Jurisdiction D News from Noridian Administrative Services, LLC.

Happenings

June 2010
Issue No. 27

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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Educational

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

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 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

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*	June 18
Independence Day	July 5
Off-the-Phone Training*	July 16
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
New Years Day	January 1
Good Friday	April 2
Memorial Day	May 31
Independence Day	July 5
Labor Day	September 6
Thanksgiving	November 25 and 26
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.hhs.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.

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

MCPSS - Have You Responded?

CMS wants to hear from you about your satisfaction with the services provided by the Medicare fee-for-service (FFS) contractor that processes and pays your Medicare claims.

CMS is now conducting the fifth national administration of the Medicare Contractor Provider Satisfaction Survey (MCPSS). The results of this annual survey are used by CMS to monitor trends, improve contractor oversight, and increase efficiency of the Medicare program. The MCPSS provides contractors with more insight into their provider communities and allows them to make process improvements based on provider feedback.

In January, CMS notified approximately 30,000 Medicare FFS providers and suppliers that they were randomly selected to participate in the 2010 study. CMS urges all selected health care providers and suppliers to take a few minutes to complete and return this important survey.

CMS recognizes that each provider and supplier's time is limited; therefore, if you have been notified that you were selected to participate in this study and have not yet done so, we welcome you to designate a proxy who you believe to be the most knowledgeable person in your practice to answer the survey questions on your behalf. This person may be your management or billing personnel or other knowledgeable designee. You can designate a proxy to respond on your behalf by emailing the designated proxy's name, telephone number, mailing and email addresses to SciMetrika (mcpss@scimetrika.com), the public health consulting firm, contracted by CMS to administer the MCPSS study. SciMetrika will then send survey instructions to the designee to facilitate a quick completion of the survey without interrupting your day-to-day operations.

If you prefer to personally respond to the survey questions yourself and no longer have your online survey tool access information or need help accessing the survey tool, please call the MCPSS Provider Helpline at 1-800-835-7012 or send an email to mcpss@scimetrika.com. Someone on the MCPSS team will be happy to assist you.

The views of every health care professional asked to participate in the 2010 study are very important to the success of this study, as each one of you represents many other organizations that are similar in size, practice type, and geographical location. Please complete and return your survey today. CMS is waiting to hear from you!

Please Note: Only providers and suppliers already notified that they have been randomly selected to take part in the 2010 MCPSS may participate in this study. A new random sample of providers and suppliers is selected annually to participate in the MCPSS study.

For more information about the MCPSS, please visit the CMS MCPSS website at http://www.cms.hhs.gov/mcpss, or read the CMS MLN Matters Special Edition article at http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE1005.pdf featuring the survey.

CMS Needs Your Feedback

The Centers for Medicare & Medicaid Services (CMS) is conducting the fifth national administration of the **Medicare Contractor Provider Satisfaction Survey (MCPSS)**. This survey is designed to collect quantifiable data on providers' satisfaction with the performance of the Medicare fee-for-service (FFS) contractors that process and pay their Medicare claims. CMS conducts the MCPSS on an annual basis and uses the results for Medicare contractor oversight and process improvement initiatives.

In January, CMS notified approximately 30,000 Medicare FFS providers and suppliers that they had been randomly selected to participate in the 2010 MCPSS study. As representatives of the more than 1.5 million providers nationwide who serve Medicare beneficiaries across the country, these providers and suppliers have an opportunity to give CMS valuable feedback on their satisfaction, attitudes, perceptions, and opinions about the services provided by their respective contractor.

FYI CONT'D

If you have been notified that you were selected to participate in this study and have not yet done so, **CMS is listening and wants to hear from you**. Please take a few minutes to go online and complete your survey via a secure online Internet survey tool. Responding online is a convenient, easy, and quick way to provide CMS with your feedback. Survey questionnaires can also be submitted by mail, secure fax, and over the telephone. The survey takes approximately 20 minutes to complete.

CMS has contracted with SciMetrika, a public health consulting firm, to administer this important survey and report statistical data to CMS. If you received notification that you were selected to participate in the MCPSS study and you no longer have your online survey tool access information or need help accessing the survey tool, please call the MCPSS Provider Helpline at **1-800-835-7012** or send an email to MCPSS@scimetrika.com.

Please Note: Only providers and suppliers notified that they have been randomly selected to take part in the 2010 MCPSS may participate in this study. A new random sample of providers and suppliers is selected annually to participate in the MCPSS study.

For more information about the MCPSS, please visit the CMS MCPSS website at http://www.cms.hhs.gov/mcpss, or read the CMS MLN Matters Special Edition article at http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE1005.pdf featuring the survey.

CMS urges you to please take a few moments to complete your survey today.

Delayed - Editing Ordering/Referring Provider in DMEPOS Claims

CMS has delayed the implementation of Phase 2 of CMS Change Request (CR) 6421 for DMEPOS suppliers and CR 6417 for Part B providers until January 3, 2011.

The delay in implementing Phase 2 of these CRs will give physicians and nonphysician practitioners who order or refer items or services for Medicare beneficiaries to other Medicare providers/suppliers sufficient time to enroll in Medicare or take the action necessary to establish a current enrollment record in Medicare prior to Phase 2 implementation.

As part of Phase 1 for CR 6421, Common Electronic Data Interchange (CEDI) implemented warning errors/edits to be returned on the CEDI GenResponse Report (GENRPT) if the referring/ordering provider submitted on the claim was not enrolled in PECOS and/or not eligible to order or refer services.

Should a DMEPOS supplier receive one of these warning errors/edits on a claim, CEDI recommends the following:

- Contact the ordering/referring provider to verify their eligibility with PECOS.
- Contact the ordering/referring provider to verify how their name is listed with their PECOS enrollment and ensure the name submitted on the claim matches the PECOS record.
- CMS has made available a file that contains 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 PECOS that contain an NPI). This file is downloadable from the Medicare provider/supplier enrollment website http://www.cms.hhs.gov/MedicareProviderSupEnroll, click on "OrderingReferringReport" on the left-hand side.
- **This .pdf file contains approximately 800,000 records. Due to the large size of this .pdf file CEDI suggests you right click and select "Save as" before attempting to open this file.**
- Verify the Type I (individual physician's) NPI and name of the ordering/referring provider is submitted on the claim. If the Type II (physician's group) NPI and name is submitted, a match will not be found on the PECOS file.

For DMEPOS suppliers:

- CEDI validates the NPI, first four characters of the ordering/referring provider's last name and first one character of the ordering/referring provider's first name to perform the edits.
- Verify the ordering/referring provider name is submitted on the electronic claims in all uppercase letters.
- Verify the name of the ordering/referring provider matches how the provider is enrolled in 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")
- Many ordering/referring providers are getting their enrollment information into PECOS or are updating their enrollment information. It may take some time for a Medicare enrollment contractor to process these enrollment applications. Once an application has been approved, the ordering/referring provider will have an enrollment record in PECOS that contains the NPI. The CMS PECOS list will be updated periodically to include ordering/referring providers that have updated their enrollment information.
- Upon implementation of Phase 2, only accept and fill orders from eligible Medicare providers.

CMS continues to urge physicians and nonphysician practitioners who are enrolled in Medicare but who have not updated their Medicare enrollment record since November 2003 to update their enrollment record now. If these physicians and nonphysician practitioners have no changes to their enrollment data, they need to submit an initial enrollment application which will establish a current enrollment record in PECOS.

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

Overpayment Information Now Available Through IVR System

Beginning Friday, March 19th, 2010, suppliers will be able to obtain overpayment information through the NAS Jurisdiction D Interactive Voice Response (IVR) System. Below are instructions on how to utilize this new menu option.

Overpayments
To access the overpayment option from the main menu, key or speak the selection as below:

Touch-tone Option	Vocal Option
8	Financial

The financial menu is a new menu option which encompasses checks, payment floor information, and overpayments. The IVR will obtain the supplier authentication elements before proceeding. When requested, key or speak the following information:

- National Provider Identifier (NPI)
- Provider Transaction Access Number (PTAN)
- Last five digits of supplier Tax Identification Number (TIN)

After the authentication elements have been verified the financial menu will play. Key or speak the overpayment selection as below:

Touch-tone Option	Vocal Option
3	Overpayments

When requested, key or speak the following information:

- 14-digit financial control number (FCN)

The FCN can be found on the remittance advice in the provider adjustment details section. If the FCN contains more than 14 digits, drop the first two leading zeros and enter the remaining 14 digits.

TOTALS:	# of CLAIMS	BILLED AMT	ALLOWED AMT	DEDUCT AMT	COINS AMT	TOTAL MC AMT	PROV PD AMT	PROV ADJ AMT	CHECK AMT
	5	321.00	211.47	0.34	39.88	109.52	161.25	25.44	135.81

PROVIDER ADJ DETAILS:	PLB REASON CODE	FCN	HIC	AMOUNT
	50			15.44
	FB	02021993067 70	9999999999	10.00

Successful Request

If the request is successful, the IVR will provide the name of the beneficiary, the dates of service, and the amount of the overpayment. If the overpayment has more than one claim associated with it, the IVR will indicate how many overpaid claims are involved and provide the details for each.

If there are more than 10 overpaid claims associated with the overpayment the IVR will not provide any of the overpayment information. The caller will be referred to the Supplier Contact Center for further assistance.

Navigation
Once all information has been provided, key or speak the selection as below to continue:

Touch-tone Option	Vocal Option
1	Repeat That
2	Another Overpayment
3	Change NPI

Unsuccessful Request
If the request is unsuccessful, the IVR will advise the caller no overpayment was found with the information provided. Verify that the correct FCN and NPI/PTAN pair was entered.

Note: With the addition of Overpayments to the IVR, some of the menu options have changed. Refer to the updated IVR User Guide and IVR At-A-Glance brochure for complete information on how to use the updated IVR.

PECOS Information Now Available Through IVR System

Beginning Friday, March 19th, 2010, suppliers will be able to obtain provider enrollment information in the Medicare Provider Enrollment, Chain and Ownership System (PECOS) through the NAS Jurisdiction D Interactive Voice Response (IVR) System. Below are instructions on how to utilize this new menu option.

Provider Enrollment
To access the Provider Enrollment, Chain and Ownership System (PECOS) from the main menu, key or speak the selection as below:

Touch-tone Option	Vocal Option
7	Provider Enrollment

When requested, key or speak the following information:

- NPI of the referring physician
- Name of the referring physician

Note: The name of the referring physician may be keyed or spoken as below:

- Spoken: first name, last name
- Keyed: first four letters of the physician's last name followed by the first initial of the first name. When using the IVR, a key entry is not required for the spaces between first and last name or hyphenated last names, etc.

Successful Request
If the request is successful, the IVR will indicate either a) the referring physician is currently enrolled in the Medicare program or b) the referring physician is not currently able to refer Medicare services.

Unsuccessful Request
If the IVR is unable to locate a referring physician record with the information entered, verify the NPI and name of the physician were correct as provided. For assistance in verifying this information, contact the referring physician or use the National Plan and Provider Enumeration System registry.

FYI CONT'D

Navigation
Once the provider enrollment information has played, key or speak the selection as below to continue:

Touch-tone Option	Vocal Option
1	Repeat That
2	Another referring NPI
5	Main Menu

Note: With the addition of PECOS to the IVR, some of the menu options have changed. Refer to the updated IVR User Guide **and** IVR At-A-Glance **brochure for complete information on how to use the updated IVR.**

Same or Similar Option 5 on IVR

Due to the recent upgrades to the interactive voice response (IVR) system, same or similar is option 5 on the main menu. Suppliers can access the same or similar HCPCS lookup option by keying or speaking the selection as below:

Touch-tone Option	Vocal Option
5	Same or Similar HCPCS Lookup

Key or speak the following when requested:

- NPI
- PTAN
- Last 5 digits of TIN
- Patient's Medicare number
- Patient's first and last name
- Patient's date of birth
- HCPCS code
- Modifier used, if no modifier used, say "No modifier"

The IVR will provide the following information to the caller when a same or similar HCPCS code is found in the common working file or DME Jurisdiction D's local records:

- HCPCS code and modifier
- Initial date on file
- Recertification date (if applicable)
- Last day the item was billed
- Supplier name
- Supplier phone number

The appropriate modifier must be provided when checking for same or similar equipment or the information returned may be incomplete and/or inaccurate. For assistance in determining which modifier is appropriate, see the article Modifier Required When Using the IVR for Same or Similar Inquiries. If checking for equipment more than 5 years old, call the DME Jurisdiction D Supplier Contact Center.

Reminder: Whenever there are changes to the IVR, be sure to listen to the menu options and review the IVR User Guide and IVR-At-A-Glance for changes which may affect how you use the IVR.

Medicare Quality Standards and Beneficiary Protections for Respiratory Equipment, PMDs, and Other Related DME

MLN Matters® Number: SE1009

Provider Types Affected
This article is for all suppliers who bill Medicare Durable Medical Equipment Medicare Administrative Contractors (DME MAC) for providing respiratory equipment, power mobility devices (PMD) and other related DME to Medicare beneficiaries.

What You Need to Know
This Special Edition article provides the Medicare quality standards for beneficiary protection and safeguard requirements related to respiratory therapy equipment, PMDs, and other related DME.

Background

Beneficiary Assurances
All Medicare billed durable medical equipment (DME) has beneficiary protections such as:

- The equipment that the beneficiary uses meets all manufacturer standards, is provided by trained professionals in the manner that is 1) nationally recognized for safe and effective patient care and that 2) meets their needs and therapeutic goals, and that they are provided education in order to minimize any hazard or safety risks;
- All personnel who are educating the beneficiary, or repairing their equipment, are working within the scope of their practice and their state requirements;
- Whenever the beneficiary needs assistance, someone with the right professional knowledge will be able to answer all of their questions or come out to their home, if necessary, to provide additional equipment or troubleshoot an issue with the existing equipment; and
- If there is an incident with their equipment, the supplier will be responsive in determining what caused the problem, in removing the problem and in assuring the beneficiary that the risk of the same issue occurring has been minimized.

In order to provide these beneficiary assurances, all suppliers that provide any DME to Medicare beneficiaries must:

- Provide only items that meet applicable Food and Drug Administration (FDA) regulations and medical device effectiveness and safety standards, and provide manufacturer copies of the features, warranties, and instructions for each type of non-custom fabricated item to the beneficiary;
- Have equipment delivery, set-up, and beneficiary education accomplished by competent technical and professional personnel who are licensed, certified, or registered, and who are functioning within their scope of practice as required by their State standards;
- Make repair and maintenance available on all equipment and item(s) provided;

- Provide regular business hour and after-hour access telephone number(s) for customer service, and for information about equipment repair, and emergency coverage;
- Implement a program that promotes the safe use of equipment, and minimizes safety risks, infections, and hazards; and
- Investigate any incident, injury, or infection in which DMEPOS may have been a contributor, when they become aware.

Beneficiary Safeguards
Medicare beneficiaries who use DME are assured that:

- They are made knowledgeable about the safe use and maintenance of their equipment;
- By complying with appropriate maintenance standards (such as not developing a secondary infection from respiratory equipment, by maintaining it according to OSHA standards), they will not acquire an equipment related complication;
- The equipment can be used wherever the beneficiary lives (at home or in various care facilities, such as an assisted care facility or a nursing home); and
- Their needs are consistently reevaluated by both the prescribing physician and the supplier to make certain that the equipment is being used appropriately and is meeting the intended therapeutic goals.

In order to provide these beneficiary safeguards, all suppliers that provide any DME to Medicare beneficiaries must:

- Provide the appropriate information about equipment set-up features, routine use, troubleshooting, cleaning, and maintenance;
- Provide education and any instructional material that is tailored to the beneficiary's particular needs, abilities, learning preferences, and language;
- Provide relevant information about infection control issues related to the use of all equipment and item(s) provided;
- Ensure that the beneficiary can use all equipment and item(s) provided safely and effectively in the settings of anticipated use; and
- Provide follow-up services to the beneficiary, consistent with the types of equipment provided, and recommendations from the prescribing physician.

Beneficiary Safeguards for Respiratory Equipment
Medicare beneficiaries who use respiratory equipment are assured that:

- When they need assistance, someone with the professional knowledge will be able to come out to their home, if necessary, to provide additional equipment or troubleshoot an issue with the existing equipment;
- All equipment is provided by trained professionals in the clinical manner that is nationally recognized for safe and effective patient care; and
- They receive, in accordance with the *American Association for Respiratory Care Practice Guidelines*, the proper education on the safe and effective use of their equipment and treatment modality.

Note: Such standards ensure beneficiaries have the information they need to be an active participant in their care.

In order to provide these beneficiary safeguards, all suppliers that provide any respiratory equipment to Medicare beneficiaries must:

- Provide respiratory services 24 hours a day, 7 days a week, as required;
- Comply with the current version of the American Association for Respiratory Care Practice Guidelines for Oxygen Therapy in the Home or Extended Care Facility; Long Term Invasive Mechanical Ventilation in the Home; and Intermittent Positive Pressure Breathing (IPPB); and
- Provide training to the beneficiary consistent with the current version of the *American Association for Respiratory Care (AARC) Practice Guidelines*.

Note: AARC guidelines can be found at http://www.rcjournal.com/cpgs/index.cfm on the Internet.

Beneficiary Safeguards for Any Power Mobility Devices (PMDs)

PMDs include power wheelchairs and power operated vehicles (POVs) and accessories. Complex Rehabilitative Wheelchairs are: 1) Group 2 power wheelchairs with power options; and 2) Group 3 and higher power and manual wheelchairs that can accommodate rehabilitative accessories and features, for example, tilt in space.

Medicare beneficiaries who use Manual wheelchairs, PMDs, and complex rehabilitative wheelchairs and assistive technology are assured that they receive the wheelchair that best meets their needs based on a complete physical and environmental assessment.

All suppliers that provide any Manual Wheelchairs, Power Mobility Devices (PMDs), and Complex Rehabilitative Wheelchairs and Assistive Technology must verify that seating, positioning and specialty assistive technology have been evaluated.

Beneficiary Safeguards for any Complex Rehabilitative Wheelchairs and Assistive Technology

Medicare beneficiaries who use complex rehabilitative wheelchairs and assistive technology are assured that:

- Anyone evaluating them has the training and experience to handle all of the technology and understands their very complex needs;
- Their privacy will be maintained, and that they will be treated with respect;
- The equipment they receive can always be repaired, modified, and maintained (one of the most important aspects of providing safe and therapeutic complex rehabilitation);
- Everyone associated with the equipment is always actively participating in assessing, and with providing the optimal care and equipment that they require;

- The equipment will be reliable and will work for the beneficiary without worry; and
- Beneficiaries receive the equipment at their convenience, in a prompt manner and according to both the prescribing physician's recommendations and the beneficiaries assessed needs.

