Jurisdiction D News from Noridian Administrative Services, LLC.

Happenings

August 2010
Issue No. 28

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

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CEDI

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

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Jurisdiction D DME MAC Supplier Contacts and Resources

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

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

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

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

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

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

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

FYI

DME Happenings Mailing Schedule

Hardcopy DME Happenings will continue to be mailed on a quarterly basis containing articles published in the prior three months. To receive more timely Medicare updates, visit https://www.noridianmedicare.com/dme and/or subscribe to our email updates at https://www.noridianmedicare.com/dme/news/docs/email_brochure.pdf.

2010 Holiday and Training Closures

NAS offices will be closed on the days listed below.

Supplier Contact Center

Event	Date
Off-the-Phone Training*	August 20
Labor Day	September 6
Off-the-Phone Training*	September 17
Columbus Day*	October 11
Veterans Day*	November 11
Thanksgiving	November 25 and 26
Off-the-Phone Training*	December 17
Christmas Eve	December 24
New Years Day	December 31
Days noted with a (*) are days that the NAS offices will be open and the Contact Center representatives will be available from 12:30 - 5:30 p.m. CT.	

Telephone Reopenings

Holiday	Date
Training	August 17 from 9 - 11 a.m. CT
Labor Day	September 6
Training	September 9 from 8 - 9 a.m. CT
Training	September 15 from 9 - 11 a.m. CT
Training	October 14 from 8 - 9 a.m. CT
Training	October 20 from 9 - 11 a.m. CT
Training	November 11 from 8 - 9 a.m. CT
Training	November 17 from 9 - 11 a.m. CT
Thanksgiving	November 25 and 26
Training	December 9 from 8 - 9 a.m. CT
Training	December 15 from 9 - 11 a.m. CT
Christmas Eve	December 24
New Years Day	December 31

Medicare Learning Network Matters Disclaimer Statement

Below is the Centers for Medicare & Medicaid (CMS) Medicare Learning Network (MLN) Matters Disclaimer statement that applies to all MLN Matters articles in this bulletin.

"This article was prepared as a service to the public and is not intended to grant rights or impose obligations. MLN Matters articles may contain references or links to statutes, regulations or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents."

Sources for "Jurisdiction D Happenings" Articles

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

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

Free Online Eligibility and Claim Status

Jurisdiction D suppliers are strongly encouraged to register for a new "portal" called Endeavor which offers free, online access to patient eligibility, claim status, and remittance advices. Endeavor registration is simple and the processing is very timely. There are hundreds of suppliers who are already enjoying the benefits of this tool.

The hours of availability are:

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

Endeavor Overview

Before registering, review the Endeavor Overview which is located on the Claims page of the NAS DME website. This page contains Endeavor information and resources including

the User Manual, registration information, password requirements, forms, and tips.

Registration

Suppliers must register by going to the Endeavor Overview page. Specific information is provided on how to register for multiple National Provider Identifiers (NPIs) and for third parties.

Registrations are processed within seven business days. Additional verification items may be requested of the registrant via fax. Ensure the fax number and email address on the registration are correct.

Once a registration is processed, suppliers will receive a fax with approval information or a reason for rejection. If approved, view the User Guide available in the upper right corner of the Endeavor Main Menu for instructions on use.

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

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
3	Detailed Written Orders	Changed IOM reference to Chapter 5, Section 5.2.3	06/22/10
3	Advance Beneficiary Notice of Noncoverage	Removed effective date of ABN form	06/22/10
4	Instructions for Completing a CMN and DIF	Removed effective date of unacceptable signature stamps	06/22/10
4	Replacing Oxygen Equipment - CMN Requirements	Removed effective date of oxygen payment policy	06/22/10
10	Background	Removed notice and program end date	06/22/10
15	Overpayment offsets	Clarified that suppliers may request an offset when first notifying NAS of an overpayment	06/22/10
Appendix	Contacting NAS and Inquiries	Added Endeavor information	06/22/10
13	Administrative Law Judge	Updated Amount in Controversy	05/18/10

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

Physician Documentation Responsibilities

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

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

Quarterly Provider Updates

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

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

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

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

Refunds to Medicare

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

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

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

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

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

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

Update to Banking Transition Date

The CMS awarded new banking contracts to U.S. Bank and JP Morgan Chase. Medicare providers do not have to take any action. However, providers should be aware that the Medicare payments may be made by a different bank than in the past because of these new banking contractors.

Due to issues identified in testing, providers that submit claims to CIGNA Government Services, Highmark Medicare Services, National Government Services, NHIC, and Noridian Administrative Services will experience a delay in the transition to U.S. Bank. The transition will now occur on **August 30, 2010**.

There Is No 'One-Size-Fits-All' in Building a Nationwide Health Information Network

A Message from Dr. David Blumenthal, National Coordinator for Health Information Technology

May 14, 2010

Private and secure health information exchange enables information to follow the patient when and where it is needed for better care. The Federal government is working to enable a wide range of innovative and complementary approaches that will allow secure and meaningful exchange within and across states, but all of our efforts must be grounded in a common foundation of standards, technical specifications, and policies. Our efforts must also encourage trust among participants and provide assurance to consumers about the security and privacy of their information. This foundation is the essence of the Nationwide Health Information Network (NHIN).

The NHIN is not a network per se, but rather a set of standards, services, and policies that enable the Internet to be used for the secure exchange of health information to improve health and health care. Different providers and consumers may use the Internet in different ways and at different levels of sophistication. To make meaningful use possible, including the necessary exchange of information, we need to meet providers where they are, and offer approaches that are both feasible for them and support the meaningful use requirements of the Centers for Medicare & Medicaid Services (CMS) Electronic Health Record Incentives Programs. As with the Internet, it is likely that what is today considered "highly sophisticated" will become common usage. Moreover, users may engage in simpler exchange for some purposes and more complex exchange for others.

Current NHIN exchange capabilities are the result of a broad and sustained collaboration among Federal agencies, large provider organizations, and a variety of state and regional health information organizations that all recognized a need for a high level of interoperable health information exchange that avoided "one-off" approaches. Based on this pioneering work, a subset of these organizations is now actively exchanging information. This smaller group currently includes the Department of Defense, Social Security Administration, Veterans Health Administration, Kaiser Permanente, and MedVirginia. They initially came together to show, on a pilot scale, that this type of highly evolved exchange was possible. Having succeeded, they continue to expand the level of exchange among their group and with their own respective partners in a carefully phased way to demonstrate and learn from these widening patterns of exchange. The robust exchange occurring at this level has several key attributes, including the:

1. Ability to find and access patient information among multiple providers;
2. Support for the exchange of information using common standards; and
3. Documented understanding of participants, enabling trust, such as the Data Use and Reciprocal Support Agreement (DURSA).

Not every organization and provider, however, needs or is ready for this kind of health information exchange today. Nor do the 2011 meaningful use requirements set forth by CMS in the recent proposed rule require it. Direct, securely routed information exchange may meet the current needs of some providers for their patients and their practices, such as receiving lab results or sending an electronic prescription.

To enable a wide variety of providers – from small practices to large hospitals – to become meaningful users of electronic health records in 2011, we need to ensure the availability of a reliable and secure "entry level" exchange option that aligns with the long-range information exchange vision we have for our nation. Such an option should balance the need for a consistent level of interoperability and security across the exchange spectrum with the reality that not all users are at the same point on the path to comprehensive interoperability. In an effort to provide the best customer service possible, the Office of the National Coordinator for Health IT (ONC) will consider what a complete toolkit would be for all providers who want to accomplish meaningful health information exchange.

Broadening the use of the NHIN to include a wider variety of providers and consumers who may have simpler needs for information exchange, or perhaps less technically sophisticated capabilities, is critical to bolstering health information exchange and meeting our initial meaningful use requirements. Building on the solid foundation established through the current exchange group mentioned above and the recommendations of the HIT Policy Committee (which originated with the Committee's NHIN Workgroup), ONC is exploring this expansion of NHIN capabilities to find solutions that will work across different technologies and exchange models.

The newly launched NHIN Direct Project is designed to identify the standards and services needed to create a means for direct electronic communication between providers, in support of the 2011 meaningful use requirements. It is meant to enhance, not replace, the capabilities offered by other means of exchange. An example of this type of exchange would be a primary care physician sending a referral and patient care summary to a specialist electronically.

We are on an aggressive timeline to define these specifications and standards and to test them within real-world settings by the end of 2010. Timing is critical so that we may provide this resource to a broader array of participants in health information exchange as a wave of new, meaningful users prepare to qualify for incentives provided for in the HITECH Act and ultimately defined by CMS. This model for exchange will meet current provider needs within the broader health care community, complement existing NHIN exchange capabilities, and strengthen our efforts toward comprehensive interoperability across the nation.

A natural evolution in NHIN capabilities to support a variety of health information exchange needs is being reinforced by trends that are leading us toward widespread multi-point interoperability. The current movement toward consolidation in health care, coupled with health reform's encouragement of bundled payments for coordinated care, will mean more providers need it. Quality improvement, public health, research, and a learning health care system all require it. Ultimately, simple exchange will be part of a package of broader functions that allows any provider, and ultimately consumers, to exchange information over the Internet, enabled by NHIN standards, services, and policies.

Your continued input will help guide us toward and maintain a direction that is in harmony with the rapid innovations in health IT today. The NHIN Direct Project will conduct an open, transparent, and collaborative process throughout its development by using a community wiki, blogs, and open source implementation already available on the project's website (http://nhindirect.org). I encourage you to participate through the website, via public participation at the implementation group meetings, and by deploying and testing the resulting standards and specifications. For those of you who are participants in the current exchange group, I urge you to take every opportunity to share your experiences. Lessons learned from the NHIN Direct Project and the exchange group will inform the evolution of the NHIN as new uses and users come forward, and as continued innovation occurs to meet the growing needs of our community.

As we head into the next stage in the development of nationwide health information exchange, we should all take a moment to reflect on how far we have come and evaluate our plans for the future. ONC is committed to providing resources and guidance to stakeholders at all levels of exchange through HITECH programs, such as the Health IT Regional Extension Centers, the national Health IT Research Center, and the State Health Information Exchange Program. As you assess your own needs for exchange, please take advantage of the many Federal resources available to you on the ONC website and the online resources of the programs mentioned above, as well as through the "NHIN University" education program hosted by our public-private partner, the National eHealth Collaborative.

We have done a great deal of work in the short period of time since the passage of the HITECH Act. We at ONC appreciate your willingness to stay engaged and involved in every step of our journey, and we look forward to our continuing collaboration to improve the health and well-being of our nation.

Sincerely,
David Blumenthal, M.D., M.P.P.
National Coordinator for Health Information Technology
U.S. Department of Health & Human Services

HCPCS Quarterly Update

CMS is pleased to announce the scheduled release of modifications to the Healthcare Common Procedure Coding System (HCPCS) code set. These changes have been posted to the HCPCS Web page at http://www.cms.hhs.gov/HCPCSReleaseCodeSets/02_HCPCS_Quarterly_Update.asp.

Changes are effective on the date indicated on the update.

Updates from Medicare Learning Network: Web-Based Training and Misdirected Mailings

Web-Based Training

Need to know the Medicare basics? The Medicare Learning Network (MLN) offers a series of web based training (WBT) courses to teach health care professionals the fundamentals of the Medicare Program. The first in the series, the "World of Medicare", offers a basic introduction to Medicare. The second in the series "Your Office in the World of Medicare" focuses on Medicare knowledge required by health care professionals and their office personnel. Both activities now offer continuing education (noted by ★) and are available from the MLN at http://www.cms.gov/MLNproducts/ by scrolling to the bottom of the page and selecting Web based Training Modules from the Related Links Inside CMS section of the CMS website.

Misdirected Mailings from Medicare

As a health care provider subject to the privacy and security requirements under the Health Insurance Portability and Accountability Act of 996 (HIPAA) and/or under State law, you must safeguard patients' personally identifiable health information. If you receive a remittance advice on a Medicare beneficiary who's not your patient, you should 1) destroy it and 2) report it to your fiscal intermediary, carrier, or Medicare Administrative Contractor, as appropriate.

Signature Guidelines for Medical Review Purposes

MLN Matters® Number: MM6698 Revised
Related Change Request (CR) #: 6698
Related CR Release Date: March 16, 2010
Related CR Transmittal #: R327PI
Effective Date: March 1, 2010
Implementation Date: April 16, 2010

Note: This article was revised on June 16, 2010 to include on pages 6-7 a table excerpted from CR 6698 that summarizes signature requirements. All other information is the same.

Provider Types Affected

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

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) issued CR 6698 to clarify for providers how Medicare claims review contractors review claims and medical documentation submitted by providers. CR 6698 outlines the new rules for signatures and adds language for E-Prescribing. See the rest of this article for complete details. These revised/new signature requirements are applicable for reviews conducted on or after the implementation date of April 16, 2010. **Please note that all signature requirements in CR 6698 are effective retroactively for Comprehensive Error Rate Testing (CERT) for the November 2010 report period.**

Background

Those contractors who review Medicare claims include MACs, Affiliated Contractors (ACs), the CERT contractors, Recovery Audit Contractors (RACs), Program Safeguard Contractors (PSCs), and Zone Program Integrity Contractors (ZPICs). These contractors are tasked with measuring, detecting, and correcting improper payments as well as identifying potential fraud in the Fee for Service (FFS) Medicare Program.

The previous language in the Program Integrity Manual (PIM) required a "legible identifier" in the form of a handwritten or electronic signature for every service provided or ordered. CR 6698 updates these requirements and adds E-Prescribing language.

For medical review purposes, Medicare requires that services provided/ordered be authenticated by the author. The method used must be a hand written or an electronic signature. Stamp signatures are not acceptable. There are some exceptions, i.e.:

EXCEPTION 1: Facsimiles of original written or electronic signatures are acceptable for the certifications of terminal illness for hospice.

EXCEPTION 2: There are some circumstances for which an order does not need to be signed. For example, orders for clinical diagnostic tests are not required to be signed. The rules in 42 CFR 410 and the Medicare Benefit Policy Manual, chapter 15, section 80.6.1, state that if the order for the clinical diagnostic test is unsigned, there must be medical documentation by the treating physician (e.g., a progress note) that he/she intended the clinical diagnostic test be performed. This documentation showing the intent that the test be performed must be authenticated by the author via a handwritten or electronic signature.

EXCEPTION 3: Other regulations and CMS instructions regarding signatures (such as timeliness standards for particular benefits) take precedence. For medical review purposes, if the relevant regulation, NCD, LCD and CMS manuals are silent on whether the signature be legible or present and the signature is illegible/missing, the reviewer shall follow the guidelines listed below to discern the identity and credentials (e.g.MD, RN) of the signator. In cases where the relevant regulation, NCD, LCD and CMS manuals have specific signature requirements, those signature requirements take precedence.

The AC, MAC and CERT reviewers shall apply the following signature requirements:

If there are reasons for denial unrelated to signature requirements, the reviewer need not proceed to signature authentication. If the criteria in the relevant Medicare policy cannot be met but for a key piece of medical documentation which contains a missing or illegible signature, the reviewer shall proceed to the signature assessment.

Providers should not add late signatures to the medical record, (beyond the short delay that occurs during the transcription process) but instead may make use of the signature authentication process.

Keep in mind that a handwritten signature is a mark or sign by an individual on a document to signify knowledge, approval, acceptance or obligation and note the following:

- If the signature is illegible, ACs, MACs, PSCs, ZPICs and CERT shall consider evidence in a signature log or attestation statement to determine the identity of the author of a medical record entry.
- If the signature is missing from an order, ACs, MACs, PSCs, ZPICs and CERT **shall disregard the order** during the review of the claim.
- If the signature is missing from any other medical documentation, ACs, MACs, PSCs, ZPICs and CERT shall accept a signature attestation from the author of the medical record entry.

The following are the signature requirements that the ACs, MACs, RACs, PSCs, ZPICs, and CERT contractors will apply:

- Other regulations and CMS instructions regarding signatures (such as timeliness standards for particular benefits) take precedence.
- **Definition of a handwritten signature** is a mark or sign by an individual on a document to signify knowledge, approval, acceptance or obligation.
- For medical review purposes, if the relevant regulation, NCD, LCD, and other CMS manuals are silent on whether the signature must be dated, the reviewer shall review to ensure that the documentation contains enough information for the reviewer to determine the date on which the service was performed/ ordered. **EXAMPLE:** The claim selected for review is for a hospital visit on October 4. The Additional Documentation Request (ADR) response is one page from the hospital medical record containing three entries. The first entry is dated October 4 and is a physical therapy note. The second entry is a physician visit note that is undated. The third entry is a nursing note dated October 4. The reviewer may conclude that the physician visit was conducted on October 4.

- **Definition of a Signature Log:** Providers will sometimes include, in the documentation they submit, a signature log that identifies the author associated with initials or an illegible signature. The signature log might be included on the actual page where the initials or illegible signature are used or might be a separate document. Reviewers will consider all submitted signature logs regardless of the date they were created.
- **Definition of an Attestation Statement:** In order for an attestation statement to be considered valid for Medicare medical review purposes, the statement must be signed and dated by the author of the medical record entry and contain the appropriate beneficiary information.
- Providers will sometimes include in the documentation they submit an attestation statement. In order to be considered valid for Medicare medical review purposes, an attestation statement must be signed and dated by the author of the medical record entry and must contain sufficient information to identify the beneficiary. Should a provider choose to submit an attestation statement, they may choose to use the following statement:

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

- While this sample statement is an acceptable format, at this time, CMS is neither requiring nor instructing providers to use a certain form or format. A general request for signature attestation shall be considered a non-standardized follow-up question from the contractors to the providers so long as the contractors do not provide identical requirements or suggestions for the form or format of the attestation. The above format has not been approved by the Office of Management and Budget (OMB) and therefore it is not mandatory. However, once OMB has assigned an OMB Paperwork Reduction Act number to this attestation process, a certain form/format will be mandatory.
- Claims reviewers will not consider attestation statements where there is no associated medical record entry or from someone other than the author of the medical record entry in question. Even in cases where two individuals are in the same group, one may not sign for the other in medical record entries or attestation statements.
- If a signature is missing from an order, claims reviewers will disregard the order during the review of the claim.
- Reviewers will consider all attestations that meet the guidelines regardless of the date the attestation was created, except in those cases where the regulations or policy indicate that a signature must be in place prior to a given event or a given date.
- The following are the signature guidelines in section 3.4.1.1.B.c as shown in the manual revision attachment of CR 6698:
  - In the situations where the guidelines indicate "**signature requirements met**," the reviewer will consider the entry.
  - In situations where the guidelines indicate "**contact provider and ask a non-standard follow up question,**" the reviewer will contact the person or organization that billed the claim and ask them if they would like to submit an attestation statement or signature log within 20 calendar days. The 20 day timeframe begins once the contractor makes an actual phone contact with the provider or on the date the request letter is received at the post office. (Reviewers will not contact the provider if the claim should be denied for reasons unrelated to the signature requirement.)
  - In the situations where the guidelines indicate "**signature requirements NOT met**," the reviewer will disregard the entry and make the claims review determination using only the other submitted documentation.

Electronic Prescribing

Electronic prescribing (e-prescribing) is the transmission of prescription or prescription-related information through electronic media. E-prescribing takes place between a prescriber, dispenser, pharmacy benefit manager (PBM), or health plan. It can take place directly or through an e-prescribing network. With e-prescribing, health care professionals can electronically transmit both new prescriptions and responses to renewal requests to a pharmacy without having to write or fax the prescription. E-prescribing can save time, enhance office and pharmacy productivity, and improve patient safety and quality of care. Note the following key points:

- Reviewers will accept as a valid order any Part B drugs, other than controlled substances, ordered through a qualified E-Prescribing system. For Medicare Part B medical review purposes, a qualified E-Prescribing system is one that meets all 42 CFR 423.160 requirements. To review the official standards for electronic prescribing, 42 CFR 423.160 Standards for Electronic Prescribing, you may go to http://edocket.access.gpo.gov/cfr_2008/octqtr/pdf/42cfr423.160.pdf on the Internet.
- When Part B drugs, other than controlled substances, have been ordered through a qualified E-Prescribing system, the reviewer will NOT require the provider to produce hardcopy pen and ink signatures as evidence of a drug order.
- At this time, AC, MAC, CERT, PSC, and ZPIC reviewers shall NOT accept as a valid order any controlled substance drugs that are ordered through any E-Prescribing system, even one which is qualified under Medicare Part D. When reviewing claims for controlled substance drugs, the reviewer shall only accept hardcopy pen and ink signatures as evidence of a drug order.

- At this time, the AC, MAC, CERT, PSC and ZPIC reviewers shall accept as a valid order any drugs incident to DME, other than controlled substances, ordered through a qualified E-Prescribing system. For the purpose of conducting Medicare medical review of drugs incident to DME, a qualified E-Prescribing system is one that meets all 42 CFR 423.160 requirements. When drugs incident to DME have been ordered through a qualified E-Prescribing system, the reviewer shall NOT require the provider to produced hardcopy pen and ink signatures as evidence of a drug order.

Additional Information

		Signature Requirement Met	Contact billing provider and ask a non-standardized follow up question
1	Legible full signature	X	
2	Legible first initial and last name	X	
3	Illegible signature over a typed or printed name	X	
4	Illegible signature where the letterhead, addressograph or other information on the page indicates the identity of the signator. Example: An illegible signature appears on a prescription. The letterhead of the prescription lists 3 physicians' names. One of the names is circled.	X	
5	Illegible signature NOT over a typed/ printed name and NOT on letterhead, but the submitted documentation is **accompanied** by: A signature log, or An attestation statement	X	
6	Illegible signature NOT over a typed/ printed name, NOT on letterhead and the documentation is **Unaccompanied** by A signature log, or An attestation statement		X
7	Initials over a typed or printed name	X	
8	Initials NOT over a typed/printed name but **accompanied** by: A signature log, or An attestation statement	X	
9	Initials NOT over a typed/printed name **Unaccompanied** by: A signature log, or An attestation statement		X
10	Unsigned typed note with provider's typed name Example: John Whigg, MD		X
11	Unsigned typed note without providers typed/printed name		X
12	Unsigned handwritten note, the only entry on the page		X
13	Unsigned handwritten note where other entries on the same page in the same handwriting are signed	X	
14	"signature on file"		X

The official instruction, CR6698, issued to your Medicare FI, carrier, A/B MAC, RHHI or DME MAC regarding this change may be viewed at http://www.cms.gov/Transmittals/downloads/R327PI.pdf on the CMS website.

Clinical Review Judgment

MLN Matters® Number: MM6954
Related Change Request (CR) #: 6954
Related CR Release Date: May 14, 2010
Related CR Transmittal #: R338PI
Effective Date: April 23, 2010
Implementation Date: June 15, 2010

Provider Types Affected

This impacts all physicians, providers, and suppliers who bill Medicare contractors (carriers, fiscal intermediaries (FI), regional home health intermediaries (RHHI), Medicare Administrative Contractors (A/B MAC), or Durable Medical Equipment Contractors (DME MAC)) for services provided to Medicare beneficiaries.

What You Need to Know

CR 6954, from which this article is taken:

- Adds Section 3.14 (Clinical Review Judgment) to the *Medicare Program Integrity Manual*, clarifying existing language regarding clinical review judgments; and
- Requires that Medicare claim review contractors instruct their clinical review staffs to use clinical review judgment when making complex review determinations about a claim.

Background

Medicare claim review contractors (Carriers, Fiscal Intermediaries (called affiliated contractors, or ACs), Medicare Administrative Contractor (MACs), the Comprehensive Error Rate Testing (CERT) contractor, and Recovery Audit Contractors (RACs)), along with Program Safeguard Contractors (PSC) and ZoneProgram Integrity Contractors (ZPIC) are tasked with measuring, detecting and correcting improper payments in the Fee for Service (FFS) Medicare Program.

CR 6954, from which this article is taken, updates the *Medicare Program Integrity Manual* by adding a new Section (3.14 -- Clinical Review Judgment) which clarifies existing language regarding clinical review judgments; and also requires that Medicare claim review contractors instruct their clinical review staffs to use the clinical review judgment process when making complex review determinations about a claim.

This clinical review judgment involves two steps:

1. The synthesis of all submitted medical record information (e.g. progress notes, diagnostic findings, medications, nursing notes, etc.) to create a longitudinal clinical picture of the patient; and
2. The application of this clinical picture to the review criteria to determine whether the clinical requirements in the relevant policy have been met.

Note: *Clinical review judgment does not replace poor or inadequate medical record documentation, nor is it a process that review contractors can use to override, supersede or disregard a policy requirement (policies include laws, regulations, Centers for Medicare & Medicaid (CMS) rulings, manual instructions, policy articles, national coverage decisions, and local coverage determinations).*

Additional Information

You can find more information about clinical review judgment by going to CR 6954, located at http://www.cms.gov/Transmittals/downloads/R338PI.pdf on the Centers for Medicare & Medicaid Services (CMS) website. You will find the updated *Medicare Program Integrity Manual*, Chapter 3 (Verifying Potential Errors and Taking Corrective Actions), Section14 (Clinical Review Judgment) as an attachment to that CR.

Reprocessing Claims for Certain Replacement Parts, Accessories, or Supplies for Prosthetic Implants and Surgically Implanted DME

MLN Matters® Number: MM6970
Related Change Request (CR) #: 6970
Related CR Release Date: June 11, 2010
Effective Date: October 27, 2008
Related CR Transmittal #: R719OTN
Implementation Date: October 4, 2010

Provider Types Affected

This article impacts DME suppliers billing Medicare Carriers and Part A/B Medicare Administrative Contractors (A/B MACs) for certain replacement parts, accessories, or supplies for prosthetic implants and surgically implanted DME with dates of service of October 27, 2008, through December 31, 2009.

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 6970 in order to augment previously issued CR 6573. CMS issued CR 6573, Transmittal 531 on August 14, 2009. That CR included a list of Healthcare Common Procedure Coding System (HCPCS) codes that could be billed as a replacement part, accessory, or supply for prosthetic implants and surgically implanted DME according to guidelines established by CR 5917. CR 6970 directs Medicare Contractors to **reprocess claims with dates of service October 27, 2008, through December 31, 2009, containing the HCPCS codes found in the attachment to CR 6573**, using the guidelines established by CRs 5917 and 6573. That list is an attachment to CR 6573 at http://www.cms.gov/Transmittals/downloads/R531OTN.pdf on the CMS website. Make certain your billing staffs are aware of these adjustments that will be processed later this year.

Background

CR 5917, Transmittal 1603, issued on September 26, 2008, "Claims Jurisdiction and Enrollment Procedures for Suppliers of Certain Prosthetics, Durable Medical Equipment (DME) and Replacement Parts, Accessories and Supplies," communicated that entities enrolled with the National Supplier Clearinghouse (NSC) as a Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) supplier may enroll with and bill to the carrier/A/B MAC replacement parts, accessories, and supplies for prosthetics implants and surgically implanted DME items that are not required to be billed to the Medicare fiscal intermediary. Included with CR 5917 was an excerpt of the 2008 annual jurisdiction list containing HCPCS codes, which CMS instructed at the time may be billed to the carrier/MAC as a replacement part, accessory or supply for prosthetic implants and surgically implanted DME.

CR 6573, Transmittal 531, issued on August 14, 2009, clarified the claims filing jurisdiction and payment policies for DMEPOS items submitted under the guidelines established in CR 5917. CR 6573 also provided an updated list of HCPCS codes that may be billed as a replacement part, accessory, or supply for prosthetic implants and surgically implanted DME, under these guidelines. CR 6573 was effective for DMEPOS claims with dates of service on and after January 1, 2010.

Key Points of CR 6970

- Medicare Contractors will reprocess claims with dates of service of October 27, 2008 through December 31, 2009 containing the HCPCS codes found in Attachment A of CR 6573, using the claims processing instructions previously communicated in CRs 5917 and 6573.

- CR 6970 and the billing guidelines for replacement parts, accessories and supplies for implanted devices established in CRs 5917 and 6573 apply only to DMEPOS suppliers enrolled with the NSC and their local carrier/A/B MAC and does not change the existing carrier/A/B MAC billing rules that apply to physicians, facilities, or other entities that are implanting the devices.

Additional Information

The official instruction (CR6970) issued to your Medicare Carrier or A/B MAC is available at http://www.cms.gov/Transmittals/downloads/R719OTN.pdf on the CMS website.

CR 6573 contains the ***2008 DMEPOS Fee Schedule HCPCS Codes Payable as a Replacement Part, Accessory or Supply for Prosthetic Implants and Surgically Implanted DME*** (Rev. March 2009) and that list is an attachment to CR 6573 at http://www.cms.gov/Transmittals/downloads/R531OTN.pdf on the CMS website.

Preparing for a Transition from an FI/Carrier to a MAC or from one DME MAC to another DME MAC – SE1017

MLN Matters® Number: SE1017

This article was initially issued as SE0837 in 2008. It is being re-issued as SE1017 in order to update the content to reflect current experiences with transitions to a MAC.

Provider Types Affected

All fee-for-service physicians, providers, and suppliers who submit claims to Fiscal Intermediaries (FIs), Carriers, Regional Home Health Intermediaries (RHHIs), or DME MACs for services provided to Medicare beneficiaries. **Providers already billing Medicare Administrative Contractors (MACs) have already transitioned and need not review this article. However, suppliers billing DME MACs may find the article of value as the Centers for Medicare & Medicaid Services (CMS) recompetes the DME MAC contracts, which could cause a transition from an incumbent DME MAC to a new DME MAC.**

Impact on Providers

This article is intended to assist all providers that will be affected by Medicare Administrative Contractor (MAC) implementations (or DME MAC transitions due to recompeting the DME MAC Contracts). CMS is providing this information to make you aware of what to expect as your FI or carrier transitions its work to a MAC (or your DME MAC to another DME MAC). Knowing what to expect and preparing as outlined in this article will minimize disruption in your Medicare business. Please note that other Medicare contractors servicing your region will be unaffected by this change, such as the Qualified Independent Contractor (QIC for reconsiderations), Recovery Audit Contractor (RAC), the Program Safeguard Contractor (PSC), and the Zone Program Integrity Contractor (ZPIC).

NOTE to DME suppliers: The remainder of this article focuses on transitions from carriers or FIs to MACs, but suppliers note the information may also pertain to your business if there is a transition from your DME MAC to another DME MAC as those contracts are recompeted.

Background

Medicare Contracting Reform (or section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003) mandates that the Secretary for Health & Human Services replace the current contracting authority to administer the Medicare Part A and Part B Fee-For-Service (FFS) programs, contained under Sections 1816 and 1842 of the Social Security Act, with the new MAC authority. Medicare Contracting Reform requires that CMS conduct full and open competitions, in compliance with general federal contracting rules, for the work currently handled by FIs and carriers in administering the Medicare FFS program.

When completed, there will be 15 new MACs processing Part A and Part B claims. Each MAC services a distinct set of contiguous states, also known as a "jurisdiction". Each MAC will handle different volumes of work based upon the geographic breakout of the 15 MACs. Because of this, the MACs will vary in geographic size and the amount of work they handle. Having 15 MACs should result in greater consistency in the interpretation of Medicare policies, which is a key goal of Medicare Contracting Reform.

MAC Implementation Milestones/Definition

There are specific milestones in the cutover from carrier or FI work to MAC. In this article, providers are advised to be aware of, and to take specific action relative to the milestones defined below:

Award – This is the point at which a MAC is announced as having won the contract for specific FI or carrier work.

Cutover – This is the date on which the carrier or FI work ceases and MAC work begins. Cutover is often done in phases by State-level jurisdictions. Because of the amount of activity involved in a cutover, there may be interrupted services for a day or two.

Outgoing Contractor – A Medicare carrier or FI whose Title XVIII contract is non-renewed as a result of Medicare Contracting Reform and whose work will transition to a MAC.

Incoming MAC – The entity that has won a contract under Medicare Contracting Reform and which will assume the workload that was performed by a carrier or FI.

Pre-Award

If you are in a jurisdiction where a new MAC has not yet been awarded, you can remain current with updates on Medicare Contracting Reform by visiting http://www.cms.gov/medicarecontractingreform/ on the CMS website.

Post-Award

Once the award to the MAC is made, you should immediately begin to prepare for the cutover. The following are recommendations to help you in this effort:

Pay attention to the mail you receive from your outgoing Medicare contractor and your new MAC--you will be receiving letters and listserv messages about the cutover from both. These letters should include discussions on what, if any, impact the cutover will have on your payment schedule, issuance of checks, impact on paper and electronic claims processing, electronic funds transfers, appeals, customer service, etc. Focus on necessary actions you must take and the critical due dates assigned, to avoid any disruptions in claims payment.

Sign up for your new MAC's listserv or if you aren't signed up for your current FI or carrier's listserv, please do so immediately. While in many cases the list of providers that were in the jurisdiction of the outgoing Medicare contractor will be shared with the incoming MAC, that may not always be the case. Subscribing to the MAC listserv distribution will ensure that you receive news and resource tools as they become available concerning the implementation.

