Jurisdiction D News from Noridian Administrative Services, LLC.

Happenings

March 2010
Issue No. 26

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 web site, www.noridianmedicare.com.

In This Issue...

FYI

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 web site and select the "E-mail List Signup" from the DME Quick Links.

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CEDI

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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

web site: 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	www.medicarenhic.com
Jurisdiction B: National Government Services	1-877-299-7900	www.adminastar.com
Jurisdiction C: CIGNA Government Services	1-866-270-4909	www.cignagovernmentservices.com

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

FYI

2010 Holiday and Training Closures

NAS offices will be closed on the days listed below.

Supplier Contact Center

Event	Date
New Years Day	January 1
Martin Luther King Day*	January 18
Presidents Day*	February 15
Off-the-Phone Training CMS Approved	March 19
Good Friday	April 2
Off-the-Phone Training CMS Approved	April 16
Off-the-Phone Training CMS Approved	May 21
Memorial Day	May 31
Off-the-Phone Training CMS Approved	June 18
Independence Day	July 5
Off-the-Phone Training CMS Approved	July 16
Off-the-Phone Training CMS Approved	August 20
Labor Day	September 6
Off-the-Phone Training CMS Approved	September 17
Columbus Day*	October 11
Veterans Day*	November 11
Thanksgiving	November 25 and 26
Off-the-Phone Training CMS Approved	December 17
Christmas Eve	December 24
New Years Day	December 31
Federal holidays noted with a (*) are days that the NAS offices will be open and the Contact Center representatives will be available from 12 - 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 web site, 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

FYI CONT'D

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 web site, 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

Policy-Specific Pages Available

Find resources, reminders and publications for the following policies all on one page:

- Oxygen and Oxygen Equipment
- Enteral Nutrition
- Glucose Monitors and Testing Supplies
- Positive Airway Pressure Devices
- Power Mobility Devices

These pages are available on the Publications page under Policy Resources.

Summary of Supplier Manual Updates

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

Chapter	Subheading	Supplier Manual Update	Change Date
3	Verbal and Preliminary Orders	Added Reminders	12/29/09
3	Detailed Written Orders	Bulleted items required	12/29/09
3	Advance Beneficiary Notice of Noncoverage	Removed March 3, 2008, implementation of revised ABN information	12/29/09
1	What is Medicare?	Changed deductible to $155 for 2010	12/29/09
13	Reconsiderations	Changed Rivertrust Solutions, Inc. address	12/29/09
6	Ordering CMS-1500 Claim Forms	Changed to general information	12/29/09
6	Limitation on Liability and Refund Requirements	Removed ABN information - this is found in Chapter 3	12/29/09
9	General Medical Policy Information	Changed Local Coverage Determination, Policy Article and National Coverage Determination links to our web site	12/29/09
9	Local Coverage Determinations and Policy Articles	Changed Policy Articles link to our web site	12/29/09
5	Billing Contents	Changed HCPCS codes E1390 and E1391 to E0431 and E0434 for billing contents after the 36th payment for equipment.	12/29/09
5	Repairs, Maintenance, and Replacement	Added MS modifier to the Maintenance and Servicing section	12/29/09
15	RAC Overpayments	Added RAC Overpayments section	12/29/09
17	Medicare Remittance Notice	Added Remittance Advice Tutorial sentence.	12/29/09
Appendix - Resources	Jurisdiction D Fax Numbers	Added Immediate Offsets, DME RAC Offsets and DME RAC Redeterminations	12/29/09
Appendix - Resources	Jurisdiction D Addresses	Added DME RAC Redeterminations	12/29/09
Appendix - Resources	Additional DME Contacts	Changed CEDI Help Desk hours to 8 a.m. - 6 p.m. CT	12/29/09

Appendix - Resources	CMS web site Resources	Removed opening statement	12/29/09
Appendix - Contacting NAS and Inquiries	Telephone Inquiries	Added "Duplicate Remittance Advices" to IVR options	12/29/09
1	What is Medicare?	Added HMO information	12/29/09
10	Background	Added second paragraph	12/29/09
Appendix	Resources	Changed the US Government Printing Office phone number	12/29/09
16	HCPCS A Codes	Added/changed A4336, A4360, A4365, A4456, A4466, A6200, A6201, A6202, A6542, A6543, A6549	12/29/09
16	HCPCS E Codes	Added/changed E0249, E0433, E0441, E0442, E0443, E0444, E0700, E1035, E1036, E2223, E2393, E2399	12/29/09
16	HCPCS J Codes	Added/changed J0460, J0461, J0530, J0540, J0550, J0559, J0585, J0586, J0587, J0835, J1565, J7192, J9170	12/29/09
16	HCPCS L Codes	Added/changed L0210, L1800, L1815, L1825, L1901, L2770, L3651, L3652, L3700, L3701, L3909, L3911, L4396, L5973, L6639, L8030, L8031, L8032, L8619, L8680, L8681	12/29/09
16	HCPCS Q Codes	Added/changed Q0496, Q2009, Q4074, Q4080, Q4115, Q4116	12/29/09
16	Modifiers	Added AI and J4	12/29/09
16	E codes	Removed CMN/DIF Required for E0776	12/04/09

Physician NPI File Now Available - Revised

The Centers for Medicare & Medicaid Services (CMS) provider listserv messages that were sent last fall concerning Change Requests 6417 and 6421, CMS has made available a file that contains the National Provider Identifier (NPI) and the name (last name, first name) of all physicians and non-physician 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 web site: http://www.cms.hhs.gov/MedicareProviderSupEnroll - click on "Ordering/Referring Report" on the left-hand side.

This .pdf file contains approximately 800,000 records. A new file will be made available periodically that will replace the posted file; at any given time, only one file (the most recent) will be available. The file can be viewed online. In addition, it can be downloaded by users with technical expertise and further sorted or manipulated. It can also be used to search for a particular physician or non-physician practitioner by NPI or by name.

Please note the following:

1. Records are in alphabetical order based on the surname of the physician or non-physician practitioner.
2. Name suffixes (e.g., Jr.), if they exist, are not displayed.
3. There are no "duplicates" in the file. Many physicians or non-physician practitioners share the same first and last name; their corresponding NPIs are the assurance of uniqueness.
4. Deceased physicians and non-physician practitioners are not included in the file.
5. If a user is unsure of a physician or non-physician practitioner's NPI, he or she can look it up in the NPI Registry (https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do).

Keep in mind that the record in the NPI Registry is not the Medicare PECOS enrollment record.

Duplicate Remittance Advice on IVR System – Updated

Beginning Friday, December 18, 2009, the Duplicate Remittance Advice menu option on the Interactive Voice Response (IVR) System will have updated functionality.

Currently, the Duplicate Remittance Advice option allows suppliers to order duplicate remittance advices by two methods: check number and date or claim control number (CCN). The update will require the check date to be entered with the CCN. This will greatly increase the number of successful requests when utilizing the CCN method. Below are the instructions for utilizing both methods.

To access the Duplicate Remittance Advice option from the Main Menu, key or speak the selection as below:

Touch-tone Option	Vocal Option
7	Duplicate Remittance Advice

When requested, key or speak the following information:

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

The IVR will offer to find the remittance advice using the check number and date or the CCN and date.