All suppliers that provide any Complex Rehabilitative Wheelchairs and Assistive Technology must:

- At each of their locations, employ (as a W-2 employee) at least one qualified individual as a Rehabilitative Technology Supplier (RTS), who is either a Certified Rehabilitative Technology Supplier (CRTS); or an Assistive Technology Professional (ATP).
- Have at least one or more trained technicians available to service each location, who is identified by the following:
  - Factory trained by manufacturers of the products supplied by the company;
  - Experienced in the field of Rehabilitative Technology, (e.g., on the job training, familiarity with rehabilitative clients, products and services);
  - Completed at least 10 hours annually of continuing education specific to Rehabilitative Technology; and
  - Able to program and repair sophisticated electronics associated with power wheelchairs, alternative drive controls, and power seating systems.
- Provide the beneficiary private, clean, and safe rooms appropriate for fittings and evaluations;
- Maintain a repair shop located in the facility (or in close proximity, or easily accessible from another of the supplier's locations), as well as an area appropriate for product assembly and modification;
- Ensure that the RTS coordinates services with the prescribing physician to conduct face-to-face evaluations of the beneficiary in an appropriate setting and include input from other members of the health care team (i.e., Physical Therapist, Occupational Therapist, etc.);
- Provide the beneficiary with appropriate equipment for trial and simulation, when necessary.
- Implement procedures for assembly and set-up of equipment as well as a process to verify that the final product meets the specifications of the original product recommendation approved by the prescribing physician.

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 and re-issued on April 26, 2010, to include additional clarifying language from CR 6698.

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

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.

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
6	Time Limit for Filing Claims	Changed time limits per PPACA	04/09/10
2	Accreditation and Surety Bond	More information may be found on the NSC website.	03/18/10
10	IHS	Added Notice section	03/18/10
6	Assignment Agreement	Removed source	03/18/10

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

Banking Transition

The CMS recently 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.

The following Medicare claims processing contractors will remain with JP Morgan Chase: Cahaba Government Benefit Administrators, Pinnacle Business Solutions, First Coast Service Options, Palmetto GBA (except for A/B MAC Jurisdiction 1) and Wisconsin Physician Service. Providers that bill to these contractors will not experience any change.

The following Medicare claims processing contractors will transition to JP Morgan Chase on June 1, 2010: Palmetto A/B MAC Jurisdiction 1 and Trailblazer.

The following contractors will transition to U.S. Bank on June 1, 2010: CIGNA Government Services, Highmark Medicare Services, National Government Services, NHIC and Noridian Administrative Services.

Reminder to Log Into Standard Systems Every 25 Days

All active users which have access to the standard systems (DDE, PPTN, CSI) will receive an email from Noridian Administrative Services Data Security every 25 days. The intent of the email will be to encourage all users to log into the system so as to avoid becoming revoked out of the system(s). It is the users responsibility to ensure they are maintaining their access as needed. Also, it is the users responsibility to notify Noridian Administrative Services Data Security when access is no longer needed.

This notification is only sent to the POC's (Points of Contact) at each facility. The POC's are to inform their staff of this notification and work with them as needed to ensure all users are logging into the system as needed.

If you have any questions, please feel free to contact your NAS Data Security contact directly.

Effective Date: March 22, 2010

Revised Medicare Fraud & Abuse Fact Sheet

The *Revised Medicare Fraud & Abuse* fact sheet (February 2010), directs you to a number of sources of information pertaining to Medicare fraud and abuse, and helps you understand what to do if you suspect or become aware of incidents of potential Medicare fraud or abuse. It can be downloaded at http://www.cms.hhs.gov/MLNProducts/downloads/Fraud_and_Abuse.pdf from the CMS Medicare Learning Network.

Medicare Learning Network – Quality You Can Trust

All Medicare Learning Network products are thoroughly researched and cleared by the experts at CMS.

What does that mean to you?

It means there is official Medicare Fee-For-Service (FFS) Program information always available for your immediate use to assist you with your business needs. The Medicare Learning Network knows how to translate complex language into easier to understand language and in various formats, e.g., guides, booklets, Web-based training courses, brochures, national articles and fact sheets.

Test the quality of our products for yourself and begin obtaining information regarding billing and Medicare coverage & payment – or even basic information such as office management. Visit the MLN Publications page on the CMS website to view downloadable publications or click on the Product Ordering Page to see what is available in hard copy.

Remember…there's never a charge for Medicare Learning Network products!

Trading Partner Criteria Selections for Crossing Over Claims

Medicare contractors coordinate with the Coordination of Benefits Contractor (COBC), Group Health Incorporated (GHI), to automatically cross over claims payment information for their policyholders.

An eligibility file furnished by the supplemental insurer is used to drive the process rather than information found on the claim. These eligibility files are matched, based on the Health Insurance Claim (HIC) number, against Medicare's internal eligibility file. If a match occurs, the beneficiary's record is flagged indicating to which company we will cross claim payment information. NAS than sends the file of claims to the COBC who consolidates the claims for all contractors and forwards it on to the trading partners (supplemental insurance companies). If no match occurs, the claim is not flagged for crossover.

Each trading partner is given the opportunity to specify criteria related to the claims the insurer wants or does not want Medicare to crossover.

FYI CONT'D

Trading Partners can choose from the below conditions to allow or refuse a claim crossover from Medicare:

- Medicare Secondary Payer (MSP) Claims
- MSP Cost Avoid Claims
- Claims if other insurance (such as Medigap, supplemental, TRICARE, or other) exists for beneficiary. Applies to State Medicaid Agencies only.
- Claim is a mass adjustment- Medicare Physician Fee Schedule (MPFS)
- Claim is a mass adjustment-Other
- Claim is an archived adjustment
- A specific Contractor ID
- A specific provider identification (ID) or provider state
- Original Fully Paid Medicare claims without deductible and co-insurance remaining
- Original Medicare claims paid at greater than 100% of the submitted charges without deductible or co-insurance remaining (Part A) - Also covers the exclusion of Original Medicare claims paid at greater than 100% of the submitted charges excluded for Part B ambulatory surgical center (ASC)
- Adjustments
- Adjustments, non-monetary/statistical claims
- Adjustments, monetary claims
- Adjustment claim that includes an original claim that was not crossed over
- 100% denied claims, with additional beneficiary liability
- 100% denied claims, with no additional beneficiary liability
- Adjustment claim, 100% denied, with additional beneficiary liability
- Adjustment claim, 100% denied, with no additional beneficiary liability.
- Adjustment fully paid claims with no deductible or co-Insurance remaining
- Original claims paid at greater than 100% of s ubmitted charge
- Original claims paid at 100%
- Fully reimbursable claim containing denied lines with no beneficiary liability
- Invalid Claim-based Medigap crossover ID included on the claim
- Non-assigned claims
- Claim contains a placeholder provider value
- Claim represents an excluded demonstration (DEMO) project
- National Council Prescription Drug Program Claims
- Type of Bill (TOB) 11 - Hospital: Inpatient Part A
- TOB 12 - Hospital: Inpatient Part B
- TOB 13 - Hospital: Outpatient
- TOB 14 - Hospital: Other Part B (Non-patient)
- TOB 18 - Hospital: Swing Bed
- TOB 21 - Skilled Nursing Facility: Inpatient Part A
- TOB 22 - Skilled Nursing Facility: Inpatient Part B
- TOB 23 - Skilled Nursing Facility: Outpatient
- TOB 24 - Skilled Nursing Facility: Other Part B (Non-patient)
- TOB 28 - Skilled Nursing Facility: Swing Bed
- TOB 32 - Home Health: Part B Trust Fund
- TOB 33 - Home Health: Part A Trust Fund
- TOB 34 - Home Health: Outpatient
- TOB 41 - Christian Science/Religious Non-Medical Services (Hospital)
- TOB 71 - Clinic: Rural Health
- TOB 72 - Clinic: Freestanding Dialysis
- TOB 73 - Clinic: Federally Qualified Health Center
- TOB 74 - Clinic: Outpatient Rehabilitation Facility
- TOB 75 - Clinic: Comprehensive Outpatient Rehabilitation Facility (CORF)
- TOB 76 - Clinic: Comprehensive Mental Health Clinic
- TOB 79 - Clinic: Other
- TOB 81 - Special Facility: Hospice Non-Hospital
- TOB 82 - Special Facility: Hospice Special Facility: Hospice Hospital
- TOB 83 - Special Facility: Ambulatory Surgical Center
- TOB 85 - Primary Care Hospital
- Submission for Request for Anticipated Payment [RAP] claims (TOB=322 and 332)
- All Part A Claims
- All Part B Claims
- All DMERC Claims
- All Part A/RHHI Providers
- The claim contains only PQRI codes
- Sanctioned provider claim during service dates indicated
- Claim transferred for Medicaid quality project purposes only
- Recovery audit contractor (RAC)-initiated adjustment
- Individual COBA ID did not have a matching COIF
- Claim already utilized in another current CWF application or process
- Beneficiary identified on Medigap insurer eligibility file; duplicate Medigap claim-based crossover
- Claim submitted on 4010A1 file
- Claim submitted on 5010 file
- NCPDP claim submitted on D.0 file
- NCPDP claim submitted on 5.1 file

If you have questions, visit the COBC website or contact the COBC toll-free at 1-800-999-1118 or TTY/TDD line at 1-800-318-8782 for the hearing and speech impaired.

CMS Public Website Address Change

On Friday, April 2, 2010, the Centers for Medicare & Medicaid Services (CMS) will be changing our website address from http://www.cms.hhs.gov to http://www.cms.gov. Existing bookmarks and links from other websites will continue to work following this address change.

Medicare Learning Network Video Now on You Tube!

Watch the Medicare Learning Network video–now playing on CMS' You Tube channel at http://www.youtube.com/watch?v=GOzh7kpAwUo on the web. This information video provides you with information on what the Medicare Learning Network has to offer you in your Medicare business practices as well as other helpful resources that CMS offers to Medicare fee-for-service providers.

Don't forget, you can also order your copy of this video on DVD today; visit http://www.cms.hhs.gov/MLNGenInfo, scroll down to "Related Links Inside CMS" and select "MLN Product Ordering Page." It's a great conference presentation!

CMS Using Social Media

CMS continues to break new ground to enhance our Medicare Fee-For-Service outreach efforts. CMS is now using the following social media outlets to get information out to our audience as fast as possible.

LinkedIn: Join the CMS group at http://www.LinkedIn.com/in/CMSGov

YouTube: Log on to the official CMS YouTube channel at http://www.YouTube.com/CMSHHSGov to view several videos currently available and more to come in the upcoming months.

Twitter: Follow CMS' two accounts to get the latest updates on information you need know about CMS (including Medicare Learning Network updates) and Insure Kids Now.

1. For CMS & Medicare Learning Network updates, visit http://www.twitter.com/CMSGov (Twitter handle = @CMSGov)
2. For Insure Kids Now updates, visit http://www.twitter.com/IKNGov (Twitter handle = @IKNGov)

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.

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

NAS Website Changes Coming in May!

In May, visitors to the NAS website, https://www.noridianmedicare.com, will see navigation changes and easy access to the top tasks performed, the most frequently viewed content, and contact information. More information about the changes and a link to preview the website design changes are included within this article.

Navigation
The category titles currently on the top menu tabs of each web page will move to a left-side navigation area. Users will be able to hover over a category title to view the information available within that page. By selecting the category title, the web page of that category will display. Existing site addresses and bookmarks will not be affected.

Contact Information
Part A, Part B, and DME homepages will continue to continuedisplay contact information and scheduled closures in the right column of the page. Part A and Part B pages also include production alerts and a link to Recovery Audit Contractor (RAC) information.

Links to Frequently Used Information
Each homepage offers links directly to the most frequently used information and web tools, such as:

- Local Coverage Determinations
- Fee Schedules
- Forms
- Training Events
- IVR Guide
- Remittance Advice Tutorial
- Timeline Calculators

To see the upcoming changes and familiarize yourself with the changes before they are implemented in May, view the new NAS Tour. The changes are based on provider and supplier comments within surveys, data analysis, CMS guidance, and customer testing and feedback. We encourage providers and 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.

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 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 website. 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

- Oxygen and Oxygen Equipment – July 14
- 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.

Self-Paced Tutorials Now Available on Training/Events Page

NAS DME now offers self-paced learning tutorials on the Training/Events page that contain topic-specific content, questions, a certificate of completion and a survey. The topics currently available are: Documentation Prior to DME Claim Submission; Basics of Medicare (Putting the Pieces of DME Together: Background Knowledge); Refractive Lenses.

These tutorials are interactive so be sure to click on the buttons to read more information and answer the questions throughout the tutorial. Acronyms are defined by either rolling the mouse over the letters or clicking on them, depending on the lesson.

We appreciate and value your thoughts and suggestions. Please provide feedback on the tutorials by completing the survey at the end.

PAP Device Ask the Contractor Q&A – March 17, 2010

Prior to taking questions, NAS provided the following updates regarding the Positive Airway Pressure (PAP) Local Coverage Determination (LCD) for April 2010:

Refill Supplies
The DME Medical Directors are updating any policy which could potentially have refill supplies to include language from the CMS Internet-Only Manual (IOM), Program Integrity Manual (PIM), Publication 100-8, Chapter 4, Section 4.26.1, which states "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." The supplier must not automatically dispense a quantity of supplies on a predetermined regular basis, even if the beneficiary has "authorized" this in advance. This is not a change, but rather additional language added to the local coverage determination (LCD) for April 2010.

PAP Device Replacement Instructions
Replacement instructions were added for PAP devices that were initially provided and covered while the beneficiary was in Medicare fee-for-service (FFS) as follows:

- If a PAP device is replaced during the 5 year reasonable useful lifetime (RUL) because of loss, theft, or irreparable damage due to a specific incident, there is no requirement for a new clinical evaluation, sleep test, or trial period.
- If a PAP device is replaced following the 5 year RUL, there must be a face-to-face evaluation by their treating physician that documents that the beneficiary continues to use and benefit from the PAP device. There is no requirement for a new sleep test or trial period.

For beneficiaries entering Medicare who have already received a PAP device prior to enrollment, the policy was revised to include the beneficiary seeking **rentals**, as well as a replacement device and/or supplies. Those requirements have not changed, only the inclusion of seeking rental payments changed.

Replacement of a Continuous Positive Airway Pressure (CPAP) Device (E0601) with a Bi-level Respiratory Assist Device RAD) (E0470)
To be able to make the significant change from an E0601 to an E0470 the chart must document medical necessity for the E0470 and that the E0601 is inadequate. This has always been the case, though we find a number of charts have failed to do so, resulting in either initial denials or Comprehensive Error Rate Testing (CERT) (or other) denials. The outlined elements added in the policy are the logical elements that will help convey the necessity and really would be present to evidence this necessity now. The LCD change has been made to try to make this more explicit and decrease the number of retrospective denials. Therefore, the following was added to criterion D: "Ineffective is defined as documented failure to meet therapeutic goals using an E0601 during the titration portion of a facility-based study or during home use despite optimal therapy (i.e., proper mask selection and fitting and appropriate pressure settings)."

Documentation was added to the Documentation section of the LCD to state: "For beneficiaries changing from an E0601 to E0470 due to ineffective therapy while on E0601 (either during a facility-based titration or in the home setting), the treating physician must document:

- The beneficiary tried but was unsuccessful with attempts to use the E0601 device; and
- Multiple interface options have been tried and the current interface is most comfortable to the beneficiary; and
- The work of exhalation with the current pressure setting of the E0601 prevents the beneficiary from tolerating the therapy; and
- Lower pressure settings of the E0601 fail to adequately control the symptoms of OSA or reduce the AHI/RDI to acceptable levels."

Questions received prior to the call:

Q1. The auto-titrating, single-level CPAP (aka APAP) is not listed in the LCD. How would this be billed?

A1. For auto-titrating CPAP devices, use Healthcare Common Procedure Coding System (HCPCS) code E0601. This information can be found in the Policy Article.

Q2(a). Scenario: Patient continues to have equipment from initial set-up. Three initial rental months were billed with the KX modifier indicating initial coverage criteria has been met. Subsequent dates of service were held for verification of physician face-to-face re-evaluation and documented adherence to therapy (use of PAP four hours per night on 70 percent of nights during a consecutive 30 day period anytime during the first three months of initial usage). It was determined the patient was non-compliant. The physician did a re-evaluation and a new sleep study was ordered and taken. The physician ordered the patient to re-start the treatment with the equipment (no upgrades are involved from E0601 to E0470). Is the date of this new order for continued treatment after the date of the second sleep study, the start of fourth rental month? Or does

a supplier wait for a positive adherence to therapy and another physician re-evaluation to occur and use the latter date as the fourth month rental? (This would be more than six months from initial treatment start date).

A2(a). The fourth month covered rental would begin when the patient meets the two re-qualification criteria as follows:

- Face-to-face clinical re-evaluation by the treating physician to determine the etiology of the failure to respond to PAP therapy; and,
- Repeat sleep test in a facility-based setting (Type 1 study).

Q2(b). What type of second re-qualification sleep study is acceptable in the Type I category? There are three different types of the diagnostic polysomnogram (PSG);

- **Full night study for diagnosis only;**
- **Split night study, which is the initial section as a diagnostic and the second part of that study with titration on the PAP device to evaluate treatment; and**
- **Third option is titration study for evaluating different pressure settings on prescribed therapy for effectiveness.**

A2(b). The repeat sleep test must be in a facility-based setting (Type 1 study). It may be performed as either a whole night study for diagnosis only or as a split night study to diagnose and initially evaluate treatment.

Q3. If a supplier gets a physician order for a CPAP to be set up in 2010, but the sleep study was done in 2007, and the patient never previously tried CPAP therapy, what documentation is required? Is a face-to-face evaluation prior to set up in 2010 sufficient? Does the patient require a new sleep test so a face-to-face evaluation can be done before the sleep study?

A3. The current coverage criteria must be met and documented in the patient's medical record. If a face-to-face evaluation was not performed prior to the sleep study, that would not meet the qualification of the policy.

Q4. A patient's CPAP machine is not working and is more than five years old. A replacement machine is ordered along with a humidifier. The patient's physician conducts a face-to-face evaluation. The patient's humidifier was received less than five years ago and is not compatible with the new CPAP. Will Medicare pay for a new humidifier to go with the replacement CPAP?

A4. The replacement humidifier may deny as same or similar equipment. However, the supplier can go through the Appeal process with supporting documentation to show the necessity for the new humidifier based on the replacement CPAP.

Q5. If a CPAP was set up prior to the face-to-face evaluation requirement, what documentation is required?