Access and bookmark the MAC's website, particularly any part of the site devoted to information about the MAC transition/implementation) and visit it regularly. The MAC may have a new website that will have general information, news and updates, information on the MAC's requirements of providers, copies of newsletters and information on meetings and conference calls that are being conducted by the MAC.

Review the Frequently Asked Questions (FAQs) on the MAC's website.

Participate in the MAC's advisory groups and "Ask the Contractor" teleconferences. (Note that these advisory groups are usually limited in size.) Every MAC will be conducting conference calls to give providers the opportunity to ask questions and have open discussion. Take advantage of the opportunity to communicate with the new MAC!

Review the MAC's Local Coverage Determinations (LCDs) as they may be different from the outgoing contractor's LCDs. The MAC must provide education on LCDs. Providers should monitor MAC communications and website for information regarding potential changes to the LCDs.

Two-Three Months Prior to Cutover

- **Complete and return your Electronic Funds Transfer (EFT) agreements.** CMS requires that each provider currently enrolled for EFT complete a new CMS-588 for the new MAC and, if you are not on EFT, this may be a good opportunity to consider enrollment in EFT. (If your new MAC is the same entity as your current FI/carrier, then a new EFT agreement is not needed.) This form is a legal agreement between you and the MAC that allows funds to be deposited into your bank account. It is critical for the MAC to receive these forms before any payments are issued. Complete the CMS-588 and submit it to the MAC to ensure that there is no delay or disruption in payment. We encourage you to do this no later than 60 days prior to cutover. If you fail to submit the CMS-588 form as required, the new MAC will place you in a "Do Not Forward" (DNF) status as required by Chapter 1, Section 80.5 of the *Medicare Claims Processing Manual*. Contact your MAC with any questions concerning the agreement.

  The CMS-588 form can be found at http://www.cms.gov/cmsforms/downloads/CMS588.pdf on the CMS website.

  You are encouraged to submit the agreements no later than 60 days prior to the planned cutovers. To do so, you will need to note the mailing address for the form, which is available on the MAC's website. Your current contractor may also provide instructions on its website on accurately completing the form.

- Your new MAC may also request you to execute a new **Electronic Data Interchange (EDI) Trading Partner Agreement** as well. If so, be sure to complete that agreement timely. Some helpful information on such agreements is available at http://www.cms.gov/EducationMaterials/downloads/TradingPartner-8.pdf on the CMS website.

- Some (not all) MAC contractors may assign you a new EDI submitter/receiver and logon IDs as the cutover date approaches. Review your mailings from the MAC and/or their website for information about assignment of new IDs and whether you have to do anything to get those IDs. The MAC EDI staff will send these submitter IDs and passwords to you in hardcopy or electronically. **You don't need to do anything to get the new IDs**; however, if you do receive a new ID and password, CMS strongly suggests that you contact the incoming MAC to test these IDs. Since there may be a different EDI platform, it is critical to consider testing to minimize any disruption to your business at cutover.

- **Contact your claims processing vendor, billing department, and clearinghouse** to ensure that they are aware of all changes affecting their ability to process claims with the new MAC. Ask your vendor, "Are you using the new contractor number or ID of the new MAC, submitter number and logon ID?"; "Have you tested with the MAC?"

- Because the contractor number is changing, your EDI submissions need to reflect the new MAC number at cutover.

- Be aware of the last date you can receive and download electronic remittance advices (ERAs) from your outgoing contractor.

- Be aware that some MACs may offer participation in an "early boarding" process for electronic claims submission and/or Electronic Remittance Advice (ERA). This will enable submitters the ability to convert to the new MAC prior to cutover. If you are currently receiving ERAs, you will continue to do so after cutover. As mentioned previously, some MACs may assign a new submitter/receiver ID and password –watch for and document them for use after cutover to the MAC.

Cutover Weekend

Be aware that in certain situations, CMS will have the outgoing Medicare contractor release claims payments a few days early in preparation for implementation weekend (weekend prior to cutover). Providers will be notified prior to the cutover date if they will receive such payments. While the net payments are the same, providers will experience increased total payments followed by no payments for a two week period.

Be aware that providers may also experience system "**dark days**" around cutover weekends. Providers will be notified by the MAC or outgoing contractor if a dark day(s) is planned for the MAC implementation. During a dark day, the Part A provider will have limited EDI processing and no access to Fiscal Intermediary Standard System (FISS) to conduct claim entry or claim correction, verify beneficiary eligibility and claim status. Those providers who currently bill carriers may also experience some limited access to certain functions, such as beneficiary eligibility and claims status on dark days.

Be aware that some Interactive Voice Response (IVR) functionality may also be unavailable during a dark day.

Post-Cutover

- The first 1-2 weeks may be extremely busy at the MAC. The outgoing Medicare contractor will have the "in-process" work delivered to the new MAC shortly after cutover. It takes a week in most cases to get that workload into the system and distributed to staff.
- The new MAC will likely have new mailing addresses and telephone numbers or will transition the outgoing contractor toll-free number for use.
- Be prepared that you may experience longer than normal wait times for Customer Service Representatives (CSRs) and lengthier calls the first few weeks after implementation. The telephone lines are always very busy immediately following cutover. The MAC's staff will carefully research and respond to new callers to be certain that there are no cutover issues that have not been discovered.
- **Learn how to use the MAC's IVR.** The MAC IVR software and options may be different from the outgoing FI or carrier. A new IVR can take time to learn. Most calls are currently handled by IVR. If users are unfamiliar and resort to calling the Customer Service Representative (CSR) line, the result is a spike in volume of calls to CSRs that are difficult to accommodate.
- Check the MAC's outreach and education event schedule on the MAC's and outgoing contractor's websites. It is recommended that you have staff attend some of the education courses that may be offered by the MAC.
- Be aware that there may be changes in faxing policies (e.g., for medical records).
- Be aware that there will be changes to PO Boxes and addresses for the submission of requests for Redeterminations (appeals), inquiries, and written reopening requests.
- Be aware that the MAC may edit claims differently from your outgoing contractor, so it is important to review your Remittance Advices (RAs) carefully to identify when this occurs.
- Be aware that you may experience changes in RA coding. While the combination of codes used on the RA is often directed by CMS, there may be payment situations where the codes used on the RA are at the discretion of the contractor. In addition, some contractors may have their own informational codes that they use on paper RA for some payment situations.

CMS Post-Cutover Monitoring

Post-cutover is the CMS-designated period of time beginning with the MAC's operational date. During the post-cutover period, CMS will monitor the MAC's operations and performance closely to ensure the timely and correct processing of the workload that was transferred. The post-cutover period is generally three months, but it may vary in length depending on the progress of the implementation.

Additional Assistance

There are three attachments at the end of this article to assist you in keeping informed of the progress of the cutover as well as documenting important information:

- Attachment A is a summary of what you need to do and information you will need;
- Attachment B may be used to track communications offered by the MAC, such as training classes and conferences, and your staff participation; and
- Attachment C may be used to assist you in tracking major MAC milestones.

Additional Information

The following MLN Matters article provides additional information about the MAC implementation process:

- MM5979: "Assignment of Providers to Medicare Administrative Contractors" located at http://www.cms.gov/MLNMattersArticles/downloads/mm5979.pdf on the CMS website.
- MM6207: "Initial Enrollment Assignment for Federally Qualified Health Centers (FQHCs), End Stage Renal Disease (ESRD) Facilities, and Rural Health Clinics (RHCs)", located at http://www.cms.gov/MLNMattersArticles/downloads/MM6207.pdf on the CMS website.

Attachment A
TIMELINE AND CHECKLIST FOR PREPARING FOR MAC IMPLEMENTATION

Scheduled Award Date:	**MAC Cutover Date:**
Actual Award Date:	**MAC Scheduled Dark Days**
MAC Contractor:	**MAC Website:**
MAC Contractor Number:	**MAC Contact Center Number: 1-800-**
MAC Mailing Address:	**MAC EDI Mailing Address:**

90 DAYS BEFORE CUTOVER

1. Visit MAC website and bookmark for future use.
2. Join the MAC Listserv.

3. **Monitor**:
   LCDs published by the new MAC; compare current LCDs that affect your practice's services.
4. **Review**:
   Provider enrollment status for all providers, update as needed. Pay-to address information for practice/ providers, update as needed.
5. **Contact**:
   Your Practice Management/Billing software vendor to determine if your system will be able to send & receive data to/from the new MAC.
6. Your claims clearinghouse (if used) to confirm they are or will be able to send and receive data to/from the new MAC.
7. Your billing department, vendor, or clearinghouse to be sure they are aware of the changes communicated from the incoming and outgoing contractors. To avoid delays in claims submission and processing and appeals requests submission, effective dates must be communicated to your appropriate provider staff and resources.

75 DAYS BEFORE CUTOVER

1. Check the MAC's website and/or Listserv for outreach programs, educational and informational events, FAQs, and conference calls.
2. Check your state's Medical Society or local provider organization website for MAC transition information, MAC Coordinators.

60 DAYS BEFORE CUTOVER

1. Submit CMS Form 588 – EFT form(s) to the new MAC, if needed.
2. Register for Electronic Remittance Advice (ERA) enrollment, if you are not already enrolled.
3. Download or request a sample Remittance Advice (RA). RA codes are standard but use of codes may vary across contractors.
4. Submit test electronic claims as soon as new MAC indicates this is possible.

45 DAYS BEFORE CUTOVER

1. Monitor current carrier/FI claim submissions and follow-up any open or unanswered claims that are more than 30 days past submission date.
2. Begin staff training on the MAC transition, covering locations, LCDs, telephone and fax numbers and other changes.
3. Verify readiness of software vendor, clearinghouse(s) and other trading partners.

30 DAYS BEFORE CUTOVER

1. Continue to monitor current carrier/FI claim submissions and follow-up any open or unanswered claims that are more than 30 days past submission date.
2. New EDI Submitter ID number and password should be received.
3. New ERA enrollment confirmation should be received.
4. Submit test electronic claims if you have not done so by now.
5. Address and resolve any electronic claim issues within 10 business days.
6. Begin daily monitoring of the MAC website and e-mail from the MAC Listserv.

15 DAYS BEFORE CUTOVER

1. Continue to monitor current carrier/FI claim submissions.
2. Verify EDI and ERA connections are operational in the new environment.
3. Collect and record all MAC telephone and fax numbers for: General Inquiry Customer Service, Provider Enrollment, Provider Relations, EDI and ERA.
4. Become familiar with the MAC IVR query system by taking advantage of educational opportunities as most IVRs are not available until cutover because new outgoing claims/NPI information has not been loaded for accessibility.
5. Continue daily monitoring of e-mail from the MAC Listserv and the MAC website.

10 DAYS BEFORE CUTOVER

1. Address any existing open items.
2. Continue daily monitoring of e-mail from the MAC Listserv and the MAC website.

5-10 DAYS AFTER CUTOVER

1. Begin submitting claims to the new MAC.
2. Continue daily monitoring of e-mail from the MAC Listserv and the MAC website.
3. Monitor and follow up on the MAC Open Item list.

30 DAYS AFTER CUTOVER

1. Electronic payments should be arriving by now.
2. Payments for paper claims may be arriving by now.

Attachment B
SCHEDULE OF MAC CONTRACTOR TRAINING CLASSES

Scheduled Date	Title of Class	Attendee

SCHEDULE OF MAC CONFERENCES

Scheduled Date	Conference Subject	Attendee

Attachment C
Important MAC Implementation Dates

MAC Dark Days	
Cutoff Date for Claims Submission to the Outgoing Contractor	
Last Date Outgoing Contractor Will Make Payment	
Last Date Outgoing Contractor Will Have Telephone/Customer Service	
Last Date Outgoing Contractor Will Send File to Bank	
Last Date to Retrieve ERAs from Outgoing Contractor	
Date MAC Will Accept Electronic Claims	
Date MAC Will Accept Paper Claims	
Date MAC Bill/Claim Cycle Begins	
Date MAC Will Accept Written Appeals Requests (Redeterminations)	
First Anticipated MAC Payment Date	
Date MAC Begins Customer Service	

Preparing for a Transition from an FI/Carrier to a MAC or from one DME MAC to another DME MAC – SE0837

MLN Matters® Number: SE0837

This article, SE0837, has been updated and re-issued as SE1017. You can find the updated article at http://www.cms.gov/MLNMattersArticles/downloads/SE1017.pdf on the Centers for Medicare & Medicaid Services website.

A Health Information Technology Update

Beacon Communities Lead the Charge to Improve Health Outcomes Establishing Beacons for Nationwide Advances in Health IT

A Message from Dr. David Blumenthal, National Coordinator for Health Information Technology

May 5, 2010

Healthcare professionals appreciate opportunities to learn from innovative colleagues and communities – to see what really works, to get "boots-on-the-ground" perspectives, to learn best practices, and to use the experience of other leaders to inform how to improve performance more broadly.

The Beacon Community Cooperative Agreement Program, by its very design, was intended to shine a spotlight on health information technology (health IT) innovators, so that we all might learn from them. Yesterday, Secretary Sebelius awarded $220 million to establish 15 Beacon Communities throughout America. These community consortia – selected from 130 applicants – have demonstrated leadership in developing advanced health IT solutions to help improve specific health outcomes. They also share a strong conviction in the benefits of health IT as a critical pillar to advance broad and sustainable health system improvement. The average award amount is $15 million over 36 months.

The Beacon Community awards recognize collaborative community efforts operating at the cutting edge of health IT and health care delivery system innovation. Beacon Communities will implement a range of care delivery innovations building on existing infrastructure of interoperable health IT and standards-based information exchange, in coordination with the Regional Extension Center Program and State Health Information Exchange Program.

In addition, the program will help Beacon Communities plan and develop new initiatives that can ensure the longer-term sustainability of health IT-enabled improvements in health care quality, safety, efficiency, and population health. This includes preparing for future policy changes resulting from enactment of health care reform legislation that will permit providers, states, and regional health care organizations to test new payment methods emphasizing improvements in quality and value.

Like so many other providers who effectively implement health IT, Beacon Communities will leverage other existing federal programs and resources to promote health information exchange at the community level. These resources include:

- Department of Defense and the Department of Veterans Affairs Virtual Lifetime Electronic Record (VLER) program, which aims to develop a longitudinal electronic health record for all active duty, Guard and Reserve, retired military personnel, and eligible separated Veterans
- Health Resources and Services Administration (HRSA) programs at federally qualified health centers (FQHCs) and Health Center Controlled Networks (HCCNs) to advance the adoption of certified electronic health records and exchange of health information
- Department of Agriculture and Department of Commerce efforts to extend broadband infrastructure

The partnership with applicable VLER, FQHC, and HCCN sites is particularly important to ensure we realize measurable and tangible results in federally funded, military, and private sector health care settings alike.

I would like to acknowledge and praise the many applicants who were not funded today, but whose experience and commitment suggests our nation has an encouraging foundation of health information exchange to build on. An additional $30.3 million is currently available to fund additional Beacon Community cooperative agreement awards. An announcement to apply will be made in the near future.

FYI CONT'D

Especially, I am particularly pleased by the diversity among Beacon awardees: geographically, they span the continental United States and reach as far as Hawaii; both urban and rural communities are well represented; and targeted program outcomes span some of America's most pressing health concerns, from reducing medication errors and improving the care of individuals with cardiovascular disease to reducing disparities in access and outcomes for patients with diabetes. Additionally, the programs bring health IT innovation to a variety of underserved populations to address health disparities and improve patient care. The Beacon Communities demonstrate that health IT can bring meaningful change to health care for all Americans — not just the healthiest, wealthiest, or best insured.

I extend my sincere congratulations to our 15 Beacon Communities. Your work inspires me, and I believe that in the coming months, it will inspire and inform America's medical and health IT communities.

Sincerely,
David Blumenthal, M.D., M.P.P.
National Coordinator for Health Information Technology

U.S. Department of Health & Human Services

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

EDUCATIONAL

Self-Paced DME Tutorials

With the addition of several self-paced tutorials available on the Training/Events page, the Online Learning Center will be removed from our website. The self-paced tutorials include questions and resources throughout the lesson, a certificate of completion and a survey. The tutorials currently available are:

- Advance Beneficiary Notice of Noncoverage
- DME Modifiers
- Documentation Prior to DME Claim Submission
- Enteral Nutrition
- Glucose Monitors and Testing Supplies
- Hospital Beds
- Manual Wheelchair Bases
- Ostomy Supplies
- Putting the Pieces of DME Together: Basics of Medicare and DME, Email Updates, Upgrades
- Refractive Lenses

Sign-up for our email updates to receive announcements of new topic availability.

2010 Ask the Contractor Teleconferences

If you have a question on your mind and are not sure who to ask - the Ask the Contractor Teleconferences are

EDUCATIONAL CONT'D

your opportunity to speak directly to your contractor. Knowledgeable NAS staff representing a variety of functions will be available to answer your questions. If we cannot answer your question during the teleconference, we will research the issue and then call you with the answer.

Following each teleconference the questions and answers (Q&A) will be posted to our Web site. You can view the Q&A from the NAS home page by choosing Durable Medical Equipment > Training/Events > ACT Questions & Answers.

To participate in these ACTs, dial 1-800-553-0288. For those suppliers who may need an international number (American Samoa, Guam or the Northern Mariana Islands) dial 1-612-332-0530.

The following ACTs are offered:

General – 3 p.m. CT

- August 25
- November 10

Topic Specific – 3 p.m. CT

- Enteral Nutrition - October 20

After placing the call for the ACT, you will be asked to provide the following:

- Conference Name: DME Jurisdiction D Ask the Contractor Teleconference
- Your name
- Name of the organization you represent
- State from which you are calling

NAS looks forward to your participation in these Ask the Contractor Teleconferences.

Ask the Contractor Q&A – May 20, 2010

Prior to taking questions, NAS provided the following updates:

Endeavor

Suppliers are strongly encouraged to register for a new "portal" called Endeavor which offers free, online access to patient eligibility, claim status, and remittance advices.

The hours of availability are:

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

Suppliers, billers and third parties may register for Endeavor.

Note: Each person accessing Endeavor must register for their own User ID. User IDs can not be used by more than one person.

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

New Website

The NAS website has a new look. To familiarize yourself with the changes, go to the website and navigate around or take the Web Tour on the NAS homepage. The changes are based on provider and supplier comments within surveys, data analysis, CMS guidance, and customer testing and feedback. We encourage suppliers to continue completing the website Satisfaction Survey each time it is presented. This will allow NAS to continue to improve our website to more effectively meet your needs.

Timely Filing Requirements for Medicare Fee-For-Service Claims

On March 23, 2010, President Obama signed into law the *Patient Protection and Affordable Care Act* (PPACA), which amended the time period for filing Medicare fee-for-service (FFS) claims as one of many provisions aimed at curbing fraud, waste, and abuse in the Medicare program.

Under the new law, claims for services furnished on or after January 1, 2010, must be filed within one calendar year after the date of service. In addition, Section 6404 mandates that claims for services furnished before January 1, 2010, must be filed no later than December 31, 2010. The following rules apply to claims with dates of service prior to January 1, 2010. Claims with dates of service before October 1, 2009, must follow the pre-PPACA timely filing rules. Claims with dates of service October 1, 2009, through December 31, 2009, must be submitted by December 31, 2010.

IVR Updates

The Interactive Voice Response (IVR) system now offers a feature that allows suppliers to research ordering and referring physician information to help avoid PECOS error messages. Enter the NPI, the first name, and the last name of the referring physician to determine if that physician is or is not enrolled in the Medicare Provider Enrollment, Chain and Ownership System.

Overpayments, also known as offset, inquiries are now available from the IVR. Suppliers will need to enter their fourteen digit Financial Control Number (FCN) as it appears on the remittance advice to obtain the name of the beneficiary, the dates of service, the amount of the overpayment, and how many overpaid claims are involved and provide the details for each overpayment (up to ten claims per FCN).

Q1. If a beneficiary has a rental item through a different insurance and then in the fifth rental month becomes Medicare eligible, do we continue billing the same rental period (month six) or does this start over as a new capped rental period?
A1. This would begin as a new rental period as long as the beneficiary meets the medical necessity for the item and has a new order. Months paid for by other insurances do not go towards the Medicare benefit of 13 rental payments for a capped rental item.

Q2. Where does it state in writing that CMS does not recognize addendums to medical records as stated in previous Ask the Contractor Teleconferences (ACT)?
A2. The issue is not that 'CMS does not recognize addendums' but rather that the order on which delivery of a service or supply is based must be complete at the time it is used to determine that supply or service. It cannot be lacking some essential piece of information that is subsequently filled in or added. Required medical information can be found in the *Program Integrity Manual Publication* 100-8 Chapter 5, as well as the specific local coverage determination.

Q3. The new continuous positive airway pressure (CPAP) device instructions state as long as the patient has a compliance download that is over 70 percent, the face-to-face evaluation does not have to fall within the 31st and 90th day (for example, doctor or patient is on vacation that month). Is it true as long as we have a good compliance download, the follow up face-to-face can be at any point?
A3. The patient must be compliant between the 31st and 90th day, which states ≥ 4 hours per night on 70 percent of nights during a consecutive 30 day period anytime during the first three months of initial usage. If the face-to-face evaluation occurs after the 91st day, and if the physician determines the patient is benefiting from the CPAP therapy, coverage would continue on the date of the re-evaluation.

Q4. A patient's oxygen equipment broke in the 59th month so we replaced it even though he wasn't eligible for the new five year rental period until month 60. Now he is in the 60th month and we are able to set him up to begin a new five year rental period. Can this replaced piece of equipment be considered the new equipment for the new five year rental period?
A4. No. In order to bill for a new 36 month capped rental period, you need to replace the equipment after the five year reasonable useful lifetime (RUL) has been reached and have proof of delivery to reflect the RUL has been reached.

Follow-up. It does not matter that the patient received the new equipment prior to the end of the 60 months as long as the equipment lasts five years; we have a new order, all required documentation, and new CMN?
A. Yes it does matter. The new 36 month rental cannot begin until new equipment has been delivered after the five year RUL.

Q5. We are having problems determining if a beneficiary is in home health until after our money is recouped. Is there something we can do proactively so we do not have to refund our money? Nine out of ten times their home health diagnosis has nothing to do with our equipment.
A5. Home health is not based on diagnosis although hospice is. It is important to complete a thorough intake process in order to know if the patient is in a home health episode. If the patient is in a home health episode, the home health agency receives payment for most supplies needed by the beneficiary. It is the supplier's responsibility to make an agreement with the home health agency in order to receive reimbursement for the supplies they provide. A listing of supplies the home health agency will receive payment for are located at the following link under Home Health Consolidated Billing Master Code List: http://www.cms.hhs.gov/HomeHealthPPS/03_coding_billing.asp.

Follow-up. When I bill for an item that is not on the home health list and receive a denial, can I appeal that decision?
A. Yes.

Q6. Are signature and date stamps allowed on written orders and CMNs? I was under the impression they were not allowed; however, I found a frequently asked question (FAQ) on your website stating otherwise.
A6. This FAQ was correct at the time of posting; however, guidelines have changed since then and this will be updated on the website. It is not the presence of a stamp that is unacceptable; it is the lack of a valid signature. You will have some circumstances where a signature will be stamped and then someone overwrites it with the way they do their signature that is not legible. This would be acceptable but is must be an identifiable signature. Please refer to MLN Matters 6261 Signature and Date Stamps for DME Supplies, Certificates of Medical Necessity and DME Information Forms posted to our website on January 6, 2009, for more information.

Q7. We have been receiving Comprehensive Error Rate Testing (CERT) denials stating they cannot read the doctor's signature. A consultant at Medtrade told us to send letters to our physicians and have them write their name on the letter and sign it and keep it on file so when we get a CERT audit or Advance Determination of Medicare Coverage (ADMC) we would be able to send that letter to whomever needed it. Is this a good business practice?
A7. Yes, this would be a good business practice. The signature needs to be identifiable and if you have a key stating whose signature it is, that would be acceptable.

Q8. Could you please clarify the implementation date for PECOS?
A8. The implementation date is January 3, 2011.

Q9. We are receiving payment on claims submitted with a GA modifier indicating we have a valid Advance Beneficiary Notice of Noncoverage (ABN) on file when we are expecting a denial. We call redeterminations to let them know we are giving the money back and have them reprocess the claim. Is there a reason we are still getting payment when we append the GA modifier?
A9. Examples were faxed and this was an internal error that has been fixed.

Q10. This is regarding CPAPs. The patient sees their doctor on the 40th day from setup but does not meet compliance until the 80th day. Does the patient need to go back to the doctor if the doctor charted some subjective improvement on the 40th day? Are they okay with the doctor visit? It has also happened where subjectively they are showing improvement by what they are telling the physician, which appears to meet the requirement, but they are not compliant yet because they are not at 70 percent, they are at 68 percent and I need more time to get them compliant.
A10. The first scenario is fine as long as there is a compliance report included in the physician's medical records that shows adherence to therapy within the first 90 days. Refer to the PAP Devices – Supplier Frequently Asked Questions Revised September 2009 question number four. In the second scenario, there must be documented proof of adherence to therapy before the 91st day in order to meet the criteria for continued coverage, which is ≥ 4 hours per night, 70 percent of a consecutive 30 day period.

Q11. We have patients who are using their relatives CPAP machine rather than receiving one of their own to save money. How do we bill Medicare for replacement supplies?
A11. Indicate on the narrative of the claim that the patient owns the CPAP. In order to use the KX modifier as stated in the policy, the patient must meet the qualifications for the CPAP. Also, ensure all supporting documentation is in your records.

Q12. We have a patient who has a CPAP purchased by a private insurance. Subsequently, they enrolled in Medicare prior to the 2008 policy changes where they were eligible for Medicare to reimburse for replacement supplies through another company. Now the patient is choosing us as their supplier and we will be billing Medicare for the replacement supplies. What kind of documentation do we need since the patient was 'grandfathered' in with another supplier?
A12. Supporting documentation should be kept in your records showing the patient qualified for the CPAP at the time Medicare began reimbursing the previous supplier for the supplies. When submitting the claim, indicate on the narrative that the patient owns the CPAP from a previous insurance. Please refer to the article "Supplies and Accessories Used with Beneficiary Owned Equipment" posted to our website June 10, 2009, for more information.

Q13. Our office recently went from paper charting to electronic charts. If everything is scanned into our system, which paper originals are we required to keep on file?
A13. It is recommended to seek personal legal counsel for your business and ask them to render their professional opinion.

Q14. In our hospitals, we are using bar codes that are not actual signatures. It is a bar code that the doctor is filling out at the bottom of the sheet. A lot of hospitals attach to that bar code what the doctor's signature is. Are bar codes going to be acceptable?
A14. For medical review purposes, Medicare requires that services provided/ordered be authenticated by the author. The method used must be a hand written or electronic signature. Legal counsel should be consulted to determine if a bar code is an electronic signature.

Q15. I have a question about face-to-faces. We are having a lot of issues with our doctors about what is part of the chart notes. We had a patient try to get an ADMC for a power wheelchair and had a therapist specialty evaluation. The therapist wants to keep the documentation she wrote, which the doctor signed off on, since she believes that should not be considered part of the patient's chart and be available to the supplier. It is my understanding that the chart notes would be what the doctor is writing at the time of the face-to-face visit when they are discussing getting a new chair. Is this correct?
A15. Generally, anything the physician puts into the record and acknowledges and keeps in a manner that identifies the patient, date, and requirements, will be part of the record.

These are things relating to the patient's status that can be generated from the chart that would be part of the record.

Follow-up. My understanding of what is needed for the face-to-face is correct? It is what the doctor is recording that day on the visit? What they have discussed and entered, his evaluation of the patient?
A. Refer to the face-to-face exam requirements in the power mobility device policy article.

Follow-up. Scenario: The patient goes in for the face-to-face today and the doctor sends him out to get a specialty evaluation, which can take a while. When that specialty evaluation comes back, is that considered part of the face-to-face that occurred 45 days before?
A. Per the policy article, the face-to-face is determined to have occurred on the date the physician reviews the specialty evaluation report from the therapist and stated concurrence or any disagreement with that examination. The supplier would need to receive the 7-element order from the physician with 45 days of that date. If the physician decides to see the patient again after the specialty examination, then that would become the end of the face-to-face examination. Again, please refer to the Power Mobility Devices policy article for various situations regarding the face-to-face examination.

Follow-up. This would be the date of the face-to-face?
A. Yes, in the situation where the physician sends the patient off for a specialty evaluation, gets the report back and the date the report is reviewed and signed off, even if there wasn't a face-to-face that occurred that day, this becomes the new face-to-face date.

Q16. If I have a patient that rented a patient lift through a Heath Maintenance Organization (HMO) type insurance for 12 months and then becomes Medicare eligible, do we start with month one when billing Medicare?
A16. Medicare entitlements begin when the beneficiary becomes Medicare eligible. If the beneficiary does not own the equipment, the supplier may begin submitting claims to Medicare for the covered item. Month one begins on the date of Medicare eligibility.

Q17. We have a CMN for oxygen for a patient that is missing the qualifying test date and saturation rates. The physician will not take the patient off the oxygen to complete the testing because of their condition. He did the test with oxygen and the saturation levels were 95. How do I bill for this?
A17. If a CMN is submitted to Medicare with non-qualifying or missing information, the claim will deny. You can appeal the decision with a complete CMN. It is suggested to send in a separate letter with your appeal indicating the physician believing there is a safety reason to not be able to comply with the CMN and this may be taken into consideration.

Q18. According to the clarification on detailed written orders that came out April 1st, it states you can not list incompatible items on the same order. New CPAPs are coming out that have heated and regular tubing. Would that be considered incompatible?
A18. No. These items are considered compatible with a CPAP. The clarification describes items that would not work with the CPAP. However, the physician should only be ordering the tubing that will be used with the CPAP machine, not both.

Q19. Is there an end date in sight for the K0004 pre-pay review?
A19. At this point there is not an end date. Any information regarding the pre-pay review will be posted to the What's New section of our website.

Q20. When a patient has received a power operated vehicle (POV) from a different vendor and comes to us for repairs, what type of documentation is needed in our files?
A20. The documentation required is stated within the LCD. If you are unable to obtain the required documentation to prove medical necessity or are able to obtain it but it doesn't prove medical necessity, execute an ABN to protect yourself from liability and append the GA modifier to the code. This claim is likely to deny and can then be billed through secondary insurance.

Q21. Is there anyway to find out prior to billing Medicare if patient is in a home health episode?
A21. You can call the IVR for eligibility status. Also, complete a thorough intake process by asking the patient if they are in a home health episode.

Q22. Can we get pre-approval on power wheelchairs?
A22. Yes. You can complete an Advance Determination of Medicare Coverage (ADMC) for power wheelchairs to determine in advance whether payment for the item may not be made because it is a noncovered item.

Q23. We have dispensed a CPAP with a written order for the CPAP in pressure but the physician writes "patient choice on mask". We fit the patient upon setup with a nasal mask. Ten days later it doesn't work so we give them nasal pillows. They are still not happy so ten days later we give them a full face mask. We now have to get a detailed written order for each supply, mask, tubing, and heater. This happened 30 days after we dispensed the CPAP yet we haven't billed. We send the detailed written order to the physician to sign. Since there are three different days of service, do we have to get three different detailed written orders (one for the nasal mask, one for the nasal pillows and one for the full mask)? Or can we signify that all three were used by the time the detailed written order was signed?
A23. The physician should confirm **each** verbal order by signature. This validates the order. Even when both orders are on a single page, if they were received as different verbal orders (as distinct from separate items all part of a single order), then each verbal order should be validated by a signature.

Q24. Is a physical therapist evaluation enough documentation to provide a manual wheelchair and a walker on initial issue?
A24. We do not cover two pieces mobility assistive equipment (MAE) at the same time. If the claim is denied, you can go through the appeals process and submit any supporting medical documentation stating why the patient needs both pieces of equipment.

Q25. Can we call the IVR for home health start and end dates?
A25. The IVR will give that information only if the home

health agency has billed for it. If they haven't billed for it, our system would not be able to access that information for you. Endeavor will also supply you with home health information.

Q26. When will same or similar be available through Endeavor?
A26. This is in process with no time frame.

Q27. In regards to the detailed written orders for CPAP, we have been using the order that lists all of the interfaces and we only supply the patient with what replacement items they need and at the specific frequency. Do we have to get a new order that only lists what the patient is supplied with?
A27. The detailed order must be specific. The order can take different forms (blank, fill-in, check-off, circle, etc.) but it should be clear as to which components have or have not been ordered. It is not acceptable to order "any of the above that are appropriate" with a long list.

Glucose Monitor and Testing Supplies Ask the Contractor Q&A – April 21, 2010

Additional Resources for Glucose Monitor and Testing Supplies is available within the Local Coverage Determination (LCD) and Policy Article.