1. **Check Number**
   To order a duplicate remittance advice using the check number and date option, key or speak the selection as below:

Check Number and Date

Touch-tone Option	Vocal Option
1	Check Number

Key or speak the following information when requested:

- 11 digit check number
- Check date (if keying the date, enter it in the mmddyy format)

Note: Using the 15 digit Electronic Funds Transfer (EFT) Transaction Number will result in an unsuccessful remittance request.

2. Claim Control Number
To order a duplicate remittance advice using the CCN, key or speak the selection as below:

Claim Control Number

Touch-tone Option	Vocal Option
2	Claim Control

Key or speak the following information when requested:

- 14 digit CCN
- Check date (if keying the date, enter it in the mmddyy format)

Note: The entire remittance advice will be ordered and sent, not only the portion corresponding to the CCN entered.

Successful Request

If the request is successful, the IVR will state the duplicate remittance should be received in 7-10 days and will be sent to the address on file with the National Supplier Clearinghouse (NSC). The IVR will than offer to order another duplicate remittance, order a duplicate remittance advice for another PTAN, or order a duplicate remittance advice for another NPI. Key or speak the selection as below:

Touch-tone Option	Vocal Option
2	Another Duplicate Remittance
3	Change PTAN
4	Change NPI

Unsuccessful Request

If the request is unsuccessful, the IVR will indicate this and request that the NPI, PTAN, check number, check date, and CCN provided be verified for accuracy.

The CCN, check number and check date are readily available on the IVR through the Main Menu using the Claims option. Please refer to the IVR User Guide for additional assistance using the IVR. To access the Main Menu at any point during the call simply say "Main Menu".

Note: Duplicate remittance advices which are more than five years old will need to be ordered through the Jurisdiction D Supplier Contact Center at 1-866-243-7272.

CMN Status on IVR System - Updated

To ensure consistent and complete information, the Certificate of Medical Necessity (CMN) Status menu option on the Interactive Voice Response (IVR) System has been updated to redirect inquiries through the Same or Similar Healthcare Common Procedure Coding System (HCPCS) Lookup menu option. This allows suppliers to receive equipment history from the national Common Working File (CWF) and DME Jurisdiction D's local files. Previously, the CMN Status Option was only returning information found in the CWF.

The IVR is available from 6 a.m. to 6 p.m. CT for menu options requiring system access. Those options are Eligibility, Same or Similar HCPCS Lookup, Claim Status, Payment Floor, Checks, Duplicate Remittance Advice and CMN Status. The IVR is available 24 hours a day 7 days a week for general information.

For additional information on utilizing the IVR refer to the IVR User Guide and IVR-At-A-Glance.

Same or Similar HCPCS Lookup for Oxygen Codes on IVR System - Updated

Beginning Friday, December 18, 2009, the Interactive Voice Response (IVR) will return more complete information when using the Same or Similar Healthcare Common Procedure Coding System (HCPCS) Lookup option for oxygen codes. The IVR will be returning all codes which are considered same or similar according to the Same or Similar Reference Chart.

The IVR is available from 6 a.m. to 6 p.m. CT for menu options requiring system access. Those options are Eligibility, Same or Similar HCPCS Lookup, Claim Status, Payment Floor, Checks, Duplicate Remittance Advice and Certificate of Medical Necessity (CMN) Status. The IVR is available 24 hours a day 7 days a week for general information.

For additional information on utilizing the IVR refer to the IVR User Guide and IVR-At-A-Glance.

Compliance Standards for Consignment Closets and Stock and Bill Arrangements

MLN Matters® Number: 6528 Rescinded
Related Change Request (CR) #: 6528
Related CR Release Date: September 1, 2009
Related CR Transmittal #: R300PI
Effective Date: September 8, 2009
Implementation Date: March 1, 2010

Note: This article was rescinded on February 5, 2010, as the related CR 6528 was rescinded on February 4, 2010.

CMS to Conduct Fifth Annual Medicare Contractor Provider Satisfaction Survey

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

The survey will be sent to a random sample of approximately 30,000 Medicare FFS providers and suppliers. Those who are selected to participate in the 2010 MCPSS will be notified starting in January. If you are selected to participate, please take a few minutes to complete this important survey. Providers and suppliers can complete the survey on the Internet via a secure website or by mail, fax, or telephone. To learn more about the MCPSS, please visit http://www.cms.hhs.gov/MCPSS on the CMS web site.

Providers Randomly Selected to Participate in MCPSS Urged to Respond

MLN Matters Number: SE1005

Provider Types Affected

Medicare fee-for-service (FFS) physicians, providers, suppliers, and other health care practitioners that received a letter indicating they were randomly selected to participate in the 2010 Medicare Contractor Provider Satisfaction Survey (MCPSS) should review this article.

Provider Action Needed

This Special Edition article alerts providers that the Centers for Medicare & Medicaid Services (CMS) has launched the fifth annual national administration of the MCPSS. If you received a letter indicating you were randomly selected to participate in the 2010 MCPSS, CMS urges you to take a few minutes to go online and complete this important survey via a secure Internet web site. Responding online is a convenient, easy, and quick way to provide CMS with your feedback on the performance of your FFS contractor. Survey questionnaires can also be submitted by mail, secure fax, and over the telephone.

Background

CMS is responsible for the administration of the FFS Medicare program and does so primarily through its Medicare FFS contractors. As Medicare's agents, these contractors are responsible for executing the daily operational aspects of the FFS Medicare program by processing and paying the more than $370 billion in Medicare claims each year and performing other related business functions that support regular daily interactions with Medicare FFS providers.

The MCPSS that is conducted annually by CMS is designed to collect quantifiable data on provider satisfaction with the performance of Medicare FFS contractors. The MCPSS offers Medicare FFS providers an opportunity to give CMS valuable feedback on their satisfaction, attitudes, perceptions, and opinions about the services provided by their respective contractor. Survey questions focus on seven key business functions of the provider-contractor relationship:

- Provider Inquires
- Provider Outreach & Education
- Claims Processing
- Appeals
- Provider Enrollment
- Medical Review
- Provider Audit & Reimbursement

The MCPSS is a result of the Medicare Prescription Drug, Improvement and Modernization Act of 2003, which mandated CMS to develop contract performance requirements, including measuring health care provider satisfaction with Medicare contractors. The MCPSS enables CMS to hear provider concerns, 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.

The 2010 MCPSS Study

Sample Selection

Each year, a new random sample of Medicare FFS providers is selected to participate in the MCPSS. For the 2010 MCPSS study, CMS will ask approximately 30,000 Medicare FFS providers and suppliers to participate in the MCPSS. The sample is scientifically designed, and then randomly selected, to represent the community of more than 1.5 million Medicare providers nationwide who serve Medicare beneficiaries across the country. The sample includes Medicare FFS physicians, limited licensed practitioners (LLP), labs, hospitals, skilled nursing facilities (SNF), rural health clinics (RHC), home health agencies (HHA), federally qualified health centers (FQHC), hospice facilities, end-stage renal disease (ESRD) facilities, durable medical equipment (DME) suppliers, ambulance service providers, and other Part A institutional facilities and Part B health care practitioners. Those health care providers randomly selected to participate in the 2010 MCPSS were notified in January.