A5. For a CPAP device dispensed prior to November 1, 2008, if the initial Medicare coverage criteria in effect at the time were met and the criteria for coverage after the first three months that were in effect at the time were met, the device will continue to be covered for dates of service on or after November 1, 2008, as long as the patient continues to use the device.

Q6. Does a supplier need to have clinical notes in our patient's chart of the face-to-face examination from when the doctor ordered the CPAP machine?

A6. Physicians shall document the face-to-face clinical evaluations and re-evaluations in a detailed narrative note in their charts in the format they use for other entries. It is a supplier's business practice decision as to when to obtain this documentation, but it must be available upon request.

Q7. If it is determined that a CPAP is ineffective during a facility based titration, the patient has no current, comfortable interface; they only have the mask used during the sleep study, they may not have tried multiple interface options. There is not enough time for that during a sleep study and it may not have been necessary. What action should a supplier take?

A7. If a specific documentation requirement is not met, it may be necessary to appeal with documentation to support a failure to meet therapeutic goals using an E0601 during the titration portion of a facility-based study.

Q8. Medicare only pays for a new mask every three months and a new headgear every six months. Because many mask/headgear combinations are proprietary, will the beneficiary have to wait a year or more to be able to say that "multiple interface" options have been tried in order to therapeutically switch to a bi-level respiratory device?

A8. No. Issues with the mask arising in the first few days of treatment must be aggressively addressed by the supplier and/or treating physician in order to meet compliance. A second mask will initially be denied by NAS but will be considered for payment at the appeal level with documentation to support why a second mask was needed within the initial three months.

Q9. How is it determined that the work of exhalation with the current pressure setting of E0601 prevents the beneficiary from tolerating treatment?

A9. This would be documented based on the judgment of the qualified interpreting/treating physician of the sleep study.

Questions and answers taken during the call:

Q1. A patient's sleep study report does not indicate obstructive sleep apnea (OSA), but rather it indicates there is rapid eye movement (REM) sleep behavior disorder and the patient has sleep apnea not otherwise specified (NOS). The prescription reflects diagnosis 327.3 (sleep apnea); however, the records do not specifically say OSA anywhere in the sleep study report or in the impressions. The prescription indicates the ICD-9-CM diagnosis code for OSA, 327.3 and the supplier has a good face-to-face documented. There are no medical records indicating the OSA, 327.23 diagnosis. Would the patient qualify for coverage?

A1. The LCD itself is specific to obstructive sleep apnea and diagnosis code 327.23. If there is no indication in the medical record of OSA, only on the actual order, the beneficiary would not qualify for coverage.

Q2. A patient purchased a PAP device before January 1, 2008, and it needs to be repaired. Does the patient have to have a new face-to-face evaluation with a physician and PAP order to be reimbursed for the PAP repairs?

A2. No, a new physician order is not required for repairs.

Q3. If the physician is an active member of a sleep lab that is based in a hospital and the hospital is accredited by the Joint Commission, is that acceptable proof of credentials for thae physician interpreting the sleep study?

A3. The fourth criteria is an active staff member of a sleep center or laboratory accredited by the American Academy of Sleep Medicine or the Joint Commission, so that would be acceptable.

Q4. Who is considered the treating physician?

A4. The treating physician is anybody who is actively involved in the patient's care. It could be the actual physician who does the initial face-to-face examination when a patient describes their symptoms prior to the sleep study or it could be the physician who actually reads the sleep study test results. The physician who sent the patient to the face-to-face evaluation is going to be the one that the supplier will want the records from to ensure the patient had a face-to-face evaluation prior to the sleep study and qualified. If a CPAP is then ordered, the treating physician could be the physician who is reviewing the sleep study. A supplier must ensure the patient had a face-to-face examination prior to the sleep test and that the documentation is available upon request.

Q5. Sometimes face-to-face evaluation notes are received that have an addendum added which indicates the face-to-face was performed March 2009, and then there is a note that the doctor adds more information and then signs it July 2009, and states this is an addendum to previous notes. The physician is telling the supplier (verbally) that the physicians take dictation and they are going back and adding information to chart notes that was missing. Is that acceptable?

A5. Addendums are not acceptable.

Q6. What documentation does a supplier need to have on file to bill to Medicare for replacement supplies (i.e., mask, tubing) for a patient who received their CPAP from another organization?

A6. Ensure the documentation which reflects the beneficiary meets the coverage criteria is available upon request. NAS will not pay for accessories unless the coverage criteria for the CPAP have been met. Suppliers may want to work with the original supplier who dispensed the CPAP to obtain a copy of the sleep study and the face-to-face examination. Without this documentation, a claim may deny in the event of an audit.

Q7. Does a patient who failed the initial 12-week trial need to a) have a new face-to-face evaluation by their treating physician, b) repeat the sleep test showing they adhered to use of the device more than 70 percent of the nights at greater than four hours, and c) prove compliance and to have their CPAP usage covered.

A7. Yes, the patient is going to be redoing the qualification/compliance cycle if they failed their initial CPAP trial period.

Q8. When physicians are not documenting the adherence to CPAP therapy in their chart notes upon re-evaluation, this becomes a challenge for suppliers. The LCD indicates specifically that this has to be documented in normal chart notes. The physician letter written by NAS' DME Medical Director, Dr. Whitten, does not indicate the CPAP therapy adherence; instead, the letter indicates there needs to be a data report. This causes some of our referring/ordering physicians to state that even though the CPAP therapy adherence is not in their chart notes, they do have the data report. Has Dr. Whitten expressed any interest in changing that letter?

A8. CPAP therapy adherence does need to be documented in the patient's chart. If it is not documented and available upon request, it may cause denial during an audit or claim review. Dr. Whitten is willing to modify his physician letter to reflect that LCD information; https://www.noridianmedicare.com/dme/news/docs/2008/12-dec/dear_physician_pap.pdf.

Q9. A supplier gives a CPAP replacement to a patient who has had the CPAP for over five years but the original CPAP is still on the maintenance and service plan. If the patient chooses the rental option, does that affect the payments the supplier will receive for the replacement CPAP? Will we have to refund any maintenance and servicing payments received up to the point of the new CPAP?

A9. No, a refund is not needed. If it has been over five years and the patient elects the rental option for the CPAP, the supplier could begin the new initial CPAP process. Per the new guidelines, the supplier needs to make sure that prior to the new CPAP, they obtain documentation of a face-to-face evaluation that indicates the patient is still benefiting from the CPAP therapy. Per the CMS IOM, Publication 100-4, Chapter 20, after five years the capped rental items can be replaced.

Q10. A patient was using a CPAP and could not tolerate the treatment due to the high pressure so he returned it after 29 days and then went back to his doctor. Two months later, the doctor ordered the patient to try a BiPAP. Does that mean he has only 60 days left in the trial period?

A10. The medical necessity would indicate that the patient needed to move on to a RAD, so the supplier would be able to start fresh with a new capped rental period for the E0470 using the KH modifier. The new trial period is still going to be 90 days.

Q11. What can a supplier do when a patient refuses to sign and Advance Beneficiary Notice of Noncoverage (ABN) or return a supplier's equipment and the doctor refuses to release the liability?

A11. It is a supplier's business practice decision as to what to do. If the claim was submitted on an assigned basis and the patient refuses to sign the ABN, a supplier can have somebody note that the patient refused to sign the ABN and then bill the claim with the GA modifier to Medicare.

Q12. Is it okay if a physician does not have the test download at the time of the re-evaluation to add an addendum when he gets that 30 consecutive compliance report? Would it be okay in that instance to use the addendum?

A12. The physician may see the patient any time between the 31st and the 91st day and they may not see the report of adherence to therapy until after that. Once the physician receives that report, the physician can then include the test information into the medical record. This is really not an addendum; the physician is actually adding the information to the medical record when he/she is actually reviewing that report.

Q13. Does a patient need to have a new face-to-face evaluation before a supplier can provide the replacement device?

A13. Guideline changes effective April 1, 2010, will require the new face-to-face evaluation.

Q14. If a supplier sends a patient who is noncompliant with the coverage criteria a certified letter, which the patient signs stating that it is their financial responsibility to pay for the equipment due to their lack of compliance, will that suffice as notification the same as an ABN?

A14. NAS suggests using the ABN in addition to the certified letter with the explanation of noncoverage and liability defined. The certified letter could help justify that the patient refused to sign the ABN yet notification was given. The supplier would also need to have the ABN initialed by a second person showing the patient refused to sign the ABN.

Q15. If the doctor and/or the patient is insisting that the equipment and supplies be provided before the supplier has an opportunity to gather their intake information (i.e. weekend) to see if the patient qualified, can the supplier execute an ABN? What would be entered on the ABN for a reason why the equipment is not medically necessary? Will this ABN place the financial liability on the patient?

A15. Suppliers need to try to get the documentation ahead of time. If it is a situation where the physician wants the beneficiary to have the equipment now and they are unable to prove the supplier with documentation to support that the medical coverage criteria is met, the supplier has a business decision to make. The supplier may choose whether or not they dispense the equipment or not. If they elect to dispense the equipment and properly execute an ABN, they need to indicate to the beneficiary that without documentation, the patient's coverage criteria can not be determined. In this situation, the ABN rational may be, "the physician wants the beneficiary to have it now and we have no information if the patient has had a sleep study or if they meet the qualifications." This situation should not be a routine practice. Ensure the specific documentation that is missing is noted within the ABN. Possibly you can get a hold of the medical record from the physician who calls in the order; however, the sleep study information is unavailable. The properly executed ABN is a protective measure that does place financial liability with the patient if you can not get a hold of the needed documentation.

Q16. The PAP policy revised April 1, 2010, states "The respiratory disturbance index (RDI) is defined as the average number of apneas plus hypopneas per hour of recording without the use of a positive airway pressure device. For purposes of this policy, respiratory effort related arousals (RERAs) are not included in the calculation of the RDI. The RDI is reported in Type III, Type IV, and Other home sleep studies." Does this mean suppliers can only take the apneal/hypopnea indexes (AHI) only when the sleep test is done on the Type I or Type II sleep studies? Can suppliers accept the RDIs in the sleep study when it is done under the Type III or IV sleep test?

A16. Correct, Type I through Type IV is acceptable for AHIs and RDIs.

Q17. There are many steps necessary that need to be documented concerning the upcoming rule about switching from CPAP to a BiPAP. In this case, would a template be acceptable? To be able to educate the doctors on what a supplier needs is difficult to communicate without a template. Masks and interfaces are seldom mentioned in sleep study reports.

A17. The documentation section states that it is in the patient's medical record; therefore, the physician must complete the documentation in the patient's medical record, so a form/template is not acceptable. The doctor can create a template if they so choose; however, he/she needs to be logging that kind of information in the same format for any chart notes. Many elements are recorded on the actual report of the sleep study, often in a chart format instead of narrative format. NAS has medical review nurses review the medical records and they are able to interpret a medical report based on the sleep study. When the contents are listed in the medical report of the sleep study it should be sufficient and not require an additional template/narrative. If the CPAP is not being tolerated by the patient during their study and they switch it to a RAD with a different interface, that would meet the multiple interface options criteria.

Q18. For replacement supplies, there are patients that have had sleep studies done before, copies of the prior study is received, and then the new supplier makes sure that they also obtain the face-to-face evaluation in order to replace the patient's supplies. How long is a sleep study good for and how many years must pass before a patient has to do a new sleep study?

A18. The supplier needs to obtain the face-to-face evaluation. If the patient is using their device, the sleep study results do not necessarily expire. If the patient is continuing to use their CPAP device and the documentation shows they are benefiting from it, the patient does not need to get a new sleep study.

Q19. In the LCD, there are different criteria for whether the initial CPAP and RAD device was paid for by Medicare, by a private insurer, or paid prior to entering FFS Medicare. The only guidance I can find is located within NAS' November 2008, ACT, Question 28**. What are the criteria for replacement of the device if the initial device was paid by a private insurer?**

A19. When a supplier is seeking replacement and the device was initially paid by a private insurer, there needs to

be documentation of the sleep test that meet the current coverage criteria regarding the AHI and the RDI, as well as a clinical evaluation following enrollment in the FFS Medicare by the beneficiary's treating physician. This evaluation needs to reflect the patient has OSA and they are benefiting from the use of the device. Note, even if the patient had Medicare as a secondary insurance at the time a private insurer paid for the initial device, in order for Medicare to pay any of the co-insurance or deductible for that primary insurance, the patient would have to meet the current Medicare guidelines. In order for Medicare to pay for any accessories to the device, the coverage criteria for the device would have to be met.

Q20. If the patient is not using the device, would they need a new sleep study?

A20. If the patient has not been compliantly using the device and if their medical condition has changed where they did not need it for 60 plus the days remaining in that last rental month, then the supplier and patient would begin the new face-to-face evaluation and sleep study process per the LCD and policy article.

Q21. How often will Medicare pay for a sleep study?

A21. Since DME does not cover that portion of the testing requirement, a supplier would want to research the question with either the Medicare Part Fiscal Intermediary or Medicare Part B Carrier.

Q22. If the PAP device is replaced during the five year RUL because it got lost, was stolen, or damaged due to a specific incident, does a supplier need a new clinical evaluation, sleep test, or trial period? Can you confirm, effective April 1, 2010, if the device is being replaced because it is past the five year timeline and the patient wants to replace it, does the supplier need to obtain a new face-to-face evaluation?

A22. A replacement within five years RUL due to lost, theft, or damage does not require a new face-to-face evaluation. Effective April 1, 2010, a new face-to-face evaluation is needed when a device is replaced due to the five year RUL expiring.

Q23. There have been supplier concerns about educating the physicians on the exact documentation requirements. Does NAS believe the implementation surrounding physician documentation when a patient changes from and E0601 to an E0470, criteria may be delayed until after April 1st, similar to what was delayed for the oxygen equipment?

A23. According to the Medical Director's Assistant, NAS does not believe this will be delayed. This will be taken to the Medical Directors for all four DME MAC Jurisdictions to discuss.

Q24. A patient had a sleep study done five years ago (i.e. 2005) when they had private insurance and they only used the CPAP for a two months. In 2010, the doctor is sending over an order for a CPAP. Does that patient need a new sleep study?

A24. Because this patient only used the CPAP for two months, and the patient's condition had changed over time, the patient would need a new sleep study. If the sleep study that was conducted met the current coverage criteria and the patient's criteria had not changed, the patient would not need a new sleep study.

Q25. If the patient was previously on a commercial insurance policy and now receives Medicare, does the patient need a new face-to-face evaluation if it is for the machine versus just the supplies?

A25. It does not matter if it is for the machine or the supplies. If the patient is coming on to Medicare, they need to have that face-to-face evaluation once they are Medicare enrolled.

Q26. Where can I find the most updated guidelines for how soon a supplier can replace the disposable supplies? For example tubing (A7037), conversations with suppliers indicate this can be replaced once every three months when a supply book indicates it can be replaced once per month.

A26. For Medicare patients, suppliers need to follow the LCD. Per the LCD, A7037 is allowed once every three months.

Q27. If the CPAP was replaced during the five year RUL due to the loss, theft, or irreparable damage due to a specific incident, what kind of documentation is needed?

A27. If it was lost, stolen, or burned in a fire, there would be a police report. Notify NAS of this situation through the use of the notes/comments field (HAO electronic submission). This documentation must be available upon request.

Q28. Situation: A patient received a CPAP from an initial supplier which paid for over 13 months; therefore, the patient owned the device and was unaware they owned it. The patient then entered a Medicare HMO and the initial supplier started charging the HMO for a CPAP. When the patient left the HMO, the supplier picked up the device even though the patient owned the device. The patient now needs a CPAP and no longer has the one she owned.

A28. The patient should call 1-800-MEDICARE (1-800-633-4227) to discuss her prior claims and equipment. If Medicare FFS paid 13 months, it is beneficiary owned and the initial supplier needs to return her CPAP device.

Q29. If a patient failed during the 12 week period, went back, had a new face-to-face evaluation and new sleep study, how many months after the sleep study should the patient be set up again with a PAP device?

A29. The patient should have a new PAP device as soon as the physician ordered it and the beneficiary qualified based on the AHI on the second sleep study. It would be in a reasonable amount of time within three months.

Q30. Scenario: A patient was set up on the Bi-PAP machine and went to Hawaii for the winter. The patient did not see a doctor during the timeframe for the re-evaluation. The patient is returning April 1st and the trial period will be over. Are there any exceptions?

A30. If the face-to-face examination occurs after the trial period but the supplier has documentation to support that the adherence to therapy was being met during the trial period, coverage would begin once the patient does have the face-to-face evaluation. The supplier was encouraged to suspend billing until the face-to-face re-evaluation occurs.

Top Ten Phone Inquiries (January – March 2010)

Q1. How do I check for Same or Similar on an E0260 (Hospital bed)? (New April 2010)

A1. Same or Similar can be checked by pressing/speaking option number five on the Interactive Voice Response (IVR). Once you are authenticated, you can speak the code and modifier you wish to check Same and Similar on.

Q2. Can information pertaining to a claim that denied for Same and Similar be checked on the IVR? (New April 2010)

A2. Yes. This can be checked by utilizing option five on the IVR.

Q3. I need to obtain an entitlement date for a patient. How do I do this without having to call the Contact Center? (New April 2010)

A3. Entitlement can be obtained by pressing/speaking option two on the IVR and listening to the prompts.

Q4. My claim denied for the patient being enrolled in a Health Maintenance Organization (HMO) during the time of service. How do I verify this? (New April 2010)

A4. This can be verified by pressing/speaking option two on the IVR and checking the patient's entitlement.

Q5. I have a Financial Control Number (FCN) on my remittance advice but I need to know the patient who caused the offset. How do I find this information? (New April 2010)

A5. Patients that caused an overpayment can be obtained by first pressing/speaking option eight and then option three within the financial section of the IVR. This will provide date span of the claim as well as the patient and amount overpaid.

Q6. I called the IVR and found out my oxygen claim denied as not medically necessary. How do I find out what I need to support medical necessity? (New April 2010)

A6. Once you know your claim has denied as not medically necessary, the next step is to search the policies under the Coverage/MR tab of our website. Click on the Local Coverage Determinations (LCD) and scroll down to the policy that pertains to your denied claim.

Q7. Where is another place I can check for coverage criteria if I know there isn't an LCD? (New April 2010)

A7. Another place to check is the National Coverage Determinations. These are located under the Coverage/MR tab and click on the NCD tab.

Q8. How can I check the status of my appeal? (New April 2010)

A8. Currently, the only way to check the status of an appeal is to call the Contact Center.

Q9. My claim denied for no Part B coverage. How can I verify this? (New April 2010)

A9. This can be verified by pressing/speaking option two on the IVR.

