the services tracking slip, and the suppliers own shipping invoice.
- Per LCD L11495, a claim for code E0731 must be accompanied by the brand name and model number of the conductive garment.
- A large number of suppliers failed to respond to our request for records. Suppliers are in violation of Supplier Standard #28 when, upon request, they fail to provide requested documentation to a Medicare contractor. Medicare regulations (42 C.F.R §424.516[f]) stipulate that a supplier is required to maintain documentation for seven years from the date of service and, upon the request of CMS or a Medicare contractor, provide access to that documentation. Therefore, the consequences of failure to provide records may not only be a claim denial but also referral to the NSC.

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Transcutaneous Electrical Nerve 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.gov/manuals/downloads/pim83c03.pdf

Results for Widespread Service-Specific Prepayment Review for A5500 and A5512 Therapeutic Shoes and Inserts – Revised

The Jurisdiction D DME MAC Medical Review Department has conducted a widespread service -specific probe complex review of HCPCS code A5500 (off-the-shelf depth-inlay shoe) and A5512 (multiple density inserts). This review was conducted based on CERT review analysis. A sample of 100 claims were randomly selected from a total of 91 different suppliers from March, 2011 through July, 2011. The results are as follows:

We found that 98 of these claims contained errors, which calculates to an overall "error ratio" of 97%. However, because the error rate remains high, NAS will continue with the widespread complex review.

The following is a summary of claims reviewed during the probe, including determinations made and the primary denial reasons.

- 2 claims were paid
- 98 claims were denied in full for the following reasons per LCD L157 and Policy Article A37076.
  - 63 claims were denied for not meeting criterion 3
  - 62 claims were denied for not meeting criterion 2
  - 35 claims were denied for not meeting criterion 4
  - 33 claims were denied for not meeting criterion 1
  - 24 claims were denied for no documentation received in response to the ADR letter request within the 30 day requirement.

The total claim volume is more than 100 as some of the claims have multiple errors.

Per Policy Article A37076 and LCD L157:

Criterion 1

The patient has diabetes mellitus (ICD-9 diagnosis codes 249.00-250.93)

Criterion 2

The certifying physician has documented in the patient's medical record one or more of the following conditions:

1. Previous amputation of the other foot, or part of either foot, or
2. History of previous foot ulceration of either foot, or
3. History of pre-ulcerative calluses of either foot, or
4. Peripheral neuropathy with evidence of callus formation of either foot, or
5. Foot deformity of either foot, or
6. Poor circulation in either foot; and

Criterion 3

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

Have an in-person visit with the patient during which diabetes management is addressed within 6 months prior to delivery of the shoes/inserts; and

Sign the certification statement (refer to the Documentation Requirements section of the related Local Coverage Determination) on or after the date of the in-person visit and within 3 months prior to delivery of the shoes/inserts.

Criterion 4

Prior to selecting the specific items that will be provided, the supplier must conduct and document an in-person evaluation of the patient. (Refer to the related Local Coverage Determination, Documentation Requirements section, for additional information.)

THERAPEUTIC SHOES CONT'D

No documentation received in response to the ADR letter within the required 30 days

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

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

Provider outreach education also has resources available for reference relating to therapeutic shoes and inserts that are available on the NAS website. https://www.noridianmedicare.com/dme/train/presentations/therapeutic_shoes.pdf

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

VERSION 5010

First National Version 5010 Testing Day Results Now Available

The CMS Version 5010 Team held its first National Testing Day on June 15, 2011. On National Testing Day, 349 Medicare fee-for-service (FFS) trading partners conducted testing using the Version 5010 format that all covered entities are required to use starting January 1, 2012.

From those 349 trading partners, 974 files were submitted and there were no significant error scenarios reported. Sixty-eight trading partners responded to a follow-up survey about National Testing Day. Of those who responded to the survey, 32 percent stated that they feel ready to process Version 5010 production transactions. In addition, 39 percent of the respondents stated that they were able to receive and process a 277CA while testing on National Testing Day.

The following metrics represent **5010 production** transactions:

- Part B claims processed (May and June) – 59,778
- COB Part B claims (May and June) – 4,041
- Trading Partners for Part B Claims and COB (as of June) – Part A - 43, Part B- 84, COB- 24
- Eligibility inquiries (May and June) – 305,884 inquiries

CMS and the Medicare FFS Program have scheduled a National 5010 Testing Week for **August 22 - 26, 2011**. National 5010 Testing Week provides an opportunity for trading partners to test compliance efforts that are already underway, with the support of a real-time help desk and access to Medicare Administrative Contractors. Check the Version 5010 section of the CMS website for more information about the transition to Version 5010.

Keep Up to Date on Version 5010 and ICD-10

Please visit http://www.cms.gov/ICD10 for the latest news and resources to help you prepare!