Web-based Survey Questionnaire

CMS continues to make completing and returning the survey simple by migrating to an easy to use web-based survey. Providers selected to participate in the 2010 study will have access to an online web-based survey tool where they can rate their contractor's performance and complete and submit their survey questionnaire over a secure Internet web site. The Internet is a quick, convenient, and environmentally friendly way for providers to contribute directly to CMS' understanding of contractor performance. CMS encourages all participants with Internet access to submit their completed survey online. Participants may also submit their completed survey questionnaire via mail, secure fax, and over the telephone. The 2010 MCPSS takes approximately 20 minutes to complete.

New Satisfaction Rating Scale

The 2010 survey questions use a fully-labeled five-point Likert response scale with "1" representing "Very Dissatisfied" and "5" representing "Very Satisfied". In contrast to previous years' surveys which used a six-point scale, where only the end-points were labeled, this new scale assigns words to every answer category and includes a neutral category. The change will allow CMS to communicate a well-defined message about the performance of the Medicare contractors. While only health care providers selected to participate in the 2010 MCPSS may complete and return the survey questionnaire, a sample of the 2010 MCPSS questionnaire is available for viewing at http://www.cms.hhs.gov/mcpss for informational purposes.

Reporting Results

CMS will analyze the 2010 MCPSS data and release a summary report on the CMS web site in the summer of 2010. The report prepared for this study will summarize findings across the sample and will not associate responses with a specific individual, practice, or facility. CMS has contracted with SciMetrika, a public health consulting firm, to administer this important survey and report statistical data to CMS.

Provider Participation Key to Success of Study

Participation in the MCPSS is voluntary, however, the survey offers providers the opportunity to contribute directly to CMS' understanding of Medicare contractor performance, as well as aid future process improvement efforts at the contractor level. The views of every health care provider asked to participate in the 2010 study are very important to the success of this study, as each one represents many other organizations that are similar in size, practice type, and geographical location.

The feedback captured through the MCPSS is important. CMS urges all providers selected to participate in the 2010 study to take this opportunity to provide CMS with their feedback on the performance of the Medicare FFS contractor that processes and pays their Medicare claims. CMS requests that you complete your survey questionnaire as quickly as possible when you receive it.

CMS is listening and wants to hear from you.

Additional Information

For more information about the MCPSS, including results of the 2009 MCPSS, please visit http://www.cms.hhs.gov/mcpss on the CMS web site.

Email Available for Redetermination and Reopening Questions

Suppliers can email questions and concerns regarding reopenings and redeterminations to dmeredeterminations@noridian.com. Communication with suppliers is important to NAS so we want to provide an additional avenue of communication for redetermination and reopening questions.

Questions and concerns may include but are not limited to:

- Timely Filing Inquiries
- Appeal Regulations
- Coverage Questions
- Appeal Rights
- Documentation Requirements for Redeterminations
- Redetermination/Reopening Request Forms
- Redetermination Letter Wording
- Social Security Laws
- Interpretation of Denial Messages
- Policies

Confidential information cannot be e-mailed. This includes Protected Health Information (PHI), such as patient names, claim information, Health Insurance Claim (HIC) numbers, Social Security numbers, Claim Control numbers (CCNs) or supplier numbers. This type of information cannot be e-mailed because it may be possible for others to view the contents. If you have a question that would contain PHI, please call our Contact Center at 1-866-243-7272.

The Centers for Medicare & Medicaid Services (CMS) state that PHI cannot be transmitted via e-mail, therefore, NAS will not respond to any requests that contain PHI. Those requests that do not contain PHI will be answered within two business days.

This e-mail option is for suppliers only and is not to be used by beneficiaries. All beneficiary inquiries should be directed to 1-800-MEDICARE (1-800-633-4227).

Update to the Medicare Remit Easy Print Codes

The latest Claim Adjustment Reason Codes and Remittance Advice Remark Codes are available in the Codes.ini file for the Medicare Remit Easy Print (MREP) software. You can access this file in the zipped folder for "Medicare Remit Easy Print - Version 2.7" at http://www.cms.hhs.gov/AccesstoDataApplication/02_MedicareRemitEasyPrint.asp on the CMS web site.

Claim Crossover Process

CMS reminds all providers, physicians, and suppliers to allow sufficient time for the Medicare crossover process to work - approximately 15 work days after Medicare's reimbursement is made, as stated in MLN Matters Article SE0909 - **before** attempting to balance bill their patients' supplemental insurers. That is, **do not balance bill** until you have received written confirmation from Medicare that your patients' claims **will not** be crossed over, or you have received a special notification letter explaining why specified claims cannot be crossed over. Remittance Advice Remark Codes MA18 or N89 on your Medicare Remittance Advice (MRA) represent Medicare's intention to cross your patients' claims over. Medicare will continue to issue supplemental notifications to all participating providers, physicians, and suppliers informing them if claims targeted for crossover, as evidenced by MA18 or N89 on the MRA, do not actually result in successful crossover transmissions.

Members of the supplemental payer/Medigap market are noting higher than average receipts of Medicare Part A paper claims that are preceding the arrival of Medicare's 837 institutional COB crossover claims. The arrival of paper

claims in advance of Medicare crossover claims is resulting in supplemental payer receipt of duplicate claims. This trend is particularly pronounced among hospital providers within the states of Iowa, Missouri, and Wisconsin.

Current trending suggests that approximately 99 percent of all claims that Medicare identifies for crossover, as cited on your Medicare Remittance Advice, **actually are crossed over** by CMS' Coordination of Benefits Contractor (COBC). The remaining percentage error out at the COBC due to HIPAA compliance issues or related data errors, resulting in the provider, physician, or supplier's receipt of a Medicare-generated special notification letter specifying the reason for the claim's failure to cross over. This trending demonstrates that the crossover process is becoming more reliable all the time. The CMS requests that providers, physicians, and suppliers ensure that the trend continues.

CMS MLN Matters Indices Redesigned

The 2007 through 2009 MLN Matters articles indices have been redesigned! These redesigned indices are much more user friendly and are now available for use on the MLN Matters web page at: http://www.cms.hhs.gov/MLNMattersArticles/ (see the downloads section). Use the new indices to find relevant articles needed to explain and support CMS transmittals - zero in on the article needed to get the information you want now!

Medicare Systems Edit Refinements Related to Hospice Services

MLN Matters® Number: MM6778
Related Change Request (CR) #: 6778
Related CR Release Date: February 5, 2010
Related CR Transmittal #: R121BP and R1907CP
Effective Date: Claims submitted on or after July 6, 2010
Implementation Date: July 6, 2010

Provider Types Affected

Providers submitting claims to Medicare contractors (Fiscal Intermediaries (FIs), carriers, Part A/B Medicare Administrative Contractors (A/B MACs), Durable Medical Equipment Medicare Administrative Contractors (DME MACs) and/or Regional Home Health Intermediaries (RHHIs)) for services provided to Medicare beneficiaries that have elected the hospice benefit.

Provider Action Needed

This article is based on Change Request (CR) 6778 which:

1. Revises existing Medicare standard systems edits to allow Medicare fee for service (FFS) claims to process for beneficiaries in a Medicare Advantage plan on the date of a Medicare hospice election.
2. Adds new edits ensuring the appropriate place of service is reported for hospice general inpatient care (GIP), respite, and continuous home care (CHC); and
3. Provides a technical correction to the *Medicare Benefit Policy Manual* regarding the requirement for nursing care related to hospice continuous home care.

Be certain your billing staffs are aware of these Medicare changes.