Prior to taking questions, NAS provided the following updates:

PECOS on IVR

The IVR, (877) 320-0390, now offers a feature that allows suppliers to research ordering and referring physician information to help avoid Medicare Provider Enrollment, Chain and Ownership System (PECOS) error messages. Enter the NPI, the first name, and the last name of the referring physician to determine if that physician is or is not enrolled in PECOS.
https://www.noridianmedicare.com/dme/news/docs/2010/03_mar/pie_available_through_ivr.html

Overpayments on IVR

Overpayment, also known as offset, inquiries are now available from the IVR. Suppliers will need to enter their fourteen digit financial control number (FCN) as it appears on the remittance advice to obtain the name of the beneficiary, the dates of service, the amount of the overpayment, and how many overpaid claims are involved and provide the details for each overpayment (up to ten claims per FCN).
https://www.noridianmedicare.com/dme/news/docs/2010/03_mar/overpayment_information_available_through_ivr.html

Self-paced Audio Courses Available

Self-paced audio courses are now available on our website under the Training/Events tab. Two courses are currently available including Advance Beneficiary Notice of Noncoverage (ABN) and Glucose Monitors and Testing Supplies.

DME Emial Listserv

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

Patient Protection and Affordable Care Act

On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act (PPACA), which amended the time period for filing Medicare fee-for-service (FFS) claims as one of many provisions aimed at curbing fraud, waste, and abuse in the Medicare program. Under the new law, claims for services furnished on or after January 1, 2010, must be filed within one calendar year after the date of service. In addition, Section 6404 mandates that claims for services furnished before January 1, 2010, must be filed no later than December 31, 2010. The following rules apply to claims with dates of service prior to January 1, 2010. Claims with dates of service before October 1, 2009, must follow the pre-PPACA timely filing rules. Claims with dates of service October 1, 2009, through December 31, 2009, must be submitted by December 31, 2010.

Questions received prior to the call:

Q1. Are suppliers required to obtain supporting medical necessity documentation prior to dispensing from the ordering physician for patients who are non-insulin, testing greater than 1x a day, and for insulin dependent patients testing greater than 3x a day?
A1. It is a business practice decision when you collect this documentation; however, medical necessity information must be available upon request. Medical records created after the item has been dispensed will not be used to support coverage criteria for those previously dispensed dates of service.

Q2. Are suppliers required to obtain supporting medical necessity documentation from the ordering physician every six months prior to dispensing to patients who use over the normal guidelines? Can a glucose log from the patient suffice?
A2.It is a business practice decision when you collect documentation, but must be available upon request and created prior to the date of service for the quantities of supplies above the normal guideline. A patient's glucose log may support coverage criteria F (proof that the patient is testing at a frequency that corroborates the amount dispensed) for dates of service prior to the refill, but documentation to support D and E is also required:

- D. The treating physician has ordered a frequency of testing that exceeds the utilization guidelines and has documented in the patient's medical record the specific reason for the additional materials for that particular patient.
- E. The treating physician has seen the patient and has evaluated their diabetes control within six months prior

to ordering quantities of strips and lancets, or lens shield cartridges that exceed the utilization guidelines.

Q3. Please define in writing what determines or what are the criteria to determine a diabetic patient is receiving comprehensive care/treatment for their diabetic condition.
A3. The treating physician maintains records reflecting the care provided including, but not limited to, evidence of medical necessity for the prescribed frequency of testing.

Q4. During another Jurisdiction's webinar, it was communicated that patients can call and request a refill of diabetes testing supplies earlier than the "seven day window". The example was given that if a customer calls in nine days prior to their expected supply exhaustion date, it is acceptable to use that contact as consent for the refill order. However, they were unable to provide a clear guideline as to how much earlier the customer's call can be accepted. Is there a guideline from Jurisdiction D on this?
A4. The approximate "seven days contact" window and approximately "five day dispensing window" is regarding the supplier contacting the beneficiary and not the beneficiary contacting the supplier. The policy states that "a beneficiary or their caregiver must specifically request refills of glucose monitor supplies before they are dispensed". Therefore, suppliers should not deny the beneficiary their needed supplies. The beneficiary may have lost or have had their supplies irreparably damaged (fell into water). Medicare pays for lost or irreparably damaged items. A note in the narrative section of the claim would be helpful for development purposes in the event the overlap is excessive.

Questions and answers taken during the call:

Q1. A patient is insulin treated, type-2 patient and is allowed to test three times per day according to the LCD. The patient is testing four or five times per day and the physician's documentation instructs the patient to test at this frequency. The supplier returns the requested documentation for the insulin patient. Why would the supplies that exceed the three time per day limit not be paid if they meet the LCD coverage criteria and only the excess (fourth or fifth testing) be denied? Why does NAS not at least pay for the LCD quantity of lancets? Are claims developed with requests sent to suppliers for additional documentation to process the claim, based on the total lancets billed in the preceding 90 days?
A1. A patient's claim history is taken into consideration during the claim processing decision. When there are multiple suppliers billing for the same patient during some/all of the same timeline or a large quantity of supplies has already been billed that meet the LCD coverage criteria, a supplier is likely to have their claim denied for over utilization. When the supplier bills over the LCD coverage criteria and does not overlap with another supplier billing also, NAS will likely develop the claim for documentation to support the quantity being billed. When the documentation is received, if it is missing a valid physicians order or proof of beneficiary exhaustion, the entire claim line for the lancets/strips will be denied for over utilization. If the documentation is received and the only item missing is the beneficiary's testing logs, NAS will divide the lines and pay for the LCD quantity approved amount on one line and place the overutilized units on a separate line and deny. Denial narratives are provided:

Reason Code CO-150: Contractual Obligation, Payer deems the information submitted does not support this level of service.

Remark Code-N115: This decision was based on a local medical review policy (LMRP) or Local Coverage Determination (LCD).An LMRP/LCD provides a guide to assist in determining whether a particular item or service is covered. A copy of this policy is available at http://www.cms.hhs.gov/mcd, or if you do not have Web access, you may contact the contractor to request a copy of the LMRP/LCD.

Follow up question: A patient is insulin dependent and testing five times a day per the prescription the supplier has on file. The supplier has obtained documentation leading them to believe that is a qualified order. A number of months or years later, the supplier is audited and requests more documentation from the doctor to continue to support the high testing frequency. The supplier then learns the patient's frequency should have been reduced to three times a day. If there is a patient who does not qualify for any level of over-utilization, but is clearly diabetic with a prescription, Medicare should pay for testing once per day at minimum. When audited, why is the entire claim denied instead of having one time per day paid and the remaining two times per day denied?
Follow up answer: When the documentation is received but is missing a valid physician's order or proof of beneficiary exhaustion, the entire claim line of lancets/strips will be denied for over utilization. If the documentation is received and the only item missing is the beneficiary testing logs, NAS will divide the lines and pay for the LCD quantity approved amount on one line and place the overutilized units on a separate line and deny with Reason Code CO-150 and Remark Code-N115.

Q2. When a supplier has a billing error and neglects to include the KX modifier or they mistakenly submit the modifier KS instead of KX for the insulin patient testing three or more times a day, why are those claims not paid until they go to the next level review like redeterminations, reconsiderations, or the Administrative Law Judge? If the patient's test log reflects the patient is in fact testing three times a day, the order states they are to test at that frequency, and the patient is insulin treated, why is it such a challenge to have the claims reprocessed for payment?
A2. If the patient is being treated with insulin injections, the KX modifier must be added to the code for the monitor and each related supply on every claim submitted. Placing the KS modifier on the claim is notifying Medicare that the patient is non-insulin dependent. If the claim was not submitted with the correct modifier, the appeal process would need to be pursued to make that correction. When the beneficiary meets all the coverage criteria and there is documentation to support testing over the guidelines, indicate that by using the KX modifier. If the patient does not meet the coverage criteria and/or it is not documented, it is recommended that a supplier split the claim line out for what is covered and what is not covered for claims processing by Medicare. Claim approval requires more than a patient's test log if/

when they are testing over three times a day. Medicare looks for justification for why the physician feels that they need to test in those quantities and that is why it would have to go through the appeals process so a medical review nurse can review the medical documentation.

Q3. On April 20, CMS sent out a MLN Matters article titled, "Medicare Coverage of Blood Glucose Monitors and Testing Supplies", SE1008. It reverts back to the policy from a few years ago that stated orders are valid for up to 12 months. Was this a mistake by CMS?
A3. This MLN Matters, SE1008 had a website modification date April 28, 2010, and the content from the MLN Matters was removed and replaced with a note: "This article is being revised and is temporarily unavailable. It will be re-posted as soon as possible." The article was reissued May 5 and is available within the What's New section of the NAS website. This article states, "A new order for diabetic testing supplies is required only if there is a change in the frequency of testing or a change in supplier."

Q4. Within the MLN Matters SE1008 article previously mentioned, it indicates "CMS expects the physician's records to reflect the care provided, including, but not limited to, evidence of medical necessity for prescribed frequency of testing. Physicians are not required to fill out additional forms from suppliers or to provide additional information to suppliers unless specifically requested of the supplier by the DME MAC." What does this mean?
A4. It is NAS' understanding this statement is in regards to the completion of a supplier-generated form. Since there is not a Certificate of Medical Necessity (CMN) attached to this policy, suppliers are not required to fill out that kind of information.

Q5. A physician is indicating his prescription reflecting how many times a day the patient is testing should suffice. The physician will not send medical records and stated that he would take his business to another company if persistence for documentation continued as this supplier is the only one asking for medical record information.
A5. The supplier is correct and should be requesting patient's medical documentation from the physician's office. NAS offers some supplier/physician resources that may assist in educating physician's / referral sources about the need to send the supplier documentation for their beneficiaries.

- Patient Documentation Form - Insulin Using [PDF]
- Patient Documentation Form - Non-Insulin Using [PDF]
- Physician Documentation Requirements - Blood Glucose Strips and Lancets [PDF]
- Physician Letter - Medical Records [PDF]

Q6. There have been denials based on how soon a patient is called for or shipped refills and/or lost supplies. Can a supplier mail supplies seven days early? When the patient states they have lost, damaged, or stolen supplies, can a supplier ship the supplies when requested, up to seven days early?
A6. A portion of the Program Integrity Manual (PIM) regarding supplies that can be dispensed as refills has been included within the LCD for glucose monitors and testing supplies. Per the LCD, the supplier should not make contact with the beneficiary any sooner than approximately seven days prior to the end of usage and should not ship the supplies any sooner than approximately five days prior to the end of usage. If denials were received for claims within the five days end of usage, it is recommended to pursue the appeals process as this would be an incorrect denial as long as the refill was requested by the beneficiary. The date of service is the shipping date so the Medicare claims processing system will deny any claims with dates of service greater than five days prior to the end of usage.

Q7. In regards to audits, when a patient is under-utilization or at the utilization outlined in the policy, either non-insulin dependent patients testing one time a day or insulin dependent patients testing three times a day or less, suppliers are asked to provide documentation that is only specified in the LCD for those over-utilized situations, i.e., logs, labs, doctors' notes. Basic claim submission often results in an Additional Documentation Request (ADR) or in a denial that is later appealed. We have attempted to reflect with the claim that the patient qualifies under the LCD guidelines and we specify the part of the policy that pertains to the lesser utilized patients to see if that will prevent/decrease ADRs. Why do claim reviewers/auditor's ask for this information when the policy specifically indicates the criteria is for over-utilization patients?
A7. In regards to Comprehensive Error Rate Testing (CERT) audits, the patient's medical records must reflect the patient has diabetes even when the patient tests at the level of the utilization guidelines. Section 1833 of the Social Security Act indicates the auditor can ask for the medical records to reflect the items are reasonable and necessary. CERT is a random audit and if glucose claims are selected, they may be for either over-utilized patients or "at-utilization" patients. Make sure each element being requested in the audit is provided.

- 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.

Q8. When a fraud referral was submitted to the Office of Inspector General Hotline for a beneficiary who was conducting potentially fraudulent activity in regards to obtaining diabetic test strips, the response received from the fraud agency was "at this time there is no interest in capturing fraud referral information regarding beneficiary activity" as they were more interested in capturing supplier fraud activities. What steps are in place to report when it is identified that there is potentially beneficiary fraudulent activity in relation to the use of diabetic supplies?
A8. To report potential fraud, call the tip line, 1-800-HHS-TIPS (1-800-447-8477). Beneficiaries may report fraud by calling 1-800-MEDICARE (1-800-633-4227). NAS also recommends sending in the fraud information to the

attention of our Benefit Protection (BP) team and our staff who works directly with the Program Safeguard Contractor (PSC) can refer the report for investigation.

NAS DME JD – Benefit Protection
PO Box 6736
Fargo ND 58108-6736

Q9. When redetermination denials are received, they indicate "there is no clear narrative statement as to why the patient should be testing at this frequency." Examples submitted by the supplier have included a) "blood sugars are on a roller coaster and there needs to be a change in insulin dosage" b) "insulin this many units, breakfast, lunch, dinner, evening snack" c) chart notes from the endocrinologists, or d) underlined criteria meeting the LCD requirement within the medical records, progress notes, the test logs, copy of the order, and/or copy of the pick-up slip. What is actually considered a narrative statement?
A9. That statement is resulting from what is/is not found within the patient's actual medical record when received and reviewed by NAS' Medical Review examiners. When a supplier receives and reviews the medical record and finds there is a physician's narrative statement indicating why that patient's diabetes is out of control or "it's up and down," that should suffice. Examples were asked to be sent in by the supplier and were not received.

Q10. A recommendation was received in regards to future LCD policy revisions. NAS was asked to consider the situation for newly diagnosed or hypertension diabetic patients with over-utilization testing regimens prescribed. A new patient will return the test log having multiple tests per day. The physician is notified the testing plan and purpose needs to be in the patient's notes and available when requested by the supplier. The patient's lab results return as "unremarkable." The test log results are not erratic in any way. The doctor's evaluation and notes compared to the clinical results does not portray a patient with difficulty controlling their diabetes; which causes concerns when an audit occurs. The supplier is placed in the position of providing something the doctor asked for, but yet not getting paid. It becomes an uncomfortable position for a supplier to inform a doctor that their clinical guidance and lack of "a remarkable theme" for overutilization does not match Medicare's guidance.
A10. NAS recommends properly executing an Advance Beneficiary Notice of Noncoverage (ABN) for the amount that is over what you feel you have documentation to support. CMS is working with Medicare Part A and Part B contractors to improve CERT. The two aspects they will address first are signature requirements and physician's documentation needs for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) they order. This concern/recommendation will be shared with CMS.

Q11. What is a comprehensive care and treatment plan in regards to a patient needing to be under a diabetic comprehensive plan of treatment?
A11. The glucose policy does not reference wording regarding a "comprehensive" plan of treatment for the patient with diabetes. The policy states that the patient must have diabetes and being treated by a physician for this diagnosis. In addition, the LCD states that the glucose monitor and related accessories and supplies are to be ordered by a physician who is treating the patient's diabetes and that this treating physician maintains records reflecting the care provided, including, but not limited to, evidence of medical necessity for the prescribed frequency of testing.

The policy for Therapeutic Shoes for Persons with Diabetes does reference a "comprehensive plan of care" which is in regards to the treating physician's documented plan for monitoring the patient's disease.

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

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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.

CEDI

CEDI Help Desk Telephone Line Modifications Effective Friday, May 28, 2010

The following changes are being made to better serve our Common Electronic Data Interchange (CEDI) customers. Effective **Friday, May 28, 2010**, the menu options for the CEDI Help Desk will be modified. The CEDI Help Desk will be adding an interactive voice response (IVR) system for checking status of CEDI enrollment forms.

The IVR will allow customers to check the status of their online enrollment forms within 24 hours of submission. To access the IVR, call 866-311-9184 and select Option 2 from the main menu. The IVR will ask for the Request ID (RID), Provider Transaction Access Number (PTAN), and National Provider Identifier (NPI) from the paperwork. Status of enrollment forms can be checked through the IVR 24 hours a day.

Note: The RID can be found in the e-mail notification of the online submission as well as on the printed copy of the forms.

Below are the options callers will hear when they contact the CEDI Help Desk by telephone at 866-311-9184.

Press 1 to hear the hours of operation and e-mail address:
To report issues via e-mail, submit issue to ngs.cedihelpdesk@wellpoint.com.
Hours of operation are Monday through Friday, 9:00 a.m. to 7:00 p.m. ET.

Press 2 to check the status of EDI Enrollment Forms
Provide the RID, PTAN, and NPI
Status of forms will be available 24 hours after online submission

Press 3 to speak to a DME CEDI Help Desk Technician
Please be prepared to provide your NPI or PTAN number as well as your Trading Partner ID (Sender ID). Your Trading Partner ID begins with an A08, B08, C08 or D08.

Implementation of New HIPAA Formats for All DME MAC Electronic Trading Partners

Are you prepared for the conversion to the new Health Insurance Portability and Accountability Act (HIPAA) formats? Will your software be ready in time? The Centers for Medicare & Medicaid Services (CMS) has mandated the industry upgrade to X12 version 5010 and National Council

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for Prescription Drug Programs (NCPDP) version D.0 (the NCPDP D.0 format is used by retail pharmacies) by January 1, 2012. Even though this deadline seems far away, now is the time to start preparing for these changes.

National Government Services, Inc. will be fully compliant with ANSI X12 version 5010 and NCPDP version D.0 code sets according to the timelines established by the U.S. Department of Health and Human Services (HHS).

Timelines

January 1, 2011	The Common Electronic Data Interchange (CEDI) will open testing of the new HIPAA formats to all software vendors or suppliers with proprietary systems. Once a software vendor is approved, they can begin moving their customers into production.
January 1, 2012	CEDI will only accept and return the new HIPAA formats (ANSI X12 5010 and NCPDP D.0). All DME MAC electronic trading partners must be in production with the new HIPAA formats by this date. Note: Electronic trading partners can move into production any time on or after January 1, 2011 as long as their software has been approved for the new HIPAA format(s) (ANSI X12 5010 and/or NCPDP D.0).

Front-end Reports

The current X12 version 4010A1 electronic claims front-end reports created and produced by the Common Electronic Data Interchange (CEDI) (997, TRN and GenResponse) will be replaced with the 999 and 277CA transactions once an electronic trading partner begins using the new X12 version 5010 format. The 999 and 277CA transactions will not be readable without translation, so suppliers will have to get these new reports read by their software. The 999 and 277CA transactions are not HIPAA mandated; however, CMS is requiring these transactions for all Medicare business.

Note: The TA1 produced by CEDI and the Certificate of Medical Necessity (CMN) rejection report produced by the durable medical equipment Medicare administrative contractors (DME MACs) and delivered by CEDI will continue to be produced for X12 version 5010 transactions.

The current NCPDP version 5.1 front-end report created and produced by CEDI will be replaced with an NCPDP formatted transmission response report for NCPDP version D.0 claims. The version D.0 NCPDP transmission response report will not be readable with out translation, so suppliers will need to have these reports read by their software.

PC-ACE Pro32 Users

The PC-ACE Pro32 software will be updated for the new HIPAA X12 version 5010 claims format and made available in 2011. CEDI will provide notification via the CEDI

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Listserv and website as soon as the X12 version 5010 of the PC-ACE Pro32 software is available.

Express Plus Users

The Common Electronic Data Interchange no longer supports the Express Plus software; therefore it will not be updated for the new HIPAA X12 version 5010 format. All suppliers using Express Plus should have converted to PC-ACE Pro32 or another software program as of April 1, 2010.

What You Need to Do

All DME MAC electronic trading partners need to make sure their software programs will be ready for the new X12 version 5010 and/or NCPDP version D.0 standards according to the timelines listed above. National Government Services CEDI suggests you contact your software vendor, billing service or clearinghouse to make sure they are aware of the changes to the new HIPAA formats.

A list of questions to ask your software vendor, billing service, or clearinghouse:

- Will you be upgrading my current system to accommodate the ANSI X12 5010 and/or NCPDP D.0 transactions?
- Does my contract include an update to the ANSI X12 5010 and/or NCPDP D.0 standards or will I be required to pay for this upgrade? If so, how much will it cost?
- When will my system be upgraded with the ANSI X12 5010 and/or NCPDP D.0 standards?
- When will the installation to my system be completed?
- Will I need to purchase any new hardware?
- Will you be increasing your fees to cover the cost of the ANSI X12 5010 and/or NCPDP D.0 implementation?
- Will you have any testing and validation phases with me directly so I can see if any problems occur when submitting claims?
- Who should I call if we have problems submitting claims with the ANSI X12 5010 and/or NCPDP D.0 formats?
- Will the ANSI X12 5010 upgrade include a way to translate the 277 claims acknowledgement (277CA) electronic transaction into a format to show me if there was an error in the claim?
- Will the ANSI X12 5010 upgrade include a way to translate the Functional Transaction 999 into a format to show me the file was accepted by the Medicare contractor?
- Will the NCPDP D.0 upgrade include a way to translate the NCPDP front-end transmission response report into a readable format to show me if the claim was accepted by the Medicare contractor or if there was an error on the claim?
- Will this require any additional training by my staff? If so, where can I obtain this training and will there be additional costs for this training?

Important: It is up to you as the health care provider to ensure your transactions are conducted in compliance with HIPAA regulations—whether or not you contract with a software vendor, billing services, or clearinghouse.

Additionally, The Administrative Simplification Compliance Act (ASCA) requires the use of electronic claims (except for certain rare exceptions) in order for suppliers to receive Medicare payment. Therefore, effective January 1, 2012, you must be ready to submit your claims electronically using the X12 version 5010 and/or NCPDP version D.0 standards.

Remember, the X12 version 5010 and version D.0 HIPAA standards are national standards and apply to your electronic transactions with all payers, not just with fee-for-service (FFS) Medicare. Therefore, you must be prepared to implement these transactions with regard to your non-FFS Medicare business as well.

Additional Information/Resources

CMS has created an entire section of their website devoted to the new HIPAA formats, including a Medicare comparison of the current and new formats, at http://www.cms.gov/ElectronicBillingEDITrans/18_5010D0.asp.

The CMS website for industry-wide information, including upcoming free educational seminars is: http://www.cms.hhs.gov/Versions5010andD0/40_Educational_Resources.asp.

ENROLLMENT

Guidance on Implementing System Edits for Certain DMEPOS

MLN Matters® Number: MM6566 Revised
Related Change Request (CR) #: 6566
Related CR Release Date: May 21, 2010
Related CR Transmittal #: R710OTN
Effective Date: July 1, 2010
Implementation Date: July 6, 2010

Note: This article was revised on May 24, 2010, to reflect changes made to CR 6566 on May 21, 2010. The CR release date, transmittal number, and the Web address for accessing CR 6566 were changed. All other information is the same. Provider Types Affected

Prvider Types Affected

This article is for suppliers who submit claims to Medicare DME Medicare Administrative Contractors (DME MACs) for DMEPOS provided to Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 6566. The Centers for Medicare & Medicaid Services (CMS) is issuing CR6566 to provide further guidance to suppliers of DMEPOS regarding licensing, accreditation, or other mandatory quality requirements that may apply. DMEPOS suppliers should be aware that if they are not identified by the National Supplier Clearing House-Medicare Administrative Contractor (NSC-MAC) **as being accredited** to supply the specific product/service AND they are not exempt from accreditation, their claims will be automatically denied by Medicare.

Background

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

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

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

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

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

- Orthotists;
- Prosthetists;
- Opticians; and
- Audiologists.

Key Points of CR6566

Edits for the Healthcare Common Procedure Coding System (HCPCS) codes in the product categories designated by MIPPA as requiring accreditation will be in effect. Effective for claims with dates of service on or after July 6, 2010, this Medicare systems edit will automatically deny claims for these codes unless:

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

Take Note: Products and services requiring accreditation found on CMS 855S, Section 2D next to the NSC-MAC product codes along with HCPCS codes are as follows:

(To review the descriptors that accompany the HCPCS codes in the product categories see **Attachment C of CR6566**. The Web address of CR6566 can be found in the *Additional Information* section of this article.)

NSC-MAC Product Code	Product Category	HCPCS codes
DM06	Blood Glucose Monitors and Supplies (mail order)	A4253, A4259, A4256, A4258, A4235, A4233, A4234, A4236
M01	Canes and Crutches	A4636
R01	Continuous Positive Airway Pressure (CPAP) Devices	E0601, A7034, E0562, A7030, A7037, A7035, A7032, A7038, A7033, A7031, A7039, A7046, A7036, E0561, A4604, A7044, A7045
PE01	Enteral Nutrients, Equipment and Supplies	B4035, B4154, B4150, B4152, B4034, B9002, B4153, B4036, B4155, B4149, B9000, B4082, B4081, B4083, B4087, B4088

NSC-MAC Product Code	Product Category	HCPCS codes
DM09	Hospital Beds – Electric	E0260, E0261, E0265, E0294, E0295, E0266, E0296, E0297
DM10	Hospital Beds – Manual	E0303, E0255, E0910, E0250, E0940, E0271, E0304, E0301, E0912, E0272, E0302, E0310, E0256, E0911, E0316, E0305, E0292, E0251, E0290, E0293, E0300, E0280, E0291
R08	Oxygen Equipment and Supplies	E1390, E0431, E0439, E0434, K0738, E1392, E0424, E0443, E1391, E0442, E0441, E0443, E0444
R09	Respiratory Assist Devices	E0470, E0471, E0472
DM20	Support Surfaces: Pressure Reducing Beds/ Mattresses/Overlays/ Pads	E0277, E0372, E0373, E0371, E0193
M05	Walkers	E0143, E0135, E0156, E0149, E0154, E0141, E0147, E0155, E0148, E0140, E0144, E0130, E0158, E0159, E0157, A4637
M09 M09A	Wheelchairs – Complete Rehabilitative Power Wheelchairs Wheelchairs – Complete Rehabilitative Power Wheelchair Related Accessories	K0835, K0836, K0841, K0838, K0837, K0842, K0839, K0840
M07 M07A	Wheelchairs – Standard Power Wheelchairs – Standard Power Related Accessories	K0823, K0822, K0825, K0800, K0824, K0814, K0821, K0801, K0816, K0827, K0815, K0826, K0813, K0806, K0807, K0828, K0802, K0829, K0820, K0808

Additional Information

The official instruction (CR6566) issued to your Medicare DME MAC is available at http://www.cms.gov/Transmittals/downloads/R710OTN.pdf on the CMS website.

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

ACCREDITATION

New Information Regarding DMEPOS Accreditation for Pharmacies

CMS announces the availability of a new fact sheet that discusses changes The Patient Protection and Affordable Care Act (PPACA) made to the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008. The changes extend the deadline for pharmacies to submit to the Secretary evidence of accreditation until January 1, 2011.

In addition, pharmacies that furnish durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) may qualify for an exemption to such requirements if the pharmacy meets certain criteria.

For more information on these changes and criteria, please see the fact sheet at the following link:

http://www.cms.gov/MedicareProviderSupEnroll/Downloads/EPOSAccExemptForCertainPharmaciesFactSheet.pdf

Guidance on Implementing Section 3109 of Patient Protection and Affordable Care Act

MLN Matters® Number: MM7021
Related Change Request (CR) #: 7021
Related CR Release Date: June25, 2010
Related CR Transmittal #:R346PI
Effective Date: January 1, 2011
Implementation Date: January 3, 2011

Provider Types Affected

This article is for Durable Medical Equipment Prosthetics and Orthotics Suppliers (DMEPOS).

Provider Action Needed

This article is based on Change Request (CR) 7021, which revises the Medicare Program Integrity Manual (Chapter 15 (Medicare Provider/Supplier Enrollment)) to include Section 38.6.1 (Compliance Standards for Pharmacy Accreditation). This article explains the revised requirements for pharmacies as a result of Section 3109 (a) of the Patient Protection and Affordable Care Act (ACA). That section states that certain pharmacies are not required to have submitted evidence of accreditation to the Secretary of Health and Human services

prior to January 1, 2011. See the Background section of this article for complete details.

Background

The Medicare Modernization Act of 2003 (MMA; Section 302) added a new paragraph 1834(a)(20) to the Social Security Act (see http://www.ssa.gov/OP_Home/ssact/title18/1834.htm on the Internet) that required the Centers for Medicare & Medicaid Services (CMS) to establish and implement quality standards for suppliers of DMEPOS. All DMEPOS suppliers that furnish such items or services identified in Section 1834(a)(20)(D) of the Social Security Act (as CMS determines appropriate) must comply with the quality standards in order to receive Medicare Part B payments and to retain Medicare billing privileges.

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA); Section 154(b); (see http://thomas.loc.gov/cgi-bin/bdquery/z?d110:SN03101 on the Internet) added a new subparagraph (F) to Section 1834(a)(20) of the Social Security Act. In implementing quality standards under this paragraph, CMS required suppliers furnishing items and service on or after October 1, 2009, to have submitted evidence of accreditation by an accreditation organization designated by CMS.

The ACA, Section 3109 (a)) amends MIPPAA (subparagraph (F)(i) of Section 154(b)(1)(A)) by not requiring a pharmacy to submit to CMS such evidence of accreditation prior to January 1, 2011.

Also, with respect to items and services furnished on or after January 1, 2011, the ACA (section 3109 (a)) provides that the quality standards and accreditation requirements set forth in MIPPA (Section 1834(a)(20)(F)) will not apply to such pharmacies if the pharmacy meets each of the following:

1. The total billings by the pharmacy for such items and services under this title are less than 5 percent of total pharmacy sales for the previous 3 calendar years, 3 fiscal years, or other yearly period specified by the CMS;
2. The pharmacy has been enrolled under Section 1866(j) of the Social Security Act as a supplier of DMEPOS, and has been issued a provider number for at least 5 years;
3. No final adverse action (as defined in Section 424.579a) of title 42, Code of Federal Regulations) has been imposed in the past 5 years;
4. The pharmacy submits an attestation that the pharmacy meets the first three criteria listed above; and
5. The pharmacy agrees to submit materials as requested during the course of an audit conducted on a random sample of pharmacies selected annually.

The National Supplier Clearinghouse (NSC) will not require that a pharmacy be accredited as a condition of enrollment before January 1, 2011. The NSC-Medicare Administrative Contractor (MAC) will determine which enrolled suppliers are pharmacies that are not accredited and who will be enrolled for 5 calendar years prior to January 1 of the next calendar year. The NSC-MAC will then send a notice of revocation by January 10, 2011, to all enrolled pharmacies who are not accredited **or who are not exempt from the accreditation requirements.** The NSC-MAC will prepare a letter which enables all individually enrolled practice locations of pharmacies who have been enrolled for five calendar years prior to January 1, 2011, to attest that they are exempt from the requirement to be accredited because their total DMEPOS billings subject to accreditation are less than 5 percent of their total pharmacy sales, as determined based upon the total pharmacy sales of the pharmacy for the previous 3 calendar or fiscal years. The letter will cite that the attestation requires the signature of the authorized or delegated official of the entity. The authorized and delegated officials are defined in Section 15 of the Medicare Enrollment Application (CMS -855S) and as described in the internet enrollment application version of the Provider Enrollment, Chain and Ownership System (PECOS). The letters should be mailed between October 1, 2010, and October 31, 2010.

For pharmacies with more than one practice location, the letters will cite the need for each individually enrolled practice location to attest that they are exempt from the accreditation requirements. New locations of enrolled chain pharmacies will not be considered to have been enrolled for five calendar years. Pharmacies that have had a change of ownership in the prior five years, which resulted in a change in their legal business entity, including a change in their tax identification number (TIN), will not qualify for an attestation accreditation exemption.

The NSC-MAC will review the attestations received from pharmacies. Pharmacies that properly signed the attestation letter will be given an accreditation status of exempt. The NSC will make attempts to assist and follow-up with pharmacy suppliers that have not submitted or properly completed their attestations. The NSC-MAC will send a notice of revocation by January 10, 2011, to all enrolled pharmacies who were sent an attestation letter and have not properly completed it as of the date of the notice of revocation. The notice of revocation will cite that the revocation is for a lack of required accreditation.

Between April 1, 2011, and April 30, 2011, the NSC-MAC will compile a sample listing of at least 10 percent of the pharmacies that have submitted an NSC accepted attestation exempting them from accreditation. The NSC-MAC will develop a letter to be sent to pharmacies that will be audited to determine if their accreditation exemption attestations are correct. The letter will request submission of evidence substantiating the validity of the pharmacy supplier's attestation. At a minimum, requested materials for this evidence will include a certification by an accountant on behalf of the pharmacy or the submission of tax returns filed by the pharmacy during the relevant periods.

The NSC-MAC will determine the acceptability of the replies received in response to the audit verification random sample mailing. The NSC will use DMEPOS billing data for only products and services requiring accreditation to assist in the determination. The NSC will make attempts to assist and follow-up with pharmacy suppliers that have not submitted or properly completed their audit verifications.