Important Update Regarding 5010/D.0 Implementation – Action Needed Now

MLN Matters® Number: SE1131

Provider Types Affected

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

Provider Action Needed

You and your billing and software vendors must be ready to begin processing the Health Insurance Portability and Accountability Act (HIPAA), Versions 5010 & D.0 production transactions by December 31, 2011. Beginning January 1, 2012, all electronic claims, eligibility and claim status inquiries, must use Versions 5010 or D.0. Version 4010/5.1 claims and related transactions will no longer be accepted. The electronic remittance advice will only be available in the 5010 version.

You must comply with this important deadline to avoid delays in payments for Medicare Fee-For-Service (FFS) claims after December 31, 2011. The implementation requires changes to the software, systems, and perhaps procedures that you use for billing Medicare and other payers.

Contact your MACs to receive the free Version 5010 software (PC-Ace Pro32) and begin testing now. Consider contracting with a Version 5010 compliant clearinghouse who can translate the non-compliant transactions into compliant 5010 transactions. For Part B and DME providers, download the free Medicare Remit Easy Print (MREP) software to view and print compliant HIPAA 5010 835 remittance advices, which are available at http://www.cms.gov/AccesstoDataApplication/02_MedicareRemitEasyPrint.asp on the CMS website. Part A providers may download the free PC-Print software to view and print compliance HIPAA 5010 835 remittance advices, which is available on your A/B MACs website. Contact your respective professional associations and other payers for guidance and resources in order to meet their deadlines.

Background

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.

The implementation of HIPAA 5010 and the National Council for Prescription Drug Programs (NCPDP) Version 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.

Version 5010 refers to the revised set of HIPAA transaction standards adopted to replace the current Version 4010/4010A standards. Every standard has been updated, from claims to eligibility to referral authorizations.

All HIPAA covered entities must transition to Version 5010 by **January 1, 2012**. Any electronic transaction for which a standard has been adopted must be submitted using Version 5010 on or after January 1, 2012. Electronic transactions that do not use Version 5010 are not compliant with HIPAA and **will be rejected**.

To allow time for testing, CMS began accepting electronic transactions using either Version 4010/4010A or Version 5010 standards on January 1, 2011, and will continue to do so through December 31, 2011. This process allows a provider and its vendors to complete end-to-end testing with Medicare contractors and demonstrate that they are able to operate in production mode with Versions 5010 and D.0.

Note: 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 FFS Medicare. **Therefore, you must be prepared to implement these transactions for your non-FFS Medicare business as well**.

Are You at Risk of Missing the Deadline?

If you can answer **NO** to any of the following questions, you are at risk of not being able to meet the January 1, 2012, deadline and not being able to submit claims:

1. Have you contacted your software vendor (if applicable) to ensure that they are on track to meet the deadline or contacted your MAC to get the free Version 5010 software (PC-Ace Pro32)?
2. Alternatively, have you contacted clearinghouses or billing services to have them translate your Version 4010 transactions to Version 5010 (if not converting your older software)?
3. Have you identified changes to data reporting requirements?
4. Have you started to test with your trading partners, which began on January 1, 2011?
5. Have you started testing with your MAC, which is required before being able to submit bills with the Version 5010?
6. Have you updated MREP software to view and print compliant HIPAA 5010 835 remittance advices?

Additional Information

MLN Matters® Article #MM7466, "Medicare Remit Easy Print (MREP) and PC Print User Guide Update for Implementation of Version 5010A1," is available at http://www.cms.gov/MLNMattersArticles/downloads/MM7466.pdf on the CMS website.

The Medicare Learning Network® (MLN) fact sheet, "Preparing for Electronic Data Interchange (EDI) Standards: The Transition to Versions 5010 and D.0," is available at http://www.cms.gov/Versions5010andD0/downloads/w5010TransitionFctSht.pdf on the CMS website.

MLN Matters® Special Edition Article #SE1106 titled "Important Reminders about HIPAA 5010 & D.0 Implementation," is available at http://www.cms.gov/MLNMattersArticles/Downloads/SE1106.pdf on the CMS website.

Additional educational resources about HIPAA 5010 & D.0 are available at http://www.cms.gov/Versions5010andD0/40_Educational_Resources.asp on the CMS website.

Make Sure You Know How to Meet Version 5010 Level II Compliance

The Version 5010 compliance deadline is less than 90 days away. All entities covered under the Health Insurance Portability and Accountability Act (HIPAA) must be ready to implement the Version 5010 transaction standards by December 31, 2011. In order to meet this compliance deadline, you need to conduct both Level I Internal Testing, and Level II External Testing of transactions.

Level I Internal Testing

Level I Internal Testing allows you to identify and address any potential issues that may arise in advance of testing with external business partners. If you have not yet done so, take action now to complete your internal testing as soon as possible. By now, you should have completed Level I Internal Testing, and begun Level II External Testing.