Background

Claims for Medicare Advantage (MA) Plan Beneficiaries Electing Hospice

In an effort to alleviate the often timely process involved for providers to resolve claim disputes on payment responsibility between MA plans and FFS Medicare, The Centers for Medicare & Medicaid Services (CMS) is revising the Medicare hospice and MA enrollment edit(s) for claims submitted on or after July 6, 2010 to allow claims to be processed by FFS Medicare for services occurring on the date of the hospice election. This will prevent services provided on the date of the election from rejecting as MA Plan responsibility. Providers that have claims being disputed may resubmit their claims on or after July 6, 2010 to FFS Medicare for payment consideration. Contractors will not be required to provide automated adjustments.

Place of Service for General inpatient care (GIP, Respite, and Continuous Home Care CHC)

Medicare hospice patients are able to receive hospice care in a variety of settings. CMS began collecting additional data on hospice claims in January 2007 with CR 5245, available at http://www.cms.hhs.gov/transmittals/Downloads/R1011CP.pdf, which required reporting of a Healthcare Common Procedure Coding System (HCPCS) code on the claim to describe the location where services are provided. Coverage and payment regulations at 42 CFR 418.202 and 418.302 define the locations where certain levels of care can be provided. GIP is described in the regulations at 42 CFR 418.202(e) as "short term inpatient care provided in a participating hospice inpatient unit, or a participating hospital or skilled nursing facility (SNF)..." Additionally, the regulations at 42 CFR 418.202(e) require that respite care be furnished in an inpatient setting, as described in 418.108, which limits care settings to a participating Medicare or Medicaid hospital, SNF, hospice facility, or nursing facility (NF). Finally, payment regulations at 42 CFR 418.302(a)(2) define CHC as "a day on which an individual who has elected to receive hospice care is not in an inpatient facility and receives hospice care consisting predominantly of nursing care on a continuous basis at home." Because CMS now has site-of-service data on hospice claims, they are able to use system edits to ensure more accurate billing of Medicare claims. CMS now edits claims to ensure that the level of care billed, for hospice, was provided at an appropriate site.

To facilitate more accurate billing of Medicare hospice claims, CMS is implementing several edits within the claims processing system to return to providers (RTP), claims submitted on types of bill 81x or 82x for which hospice days are billed for services provided in non-covered settings. Claims for days of GIP care (revenue code 0656) will be RTP'd if HCPCS site of service locations Q5001 (patient's home/residence), Q5002 (assisted living facility), or Q5003 (nursing long term care facility of non-skilled nursing facility) are reported on the same line, as these are not appropriate settings for payment of GIP. GIP may only be provided at Medicare certified hospice facilities, hospitals, or SNFs.

Similarly, claims for respite days (revenue code 0655) will be RTP'd if HCPCS site of service codes Q5001 (patient's

FYI CONT'D

home/residence) or Q5002 (assisted living facility) are reported on the same line, as these are not appropriate settings for payment of this level of care. Respite care may only be provided in a Medicare or Medicaid participating hospital, SNF, hospice facility, or NF.

Finally, claims for days of CHC care (revenue code 0652) will be RTP'd if HCPCS site of service locations Q5004 (skilled nursing facility), Q5005 (inpatient hospital), Q5006 (inpatient hospice), Q5007 (long term care hospital), or Q5008 (inpatient psychiatric facility) are reported on the same line, as these locations are not appropriate settings to bill for payment of CHC. CHC may only be provided in the patient's home, and may not be provided in these types of facilities. We believe these edits will improve the accuracy of Medicare billing and payment for hospice services.

Technical Correction

Regulations at 42 CFR 418.204 describe CHC as being provided during periods of crisis as necessary to maintain an individual at home. The regulation requires that care provided on days billed as CHC be "predominantly nursing care". This means that more than half of the time the nurse, aide, or homemaker spends providing care must be nursing hours.

Manual Clarification Regarding Ambulance Transport on the Date of Hospice Election

CR 6778 also revises the Medicare Benefit Policy Manual to clarify policy regarding payment of ambulance transports on the effective date of hospice election. Hospices do not feel that they are responsible for an ambulance transport which occurs on the effective date of hospice election, if the hospice has not yet conducted their initial assessment.

The deciding factor in determining whether a hospice is financially responsible for an ambulance transport on the effective day of hospice election is when the transport occurred, relative to when all the hospice coverage and eligibility criteria are met. If an ambulance transport occurs on the date of hospice election, but before all the criteria for hospice eligibility and coverage are met (i.e. the initial assessment has been conducted and the plan of care has been developed and includes the ambulance transport), the hospice is not responsible for the transport and the ambulance transport is covered through the ambulance benefit.

Additional Information

The official instruction, CR6778, was issued to your MAC, carrier, RHHI or FI regarding this change via two transmittals. The first, located at http://www.cms.hhs.gov/Transmittals/downloads/R121BP.pdf, contains revisions to the *Medicare Benefit Policy Manual*. The second transmittal at http://www.cms.hhs.gov/Transmittals/downloads/R1907CP.pdf contains revisions to the *Medicare Claims Processing Manual*.

MM5245, Instructions for Reporting Hospice Services in Greater Line Item Detail, is available at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5245.pdf on the CMS web site. For additional information regarding the Hospice Payment System see http://www.cms.hhs.gov/MLNProducts/downloads/hospice_pay_sys_fs.pdf on the CMS web site.

Hold the Date - PAOC Update Meeting on Competitive Acquisition for DMEPOS

Program Advisory and Oversight Committee (PAOC) Meeting
DMEPOS Competitive Bidding Program

February 23, 2010
8 a.m. - 4:30 p.m. ET

Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244

CMS will be hosting a meeting with the Program Advisory and Oversight Committee (PAOC) on February 23, 2010, to discuss the Round 1 Rebid and upcoming Rounds of the Medicare DMEPOS Competitive Bidding Program. Please mark your calendars!

CMS expects to begin registration for the meeting within the next few weeks and will send a listserv notification when registration opens. For more information about the DMEPOS competitive bidding program, including information about the PAOC, please visit: http://www.cms.hhs.gov/DMEPOSCompetitiveBid.

EDUCATIONAL

Announcing Face-to-Face Workshops for Spring/Summer 2010!

NAS is pleased to announce the Outreach and Education team will be conducting face-to-face workshops for DMEPOS suppliers!

Building the Foundation for Success

Attend this all-day workshop to gain the foundation needed for efficient billing. The goal of the workshop is to help you maintain and submit complete documentation, ensure your claims do not contain errors that delay processing and payment, learn where to locate answers and avoid claim denials, know how to submit a comprehensive appeal request, and access tools without having to incur the extra time and expense caused by incomplete claim submission.

Suppliers will be able to ask questions and network with other suppliers for best practices.

The following topics will be discussed:

- Comprehensive Error Rate Testing
- High Error Rate Policies
- Avoid Documentation Errors
- How to Appeal a Dispute
- Top Inquiries
- Telephone
- Written
- Redetermination

- Front End Errors
- Claim Error Report
- Know Your Payment Category
- Proper Use of Modifiers
- Successful Claim Filing
- NAS web Tour

Schedule

Workshop Check-in	7:30 a.m. - 8 a.m.
Workshop	8 a.m. - 4 p.m.
Lunch (on your own)	12 p.m. - 1 p.m.