By June 30, 2011, the NSC-MAC will send a notice of revocation to all enrolled pharmacies that were sent an audit verification letter who did not submit satisfactory evidence

ACCREDITATION CONT'D

that they were in compliance with the requirements to obtain an accreditation exemption. The notice of revocation will cite that the revocation is for a lack of required accreditation.

Additional Information

The official instruction, CR 7021, issued to your DME MAC regarding this change may be viewed at http://www.cms.gov/Transmittals/downloads/R346PI.pdf on the CMS website.

PECOS

CMS to Review PECOS Enrollment Process

Medicare Working with Ordering and Referring Providers and Suppliers to Streamline Enrollment Process

CMS is working with providers to address concerns about enrollment in the Provider Enrollment, Chain and Ownership System (PECOS) to ensure that Medicare beneficiaries continue to receive the health care services and items they need. PECOS is the electronic system used to enroll physicians and eligible professionals into the Medicare program.

As part of those efforts, CMS will, for the time being, not implement changes that would automatically reject claims based on orders, certifications, and referrals made by providers that have not yet had their applications approved by July 6, 2010. While more than 800,000 physicians and other health professionals have enrolled and have approved applications in the PECOS system, some providers have encountered problems. CMS is continuing to update and streamline the process, and more providers have been enrolled in the past few days.

CMS issued an interim final regulation on May 5, 2010, implementing provisions of the Affordable Care Act that permit only a Medicare enrolled physician or eligible professional to certify or order home health services, durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS), and certain items and services under Medicare Part B. The new law applies to orders, referrals and certifications made on or after July 1. The comment period for the regulation closes on July 6, after which the comments will be reviewed and considered before a final regulation is issued.

The Affordable Care Act provisions and the regulation were designed as steps to prevent fraud in Medicare by ensuring that only eligible and identifiable providers and suppliers can order and refer covered items and services to Medicare beneficiaries.

Many physicians and other providers and suppliers have continued to make good faith efforts to comply with the requirements of the law and regulation. These efforts will be a significant factor in determining the procedures and processes that will be incorporated in the final rule.

While the regulation will be effective July 6, 2010, CMS will not implement automatic rejections of claims submitted by providers that have attempted to enroll in PECOS. However,

PECOS CONT'D

until the automatic rejections are operational, providers should not see any change in the processing of submitted claims, they will continue to be reviewed and paid as they have historically been reviewed and paid.

Additionally, though CMS is taking a more deliberative approach to using the PECOS enrollment system, the agency will employ a contingency plan to meet the ACA requirement that written orders and certifications are only issued by eligible professionals effective July 1.

CMS will continue to send informational notices to providers reminding them of the need to submit or update their enrollment and will work with the provider community to provide guidance on enrollment and will process all applications expeditiously.

CEDI Ordering/Referring Provider Edits

The Centers for Medicare & Medicaid Services (CMS) has updated the "OrderingReferringReport" file containing the National Provider Identifier (NPI) and the name (last name, first name) of all physicians and nonphysician practitioners who are of a type/specialty that is eligible to order and refer in the Medicare Program and who have current enrollment records in Medicare (i.e., they have enrollment records in Provider Enrollment Chain & Ownership System (PECOS) that contain an NPI).

This file is downloadable from the Medicare provider/supplier enrollment website www.cms.hhs.gov/MedicareProviderSupEnroll, click on "OrderingReferringReport" on the left-hand side.

Note: The "Ordering Referring Report" is a large .pdf file (20000 KB). Due to the large size, CEDI suggests you right click and select "Save as" before attempting to open this file.

The Common Electronic Data Interchange (CEDI) receives PECOS updates Monday through Saturday and some holidays with physicians and nonphysician practitioners who are of a type/specialty that is eligible to order and refer in the Medicare program. These updates are incorporated by CEDI to be used to perform the PECOS edits.

In order to determine if the ordering and/or referring provider submitted on the claim to CEDI matches the records with PECOS, CEDI performs the following steps:

1. CEDI first checks if the Ordering/Referring Provider's NPI submitted on the claim is on the file CEDI has received from PECOS.
   - If not, the CEDI edit will set.
   - If the NPI matches the PECOS file, CEDI then verifies the Ordering/Referring Provider's name as submitted on the claim matches the name associated with the NPI.
2. CEDI compares the first four characters of the last name to the Ordering/Referring Provider's name received from PECOS

PECOS CONT'D

- CEDI compares the first letter of the first name to the Ordering/Referring Provider's name received from PECOS

3. If the first or last name does not match, the CEDI edit will set.

Suppliers should:

- Verify with the provider who ordered or referred services that they are enrolled in PECOS.
- Submit the Ordering/Referring Provider's name as enrolled with PECOS.
  - Do include spaces in last names. For example, if the ordering/referring provider's last name is "A BCDE" do not submit the last name as "ABCDE"
  - Do include special characters in last names. For example, if the ordering/referring provider's last name is "A-BCDE" or "A'BCDE" do not submit the last name as "ABCDE"
  - Do not use nicknames ("BOB" for "ROBERT")
  - Do not use credentials ("DR JOHN" for "JOHN")
- Submit the name in upper case letters. Lower case letters will not find a match on the PECOS file as the PECOS file only contains upper case.
- Submit the Type 1 (individual physician's) NPI and name of the Ordering/Referring Provider. If the Type II (physician's group) NPI and name is submitted, a match will not be found on the PECOS file.

When the CEDI front end edits begin rejecting claims, suppliers will be able to correct and resubmit the claims once the physician or nonphysician practitioner has updated their enrollment in PECOS. **The PECOS edits are based on date of receipt and not date of service.**

ICD-10

Version 5010 and ICD-10 Are Coming - Will You be Ready?

Will you be ready for:

- The updated Version 5010 standards for HIPAA electronic transactions on January 1, 2012?
- The ICD-10 medical code set transition on October 1, 2013?

CMS has new resources to help you prepare. Visit http://www.cms.gov/ICD10 and click on:

- **Provider Resources** to find out about basic steps medical practices can take to prepare for ICD-10 and for a fact sheet on talking with your vendors about the Version 5010 and ICD-10 transitions
- **Vendor Resources** for tips for software vendors about talking with customers about the transitions

ICD-10 CONT'D

Software vendors, third-party billers, and clearinghouses can view materials from our recent conference at http://www.cmsvendorconference.com. Here you can also request information about working with CMS to help raise awareness about the Version 5010 and ICD-10 transitions.

Keep Up to Date on Version 5010 and ICD-10
Please visit http://www.cms.gov/icd10 for the latest news and coming soon.

Talking About Version 5010 and ICD-10 – Vendors and Providers, Get the Conversation Started

Providers: The first recommended deadline for a successful transition to Version 5010 is only five months away. By December 31, providers should complete their internal testing, and be ready to test with external partners beginning in January 2011.

Now is a great time for providers to check in with your vendors about their transition preparations. Not only is it important for you to make sure that you can count on them during the transition, but they are a great resource to provide you with details about what you need to do to comply with Version 5010 standards and ICD-10.

Vendors: You play a vital role in the Version 5010 and ICD-10 transition. Your customers will be looking to you for guidance to navigate them through the changes. Your products and services will be obsolete if steps are not taken NOW to get ready. Start talking with your customers about preparing for the Version 5010 and ICD-10 transitions.

CMS is here to help you both talk to each other - even help you get the conversation started if you haven't already. Go to our website, http://www.cms.gov/ICD10, for Provider and Vendor Resource pages that includes fact sheets with tips on asking each other the right questions.

Keep Up to Date on Version 5010 and ICD-10

Please visit http://www.cms.gov/icd10 for the latest news and coming soon: sign up for Version 5010 and ICD-10 e-mail updates!

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

ICD-10 Conference Call Transcript Available

The audio transcript of the June 15, 2010, national provider conference call, "ICD-10 Implementation in a 5010 Environment", hosted by CMS is now available. To access the transcript, go to http://www.cms.gov/ICD10/02c_CMS_Sponsored_Calls.asp on the CMS website. In the Downloads section select the **June 15, 2010 ICD-10 Conference Call** Zip file. The audio transcript is 1 hour and 51 minutes in length. The written transcript will be available soon.

Now Available - Transcript of June 15, 2010, ICD-10 Implementation in 5010 Environment Teleconference

The written transcript of the Centers for Medicare & Medicaid Services' (CMS) June 15, 2010, national provider conference call, "ICD-10 Implementation in a 5010 Environment", is now available. To access the transcript, go to http://www.cms.gov/ICD10/02c_CMS_Sponsored_Calls.asp on the CMS website. In the Downloads section select the "June 15, 2010 ICD-10 Conference Call" Zip file. This Zip file contains the written and audio transcripts, as well as the slide presentation used during the teleconference. **Note:** The length of the audio transcript is 1 hour and 51 minutes.

ICD-10 Implementation Information

MLN Matters® Number: SE1019

Provider Types Affected

This issue impacts all physicians, providers, suppliers, and other covered entities who submit claims to Medicare contractors for services provided to Medicare beneficiaries in any health care setting.

What You Need to Know

This MLN Matters® special edition article provides information about the implementation of the International Classification of Diseases, 10th Edition, Clinical Modification and Procedure Coding System (ICD-10-CM/ICD-10-PCS) code sets to help you better understand (and prepare for) the United States health care industry's change from ICD-9-CM to ICD-10 for medical diagnosis and inpatient hospital procedure coding.

The first ICD-10-related compliance date is less than 2 years away. On **January 1, 2012**, standards for electronic health transactions change from Version 4010/4010A1 to Version 5010. Unlike Version 4010, Version 5010 accommodates the ICD-10 code structure. This change occurs before the ICD-10 implementation date to allow adequate testing and implementation time.

On **October 1, 2013**, medical coding in U.S. health care settings will change from ICD-9-CM to ICD-10. The transition will require business and systems changes throughout the health care industry. Everyone who is covered by the Health Insurance Portability and Accountability Act (HIPAA) must make the transition, not just those who submit Medicare or Medicaid claims. The compliance dates are firm and not subject to change. If you are not ready, your claims will not be paid. Preparing now can help you avoid potential reimbursement issues.

Background

ICD-10 Implementation Compliance Date
On October 1, 2013, the Centers for Medicare & Medicaid Services (CMS) will implement the ICD-10-CM (diagnoses) and ICD-10-PCS (inpatient procedures), replacing the ICD-9-CM diagnosis and procedure code sets.

- ICD-10-CM diagnoses codes will be used by all providers in every health care setting.
- ICD-10-PCS procedure codes will be used only for hospital claims for inpatient hospital procedures.
- The compliance dates are firm and not subject to change.
  - There will be no delays.
  - There will be no grace period for implementation.

Important, please be aware:

- ***ICD-9-CM codes will not be accepted for services provided on or after October 1, 2013.***
- ***ICD-10 codes will not be accepted for services prior to October 1, 2013.***

You **must** begin using the ICD-10-CM codes to report diagnoses from all ambulatory and physician services on claims with dates of service on or after October 1, 2013, and for all diagnoses on claims for inpatient settings with dates of discharge that occur on or after October 1, 2013.

Additionally, you must begin using the ICD-10-PCS (procedure codes) for all hospital claims for inpatient procedures on claims with dates of discharge that occur on or after October 1, 2013.

Note: Only ICD-10-CM, not ICD-10-PCS, will affect physicians. ICD-10-PCS will only be implemented for facility inpatient reporting of procedures – it will not be used for physician reporting. There will be no impact on Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes. You should continue to use these codes for physician, outpatient, and ambulatory services. Physician claims for services provided to inpatient patients will continue to report CPT and HCPCS codes.

What are the Differences Between the ICD-10-CM/ICD-10-PCS and ICD-9-CM Code Sets?

The differences between the ICD-10 code sets and the ICD-9 code sets are primarily in the overall number of codes, their organization and structure, code composition, and level of detail. There are approximately 70,000 ICD-10-CM codes compared to approximately 14,000 ICD-9-CM diagnosis codes, and approximately 70,000 ICD-10-PCS codes compared to approximately 4,000 ICD-9-CM procedure codes.

In addition, ICD-10 codes are longer and use more alpha characters, which enable them to provide greater clinical detail and specificity in describing diagnoses and procedures. Also, terminology and disease classification have been updated to be consistent with current clinical practice.

Finally, system changes are also required to accommodate the ICD-10 codes.

What are Benefits of the ICD-10 Coding System?

The new, up-to-date classification system will provide much better data needed to:

- Measure the quality, safety, and efficacy of care
- Reduce the need for attachments to explain the patient's condition

- Design payment systems and process claims for reimbursement
- Conduct research, epidemiological studies, and clinical trials
- Set health policy
- Support operational and strategic planning
- Design health care delivery systems
- Monitor resource utilization
- Improve clinical, financial, and administrative performance
- Prevent and detect health care fraud and abuse
- Track public health and risks

ICD-10-CM Code Use and Structure

The ICD-10-CM (diagnoses) codes are to be used by all providers in all health care settings. Each ICD-10-CM code is 3 to 7 characters, the first being an alpha character (all letters except U are used), the second character is numeric, and characters 3-7 are either alpha or numeric (alpha characters are not case sensitive), with a decimal after the third character. Examples of ICD-10-CM codes follow:

- A78 – Q fever
- A69.21 – Meningitis due to Lyme disease
- O9A.311 – Physical abuse complicating pregnancy, first trimester
- S52.131A – Displaced fracture of neck of right radius, initial encounter for closed fracture

Additionally, the ICD-10-CM coding system has the following new features:

1. Laterality (left, right, bilateral)

   For example:

   - C50.511 – Malignant neoplasm of lower-outer quadrant of right female breast
   - H16.013 – Central corneal ulcer, bilateral
   - L89.022 – Pressure ulcer of left elbow, stage II

2. Combination codes for certain conditions and common associated symptoms and manifestations

   For example:

   - K57.21 – Diverticulitis of large intestine with perforation and abscess with bleeding
   - E11.341 – Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema
   - I25.110 – Atherosclerotic heart disease of native coronary artery with unstable angina pectoris

3. Combination codes for poisonings and their associated external cause

   For example:

   - T42.3x2S – Poisoning by barbiturates, intentional self-harm, sequela

4. Obstetric codes identify trimester instead of episode of care

   For example:

   - O26.02 – Excessive weight gain in pregnancy, second trimester

5. Character "x" is used as a 5th character placeholder in certain 6 character codes to allow for future expansion and to fill in other empty characters (e.g., character 5 and/or 6) when a code that is less than 6 characters in length requires a 7th character

   For example:

   - T46.1x5A – Adverse effect of calcium-channel blockers, initial encounter
   - T15.02xD – Foreign body in cornea, left eye, subsequent encounter

6. Two types of Excludes notes

   Excludes 1 – Indicates that the code excluded should never be used with the code where the note is located (do not report both codes).

   For example:

   - Q03 – Congenital hydrocephalus (Excludes1: Acquired hydrocephalus (G91.-)

   Excludes 2 – Indicates that the condition excluded is not part of the condition represented by the code but a patient may have both conditions at the same time, in which case both codes may be assigned together (both codes can be reported to capture both conditions).

   For example:

   - L27.2 – Dermatitis due to ingested food (Excludes 2: Dermatitis due to food in contact with skin (L23.6, L24.6, L25.4)

7. Inclusion of clinical concepts that do not exist in ICD-9-CM (e.g., underdosing, blood type, blood alcohol level)

   For example:

   - T45.526D – Underdosing of antithrombotic drugs, subsequent encounter
   - Z67.40 – Type O blood, Rh positive
   - Y90.6 – Blood alcohol level of 120–199 mg/100 ml

8. 8) A number of codes have been significantly expanded (e.g., injuries, diabetes, substance abuse, postoperative complications)

   For example:

   - E10.610 – Type 1 diabetes mellitus with diabetic neuropathic arthropathy
   - F10.182 – Alcohol abuse with alcohol-induced sleep disorder
   - T82.02xA – Displacement of heart valve prosthesis, initial encounter

9. Codes for postoperative complications have been expanded and a distinction made between intraoperative

complications and postprocedural disorders

For example:

- D78.01 – Intraoperative hemorrhage and hematoma of spleen complicating a procedure on the spleen
- D78.21 – Postprocedural hemorrhage and hematoma of spleen following a procedure on the spleen

Finally, there are additional changes in ICD-10-CM, to include:

- Injuries are grouped by anatomical site rather than by type of injury
- Category restructuring and code reorganization have occurred in a number of ICD-10-CM chapters, resulting in the classification of certain diseases and disorders that are different from ICD-9-CM
- Certain diseases have been reclassified to different chapters or sections in order to reflect current medical knowledge
- New code definitions (e.g., definition of acute myocardial infarction is now 4 weeks rather than 8 weeks)
- The codes corresponding to ICD-9-CM V codes (Factors Influencing Health Status and Contact with Health Services) and E codes (External Causes of Injury and Poisoning) are incorporated into the main classification rather than separated into supplementary classifications as they were in ICD-9-CM.

To learn more about the ICD-10-CM coding structure you may review "Basic Introduction to ICD-10-CM" audio or written transcripts from the March 23, 2010 provider outreach conference call. Go to http://www.cms.gov/ICD10/02c_CMS_Sponsored_Calls.asp#TopOfPage on the CMS website. Scroll to the bottom of the web page to the Downloads section and select the 2010 ICD-10 Conference Calls zip file and locate the March 23rd written or audio transcript.

ICD-10-PCS Code Use and Structure

The ICD-10-PCS codes are for use only on hospital claims for inpatient procedures. ICD-10-PCS codes are not to be used on any type of physician claims for physician services provided to hospitalized patients. These codes differ from the ICD-9-CM procedure codes in that they have 7 characters that can be either alpha (non-case sensitive) or numeric. The numbers 0 - 9 are used (letters O and I are not used to avoid confusion with numbers 0 and 1), and they do not contain decimals.

For example:

- 0FB03ZX - Excision of liver, percutaneous approach, diagnostic
- 0DQ10ZZ - Repair, upper esophagus, open approach

Help with Converting Codes

The General Equivalence Mappings (GEMs) are a tool that can be used to convert data from ICD-9-CM to ICD-10-CM/PCS and vice versa. Mapping from ICD-10-CM/PCS codes back to ICD-9-CM codes is referred to as backward mapping. Mapping from ICD-9-CM codes to ICD-10-CM/PCS codes is referred to as forward mapping. The GEMs are a comprehensive translation dictionary that can be used to accurately and effectively translate any ICD-9-CM-based data, including data for:

- Tracking quality
- Recording morbidity/mortality
- Calculating reimbursement
- Converting any ICD-9-CM-based application to ICD-10-CM/PCS

The GEMs can be used by anyone who wants to convert coded data, including:

- All payers
- All providers
- Medical researchers
- Informatics professionals
- Coding professionals—to convert large data sets
- Software vendors—to use within their own products;
- Organizations—to make mappings that suit their internal purposes or that are based on their own historical data
- Others who use coded data

The GEMs are not a substitute for learning how to use the ICD-10 codes. More information about GEMs and their use can be found on the CMS website at http://www.cms.gov/ICD10 (select from the left side of the web page ICD-10-CM or ICD-10-PCS to find the most recent GEMs).

Additional information about GEMs was provided on the following CMS sponsored conference call - May 19, 2009, "ICD-10 Implementation and General Equivalence Mappings". Go to http://www.cms.gov/ICD10/02c_CMS_Sponsored_Calls.asp, scroll to the bottom of the page, under Downloads select – 2009 ICD-10 Conference Calls to locate the audio and written transcripts.

What to do Now in Preparation for ICD-10 Implementation?

- Learn about the structure, organization, and unique features of ICD-10-CM - all provider types
- Learn about the structure, organization, and unique features of ICD-10-PCS - inpatient hospital claims
- Learn about system impact and 5010
- Use assessment tools to identify areas of strength/weakness in medical terminology and medical record documentation
- Review and refresh knowledge of medical terminology as needed based on the assessment results
- Provide additional training to refresh or expand knowledge in the biomedical sciences (anatomy, physiology, pathophysiology, pharmacology, and medical terminology)
- Plan to provide intensive coder training approximately 6 -9 months prior to implementation
- Allocating 16 hours of ICD-10-CM training will likely be adequate for most coders, and very proficient ICD-9-CM coders may not need that much

Additional Information

To find additional information about ICD-10, visit http://www.cms.gov/ICD10 on the CMS website. In addition, CMS makes the following resources available to assist in your transition to ICD-10:

- **Medicare Fee-for-Service Provider Resources Web Page** - This site links Medicare fee-for-service (FFS) providers to information and educational resources that are useful for all providers to implement and transition to ICD-10 medical coding in a 5010 environment. As educational materials become available specifically for Medicare FFS providers, they will be posted to this web page. Bookmark http://www.cms.gov/ICD10/06_MedicareFeeforServiceProviderResources.asp and check back regularly for access to ICD-10 implementation information of importance to you. **Note:** Use the links on the left side of the web page to navigate to ICD-10 and 5010 information applicable to your specific interest.
- CMS Sponsored National Provider Conference Calls - During the ICD-10 implementation period, CMS will periodically host national provider conference calls focused on various topics related to the implementation of ICD-10. Calls will include a question and answer session that will allow participants to ask questions of CMS subject matter experts. These conference calls are offered free of charge and require advance registration. Continuing education credits may be awarded for participation in CMS national provider conference calls. For more information, including announcements and registration information for upcoming calls, presentation materials and written and audio transcripts of previous calls, please visit http://www.cms.gov/ICD10/02c_CMS_Sponsored_Calls.asp#TopOfPage on the CMS website.
- **Frequently Asked Questions (FAQs)** - To access FAQs related to ICD-10, please visit the CMS ICD-10 web page at http://www.cms.gov/ICD10, select the **Medicare Fee-for-Service Provider Resources** link from the menu on the left side of the page, scroll down the page to the "Related Links Inside CMS" section and select "ICD-10 FAQs." Please check the ICD-10 FAQ section regularly for newly posted or updated ICD-10 FAQs.

The following organizations offer providers and others ICD-10 resources:

- **Workgroup for Electronic Data Interchange** (WEDI) http://www.wedi.org; ***and***
- **Health Information and Management Systems Society (HIMSS)** http://www.himss.org/icd10 on the Internet.

CMS Announces DMEPOS Competitive Bidding Payment Amounts

CMS has announced the single payment amounts for the Round 1 Rebid of the Medicare DMEPOS Competitive Bidding Program.

To view the Press Release, please click: http://www.cms.hhs.gov/apps/media/press_releases.asp

To view the Fact Sheet, please click: http://www.cms.hhs.gov/apps/media/fact_sheets.asp

Visit the CMS website at: http://www.cms.gov/DMEPOSCompetitiveBid/01A1_Announcements_and_Communications.asp to view additional information.

Medicare DMEPOS Competitive Bidding Program Payment for Grandfathering

Provisions for Notice of Proposed Rulemaking (1503-P)

Background

Under current regulations at 42 CFR Section 414.408(i)(2), when a beneficiary switches to a contract supplier rather than using a grandfathered supplier to receive their oxygen equipment and supplies, the contract supplier receives a minimum of 10 monthly payments for taking over the furnishing of oxygen and oxygen equipment. When a beneficiary switches to a contract supplier rather than using a grandfathered supplier to furnish capped rental DME, section Section 414.408(h)(2) restarts the 13-month capped rental period. These rules were established, in part, based on advice from the Program Advisory and Oversight Committee (PAOC) and are intended to give bidding suppliers an assurance that they would receive a minimum number of payments in these situations and would not have to factor into their bids the cost of receiving as few as one monthly payment for beneficiaries near the end of the 13-month cap for capped rental items and 36-month cap for oxygen equipment.

The grandfathering rules described above place a financial burden on beneficiaries who are near the end of the respective 13 or 36-month cap rental periods and must switch to a contract supplier because their existing supplier chooses not to be a grandfathered supplier under the DMEPOS CBP. In such cases, the beneficiary may be responsible for additional co-insurance payments. As a result, we believe it is important to reevaluate these rules and are therefore soliciting public comments on whether or not the current rules should be changed to reduce the minimum number of payments the contract supplier would receive in these situations. We also plan to solicit advice from the PAOC on this subject at a future committee meeting.

Medicare DMEPOS Competitive Bidding Program Appeals Process

Provisions for Notice of Proposed Rulemaking (1503-P)

Background

We are proposing to add a new Section 414.423 to establish an appeals process for contracts terminated under section 1847(a) and (b) of the Act. Proposed section 414.423, this rule, sets forth policies and procedures relating to breach of contract determinations and an appeals process for contract suppliers that are considered to be in breach of contract. In addition, we are proposing to amend Section 414.402 to include definitions for the following terms: affected party, breach of contract, corrective action plan (CAP), hearing officer (HO), and parties to the hearing.

Proposed Provisions to Current Rule

We are proposing an appeals process for situations in which a supplier's Competitive Bidding Program (CBP) contract is determined to be in breach of contract.

Under the proposed rule, the Competitive Bidding Implementation Contractor (CBIC) will work with suppliers to informally resolve any performance deficiencies prior to sending a recommendation to CMS that the supplier's contract be terminated.

Supplier considered in breach of their contract will be notified by certified mail that their DMEPOS competitive bidding contract will be terminated within 45 calendar days from the date of the notification of termination. In most cases the notice would indicate that the supplier may submit a corrective action plan to address the breach of contract.

Any supplier who receives a notice that we consider them in breach of contract will have the right to request a hearing before a CBIC HO who was not involved with the original breach of contract determination. The hearing request must be received by the CBIC within 30 calendar days from the date of the termination letter. The HO will conduct a thorough and independent review and will make a recommendation based on all the information submitted and presented at the hearing. The HO would issue a written recommendation to CMS within 30 days of the close of the hearing. The HO's recommendation would include the rationale for his or her recommendation regarding the termination of the supplier's contract. The HO would submit this recommendation to CMS for its determination.

CMS would make the final determination regarding whether to terminate the supplier's contract. CMS's determination will be based upon on the record of the hearing, evidence, and documents considered by the HO as part of the HO recommendation and will be made within 30 days of the receipt of the HO's recommendation. If CMS's decision is to terminate the contract, the supplier will be notified of the effective date of termination by certified mail. CMS makes the final decision regarding termination of the contract.

CMS Announces Release of New DMEPOS Competitive Bidding Program Fact Sheet for Referral Agents

The Medicare DMEPOS Competitive Bidding Program is scheduled to begin in nine competitive bidding areas (CBAs) on January 1, 2011. The competitive bidding program will offer beneficiaries in the designated CBAs access to quality DMEPOS products and services with lower out-of-pocket costs.

When the program starts, beneficiaries located in the CBAs must obtain these items from a contract supplier unless an exception applies. The Centers for Medicare & Medicaid Services (CMS) has offered contracts to DMEPOS suppliers to become contract suppliers in the nine CBAs. All suppliers being offered contracts went through a thorough vetting process, are licensed and accredited, and meet financial standards. This means that Medicare beneficiaries will continue to receive quality items and services from DMEPOS suppliers they can trust.

CMS expects to complete the contracting process in time to announce the contract suppliers in September 2010. Referral agents located in CBAs who prescribe DMEPOS for beneficiaries or refer beneficiaries to specific suppliers should be aware of which suppliers in the area are contract suppliers as well as other important referring information. **Referral agents** include such entities as Medicare enrolled providers, physicians, treating practitioners, discharge planners, social workers, and pharmacists who refer beneficiaries for services in a CBA.

More information for referral agents can be found in the new Medicare Learning Network® fact sheet located at: http://www.cms.gov/DMEPOSCompetitiveBid/04_Educational_Resources.asp.

For more general information about the DMEPOS Competitive Bidding Program, please visit http://www.cms.gov/DMEPOSCompetitiveBid on the CMS dedicated website.

Payment of Oxygen Contents to Suppliers After 36th Month Rental Cap Under Medicare DMEPOS Competitive Bidding Program

MLN Matters® Number: MM6939
Related Change Request (CR) #: 6939
Related CR Release Date: April 27, 2010
Related CR Transmittal #: R676OTN
Effective Date: October 1, 2010 for Medicare system changes
Implementation Date: October 4, 2010

Provider Types Affected

This article is for suppliers who have received payment for the 36th continuous use of oxygen equipment for a Medicare patient and billing Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for oxygen contents used with that liquid or gaseous oxygen equipment (stationary or portable).

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 6939 to alert suppliers that Medicare law requires that the supplier that furnishes liquid or gaseous oxygen equipment (stationary or portable) for the 36th continuous month must continue to furnish the oxygen contents necessary for the effective use of the liquid or gaseous equipment for any period of medical need after the payment cap for the remainder of the reasonable useful lifetime of the equipment. This requirement continues to apply under the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding Program, regardless of the role of the supplier (i.e., contract supplier, grandfathered supplier, or non-contract supplier) and the location of the beneficiary (i.e. residing within or outside a competitive bidding area (CBA)). See the Key Points section of this article for more of the specifics of CR6939.

Background

On July 15, 2008, section 144(b) of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) amended section 1834(a)(5)(F) of the Social Security Act (the Act) to repeal the transfer of ownership provision established by the Deficit Reduction Act of 2005 for oxygen equipment and establish new payment rules and supplier responsibilities after the 36 month payment cap. One of the MIPPA 144(b) provisions requires that Medicare payment for oxygen contents used with liquid or gaseous oxygen equipment (stationary or portable) continue after the 36-month rental cap. As further defined in Federal Regulations (42 CFR 414.226(f)(2)), **the supplier that furnishes liquid or gaseous oxygen equipment (stationary or portable) for the 36th continuous month must continue to furnish the oxygen contents necessary for the effective use of the liquid or gaseous equipment during any period of medical need for the remainder of the reasonable useful lifetime established for the equipment. If a beneficiary relocates, the supplier that received the payment for the 36th continuous month must arrange for furnishing the oxygen contents with another supplier if the beneficiary relocates to an area that is outside the normal service area of the supplier.** This MIPPA requirement for the supplier that received the 36th month payment to continue furnishing oxygen contents during any period of medical need for the remainder of the reasonable useful lifetime remains in effect regardless of whether the beneficiary resides in a CBA or the oxygen supplier is a contract, non-contract or grandfathered supplier under the DMEPOS competitive bidding program.

Key Points of CR6939

- If a beneficiary travels or temporarily relocates to a CBA, the oxygen supplier that received the payment for the 36th continuous month must make arrangements for furnishing oxygen contents with a contract supplier in the CBA in the event that the supplier that received the 36th month payment elects to make arrangements for a temporary oxygen contents billing supplier.
- The Medicare payment amount is always based on the location in which the beneficiary maintains a permanent residence. If the beneficiary resides in a CBA, payment for the oxygen contents will be based on the single payment amount for that CBA. If the beneficiary resides outside of a CBA and travels to a CBA, payment for the oxygen contents will be based on the fee-schedule amount for the area where the beneficiary maintains a permanent residence.
- The changes specified in this CR6939 are in preparation for the DMEPOS Competitive Bidding Program Round One Rebid (the Round One Rebid) implementation. The target implementation date for the Round One Rebid is January 1, 2011 and is subject to change. CMS will send notification of the actual start date for the Round One Rebid in a separate instruction.
- **Remember** claims will be denied for both base oxygen equipment and related oxygen contents claims from non-contract suppliers in CBAs when the initial date on the beneficiary's oxygen Certificate of Medical Necessity (CMN) is on or after the start date for the Round One Rebid. Medicare will also deny such claims from non-contract suppliers when the rental period for the base oxygen equipment began on or after the start date of the Round One Rebid.
- **Note:** CR6939 provides instructions for processing oxygen contents claims received from a supplier when the beneficiary resides in a CBA and the 36-month payment cap has been reached for the related base equipment. The CR6939 does not address situations in which a beneficiary travels or temporarily relocates to a CBA. Moreover, it does not address the oxygen claim payment policies applicable to beneficiaries who do not reside in a CBA. The claims processing instructions related to these policies will be provided in a subsequent CR.

Additional Information

The official instruction associated with this CR6939 issued to your Medicare MAC regarding this change may be viewed at http://www.cms.gov/Transmittals/downloads/R676OTN.pdf on the CMS website.

To review the CMS DME website that provides a complete listing of links to DME related information you may go to http://www.cms.gov/center/dme.asp on the CMS website.

DME National Competitive Bidding Implementation -- Phase 10C: Exception for Medicare Beneficiaries Previously Enrolled in Medicare Advantage Plan

MLN Matters® Number: MM6918 Revised
Related Change Request (CR) #: 6918
Related CR Release Date: June 18, 2010
Related CR Transmittal #: R721OTN
Effective Date: October 1, 2010
Implementation Date: October 4, 2010

Note: This article was revised on June 21, 2010, to reflect the revised CR 6918 that was issued on June 18, 2010. The

article was changed to include a revised first bullet point in the "Key Points of CR 6918" section. Also, the CR release date, transmittal number, and the Web address for accessing CR 6918 were revised. All other information remains the same.

Provider Types Affected

Suppliers billing Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for services provided to Medicare beneficiaries are impacted by this issue.