Q10. How can I obtain the payment information for my claim? (New April 2010)

A10. Paid claim information can be found by pressing/speaking option one in the IVR. This will give full details such as the Claim Control Number (CCN), number of line items, date of service, submitted amount, allowed amount, HCPCS code and diagnosis code.

Revised Guided Pathways to Medicare Resources Now Available

The Revised *Guided Pathways to Medicare Resources* (1st Quarter 2010), are now available from the CMS Medicare Learning Network. *Guided Pathways* leads Medicare Fee-For-Service providers through a variety of resources organized by topic. Quickly explore these three easy-to-navigate online guides to learn important Medicare policy and requirements. Guided Pathways information is available at http://www.cms.hhs.gov/MLNEdWebGuide/30_Guided_Pathways.asp on the CMS website.

- Guided Pathways Basic Booklet January 2010 [PDF, 831KB] - Includes updated information on Medicare resources that provide a fundamental overview of the Medicare program. For all Medicare providers
- Guided Pathways Intermediate Part A Booklet January 2010 [PDF, 898KB] - Includes updated information on Medicare Institutional Requirements, Reimbursement and Coverage, Medicare Services such as; clinical trials, health care cost report information, MedPAC, Medicare approved facilities, demonstrations, enrollment reports, Fee-For-Service statistics, the Medicare-Medicaid relationship, program rates and statistics, sustainable growth rates & conversion factors and telehealth. *For Medicare FFS Health Care Providers who enroll in Medicare using the 855 A form*

NPI Booklet Now Available

The National Provider Identifier (NPI): What You Need to Know *Booklet* is now available for download! The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandated the adoption of a standard, unique health identifier for each health care provider. The NPI Final Rule, published on January 23, 2004, established the NPI as this standard. Covered entities under HIPAA are required by regulation to use NPIs to identify health care providers in HIPAA standard transactions. This booklet contains information previously available in NPI fact sheet and tip sheets and can be found at: http://www.cms.gov//MLNProducts/.

Note: If you have problems accessing the hyperlinks in this message when you click on the link (including coming to a login page), please copy and paste the URL into your Internet browser instead.

EDUCATIONAL CONT'D

Fraud and Abuse Web-Based Training Course Revised

The Medicare Fraud and Abuse web-based Training Course has been revised and is now available.

The course provides information helpful for Medicare providers and suppliers involved in providing and billing for services to people with Medicare. This activity provides information that will increase awareness of Medicare fraud and abuse; provide information regarding correct billing practices, and help Medicare providers, suppliers and staff to file claims correctly. The course offers continuing education credits; please see the course description page for details. To access the course, go to the MLN Products page at http://www.cms.gov/MLNProducts/, and select the web-based training modules link in the "Related Links Inside CMS" section. Once the web-based training courses page is displayed, select the Medicare Fraud and Abuse WBT from the list provided.

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 CDC sends written requests for medical records to suppliers that include a checklist of the types of documentation required. The CDC 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 CDC 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 CDC at (301) 957-2380 with questions regarding specific documentation to submit.

CERT CONT'D

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

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

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

Letter to Physicians – CERT

Suppliers may use this letter to encourage physicians to provide documentation the Comprehensive Error Rate Testing (CERT) contractor is requesting.

NORIDIAN Administrative Services LLC

Medicare

March 2010

Dear Physician,

The National Durable Medical Equipment Medicare Administrative Contractor (DME MAC) CERT Education Task Force would like to encourage physicians to please respond to any Comprehensive Error Rate Testing (CERT) documentation request they receive from CERT or the providing supplier.

DMEPOS suppliers can only provide to the CERT contractor the documentation that the physicians provide to them. In order for DMEPOS suppliers to continue to provide the necessary items/service to your patient, they must be able to rely on your cooperation in providing any additional documentation requested. Since physicians are the ones treating the beneficiaries and are responsible for maintaining records to support medical necessity of the services they provide, this typically means copies of your office notes, pertinent test reports, and other pertinent healthcare records maybe required to support the DMEPOS items/service ordered. As it is stated in the Social Security Act:

> *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.*

When physicians are unable to provide the requested documentation, the suppliers receive denials for the items billed and their payment is recouped which could result in your patient being financially responsible for all or part of the charges for the items/service received.

The National DME MAC CERT Education Task Force is asking for the cooperation of the physician community. If a supplier contacts your office to request additional clinical documentation, partner with the supplier to establish what clinical records are needed to support that the service/item you ordered is medically necessary.

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

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

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

The National DME MAC CERT Education Task Force

CMS CENTERS for MEDICARE & MEDICAID SERVICES

20312096 A CMS Contracted Medicare Administrative Contractor (3203)3-09

ENROLLMENT

Reporting Changes in Surety Bonds

MLN Matters® Number: MM6854
Related Change Request (CR) #: 6854
Related CR Release Date: March 26, 2010
Related CR Transmittal #: R332PI
Effective Date: June 28, 2010
Implementation Date: June 28, 2010

Provider Types Affected
Suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) submitting claims to Medicare DME Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries are impacted by this issue.

Provider Action Needed
This article is based on Change Request (CR) 6854 which clarifies the situations in which certain DMEPOS surety bond changes must be reported to the National Supplier Clearinghouse (NSC). Be certain to comply with these changes.

Background
CR 6854 outlines scenarios in which suppliers of DMEPOS are required to report certain surety bond changes to the NSC.

A DMEPOS supplier must submit an addendum to the existing bond (or, if the supplier prefers, a new bond) to the NSC in the following instances: (1) a change in bond terms, (2) a change in the bond amount, or (3) a location on a bond covering multiple non-chain locations is being added or deleted.

In addition, pursuant to 42 CFR 424.57(d)(6)(iv), (at http://edocket.access.gpo.gov/cfr_2002/octqtr/pdf/42cfr424.57.pdf on the Internet) the surety must notify the NSC if there is a lapse in the surety's coverage of the DMEPOS supplier. This can be done via letter, fax, or e-mail to the NSC; the appropriate addresses can be found on the NSC's website at NSC Contact Information on the Internet.

Additional Information
If you have questions, please contact the NSC at (866) 238-9652 from 9 a.m. until 5 p.m. EST to reach a customer service representative. The official instruction, CR6854, issued to your Medicare MAC regarding this change may be viewed at http://www.cms.gov/Transmittals/downloads/R332PI.pdf on the CMS website.

Medicare's surety bond requirements are summarized in detail in article MM6392 at http://www.cms.gov/MLNMattersArticles/downloads/MM6392.pdf on the CMS website.

To review 42 CFR 424.57 you may go to http://edocket.access.gpo.gov/cfr_2002/octqtr/pdf/42cfr424.57.pdf on the Internet.

NSC Hearings and Appeals Checklist

DMEPOS suppliers choosing to appeal a Medicare denial or revocation are encouraged to use the Hearings and Appeals checklist found on the National Supplier Clearinghouse (NSC) website when submitting documentation for review. Suppliers are still required to submit a detailed cover letter specifying the request of reconsideration or a Corrective Action Plan (CAP). The checklist should be submitted along with the CAP/reconsideration packet.

Source: National Supplier Clearinghouse

CEDI

CEDI Inactive Trading Partners

Beginning March 31, 2010, CEDI will disable Submitter/Trading Partner IDs that have been inactive for 90 days. Submitters/Trading Partners who do not log in to the CEDI Gateway within 90 days will need to contact the CEDI Help Desk to have their Submitter/Trading Partner ID re-enabled.

CEDI will continue to identify inactive Submitters/Trading Partners who have not logged in to the CEDI Gateway within 13 months and remove those IDs from the CEDI Gateway. If your Submitter/Trading Partner ID is removed for non-use, you will need to visit the CEDI website at http://www.ngscedi.com to complete and submit the Submitter Action Request Form to reapply for a new Submitter ID or to have your previous Trading Partner/Submitter ID reinstated.

Note for Vendors: Vendor IDs will also be disabled if they are inactive for 90 days and removed from the CEDI system if inactive for 13 months.

New Feature Added to CEDI Website – Important CEDI Events Page

The Common Electronic Data Interchange (CEDI) website now offers an Important CEDI Events page listing CEDI website outages, holiday observances, gateway outages, code updates, and other important CEDI events. The list provides the month, day, and short description of upcoming events, as well as a calendar marking the important dates.

Please check the CEDI website for updates to this page.

CEDI will continue to send out Listserv notices and reminders of these events.

The list is available at http://www.ngscedi.com/events/events.htm.

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

CEDI Enrollment IVR

Common Electronic Data Interchange (CEDI) will be implementing an Interactive Voice Response (IVR) system for CEDI enrollment form status in late May. Status of CEDI enrollment forms will be available on the IVR system 24 hours after the online submission has been made.

To check the status of CEDI enrollment forms, you will need the National Provider Identifier (NPI), Provider Transaction Access Number (PTAN) and the Request ID (RID) located on the printed copy of each enrollment form submitted.

More details will follow as information about the new CEDI enrollment IVR system becomes available.

Implementation of HIPAA Version 005010 MAC Requirements

MLN Matters® Number: MM6472
Related Change Request (CR) #: 6472
Related CR Release Date: June 19, 2009
Related CR Transmittal #: R506OTN
Effective Date: October 1, 2009
Implementation Date: October 5, 2009

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

Provider Action Needed
This article is informational only for providers. It is based on Change Request (CR) 6472 which provides Medicare Administrative Contractors (MACs), and DME MACs, and the DME MACs Common Electronic Data Interchange (CEDI) Contractor with requirements to prepare their systems to process ASC X12 (also known as ANSI ASC X12) version 005010 (both A/B and DME MACs) transactions and National Council for Prescription Drug Programs (NCPDP) version D.0 (only DME) transactions. While CR 6472 requires no action for providers, you may want to review MLN Matters® article SE0904, at http://www.cms.gov/MLNMattersArticles/downloads/SE0904.pdf, for an introductory overview of these HIPAA standards.

Background
The Secretary of the Department of Health and Human Services (DHHS) has adopted Accredited Standards Committee (ASC) X12 version 5010 and National Council for Prescription Drug Programs (NCPDP) version D.0 as the next Health Insurance Portability and Accountability Act (HIPAA) transaction standards for covered entities to exchange HIPAA transactions. The DHHS published the final rule on January 16, 2009, which can be reviewed at http://edocket.access.gpo.gov/2009/pdf/E9-740.pdf on the Internet. The Centers for Medicare & Medicaid Services (CMS) is in the process of implementing this next version of HIPAA transaction standards.

The purpose of Change Request 6472 is to provide the MACs and the DME MACs Common Electronic Data Interchange (CEDI) Contractor with the necessary requirements to prepare their systems to process ASC X12 version 005010 (both A/B and DME MACs) and NCPDP version D.0 (only DME) transactions.

Note: The DHHS has promulgated in the Final Rules provisions which permit dual use of existing standards [*ASC X12 4010A1 and NCPDP 5.1*] and the new standards [*ASC X12 version 5010 and NCPDP version D.0*] from March 17, 2009 (the effective date) until January 1, 2012 (the compliance date) to facilitate testing (subject to trading partner agreement).

Additional Information
The official instruction, CR 6472, issued to your MAC or DME MAC regarding this change may be viewed at http://www.cms.gov/Transmittals/downloads/R506OTN.pdf on the CMS website.

Overpayment Process

There are many circumstances when a supplier may owe Medicare a refund after being paid for a claim. Adjustments to a processed claim may cause the original paid amount to decrease.

- Wrong supplier paid for services
- Beneficiary returns items after the supplier was paid by Medicare
- Billed Medicare in error
- Beneficiary had other insurance that should have paid before Medicare

The department that processes overpayments at NAS is called the Recoupment (RCP) Team. Examiners on this team are responsible for making adjustments to correct claims, sending refund request letters to suppliers and beneficiaries and applying checks refunded to Medicare.

NAS is notified of potential overpayments in various ways:

- Supplier notifies NAS by mail or phone
- Beneficiary notifies NAS by mail
- Redetermination staff requests a recoupment
- Beneficiary was in a Skilled Nursing Facility (SNF)
- Beneficiary was in an episode of Home Heath (HH) care
- Beneficiary was participating in a Managed Care Organization (MCO) [also known as a Health Maintenance Organization (HMO)]

Full Claim Adjustments
If an entire claim was billed incorrectly the entire claim must be denied. When NAS adjusts an entire claim to deny, it is a Full Claim Adjustment. This results in an overpayment that must be refunded to Medicare. When submitting a claim to be fully recouped, the supplier is responsible to provide (at a minimum):

- Supplier number and National Provider Identifier (NPI)
- Beneficiary Health Insurance Claim Number (HICN)

OVERPAYMENTS CONT'D

- Claim Control Number (CCN)
- Date of Service (DOS)
- Reason for the overpayment

Partial Claim Adjustments
If only a portion of a claim needs to be denied (some of the dressings are returned, only one service on a claim was billed in error, the wrong code was billed) then only part of a claim is denied. This is a Partial Claim Adjustment. It is critical to note that if the specific HCPCS and quantity information is not included in the refund notification and the RCP examiner cannot determine which services should be denied, the entire claim could be denied and the supplier will receive a refund request letter for the full amount. The supplier will then need to re-submit the claim to be paid correctly. Submitting a dollar amount to be recouped without HCPCS and quantity information is not acceptable. The following must be included on the Refunds to Medicare form.

- Healthcare Common Procedure Coding System (HCPCS) of the service or supplies in question,
- Quantity(ies)
- Supplier number and NPI
- Beneficiary's HICN
- CCN or DOS
- Reason for the overpayment

Failure to provide this information may lead to delays in processing or a request to resubmit the refund with complete information. CMS requires suppliers to provide this information to the contractors who process overpayments or lose their appeal rights for that particular recoupment.

Refunds to Medicare Form
Use the Refunds to Medicare form to report an overpayment. The form can be mailed or faxed to:

Noridian Administrative Services
PO Box 6727
Fargo ND 58108-6727

Fax: 888-529-3666

APPEALS

Top Ten Redeterminations

The purpose of this article is to assist suppliers with solutions to the top ten redeterminations our Appeals staff received from July 2009 – December 2009.

1. Medical Necessity
These are non-covered services because this is not deemed a "medical necessity" by the payer.

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

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

Suppliers are encouraged to consult the local coverage determination (LCD) and related policy article for medical policy coverage criteria. Suppliers are also encouraged to subscribe to the NAS DME electronic mailing list to receive updates regarding LCDs and policy articles.

2. Maximum Amount Paid
This is the maximum approved amount for this item.

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

3. Certification of Medical Necessity Needed
No Certification of Medical Necessity was received for this equipment.

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

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

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

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

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

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

APPEALS CONT'D

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

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

6. Frequency
Payment denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, this dosage or this day's supply.

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

- Ensure the dates are spanned, if applicable.
- Ensure the number of units are correct. If more units are necessary, proper documentation will need to be on file to support the increased units.

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

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

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

7. Recertification of Medical Necessity Needed
No recertification or revision of medical necessity was received for this equipment.

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

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

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

The most common type of service where this denial is seen is parenteral/enteral nutrition when the nutrition is denied for needing a DIF, In turn the accessories also deny. To minimize these types of denials, send the DIF electronically attached to the initial claim or when calorie changes occur.

9. Noncovered Charges
Noncovered charges.

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

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

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

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

APPEALS CONT'D

- 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.

Medicare Appeals Process Brochure Revised

The revised *Medicare Appeals Process brochure* (January 2010), which 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, is now available in downloadable format from the Centers for Medicare & Medicaid Services **Medicare Learning Network** at http://www.cms.hhs.gov/MLNProducts/downloads/MedicareAppealsProcess.pdf.

REIMBURSEMENT

April 2010 ASP Files Now Available

CMS has posted the April 2010 Average Sales Price (ASP) and Not Otherwise Classified (NOC) pricing files and crosswalks. The ASP pricing files for January 2010, October 2009, July 2009, and April 2009 have also been updated. All are available for download at: http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/ (see left menu for year-specific links).

CODING

Spinal Orthoses – Coding Verification Review Requirement

The **Spinal Orthoses: TLSO and LSO - Policy Article - Effective July 2010** published March 11, 2010, contains revised coding guidelines requiring certain products to be evaluated by the Pricing, Data Analysis, and Coding (PDAC) contractor for proper coding. Coding verification will be required for both prefabricated and custom fabricated products. Products evaluated by the PDAC will be listed on the PDAC Durable Medical Equipment Coding System (DMECS) website at https://www.dmepdac.com/dmecsapp/do/search. Products that do not appear in the DMECS Product Classification List must be coded A9270. These revised requirements are effective for claims with dates of service on or after July 1, 2010.

The Coding Guidelines section of the Policy Article states:

> Effective for claims with dates of service on or after July 1, 2010, the only products that may be billed using codes L0450, L0454-L0472, L0488-L0492, L0625-L0628, L0630, L0631, L0633, L0635, L0637, and L0639 for prefabricated orthoses are those that are specified in the Product Classification List on the Pricing, Data Analysis, and Coding (PDAC) contractor website.
>
> There are two categories of custom fabricated spinal orthoses (codes L0452, L0480-L0486, L0629, L0632, L0634, L0636, L0638, and L0640):
>
> - Orthoses that are custom fabricated by a manufacturer/central fabrication facility and then sent to someone other than the patient. Effective for claims with dates of service on or after July 1, 2010, these items may be billed using one of these codes only if they are listed in the Product Classification List on the PDAC website.
> - Orthoses that are custom fabricated from raw materials and are dispensed directly to the patient by the entity that fabricated the orthosis. These items do not have to be listed on the PDAC website in order to be billed using a custom fabricated spinal orthosis code. However, the supplier must provide a list of the materials that were used and a description of the custom fabrication process on request.
>
> Effective for claims with dates of service on or after July 1, 2010, prefabricated spinal orthoses and spinal orthoses that are custom fabricated by a manufacturer/central fabrication facility which have not received coding verification review from the PDAC must be billed with code A9270.

Refer to the complete Local Coverage Determination and Policy Article for additional information.

CODING CONT'D

Hand-Finger Orthoses (L3923) – Use of CG Modifier

Elastic garments do not meet the statutory definition of a brace. Code L3923 (Hand finger orthosis, without joints, prefabricated) includes both elastic and non-elastic items.

Elastic garments may be made of a variety of materials, including but not limited to neoprene or spandex (elastane, Lycra™). They are considered to be elastic even if they have flexible plastic or metal stays. If a garment made with elastic material has a rigid plastic or metal component, it is considered a nonelastic orthosis for purposes of coverage and coding.