2010 Locations

California
Long Beach - March 23
Pasadena - March 25
Sacramento - April 27
San Diego - May 17

Utah
Salt Lake City - April 29

Nevada
Henderson - May 19

Iowa
Des Moines - June 22

Kansas
Kansas City - June 24

Register Now!

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 web site. You can view the Q&A from the NAS home page by choosing Durable Medical Equipment > Training/Events > ACT Questions & Answers.

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

The following ACTs are offered:

General – 3 p.m. CT

- February 17
- May 20
- August 25
- November 10

Topic Specific – 3 p.m. CT

- Power Mobility Devices - February 4
- Positive Airway Pressure Device - March 17
- Glucose Monitor and Testing Supplies - April 21
- 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.

New Quick Reference Charts Now Available from Medicare Learning Network

Quick reference charts can be handy lists for looking up information!

The Medicare Learning Network (MLN) has produced two Quick Reference Charts, which provide information on frequently used CMS web pages.

The Quick Reference: All Medicare Providers (DEC2009) chart includes a list of CMS web pages that **all** Medicare providers use most frequently.

The Quick Reference: New Medicare Provider (DEC2009) chart includes a list of CMS web pages that **new** Medicare providers use most frequently.

These charts can be bookmarked and viewed online or they can be printed and used as ready references. Both charts can be located at http://www.cms.hhs.gov/MLNProducts/MPUB/list.asp on the MLN Publications page. Use search key word *"quick"* to locate these publications.

Medicare Learning Network – Celebrating 10 Years as Your Medicare Educational Resource!

This year marks the 10th anniversary for the Medicare Learning Network (MLN) – the home for official information for Medicare Fee-For-Service providers. We're located within the Centers for Medicare & Medicaid Services (CMS) and over the past decade, we've been very busy:

- Producing quality educational products designed to meet the needs and learning styles of busy health care professionals;
- Adding continuing education credits to many of our online courses; and
- Developing new and different ways to make our products accessible and available to the FFS provider community.

Whether you're familiar with the Medicare Learning Network or just curious about us, our upcoming marketing campaign will help you to discover or re-discover the features and benefits that so many members of the FFS provider community turn to on a daily basis. So, check your e-mails and join us as we enter our second decade of dedication to providing the Medicare FFS provider community with the education and information resources it needs.

Learn More about the Medicare Learning Network Right Now!

Download the Medicare Learning Network Marketing Brochure

View our new Marketing Brochure online to learn what the Medicare Learning Network has to offer – print copies of this brochure will soon be available on our Product Ordering System.

Order the Medicare Learning Network DVD– A Good Place to Start

This DVD contains quick and basic information about the Medicare Learning Network and its benefits to providers. The DVD is suitable for self instruction, as well as exhibits and training events. National and local provider associations are encouraged to post this product on their web sites and/or distribute via electronic newsletters or mailing lists. Run time is 7 minutes, 7 seconds.

Visit the Medicare Learning Network Product Ordering Page and scroll down to the "Educational Tool" topic category to find the DVD and place your order. You can also view the video online.

Stay tuned for more!

Revised CMS web-Based Training: Understanding the RA for Professional Providers

The revised Understanding the Remittance Advice (RA) for Professional Providers web-Based Training (WBT) has been made available by the CMS Medicare Learning Network (MLN).

Available for Continuing Education credit, this course provides instructions to help fee-for-service Medicare providers and their billing staffs interpret the RA received from Medicare and reconcile it against submitted claims. It additionally provides guidance on how to read Electronic Remittance Advices (ERAs) and Standard Paper Remittance Advices (SPRs), as well as information for balancing an RA. This course also presents an overview of software that Medicare provides free to providers in order to view ERAs. This training can be accessed by visiting http://www.cms.hhs.gov/MLNgeninfo/ and scrolling to the "Related Links Inside CMS" page section. Within these links, select web Based Training (WBT) Modules and then Understanding the Remittance Advice for Professional Providers from the list of training courses provided.

Revised Guided Pathways Booklets Now Available

Revised Guided Pathways (NOV2009) booklets now available at http://www.cms.hhs.gov/MLNEdwebGuide/30_Guided_Pathways.asp.

Are you wondering how to find the latest and greatest resources by subject? The Revised Guided Pathways (Nov2009) booklets incorporate existing Medicare Learning Network (MLN) products and other centers resources into well organized sections that can help Medicare Fee-for-Service (FFS) providers and suppliers find information to understand and navigate the Medicare Program. These booklets guide learners to Medicare program resources, FFS policies and requirements. You can access the Revised Guided Pathways (NOV2009) booklets at http://www.cms.hhs.gov/MLNEdwebGuide/30_Guided_Pathways.asp on the Medicare Learning Network.

New MLN Booklet: How to Use Medicare Coverage Database Search Tool

Do you ever wonder about how to utilize search tools in selected areas of the CMS web site? The searchable Medicare Coverage Database (MCD) contains all Medicare National Coverage Determinations (NCDs), National Coverage Analyses (NCAs), Local Coverage Determinations (LCDs), and local policy articles. The Medicare Learning Network (MLN) has produced a "How To" booklet (2.5 MB), that provides an explanation of the MCD, as well as how to use the Search, Indexes, Reports and Downloads features. The How to Use the Medicare Coverage Database booklet (November 2009) can be located at http://www.cms.hhs.gov/MLNProducts/MPUB/list.asp on the MLN Publications page. Use search key words *"how to"* to locate this publication quickly. Understanding the search tool is the best way to find the information for which you are looking!

Free Educational Products and Free Shipping from Medicare Learning Network

The high quality Medicare Learning Network products you depend on are always free! Did you know that shipment to your office or home is also free?

Go to the MLN Product Ordering page for a listing of products available in hard copy, and then add the products to your shopping cart. Your order will be processed for delivery and shipped right to your door!

Need multiple copies? When you checkout, just increase the quantity and follow the system prompts. Make sure to include your e-mail address in case we need to contact you to process your order.

Visit the MLN Products page and scroll down to MLN Ordering Page to start learning today.

Did You Resolve to Learn Something New This Year?

The Medicare Learning Network (MLN) web-based training courses are a perfect way to make good on that resolution. You can choose from a variety of courses that cover Medicare Program policy topics, ranging from general overviews to specific billing and coding information, as well as important education on new CMS initiatives.

You won't have to miss a moment in the office because you can access any course 24 hours a day, 7 days a week - and it's easy to complete the courses at your own pace. Each course is a compact learning opportunity; you gain a significant amount of information in just a short period of time. Stay on track with our Learning Management System. The System charts your completed courses and evaluations, and even remembers the chapters you have completed if you are not able to finish in one sitting.

Here is another benefit: many of our courses offer continuing education credits to help you meet academic requirements to obtain or maintain your license or certification.

And, remember - like all Medicare Learning Network products - our web-based training courses are free of charge.

Resolve to visit the MLN Products page today. Find out more information and click on web-Based Training to get started!

World of Medicare: New CMS web-Based Training Course

Looking for help with the fundamentals of the Medicare Program? This NEW web-based training (WBT) course from the Medicare Learning Network (MLN) can help!

The World of Medicare WBT is designed for health care professionals who want to understand the fundamentals of the Medicare Program. After completing this course, participants should be able to differentiate between Medicare Part A, Part B, Part C, and Part D, identify Medicare beneficiary health insurance options, eligibility, and enrollment, as well as recognizing how Medigap and Medicaid work with the Medicare Program.