What You Need to Know

The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 6918 to alert providers that under certain circumstances Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) payment will be allowed for grandfathered items for beneficiaries who received services from a DMEPOS supplier while under a Medicare Advantage plan. Those items should be furnished by a non-contract Medicare Advantage (MA) supplier under the DMEPOS Competitive Bidding Program for a beneficiary who resides in a competitive bidding area (CBA) and elects to leave their MA plan or loses his/her coverage under this plan. Such beneficiary may continue to receive items requiring frequent and substantial servicing, capped rental, oxygen and oxygen equipment, or inexpensive or routinely purchased rented items from the same DME supplier under the MA plan without going to a contract supplier under the Medicare DMEPOS Competitive Bidding Program.

However, the supplier from whom the beneficiary previously received the item under the plan must be a Medicare enrolled supplier; meet the Medicare fee for service (FFS) coverage criteria and documentation requirements; and elect to become a grandfathered supplier.

Key Points of CR6918

- Medicare will pay oxygen claims that qualify for the MA plan grandfathering at the Round One bid amount and will pay capped rental claims that qualify for the MA plan grandfathering at the fee schedule amount during the Round One contract period. The target implementation date for the Round One Rebid is January 1, 2011, and is subject to change.
- The beneficiary must have been enrolled in a MA plan on the day prior to the start date for the Round One Rebid to qualify for the MA plan grandfathering exception.

Background

The Medicare DMEPOS Competitive Bidding Program was established by section 302(b)(1) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L. 108-173) which amended section 1847 of the Social Security Act (the Act) to require the Secretary of Health and Human Services to establish and implement programs under which competitive bidding areas (CBAs) are established throughout the United States for contract award purposes for the furnishing of certain competitively priced items and services for which payment is made under Medicare Part B.

Section 1847(a)(4) requires that in the case of covered DME items for which payment is made on a rental basis under section 1834(a) of the Act, and in the case of oxygen for which payment is made under section 1834(a)(5) of the Act, the Secretary must establish a "grandfathering" process by which rental agreements for the DME covered items and oxygen are entered into before the start of the competitive bidding program may be continued.

Additional Information

The official instruction associated with this CR6918, issued to your Medicare DME MAC regarding this change may be viewed at http://www.cms.gov/Transmittals/downloads/R721OTN.pdf on the CMS website.

To review the complete listing of links to DME related information you may go to http://www.cms.gov/center/dme.asp on the CMS website.

DME National Competitive Bidding Implementation -- 10G: Paying for Oxygen Equipment when Grandfathered

MLN Matters® Number: MM6934
Related Change Request (CR) #: 6934
Related CR Release Date: June 10, 2010
Related CR Transmittal #: R718OTN
Effective Date: October 1, 2010
Implementation Date: October 4, 2010

Provider Types Affected

This article is for grandfathered suppliers billing Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for oxygen equipment furnished to Medicare beneficiaries after the start of a DMEPOS Competitive Bidding Program.

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 6934 to alert suppliers that a non-contract supplier who chose to be a grandfathered supplier for oxygen and oxygen equipment (i.e. portable or stationary) should also furnish additional oxygen equipment when medically necessary (i.e. portable or stationary) after the start of a Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding Program to beneficiaries residing in a Competitive Bidding Area (CBA) who are already receiving oxygen equipment from the grandfathered supplier.

Key Points of CR6934

- If a beneficiary resides in a CBA, Medicare will pay claims for portable or stationary oxygen equipment that is acquired on or after the start of the Round One Rebid, at the single payment amount, when submitted by a grandfathered supplier, if the same supplier furnished stationary or portable oxygen equipment (grandfathered item), respectively, prior to the start of the Round One Rebid DMEPOS Competitive Bidding Program.
- If a beneficiary resides in a CBA, **claims will be denied**

for portable or stationary oxygen equipment that is acquired on or after the start date for the Round One Rebid, **when submitted by a non-contract supplier**, if the **supplier did not furnish the portable or stationary oxygen equipment prior to the start of the National Competitive Bid Round One Rebid** (the portable or stationary oxygen equipment is not a grandfathered item).

- For oxygen equipment (stationary or portable) claims with dates of service on or after the start of the Round One Rebid, for a beneficiary residing in a CBA, claims will be denied when submitted by a grandfathered supplier, if the same grandfathered supplier did not furnish oxygen equipment (portable or stationary) prior to the start of the Round One Rebid (the items are not grandfathered).
- **Be aware that** a grandfathered supplier of oxygen and oxygen equipment cannot elect to grandfather stationary oxygen equipment and not portable oxygen equipment or vice versa. In accordance with the Medicare law and regulations, the Medicare monthly payment amount for stationary oxygen equipment includes payment for stationary oxygen equipment, stationary oxygen contents, and portable oxygen contents. If the supplier is also furnishing portable oxygen equipment, an add-on payment is made for the portable oxygen equipment only. Since payment for portable oxygen contents is included in the monthly payment amount for stationary oxygen equipment , the supplier must be a grandfathered supplier for both stationary and portable oxygen equipment in order to be in compliance with the statutorily mandated payment structure for oxygen and oxygen equipment. The grandfathered supplier that is grandfathering oxygen & oxygen equipment (i.e. stationary or portable) to a beneficiary residing in a CBA is required to furnish any additional oxygen equipment (i.e. portable or stationary) the beneficiary needs following the implementation of a competitive bidding program.

Note: "*Acquisition*" in the context of CMS business rules means that the beneficiary's oxygen Certificate of Medical Necessity (CMN) initial date is prior to the start date for the DMEPOS Competitive Bidding Program Round One Rebid.

Background

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L. 108-173) amended section 1847 of the Social Security Act (the Act) requires the Secretary to establish and implement programs (the "Medicare DMEPOS Competitive Bidding Program") under which CBAs are established throughout the United States for contract award purposes for the furnishing of certain competitively priced items and services for which payment is made under Medicare Part B.

Additional Information

The official instruction associated with this CR6934, issued to your Medicare MAC regarding this change may be viewed at http://www.cms.gov/Transmittals/downloads/R718OTN.pdf on the CMS website.

To review a complete listing of links to DME related information you may go to http://www.cms.gov/center/dme.asp on the CMS website.

Home Health Agencies Providing DME in Competitive Bidding Areas

MLN Matters® Number: MM7014
Related Change Request (CR) #: 7014
Related CR Release Date: July 30, 2010
Related CR Transmittal #: R741OTN
Effective Date: January 1, 2011
Implementation Date: January 3, 2011

Provider Types Affected

This article is for all HHAs submitting claims to Regional Home Health Intermediaries (RHHIs) for DME provided to Medicare beneficiaries residing in competitive bidding areas.

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 7014 to alert HHAs that edits will be in place, effective for services on or after January 1, 2011, to prevent HHAs from billing competitively bid DME items in competitive bidding areas and consequently preventing the inappropriate payment of competitively bid DME items to HHAs. Make certain your billing staffs are aware of these changes.

Background

Beginning January 1, 2011, in a competitive bidding area, a supplier must be awarded a contract by Medicare in order to bill Medicare for competitively bid DME. Therefore, HHAs that furnish DME and are located in an area where DME items are subject to a competitive bidding program must either be awarded a contract to furnish the items in this area or use a contract supplier in the community to furnish these items. The competitive bidding items will be identified by HCPCS codes and the competitive bidding areas will be identified based on zip codes where beneficiaries receiving these items maintain their permanent residence. The DME MACs will have edits in place indicating which entities are eligible to bill for competitive bid items and the appropriate competitive bid payment amount.

Key Points of CR 7014

- Your Medicare contractor will return HH claims (types of bill 32x, 33x and 34x) to you when such claims contain Healthcare Common Procedure Coding System (HCPCS) codes that are identified as being for items or services subject to competitive bidding in a competitive bidding area.
- For your HHA to bill competitively bid items, your HHA must also be a contract supplier under Medicare's DME competitive bidding program.
- Note: All suppliers of competitively bid DME must bill the DME Medicare Administrative Contractors (MAC) for these items and will no longer be allowed to bill for competitive bid items to Medicare contractors processing home health claims. Home health claims submitted for HCPCS codes subject to a competitive bidding program will be returned to the provider to remove the affected DME line items.

- The applicable HCPCS codes and Zip Codes for the competitive bidding areas can be found on the "Supplier" page of the following Competitive Bid Implementation Contractor (CBIC) website at http://www.dmecompetitivebid.com/Palmetto/Cbic.nsf/DocsCat/Home on the Internet.
- Claims for DME furnished by HHAs that are not subject to competitive bidding may still be submitted to the appropriate home health claims processing contractor.

Additional Information

The official instruction associated with this CR7014, issued to your Medicare RHHIs regarding this change may be viewed at http://www.cms.gov/Transmittals/downloads/R741OTN.pdf on the CMS website.

Medicare DMEPOS Competitive Bidding Program ACA Section 3136 Power-Driven Wheelchairs

Background

ACA Section 3136 Power-Driven Wheelchairs
We are proposing to amend the regulations to adjust payment for power-driven wheelchairs under the Medicare Part B Durable Medical Equipment Orthotics and Prosthetics (DMEPOS) fee schedule to pay 15 percent (instead of 10 percent) of the purchase price for the first three months under the monthly rental method and 6 percent (instead of 7.5 percent) for remaining rental months. Payment is based on the lower of the supplier's actual charge and the fee schedule amount. These changes are mandated by section 3136(a)(1) of the ACA and are effective for items furnished on or after January 1, 2011.

We are also proposing to amend the regulations to eliminate lump sum (up-front) purchase payment for standard power-driven wheelchairs. We are revising the regulations to permit payment only on a monthly rental basis for standard power-driven wheelchairs effective for items furnished on or after January 1, 2011. For complex rehabilitative power-driven wheelchairs, the regulations will continue to permit payment to be made on a lump sum purchase method or a monthly rental method. These changes are mandated by section 3136(a)(2) of the ACA.

In accordance with ACA, we are specifying that these changes do not apply to power-driven wheelchairs furnished pursuant to contracts entered into prior to January 1, 2011, as part of the Medicare DMEPOS competitive bidding program.

Proposed DMEPOS Regulatory Updates

CMS has announced certain proposed regulatory provisions for Medicare durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) in the 2011 Physician Fee Schedule and Other Revisions to Part B regulation (CMS-1503-P).

The following proposals will impact the Medicare DMEPOS Competitive Bidding Program:

- The establishment of an appeals process for competitive bidding contract suppliers that are notified that they are in breach of contract.
- The subdivision of metropolitan statistical areas (MSAs) with populations over 8,000,000 into smaller competitive bidding areas (CBAs).
- The addition of 21 MSAs to the 70 MSAs already designated as included in the Round 2 Competitive Bidding program, for a total of 91 MSAs.
- The addition of the following policies affecting diabetic testing supplies:
  - Revising the definition of a "mail order" item to include any item shipped or delivered to a beneficiary's home;
  - Requiring contract suppliers to provide at least 50% of the types of test strips on the market; and
  - Prohibiting contract suppliers from influencing or incentivizing beneficiaries to switch types of test strips.
- The exemption of off-the shelf orthotics from competitive bidding when provided by a physician to his or her own patients or a hospital to its own patients.

The regulation also solicits comments on whether to maintain the additional rental payments made to contract suppliers when a beneficiary does not continue to get capped rental or oxygen equipment from his or her current supplier.

In addition to the competitive bidding proposals, the regulation proposes the following payment policies for power-driven wheelchairs and oxygen and oxygen equipment:

- The elimination of the lump sum purchase option for standard power wheelchairs furnished on or after January 1, 2011, and an adjustment to the amount of the capped rental payments for power wheelchairs.
- The establishment of additional rules to safeguard beneficiary access to oxygen and oxygen equipment in situations where a beneficiary relocates after the 18th month rental payment and before the 36-month rental payment.

These proposed provisions are found in Sections H, N, P, Q, and R of the 2011 Physician Fee Schedule proposed rule, which is now on display at the Office of the Federal Register. The proposed rule is available at: http://www.cms.gov/PhysicianFeeSched/PFSFRN/itemdetail.asp?itemID=CMS1236707.

Background materials on these provisions may be found at: http://www.cms.gov/DMEPOSCompetitiveBid/01_overview.asp and http://www.cms.gov/DMEPOSCompetitiveBid/02_Federal_Regulations_Notices_and_Manual_Instructions.asp.

CMS will accept comments on the proposed rule until August 24, 2010, and will respond to them in a final rule to be issued on or about November 1, 2010.

Telephone Reopenings: What Can and Cannot be Requested

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

What Can be Done as a Reopening

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

- Diagnosis changes/additions
- Date of service changes
- Procedure code changes
- Certificate of Medical Necessity (CMN)/DME Information Form (DIF) Updates (with the exception of parenteral and enteral nutrition, which must be done as a written redetermination and oxygen Break In Service (BIS) which can only be done as a written reopening)
- Certain modifier changes/additions (not all inclusive list):
  - KH - DMEPOS item, initial claim, purchase or first month
  - KI - DMEPOS item, second or third month rental
  - KJ - DMEPOS item, parenteral enteral nutrition (PEN) pump or capped rental, months four to fifteen
  - KX - Specific required documentation on file
  - RR - Rental
- Surgical Dressing (when number of services are within the policy-if the request is to allow over the policy amount, these must go to written redeterminations)
- Wheelchairs/Power Mobility Devices - HCPCS K0004 and lower

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

What Can Not be Done as a Reopening

The following issues must be requested and completed as a redetermination rather than a telephone or written reopening:

- Any item billed over the allowance listed in the medical policy-documentation is required to support amount billed
- Parenteral and Enteral CMN/DIF issues
- Oxygen BIS
- Wheelchairs/Power Mobility Devices - HCPCS K0005 and higher
- Recoupment/Reduction of payment - Complete Refunds to Medicare Form
- Medicare Secondary Payer (MSP)-send inquiry to MSP Department
- Timely Denials
- Late Files
- Requests that require documentation
- ABN Issues
- GA/GY/GZ Modifiers
- Liability Issues
- Repairs to equipment
- Miscellaneous codes
- Labor codes

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

Change in Amount in Controversy Requirement for Administrative Law Judge Hearings and Federal District Court Appeals

MLN Matters® Number: MM6894
Related Change Request (CR) #: 6894
Related CR Release Date: May 7, 2010
Related CR Transmittal #: R1965CP
Effective Date: August 9, 2010
Implementation Date: August 9, 2010

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 6894, which notifies Medicare contractors of the Amount in Controversy (AIC) required to sustain Administrative Law Judge (ALJ) and Federal District Court appeal rights beginning January 1, 2010.

- The amount remaining in controversy requirement for ALJ hearing requests made before January 1, 2010, is $120. **The amount remaining in controversy requirement for requests made on or after January 1, 2010, is $130.**
- **For Federal District Court review, the amount remaining in controversy goes** from $1,220 for requests on or after January 1, 2009, **to $1,260 for requests on or after January 1, 2010.**

Please ensure that your staff knows of these changes.

Background

The Medicare claims appeal process was amended by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA). CR 6894 modifies the *Medicare Claims Processing Manual*, Chapter 29, Sections 220, 330.1, and 345.1 to update the AIC required for an ALJ hearing or judicial court review. CR 6894 also expands the background information in the Amount in Controversy General Requirements, Principles for Determining Amount in Controversy, and Aggregation of Claims to meet Amount in Controversy sections 250, 250.1, 250.2 and 250.3 in the Claims Processing Manual, Chapter 29. The revised portions of the manual are attached to CR 6894.

Additional Information

The official instruction (CR 6894) issued to your Medicare Carrier, A/B MAC, DME MAC, FI, and/or RHHI is available at http://www.cms.gov/Transmittals/downloads/R1965CP.pdf on the Centers for Medicare & Medicaid Services (CMS) website.

A brochure entitled, *The Medicare Appeals Process: Five Levels To Protect Providers, Physicians And Other Suppliers*, provides an overview of the Medicare Part A and Part B administrative appeals process available to providers, physicians and other suppliers who provide services and supplies to Medicare beneficiaries, as well as details on where to obtain more information about this appeals process. The brochure is available at http://www.cms.hhs.gov/MLNProducts/downloads/MedicareAppealsProcess.pdf on the CMS website.

Accepting and Processing Appeals via Facsimile or a Secure Internet Portal/Application

MLN Matters® Number: MM6958
Related Change Request (CR) #: 6958
Related CR Release Date: June 11, 2010
Related CR Transmittal #: R1986CP
Effective Date: October 1, 2010
Implementation Date: October 1, 2010

Provider Types Affected

This article is for physicians, providers, and suppliers submitting Medicare fee-for-service (FFS) claim appeal requests to Medicare contractors (carriers, Durable Medical Equipment Medicare Administrative Contractors (DME MACs), Fiscal Intermediaries (FIs), Part A/B Medicare Administrative Contractors (A/B MACs), and/or Regional Home Health Intermediaries (RHHIs)).

Provider Action Needed

This article is based on Change Request (CR) 6958 which updates the current instructions in the Medicare Claims Processing Manual, Chapter 29, to allow Medicare contractors to accept claim appeal requests via facsimile and/or via a secure Internet portal/application.

CR 6958 provides guidance to Medicare contractors who have already modified or currently wish to modify their procedures to allow for receipt and/or processing of redetermination requests via facsimile and/or via a secure Internet portal/application. At this time, Medicare contractors are not required to accept appeals via facsimile or via secure Internet portal/application. Medicare contractors wishing to utilize a secure Internet portal/application must seek approval from the Centers for Medicare & Medicaid Services (CMS) prior to implementation of that portal/application.

Note that, even if your contractor allows submission of appeal requests via facsimile and/or via a secure Internet portal/application, the decision to use those venues is yours. Your contractor may not require you to use those venues. See the Background and Additional Information Sections of this article for further details regarding these changes.

Background

Several Medicare contractors have requested authority from the CMS to utilize a secure Internet portal/application to receive and process Medicare FFS claim appeal requests. In addition, several Medicare contractors have begun to accept claim appeal requests received in writing via facsimile.

CR 6958 provides guidance regarding appeal requests received in writing via facsimile or via a secure Internet portal/application, and it provides guidance to Medicare contractors who have already modified or currently wish to modify their procedures to allow for receipt and/or processing of redetermination requests via these mechanisms.

The purpose of CR 6958 is to update the current instructions in the Medicare Claims Processing Manual, Chapter 29 (Appeals of Claims Decisions), to allow Medicare contractors to accept appeal requests via facsimile and/or via a secure Internet portal/application.

CMS does not require its contractors to utilize a facsimile and/or a secure Internet portal/application for performing appeals activities. Contractors may not require an appellant to file an appeal electronically (e.g., via facsimile and/or a secure Internet portal/application). Submission of appeal requests via facsimile or a portal/application is at the discretion of the appellant. Contractors will continue to accept appeal requests in hard copy via mail. Key portions of CR 6958 for providers are as follows:

What Constitutes a Request for Redetermination

Written Requests for Redetermination Submitted by a State, Provider, Physician or Other Supplier

States, providers, physicians, or other suppliers with appeal rights must submit written requests via mail, facsimile (if the contractor chooses to receive requests via facsimile), or, where available, secure Internet portal/application indicating what they are appealing and why. The acceptable written ways of doing this are via:

- **A completed Form CMS-20027 (constitutes a request for redetermination).** The contractor supplies these forms upon request by an appellant. "Completed" means that all applicable spaces are filled out and all necessary attachments are included with the request.
- **A written request not on Form CMS-20027.**

  At a minimum, the request shall contain the following information:

- Beneficiary name;
- Medicare health insurance claim (HIC) number;
- The specific service(s) and/or item(s) for which the redetermination is being requested;
- The specific date(s) of the service; and
- The name and signature of the party or the representative of the party.

Frequently, a party will write to a contractor concerning the initial determination instead of filing Form CMS-20027. How to handle such letters depends upon their content and/or wording. A letter serves as a request for redetermination if it contains the information listed above and either: (1) explicitly asks the contractor to take further action, or (2) indicates dissatisfaction with the contractor's decision. The contractor counts the receipt and processing of the letter as an appeal only if it treats it as a request for redetermination.

- **A secure Internet portal/application.** If a contractor has received CMS approval for the use of a secure Internet portal/application to support appeals activities, appellants may submit redetermination requests via the secure Internet portal/application. Written requests submitted via the portal/application shall include the required elements for a valid appeal request as outlined under Chapter 29, Section 310.1.B.2.b which is attached to CR 6958.

NOTE: Some redetermination requests may contain attachments. For example, if the Remittance Advice (RA) is attached to the redetermination request that does not contain the dates of service on the cover and the dates of service are highlighted or emphasized in some manner on the attached RA, this is an acceptable redetermination request.

Requirements for a Valid Signature on an Appeal Request

For appeal purposes, the only acceptable method of documenting the appellant's signature on the appeal request is by written, digital, digitized, or electronic signature as discussed below:

- A **written signature** may be received via hard copy mailed correspondence or as part of an appeal request submitted via facsimile.
- An **electronic, digital, and/or digitized signature** is an acceptable signature on a request submitted via a CMS-approved secure Internet portal/application. The secure Internet portal/application shall include a date, timestamp, and statement regarding the responsibility and authorship related to the electronic, digital, and/or digitized signature within the record. At a minimum, this shall include a statement indicating that the document submitted was, "electronically signed by" or "verified/approved by" etc.
- A **stamp signature or other indication that a "signature is on file"** on the CMS 20027 form or other documentation (such as a blank claim form) submitted to support the appeal request **shall not** be considered an acceptable/valid signature regardless of whether the appeal request is submitted via hard copy mail or via facsimile.

How Contractors will Handle Multiple Requests for Redetermination for the Same Item/Service

If a contractor receives multiple timely requests for redetermination for the same item or service from either multiple parties or via multiple venues (i.e., hard copy mail, facsimile, or via a secure Internet portal/application) the contractor acts as follows:

- If a decision or dismissal notice has already been issued or the claim for the item/service at issue has been adjusted/paid in accordance with the redetermination decision and the contractor receives additional redetermination request(s) for the same items/services, the contractors will treat the additional request as an inquiry. Contractors shall not issue a dismissal notice.

Note: In accordance with the Medicare Claims Processing Manual (Chapter 29, Section 310.6.3 which is attached to CR6958), if an appellant requests that the contractor vacates its dismissal action and the contractor determines that it cannot vacate the dismissal; it sends a letter notifying the appellant accordingly. The contractor shall not issue a second dismissal notice to the appellant since a dismissal should only be issued in response to an appeal request.

- If a decision or dismissal notice has not been issued (i.e., the appeal is pending), and the claim for the items/services at issue has not been otherwise adjusted/paid following the redetermination decision, then upon receipt of additional redetermination request(s) for the same items/services, the contractor shall:
  1. Combine the redetermination requests and issue a decision within 60 days of the latest filed request, in accordance with the requirements as outlined in 42 CFR 405.944(c). See http://edocket.access.gpo.gov/cfr_2009/octqtr/pdf/42cfr405.944.pdf on the Internet.
  2. When issuing the decision or dismissal notice, the contractor shall include verbiage indicating that multiple requests for redetermination had been received (on what dates and via what venues, if multiple venues were utilized) so that it is clear to the appellant that the decision or dismissal was issued timely in accordance with 42 CFR 405.944(c).
- If the contractor identifies a pattern in which an appellant or groups of appellants are repeatedly submitting multiple requests for redetermination via multiple venues, the contractor shall take additional steps to educate the appellant regarding the appeals process.

Timely Processing Requirements

The contractor must complete and mail a redetermination notice for all requests for redetermination within 60 days of receipt of the request (with the exception of the *Medicare Claims Processing Manual*, Chapter 29, Section 310.4(D)(4), which is attached to CR 6958). The date of receipt for purposes of this standard is defined as the date the request for redetermination is received in the corporate mailroom or the date when the electronic request for appeal is received via facsimile or through the secure Internet portal/application.

APPEALS CONT'D

Completion is defined as:

1. For affirmations, the date the decision letter is mailed to the parties. Affirmations processed via a CMS approved secure Internet portal/application shall be considered complete on the date the electronic redetermination notice is transmitted to the appellant through the secure Internet portal/application.
2. For partial reversals and full reversals, when all of the following actions have been completed:
   - The decision letter, if applicable, is mailed to the parties (or if processed via a CMS approved secure Internet portal/application, it shall be considered complete on the date the electronic redetermination notice is transmitted to the appellant through the secure Internet portal/application), and
   - The actions to initiate the adjustment action in the claims processing system are taken.
3. For withdrawals and dismissals, the date that the dismissal notice is mailed (or if processed via a CMS approved secure Internet portal/application, it shall be considered complete on the date the notice is transmitted to the appellant through the secure Internet portal/application) to the parties.

The Redetermination Decision

The law requires contractors to conclude and mail and/or otherwise transmit, as noted below, the redetermination within 60 days of receipt of the appellant's request, as indicated in the ***Medicare Claims Processing Manual***, Chapter 29, Section 310.4, which is attached to CR 6958. For unfavorable redeterminations, the contractor mails the decision letter to the appellant, and mails copies to each party to the initial determination (or the party's authorized representative and appointed representative, if applicable).

Contractors shall provide the decision, as required below; in writing via hard copy mail (unless the contractor has submitted a request and received approval for use of secure Internet portal/application as part of the appeals process and the appellant has submitted the request for appeal electronically). Contractors may transmit appeal decisions (favorable, partially favorable, or unfavorable) via a secure Internet portal/application if the appeal request was received via that mechanism.

Requirements for Use of Secure Internet Portal/Application to Support Appeals Activities

Contractors who develop and utilize a secure Internet portal/application for appeals purposes will ensure, at a minimum:

- CMS approves the proposed portal/application and usage prior to development and implementation.
- Appropriate procedures are in place to provide appellants with confirmation of receipt of the appeal request (the system must include verbiage instructing the appellant not to submit additional redetermination requests for the same item/service via a different venue).
- The secure Internet portal/application includes a formal registration process that validates the signature and requires, at a minimum, use of restricted user IDs and passwords.
- Templates for submission of electronic appeal requests must include, at a minimum, a method for authenticating that the appellant has completed the portal/application registration process and has been properly identified by the system as an appropriate user.
- Contractors utilizing an approved portal/application must provide education to appellants regarding system capabilities/limitations prior to implementation and utilization of the secure portal/application.
- Contractors must also educate appellants that participation/enrollment in the secure portal/application is at the discretion of the appellant and the appellant bears the responsibility for the authenticity of the information being attested to.
- Contractors utilizing a secure portal/application shall ensure that there is a process in place by which an appellant can submit additional documentation/materials concurrent with the appeal request so as not to cause a delay in the timely processing of the appeal. The portal/application shall have the capability to accept additional documentation and/or other materials to support appeal requests.
- Redetermination decision and/or dismissal notices transmitted via a secure Internet portal/application shall comply with the timeliness and content requirements. In addition, contractors shall provide hard copy decision and/or dismissal notices to parties to the appeal and who do not have access to the secure Internet portal/application. The notices must be mailed and/or otherwise transmitted concurrently (i.e., mailed on the same day the notice is transmitted via the secure portal/application).
- Contractors will also ensure that appellants may save and print the decision or dismissal notice and that the secure portal/application includes a mechanism by which the date/time of the notification is tracked/marked both in the system and on any printed decision or dismissal notices so as to adequately inform the appellant of timeframes for ensuring timely submission of future appeal requests.

Additional Information

The official instruction, CR 6958, issued to your carrier, FI, A/B MAC, RHHI, and DME MAC regarding this change may be viewed at http://www.cms.gov/Transmittals/downloads/R1986CP.pdf on the CMS website.

REIMBURSEMENT

July Quarterly Update for 2010 DMEPOS Fee Schedule

MLN Matters® Number: MM6945
Related Change Request (CR) #: 6945
Related CR Release Date: July 1, 2010
Related CR Transmittal #: R1993CP

Effective Date: January 1, 2010 for implementation of fee schedule amounts for codes in effect on January 1, 2010; April 1, 2010 for the revisions to the RA & RB modifier descriptors which became effective April 1, 2010; July 1, 2010 for all other changes
Implementation Date: July 6, 2010

Note: This article was revised on July 1, 2010, to reflect changes made by the release of an updated Change Request (CR) 6954. Language on page 2 **in bold** was corrected to state that claims for codes A4336, E1036, L8031, L8032, L8629 and Q0506 will be adjusted if brought to the contractor's attention. In addition, the Transmittal number, CR release date, and web address for the CR has been changed. All other material remains the same.

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 6945 and alerts providers that the Centers for Medicare & Medicaid Services (CMS) has issued instructions updating the DMEPOS fee schedule payment amounts. Be sure your billing staffs are aware of these changes.

Background

The DMEPOS fee schedules are updated on a quarterly basis, when necessary, in order to implement fee schedule amounts for new codes and to correct any fee schedule amounts for existing codes. Payment on a fee schedule basis is required for durable medical equipment (DME), prosthetic devices, orthotics, prosthetics and surgical dressings by Sections 1834(a), (h), and (i) of the Social Security Act. Payment on a fee schedule basis is required for parenteral and enteral nutrition (PEN) by regulations contained in 42 CFR 414.102.

Key Points of CR6945

- Healthcare Common Procedure Coding System (HCPCS) codes A4336, E1036, L8031, L8032, L8629 and Q0506 were added to the HCPCS file effective January 1, 2010. The fee schedule amounts for the aforementioned HCPCS codes are established as part of this update and are effective for claims with dates of service on or after January 1, 2010. These items were paid on a local fee schedule basis prior to implementation of the fee schedule amounts established in accordance with this update. **Claims for codes A4336, E1036, L8031, L8032, L8629 and Q0506 with dates of service on or after January 1, 2010 that have already been processed may be adjusted to reflect the newly established fees if brought to the attention of your Medicare contractor.**
- CMS notes that they have received questions requesting clarification concerning what items and services a supplier must furnish when billing HCPCS code - A4221 Supplies for Maintenance of Drug Infusion Catheter, Per Week. To restate existing policy, all supplies (including dressings) used in conjunction with a durable infusion pump are billed with codes A4221 and A4222 or codes A4221 and K0552. Other codes should not be used for the separate billing of these supplies. Code A4221 includes dressings for the catheter site and flush solutions not directly related to drug infusion. Code A4221 also includes all cannulas, needles, dressings and infusion supplies (excluding the insulin reservoir) related to continuous subcutaneous insulin infusion via an external insulin infusion pump and the infusion sets and dressings related to subcutaneous immune globulin administration. The payment amount for code A4221 includes all necessary supplies for one week in whatever quantity is needed by the beneficiary for that week. Suppliers that bill HCPCS code A4221 are required to furnish the items and services described by the code in the quantities needed by the beneficiary for the entire week.
- CR6945 also clarifies that modifiers RA and RB, for repair and replacement of an item, added to the HCPCS code set effective January 1, 2009, are also available for use with prosthetic and orthotic items. Additionally, the descriptors for RA and RB are being revised, effective April 1, 2010, to read as follows:
  - RA- Replacement of a DME, Orthotic or Prosthetic Item
  - RB- Replacement of a Part of a DME, Orthotic or Prosthetic Item Furnished as Part of a Repair
- Suppliers should continue to use the RA modifier on DMEPOS claims to denote instances where an item is furnished as a replacement for the same item which has been lost, stolen or irreparably damaged. Likewise, the RB modifier should continue to be used on DMEPOS claims to indicate replacement parts of a DMEPOS item (base equipment/device) furnished as part of the service of repairing the DMEPOS item (base equipment/device.)
- Under the regulations at 42 CFR 414.210(f), the reasonable useful lifetime of DMEPOS devices is 5 years unless Medicare program/manual instructions authorize a specific reasonable useful lifetime of less than 5 years for an item. After a review of product information and in consultation with the DME MAC medical officers, CMS has determined that a period shorter than 5 years more accurately reflects the useful lifetime expectancy for a reusable, self-adhesive nipple prosthesis. CR6945 lowers the reasonable useful lifetime period for a reusable, self-adhesive nipple prosthesis to 3 months.
- HCPCS code Q0506 Battery, Lithium-Ion, For Use With Electric or Electric/Pneumatic Ventricular Assist Device, Replacement Only was added to the HCPCS effective January 1, 2010. Based on information furnished by ventricular assist device (VAD) manufacturers, CMS determined that the reasonable useful lifetime of the lithium ion battery described by HCPCS code Q0506 is 12 months. Therefore, CR 6945 is establishing edits to deny claims that are submitted for code Q0506 prior to the expiration of the batteries' reasonable useful lifetime. The reasonable useful lifetime of VAD batteries other than

lithium ion – HCPCS codes Q0496 and Q0503 – remains at 6 months as described in CR3931, Transmittal 613, issued July 22, 2005. Additionally, suppliers and providers will need to add HCPCS modifier RA (Replacement of a DME, Orthotic or Prosthetic Item) to claims for code Q0506 in cases where the battery is being replaced because it was lost, stolen, or irreparably damaged. Per the VAD replacement policy outlined in CR3931, if the A/B MAC, local carrier, or intermediary determines that the replacement of the lost, stolen, or irreparably damaged item is reasonable and necessary, then payment for replacement of the item can be made at any time, irrespective of the item's reasonable useful lifetime.