Level II External Testing

For Level II External Testing, you should identify the business partners you currently conduct transactions with, and create a schedule and timeline for external testing with each partner. If you trade with a large number of business partners, identify priority partners to conduct testing with first.

To meet Level II compliance, business partners that should be included in external testing include:

- Billing services
- Clearinghouses
- Pharmacies
- Entities responsible for coverage and benefit determinations
- Payers

To ensure a smooth transition during Level II External Testing, you should first test the transactions you currently use on a daily basis, such as:

- Claims
- Eligibility determinations

- Remittances
- Referral authorizations

After testing your daily transactions, you are ready to test all remaining transactions to ensure that you are fully compliant for Level II External Testing.

Keep Up to Date on Version 5010 and ICD-10

Please visit the ICD-10 website for the latest news and resources to help you prepare, and to download and share the implementation widget today!

New Version 5010 Testing Readiness Fact Sheet Available

All covered entities under the Health Insurance Portability and Accountability Act (HIPAA) must be ready to implement the Version 5010 transaction standards on January 1, 2012. A critical step to reaching this milestone is testing Version 5010 transactions prior to going live. With less than four months until the transition, it is time to take action, especially on external (Level II) testing. CMS has posted a new fact sheet to help you better understand testing and the steps involved.

External testing with business partners in the new Version 5010 format will ensure that you are able to send and receive compliant transactions prior to the deadline. You should begin testing as soon as possible if you have not already done so. Waiting until the last minute may result in long testing queues, so plan ahead to avoid the rush.

Here are some suggested steps to take now:

- Identify the partners you currently conduct transactions with
- Create a schedule and timeline for external testing with each partner
- Identify priority partners to conduct testing with if you trade with a large number of business partners

Keep Up to Date on Version 5010

Please visit the 5010 website located at https://www.CMS.gov/Versions5010andD0/ for the latest news and resources to help you prepare today!

Populating REF Segment - Other Claim Related Adjustment - for Healthcare Claim Payment/Advice or Transaction 835 Version 5010A1

MLN Matters® Number: MM7484 Revised
Related Change Request (CR) #: CR 7484
Related CR Release Date: September 2, 2011
Related CR Transmittal #: R959OTN
Effective Date: January 1, 2012
Implementation Date: January 3, 2012

Note: This article was revised on September 6, 2011, due to changes in CR7484. The CR was revised to add qualifier "FI" in Loop 2100 NM1 – Service Provider Name under special situations where the NPI is not available - enabling Medicare to report the Federal Taxpayer's Identification Number instead of NPI if NPI is not available for the Rendering Provider and the Rendering provider is different from the Payee. The CR release date, transmittal number, and the Web address for accessing the CR were also revised. All other information remains the same.

Provider Types Affected

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

Provider Action Needed

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

populated for the Part B remittance advice.

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

- PLB Code 90;
- Qualifier "PQ" to be used in Loop 1000B REF – Payee Additional Information under some special situations where the National Provider Identifier (NPI) is not available; and
- Qualifier "F1" to be used in Loop 2100 NM1 – service payable under some special situations where NPI is not available.

Background

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

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

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

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

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

Additional Information

You can find the official instruction, CR7484, issued to your FI, carrier, A/B MAC, RHHI, or DME MAC by visiting http://www.cms.gov/Transmittals/downloads/R959OTN.pdf on the CMS website. You will find the updated 835 T 5010A1 flat file containing the qualifiers as an attachment to that CR.

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

Version 5010 Testing Week Shows Promising Version 5010 Testing Results

The CMS Version 5010 team held its second National Testing event the week of Monday, August 22 to Friday, August 26, 2011. During National Testing Week, 1,252 Medicare Fee-For-Service (FFS) trading partners conducted testing with the Medicare Administrative Contractors using the Version 5010 format that all covered entities are required to use beginning January 1, 2012.

Results

These 1,252 trading partners submitted a total of 67,782 test files and no significant error scenarios were reported. Additionally, 74 trading partners responded to a follow-up survey about National Testing Week that found:

- 45% of those surveyed responded that they were testing the 837I with Medicare;
- 72% responded they were testing the 837P with Medicare;
- 43% responded they were testing the 835 with Medicare;
- 24% responded they were testing the 276/277 with Medicare; and
- 54% responded they were exchanging test files with payers other than Medicare.

Additional results show that transition to production is progressing. Twenty-six percent of trading partners stated they were currently in production status, with an additional 42% stating that they expect to be in production status within the next month. Most respondents (72%) stated that they were able to receive and process a 277CA while testing.

Keep Up to Date on Version 5010 and ICD-10

Please visit the ICD-10 website for the latest news and resources to help you prepare, and to download and share the implementation widget today!

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