This WBT course offers continuing education credits, please see the course description for details. This training can be accessed by visiting http://www.cms.hhs.gov/MLNgeninfo/ and scrolling to the "Related Links Inside CMS" page section. Within these links, select web Based Training (WBT) Modules and then *World of Medicare (January 2010)* from the list of trainings provided.

ICD-10-CM/PCS Conference Call Transcript Summaries

The written and audio transcript summaries of the ICD-10-CM/PCS Medicare Severity - Diagnosis Related Group Conversion Project National Provider Conference Call, which was conducted by the Centers for Medicare & Medicaid Services on November 19, 2009, are now available in the Downloads Section at http://www.cms.hhs.gov/ICD10/06a_2009_CMS_Sponsored_Calls.asp.

Top Ten Reopenings

The purpose of this article is to assist suppliers with solutions to the Top Ten reopenings our Appeals staff received from July – 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 maxinum approved amount for this item.

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

3. **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.

4. **Non-covered Charges**
   Non-covered charges.

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

5. **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.

Again, refer to the individual LCD and related Policy Articles for proper claims submission.

6. **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 Certificates of Medical Necessity (CMNs) or a DME Information Form (DIF). Ensure the

CMN or DIF is submitted with the correct information on the initial claim submission.

Another suggestion is to submit the initial claim and wait at least five days to submit consecutive months. This will ensure the initial claim has processed and the CMN was 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 web site 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.

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

8. **Procedure Code Invalid on Date of Service**
   Procedure code was invalid on the date of service.

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

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

Suppliers should review the documentation section of each individual medical policy to verify the utilization guidelines and the documentation requirements needed when billing for quantities of supplies greater than those described in the policy. The policies can be accessed from the Coverage/MR section of our web site by going to the section titled Local Coverage Determinations.

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

10. **No Prescription 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.

Top Ten Telephone Inquiries – July – September 2009

The purpose of this article is to assist suppliers with solutions to the "Top Ten" telephone inquiries our Supplier Contact Center received from July – September 2009 excluding eligibility and claim status. Our web site, https://www.noridianmedicare.com/dme, contains excellent information to assist with supplier inquiries.

1. Frequency/Dollar Amount Limitation

Suppliers will most often receive this denial when the quantity of supplies being billed is greater than the medical policy allows or payment has already been made for a same or similar item.

Suppliers should review each individual medical policy to verify the utilization guidelines and review the documentation requirements for billing quantities of supplies greater than those described in the policy. Each claim submitted for quantities of supplies greater than those described in the policy must have documentation supporting the medical necessity of the higher utilization. This supporting information should be reported in Item 19 on the CMS-1500 claim form or the narrative field of an electronic claim.

The policies can be accessed from the Coverage/MR Section of the NAS DME web site by going to the section titled Local Coverage Determinations.

To avoid receiving a same or similar denial, it is very important for suppliers to complete a thorough intake assessment. Suppliers should ask the beneficiary if they currently have or have had an identical or similar piece of equipment.

Utilize the Interactive Voice Response (IVR) system to verify the same or similar information provided by the beneficiary. Be aware, failure to use the appropriate modifier when checking same or similar on the IVR may result in inaccurate or incomplete same or similar information being returned. For complete information on modifier usage see the article titled Modifier Required When Using the IVR for Same or Similar Inquiries.

2. Common Working File (CWF) Rejects

These denials most often occur when the beneficiary is not eligible for Part B benefits because they are in an inpatient stay or home health episode on the date of service billed. During the intake process, suppliers should be asking

beneficiaries very specific questions, especially regarding home health. For example, ask the beneficiary if anyone is coming into the home to aid in any way.

If your patient is in a covered home health episode, some of the items you provide may be included in the home health prospective payment system (PPS) regardless of the reason the beneficiary is receiving home health benefits. A list of the items included in a covered home health episode is found on the CMS web site at http://www.cms.hhs.gov/HomeHealthPPS/03_coding_billing.asp.

3. Medical Necessity

Suppliers are encouraged to consult the Local Coverage Determination (LCD) and related Policy Article for medical policy coverage criteria.

If you receive a medical necessity denial, you have the option to submit a signed written request to appeal the decision. If you choose to appeal the decision, NAS recommends using the DME Inquiry/Redetermination form. Submit the request along with all pertinent medical documentation supporting the need for the item to:

Noridian Administrative Services
Attn: DME Redeterminations
PO Box 6727
Fargo ND 58108-6727

You may also fax your signed request and documentation to 1-888-408-7405.

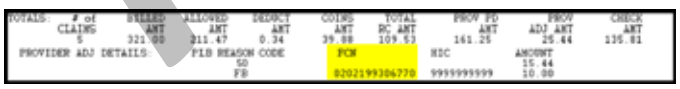
4. Certification Requirements

Oxygen equipment, pneumatic compression devices, osteogenesis stimulators, transcutaneous electrical nerve stimulators (TENS), and seat lift mechanisms require Certificates of Medical Necessity (CMNs). External infusion pumps and enteral and parenteral nutrition require DME Information Forms (DIFs). Suppliers should be knowledgeable regarding the medical policies for these items, as this will aid in completing the CMNs and DIFs. The medical policies can be accessed from the Coverage section of our web site.

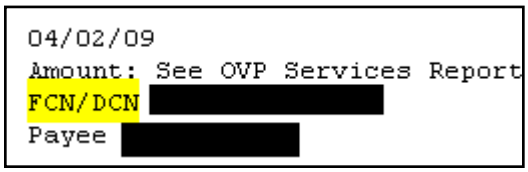
All CMNs and DIFs are located on the DME web site under the Forms section. The back of the CMN and DIF forms contain instructions for completing the form. Additional information regarding CMN requirements can be found in Chapter 4 of the DME MAC Jurisdiction D Supplier Manual.

5. Offsets

When calling for additional information on an offset or overpayment letter, please have the financial control number (FCN) available.



The FCN is available on your remittance advice when the adjustment refers to a claim that appeared on a previous remittance advice. The FCN is also located on the upper right hand portion of an overpayment letter.



We are able to provide the beneficiary name, date of service, dollar amount, and patient account number related to the offset, but not the beneficiary's Medicare identification number.

If you have multiple National Provider Identifier (NPI)/ Provider Transaction Access Number (PTAN) combinations, be sure to provide the pair associated with the FCN in question.

6. Duplicate Remittance Advice

On October 30, 2009, an option which allows suppliers to order duplicate remittance advices was added to the IVR. 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 article Duplicate Remittance Advice on the Interactive Voice Response System – Updated.

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 and remittance advice remark code (CARC and RARC) changes and allows the supplier to:

- Print ERAs in the Standard Paper Remittance (SPR) format;
- 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
web site: 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.

7. Eligibility

These denials most often occur when the beneficiary is no longer eligible for Part B benefits or the beneficiary information reported on the claim is incorrect.

It is the supplier's responsibility to determine whether the beneficiary is entitled to receive Medicare benefits and to report the Medicare number and beneficiary name as shown on the beneficiary's Medicare Health Insurance card.

Use the Eligibility option on the IVR to verify Part B entitlement, possible Health Maintenance Organization (HMO) coverage and possible date of death information.