Additional Information

The official instruction (CR6945) issued to your Medicare DME MAC may be found at http://www.cms.gov/transmittals/downloads/R1993CP.pdf on the CMS website.

Quarterly HCPCS Code Changes – July 2010 Update

MLN Matters® Number: MM6809
Related Change Request (CR) #: 6809
Related CR Release Date: May 21, 2010
Related CR Transmittal #: R1972CP
Effective Date: July 1, 2010 unless otherwise specified
Implementation Date: July 6, 2010

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 6809 which provides the Quarterly Healthcare Common Procedure Coding System (HCPCS) Code changes for the July 2010 Update. Be sure your billing staff know of these HCPCS code changes as noted below.

Background

The HCPCS code set is updated on a quarterly basis. Change Request (CR) 6809 describes the process for updating these specific HCPCS codes.

Effective for claims with dates of service on or after July 1, 2010, the following HCPCS code will be payable for Medicare:

HCPCS Code	Short Description	Long Description	MPFSDB Status Indicator
Q2025	Oral fludarabine phosphate	Fludarabine phosphate, oral, 10 mg	E

Note that suppliers are currently instructed to bill oral anti-cancer drugs to the DME MACs using the appropriate National Drug Code (NDC). The code "WW141 – Fludarabine Phosphate, oral, 10mg" will allow the DME MACs to adjudicate correctly the oral anti-cancer drug associated with Q2025 and DME MACs will accept WW141 for dates of service on or after July 1, 2010.

In addition, the Centers for Medicare & Medicaid Services (CMS) recently concluded that Dermal injections for facial lipodystrophy syndrome (LDS) are only reasonable and necessary using dermal fillers approved by the Food and Drug Administration for this purpose, and then only in HIV infected beneficiaries when facial LDS caused by antiretroviral HIV treatment is a significant contributor to their depression. Consequently, effective for claims with dates of service on or after March 23, 2010, the following HCPCS codes will be payable for Medicare:

HCPCS Code	Short Description	Long Description	MPFSDB Status Indicator
Q2026	Radiesse injection	Injection, Radiesse, 0.1 ml	E
Q2027	Sculptra Injection	Injection, Sculptra, 0.1 ml	E

Additional Information

Medicare contractors will not search their files to reprocess claims already processed, but will adjust such claims that you bring to their attention.

The official instruction, CR 6809, issued to your carrier, FI, A/B MAC, RHHI, and DME MAC regarding this change may be viewed at http://www.cms.gov/Transmittals/downloads/R1972CP.pdf on the CMS website.

October 2010 Quarterly ASP Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files

MLN Matters® Number: MM7007
Related Change Request (CR) #: 7007
Related CR Release Date: June 18, 2010
Related CR Transmittal #: R1990CP
Effective Date: October 1, 2010
Implementation Date: October 4, 2010

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 7007 and instructs Medicare contractors to download and implement the October 2010 ASP drug pricing file for Medicare Part B drugs; and, if released by the Centers for Medicare & Medicaid Services (CMS), also the revised, July 2010, April 2010, January 2010 and October 2009 files. Medicare will use these files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after October 4, 2010, with dates of service October 1, 2009, through December 31, 2010. See the Background and Additional Information Sections of this article for further details regarding these changes

Background

Section 303(c) of the Medicare Modernization Act of 2003 revised the payment methodology for Part B covered drugs and biologicals that are not paid on a cost or prospective payment basis. Beginning January 1, 2005, the vast majority of drugs and biologicals not paid on a cost or prospective payment basis are paid based on the ASP methodology, and pricing for compounded drugs has been performed by the local contractor.

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

Files	Effective Dates of Service
October 2010 ASP and ASP NOC files	October 1, 2010, through December 31, 2010
July 2010 ASP and ASP NOC files	July 1, 2010, through September 30, 2010
April 2010 ASP and ASP NOC files	April 1, 2010, through June 30, 2010
January 2010 ASP and ASP NOC files	January 1, 2010, through March 31, 2010
October 2009 ASP and ASP NOC files	October 1, 2009, through December 31, 2009

Note: The absence or presence of a HCPCS code and its associated payment limit does not indicate Medicare coverage of the drug or biological. Similarly, the inclusion of a payment limit within a specific column does not indicate Medicare coverage of the drug in that specific category. The local Medicare contractor processing the claim shall make these determinations.

Additional Information

The official instruction (CR7007) issued to your Medicare MAC, carrier, and/or FI may be found at http://www.cms.gov/Transmittals/downloads/R1990CP.pdf on the CMS website.

October Quarterly Update for 2010 DMEPOS Fee Schedule

MLN Matters® Number: MM7070
Related Change Request (CR) #: 7070
Related CR Release Date: July 23, 2010
Related CR Transmittal #: R2006CP
Effective Date: January 1, 2010 for codes in effect then, October 1, 2010 for other changes
Implementation Date: October 4, 2010

Provider Types Affected

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

Provider Action Needed

This article is based on CR 7070, which provides the required quarterly update of the 2010 DMEPOS Fee Schedule. Be sure billing staffs are aware of the update.

Background

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

Key Points of CR7070

Per Transmittal 686 (Change Request 6743), the claims filing jurisdiction for HCPCS code L8509 (*Tracheo-Esophageal Voice Prosthesis, Inserted by a Licensed Health Care Provider, Any Type*) is changing from the DME MACs to the A/B MACs/Part B carriers, **effective October 1, 2010**. To reflect this change, the claims jurisdiction for code L8509 will change in the DMEPOS fee schedule file to local carrier as part of this update.

As part of this update, the Alaska and Hawaii fee schedule amounts for HCPCS code E0973 (*Wheelchair Accessory, Adjustable Height, Detachable Armrest, Complete Assembly, Each*) are being revised in order to correct errors made in the calculation of the fee schedule amounts. Medicare contractors **will adjust previously processed claims for code E0973 with dates of service on or after January 1, 2010, if they are resubmitted as adjustments.**

Additional Information

The official instruction, CR 7070, issued to your carrier, FI, RHHI, A/B MAC, and DME/MAC regarding this change may be viewed at http://www.cms.gov/Transmittals/downloads/R2006CP.pdf on the CMS website.

An earlier MLN Matters® article, MM6743 on the Change in Claims Filing Jurisdiction for Tracheo-Esophageal Voice Prostheses Healthcare Common Procedure Coding System (HCPCS) Code may be reviewed at http://www.cms.gov/MLNMattersArticles/downloads/MM6743.pdf on the CMS website.

CODING

Coding Guidelines for Therapeutic Shoes for Persons with Diabetes

This article is being published to reemphasize a policy that has been in place since the initiation of Coding Verification Reviews of Therapeutic Shoes and Inserts.

A5500 and A5501 include two components to the codes. The first component is the fitting and follow-up associated with dispensing the shoes. The second is the composition and characteristic components of the shoe.

When a manufacturer and/or distributor submits their therapeutic shoes to the Pricing, Data Analysis, and Coding Contractor (PDAC) for coding verification review, that review is solely focused on whether the composition and characteristic components of the shoe meet the requirements specified in the Coding Guidelines section of the Therapeutic Shoes for Persons with Diabetes Policy Article. Inclusion of a shoe on the Product Classification List does not indicate whether the fitting and follow-up are acceptable. That determination is made by the Durable Medical Equipment Medicare Administrative Contractor (DME MAC), and other contractors that conduct medical review of claims.

Suppliers are reminded to access the Durable Medical Equipment Coding System (DMECS) at https://www.dmepdac.com/dmecs/index.html, or contact the PDAC Contact Center at 877-735-1326, for any questions regarding the correct coding of products.

Correct Coding for Pneumatic Compression Devices

Pneumatic compression devices (PCD) consist of an inflatable garment for the arm or leg and an electrical pneumatic pump that fills the garment with compressed air. The garment is intermittently inflated and deflated with cycle times and pressures that vary between devices. Several categories of these devices exist. It is important to use the correct HCPCS code for the item provided.

PCDs used for the treatment of lymphedema and chronic venous insufficiency with ulcers are coded based upon the characteristics of the base device. The codes used are:

- E0650 - PNEUMATIC COMPRESSOR, NON-SEGMENTAL HOME MODEL
- E0651 - PNEUMATIC COMPRESSOR, SEGMENTAL HOME MODEL WITHOUT CALIBRATED GRADIENT PRESSURE
- E0652 - PNEUMATIC COMPRESSOR, SEGMENTAL HOME MODEL WITH CALIBRATED GRADIENT PRESSURE

PCDs used for the treatment of arterial disease are coded:

- E0675 - PNEUMATIC COMPRESSION DEVICE, HIGH PRESSURE, RAPID INFLATION/DEFLATION CYCLE,FOR ARTERIAL INSUFFICIENCY (UNILATERAL AND BILATERAL SYSTEM)

Sleeves used with E0650 - E0652 and E0675 are billed separately using codes E0655 – E0673 depending upon the specific item provided.

There are other types of PCDs that are often referred to as deep vein thrombosis (DVT) pumps, massage therapy pumps, post surgical DVT preventative pumps, etc. (not all inclusive). These types of devices are coded:

- E0676 - INTERMITTENT LIMB COMPRESSION DEVICE (INCLUDES ALL ACCESSORIES), NOT OTHERWISE SPECIFIED

The garments/sleeves that are used with E0676 are included in the payment for E0676 on initial issue and must not be billed separately. If a supplier chooses to bill separately for the garment/sleeve at the time of initial issue, then HCPCS code A9900 - MISCELLANEOUS DME SUPPLY, ACCESSORY, AND/OR SERVICE COMPONENT OF ANOTHER HCPCS CODE **must** be used.

HCPCS code A4600 - SLEEVE FOR INTERMITTENT LIMB COMPRESSION DEVICE, REPLACEMENT ONLY, EACH is used only when the sleeve is being replaced, not at the time of initial issue. This code may only be used with compressors coded with E0676. HCPCS codes E0655 – E0673 must not be used when billing for garments used with E0676 devices.

Refer to the Local Coverage Determination (LCD) and Policy Article for Pneumatic Compression Devices for coverage and HCPCS coding requirements.

BILLING

Reminder: Maximum Period for Submission of Medicare Claims Reduced to Not More than 12 Months

Reminder: The Centers for Medicare & Medicaid Services (CMS) has released *MLN Matters Article #MM6960 - Systems Changes Necessary to Implement the Patient Protection and Affordable Care Act (PPACA) Section 6404 – Maximum Period for Submission of Medicare Claims Reduced to Not More Than 12 Months* to advise providers who submit claims to Medicare contractors that, as a result of the Affordable Care Act (ACA), claims with dates of service **on or after January 1, 2010**, received later than one calendar year beyond the date of service will be denied by Medicare. For more details, please read the article at http://www.cms.gov/MLNMattersArticles/downloads/MM6960.pdf on the CMS website.

Systems Changes Necessary to Implement PPACA Section 6404 - Maximum Period for Submission of Medicare Claims Reduced to Not More Than 12 Months

MLN Matters® Number: MM6960
Related Change Request (CR) #: 6960
Related CR Release Date: May 7, 2010

Related CR Transmittal #: R697OTN
Effective Date: January 1, 2010
Implementation Date: October 4, 2010

Provider Types Affected

This issue impacts all physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, durable medical equipment Medicare administrative contractors (DME MACs), fiscal intermediaries (FIs), Part A/B Medicare administrative contractors (A/B MACs), and/or regional home health intermediaries (RHHIs)) for services provided to Medicare beneficiaries.

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) is updating edit criteria related to the timely filing limits for submitting claims for Medicare Fee-for-Service (FFS) reimbursement. As a result of the PPACA, claims with dates of service on or after January 1, 2010 received later than one calendar year beyond the date of service will be denied by Medicare. Further details follow in this article. Make sure your billing staff is aware of these changes.

Background

Sections 1814(a), 1835(a)(1), and 1842(b)(3) of the Social Security Act as well as the Code of Federal Regulations (CFR), 42 CFR Section 424.44 specify the timely filing limits for submitting claims for Medicare Fee-For-Service (FFS) reimbursement. Prior to PPACA, the regulations stated the service provider or supplier must submit claims for services furnished during the first nine (9) months of the calendar year on or before December 31st of the following calendar year. For services rendered during the last quarter of the calendar year, the provider or supplier must submit the claim on or before December 31st of the second following year.

Section 6404 of PPACA amended the timely filing requirements to reduce the maximum time period for submission of all Medicare FFS claims to one calendar year after the date of service. Additionally, this section mandates that all claims for services furnished prior to January 1, 2010 must be filed with the appropriate Medicare claims processing contractor no later than December 31, 2010.

What You Need to Know

Medicare contractors are adjusting (as necessary) their relevant system edits to ensure that:

- Claims with dates of service prior to October 1, 2009 will be subject to pre-PPACA timely filing rules and associated edits;
- Claims with dates of service October 1, 2009 through December 31, 2009 received after December 31, 2010 will be denied as being past the timely filing deadline and;
- Claims with dates of service January 1, 2010 and later received more than 1 calendar year beyond the date of service will be denied as being past the timely filing deadline.

Note: For claims for services that require the reporting of a line item date of service, the line item date is used to determine the date of service. For other claims, the claim statement's "From" date is used to determine the date of service.

Section 6404 of PPACA gives CMS the authority to specify exceptions to the one (1) calendar year time limit for filing claims. Currently, there is one exception found in the timely filing regulations at 42 CFR section 424.44(b)(1), for "error or misrepresentation" of an employee, Medicare contractor, or agent of the Department that was performing Medicare functions and acting within the scope of its authority. If CMS adds additional exceptions or modifies the existing exception to the timely filing regulations, specific instructions will be issued at a later date explaining those changes.

Additional Information

The official instruction (CR6960) issued to your Medicare FI, Carrier, DME MAC, A/B MAC and/or RHHI is available at http://www.cms.gov/Transmittals/downloads/R697OTN.pdf on the CMS website.

Timely Claims Filing: Additional Instructions

MLN Matters® Number: MM7080
Related Change Request (CR) #: 7080
Related CR Release Date: July 30, 2010
Related CR Transmittal #: R734OTN
Effective Date: January 1, 2011
Implementation Date: January 3, 2011

Provider Types Affected

This issue impacts all physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, durable medical equipment Medicare administrative contractors (DME MACs), fiscal intermediaries (FIs), Part A/B Medicare administrative contractors (A/B MACs), and/or regional home health intermediaries (RHHIs)) for services provided to Medicare beneficiaries.

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 7080 to expand the Medicare Fee-for-Service (FFS) reimbursement instructions outlined in change request (CR) 6960 that specified the basic timely filing standards established for FFS reimbursement. Those basic standards are a result of Section 6404 of the Patient Protection and Affordable Care Act of 2010 (ACA) that states that claims with dates of service on or after January 1, 2010, received later than one calendar year beyond the date of service will be denied by Medicare. CR 7080 lists the standards for dates of service used to determine the timely filing of claims. Be sure your billing staffs are aware of these changes.

Background

CMS is addressing institutional claims and professional/supplier claims differently with respect to span date claims. Institutions often bill for extended length of stays that exceed a month's (or more) duration. Therefore, it is both less burdensome and more reasonable to use the claim's "Through" date rather than the "From" date as the date of service for determining claims filing timeliness.

Conversely, for physicians and other suppliers that bill claims with span dates, these span date services cannot exceed one month. Thus, there is no compelling need to create an extended filing period. CMS also notes that, if the "From" date of these span date services is timely, then those services billed within the span are timely as well, and this will generally ease the administrative burden of the claims processing contractors in their determination of timely filed claims. Therefore, the "From" date standard will be used for determining claims filing timeliness for physicians and other suppliers that bill claims with span date services. With respect to supplies and rental items, they are physically furnished at or near the beginning of the span dates on the claim. Therefore, the "From" date standard reflects more precisely when the supply or item was delivered to the beneficiary, and will be used as the date for determining claims filing timeliness.

Key Points of CR 7080:

- For institutional claims that include span dates of service (i.e., a "From" and "Through" date span on the claim), the "Through" date on the claim will be used to determine the date of service for claims filing timeliness.
- For professional claims (CMS-1500 Form and 837P) submitted by physicians and other suppliers that include span dates of service, the line item "From" date will be used to determine the date of service and filing timeliness. (This includes supplies and rental items).
- BE AWARE: If a line item "From" date is not timely, but the "To" date is timely, Medicare contractors will split the line item and deny untimely services as not timely filed.
- Claims having a date of service of February 29th must be filed by February 28th of the following year to be considered as timely filed. If the date of service is February 29th of any year and is received on or after March 1st of the following year, the claim will be denied as having failed to meet the timely filing requirement.

Additional Information

Remember CR6960 established that Medicare contractors are adjusting (as necessary) their relevant system edits to ensure that:

- Claims with dates of service prior to October 1, 2009 will be subject to pre-ACA timely filing rules and associated edits;
- Claims with dates of service October 1, 2009 through December 31, 2009 received after December 31, 2010 will be denied as being past the timely filing deadline; and
- Claims with dates of service January 1, 2010 and later received more than one calendar year beyond the date of service will be denied as being past the timely filing deadline.

You can find the official instruction, CR7080, issued to your carrier, FI, A/B MAC, or RHHI by visiting http://www.cms.gov/Transmittals/downloads/R734OTN.pdf on the CMS website.

To review MM6960, Systems Changes Necessary to Implement the Patient Protection and Affordable Care Act (PPACA) Section 6404 - Maximum Period for Submission of Medicare Claims Reduced to Not More Than 12 Months, you may go to http://www.cms.gov/MLNMattersArticles/downloads/MM6960.pdf on the CMS website.

Name on Claim Must Match Medicare ID Card

Suppliers are reminded that the beneficiary name reported on the claim must be the name shown exactly on the beneficiary's Medicare ID card. If the beneficiary name submitted does not match the name in the Social Security Administration files for that beneficiary claim number, Medicare will delete and return the claim to the supplier. The claim must be corrected and resubmitted.

Updated Form CMS-1500 Information

MLN Matters® Number: MM6929
Related Change Request (CR) #: 6929
Related CR Release Date: May 21, 2010
Related CR Transmittal #: R1970CP
Effective Date: October 1, 2010
Implementation Date: October 4, 2010

Provider Types Affected

This is an informational article for physicians, providers and suppliers who use Form CMS-1500 to submit claims to Medicare contractors (carriers, Part A/B Medicare Administrative Contractors (A/B MACs), and Durable Medical Equipment (DME) MACs) for services provided to Medicare beneficiaries.

What You Need to Know

This article, based on Change Request (CR) 6929, updates Form CMS-1500 information in the *Medicare Claims Processing Manual* by removing language allowing the use of legacy identifiers and making other technical corrections as a result of that change. As part of this update, providers are reminded that they are responsible for purchasing their own CMS-1500 forms. Forms can be obtained from printers or printed in-house as long as the forms follow the specifications approved by the Centers for Medicare & Medicaid Services as developed by the American Medical Association. Photocopies of the Form CMS-1500 are NOT acceptable. Medicare will accept any type (i.e., single sheet, snap-out, continuous feed, etc.) of the Form CMS-1500 for processing. You may purchase forms from the U.S. Government Printing Office by calling 1-202-512-1800.

Additional Information

The official instruction issued to your Medicare carrier and/or MAC regarding this change may be viewed at http://www.cms.gov/Transmittals/downloads/R1970CP.pdf on the CMS website.

Addition of Repair Codes to List of HCPCS Codes Payable Under Instructions Provided in CRs 6573 and 5917

MLN Matters® Number: MM6914
Related Change Request (CR) #: 6914
Related CR Release Date: April 30, 2010
Related CR Transmittal #: R695OTN
Effective Date: January 1, 2010
Implementation Date: October 4, 2010

Provider Types Affected

This article applies to suppliers billing Medicare Carriers and Medicare Administrative Contractors (A/B MACs) for certain DME products provided to Medicare beneficiaries.

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) issued CR 6914 in order to augment previously issued CR 6573. Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) **suppliers may bill separately for any of the repair codes listed in the Key Points section of this article in addition to the codes for replacement parts, accessories, and supplies for prosthetic implants and surgically implanted DME previously communicated in Attachment A of CR 6573**. Your Medicare contractors will reprocess any claims submitted by DMEPOS suppliers for these separately billable repair codes listed below with dates of service of January 1, 2010, through the implementation date of CR 6914 (which is October 4, 2010), according to the guidelines established in CRs 5917 and 6573.

Key Points of CR6914

The following is the list of the additional separately billable repair codes issued within CR6914

Code	Description
K0739	REPAIR OR NON-ROUTINE SERVICE FOR DURABLE MEDICAL EQUIPMENT OTHER THAN OXYGEN EQUIPMENT REQUIRING THE SKILL OF A TECHNICIAN, LABOR COMPONENT, PER 15 MINUTES
L7500	REPAIR OF PROSTHETIC DEVICE, HOURLY RATE
L7510	REPAIR OF PROSTHETIC DEVICE, REPAIR OR REPLACE MINOR PARTS
L7520	REPAIR PROSTHETIC DEVICE, LABOR COMPONENT, PER 15 MINUTES
L8627	COCHLEAR IMPLANT, EXTERNAL SPEECH PROCESSOR, COMPONENT, REPLACEMENT
L8628	COCHLEAR IMPLANT, EXTERNAL CONTROLLER COMPONENT, REPLACEMENT
L8629	TRANSMITTING COIL AND CABLE, INTEGRATED, FOR USE WITH COCHLEAR IMPLANT DEVICE
Q0506	BATTERY, LITHIUM-ION, FOR USE WITH ELECTRIC OR ELECTRIC/PNEUMATIC VENTRICULAR ASSIST DEVICE, REPLACEMENT ONLY

- Medicare contractors will allow suppliers that are dually enrolled with the National Supplier Clearinghouse (NSC) and with their local carrier or A/B MAC as DMEPOS suppliers to bill separately for any of the above listed DMEPOS repair codes as well as those codes included in Attachment A of CR 6573 when billed under the guidelines established in CRs 5917 and 6573, including items/services furnished to beneficiaries who reside in other States.
- CR 5917 may be reviewed at http://www.cms.gov/Transmittals/downloads/R1603CP.pdf and CR 6573 http://www.cms.gov/Transmittals/downloads/R531OTN.pdf on the CMS website.

Additional Information

The official instruction associated with this CR6914, issued to your Medicare MAC or carrier regarding this change may be viewed at http://www.cms.gov/transmittals/downloads/R695OTN.pdf on the CMS website.

You may review MM6573 (related to CR 6573) at http://www.cms.gov/MLNMattersArticles/downloads/MM6573.pdf and MM5917 (related to CR 5917) at http://www.cms.gov/MLNMattersArticles/downloads/MM5917.pdf on the CMS website.

Claim Status Category and Claim Status Code Update

MLN Matters® Number: MM7052
Related Change Request (CR) #: 7052
Related CR Release Date: July 16, 2010
Related CR Transmittal #: R2002CP
Effective Date: October 1, 2010
Implementation Date: October 4, 2010

Provider Types Affected

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

Provider Action Needed

This article, based on CR7052, explains that the Claim Status Codes and Claim Status Category Codes for use by Medicare contractors with the Health Claim Status Request and Response ASC X12N 276/277 along with the 277 Health Care Claim Acknowledgement were updated during the June 2010 meeting of the national Code Maintenance

Committee and code changes approved at that meeting were posted at http://www.wpc-edi.com/content/view/180/223/on or about July 1, 2010. Included in the code lists are specific details, including the date when a code was added, changed, or deleted. Medicare contractors will implement these changes on October 4, 2010. All providers should ensure that their billing staffs are aware of the updated codes and the timeframe for implementations.

Background

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

Additional Information

The official instruction, (CR7052), issued to your Medicare contractor regarding this change may be viewed at http://www.cms.gov/Transmittals/downloads/R2002CP.pdf on the CMS website.

Change in Claims Filing Jurisdiction for Tracheo-Esophageal Voice Prostheses HCPCS Code

MLN Matters® Number: MM6743
Related Change Request (CR) #: 6743
Related CR Release Date: April 29, 2010
Related CR Transmittal #: R686OTN
Effective Date: October 1, 2010
Implementation Date: October 4, 2010

Provider Types Affected

This article is for physicians, non-physician practitioners and suppliers submitting claims to Medicare contractors (Medicare Administrative Contractors (MACs), carriers and/or Durable Medical Equipment Medicare Administrative Contractors (DME MACs)) for tracheo-esophageal voice prostheses provided to Medicare beneficiaries.

Provider Action Needed

This article is based on change request (CR) 6743, which changes the claims filing jurisdiction for Healthcare Common Procedure Coding System (HCPCS) code L8509. HCPCS code L8509 describes a tracheo-esophageal voice prosthesis inserted by a licensed health care provider, any type. This device is inserted in a physician's office or other outpatient setting. Effective for dates of service on or after October 1, 2010, claims for HCPCS code L8509 must be submitted to the A/B MAC or Part B carrier, as applicable, instead of the DME MAC. This jurisdictional policy does not apply to tracheo-esophageal voice prostheses that are changed by the patient/caregiver in the home setting (HCPCS code L8507). The filing jurisdiction for these claims remains with the DME MACs. Be sure billing staff know of this change.

Key Points of CR 6743

- Effective for dates of service on or after October 1, 2010, the DME MACs will deny claims containing HCPCS code L8509 as not payable under the contractor's claims jurisdiction area. When Medicare denies such claims, the provider will receive these messages: remark code N418 (Misrouted claim. See the payer's claim submission instructions.) and reason code 109 (Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.).
- Effective for dates of service on or after October 1, 2010, the A/B MACs and Part B carriers will accept HCPCS code L8509 for processing.
- The A/B MACs and Part B carriers will cover claims for HCPCS code L8509 as a prosthetic device. The A/B MACs and Part B carriers will base the Medicare allowed payment amount on the lower of the actual charge or the fee schedule amount for HCPCS code L8509.
- Tracheo-esophageal voice prostheses that are changed by the patient/caregiver in the home setting are billed using HCPCS code L8507 (tracheo-esophageal voice prostheses, patient inserted, any type, each) and are eligible for coverage under the prosthetic device benefit. The filing jurisdiction for these claims remains with the DME MACs.
- Medicare does not cover the item if it is shipped or dispensed to the beneficiary, who then takes the item to their physician's office for insertion. The A/B MACs or Part B carriers will deny claims in these instances, as described in Chapter 15, Section 120, in, the *Medicare Benefit Policy Manual,* which states that *"Medicare does not cover a prosthetic device dispensed to a patient prior to the time at which the patient undergoes the procedure that makes necessary the use of the device. For example, the carrier does not make a separate Part B payment for an intraocular lens (IOL) or pacemaker that a physician, during an office visit prior to the actual surgery, dispenses to the patient for his or her use. Dispensing a prosthetic device in this manner raises health and safety issues. Moreover, the need for the device cannot be clearly established until the procedure that makes its use possible is successfully performed. Therefore, dispensing a prosthetic device in this manner is not considered reasonable and necessary for the treatment of the patient's condition."*

Additional Information

The official instruction, CR6743, issued to your, A/B MAC, carrier and/or DME MAC regarding this change may be viewed at http://www.cms.gov/Transmittals/downloads/R686OTN.pdf on the CMS website.

Claim Adjustment Reason Code, Remittance Advice Remark Code, and Medicare Remit Easy Print Update

MLN Matters® Number: MM6901
Related Change Request (CR) #: 6901
Related CR Release Date: April 23, 2010
Related CR Transmittal #: R1950CP
Effective Date: July 1, 2010
Implementation Date: July 6, 2010

Provider Types Affected

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

Provider Action Needed

CR 6901, from which this article is taken, announces the latest update of Remittance Advice Remark Codes (RARCs) and Claim Adjustment Reason Codes (CARCs), effective July 1, 2010. Be sure billing staff 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. The RARC list is maintained by the Centers for Medicare & Medicaid Services (CMS), and used by all payers; and additions, deactivations, and modifications to it may be initiated by any health care organization. The RARC and CARC lists are updated 3 times a year – in March, July, and November. Both code lists are posted at http://www.wpc-edi.com/Codes on the Internet. The lists at the end of this article summarize the latest changes to these lists, as announced in CR 6901.

CR 6901 conveys the following updates:

New Codes - CARC

Code	Current Narrative	Effective Date Per WPC Posting
233	Services/charges related to the treatment of a hospital-acquired condition or preventable medical error.	1/24/2010
234	This procedure is not paid separately. 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.)	1/24/2010

Modified Codes – CARC
None

Deactivated Codes – CARC
None

New Codes - RARC

Code	Current Narrative	Medicare Initiated
N523	The limitation on outlier payments defined by this payer for this service period has been met. The outlier payment otherwise applicable to this claim has not been paid.	YES
N524	Based on policy this payment constitutes payment in full.	NO
N525	These services are not covered when performed within the global period of another service.	NO
N526	Not qualified for recovery based on employer size.	YES
N527	We processed this claim as the primary payer prior to receiving the recovery demand.	YES
N528	Patient is entitled to benefits for Institutional Services.	YES
N529	Patient is entitled to benefits for Professional Services.	YES
N530	Our records indicate a mismatch in enrollment information for this patient.	YES
N531	Not qualified for recovery based on direct payment of premium.	YES
N532	Not qualified for recovery based on disability and working status.	YES

Modified Codes – RARC

Code	Modified Narrative	Medicare Initiated
N216	We do not offer coverage for this type of service or the patient is not enrolled in this portion of our benefit package	NO
N522	Duplicate of a claim processed, or to be processed, as a crossover claim.	NO

Deactivated Codes – RARC
None

Additional Information

To see the official instruction (CR6901) issued to your Medicare Carrier, RHHI, DME/MAC, FI and/or MAC, refer to http://www.cms.gov/Transmittals/downloads/R1950CP.pdf on the CMS website.

Update to HCPCS Codes for Payment of Surgical Dressings in IHS Providers

MLN Matters® Number: MM6909
Related Change Request (CR) #: 6909
Related CR Release Date: April 28, 2010
Related CR Transmittal #: R1957CP
Effective Date: January 1, 2009
Implementation Date: October 4, 2010

Provider Types Affected

This article is for all IHS and tribally owned and operated hospitals or hospital-based facilities including Critical Access Hospitals (CAHs) who bill Medicare for providing surgical dressings to Medicare beneficiaries.

What You Need to Know

CR 6909, from which this article is taken, provides no policy changes. It updates the list of surgical dressing Healthcare Common Procedure Coding System (HCPCS) codes that Indian Health Service (IHS) providers can bill to the specialty contractor (Trailblazer Health Enterprises, LLC). You should make sure that your billing staffs are aware of this update.

Background

Section 630 of the Medicare Modernization Act (MMA) of 2003 allows IHS providers to bill for other Medicare Part B services (not covered under section 1848 of the Social Security Act) for the 5 year period beginning January 1, 2005. These covered services, which include surgical dressings, are payable based on the lesser of the actual charges or the Durable Medical Equipment, Prosthetics. Orthotics and Supplies (DMEPOS) fee schedule amount. Section 2902 of the Patient Protection and Affordable Care Act indefinitely extends Section 630 of the MMA retroactive to January 1, 2010.

The Centers for Medicare & Medicaid Services (CMS) periodically updates the list of surgical dressing HCPCS codes that IHS providers can bill to the specialty contractor (Trailblazer Health Enterprises, LLC); and CR 6909, from which this article is taken, provides this update for calendar year 2009.

Note: IHS owned and operated providers, tribally owned and operated providers electing to bill as IHS, tribally operated IHS providers, and tribally owned and IHS operated providers are all referred to as IHS providers throughout this article. The term provider refers to all hospital or hospital-based facilities, including CAH's and outpatient clinics.

Effective January 1, 2009 through December 31, 2009, IHS providers can bill Trailblazer Health Enterprises, LLC for surgical dressings (including splints and casts) under revenue code 0623 (surgical dressings) on type of bill (TOB) 12X (hospital inpatient part B), 13X (hospital outpatient), or 85X (CAH) for the surgical dressings HCPCS codes payable under MMA 630 listed in the following table:

Surgical Dressing HCPCS Codes Payable to IHS Providers under MMA Section 630 for Calendar Year 2009

A6010 – A6011,	A6229
A6021 –A6024,	A6231 – A6238
A6154,	A6240 – A6248
A6196 –A6197,	A6251 – A6255
A6199,	A6257 - A6259
A6203 – A6204	A6266
A6207	A6402 –A6403,
A6209 – A6212	A6407
A6214	A6410
A6219- A6220	A6441 – A6457
A6222 – A6224	

In addition, Medicare will pay claim lines on TOBs 12X, 13X, and 85X by IHS providers with dates of service on or after January 1, 2010, through December 31, 2010, and revenue code 0623 for any of the HCPCS listed in the above table. In addition, HCPCS code A6412 is added to this list for dates of service in 2010.