If a hand-finger garment is made primarily of elastic material, it must be billed with code A4466 (Garment, belt, sleeve or other covering elastic or similar stretchable material, any type, each) and not code L3923. Claims billed with code A4466 will be denied as noncovered, no benefit category. Effective for claims with dates of service on or after July 1, 2010, if an L3923 orthosis has a rigid plastic or metal component, the supplier must add the CG modifier (policy criteria applied) to the code. Claims for L3923 billed without a CG modifier will be rejected as incorrect coding.

All products that are currently listed as code L3923 in the DMECS Product Classification List on the Pricing, Data Analysis, and Coding (PDAC) contractor website will be end-dated June 30, 2010. Manufacturers must resubmit a new Coding Verification Review request to the PDAC if they want their product to be listed in DMECS for dates of service on or after July 1, 2010.

Suppliers should contact the PDAC with questions concerning the correct coding of these items.

BILLING

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. – 7 p.m. Saturday and Sunday

Endeavor Overview
The Endeavor Overview is located on the Claims page of the NAS DME website. This page contains:

- User Manual
- Registration information
- Password requirements
- Forms
- FAQs

Before registering, review this page for complete information 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.

Timely Filing Requirements for Medicare FFS 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.

The time period for filing Medicare FFS claims is specified in Sections 1814(a), 1835(a)(1), and 1842(b)(3) of the Social Security Act and in the Code of Federal Regulations (CFR), 42 CFR Section 424.44. Section 6404 of the PPACA amended the timely filing requirements to reduce the maximum time period for submission of all Medicare FFS claims to one calendar year after the date of service.

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.

Section 6404 of the PPACA also permits the Secretary to make certain exceptions to the one-year filing deadline. At this time, no exceptions have been established. However, proposals for exceptions will be specified in future proposed rulemaking.

Please be on the alert for more information pertaining to the *Patient Protection and Affordable Care Act*.

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

MLN Matters Number: MM6421 Revised
Related Change Request (CR) #: 6421
Related CR Release Date: April 24, 2009
Effective Dates: Phase 1 – October 1, 2009
Phase 2 – January 1, 2011
Related CR Transmittal #: R643OTN
Implementation Date: Phase 1 – October 5, 2009
Phase 2 – January 3, 2011

Note: This article was revised on March 30, 2010, to reflect the changes in the release of a new CR on February 26, 2010. The implementation date and effective dates of Phase 2 are changed (see page 3, third bullet). The Transmittal number, CR release date and web address for accessing the CR has also been changed. All other information remains the same.

However, it is extremely important to read MLN Matters® Special Edition article, SE1011, at http://www.cms.gov/MLNMattersArticles/downloads/SE1011.pdf to see important clarifying information regarding this issue.

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

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

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

The providers who can order/refer are:

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

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

Key Points

- **During Phase 1 (October 5, 2009- January 2, 2011)**: If the ordering/referring provider is not on the claim, the claim will not be paid.If the ordering/referring provider is on the claim, Medicare will verify that the ordering/referring provider is in PECOS and is eligible to order/refer in Medicare. **If the ordering/referring provider is not in PECOS or is in PECOS but is not of the type/specialty to order or refer, the claim will continue to process.**
  1. If the DMEPOS supplier claim is an ANSI X12N 837P standard electronic claim, the DMEPOS supplier will receive a warning message on the Common Electronic Data Interchange (CEDI) GenResponse Report.
  2. If the DMEPOS supplier claim is a paper CMS-1500 claim, the DMEPOS supplier will not receive a warning and will not know that the claim did not pass these edits.
- **During Phase 2, (January 3, 2011 and thereafter)**: If the ordering/referring provider is not on the claim, the claim will not be paid. If the ordering/referring provider is on the claim, Medicare will verify that the ordering/referring provider is in PECOS and eligible to order and refer. **If the ordering/referring provider is not in PECOS or is in PECOS but is not of the specialty to order or refer, the claim will not be paid. It will be rejected.**
  1. If the DMEPOS supplier claim is an ANSI X12N 837P standard electronic claim, the DMEPOS supplier will receive a rejection message on the CEDI GenResponse Report.
  2. If the DMEPOS supplier claim is a paper CMS-1500 claim, the DMEPOS supplier will see the rejection indicated on the Remittance Advice.
- In both phases, Medicare will verify the NPI and the name of the ordering/referring provider reported on the ANSI X12N 837P standard electronic claim against PECOS.
- When furnishing names on the paper claims, be sure not to use periods or commas within the name. Hyphenated names are permissible.

- Providers who order or refer may want to verify their enrollment in PECOS. They may do so by accessing Internet-based PECOS at https://pecos.cms.hhs.gov/pecos/login.do on the CMS website. Before using Internet-based PECOS, providers should read the educational material about Internet-based PECOS that is available at http://www.cms.gov/MedicareProviderSupEnroll/04_InternetbasedPECOS.asp on the CMS website. Once at that site, scroll to the downloads section of that page and click on the materials that apply to you and your practice.

Additional Information
The official instruction, CR6421, issued to your Medicare DME MAC regarding this change, may be viewed at http://www.cms.gov/Transmittals/downloads/R643OTN.pdf on the CMS website.

Edits on Ordering/Referring Providers in Medicare Part B Claims

MLN Matters Number: SE1011

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

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

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

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

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

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

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

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

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

Questions and Answers Relating to the Edits

1. **What will the edits do?**

   The edits will determine if the Ordering/Referring Provider (when required to be identified in a Part B claim) (1) has a current Medicare enrollment record (i.e.,

the enrollment record is in PECOS and it contains the National Provider Identifier (NPI)), and (2) is of a type that is eligible to order or refer for Medicare beneficiaries (see list above).

2. **Why did Medicare implement these edits?**

   These edits help protect Medicare beneficiaries and the integrity of the Medicare program.

3. **How and when will these edits be implemented?**

   These edits are being implemented in two phases:

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

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

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

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

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

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

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

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

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

Effect of Edits on Providers

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

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

1. You have a current Medicare enrollment record (that is, your enrollment record is in PECOS and it includes your NPI).
   - If you enrolled in Medicare after 2003, your enrollment record is in PECOS and CMS may have added your NPI to it.
   - If you enrolled in Medicare prior to 2003 but submitted an update(s) to your enrollment information since 2003, your enrollment record is in PECOS and CMS may have added your NPI to it.
   - If you enrolled in Medicare prior to 2003 and have not submitted an update to your Medicare enrollment information in 6 or more years, you do not have an enrollment record in PECOS. **You need to take action to establish one. See the last bullet in this section.**
   - If you are not sure, you may: (1) check the Ordering Referring Report mentioned above, and if you are on that report, you have a current enrollment record in Medicare (that is, your enrollment record is in PECOS and it contains your NPI); (2) contact your designated Medicare enrollment contractor and ask if you have an enrollment record in PECOS that contains the NPI; or (3) use Internet-based PECOS to look for your PECOS enrollment record (if no record is displayed, you do not have an enrollment record in PECOS). If you choose (3), please read the information on the Medicare provider/supplier enrollment web page about Internet-based PECOS before you begin.
     - If you do not have an enrollment record in PECOS:
     - You need to submit an enrollment application to Medicare in one of two ways:

       a. Use Internet-based PECOS to submit your enrollment application over the Internet to your designated Medicare enrollment contractor. You will have to print, sign, and date the Certification Statement and mail the Certification Statement, and any required supporting paper documentation, to your designated Medicare enrollment contractor. The designated enrollment contractor cannot begin working on your application until it has received the signed and dated Certification Statement. If you will be using Internet-based PECOS, please visit the Medicare provider/supplier enrollment web page to

learn more about the web-based system before you attempt to use it. Go to http://www.cms.gov/MedicareProviderSupEnroll, click on "Internet-based PECOS" on the left-hand side, and read the information that has been posted there. Download and read the documents in the Downloads Section on that page that relate to physicians and non-physician practitioners. A link to Internet-based PECOS is included on that web page.

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

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

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

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

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

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

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

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

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

Additional Guidance

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

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

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

Additional Information

You may want to review the following related CRs:

- CR 6417 at http://www.cms.gov/Transmittals/downloads/R642OTN.pdf on the CMS website;
- CR 6421 at http://www.cms.gov/Transmittals/downloads/R643OTN.pdf on the CMS website; and
- CR 6696 at http://www.cms.gov/Transmittals/downloads/R328PI.pdf on the CMS website.

Top Ten Phone and Written Inquiries: January – March

The top ten phone and written inquiries from January – March 2010 are now available in the Frequently Asked Questions (FAQ) database on the Publications page of our website.

The FAQ topics include:

- Same or similar
- Interactive Voice Response (IVR) system
- Beneficiary eligibility
- Health Maintenance Organizations (HMOs)
- Offsets
- Medical necessity
- Coverage criteria
- Appeal status

Top 10 Written Inquiries

Q. When suppliers send written questions to NAS DME, what needs to be included?

A. When sending a general question to NAS, clearly state the question or request. If information is submitted without a specific question or request, the written correspondence staff will send a response indicating the inquiry was incomplete.

If a supplier is requesting information regarding a claim or beneficiary, before sending the request, ensure all pertinent information has been included:

- Provider Transaction Access Number (PTAN)
- National Provider Identifier (NPI)
- Tax Identification Number (TIN)
- Health Insurance Claim Number (HICN)
- Date of birth
- Date of service

Q. What happens if a supplier does not respond to an Additional Development Letter Request?

A. Failure to respond to additional development letter requests within 30 days may result in partial or complete denial of the claim. Documentation received after the timeline will be treated as a general supplier inquiry on a processed claim and will most likely result in the documentation being returned to your office.

We are unable to reprocess a claim without a redetermination request. After receiving the remittance advice and determining the claim has been denied, suppliers may submit a Redetermination Form.

Additional information on the reprocessing of these claims can be found in the Internet Only Manual 100-4 Chapter 34 Section 10.3, Reopening of Denials Based on an Unanswered ADR Request. This manual is available on CMS' website at http://www.cms.gov/Manuals/IOM/list.asp.

Q. Can I just send in correspondence to dme@noridian.com if I don't know where else it should go?

A. Forms and requests must be sent to the correct entity. NAS has been receiving correspondence intended for the National Supplier Clearinghouse (NSC), Common Electronic Data Interchange (CEDI), and other Durable Medical Equipment Medicare Administrative Contractors (DME MACs). Sending inquiries and information to the incorrect entity may cause a delay in processing.

For a list of addresses and phone numbers for these and other entities, as well as links to the other DME MACs' websites, visit the Contact section of our website.

Q. If I need a Certificate of Medical Necessity (CMN) loaded, can I send it to dme@noridian.com?

A. CMNs must be submitted along with the claim for the corresponding DMEPOS item. Requests to manually load CMNs should only be submitted if the CMN is not the most current version of the form or if the supplier is unable to submit electronically. Requests for reasons other than this will be deemed as unprocessable and returned.

BILLING CONT'D

For information regarding the cost of CMN related denials to suppliers and the Medicare Trust Fund and helpful hints on how to avoid CMN related denials, review the article CMN and DIF Denials Cost Suppliers.

Q. How can I subscribe to the Noridian Administrative Services listserv?

A. To subscribe to the NAS email list, which allows you to receive the latest news and information via email, go to the News/Publications section of our website or simply click on Sign-up for the DME Email List.

You can also make changes to an existing account, such as updating your email address, by logging in and selecting the "My Profile" link. For complete instructions on using NAS Medicare Email Lists, review the brochure at: https://www.noridianmedicare.com/dme/news/docs/email_brochure.pdf.

Q. Where do I find the documentation I need to see if my patient qualifies for an E0260 (Hospital Bed)?

A. Suppliers are encouraged to reference the Local Coverage Determinations (LCDs) and Policy Articles for specific coverage criteria.

Refer to the article "Non-Covered Items" for a list of Healthcare Common Procedure Coding System (HCPCS) codes which do not meet the definition of a Medicare benefit or are statutorily excluded.

NAS' website contains many other valuable resources related to benefits, exclusions, coverage criteria, and rules. A brief overview of some of these resources is below:

LCD/Coverage/MR: links to the LCDs, Internet Only Manuals (IOMs), and documentation checklists for various DME and supplies.

Training/Events: links to numerous presentations, created by our Education staff, as well as the online learning center (OLC), and upcoming workshops.

News/Publications: links to the DME Jurisdiction D Supplier Manual, frequently asked questions (FAQ) database, bulletins, and the What's New/Latest Updates.

Q. Where can I find information on how to submit a CMS 1500 Claim Form and other Durable Medical Equipment billing instructions?

A. Submitting a copy of an invoice or returning an education status letter asking NAS to make payment is not the appropriate procedure to receive timely reimbursement. Review Chapter 6 of the DME Jurisdiction D Supplier Manual for information regarding claims submission.

If you bill electronically and need further assistance with claims submission, visit the CEDI website at http://www.ngscedi.com or call them at 1-866-311-9184.

If you are exempt from billing electronically, you may bill using a paper CMS-1500 claim form. Reference the CMS 1500 Claim Form Instructions for assistance in properly completing the form.

Q. How can I order a duplicate remittance advice?

A. On October 30, 2009, an option which allows suppliers to order duplicate remittance advices was added to the interactive voice resonse (IVR) system. Further updates were made to the duplicate remittance advice option in December to increase its efficiency.

All requests for duplicate remittance advices should be made through the IVR. For complete instructions on how to use the IVR to order duplicate remittance advices see the IVR User Guide.

NAS also recommends suppliers download the Medicare Remit Easy Print (MREP) software, which is offered free of charge to read and print Health Insurance Portability and Accountability Act (HIPAA) compliant electronic remittance advices (ERAs).

The software is updated annually along with three additional updates to implement the claim adjustment reason code and remittance advice remark code (CARC and RARC) changes and allows the supplier to:

- Print ERAs in the standard paper remittance (SPR) format; and
- Print and export reports about ERAs including denied, adjusted and deductible applied claims.

For additional information on downloading MREP, contact the CEDI Help Desk.

E-mail: NGS.CEDIHelpdesk@wellpoint.com
Phone: 866-311-9184
website: http://www.ngscedi.com/

Many electronic claim billing software programs have a feature, which will allow an ERA to be received electronically, printed and/or posted to each beneficiary's account. Contact your software vendor for the availability of these features.

CEDI only keeps a copy of the remittance advice for 45 days. Ensure you pull the remittance advices timely from your electronic mailbox.

Q. How can I find if my patient has something same and similar to an E0143 (walker)?

A. Same and Similar can be checked by pressing/speaking option number five on the Interactive Voice Response (IVR). Once you are authenticated, you can speak the code and modifier you wish to check Same and Similar on.

Q. If I disagree with a claim denial, what is my next step?

A. Before submitting a redetermination, be sure to review the claim to determine if the denial requires substantiating information from the patient's medical record and was afforded appeal rights. If the claim meets these criteria, you may submit a redetermination request. We suggest using the interactive DME Inquiry/Redetermination form.

Be sure to provide all pertinent information and sign the form before submitting it for processing. Failure to do so may result in your request being returned as unprocessable.

The completed form and documentation may be returned to the address below or faxed to 1-888-408-7405.

Medicare DME
Attn: Claims Inquiries/Redeterminations
PO Box 6727
Fargo ND 58108-6727

If the claim does not require substantiating documentation but was afforded appeal rights, a reopening may be appropriate. Review the article "What Can and Cannot Be Done as a Reopening - Clarification" for further information.

If the claim was not afforded appeal rights, corrections must be made and a new claim submitted.

Note: The remark codes found on your remittance advice will indicate whether the claim has been afforded appeal rights. For help understanding your remittance advice, please reference the remittance advice guide available on CMS' website at http://www.cms.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf. Remittance advice remark codes and definitions can also be found on the Washington Publishing Company's website.

Claim Submission FAQs

FAQs on claim submission are now available on the Publications page of our website in the FAQ database. These FAQs review the PECOS requirements, invalid HCPCS codes and modifiers, National Provider Identifiers (NPIs)/crosswalks, submitting diagnosis codes, and more.

Q. Are resources available for suppliers to identify if an ordering/referring physician is eligible to order and/or refer their patients to receive Medicare DMEPOS because they have been enrolled in the Medicare Part A and Part B Provider Enrollment and Change in Ownership System (PECOS)? (New April 2010)

A. Yes. NAS' Interactive Voice Recognition (IVR) allows suppliers to enter the National Provider Identifier (NPI), first initial and last name of the ordering/referring physician and will notify the supplier if the individual has been enrolled in PECOS and, therefore, is eligible to order/refer patients for DMEPOS. Additionally, the CMS offers a downloadable file from their website: http://www.cms.gov/MedicareProviderSupEnroll - click on "Ordering/Referring Report" on the left-hand side.

Q. How can a supplier avoid denials for a procedure code, modifier, or procedure code and modifier combination being invalid?

A. There are multiple efforts that can be done to avoid denials associated with invalid HCPCS and modifier combination submission.

- Verify the first position of the HCPCS does not contain a space.
- Check the validity of the procedure code/modifier combination by using the Pricing, Data Analysis and Coding (PDAC) website https://www.dmepdac.com/.
- Check the Local Coverage Determination (LCD) for guidelines on procedure codes and modifier usage for that LCD.
- Reference the supplier manual at the DME MAC Jurisdiction(s).
- Contact the NAS DME Jurisdiction D Contact , 1-866-243-7272

Q. How can a supplier ensure their billing Employer Identification Number (EIN)/Social Security Number (SSN) matches the NPI on file with the DME and National Supplier Clearinghouse (NSC)?

A. To ensure the EIN/SSN submitted matches what is on file with the DME MAC or the NSC, a supplier should verify the information entered on the National Plan and Provider Enumeration System (NPPES) website matches what is being submitted. The NPPES website can be accessed at https://nppes.cms.hhs.gov/NPPES/StaticForward.do?forward=static.npistart.

Q. What can be done if a claim is rejected indicating the billing NPI is not on the crosswalk?

A. The edit C003 indicates there is no link between the NPI that was submitted and a Provider Transaction Access Number (PTAN)/NSC. Verify the PTAN/NSC has been entered on the NPPES website as Medicare NSC and/or the supplier's information at NPPES and the NSC has the same information to create a match. The following information needs to be verified:

For Individuals:

- The SSN and PTAN/NSC number entered with NPPES must match the SSN and PTAN/NSC number on file with the NSC.
- If a match cannot be found, the SSN and **Practice Address** ZIP Code at NPPES must match the SSN and **Practice Address** ZIP Code at the NSC.
- If the second match cannot be found, an active crosswalk record will not be created.