8. Appeal Status/Explanation/Resolution

NAS will send an acknowledgement letter within 10 calendar days of receiving a redetermination request. If you have sent in a redetermination request and have not received an acknowledgement letter within 10 calendar days, you may wish to resubmit your request.

Once received, NAS processes redeterminations within 60 calendar days. If a fully favorable determination is made, written notification will not be sent. CMS has determined the supplier's remittance advice and the Medicare summary notice (MSN) sent to the beneficiary provide adequate information regarding the claim reversal.

Redetermination decision letters will be sent out on unfavorable or dismissed redetermination requests. Once a redetermination has been completed, another redetermination cannot be filed on the claim. The next step in the appeal process is to file a reconsideration. For more information on the appeals process, review Chapter 13 of the DME MAC Jurisdiction D Supplier Manual.

9. Coding Errors/Modifiers

This denial is most often seen when a required modifier is missing or the modifier used is inconsistent with the Healthcare Common Procedure Code System (HCPCS) code used.

Refer to the LCDs and related Policy Articles to verify which modifiers are appropriate to use with the HCPCS code billed and that all applicable modifiers have been appended to the claim.

The Medicare Pricing, Data Analysis and Coding (PDAC) web site can be used to determine if the HCPCS code was effective for the dates of service billed. Refer questions regarding the appropriateness of the HCPCS code used to the PDAC. For further questions contact PDAC at 1-877-735-1326.

10. Other Issues

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 web site 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/p-docs/email_brochure.pdf.

Top Ten Telephone Inquiries – October – December 2009

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1. Frequency/Dollar Amount Limitation

Suppliers will most often receive this denial when the quantity of supplies being billed is greater than the medical policy allows or payment has already been made for a same or similar item.

Suppliers should review each individual medical policy to verify the utilization guidelines and review the documentation requirements for billing quantities of supplies greater than those described in the policy. Each claim submitted for quantities of supplies greater than those described in the policy must have documentation supporting the medical necessity of the higher utilization. This supporting information should be reported in Item 19 on the CMS-1500 claim form or the narrative field of an electronic claim.

The policies can be accessed from the Coverage/MR Section of the NAS DME web site by going to the section titled Local Coverage Determinations.

To avoid receiving a same or similar denial, it is very important for suppliers to complete a thorough intake assessment. Suppliers should ask the beneficiary if they currently have or have had an identical or similar piece of equipment.

Utilize the interactive voice response (IVR) system to verify the same or similar information provided by the beneficiary. Be aware, failure to use the appropriate modifier when checking same or similar on the IVR may result in inaccurate or incomplete same or similar information being returned. For complete information on modifier usage, see the article titled Modifier Required When Using the IVR for Same or Similar Inquiries.

2. Common Working File Rejects

These denials most often occur when the beneficiary is not eligible for Part B benefits because they are in an inpatient stay or home health episode on the date of service billed. During the intake process, suppliers should be asking beneficiaries very specific questions, especially regarding home health. For example, ask the beneficiary if anyone is coming into the home to aid in any way.

If your patient is in a covered home health episode, some of the items you provide may be included in the home health prospective payment system (PPS) regardless of the reason the beneficiary is receiving home health benefits. A list of the items included in a covered home health episode is found on the CMS web site at http://www.cms.hhs.gov/HomeHealthPPS/03_coding_billing.asp#TopOfPage.

3. Medical Necessity

Suppliers are encouraged to consult the Local Coverage Determination (LCD) and related Policy Article for medical policy coverage criteria.

If you receive a medical necessity denial, you have the option to submit a signed written request to appeal the decision. If you choose to appeal the decision, NAS recommends using the DME Inquiry/Redetermination form. Submit the request along with all pertinent medical documentation supporting the need for the item to:

Noridian Administrative Services
PO Box 6727
Fargo ND 58108-6727

You may also fax your signed request and documentation to 1-888-408-7405.

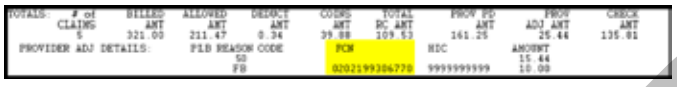
4. Certification Requirements

Oxygen equipment, pneumatic compression devices, osteogenesis stimulators, transcutaneous electrical nerve stimulators (TENS), and seat lift mechanisms require certificates of medical necessity (CMNs). External infusion pumps and enteral and parenteral nutrition require DME information forms (DIFs). Suppliers should be knowledgeable regarding the medical policies for these items, as this will aid in completing the CMNs and DIFs. The medical policies can be accessed from the Coverage section of our web site.

All CMNs and DIFs are located on the DME web site under the Forms section. The back of the CMN and DIF contains instructions for completing the form. Additional information regarding CMN requirements can be found in Chapter 4 of the DME MAC Jurisdiction D Supplier Manual.

5. Offsets

When calling for additional information on an offset or overpayment letter, have the financial control number (FCN) available.



The FCN is available on your remittance advice when the adjustment refers to a claim that appeared on a previous remittance advice. The FCN is also located on the upper right hand portion of an overpayment letter.

We are able to provide the beneficiary name, date of service, dollar amount, and patient account number related to the offset, but not the beneficiary's Medicare identification number.

If you have multiple national provider identifier (NPI)/ provider transaction access number (PTAN) combinations, be sure to provide the pair associated with the FCN in question.

6. Eligibility

These denials most often occur when the beneficiary is no longer eligible for Part B benefits or the beneficiary information reported on the claim is incorrect.

It is the supplier's responsibility to determine whether the beneficiary is entitled to receive Medicare benefits and to report the Medicare number and beneficiary name as shown on the beneficiary's Medicare health insurance card.

Use the eligibility option on the IVR to verify Part B entitlement, possible health maintenance organization (HMO) coverage, and possible date of death information.

7. Appeal Status/Explanation/Resolution

NAS will send an acknowledgement letter within 10 calendar days of receiving a redetermination request. If you have sent in a redetermination request and have not received an acknowledgement letter within 10 calendar days, you may wish to resubmit your request.

Once received, NAS processes redeterminations within 60 calendar days. If a fully favorable determination is made, written notification will not be sent. CMS has determined the supplier's remittance advice and the Medicare summary notice (MSN) sent to the beneficiary provide adequate information regarding the claim reversal.

Redetermination decision letters will be sent out on unfavorable or dismissed redetermination requests. Once a redetermination has been completed, another redetermination cannot be filed on the claim. The next step in the appeal process is to file a reconsideration. For more information on the appeals process, review Chapter 13 of the DME MAC Jurisdiction D Supplier Manual.

8. **Coding Errors/Modifiers**

This denial is most often seen when a required modifier is missing or the modifier used is inconsistent with the Healthcare Common Procedure Code System (HCPCS) code used.

Refer to the LCDs and related policy articles to verify which modifiers are appropriate to use with the HCPCS code billed and that all applicable modifiers have been appended to the claim.

The Pricing, Data Analysis and Coding (PDAC) web site can be used to determine if the HCPCS code was effective for the dates of service billed. Refer questions regarding the appropriateness of the HCPCS code used to the PDAC. For further questions contact PDAC at 1-877-735-1326.

9. Duplicate Remittance Advice

On October 30, 2009, an option which allows suppliers to order duplicate remittance advices was added to the IVR. 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 article Duplicate Remittance Advice on the Interactive Voice Response System - Updated.