You should be aware that Trailblazer Health Enterprises, LLC will not search for, and adjust, claims that have been processed prior to the implementation date; but will adjust claims that you bring to their attention.

Additional Information

You can find the official instruction issued to Trailblazer Health Enterprises, LLC, CR 6909, at http://www.cms.gov/Transmittals/downloads/R1957CP.pdf on the CMS website.

Detailed information on the HCPCS mentioned in this article, as well as other HCPCS, is available at http://www.cms.gov/HCPCSReleaseCodeSets/ on the CMS website.

If you have any questions, please contact Trailblazer Health Enterprises, LLC at their toll-free number, which may be found at http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip on the CMS website.

Home Health Consolidated Billing Enforcement Enhancements – Revised

MLN Matters® Number: MM6911 Revised
Related Change Request (CR) #: 6911

Related CR Release Date: June 14, 2010
Related CR Transmittal #: R1988CP
Effective Date: October 1, 2010
Implementation Date: October 4, 2010

This article was revised on June 14, 2010, to reflect the revised CR 6911 that was issued on that date. In this article, the CR release date and transmittal number (see above) were revised. Also, the Web address for accessing CR 6911 was revised. All other information remains the same.

Provider Types Affected

This article may impact physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, Durable medical equipment Medicare administrative contractors (DME MACs), fiscal intermediaries (FIs), Part A/B Medicare administrative contractors (A/B MACs), and/or regional home health intermediaries (RHHIs)) for services provided to Medicare beneficiaries during an episode of home health care.

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) is updating edit criteria related to the consolidated billing provision of the Home Health Prospective Payment System (HH PPS). It is also creating a new file of HH certification information to assist suppliers and providers subject to HH consolidated billing. Make sure your billing staff is aware of these changes.

What You Need to Know

Consolidated Billing Edit Modification

Non-routine supplies provided during a HH episode of care are included in Medicare's payment to the home health agency (HHA) and subject to consolidated billing edits as described in the *Medicare Claims Processing Manual*, chapter 10, section 20.2.1. (The revised chapter is attached to CR 6911.) If the date of service for a non-routine supply HCPCS code that is subject to HH consolidated billing falls within the dates of a HH episode, the line item was previously rejected by Medicare systems. Non-routine supply claims are submitted by suppliers on the professional claim format, which has both 'from' and 'to' dates on each line item.

When the HH consolidating billing edits were initially implemented in October 2000, the edit criteria were defined so that non-routine supply services were rejected if either the line item 'from' or 'to' date overlapped the HH episode dates. This allowed for supplies that were delivered before the HH episode began to be paid, since the prevailing practice at that time was that suppliers reported the delivery date in both the 'from' and 'to.' Medicare instructions regarding delivery of supplies intended for use over an extended period of time have since changed. Now suppliers are instructed to report the delivery date as the 'from' date and the date by which the supplies will be used in the 'to' date. When this causes the 'to' date on a supply line item subject to consolidated billing to overlap a HH episode, the service is rejected contrary to the original intent of this edit.

Effective October 1, 2010, CMS is implementing new requirements to modify this edit in order to restore the original intent to pay for supplies delivered before the HH episode began. Such supplies may have been ordered before the need for HH care had been identified, and are appropriate for payment if all other payment conditions are met. The edit will be changed to only reject services if the 'from' date on the supply line item falls within a HH episode.

A New File of HH Certification Information

Chapter 10, section 20.1 of the Medicare Claims Processing Manual describes the responsibilities of suppliers and therapy providers whose services are subject to HH consolidated billing to determine before providing their services whether a beneficiary is currently in a HH episode of care. To assist these suppliers and providers in determining this, CMS is creating an additional source of information. CMS will create a new file which will store and display certifications of HH plans of care.

Medicare coverage requirements state that all HH services must be provided under a physician-ordered plan of care. Upon admission to HH care and after every 60 days of continuing care, a physician must certify that the beneficiary remains eligible for HH services and must write specific orders for the beneficiary's care. Medicare pays physicians for this service using the following two codes:

- G0179 Physician Re-certification For Medicare-covered Home Health Services Under A Plan of Care
- G0180 Physician Certification For Medicare-covered Home Health Services Under A Plan of Care

Physicians submit claims for these services to Medicare contractors on the professional claim format separate from the HHA's billing their Request for Anticipated Payment (RAP) and claim on the institutional claim format for the HH services themselves. HHAs have a strong payment incentive to submit their RAP for a HH episode promptly in order to receive their initial 60% or 50% payment for that episode. But there may be instances in which the physician claim for the certification service is received before any HHA billing and this claim is the earliest indication Medicare systems have that a HH episode will be provided. As an aid to suppliers and providers subject to HH consolidated billing, Medicare systems will display for each Medicare beneficiary the date of service for either of the two codes above when these codes have been paid. Medicare systems will allow the provider to enter an inquiry date when accessing the HH certification auxiliary file. When the provider enters an inquiry date on Medicare's Common Working File (CWF) query screens, Medicare systems will display all certification code dates within 9 months before the date entered. When the provider does not enter an inquiry date, Medicare systems will display all certification code dates within 9 months before the current date as the default response.

Note: Suppliers and providers should note that this new information is supplementary to their existing sources of information about HH episodes. Like the existing HH episode information, this new information is only as complete and timely as billing by providers allows it to be. This is particularly true regarding physician certification billing. Historically, Medicare has paid certification codes for less than 40% of HH episodes. As a result, the beneficiary and their caregivers remain the first and best source of information about the beneficiary's home health status.

Additional Information

The official instruction (CR6911) issued to your Medicare RHHI/MAC is available at http://www.cms.gov/Transmittals/downloads/R1988CP.pdf on the CMS website.

Medicare Contractor Annual Update of ICD-9-CM

MLN Matters Number: MM7006
Related Change Request (CR) #: 7006
Related CR Release Date: July 2, 2010
Related CR Transmittal #: R1996CP
Effective Date: October 1, 2010
Implementation Date: October 4, 2010

Provider Types Affected

Physicians, suppliers, and providers billing Medicare contractors (carriers, Part A/B Medicare Administrative Contractors (MACs), Durable Medical Equipment MACs (DME MACs), and Fiscal Intermediaries (FIs) including Regional Home Health Intermediaries (RHHIs)).

Provider Action Needed

This article is based on Change Request (CR) 7006, which reminds the Medicare contractors and providers that the annual ICD-9-CM update will be effective for dates of service on and after October 1, 2010 (for institutional providers, effective for discharges on or after October 1, 2010).

You can see the new, revised, and discontinued ICD-9-CM diagnosis codes on the Centers for Medicare & Medicaid Services (CMS) website at http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes, or at the National Center for Health Statistics (NCHS) website at http://www.cdc.gov/nchs/icd9.htm in June of each year. You are also encouraged to purchase a new ICD-9-CM book or CD-ROM on an annual basis.

Background

The ICD-9-CM codes are updated annually as stated in the Medicare Claims Processing Manual, Chapter 23 (Fee Schedule Administration and Coding Requirements), Section 10.2 (Relationship of ICD-9-CM Codes and Date of Service).

CMS issued CR 7006 as a reminder that the annual ICD-9-CM coding update will be effective for dates of service on or after October 1, 2010 (for institutional providers, effective for discharges on or after October 1, 2010).

Remember that an ICD-9-CM code is required for all professional claims (including those from physicians, non-physician practitioners, independent clinical diagnostic laboratories, occupational and physical therapists, independent diagnostic testing facilities, audiologists, ambulatory surgical centers), and for all institutional claims. However, an ICD-9-CM code is not required for ambulance supplier claims.

Additional Information

For complete details regarding this CR, please see the official instruction (CR7006) issued to your Medicare contractor, which may be found at http://www.cms.gov/Transmittals/downloads/R1996CP.pdf on the CMS website.

Results of Widespread Prepayment Review of Claims for HCPCS Codes A4253 and A4259

The Jurisdiction D Medical Review department conducted a service specific prepayment probe review for A4253 (Blood glucose test or reagent strips for home blood glucose monitor, per 50 strips) and A4259 (Lancets, per box of 100).

A selection of claims billed by multiple suppliers was reviewed for medical necessity based on the above specific services. The documentation submitted with the majority of claims did not support the basic coverage criteria from the Glucose Monitors Local Coverage Determination (LCD) (L196) for as evidenced by the following breakdown:

A total of 87 claims were captured for review and additional documentation was requested. Of these claims:

- 18 claims were paid in full
- 69 claims were denied resulting in a 77% claim error ratio.

The following is a summary of the denial reasons:

- 18 claims were denied as the requested documentation was not provided within the allotted time frame as referenced in the Medicare guidelines.
- 11 claims were denied for no or invalid physician's written order.
- 22 claims were denied for invalid or no beneficiary evidence of exhaustion of testing supplies
- 12 claims were denied for discrepancies with proof of delivery and date of service.
- Three claims were partially denied as the documentation submitted did not support testing more than the allowed frequency.
- Two claims were denied for wrong modifier.
- One claim was denied for not meeting basic coverage criteria # 1.

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

Suppliers must not dispense a quantity of supplies exceeding a beneficiary's expected utilization. Suppliers should stay attuned to atypical utilization patterns on behalf of their clients and verify with the ordering physicians that the atypical utilization is, in fact, warranted. Regardless of utilization, a supplier must not dispense more than a 3-month quantity of glucose testing supplies at a time.

A beneficiary or their caregiver must specifically request refills of glucose monitor supplies before they are dispensed. The supplier must not automatically dispense a quantity of supplies on a predetermined regular basis, even if the beneficiary has "authorized" this in advance. 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."

Additional items noted during the review process:

- Detailed written orders were outdated as the length of need was exhausted
- Detailed written orders did not specify the frequency of testing
- Beneficiary testing logs did not support the frequency of testing that was ordered by the physician
- The specific reason for frequency of testing that exceeds the utilization guidelines was not present in the documentation submitted

Please keep in mind the following:

- Utilization Guidelines:
  - For non-insulin treated individuals, a three month supply of the following may be provided at one time:
    - 100 test strips- 2 boxes- (once/day testing)
    - 100 lancets-1 box- (once/day testing)
  - For insulin treated individuals, a three month supply of the following may be provided at one time:
    - 300 test strips-6 boxes- (three times/day testing)
    - 300 lancets-2 boxes- (three times/day testing)
- Modifiers specific to LCD L196
  - KX modifier - Added to code for the monitor and each related supply on every claim submitted when patient is treated with insulin injections
  - KS modifier - Added to code for the monitor and each related supply on every claim submitted when patient is not treated with insulin injections

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

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

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

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

Due to the high error rate found with this review, this service specific review will be continued on as a targeted service specific review as of the date of this article.

Medicare Coverage of Blood Glucose Monitors and Testing Supplies

MLN Matters® Number: SE1008 Revised

Note: This article was re-issued on May 5, 2010, to include additional information regarding special blood glucose monitors for patients with manual dexterity issues, and to clarify certain information regarding the content of orders and when new orders are needed.

Provider Types Affected

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

What You Need to Know

This special edition article is being provided by the Centers for Medicare & Medicaid Services (CMS) to remind providers what blood glucose self-testing equipment and supplies are covered for Medicare beneficiaries. In addition, prescription/order requirements, quantities and frequency limits of supplies, and documentation requirements for the beneficiary's medical record are detailed. This article reinforces information supplied in MLN Matters® article SE0738, which is available at http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0738.pdf on the Centers for Medicare & Medicaid Services (CMS) website. **This article is informational only and represents no Medicare policy changes.**

Background

Blood glucose self-testing equipment and supplies are covered for all people with Medicare Part B who have diabetes. These supplies include:

- Blood glucose monitors;
- Blood glucose test strips;
- Lancet devices and lancets; and
- Glucose control solutions for checking the accuracy of testing equipment and test strips.

Medicare Part B covers the same type of blood glucose testing supplies for people with diabetes whether or not they use insulin. However, the amount of supplies that are covered varies. Medicare provides coverage of blood glucose monitors and associated accessories and supplies for insulin-dependent and non-insulin dependent diabetics based on medical necessity. For more information regarding medical necessity, see the section below titled 'Providing Evidence of Medical Necessity.'

Diabetes (diabetes mellitus) is defined as a condition of abnormal glucose metabolism using the following criteria:

- A fasting blood glucose greater than or equal to 126 mg/dL on two different occasions;
- A 2 hour post-glucose challenge greater than or equal to 200 mg/dL on two different occasions; or
- A random glucose test over 200 mg/dL for a person with symptoms of uncontrolled diabetes.

See the *Medicare Benefit Policy Manual*, Chapter 15, at http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf on the CMS website for more information.

Coverage for diabetes-related Durable Medical Equipment (DME) is provided as a Medicare Part B benefit, and the Medicare Part B deductible and coinsurance or copayment applies. If the provider or supplier does not accept assignment, the amount the beneficiary pays may be higher. In this case, Medicare will provide payment of the Medicare-approved amount to the beneficiary.

Prescribing/Ordering a Blood Glucose Monitor and Associated Accessories

Provider Requirements

For Medicare coverage of a blood glucose monitor and associated accessories, the provider must provide a valid prescription (order) which must state to the supplier:

1. The item(s) to be dispensed;
2. The frequency of testing ("as needed" is not acceptable);
3. The physician's signature;
4. The signature date; and
5. The start date of the order – only required if the start date is different than the signature date.

For beneficiaries who are insulin-dependent, Medicare provides coverage for up to 100 test strips and lancets every month, and one lancet device every 6 months.

For beneficiaries who are non-insulin dependent, Medicare provides coverage for up to 100 test strips and lancets every 3 months, and one lancet device every 6 months.

Note: Medicare allows additional test strips and lancets **if deemed medically necessary**. See the section below titled 'Providing Evidence of Medical Necessity.' Medicare will not pay for any supplies that are not requested or were sent automatically from suppliers, even if the beneficiary has "authorized" this in advance. Contact with the beneficiary or designee regarding refills should take place no sooner than approximately seven (7) days prior to the delivery/shipping date. For subsequent deliveries of refills, the supplier should deliver the item(s) no sooner than approximately five (5) days prior to the end of usage for the current product(s). This includes lancets, test strips, and blood glucose monitors.

CR 2363 (Transmittal B-03-004) states that glucose test strips and supplies can be billed for up to 3 months of supplies at a time. Beginning April 1, 2002, claims for test strips and supplies must be submitted with the appropriate "start" and "end" dates. The "start" and "end" dates for each claim can span across 3 months. You can find CR 2363 at http://www.cms.hhs.gov/Transmittals/Downloads/B03004.pdf on the CMS website.

Suppliers may dispense most items of Durable Medical Equipment Prosthetics, Orthotics, and Supplies (DMEPOS) based on a verbal order or preliminary written order from the treating physician. This dispensing 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 to Medicare contractors upon request. If the supplier does not have an order from the treating physician before dispensing an item, the item is non-covered. See the Medicare Program Integrity Manual, Chapter 5, at http://www.cms.hhs.gov/manuals/downloads/pim83c05.pdf on the CMS website.

For verbal orders, the physician must sign and return to the supplier a written, faxed, or electronic confirmation of the verbal order. On this confirmation the item(s) to be dispensed, frequency of testing, and start date (if applicable) may be written by the supplier, but the confirmation must be reviewed, signed, and dated by the physician. Physicians should inspect these written confirmations carefully. Suppliers must not add unrelated items to the detailed written order, whether requested by the beneficiary or not, in the absence of a dispensing order from the physician for that item.

A new order for diabetic testing supplies is required only if there is a change in the frequency of testing or a change in supplier. Renewal orders must contain the same information as initial orders and be submitted to the supplier using one of the methods acceptable for initial orders.

CMS expects that physician records will reflect the care provided to the patient including, but not limited to, evidence of the medical necessity for the prescribed frequency of testing. Physicians are not required to fill out additional forms from suppliers or to provide additional information to suppliers unless specifically requested of the supplier by the DME MAC. For more information regarding evidence of medical necessity, see the section below titled 'Providing Evidence of Medical Necessity."

Note: CR 5971 (Transmittal 248) was issued to prohibit the use of stamped signatures. In addition, Medicare requires a legible identifier for services provided/ordered as outlined in CR 6698 (Transmittal R327PI). The method used should be hand written or an electronic signature (stamp signatures are not acceptable) to sign an order or other medical record documentation for medical review purposes. You can review MLN Matters® articles related to CR 5971 and CR 6698 at http://www.cms.gov/MLNMattersArticles/downloads/MM5971.pdf and http://www.cms.gov/mlnmattersarticles/downloads/mm6698.pdf on the CMS website.

Home Blood Glucose Monitors

There are several different types of blood glucose monitors that use reflectance meters to determine blood glucose levels. Medicare coverage of these devices varies, with respect to both the type of device and the medical condition of the patient for whom the device is prescribed.

Reflectance colorimeter devices used for measuring blood glucose levels in clinical settings are not covered as DME for use in the home because their need for frequent professional re-calibration makes them unsuitable for home use.

However, some types of blood glucose monitors which use a reflectance meter specifically designed for home use by diabetic patients may be covered as DME, subject to the conditions and limitations described below.

Blood glucose monitors are meter devices that read color changes produced on specially treated reagent strips by glucose concentrations in the patient's blood. The patient, using a disposable sterile lancet, draws a drop of blood, places it on a reagent strip and (following instructions which may vary with the device used), inserts it into the device to obtain a reading.

Lancets, reagent strips, and other supplies necessary for the proper functioning of the device are also covered for patients for whom the device is indicated.

Home blood glucose monitors enable certain patients to better control their blood glucose levels by frequently checking and appropriately contacting their attending physician for advice and treatment. Studies indicate that the patient's ability to carefully follow proper procedures is critical to obtaining satisfactory results with these devices. In addition, the cost of the devices, with their supplies, limits economical use to patients who must make frequent checks of their blood glucose levels.

Accordingly, coverage of home blood glucose monitors is limited to patients meeting the following conditions:

1. The patient has been diagnosed as having diabetes;
2. The patient's physician states that the patient is capable of being trained to use the particular device prescribed in an appropriate manner. In some cases, the patient may not be able to perform this function, but a responsible individual can be trained to use the equipment and monitor the patient to assure that the intended effect is achieved. This is permissible if the record is properly documented by the patient's physician; and
3. The device is designed for home use rather than clinical use.

There are also blood glucose monitoring systems designed especially for use by those with visual or manual dexterity impairments. The monitors used in such systems are identical in terms of reliability and sensitivity to the standard blood glucose monitors described above. They differ by having such features as voice synthesizers, automatic timers, and specially designed arrangements of supplies and materials to enable patients with visual or manual dexterity impairment to use the equipment without assistance.

These special blood glucose monitoring systems are covered under Medicare if the following conditions are met:

- The patient and device meet the three conditions listed above for coverage of standard home blood glucose monitors; and
- The patient's physician certifies that the beneficiary has a visual or manual dexterity impairment severe enough to require use of this special monitoring system. Note: 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…" See http://www.socialsecurity.gov/OP_Home/ssact/title18/1833.htm on the Internet.

For more information on home blood glucose monitors, including additional requirements for monitors with special features, see the Medicare National Coverage Determinations Manual, Chapter 1, Part 1 (Coverage Determinations), Section 40.2 (Home Blood Glucose Monitors) at http://www.cms.hhs.gov/manuals/downloads/ncd103c1_Part1.pdf on the CMS website and the Medicare Coverage Database for the local coverage determination (LCD) applicable to your area at http://www.cms.gov/mcd/search.asp?from2=search.asp&(search "Glucose Monitors").

The Health Care Common Procedure Coding System (HCPCS) codes used to report blood glucose self-testing equipment and supplies are shown in the following table:

HCPCS Codes for Blood Glucose Self-Testing Equipment and Supplies

HCPCS Code	HCPCS Code Descriptor
A4233	Alkaline battery for glucose monitor
A4234	J-cell battery for glucose monitor
A4235	Lithium battery for glucose monitor
A4236	Silver oxide battery glucose monitor
A4253	50 test strips for a blood glucose monitor
A4256	Calibration solutions
A4258	Spring-powered lancing device
A4259	100 lancets for a blood glucose monitor
E0607	Home blood glucose monitor
E2100	Home blood glucose monitor w voice capability (for visual impairment)
E2101	Home blood glucose monitor w integrated lancing/blood collection (for manual dexterity impairment)

Providing Evidence of Medical Necessity

For any DMEPOS item to be covered by Medicare, the patient's medical record must contain sufficient documentation of the patient's medical condition to substantiate the necessity for the type and quantity of items ordered and for the frequency of use or replacement (if applicable). There are several critical issues to address in the patient's medical record related to medical necessity for glucose testing supplies:

- Basic coverage criteria for the glucose monitor and any related supplies; and
- If ordering quantities of test strips and lancets that exceed the quantities specified in the LCD:

- Justification for testing frequency; and
- Evidence of the patient's use of the testing supplies.

To satisfy the requirements for the basic coverage criteria, the patient's medical record should provide information about the following elements:

- Diagnosis
- Treatment regimen (insulin treated versus non-insulin treated)
- Education of the patient or caregiver on the use of the glucose monitor

To support coverage for quantities of supplies that exceed the limits specified in the LCD, there must be:

- Documentation by the physician in the patient's medical record of the necessity for the higher frequency of testing. This may include some of the following elements:
  - Names, dosages, and timing of administration of medications used to treat the diabetes;
  - Frequency and severity of symptoms related to hyperglycemia and/or hypoglycemia;
  - Review of beneficiary-maintained log of glucose testing values;
  - Changes in the patient's treatment regimen as a result of glucose testing results review;
  - Dosage adjustments that the patient should make on their own based on self-testing results;
  - Laboratory tests indicating level of glycemic control (e.g., Hemoglobin A1C);
  - Other therapeutic interventions and results;
- Documentation by the beneficiary of the actual frequency of testing.
  - Logs of self-testing values including the date, time, and results
  - Information about medication dosage adjustments related to the results is also helpful.

Not every patient medical record will contain all of these elements; however, there must be enough information in the patient's medical record to support the medical necessity for the quantity of item(s) ordered and dispensed.

For more information regarding evidence of medical necessity, see the *Medicare Program Integrity Manual*, Chapter 5 (Items and Services Having Special DME Review Considerations) at http://www.cms.hhs.gov/manuals/downloads/pim83c05.pdf on the CMS website, and the Medicare Coverage Database for the local coverage determination (LCD) applicable to your area at http://www.cms.gov/mcd/search.asp?from2=search.asp& (search "Glucose Monitors").

Additional Information

You can find SE0738, An Overview of Medicare Covered Diabetes Supplies and Services at http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0738.pdf on the CMS website.

You can also find The Guide to Medicare Preventive Services at http://www.cms.hhs.gov/MLNProducts/downloads/mps_guide_Web-061305.pdf and the Medicare Preventive Services Brochure at http://www.cms.hhs.gov/MLNProducts/downloads/DiabetesSvcs.pdf on the CMS website.

Medicare Guidelines on Commodes

In order for a commode to be payable, **medical documentation must clearly show the necessity of the commode and that the criteria outlined in the Commodes Local Coverage Determination (LCD) (L11486) are met,** as follows:

A commode is covered when the patient is physically incapable of utilizing regular toilet facilities. This would occur in the following situations:

1. The patient is confined to a single room, or
2. The patient is confined to one level of the home environment and there is no toilet on that level, or
3. The patient is confined to the home and there are no toilet facilities in the home.

Confinement to a single room means the beneficiary is bedridden, cannot walk with a cane or walker, or cannot use or be wheeled in a wheelchair to access the bathroom.

A commode is not covered for the following situations:

- Urinary urgency or incontinence issues.
- For those with a slow gait who cannot get to the bathroom in a timely manner.
- When beneficiaries are able to walk with or without assistive devices, are able to use a wheelchair in their home, and are able to get to the bathroom.

Medicare Guidelines on Hospital Beds

A hospital bed is payable when medical documentation clearly addresses the criteria provided in the Hospital Beds and Accessories Local Coverage Determination (LCD) (L11572), which states:

A fixed height hospital bed (E0250, E0251, E0290, E0291 and E0328) is covered if one or more of the following criteria (1-4) are met:

1. The patient has a medical condition which requires positioning of the body in ways not feasible with an ordinary bed. Elevation of the head/upper body less than 30 degrees does not usually require the use of a hospital bed, **or**
2. The patient requires positioning of the body in ways not feasible with an ordinary bed in order to alleviate pain, **or**
3. The patient requires the head of the bed to be elevated more than 30 degrees most of the time due to congestive heart failure, chronic pulmonary disease, or problems with aspiration. Pillows or wedges must have been considered and ruled out, **or**

4. The patient requires traction equipment, which can only be attached to a hospital bed.

A variable height hospital bed (E0255, E0256, E0292 and E0293) is covered if the patient:

- Meets one of the criteria for a fixed height hospital bed **and**
- Requires a bed height different than a fixed height hospital bed to permit transfers to chair, wheelchair or standing position.

A semi-electric hospital bed (E0260, E0261, E0294, E0295, and E0329) is covered if the patient;

- Meets one of the criteria for a fixed height bed **and**
- Requires frequent changes in body position and/or has an immediate need for a change in body position.

A heavy duty extra wide hospital bed (E0301, E0303) is covered if the patient;

- Meets one of the criteria for a fixed height hospital bed **and**
- Weighs more than 350 pounds, but does not exceed 600 pounds.

An extra heavy-duty hospital bed (E0302, E0304) is covered if the patient;

- Meets one of the criteria for a hospital bed **and**
- Weighs more than 600 pounds.

A total electric hospital bed (E0265, E0266, E0296 and E0297) is not covered; the height adjustment feature is a convenience feature.

A hospital bed is not necessary due to a total joint replacement or a recent discharge from a hospital or rehabilitation hospital unless the criteria above are met.

Group 3 Support Surfaces – Coverage Criteria Reminder

Recently it has come to the attention of the DME MACs that there is confusion regarding the coverage of air-fluidized bed technology (Group 3 support surfaces) for patients who have undergone surgical flap or graft procedures. Medicare does not cover air-fluidized beds in the home setting for patients with surgical grafts or flaps. Coverage for patients with these conditions is outlined in the LCD for Group 2 support surfaces. Coverage of a Group 3 support surface is limited to bed-ridden or chair-bound patients with stage III or stage IV pressure ulcers that without the use of an air-fluidized bed would be institutionalized. The LCD contains additional coverage criteria including physician oversight requirements, conservative management and other provisions related to Medicare reimbursement for these products. Suppliers and physicians are encouraged to consult the LCD for full coverage, coding and documentation requirements.

Medicare Policy Regarding Pressure Reducing Support Surfaces

MLN Matters Number: SE1014

Provider Types Affected

Suppliers and health care providers, such as home health agencies, who bill Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for pressure reducing support surfaces for Medicare beneficiaries, are affected.

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) is issuing Special Edition (SE) 1014 to clarify existing support surface medical policies and coverage requirements. This article does not present new policy, but only reinforces existing policy. Be certain that your billing staffs are aware of these policies as outlined in the Background section of this article.

Background

In August of 2009, the Department of Health and Human Services (HHS), Office of Inspector General (OIG) issued a report entitled "Inappropriate Payments for Pressure Reducing Support Surfaces" (report numbered OEI-02-07-00420), regarding the inappropriate billing for Pressure Reducing Support Surfaces by Durable Medical Equipment Prosthetics Orthotics Supplies (DMEPOS) suppliers. The purpose was to determine the extent of inappropriate Medicare payments for pressure reducing support surfaces and to assess the effect of new 1996 DME Regional Carrier (DMERC) medical policies and coverage guidelines.

Pressure reducing support surfaces are a type of DME used for the care of pressure sores. These sores are lesions caused by unrelieved pressure resulting in damage of underlying tissue. Support surfaces are coded under one of 16 different Healthcare Common Procedure Coding System (HCPCS) codes. A major distinction between support surfaces is that some are powered by electricity and others are not. They may be categorized into the following three groups:

- **Group 1** support surfaces are generally designed to be placed on top of standard hospital or home mattresses and include pressure pads and mattress overlays (foam, air, water, or gel).
- **Group 2** support surfaces can be special mattresses used alone or placed directly over a bed frame and include powered air flotation beds, powered pressure reducing air mattresses, and non-powered advanced pressure reducing mattresses.
- **Group 3** support surfaces are complete bed systems, known as air-fluidized beds, which use the circulation of filtered air through silicone

In an effort to clarify and improve existing support surface medical policies, new DMERC guidelines became effective January 1, 1996. **These changes had the greatest impact on alternating pressure mattresses by discontinuing reimbursement for these mattresses if used for preventive**

treatment, as they had been before 1996. The new guidelines also no longer required certificates of medical necessity (CMNs) for support surface equipment with the exception of air-fluidized beds.

Additionally, the Statistical Analysis DMERC (SADMERC) improved its existing process of support surface coding verification for suppliers with questions about which code to use for their equipment.

While the new 1996 DMERC guidelines appear to be having a positive impact on controlling Medicare costs for support surfaces, inappropriate payments are still being made, and other problems continue to adversely affect Medicare reimbursement for this equipment. Therefore, CMS is taking additional steps listed here to reduce the extent of inappropriate support surface payments.

Required Documentation in Patient's Medical Record

- For any DMEPOS item to be covered by Medicare, the patient's **medical record must contain sufficient documentation** of the patient's medical condition to substantiate the necessity for the type and quantity of items ordered and for the frequency of use or replacement (if applicable). The information should include the patient's diagnosis and other pertinent information including, but not limited to, duration of the patient's condition, clinical course (worsening or improvement), prognosis, nature and extent of functional limitations, other therapeutic interventions and results, past experience with related items, etc.
- If an item requires a CMN or a DME MAC information form (DIF), it is recommended that a copy of the completed CMN or DIF be kept in the patient's record. However, neither a physician's order, nor a CMN, nor a DIF, nor a supplier prepared statement, nor a physician attestation by itself provides sufficient documentation of medical necessity, even though it is signed by the treating physician or supplier. **There must be information in the patient's medical record that supports the medical necessity for the item and substantiates the answers on the CMN** (if applicable) or DIF (if applicable) or information on a supplier prepared statement or physician attestation (if applicable). (See *Medicare's Program Integrity Manual* (PIM), Chapter 3 (http://www.cms.gov/manuals/downloads/pim83c03.pdf), Section 3.4.1.1, for additional instructions, regarding review of documentation during pre- and post-payment)
- The patient's medical record is not limited to the physician's office records. It may include hospital, nursing home, or home health agency (HHA) records and records from other health care professionals.
- The documentation in the patient's medical record does not have to be routinely sent to the supplier or to the DME MACs, DME Program Safeguard Contractors (PSCs), or Zone Program Integrity Contractors (ZPICs). However, the DME MACs, DME PSCs, or ZPICs may request this information in selected cases. If the DME MACs, DME PSCs, or ZPICs do not receive the information when requested or **if the information in the patient's medical record does not adequately support the medical necessity for the item, then on assigned claims the supplier is liable for the dollar amount involved unless a properly executed advance beneficiary notice (ABN) of possible denial has been obtained.**

Required Supplier's Documentation

- Before submitting a claim to the DME MAC the supplier must have on file a dispensing order, the detailed written order, the CMN (if applicable), the DIF (if applicable), information from the treating physician concerning the patient's diagnosis, and any information required for the use of specific modifiers or attestation statements as defined in certain DME MAC policies. The supplier should also obtain as much documentation from the patient's medical record as they determine they need to assure themselves that coverage criteria for an item have been met. If the information in the patient's medical record does not adequately support the medical necessity for the item, the supplier is liable for the dollar amount involved unless a properly executed ABN of possible denial has been obtained.
- Documentation must be maintained in the supplier's files for seven (7) years.
- Suppliers are required to maintain proof of delivery documentation in their files. The three proof of delivery requirements are:
  - Supplier delivering directly to the beneficiary or authorized representative;
  - Supplier utilizing a delivery/shipping service to deliver items; and
  - Delivery of items to a nursing facility on behalf of the beneficiary.
- Proof of delivery documentation must be available to the DME MAC, DME PSC, and ZPIC on request. All services that do not have appropriate proof of delivery from the supplier will be denied and overpayments will be requested. Suppliers who consistently do not provide documentation to support their services may be referred to the OIG for imposition of civil monetary penalties (CMPs) or administrative sanctions.

Medicare Coverage of Support Surfaces

For all three support surface groups, patients should have a care plan established by their physician or home care nurse, which is documented in their medical records. This plan generally should include, among other things, education of the patient and regular assessment by a healthcare practitioner. Coverage for all three groups continues until the patient's pressure sore is healed.

In addition to the above common requirements, coverage for specific groups of support surfaces varies as follows:

- **Group 1 -** A group 1 support surface is covered if the patient is completely immobile. Otherwise, he or she must be partially immobile, or have any stage pressure sore, and demonstrate one of the following conditions: impaired nutritional status, incontinence, altered sensory perception, or compromised circulatory status. A physician

order must be obtained prior to delivery of the equipment and should be kept on file by the supplier.