For Organizations:

- The EIN, PTAN/NSC and Practice Address ZIP Code at NPPES must match the EIN, PTAN/NSC and Practice Address ZIP Code at the NSC.
- If the match cannot be found, an active crosswalk record will not be created.
- The NPPES website can be accessed at: https://nppes.cms.hhs.gov/NPPES/StaticForward.do?forward=static.npistart

Q. What is the correct way to submit a diagnosis code? (New April 2010)

A. Submit the diagnosis code to the highest level of specificity according to the ICD-9-CM book within Item 21 of the CMS 1500-Claim Form or electronic equivalent. Do not re-enter this diagnosis code in Item 24E. Instead, refer back to the field in Item 21 that contained the most applicable, primary diagnosis for which the DMEPOS was provided.

The most common errors surrounding diagnosis code submission is the re-entry of the diagnosis code in Item 24E and/or references to more than a single diagnosis line for the item billed. Specific diagnosis guidelines for electronic

submitters has been previously published, https://www.noridianmedicare.com/dme/news/docs/2009/12_dec/avoid_diagnosis_code_cedi_rejections.html.

Q. How can claim denials for the subscriber primary ID being invalid be avoided?

A. When a claim is denied by CEDI with the code C044, it means the patient's Medicare Health Insurance Claim Number (HICN) is invalid. Verify the number on the patient's red, white, and blue Medicare card matches what is being submitted. The patient may need to contact the Social Security Administration if there has been a change and a new Medicare card is needed.

Q. Why are claims denied by CEDI "C171, Capped Rental - Modifier Missing?"

A. The item (whether for purchase or rental) is classified as a Capped Rental Item (or possibly a Pen Pump Item), and the required KH, KI, or KJ modifier (whichever is appropriate) was not submitted.

For more information regarding the Front-end edits, please review the CEDI Front End Report Manual located on the CEDI website at the following link http://www.ngscedi.com/outreach_materials/outreachindex.htm.

Q. What causes a claim to be denied by the CEDI with the code/message, "C143, Ordering Provider ID Qualifier Invalid?"

A. This edit will be received if either the ordering provider NPI was not sent or the ordering provider's NPI was sent on a charge line. Verify that the ordering provider's NPI is being sent on every charge line of the patient's claim.

Q. What causes the CEDI claim rejection "C180, Service Date Greater than Receipt Date?"

A. With date spans frequently submitted, it is important to pay close attention to the "from" and "through" month, day, and year of the item being billed.

Q. What corrective actions can be taken to avoid errors for "B108, Billing provider not authorized for submitter."

A. The NPI submitted is not linked to the Submitter ID under which the claim file was sent to CEDI. If this error is received, the supplier must complete and sign the appropriate form on the CEDI website (http://www.ngscedi.com) and return to CEDI for processing. Suppliers who use a third party (e.g. a clearinghouse or billing service) must complete the Supplier Authorization Form. Suppliers who submit their own claims and do not use a third party biller must complete the CMS EDI Enrollment Agreement.

Reasonable Useful Lifetime Reminder

Suppliers are reminded that the reasonable useful lifetime of durable medical equipment is determined through program instructions. In the absence of program instructions, carriers may determine the reasonable useful lifetime of equipment, but in no case can it be less than five years or eight years for enteral and parenteral pumps. Computation of the useful lifetime is based on when the equipment is delivered to the beneficiary, not the age of the equipment. **Replacement due to wear is not covered during the reasonable useful lifetime of the equipment. During the reasonable useful lifetime, Medicare does cover repair up to the cost of replacement** (but not actual replacement) for medically necessary equipment owned by the beneficiary.

Equipment which the beneficiary owns or is a capped rental item may be replaced when less than five years old **only** in cases of loss, i.e., theft or irreparable damage. Irreparable damage refers to a specific accident or to a natural disaster, e.g., fire, flood, etc.

Payment may be made for the replacement of a prosthetic device that is an artificial limb, or replacement part of a device if the ordering physician determines that the replacement device or part is necessary because of any of the following:

1. A change in the physiological condition of the patient;
2. An irreparable change in the condition of the device, or in a part of the device; or
3. The condition of the device, or the part of the device, requires repairs and the cost of such repairs would be more than 60 percent of the cost of a replacement device, or, as the case may be, of the part being replaced.

Sources: Medicare Benefit Policy Manual, 100-02, Chapter 15, Sections 110.2 and 120

Medicare Claims Processing Manual, 100-04, Chapter 20, Section 50.3

Supplier Manual, Chapter 5

Billing Information - Oral Appliances for Obstructive Sleep Apnea

Many providers of Oral Appliances for Obstructive Sleep Apnea (OAOSA) items are not traditional DME suppliers, coming instead from the medical and dental communities. Reimbursement policy for DME often differs from the billing for E&M services or medical and surgical procedures. This article will review some key elements about billing for OAOSA. Please note that this is not intended as an exhaustive discussion of all DME billing requirements.

Medicare provides reimbursement for OAOSA (E0485, E0486) under the Durable Medical Equipment (DME) Benefit. This means that, in order to bill for these items, a provider must enroll as a Medicare DME Supplier. Claims for these items must be submitted to the DME Medicare Administrative Contractor (MAC). Do not submit claims to a Part B carrier or to an A/B MAC. Information about enrolling as a DME Supplier is available from the National Supplier Clearinghouse at, http://www.palmettogba.com/nsc or by calling (866) 238-9652.

Billing for OAOSA items is all-inclusive, once the decision has been made to provide the device. Reimbursement for these items includes all time, labor, materials, professional services, and radiology and lab costs necessary to provide and fit the device. It also includes all costs associated with follow-up, fitting, and any adjustments after the item is provided.

Some evaluation and management (E&M) services may be separately billable. Contact your Medicare Part B carrier or A/B MAC for information.

For OAOSA (E0485, E0486), the unit of service is for the entire, complete item. Some items have multiple components. Each component is not separately billable. For example, billing E0486 (2 units) for a 2-piece appliance, top and bottom and E0486 (1 unit) for the piece that holds the tongue back, for a total of 3 units of service is not correct. One unit of service should be billed for the entire device, inclusive of all components.

Selection of the correct HCPCS code is important. The essential difference between the codes is that E0485 is for a prefabricated item while E0486 is custom fabricated. The code narrative for E0485 is:

> E0485 ORAL DEVICE/APPLIANCE USED TO REDUCE UPPER AIRWAY COLLAPSIBILITY, ADJUSTABLE OR NON-ADJUSTABLE, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT

A prefabricated device is defined as one that may be trimmed, bent, molded (with or without heat), or otherwise modified for use by a specific patient i.e., custom fitted. An OAOSA that is assembled from prefabricated components is considered prefabricated. Any device that does not meet the definition of a custom-fabricated item is considered prefabricated.

The code narrative for E0486 is:

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

A custom-fabricated OAOSA is defined as one that is individually made for a specific patient (no other patient would be able to use this item) starting with basic materials. It involves substantial work to produce, usually by a specialized lab. It may involve the incorporation of some prefabricated components. It involves more than trimming, bending, or making other modifications to a substantially prefabricated item.

For additional information on Medicare billing requirements for DME items, refer to the Supplier Manual which can be found on each DME MAC website.

Indian Health Services – Patient Protection and Affordable Care Act

Several announcements related to the Patient Protection and Affordable Care Act (PPACA) were made, including information on Please find below several announcements related to the Patient Protection and Affordable Care Act (PPACA), including information on Continuation of Payments to Indian Health Service (IHS) Providers, Suppliers, Physicians, and other Practitioners for Certain Part B Services.

Continuation of Payments to IHS Providers, Suppliers, Physicians, and Other Practitioners for Certain Part B Services

Section 630 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) allowed IHS facilities to bill for other Part B services, which were not previously covered under Section 1848 of the Act, and expanded the scope of items and services for which payment would be made to IHS providers, suppliers, physicians, and other practitioners for a 5-year period beginning January 1, 2005. Section 630 expired on December 31, 2009.

On March 23, 2010, President Obama signed into law the *Patient Protection and Affordable Care Act*. Section 2902 of the new law permanently extends Section 630 of the MMA, retroactive to January 1, 2010. The specific Part B services involved are:

- Ambulance services;
- Clinical laboratory services;
- Part B drugs processed by the J4 A/B Medicare Administrative Contractor (MAC) and the Durable Medical Equipment MACs;
- Influenza and pneumonia vaccinations;
- Durable medical equipment;
- Therapeutic shoes;
- Prosthetics and orthotics;
- Surgical dressings, splints and casts; and
- Screening and preventive services not covered prior to the implementation of
- Section 630 of the MMA.

Indian Health Service providers, suppliers, physicians and other practitioners should contact their Medicare Administrative Contractor for further guidance regarding IHS claims affected by the new law, for dates of service January 1, 2010, and after, that have been denied.

Note: It will take approximately two weeks from the date that you receive this message for contractors to update their systems to be able to pay correctly for these services. You may want to wait until the claims processing system is updated before submitting any new claims containing IHS services.

Reporting Beneficiary's Residence State Code and ZIP Code for DMEPOS Claims

MLN Matters® Number: MM6359
Related Change Request (CR) #: 6359
Related CR Release Date: February 5, 2010
Related CR Transmittal #: R634OTN
Effective Date: July 1, 2010
Implementation Date: July 6, 2010

Provider Types Affected

This article is for suppliers submitting claims to Durable Medical Equipment Medicare Administrative Contractors (DME MACs)) for DMEPOS services provided to Medicare beneficiaries.

Provider Action Needed
This article is based on change request (CR) 6359 which states that, effective for claims processed on July 6, 2010 and later, the ZIP Code of the beneficiary's address of residence should be reported on the claim. Make certain your billing staffs are aware of this requirement.

Background
Currently, the Centers for Medicare & Medicaid Services (CMS) uses the beneficiary's address of residence to determine the applicable fee schedule amount for claims for DMEPOS items. When National Competitive Bidding (NCB) is fully implemented, the ZIP code of the beneficiary's address of residence, as reported on the claim, will also be used in pricing DMEPOS claims. If the beneficiary's ZIP code information is not available on the claim, the DME MACs will deny the claim using a reason code of 16 (Claims/Service lacks information which is needed for adjudication.) and remark code MA37 (Missing/incomplete/invalid patient's address).

Additional Information
The official instruction, CR6359, issued to your DME MAC regarding this change may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R634OTN.pdf on the CMS website.

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 652	Date: March 17, 2010
	Change Request 6712

Transmittal 617, dated January 8, 2010, is being rescinded and replaced with Transmittal 652, dated March 17, 2010. This change request (1) clarifies the reference to the manual section authorizing MUEs, and (2) clarifies the name of files for the final DME list of MUEs, and provides the denial reason code to be used for MUE denials.

SUBJECT: Medically Unlikely Edits (MUEs)

I. SUMMARY OF CHANGES: CMS developed the MUE program to reduce the paid claims error rate for Medicare claims. MUEs are designed to reduce errors due to clerical entries and incorrect coding based on anatomic considerations, HCPCS/CPT code descriptors, CPT coding instructions, established CMS policies, nature of a service/procedure, nature of an analyte, nature of equipment, prescribing information, and unlikely clinical diagnostic or therapeutic services.

As clarification, an MUE is a unit of service (UOS) edit for a HCPCS/CPT code for services that a single provider/supplier rendered to a single beneficiary on the same date of service. The ideal MUE is the maximum UOS that would be reported for a HCPCS/CPT code on the vast majority of appropriately reported claims. Note that the MUE program provides a method to report medically reasonable and necessary UOS in excess of an MUE.

This CR provides updates and clarifications to MUE requirements established in 2006.

NEW / REVISED MATERIAL
EFFECTIVE DATE: APRIL 1, 2010
IMPLEMENTATION DATE: APRIL 5, 2010

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	

III. FUNDING:

SECTION A: For Fiscal Intermediaries and Carriers:
No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

SECTION B: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the contracting officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the contracting officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

One-Time Notification

Unless otherwise specified, the effective date is the date of service.

Attachment – One-Time Notification

Pub. 100-20	Transmittal: 652	Date: March 17, 2010	Change Request 6712

Transmittal 617, dated January 8, 2010, is being rescinded and replaced with Transmittal 652, dated March 17, 2010. This change request (1) clarifies the reference to the manual section authorizing MUEs, and (2) clarifies the name of files for the final DME list of MUEs, and provides the denial reason code to be used for MUE denials.

SUBJECT: Medically Unlikely Edits (MUEs)

EFFECTIVE DATE: APRIL 1, 2010
IMPLEMENTATION DATE: APRIL 5, 2010

I. GENERAL INFORMATION:

A. Background: CMS developed the MUE program to reduce the paid claims error rate for Medicare claims. MUEs are designed to reduce errors due to clerical entries and incorrect coding based on anatomic considerations, HCPCS/CPT code descriptors, CPT coding instructions, established CMS policies, nature of a service/procedure, nature of an analyte, nature of equipment, prescribing information, and unlikely clinical diagnostic or therapeutic services.

As clarification, an MUE is a unit of service (UOS) edit for a HCPCS/CPT code for services that a single provider/supplier rendered to a single beneficiary on the same date of service. The ideal MUE is the maximum UOS that would be reported for a HCPCS/CPT code on the vast majority of appropriately reported claims. Note that the MUE program provides a method to report medically likely UOS in excess of an MUE.

Further, all CMS claims processing contractors (including contractors using the Fiscal Intermediary Shared System (FISS)) shall adjudicate MUEs against each line of a claim rather than the entire claim. Thus, if a HCPCS/CPT code is changed on more than one line of a claim by using CPT modifiers, the claims processing system separately adjudicates each line with that code against the MUE.

In addition, fiscal intermediaries (FIs), carriers and Medicare Administrative Contractors (MACs) processing claims shall deny the entire claim line if the units of service on the claim line exceed the MUE for the HCPCS/CPT code on the claim line. Since claim lines are denied, the denial may be appealed.

Since each line of a claim is adjudicated separately against the MUE of the code on that line, the appropriate use of CPT modifiers to report the same code on separate lines of a claim will enable a provider/supplier to report medically reasonable and necessary units of service in excess of an MUE. CPT modifiers such as 76 (repeat procedure by same physician), 77 (repeat procedure by another physician), anatomic modifiers (e.g., RT, LT, F1, F2), 91 (repeat clinical diagnostic laboratory test), and 59 (distinct procedural service), will accomplish this purpose. Providers/suppliers should use Modifier 59 only if no other modifier describes the service.

On or about October 1, 2008, CMS announced that it would publish at the start of each calendar quarter the majority of active MUEs and post them on the MUE Webpage at "http://www.cms.hhs.gov/NationalCorrectCodInitEd/08_MUE.asp#TopOfPage."

Note that, at the onset of the MUE program, all MUE values were confidential, and for use only by CMS and CMS contractors. Since October 1, 2008, CMS has published most MUE values at the start of each calendar quarter. However, some MUE values are not published and continue to be confidential information for use by CMS and CMS contractors only. The confidential MUE values shall not be shared with providers/suppliers or other parties outside the CMS contractor's organization. The files referenced in the business requirements of this CR contain both published and unpublished MUE values. In the MUE files each HCPCS code has an associated "Publication Indicator". A Publication Indicator of "0" indicates that the MUE value for that code is confidential, is not in the CMS official publication of the MUE values, and should not be shared with providers/suppliers or other parties outside the CMS contractor's organization. A Publication Indicator of "1" indicates that the MUE value for that code is published and may be shared with other parties.

The full set of MUEs is available for the CMS contractors only via the Baltimore data center (BDC). A test file will be available about 2 months before the beginning of each quarter, and the final file will be available about 6 weeks before the beginning of each quarter. Note that MUE file updates are a full replacement. The MUE adds, deletes, and changes lists will be available about 5 weeks before the beginning of each quarter.

This CR provides updates and clarifications to MUE requirements established in 2006.

B. Policy: The NCCI contractor produces a table of MUEs. The table contains ASCII text and consists of six columns (Refer to Appendix 1 – Tabular Presentation of the Format for the MUE Transmission). There are three format charts, one for contractors using the Medicare Carrier System (MCS), one for contractors using the VIPS Medicare System (VMS) system, and one for the contractors using the FISS system.

Contractors shall apply MUEs to claims with a date of service on or after the beginning effective date of an edit and before or on the ending effective date.

Further, CMS is setting MUEs to auto-deny the claim line item with units of service in excess of the value in column 2 of the MUE table. Pub. 100-08, PIM, chapter 3, section **3.**5.1, indicates that automated review is acceptable for medically unlikely cases and apparent typographical errors.

The CMS will set the units of service for each MUE high enough to allow for medically likely daily frequencies of services provided in most settings.

Since claim lines are denied, denials may be appealed.

Appeals shall be submitted to local contractors not the MUE contractor, Correct Coding Solutions, LLC.

Note that, quarterly, the NCCI contractor will provide files to CMS with a revised table of MUEs and contractors will download via the Network Data Mover.

Furthermore, if Medicare contractors identify questions or concerns regarding the MUEs, they shall bring those concerns to the attention of the NCCI contractor. The NCCI contractor may refer those concerns to CMS, and CMS may act to change the MUE limits after reviewing the issues and/or upon reviewing data and information concerning MUE claim appeals.

Finally, a denial of services due to an MUE is a coding denial, not a medical necessity denial. A provider/supplier shall not issue an Advance Beneficiary Notice of Noncoverage (ABN) in connection with services denied due to an MUE and cannot bill the beneficiary for units of service denied based on an MUE.

The denied units of service shall be a provider/supplier liability.

The CMS will distribute the MUEs as a separate file for each shared system when the quarterly NCCI edits are distributed.