- **Group 2 -** A group 2 support surface is covered if the patient has a stage II pressure sore located on the trunk or pelvis, has been on a comprehensive pressure sore treatment program (which has included the use of an appropriate group 1 support surface for at least one month), and has sores which have worsened or remained the same over the past month. A group 2 support surface is also covered if the patient has large or multiple stage III or IV pressure sores on the trunk or pelvis, or if he or she has had a recent mycutaneous flap or skin graft for a pressure sore on the trunk or pelvis and has been on a group 2 or 3 support surface.

Additional Information

For more information regarding Documentation, refer to the PIM, Chapter 5 (http://www.cms.gov/manuals/downloads/pim83c05.pdf) on the CMS website.

Providers may want to review the following:

- *Article for Pressure Reducing Support Surfaces - Group 1 -* (Policy Article – Effective December 2009. It is a revision of an article written March 1, 2008, and is available at http://www.peakwheelchairs.com/data/SS-Group_1-LCD-PDF.pdf on the Internet; and
- *Article for Pressure Reducing Support Surfaces - Group 2* (Policy Article - Effective January 1, 2009 (A35357)). It is a revision of an article that was written on June 1, 2007. It may be reviewed at http://www.cignagovernmentservices.com/jc/education/video/MM/G2SSArticle.pdf on the Internet.
- Office of Inspector General (OIG) report, Inappropriate Payments for Pressure Reducing Support Surfaces OEI-02-07-00420, It may be reviewed at http://www.oig.hhs.gov/oei/reports/oei-02-07-00420.pdf on the Internet.

Therapeutic Shoes – In-Person Fitting and Delivery

Appendix C of the DMEPOS Quality Standards published in October 2008 addresses specific requirements for orthoses, prostheses, prosthetic devices, and therapeutic shoes. Those standards include requirements for "an in-person diagnosis-specific functional clinical examination" by the supplier to determine the need for a particular item as well as "face-to-face fitting/delivery" by the supplier. Therefore, in order for therapeutic shoes, inserts, and shoe modifications to be covered, both of the following criteria must be met:

1. Prior to selecting the specific items that will be provided, the supplier must conduct and document an in-person evaluation of the patient; and
2. At the time of delivery of the items selected, the supplier must conduct and document an in-person visit with the patient to ensure that the shoes/inserts/modifications are properly fit and meet the beneficiary's needs.

In order to meet these criteria, effective for claims with dates of service on or after July 1, 2010, the following documentation requirements must be met:

- The in-person evaluation prior to selecting the items must include at least an examination of the patient's feet with a description of the abnormalities that will need to be accommodated by the shoes/inserts/modifications. For all shoes, it must include taking measurements of the patient's feet. For custom molded shoes (A5501) and inserts (A5513), this visit must also include taking impressions, making casts, or obtaining CAD-CAM images of the patient's feet that will be used in creating positive models of the feet.
- The in-person visit at the time of delivery must include an assessment of the fit of the shoes and inserts with the patient wearing them.

Depending on the items ordered, both the evaluation and delivery could occur on the same day if the supplier had both a sufficient array of sizes and types of shoes/inserts and adequate equipment on site to provide the items that meet the beneficiary's needs. Both components of the visit (criteria 1 and 2 above) must be clearly documented.

Documentation of these visits must be available to the DME MAC, ZPIC, RAC, or CERT contractor on request. If one or more of these requirements are not met, the claim will be denied as statutorily noncovered.

This information will be incorporated in a future revision of the Therapeutic Shoes policy. Refer to the Therapeutic Shoes Local Coverage Determination and Policy Article for additional information regarding coverage, coding, and documentation.

NORIDIAN® Administrative Services LLC

Medicare

May 2010

Glucose Monitors and Supplies

Dear Physician,

Glucose monitor supplies have consistently been one of the highest sources of errors in medical reviews performed by the Durable Medical Equipment Medicare Administrative Contractors (DME MACs) and the Comprehensive Error Rate Testing (CERT) contractor. It is your responsibility as the ordering physician to determine and document the medical necessity for durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) items. The following information is intended to provide you with guidance on Medicare's coverage and documentation requirements for glucose monitors and testing supplies.

COVERAGE

Glucose monitors and related supplies are covered for patients with diabetes (ICD-9 Codes 249.00 – 250.93) if they or their caregiver can be trained to use the prescribed device appropriately.

The Glucose Monitors Local Coverage Determinations (LCDs) of the DME MACs define the quantity of test strips and lancets that are covered, if the basic criterion above is met.

	Basic coverage	
Treatment regimen	Test strips and lancets	Average testing
Insulin treated	100 per month	3x per day
Non-insulin treated	100 per 3 months	1x per day

Additional quantities of test strips can be considered for coverage **if they are deemed medically necessary** – see following section.

Coverage is also provided for a lancing device, calibration solution, and replacement batteries.

MEDICAL NECESSITY DOCUMENTATION

CMS expects that physician records will reflect the care provided to the patient including, but not limited to, evidence of the medical necessity for the prescribed frequency of testing. Physicians are not required to fill out additional forms from suppliers or to provide additional information to suppliers unless specifically requested of the supplier by the DME MAC).

CMS CENTERS for MEDICARE & MEDICAID SERVICES

COVERAGE CONT'D

There are several critical issues to address in the patient's medical record related to medical necessity for glucose testing supplies:

- Basic coverage criteria for the glucose monitor and any related supplies; and
- If ordering quantities of test strips and lancets that exceed the quantities specified in the LCD:
    - Justification for testing frequency; and
    - Evidence of the patient's use of the testing supplies.

To satisfy the requirements for the basic coverage criteria, the patient's medical record should provide information about the following elements:

- Diagnosis
- Treatment regimen (insulin treated versus non-insulin treated)
- Education of the patient or caregiver on the use of the glucose monitor

To support coverage for quantities of supplies that exceed the limits specified in the LCD, there must be:

- Documentation by the physician in the patient's medical record of the necessity for the higher frequency of testing. This may include some of the following elements:
    - Names, dosages, and timing of administration of medications used to treat the diabetes;
    - Frequency and severity of symptoms related to hyperglycemia and/or hypoglycemia;
    - Review of beneficiary-maintained log of glucose testing values;
    - Changes in the patient's treatment regimen as a result of glucose testing results review;
    - Dosage adjustments that the patient should make on their own based on self-testing results;
    - Laboratory tests indicating level of glycemic control (e.g., hemoglobin A1C);
    - Other therapeutic interventions and results.

  Not every patient medical record will contain all of these elements; however, there must be enough information in the patient's medical record to support the medical necessity for the quantity of item(s) ordered and dispensed.

- Documentation by the beneficiary of the actual frequency of testing.
    - Logs of self-testing values including the date, time, and results
    - Information about medication dosage adjustments related to the results is also helpful.

ORDERS

There must be a written order for all testing supplies. The written order must contain the following elements:

1. Item(s) to be dispensed;
2. Frequency of testing ("as needed" is not acceptable);
3. Physician's signature;
4. Signature date;
5. Start date of order – only required if start date is different than signature date.

A new order for diabetic testing supplies is required only if there is a change in the frequency of testing, a change in supplier, or a new treating physician.

Physicians should inspect these written confirmations carefully. Suppliers must not add unrelated items to the detailed written order, whether requested by the beneficiary or not, in the absence of a dispensing order from the physician for that item.

This article is only intended to be a general summary. It is not intended to take the place of the written law, regulations, national or local coverage determinations. The LCD for Glucose Monitors can be found in the Medicare Coverage Database on the CMS web site at http://www.cms.gov/mcd/search.asp?from2=search.asp& (search "Glucose Monitors").

Sincerely,

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

Revised July 2010 ASP Pricing File

CMS has posted a revised July 2010 ASP Pricing file, which is available for download at: http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/ (see left menu for year-specific links).

External Infusion Pump LCD - Immune Globulin Subcutaneous (Human), 20% Liquid (Hizentra™)

A new subcutaneous immune globulin (SCIG) preparation, **Immune Globulin Subcutaneous (Human), 20% Liquid (Hizentra™)**, has been approved for use by the Food and Drug Administration. This preparation meets the requirements necessary for inclusion in the DME MAC External Infusion Pump LCD as a covered SCIG when used for the treatment of primary immune deficiency disease. Coverage is effective for claims with dates of service on or after March 4, 2010.

Claims for Hizentra™ administered with a DME infusion pump should be submitted using HCPCS code:

- J7799 - NOC DRUGS, OTHER THAN INHALATION DRUGS, ADMINISTERED THROUGH DME

Hizentra™ is supplied in 5ml (1g protein), 10 ml (2g protein), and 20 ml (4g protein) vials. One unit of service equals 5 ml (1g protein). Since the amount of SCIG for each patient is individualized, each dose must be prepared using the combination of vial sizes that result in the least amount of wastage for the dosage amount being administered.

An E0779 infusion pump is covered for the administration of subcutaneous immune globulin.

Refer to the External Infusion Pump LCD for additional information about the coverage of SCIG. Hizentra™ will be added to a future revision of the LCD.

Immunosuppressive Drugs - Everolimus (Zortress®)

The Food and Drug Administration has approved the use of everolimus (Zortress®) tablets as prophylaxis for rejection of organ transplants. Coverage is effective for claims with dates of service on or after April 20, 2010.

Everolimus is supplied as tablets, 0.25 mg, 0.5 mg, and 0.75 mg. Until such time as an individual HCPCS code is designated, claims should be billed using HCPCS code J7599, IMMUNOSUPPRESSIVE DRUG, NOT OTHERWISE CLASSIFIED. One unit of service is 0.25 mg. As indicated in the Immunosuppressive Drugs LCD, "(When) code J7599 is billed, the claim must list the name of the drug, the dosage strength, number dispensed and administration instructions."

Refer to the Immunosuppressive Drugs LCD for modifier and additional coverage requirements. Everolimus will be added to a future revision of the LCD.

Discarded Drugs and Biologicals Updates

MLN Matters® Number: MM6711 Revised
Related Change Request (CR) #: 6711
Related CR Release Date: April 30, 2010
Related CR Transmittal #: R1962CP
Effective Date: July 30, 2010
Implementation Date: July 30, 2010

Note: This article was revised on May 21, 2010, to clarify that your Medicare contractor may require the use of the JW modifier.

Provider Types Affected

Physicians, hospitals, suppliers and other providers who bill Medicare contractors (carriers, fiscal intermediaries (FI), Part A/B Medicare Administrative Contractors (MACs), and Durable Medical Equipment Medicare Administrative Contractors (DME MACs)) for administering or supplying drugs and biologicals should review this article.

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) issued CR 6711 to include in the Medicare Claims Processing Manual the updated policy, which describes when to use the JW modifier for discarded drugs.

Background

As a reminder, your Medicare contractor may require its providers to use the JW modifier. If required, when billing Medicare for all drugs except those provided under the Competitive Acquisition Program for Part B drugs and biologicals, use the modifier JW to identify unused drugs or biologicals from single use vials or single use packages that are appropriately discarded. This modifier, billed on a separate line, will provide payment for the discarded drug or biological.

For example, a single use vial labeled to contain 100 units of a drug, where 95 units are used and billed and paid on one line, the remaining 5 units will be billed and paid on another line using the JW modifier. The JW modifier is only applied to units not used. **Note:** Multi-use vials are not subject to payment for discarded amounts of drug or biological.

Additional Information

The official instruction, CR6711, issued to your Medicare FI, carrier, A/B MAC, or DME MAC regarding this change may be viewed at http://www.cms.gov/Transmittals/downloads/R1962CP.pdf on the CMS website.

Oxygen Equipment Probe Review Summary: Notification of Continuation of Complex Review

NAS conducted a complex prepayment review on HCPCS E1390 (oxygen concentrator, single delivery port, capable of delivering 85 percent or greater oxygen concentration at the prescribed flow rate) and E0431 (portable gaseous oxygen system, rental; includes regulator, flowmeter, humidifier, cannula or mask and tubing).

The results of the review were originally posted on the NAS website on February 24, 2010. In the review, 102 claims were sampled with 86 being denied (85% error ratio).

Based on the outcome of the probe review, NAS will continue with a widespread complex review on claims billed with HCPCS E1390 and E0431.

Suppliers are reminded they will receive an Additional Documentation Request (ADR) letter asking for specific information to determine if the item billed complies with the existing reasonable and necessary criteria. Failure to supply the requested information within 30 days of the date on the letter may result in the claim being denied as not medically necessary.

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

Date of Service Clarification for Certain Oxygen Equipment Maintenance and Servicing

MLN Matters® Number: MM6990
Related Change Request (CR) #: 6990
Related CR Release Date: June 8, 2010
Related CR Transmittal #: R717OTN
Effective Date: July 1, 2010
Implementation Date: July 9, 2010

Provider Types Affected

This article is for suppliers submitting claims to Medicare contractors (Regional Home Health Intermediaries (RHHI), Medicare Administrative Contractors (MAC) and/or Durable Medical Equipment Medicare Administrative Contractors (DME MAC)) for oxygen services provided to Medicare beneficiaries.

What You Need to Know

CR 6990, from which this article is taken, clarifies (effective July 1, 2010) the date of service (DOS) of an oxygen equipment maintenance and servicing visit as discussed in CR 6792 (Maintenance and Servicing Payments for Certain Oxygen Equipment After July 1, 2010).

In particular, please note one element of this clarification, i.e., CR 6990 requires that the applicable date of Service (DOS) must be at least 6 months after the 36-month rental cap for oxygen equipment or the end of the warranty period for maintenance and servicing, whichever is later. Further, before a supplier can bill for maintenance and servicing, the supplier must verify and document in their records that the oxygen equipment is no longer covered under a warranty and the supplier must visit the beneficiary's home to inspect the equipment.

Please see the background section, below, for additional information; and you should make sure that your billing staffs are aware of these clarifications.

Background

CR 6792 (released on February 5, 2010) announced (for dates of service on or after July 1, 2010) that Medicare regulation 42 CFR 414.210(e) (5) permits one payment for all maintenance and servicing of certain oxygen equipment during each 6-month period, beginning 6 months after the end of the 36-month rental period for oxygen equipment. (You can find the associated MLN Matters® article at http://www.cms.gov/MLNMattersArticles/downloads/MM6792.pdf on the CMS website.)

Medicare contractors and durable medical equipment (DME) suppliers requested clarification for particular situations that are listed below, and CR 6990 (from which this article is taken) provides that clarification.

This clarification in date of service (DOS) applies to the following oxygen concentrators and oxygen transfilling equipment, HealthCare Common Procedure Coding System (HCPCS) codes:

- E1390 – Oxygen concentrator, single delivery port, capable of delivering 85 percent or greater oxygen concentration at the prescribed flow rate;
- E1391 – Oxygen concentrator, dual delivery port, capable of delivering 85 percent or greater oxygen concentration at the prescribed flow rate, each;
- E1392 – Portable oxygen concentrator, rental;
- E0433 – Portable liquid oxygen system, rental; home liquefier used to fill portable liquid oxygen containers, includes portable containers, regulator, flowmeter, humidifier, cannula or mask and tubing, with or without supply reservoir and contents gauge; and
- K0738 – Portable gaseous oxygen system, rental; home compressor used to fill portable oxygen cylinders; includes portable containers, regulator, flowmeter, humidifier, cannula or mask, and tubing.

It does **not** apply to beneficiary-owned oxygen equipment or to the following liquid and gaseous oxygen equipment HCPCS codes:

- E0424 – Stationary compressed gaseous oxygen system, rental; includes container, contents, regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing;
- E0431 – Portable gaseous oxygen system, rental; includes portable container, regulator, flowmeter, humidifier, cannula or mask, and tubing;
- E0434 – Portable liquid oxygen system, rental; includes portable container, supply reservoir, humidifier, flowmeter, refill adaptor, contents gauge, cannula or mask, and tubing; or
- E0439 – Stationary liquid oxygen system, rental; includes container, contents, regulator, flowmeter, humidifier, nebulizer, cannula or mask, & tubing.

CR 6990 clarifies the following situations

1. **Date of Service for Multiple Visits**
   If multiple maintenance and servicing visits are needed, the DOS is the date of the first visit in the first month of the 6-month period during which an in home inspection of the equipment was performed.
2. **Date of Service for Delayed Visits**
   If an unavoidable delay (e.g., hospitalization of the beneficiary or beneficiary is out of the service area) causes the DOS to occur after the first month of a 6-month period, the DOS is the date of the first visit after the delay during which an in home inspection of the equipment was performed. The reason for the unavoidable delay must be documented by the supplier and maintained in the supplier's records. Payment for subsequent maintenance and servicing visits can occur no earlier than 6 months after the DOS of the delayed visit (i.e., the last visit date used to bill for the maintenance and servicing payment). As a result, a new sequence of 6 month periods for maintenance and service payment is established.
3. **Date of Service for Multiple Pieces of Oxygen Equipment**
   If both a stationary concentrator and portable transfilling equipment are serviced, and the 36-month rental payment cap for one piece of equipment was reached at a different time than the 36-month rental payment cap for the other piece of equipment, the DOS is the date of the visit which occurs during the 6-month period following the earliest of the dates that the 36-month rental caps was reached for either piece of equipment. Only one payment is allowable per beneficiary regardless of the number of pieces of equipment serviced (stationary concentrator, portable concentrator, and/or transfilling equipment).
4. **Date of Service When a Maintenance and Servicing Warranty Applies**
   The applicable DOS must be at least 6 months after the 36-month rental cap for oxygen equipment or the end of the warranty period for maintenance and servicing, **whichever is later.**

Please remember that only one maintenance and servicing payment may be made for each 6-month period, regardless of the combination of stationary and portable oxygen equipment that the beneficiary uses. In addition, payment for maintenance and servicing cannot be made if the oxygen equipment is covered under a warranty; therefore, before you can bill for maintenance and servicing, you must confirm, and record, that the oxygen equipment is no longer covered under a warranty; and visit the beneficiary's home to inspect the equipment.

Finally, keep in mind that the *Medicare Claims Processing Manual*, Chapter 20 (Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)), Section 40 (Payment for Maintenance and Service for Non-ESRD Equipment), Subsection 40.1 (General) instructs your contractor to refer cases to the program integrity specialist if claims are submitted that do not appear to comply with program instructions.

For reference, a summary of service details from CR 6792 follows:

1. If a combination of stationary concentrator (E1390 or E1391) and transfilling equipment (K0738 or E0433) is furnished, the supplier should bill for the maintenance and servicing payment using the code for the concentrator (E1390 or E1391) and the MS modifier.
2. If a portable concentrator (billed using a combination of codes E1390 and E1392 during the 36-month rental period) is furnished, the supplier should bill for the maintenance and servicing payment using the code for the concentrator (E1390 or E1391) and the MS modifier.
3. Code E1392 should not be used when billing for maintenance and servicing.
4. If transfilling equipment (K0738 or E0433) is furnished and a separate concentrator is not furnished or is owned by the beneficiary, the supplier should bill for the maintenance and servicing payment using the code for the transfilling equipment (K0738 or E0433) and the MS modifier.
5. Also, only one maintenance and servicing payment may be made for each 6-month period, regardless of the number of visits. Although a visit is not required, separate payment is not allowable without an in home visit to inspect the equipment. Even if the supplier does not perform a maintenance and servicing visit and forgo payment, 42 CFR 414.226(f)(1) continues to require the supplier that furnished the oxygen equipment for the 36th continuous rental month to furnish the equipment in good working order for the remaining period of medical need or the end of the equipment's reasonable useful lifetime (5 years).

Additional Information

You can find the official instruction, CR 6990, issued to your RHHI, MAC, or DME MAC by visiting http://www.cms.gov/Transmittals/downloads/R717OTN.pdf on the CMS website.

Results of K0004 Prepayment Probe Review

The NAS Jurisdiction D DME Medical Review department conducted a service specific prepayment probe review for HCPCS code K0004 (high strength lightweight wheelchair). A selection of K0004 claims, submitted by multiple suppliers, was reviewed for medical necessity, including any accessories billed on the wheelchair.

A total of 108 claims were developed for additional documentation and reviewed. Eight claims were paid and 100 claims were fully denied resulting in a 93 percent claim error ratio. Below are the top reasons for claim denial:

- 38 claims were denied for lack of documentation to support the Manual Wheelchair Bases Local Coverage Determination (LCD) (L11454) basic coverage criteria was not present.
- 23 claims were denied as the requested documentation was not provided within the allotted time as referenced in Medicare guidelines.
- 19 claims were denied for no valid written order and/or no valid dispensing order.
- 18 claims were denied as no medical documentation was submitted.
- One claim was excluded from review.
- One claim was denied for no proof of delivery.

Review of the submitted documentation identified the basic coverage criteria from the Manual Wheelchair Bases LCD for any type of manual wheelchair was not present in the documentation.

- Criterion A: The documentation did not indicate a mobility deficit/limitation and/or mobility limitations were not addressed.
- Mobility Related Activities of Daily Living (MRADLs) were not addressed.
  - The documentation submitted did not identify limited mobility or ambulation difficulties.
  - The medical necessity for a wheelchair is not determined solely on diagnosis or medical conditions, as they vary greatly from one individual to another.
  - The documentation must meet the requirements as addressed in the Mobility Assistive Equipment National Coverage Determination (NCD) 280.3, LCD L11454 and Policy Article A25378 to support coverage by Medicare. bullets don't seem to fit with this criterion; they both need to be addressed but perhaps they should both be placed later into the article)
- Criterion B: The patient's mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker.
  - Documentation, when submitted, did not address prior use of any other mobility assistive equipment and/or why the use of a cane or walker would not resolve the mobility limitation.
- Criterion C: The patient's home provides adequate access between rooms, maneuvering space, and surfaces for use of the manual wheelchair that is provided.
  - Documentation submitted did not address any aspects of the home environment.

Also noted during the review:

- There was no documentation to support the requirements for a K0004 wheelchair as addressed in the LCD (L11454).
  - A high strength lightweight wheelchair (K0004) is covered when a patient meets the criteria in (1) and/or (2):
    1. The patient self-propels the wheelchair while engaging in frequent activities in the home that cannot be performed in a standard or lightweight wheelchair; and/or
    2. The patient requires a seat width, depth, or height that cannot be accommodated in a standard, lightweight or hemi-wheelchair, and spends at least two hours per day in the wheelchair.
  - A high strength lightweight wheelchair is rarely medically necessary if the expected duration of need is less than three months, e.g., post-operative recovery.
- There was no documentation that supports a lifetime length of need.
- There was no documentation to support criteria in the Wheelchair Options/Accessories LCD (L11462) for elevating leg rests (K0195, E0990).
- There was no documentation to support the criteria addressed in LCD L11462 for the E1226 (reclining back).

It is the supplier's responsibility to understand the Medicare coverage requirements.

Appending the KX modifier indicates "Requirements specified in the medical policy have been met" per LCD L11454. Suppliers must add a KX modifier to the code for the manual wheelchair base only if all of the coverage criteria in the Indications and

Limitations of Coverage section of this policy have been met. If the coverage criteria are not met, the KX modifier must not be used.

Please see our website for information and references:

- Mobility Assistive Equipment NCD (280.3)
- Manual Wheelchair Bases LCD (L11454)
- Manual Wheelchair Bases Policy Article (A25378)
- Wheelchair Options/Accessories LCD (L11462)
- Documentation Checklist for Manual Wheelchairs
- Supplier Manual, Chapter 3, Documentation and Order Requirements
- Manual Wheelchair Documentation Requirements, posted June 10, 2009
- Reminder Regarding Physician Orders for Manual Wheelchairs, posted November 4, 2008
- Documentation Checklist for Walkers

K0823 Probe Review Summary: Notification of Continuation of Complex Review

NAS conducted a complex prepayment review on HCPCS K0823 (Power wheelchair, group 2 standard, captain's chair, patient weight capacity up to and including 300 pounds). The results of the review were originally posted on the NAS website. In the review 117 claims were sampled with 114 being denied (97% error ratio). The primary reasons for denial were listed as:

- No response to request for documentation letter in the required 30 days
- No valid written order
  - No written order submitted with the documentation
  - No dispensing order submitted, only a detailed product description (DPD) that was completed by the supplier
  - Name of ordering physician was not legibly identified
- Insufficient medical records submitted to justify the medical necessity for the wheelchair and required documentation not submitted in full or was not complete
  - Medical records did not include the basic policy coverage criteria A-C
  - Only the Texas Academy Form was provided to support medical need with little medical records to support the form
  - No evidence of a face-to-face examination
  - No home assessment completed
  - No proof of delivery
  - Date of service on the claim was prior to date of DPD and face-to-face examination

Based on the outcome of the probe review, NAS will continue with a widespread complex review on claims billed with HCPCS K0823.

Suppliers are reminded they will receive an *Additional Documentation Request* (ADR) letter asking for specific information to determine if the item billed complies with the existing reasonable and necessary criteria. Failure to supply the requested information within **30 days** of the date on the letter may result in the claim being denied as not medically necessary.

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

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

Mounting Hardware – E1028 – Billing Reminder

Recently it has come to the attention of the DME MACs that there is confusion regarding the billing of mounting hardware for wheelchair accessories. This article provides instructions on appropriate billing of mounting hardware, Healthcare Common Procedure Coding System (HCPCS) code E1028.

Code E1028 is described as a wheelchair accessory, manual swingaway, retractable or removable mounting hardware for joystick, other control interface or positioning accessory. The local coverage determination (LCD) for Wheelchair Options and Accessories states: "One example (not all-inclusive) of a covered indication for swingaway, retractable, or removable hardware (E1028) would be to move the component out of the way so that a patient can perform a slide transfer to a chair or bed."

Since this code encompasses various types of hardware, suppliers must add a description for each E1028 billed. For example, if billing an E1028 for a joystick, add the comment "retractable joystick mounting". In addition, the description provided should coincide with a corresponding HCPCS code that requires or can accommodate specialty hardware. For example, if billing an E1028 for swingaway lateral support hardware, the corresponding code for lateral supports should be on the same claim. If the billing order does not allow this, then the corresponding code must be in the billing history for the E1028 to be paid.

Suppliers are reminded that mounting hardware, fixed, is not separately payable.

Suppliers are encouraged to read the entire LCD and policy article for Wheelchair Options and Accessories and Wheelchair Seating for additional coverage, coding and documentation requirements.

Power Wheelchair Electronics Clarification

Recently it has come to the attention of the DME MACs that there is confusion regarding the billing of wheelchair electronics. This article provides instructions on appropriate billing of power wheelchair electronics, such as motors, controllers, harnesses and interfaces.

When one power seating function/actuator/motor is provided on a power wheelchair, one unit of E2310 (electronic connection between wheelchair controller and one power seating system motor) is allowed. An expandable controller (E2377) and harness (E2313) are not allowed in this situation unless a specialty interface is used.

> **Example**: E1002 (power seating system, tilt only) is added to a power wheelchair. A power tilt system uses one power seating motor/actuator.

When two power seating functions/actuators/motors are provided, one unit of E2311 (electronic connection between wheelchair controller and two or more power seating system motors) is allowed. An expandable controller (E2377) and harness (E2313) are not allowed in this situation unless a specialty interface is used.

> **Example**: E1006 (Wheelchair accessory, power seating system, combination tilt and recline, without shear reduction) is added to a power wheelchair. The tilt and the recline functions each have one actuator or power seating system motor, for a total of two.

When three or more power seating functions/actuators/motors are provided, one unit of E2311 (electronic connection between wheelchair controller and two or more power seating system motors), one unit of E2377 (expandable controller), and one unit of E2313 (harness for upgrade to expandable controller) are allowed.

> **Example**: E1008 (Wheelchair accessory, power seating system, combination tilt and recline, with power shear reduction) is added to a power wheelchair. The tilt, recline, and power shear reduction features each have one actuator or power seating system motor, for a total of three.

An expandable controller (E2377) and the wiring harness (E2313) are also allowed when a specialty interface is required, i.e., head control interface (E2327, E2328, E2329, E2330), sip-n-puff interface (E2325), joystick other than a standard proportional joystick (E2312, E2321, E2373), or multi-switch hand control interface (E2322).

There is no separate billing/payment for electronics if a non-expandable controller and a standard proportional joystick (integrated or remote) are provided.

Codes E2310 and E2311 describe electronic components that allow the patient to control two or more of the following motors from a single interface, e.g., proportional joystick, touchpad, or nonproportional interface:

- Power tilt
- Power recline, with or without shear reduction
- Combination power tilt and recline, with or without shear reduction
- Power leg elevation with or without articulation, power center mount elevating foot platform with or without articulating properties.

The interface includes a function selection switch that allows the patient to select the motor that is being controlled and an indicator feature to visually show which function has been selected. When the wheelchair drive function has been selected, the indicator feature may also show the direction that has been selected (forward, reverse, left, right). This indicator feature may be in a separate display box or may be integrated into the wheelchair interface. Payment for the interface code includes an allowance for fixed mounting hardware for the control box and the display box, if present.

A harness (E2313) describes all the wires, fuse boxes, fuses, circuits, switches, etc. that are required for the operation of an expandable controller (E2377). It also includes all the necessary fasteners, connectors, and mounting hardware.

There is no separate billing for control buttons, displays, switches, etc. There is no separate billing for fixed mounting hardware, regardless of the body part used to activate the joystick.

Suppliers are encouraged to read the entire DME MAC local coverage determination and policy article for Wheelchair Options and Accessories for additional coverage, coding and documentation requirements.

Medicare Guidelines for Manual Wheelchairs

In order for Medicare to cover and pay for a manual wheelchair, the following criteria must be met as outlined in the Manual Wheelchair Bases Local Coverage Determination (LCD) (L11454). A manual wheelchair is covered if:

a. Criteria A, B, C, D, and E are met; and

b. Criterion F or G is met.

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

A mobility limitation is one that:

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

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

C) The patient's home provides adequate access between rooms, maneuvering space, and surfaces for use of the manual wheelchair that is provided.

D) Use of a manual wheelchair will significantly improve the patient's ability to participate in MRADLs and the patient will use it on a regular basis in the home.

E) The patient has not expressed an unwillingness to use the manual wheelchair that is provided in the home.

F) The patient has sufficient upper extremity function and other physical and mental capabilities needed to safely self-propel the manual wheelchair that is provided in the home during a typical day.

Limitations of strength, endurance, range of motion, or coordination, presence of pain, or deformity or absence of one or both upper extremities are relevant to the assessment of upper extremity function.

G) If the patient is unable to self-propel, the patient has a caregiver who is available, willing, and able to provide assistance with the wheelchair.

Suggestions for clear documentation:

- What is the patient's ability to ambulate? If they are able to ambulate, with what type of assistive device is required? If not able to ambulate, why not?
- How far is the client able to ambulate?
- How long will ambulation be a problem? Is this a short term non-weight bearing issue?
- Is the assistive device currently being used by the client safe? If not, why not?
- Is the patient able to transfer in and out of bed and/or in and out of the chair?
- Is there any equipment required for transfers from bed to chair and/or chair to toilet?
- Is the patient able to perform pressure relief/weight shift? If the patient is unable to perform a functional weight shift documentation should clearly indicate why.
- What is the patient's sitting and standing balance?
- Is there an objective functional assessment that includes impairment of strength, range of motion, sensation, or coordination of arms and legs?
- Is there presence of abnormal tone or deformities of arms, legs, or trunk, including any spasticity present?

What are the patient's neck, trunk, and pelvic posture and flexibility?

- Are there interventions that have been tried in the past by the patient and the results?
- Is there history of past use of a walker, manual wheelchair, POV, or power wheelchair and the results?
- If the patient has frequent falls, indicate why they are having falls and if the falls are occurring with or without use of an assistive device such as a walker.

Tips:

If the patient is able to safely ambulate with a cane or a walker a distance that would allow access to all necessary rooms in their home and allow them to perform their Activities of Daily Living (ADLs), a manual wheelchair would not be medically necessary and therefore, not payable by Medicare.

The Manual Wheelchair Bases Policy Article (A25378) states: If the manual wheelchair is only for use outside the home, it will be denied as noncovered. Patients who qualify for coverage of a wheelchair may use that device outside the home; however, **Medicare's coverage of a wheelchair is determined solely by the patient's mobility needs within the home.**

Medical necessity is determined by the patient's current condition and not by probable deterioration in the future.

The medical necessity for a wheelchair is not solely based on diagnosis or medical conditions. There are varying degrees of medical conditions and these medical conditions may be contributing factors to the mobility limitation.

In order for wheelchairs to be covered by Medicare the documentation must meet the mobility limitation requirements as addressed in National Coverage Determination (NCD) 280.3, LCD L11454 and Policy Article A25378.

Sources:

- NAS website (http://www.noridianmedicare.com/dme)
  - Manual Wheelchair Bases LCD (L11454)
  - Manual wheelchair Bases Policy Article (A25378)