II. BUSINESS REQUIREMENTS

Number	Requirement	A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6712.1	The shared systems maintainers shall develop a line level edit to deny the entire line on the claim when the units of service are in excess of the MUE value. FISS is not checked because FISS provides the capability for contractors to return the claim to the provider (RTP) or deny the line item that contain units that exceed the MUE. MCS and VMS are not checked because the MCS and VMS systems already meet this requirement.	X		X	X						
6712.1.1	Since contractors that use the FISS have the ability to either return the claim to the provider or deny the claim line, those contractors shall deny the line item.	X		X							

Number	Requirement	A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6712.1.2	Currently Part A contractors RTP claims that hit the MUE edit (reason code 31715). BR 6712.1, will deny the lines of service based on MUE table and the claim dates of service effective 040110. The current MUE edit (reason code 31715) shall have a term date of March 31, 2010 to stop editing when CR 6712 becomes effective.						X				
6712.1.2.1	MACs shall change the status and location of reason code 31715 from T (RTP claims) to a D (deny claims) for claims processed on and after April 1, 2010.	X		X							
6712.1.3	The shared system maintainers shall design the module to accept updates to MUEs using the format in Appendix 1.						X	X	X		
6712.1.4	The shared system maintainers shall expand the size of the maximum units (see Appendix 1) from two (size in the current MUE module) to five.						X	X	X		
6712.2	The shared system maintainer shall allow for the retention of the five most recent unit values for each MUE.						X	X	X		
6712.2.1	The shared system maintainer shall allow for all five values to be active at the same time.						X	X	X		
6712.2.2	The MUE values shall be distinguishable by the begin and end dates for each value. VMS is not checked because the VMS system already meets this requirement.						X	X			
6712.3	The shared system module shall calculate units of service for a service provided over a period of time greater than 1 day as a per day number rounded to the nearest whole number.						X				

Number	Requirement	A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	MCS and VMS are not checked because the MCS and VMS systems already meet this requirement.										
6712.3.1	For each day in the period, the shared systems shall deny the entire claim line when the units of service for the claim line is greater than the units of service stated in the file. This BR does not apply to the FISS system because the FISS system only allows one date of service per line. MCS and VMS are not checked because the MCS and VMS systems already meet this requirement.	X		X	X						
6712.3.1.1	Since contractors that use the FISS have the ability to either return the claim to the provider or deny the claim line, those contractors shall deny the line item.	X		X							
6712.4	The shared system module shall apply MUEs after all other edits and audits have completed and before the claim is sent to CWF. MCS and VMS are not checked because the MCS and VMS systems already meet this requirement.						X				
6712.5	Data centers (Enterprise Data Centers [EDCs] or contractor data centers [CDCs]) shall install the MUE shared system module developed for this CR in time for the implementation date of this CR.	X	X	X	X	X					EDCs AND CDCs
6712.6	Contractors shall insure that the MUE shared system module developed in business requirement 6712.1, begins to operate in time so that the entire claims line is denied when the units of service are in excess of the MUE value.	X	X	X	X	X					

Number	Requirement	A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6712.7	Medicare contractors shall afford physicians, suppliers, facilities and beneficiaries appeal rights under the Medicare claims appeal process (See Pub 100-4, CPM, chapter 29.)	X	X	X	X	X					
6712.8	Medicare contractors shall refer any request to modify the MUE value for a specific code to: National Correct Coding Initiative Correct Coding Solutions, LLC P.O. Box 907, Carmel, IN 46082-0907	X	X	X	X	X					
6712.8.1	Upon the review of appropriate reconsideration documents provided by a national organization/provider, CMS' data and other CMS resources, the NCCI/MUE Contractor will consult with the CMS MUE Workgroup and a decision shall be made by CMS whether or not to modify the MUE.										NCCI/ MUE Contrac-tor an d CMS /MUE Work-group
6712.9	Beginning on the implementation date for this CR, Medicare contractors shall apply MUEs to claims and adjustments with dates of service on or after the beginning effective date of the MUE and on or before the ending effective date of the MUE. VMS is not checked because the VMS system already meets this requirement.	X	X	X	X	X	X	X			
6712.9.1	Shared system maintainers shall continue to insure that MUEs are applied based on date of service. CMS has noted that all shared systems maintainer currently provide this capability.						X	X	X		
6712.10	Contractors shall begin denying the entire claim line when the units of service on that line are in excess of the	X	X	X	X	X					

Number	Requirement	A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	MUE value and assign MSN message # 15.6, ANSI reason code **151**, group code CO (contractual obligation), and remark codes # N362 and MA01 to claims that fail the MUEs.										
6712.11	Medicare contractors shall classify MUEs as PIMR activity code 21001I in PIMR and activity code 11205 in CAFM.	X	X	X	X	X	X				
6712.12	The filenames to access for the carriers and the FIs are: Test File: MU00.@BF12372.MUE.CARR.TEST02.V* MU00.@BF12372.MUE.FI.TEST02.V* MU00.@BF12372.MUE.DME.TEST02.V* Final File: MU00.@BF12372.MUE.CARR.FINAL01.V* MU00.@BF12372.MUE.FI.FINAL01.V* MU00.@BF12372.MUE.DME.FINAL01.V* Where "*" indicates current generation number for all files **except MU00.@BF12372.MUE.DME. FINAL01. *. For MU00.@BF12372.MUE. DME.FINAL01.V*, "*" indicates version number – MU00.@BF12372.MUE.DME. FINAL01.V* are flat files.**	X	X	X	X	X	X	X	X		BDC, EDC, and CDCs
6712.13	Contractors shall classify MUE denials as coding denials, not as medical necessity denials.	X	X	X	X	X					
6712.13.1	A provider shall not use an Advanced Beneficary Notice (ABN) to seek payment from a patient for UOS denied due to an MUE.	X	X	X	X	X					Providers
6712.13.2	The MUE denials shall have "provider liability."	X	X	X	X	X					
6712.13.3	The MUE denials cannot be waived	X	X	X	X	X					

Number	Requirement	A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	nor subject to an ABN.										
6712.14	Contractors may process claim service lines that exceed MUE limits and also contain a 55 modifier in a manner such that the MUE audit will not systematically deny the service line.	X		X	X	X		X			
6712.14.1	At contractor discretion, contractors may determine that these services must be suspended for contractor review and input.	X		X	X	X		X			
6712.15	Contractors shall refer providers to the website: "http://www.cms.hhs.gov/National CorrectCodInitEd/08_MUE.asp#TopOfPage" for current information on the MUE program.	X	X	X	X	X					

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
6712.16	Contractors shall post this entire instruction, or a direct link to this instruction, on their websites and include information about it in a listserv message within 1 week of the release of this instruction. In addition, the entire instruction must be included in the contractors next regularly scheduled bulletin. Contractors are free to supplement it with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X	X	X	X	X	X					

IV. SUPPORTING INFORMATION

A. For any recommendations and supporting information associated with listed requirements, use the box below:

X-Ref Requirement Number	Recommendations or other supporting information:
	None

B. For all other recommendations and supporting information, use the space below:
N/A

V. CONTACTS

Pre-Implementation Contact(s): John Stewart (410) 786-1189, John.Stewart@CMS.HHS.GOV, Val Allen (410) 786-7443 valeria.allen@cms.hhs.gov

Post-Implementation contact(s): John Stewart (410) 786-1189 John.Stewart@CMS.HHS.GOV, Val Allen (410) 786-7443 valeria.allen@cms.hhs.gov

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers*:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: *For Medicare Administrative Contractors (MACs)*:

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the contracting officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the contracting officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

Attachment

APPENDIX 1
TABULAR PRESENTATION OF THE FORMAT FOR THE MUE TRANSMISSION

Below are layouts for each of the shared systems. A description of each column on the layouts is provided below. Note that all layouts are the same.

The first column contains HCPCS codes (5 positions). The second column of the first format chart contains the maximum units of service A/B MACs and Medicare fiscal intermediaries shall allow per claim line per day for the HCPCS code in column one (5 positions with no decimal places). The second column of the second format chart contains the maximum units of service A/B MACs and Medicare carriers shall allow per claim line per day for the HCPCS code in column one (5 positions with no decimal places). The second column of the third format chart contains the maximum units of service DME MACs shall allow per claim line per day for the HCPCS code in column one (5 positions with no decimal places). The third column is the Corresponding Language Example Identification (CLEID) Number (12 positions including a decimal point). The CLEID information is for reference only. The fourth column states the beginning effective date for the edit (7 positions in YYYYDDD format), and the fifth column states the ending effective date of the edit (7 positions in YYYYDDD format). For example, April 1, 2007, is recorded as 2007091 meaning the 91st day of 2007. The fifth column will remain blank until an ending effective date is determined. The last column indicates whether CMS will publish the MUE units on the CMS website: "http://www.cms.hhs.gov/NationalCorrectCodInitEd/08_MUE.asp#TopOfPage." A "1" indicates that CMS will publish the MUE units on the CMS website.

FORMAT FOR CLAIMS PROCESSED USING THE FISS SYSTEM

HCPCS CODE	MAXIMUM MAC/FI UNITS	CLEID #	BEGINNING EFFECTIVE DATE	ENDING EFFECTIVE DATE	PUBLICATION INDICATOR
AAAAA	XXXXX	AA.AAAAAAAAA	YYYYDDD	YYYYDDD	0=NO 1=YES
AAAAA	XXXXX	AA.AAAAAAAAA	YYYYDDD	YYYYDDD	0=NO 1=YES
AAAAA	XXXXX	AA.AAAAAAAAA	YYYYDDD	YYYYDDD	0=NO 1=YES

DEFINITIONS:

DATES

A = ALPHANUMERIC CHARACTER

X = NUMERIC CHARACTER
YYYYXXX = JULIAN DATE

PUBLICATION INDICATOR
NO = CMS WILL NOT PUBLISH -- DO NOT SHARE
YES = CMS WILL PUBLISH -- OK TO SHARE

FORMAT FOR CLAIMS PROCESSED USING THE MCS SYSTEM

HCPCS CODE	MAXIMUM MAC/CARRIER UNITS	CLEID #	BEGINNING EFFECTIVE DATE	ENDING EFFECTIVE DATE	PUBLICATION INDICATOR
AAAAA	XXXXX	AA.AAAAAAAAA	YYYYDDD	YYYYDDD	0=NO 1=YES
AAAAA	XXXXX	AA.AAAAAAAAA	YYYYDDD	YYYYDDD	0=NO 1=YES
AAAAA	XXXXX	AA.AAAAAAAAA	YYYYDDD	YYYYDDD	0=NO 1=YES

DEFINITIONS:

DATES
A = ALPHANUMERIC CHARACTER
X = NUMERIC CHARACTER
YYYYXXX = JULIAN DATE

PUBLICATON INDICATOR
NO = CMS WILL NOT PUBLISH -- DO NOT SHARE
YES = CMS WILL PUBLISH -- OK TO SHARE

FORMAT FOR CLAIMS PROCESSED USING THE VMS SYSTEM

HCPCS CODE	MAXIMUM DME MAC UNITS	CLEID #	BEGINNING EFFECTIVE DATE	ENDING EFFECTIVE DATE	PUBLICATION INDICATOR
AAAAA	XXXXX	AA.AAAAAAAAA	YYYYDDD	YYYYDDD	0=NO 1=YES
AAAAA	XXXXX	AA.AAAAAAAAA	YYYYDDD	YYYYDDD	0=NO 1=YES
AAAAA	XXXXX	AA.AAAAAAAAA	YYYYDDD	YYYYDDD	0=NO 1=YES

DEFINITIONS:

DATES

A = ALPHANUMERIC CHARACTER
X = NUMERIC CHARACTER
YYYYXXX = JULIAN DATE

PUBLICATON INDICATOR

NO = CMS WILL NOT PUBLISH -- DO NOT SHARE
YES = CMS WILL PUBLISH -- OK TO SHARE

Claim Status Category Code and Claim Status Code Update

MLN Matters® Number: MM6859
Related Change Request (CR) #: 6859
Related CR Release Date: March 26, 2010
Related CR Transmittal #: R1936CP
Effective Date: July 1, 2010
Implementation Date: July 6, 2010

Provider Types Affected
All physicians, providers and suppliers submitting claims to Medicare contractors (fiscal intermediaries (FI), Regional Home Health Intermediaries (RHHI), carriers, 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 CR6859, 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 were updated during the January 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 the Internet on or about March 1, 2010. At the January 2010 meeting, the committee also decided to allow the industry 6 months for implementation of newly added or changed codes. Included in the code lists are specific details, including the date when a code was added, changed, or deleted. Medicare contractors will implement these changes on July 6, 2010. All providers should ensure that their billing staffs are aware of the updated codes and the timeframe for implementation.

Background
The Health Insurance Portability and Accountability Act requires all health care benefit payers to use only Claim Status Category Codes and Claim Status Codes approved by the national Code Maintenance Committee in the X12 276/277 Health Care Claim Status Request and Response format adopted as the standard for national use (004010X093A1). 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, (CR6859), issued to your Medicare contractor regarding this change may be viewed at http://www.cms.gov/Transmittals/downloads/R1936CP.pdf on the CMS website.

Guidance on Implementing System Edits for Certain DMEPOS

MLN Matters® Number: MM6566
Related Change Request (CR) #: 6566
Related CR Release Date: April 9, 2010
Related CR Transmittal #: R669OTN
Effective Date: July 1, 2010
Implementation Date: July 6, 2010

Note: This article was revised on April 12, 2010, to reflect changes made to CR 6566 on April 9, 2010. The article was changed to remove the (Miami only) qualification in the table entry on page 4 for the NSC-MAC Product Code DM20. Also, 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
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 mandatoryquality 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 professionals and persons. The eligible professionals who are exempt from meeting the September 30, 2009 accreditation deadline (as defined in Section 1848(k)(3)(B)) include the following practitioners:

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

Additionally, MIPPA allows 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
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	E0277, E0372, E0373, E0371, E0193

M09	Wheelchairs – Complete Rehabilitative Power Wheelchairs	K0835, K0836, K0841, K0838, K0837, K0842, K0843, K0839, K0840
M09A	Wheelchairs – Complete Rehabilitative Power Wheelchair Related Accessories	
M07	Wheelchairs – Standard Power	K0823, K0822, K0825, K0800, K0824, K0814, K0821, K0801, K0816, K0827, K0815, K0826, K0813, K0806, K0807, K0828, K0802, K0829, K0820, K0808
M07A	Wheelchairs – Standard Power Related Accessories	

Additional Information
The official instruction (CR6566) issued to your Medicare DME MAC is available at http://www.cms.gov/Transmittals/downloads/R669OTN.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.

Claims Submitted for Items or Services Furnished to Medicare Beneficiaries in State or Local Custody

MLN Matters® Number: MM6880
Related Change Request (CR) #: 6880
Related CR Release Date: April 9, 2010
Related CR Transmittal #: R1944CP and R122BP
Effective Date: July 9, 2010
Implementation Date: July 9, 2010

Provider Types Affected
This article applies to physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, DME Medicare Administrative Contractors (DME MACs), Fiscal Intermediaries (FIs), and/or A/B Medicare Administrative Contractors (A/B MACs)) for services provided to Medicare beneficiaries in State or local penal custody.

What You Need to Know
This article is based on Change Request (CR) 6880 which updates billing instructions and claims processing requirements to fully implement the policy for Medicare beneficiaries in State or local custody that was outlined in CR 6544. CR 6880 rescinds and fully replaces CR 6544, and revises the Medicare Claims Processing Manual, Chapter 1, Section 10.4 and the Medicare Benefit Policy Manual, Chapter 17, Section 50.3.3(3). These revisions are included as attachments to CR 6880.

Background
The Medicare program does not pay for services if:

- The beneficiary has no legal obligation to pay for the services, and
- No other person or organization has a legal obligation to provide or pay for that service.

Also, if services are paid for directly or indirectly by a governmental entity, Medicare does not pay for the services. See the Social Security Act Section 1862 (a)(2)&(3) at http://www.socialsecurity.gov/OP_Home/ssact/title18/1862.htm on the Internet.

In the Fiscal Year (FY) 2008 Inpatient Prospective Payment System (IPPS) final rule (72 FR 47409 and 47410; see http://edocket.access.gpo.gov/2007/pdf/07-3820.pdf on the Internet), the Centers for Medicare & Medicaid Services (CMS) clarified its regulations at 42 CFR 411.4(b) (see http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&tpl=/ecfrbrowse/Title42/42cfr411_main_02.tpl on the Internet) by stating that for purposes of Medicare payment, **individuals who are in "custody" include**, but are not limited to, individuals who are:

- Under arrest;
- Incarcerated;
- Imprisoned;
- Escaped from confinement;
- Under supervised release;
- On medical furlough;
- Required to reside in mental health facilities;
- Required to reside in halfway houses;
- Required to live under home detention; or
- Confined completely or partially in any way under a penal statute or rule.

42 CFR 411.4(b) describes the special conditions that must be met in order for Medicare to make payment for individuals who are in custody and states:

"Payment may be made for services furnished to individuals or groups of individuals who are in the custody of the police or other penal authorities or in the custody of a government agency under a penal statute only if the following conditions are met:

1. State or local law requires those individuals or groups of individuals to repay the cost of medical services they receive while in custody, and
2. The State or local government entity enforces the requirement to pay by billing all such individuals, whether or not covered by Medicare or any other health insurance, and by pursuing the collection of the amounts they owe in the same way and with the same vigor that it pursues the collection of other debts."

BILLING CONT'D

Note: Your Medicare contractor will require evidence that routine collection efforts include the filing of lawsuits to obtain liens against individuals' assets outside the prison and income derived from non-prison sources. In addition, the State or local entity must document its case with copies of regulations, manual instructions, directives, etc., spelling out the rules and procedures for billing and collecting amounts paid for prisoners' medical expenses. As a rule, your Medicare contractor will inspect a representative sample of cases in which prisoners have been billed and payment pursued, randomly selected from both Medicare and non-Medicare eligible. The existence of cases in which the State or local entity did not actually pursue collection, even though there is no indication that the effort would have been unproductive, indicates that the requirement to pay is not enforced.

The Centers for Medicare & Medicaid Services (CMS) maintains a file of incarcerated beneficiaries, obtained from the Social Security Administration (SSA) that is used to edit claims.

To avoid improper denial of claims, providers and suppliers that render services or items to a prisoner or patient in a jurisdiction that meets the conditions described above should indicate this fact with the use of a the QJ modifier on claims for such services.

For inpatient claims where the incarceration period spans only a portion of the stay, hospitals should identify the incarceration period by billing as non-covered all days, services and charges that overlap the incarceration period.

Additional Information
The official instruction, CR 6880, was issued to your carrier, FI, A/B MAC, and DME MAC in two transmittals. The first transmittal modifies the Medicare Claims Processing Manual and it is available at http://www.cms.gov/Transmittals/downloads/R1944CP.pdf on the CMS website. The second transmittal is at http://www.cms.gov/Transmittals/downloads/R122BP.pdf and it contains the revised portion of the Medicare Benefit Policy Manual regarding this change.

COVERAGE

Detailed Written Orders

Medicare requires an order for every item (except repairs) of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS). Detailed written orders are used to confirm what was ordered by the treating physician following the supplier's receipt of a verbal or written dispensing order. Detailed written orders must include separately billable options, accessories or supplies related to the base item that is ordered. Detailed written orders must not be used to add unrelated items, whether requested by the beneficiary or not, in the absence of a dispensing order from the physician for that item.

Example: The treating physician calls the supplier and prescribes a glucose monitor with a verbal order. The supplier can then create a detailed written order that includes an itemized listing of all directly related, separately billable items – i.e., the glucose monitor, test strips, lancets, calibration solution, batteries and lancing device. This detailed written order is then returned to the physician for their signature.

Although the initial dispensing order from the physician did not specifically include the test strips, lancets, and other supplies, they are clearly related to the glucose monitor. Therefore, it is an acceptable detailed written order. For detailed written orders of this type, no further action is required from the physician beyond their signature and date. However, for other types of detailed written orders other actions by the physician may be required. (See below)

In the example above, it is not acceptable for the supplier to include additional, unprescribed and unrelated items, such as a vacuum erection device, water circulating heating pad or wrist orthosis to the detailed written order. While the test strips, lancets, and other supplies are related to the glucose monitor in the original order, the vacuum erection device, water circulating heating pad and wrist orthosis are not related and therefore must not be included on the detailed written order.

Some suppliers use preprinted forms for their detailed written orders that include a listing of many different items, not all of which may be needed by an individual beneficiary. These listings often create incompatible combinations. For example, an order form for CPAP accessories might list all possible interfaces. On these forms, the final document that is signed and dated by the physician must clearly identify the specific items that are being ordered for that patient. This may be accomplished in one of two ways:

- The supplier may indicate the items that are being provided before sending the form to the physician. The physician can then review the form and accept either the items marked by the supplier or make any necessary changes. The physician must then initial and date the revised entries; **or**
- The supplier may send the form to the physician without any items selected and ask the physician to indicate which items are being ordered. The physician must make their choice clear. Check marks, circling items or other affirmative indicators are acceptable ways to show that the physician selected the item(s).

In each case, the physician must sign and date the form.

The following are examples (not all-inclusive) of forms listing multiple items, which would be considered invalid detailed written orders:

- Forms listing incompatible items without specific items being selected. For example, for CPAP, a form which includes full-face mask, nasal mask, and nasal pillows with none being specifically selected by the physician.
- Forms in which incompatible items are checked off or selected by either the supplier or the physician. For example, a form which includes full-face mask, nasal mask, and nasal pillows and two or all three are selected.

Refer to the Supplier Manual and the LCDs for additional information about order requirements.

LCD and Policy Article Revisions - Summary for February 19, 2010

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

Immunosuppressive Drugs
LCD
Revision Effective Date: 04/01/2010
HCPCS CODES AND MODIFIERS:
Revised: KX modifier
DOCUMENTATION GUIDELINES:
Added: Requirement that beneficiary was enrolled in Medicare Part A at time of the transplant

Policy Article
Revision Effective Date: 4/01/2010
CODING GUIDELINES:
Changed: SADMERC to PDAC

Pressure Reducing Support Surfaces - Group 2
LCD
Revision Effective Date: 04/01/2010
HCPCS CODES AND MODIFIERS:
Added: GA and GZ modifiers
Revised: KX modifiers
Documentation Requirements:
Added: Instructions for the use of GA and GZ modifiers

Pressure Reducing Support Surfaces - Group 3
LCD
Revision Effective Date: 04/01/2010
HCPCS CODES:
Added: GA and GZ modifiers
Revised: KX modifier
DOCUMENTATION REQUIREMENTS:
Added: Instructions for the use of GA and GZ modifiers

Urological Supplies
LCD
Revision Effective Date: 01/01/2010
INDICATIONS AND LIMITATIONS OF COVERAGE:
Added: Coverage statement for urethral inserts
Added: Statement about refilling orders
HCPCS CODES AND MODIFIERS:
Added: A4336, A4360, A4456

Policy Article
Revision Effective Date: 01/01/2010
NONMEDICAL MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: A4360 to list of statutorily excluded items
CODING GUIDELINES:
Replaced: A4365 with A4456

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

LCD and Policy Article Revisions - Summary for February 25, 2010

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

Lower Limb Prosthesis
LCD
Revision Effective Date: 01/01/2010
INDICATIONS AND LIMITATIONS OF COVERAGE:
Added: Functional level requirement for L5973
HCPCS CODES:
Added: L5973
DOCUMENTATION REQUIREMENTS:
Deleted: Outdated instruction for code L5930

Policy Article
Revision Effective Date: 04/01/2010
CODING GUIDELINES:
Revised: Instructions for use of code L7520
Deleted: Instructions for use of RP modifier
Revised: Instructions for use of ultralight component codes L5940-L5960
Added: Statement concerning rejection of claims without an RT or LT modifier

Oxygen and Oxygen Equipment
LCD
Revision Effective Date: 01/01/2010
HCPCS CODES AND MODIFIERS:
Added: E0433
Revised: E0441-E0444

Policy Article
Revision Effective Date: 01/01/2010
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Revised: Coverage for maintenance and servicing, months 37-60
CODING GUIDELINES:
Deleted: Instructions for codes E0441-E0444
Added: E0433

Patient Lifts
LCD
Revision Effective Date: 04/01/2010
INDICATIONS AND LIMITATIONS OF COVERAGE:
Added: E1036
HCPCS CODES AND MODIFIERS:
Revised: KX modifier
Added: GA and GZ modifiers
Added: E1036
Revised: E1035
DOCUMENTATION REQUIREMENTS:
Added: KX modifier requirement for E1036
Added: GA and GZ modifier instructions

Policy Article
Revision Effective Date: 01/01/2010
CODING GUIDELINES:
Added: E1036 to E1035 definition
Added: E1036 to list of codes that require PDAC coding review

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

LCD and Policy Article Revisions - Summary for March 11, 2010

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

External Breast Prostheses
LCD
Revision Effective Date: 01/01/2010
INDICATIONS AND LIMITATIONS OF COVERAGE AND/OR MEDICAL NECESSITY:
Added: Coverage information specific to mastectomy bras (L8000)
Added: Coverage information specific to breast prostheses, silicone or equal, with integral adhesive (L8031)
Added: Coverage information on quantity dispensed at a time.
HCPCS CODES AND MODIFIERS:
Added: L8031, L8032
Revised: L8030

Policy Article
Revision Effective Date: 01/01/2010
NON-MEDICAL NECESSITY AND COVERAGE AND PAYMENT RULES:
Added: Nipple prostheses have a 3 month reasonable lifetime expectancy
CODING GUIDELINES:
Added: Description for L8000
Revised: RT/LT modifier instructions
Changed: SADMERC to PDAC

Positive Airway Pressure (PAP) Devices for the Treatment of Obstructive Sleep Apnea
LCD
Revision Effective Date: 04/01/2010 (February 2010 Revision)
INDICATIONS AND LIMITATIONS OF COVERAGE:
Added: Program Integrity Manual instructions on refills of accessories
Added: Replacement instructions for beneficiaries already in Medicare
Revised: Types of sleep tests
Revised: Coverage of replacement devices and/or accessories
Revised: Beneficiaries entering Medicare instructions
DOCUMENTATION REQUIREMENTS:
Added: Replacement instructions for beneficiaries already in Medicare
Revised: Documentation of replacement devices and/or accessories
Revised: Beneficiaries entering Medicare instructions

Policy Article
Revision Effective Date: 04/01/2010
CODING GUIDELINES:
Revised: Use of RAD term
Revised: Definition of E0470 and E0471

Spinal Orthoses: TLSO and LSO
Policy Article
Revision Effective Date: 07/01/2010
CODING GUIDELINES:
Revised: Requirement for coding verification review by the PDAC.

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

LCD and Policy Article Revisions - Summary for April 1, 2010

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

Oral Anticancer Drugs
LCD
Revision Effective Date: 01/01/2010
CMS National Coverage Policy
Added: References to IOM & SSA
HCPCS CODES AND MODIFIERS:
Added: Fludarabine phosphate

Policy Article
Revision Effective Date: 06/01/2010
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Clarified: Criterion 3 to indicate coverage for those ICD-9 diagnoses specifically indicated under IOM 100-02, Section 50 – Drugs and Biologicals and under the Social Security Act, Sec.1861(s) (Q).
Added: Coverage possible at appeal for claims not listed in the section "ICD-9 Codes that are Covered" which can be shown consistent with IOM 100-02, Section 50 – Drugs and Biologicals and with the Social Security Act, Sec.1861(s) (Q).
ICD-9 CODES THAT ARE COVERED:
Changed: All ICD-9 diagnoses to those specifically indicated under IOM 100-02, Section 50 – Drugs and Biologicals and under the Social Security Act, Sec.1861(s)(Q).
Added: Diagnoses for fludarabine phosphate (effective 1/01/2010).

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

LCD and Policy Article Revisions - Summary for April 29, 2010

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

External Infusion Pumps
LCD
Revision Effective Date: 04/19/2010
INDICATIONS AND LIMITATIONS OF COVERAGE:

Removed: Specific coverage and the least costly alternative provisions from liposomal amphotericin B (J0287-J0289)

DOCUMENTATION REQUIREMENTS:

Removed: KX requirements for J0287-J0289

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

ASP Drug Pricing Files for July 2010 Quarterly Update and Revisions to Prior Files

MLN Matters® Number: MM6805
Related Change Request (CR) #: 6805
Related CR Release Date: February 19, 2010
Related CR Transmittal #: R1922CP
Effective Date: July 1, 2010
Implementation Date: July 6, 2010

Provider Types Affected
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)) are affected by this issue.

What You Need to Know
This article is based on Change Request (CR) 6805 which instructs Medicare contractors to download and implement the July 2010 ASP drug pricing file for Medicare Part B drugs; and if released by the Centers for Medicare & Medicaid Services (CMS), also the revised April 2010, January 2010, October 2009, and July 2009 files. Medicare will use the July 2010 ASP and not otherwise classified (NOC) drug pricing files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after July 6, 2010, with dates of service July 1, 2010, through September 30, 2010.

Background
The ASP methodology is based on quarterly data submitted to CMS by manufacturers. CMS will supply contractors with the ASP and NOC drug pricing files for Medicare Part B drugs on a quarterly basis. Payment allowance limits under the OPPS are incorporated into the Outpatient Code Editor (OCE) through separate instructions.

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

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

Additional Information
The official instruction (CR6805) issued to your Medicare MAC, carrier, and/or FI may be found at http://www.cms.hhs.gov/Transmittals/downloads/R1922CP.pdf on the CMS website.

Revision of Definition of Compendia as Authoritative Source for Use in Determination of Medically-Accepted Indication of Drugs/Biologicals Used Off-label in Anti-Cancer Chemotherapeutic Regimens

MLN Matters® Number: MM6806 Revised
Related Change Request (CR) #: 6806
Related CR Release Date: January 29, 2010
Related CR Transmittal #: R120BP
Effective Date: January 1, 2010
Implementation Date: March 1, 2010

Note: This article was revised on February 17, 2010, to include web links to additional information regarding this issue.

Provider Types Affected
This article is for physicians, other providers, and suppliers submitting claims to Medicare contractors (carriers, Fiscal Intermediaries (FI), Part A/B Medicare Administrative Contractors (A/B MAC), or DME Medicare Administrative Contractors (DME MAC)) for services provided to Medicare beneficiaries.

What You Need to Know
CR 6806, from which this article is taken, announces that effective January 1, 2010, the Centers for Medicare & Medicaid Services (CMS) is revising the definition of "compendium" in the *Medicare Benefit Policy Manual*, Chapter 15, (Covered Medical and Other Health Services), Section 50.4.5 (Process for Amending the List of Compendia for Determinations of Medically-Accepted Indications for Off-Label Uses of Drugs and Biologicals in an Anti-Cancer Chemotherapeutic Regimen). This revision requires a publicly transparent process for evaluating therapies and for identifying potential conflicts of interest. Please see the Background section, below, for details.

Background
A compendium is defined "as a comprehensive listing of FDA-approved drugs and biologicals (or a comprehensive listing of a specific subset of drugs and biologicals in a specialty compendium, for example, a compendium of anti-cancer treatment)."

Section 1861(t)(2)(B)(ii)(I) of the Social Security Act (the Act), as amended by section 6001(f)(1) of the Deficit Reduction Act of 2005, Pub. Law 109-171, recognizes three compendia: 1) American Medical Association Drug Evaluations (AMA-DE); 2) United States Pharmacopoeia-Drug Information (USP-DI) or its successor publication, and 3) American Hospital Formulary Service-Drug Information (AHFS-DI). To date, AHFS-DI, plus other authoritative compendia (found at http://www.cms.hhs.gov/CoverageGenInfo/02_compendia.asp) that the Secretary of Health and Human Services identifies, serve as sources for you to use in determining the "medically-accepted indication" of drugs and biologicals that are used off-label in an anti-cancer chemotherapeutic regimen *(unless the Secretary has determined that the use is not medically appropriate or the use is identified as not indicated in one or more such compendia)*.

In the Medicare Physician Fee Schedule final rule for calendar year 2008, CMS established a process for revising the list of compendia, and also increased the transparency of the process by incorporating a list of desirable compendium characteristics outlined by the Medicare Evidence Development and Coverage Advisory Committee (MEDCAC) on March 30, 2006, as criteria for decision-making.

Although the MEDCAC desirable characteristics for compendia included reference to conflict of interest and transparency, section 182(b) of the Medicare Improvements for Patients and Providers Act (MIPPA) amended Section 1861(t)(2)(B) of the Act by adding the following new sentence: "On and after January 1, 2010, no compendia may be included on the list of compendia under this subparagraph unless the compendia has a publicly transparent process for evaluating therapies and for identifying potential conflicts of interests."

CR 6806, from which this article is taken, announces that effective January 1, 2010, CMS is revising the definition of "compendium" in the *Medicare Benefit Policy Manual*, Chapter 15, Section 50.4.5 to include this public transparency requirement.

In this revised definition, a compendium:

1. Includes a summary of the pharmacologic characteristics of each drug or biological and may include information on dosage, as well as recommended or endorsed uses in specific diseases;
2. Is indexed by drug or biological; and
3. *Has a publicly transparent process for evaluating therapies and for identifying potential conflicts of interests*.

Additional Information
You can find more information about the revised definition of "compendium" by going to CR 6806, located at http://www.cms.gov/Transmittals/downloads/R120BP.pdf on the CMS website.

For more detailed information about the revised definition of "compendium" and the incorporation of MIPPA section 182 (b) into the compendia review process for current and future statutorily recognized compendia based on this provision, see Issues Related to MIPPA Number 13. Section 182(b): Revision of Definition of Medically-Accepted Indication for Drugs; Compendia for Determination of Medically-Accepted Indications for Off-Label Uses of Drugs and Biologicals in an Anti-cancer Chemotherapeutic Regimen released in the November 25, 2009 Federal Register, which you can find at http://www.gpo.gov/fdsys/pkg/FR-2009-11-25/pdf/E9-26502.pdf on the Internet.

You will find this revised compendium definition in the updated Medicare Benefit Policy Manual, chapter 15, (Covered Medical and Other Health Services), Section 50.4.5 (Process for Amending the List of Compendia for Determinations of Medically-Accepted Indications for Off-Label Uses of Drugs and Biologicals in an Anti-Cancer Chemotherapeutic Regimen) as an attachment to that CR.

You might also want to read the MLN Matters® article titled Compendia as Authoritative Sources for Use in the Determination of a "Medically Accepted Indication" of Drugs and Biologicals Used Off-Label in an Anti-Cancer Chemotherapeutic Regimen, released on October 24, 2008, which you can find at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6191.pdf on the CMS website.

OXYGEN

Billing Oxygen Equipment Covered by Multiple CMNs

NAS requests that suppliers separate oxygen equipment claims based on the corresponding Certificate of Medical Necessity (CMN). For instance, if there are six dates of service being billed and three are covered by a CMN dated in 2004 while the other three are covered by a CMN dated in 2009, two separate claims should be billed rather than billing all six dates on one claim submission.

Only one CMN for the same equipment can be valid at any given time; therefore, claims not in accordance with the above direction cannot be fully processed. First, the dates covered by the oldest CMN must be finalized. Second, the old CMN must be removed and the new CMN must be loaded. When one claim needs to read off of multiple CMNs it is impossible for both to remain paid. Each time the claim is reprocessed, one set of dates will allow, and the second set will deny, or recoup, if already allowed.

If claims are billed with multiple dates of service encompassing multiple CMNs for the same equipment, NAS will process one set of the dates and request that the supplier rebill the second set.

Results of Widespread Prepayment Review of Claims for Codes E1390 and E0431

The Jurisdiction D DME MAC Medical Review Department concluded a widespread review of HCPCS codes E1390 and E0431 from November 2009 through January 2010.

The results of the review of the claims identified 102 claims of which 86 were denied. This resulted in an overall error ratio of 85%.

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

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

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

The following are the top four reasons for denial:

A. No office visit notes to determine medical necessity within 30 days of certification or 90 days within recertification were submitted (39 claims)

B. No response to medical records request (33 claims)

C. No qualifying blood gas study submitted (30 claims)

D. Invalid Certificate of Medical Necessity (CMN) (13 claims)

The total claim volume is more than 102 as some of the claims have multiple errors.

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

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

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

B. Suppliers are reminded that documentation must be made available to the DME MAC upon request. Reference the following under the documentation requirements section in the Oxygen and Oxygen Equipment (L11457) LCD, which states in part:

   "*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" (42 U.S.C. section 13951 (e)). 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.*"

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

   Group I criteria include any of the following:

   1. An arterial PO_2 at or below 55 mm Hg or an arterial oxygen saturation at or below 88 percent taken at rest (awake), or
   2. An arterial PO_2 at or below 55 mm Hg, or an arterial oxygen saturation at or below 88 percent, for at least 5 minutes taken during sleep for a patient who demonstrates an arterial PO_2 at or above 56 mm Hg or an arterial oxygen saturation at or above 89 percent while awake, or
   3. A decrease in arterial PO_2 more than 10 mm Hg, or a decrease in arterial oxygen saturation more than 5 percent, for at least 5 minutes taken during sleep associated with symptoms (e.g., impairment of cognitive processes and [nocturnal restlessness or insomnia]) or signs (e.g., cor pulmonale, "P" pulmonale on EKG, documented pulmonary hypertension and erythrocytosis) reasonably attributable to hypoxemia, or
   4. An arterial PO_2 at or below 55 mm Hg or an arterial oxygen saturation at or below 88 percent, taken during exercise for a patient who demonstrates an arterial PO_2 at or above 56 mm Hg or an arterial oxygen saturation at or above 89 percent during the day while at rest. In this case, oxygen is provided for during exercise if it is documented that the use of oxygen improves the hypoxemia that was demonstrated during exercise when the patient was breathing room air.

   Group II criteria include the presence of (a) an arterial PO_2 of 56-59 mm Hg or an arterial blood oxygen saturation of 89 percent at rest (awake), during sleep for at least 5 minutes, or during exercise (as described under Group I criteria) and (b) any of the following:

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

Group III includes patients with arterial PO_2 levels at or above 60 mm Hg or arterial blood oxygen saturations at or above 90 percent. For these patients there is a rebuttable presumption of noncoverage.

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

It is important for suppliers to be familiar with the documentation requirements as outlined in the Oxygen and Oxygen Equipment 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.

Suppliers can review the Oxygen and Oxygen Equipment LCD on the NAS website at https://www.noridianmedicare.com/dme/. You will also find useful information and articles on this website.