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 and remittance advice remark code (CARC and RARC) changes and allows the supplier to:

- Print ERAs in the standard paper remittance (SPR) format;
- 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
web site: 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.

10. Other Issues

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 web site 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/p-docs/email_brochure.pdf.

Top Ten Written Inquiries – July – September 2009

In an effort to make our written correspondence staff more effective in helping suppliers with their inquiries, the top ten written inquiries for July - September 2009 are listed below along with reminders and resources related to each inquiry.

1. Issues Not Identified/Incomplete Information Provided

When sending correspondence 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.

Before sending your request, ensure all pertinent information has been included. NAS receives letters of medically necessity without a health insurance claim number (HICN), appeal request or date of service (DOS). Without this information, we are unable to identify the patient and/or claim in question. Lack of information may cause the inquiry to be returned as unprocessable.

2. Medical Review

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' web site at http://www.cms.hhs.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 web site.

3. Additional Development Letter Requests

Failure to respond to additional development requests (ADRs) 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' web site at http://www.cms.hhs.gov/Manuals/IOM/list.asp.

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5. Misrouted Written Correspondence

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' web sites, please visit the Contact section of our web site.

6. Claim Information Change

Before submitting a reopening request to correct information on a previously processed claim, review the claim to determine if it has been afforded appeal rights and if the error is one which can be corrected by a reopening.

Note: Please utilize the remittance advice to determine if the claim has been afforded appeal rights.

The following clerical errors or omissions **can be corrected** through a telephone reopening:

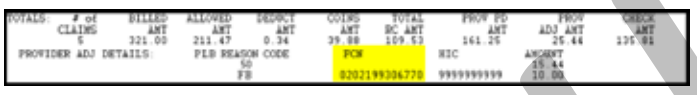
- Date of Service
- Place of Service
- HCPCS Codes
- Diagnoses
- Modifiers (with the exception of GA, GY or GZ which changes liability)
- Number of Services
- Billed Amount

The following administrative errors **cannot be corrected** through a telephone reopening and must be sent as a redetermination:

- Limitation of Liability issues, i.e., adding a GA modifier
- Requesting payment due to a break in service
- Certificate of Medical Necessity (CMN) or DME Information Form (DIF) corrections

7. Overpayments

When requesting additional information on an offset or overpayment, please include the financial control number (FCN).



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8. Benefits/Exclusions/Coverage Criteria/Rules

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

- **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, and upcoming workshops.
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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.

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6. Claim Documentation

Certificates of medical necessity (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.

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.

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EDUCATIONAL CONT'D

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CERT

DME MAC CERT ACT Pre-Submitted Questions

The following questions were received prior to the DME MAC Comprehensive Error Rate Testing (CERT) Education Task Force Ask the Contractor Teleconference (ACT) on January 13, 2010.

Q: What is the appropriate date of service for enteral nutrition? Is it the date of delivery or patient usage dates?

A: Per the Centers for Medicare and Medicaid Services (CMS) Program Integrity Manual (PIM), in instances where the supplies are delivered directly by the supplier, the date the beneficiary received the Durable Medical Equipment Prosthetics, Orthotics, and Supplies (DMEPOS) shall be the date of service on the claim. "If a supplier utilizes a shipping service or mail order, suppliers shall use the shipping date as the date of service on the claim." There is no exception specific to enteral products.

Q: Please discuss the issue of requiring physician oversight for certain DMEPOS items/services where the Local Coverage Determination (LCD) does not state this requirement.

A: For any DMEPOS item to be covered by Medicare, the patient's medical record must contain sufficient documentation of the patient's medical condition to substantiate the necessity for the type and quantity of items ordered and for the frequency of use or replacement (if applicable). The information should include the patient's diagnosis and other pertinent information including, but not limited to, duration of the patient's condition, clinical course (worsening or improvement), prognosis, nature and extent of functional limitations, other therapeutic interventions and results, past experience with related items, etc." 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."

Q: How are DME services targeted for CERT?

A: All Medicare providers and suppliers (inpatient facilities, hospitals, skilled nursing facilities, home health agencies, physicians, outpatient services and DMEPOS suppliers) are subject to a random CERT review.

Q: For overnight oximetrys, is the face sheet indicating the sum of all of the testing results sufficient or must we have the actual graphs? The referral sources always give us a hard time with this.

A: A Face Sheet (like a CMN or DIF) must have its information supported by actual clinical records, such as the actual copy of the report, or the studies documented within the doctor's or nurse's notes. "However, neither a physician's order nor a CMN nor a supplier-prepared statement nor a physician attestation by itself provides sufficient documentation of medical necessity, even though it is signed by the treating physician. There must be clinical information in the patient's medical record that supports the medical necessity for the item and substantiates the answers on the CMN (if applicable), or information on a supplier-prepared statement or physician attestation (if applicable).

Q: What specific documentation are you looking for on the annual physician's visit? Can we compose a form that is included in the visit record that the physician would complete?

A: Specific documentation in an annual doctor's visit depends on the item(s) being billed. Documentation must cite the medical necessity of the items as indicated within the specific policies listing the medical necessity of the coverage criteria. You are not prohibited from creating a form for screening purposes; however, any information contained on the form must be substantiated by comprehensive information in the medical records.

Q: Why are CERT documentation requests seemingly more stringent than the corresponding LCD?

A: CERT documentation requests may seem to be more stringent due to the fact that not only are the LCD's being taken into consideration but also ALL applicable CMS manuals and regulations are being considered.

Q: For oxygen patients we are having a difficult time with the physicians not performing actual oximetry or ABG tests. Most physicians are just doing pulse oximetry tests in the office. Is this acceptable?

A: Yes, as long as the test meets all the policy requirements.

Q: If a supplier leaves some emergency enteral supplies in a SNF for late admissions or physician order changes, what date of service do we use on the claim since there is not a delivery/shipping date? Can a delivery ticket detailing the resident it is dispensed to and a date is created to dispense emergency Part B enteral supplies in long-term-care?

A: In chapter 4 of the PIM, it does state " For those patients that are residents of a nursing facility, upon request from the DME MAC, suppliers should obtain copies of the necessary documentation from the nursing facility to document proof of delivery or usage by the beneficiary (e.g., nurse's notes).

Q: Manufacturers of enteral supplies do not recommend breaking cases to ship supplies because they can be damaged or contaminated. If a resident requires 30 bottles of enteral nutrition for the month and there are 8 bottles per case, this leaves 2 extra bottles. In 4 months, we eventually ship a case less because the beneficiary has the extra, how does the supplier get paid for the products they have provided up to 4 months ago? How do we prove this in a post-pay audit since the shipping date for the extra supplies is more than 5 days prior to the usage date?

A: It is recommended by the manufacturer to not break up cases; however, this is not a requirement. Per Medicare guidelines and regulations, suppliers should only bill and supply what the patient is actually using. Suppliers are reminded that you are only able to bill up to a one month supply at a time.

Q: What specific documentation is needed in suppliers' files for oxygen patients? Are specific oxygen test results needed in suppliers' files? How do suppliers document that the patient has been re-seen by their physician?

A: The file should contain, the written physician order, initial & recertification (if applicable) CMNs, copy of study results report, clinical evaluation/ re-evaluation (if applicable) and clinical records to support information stated in the CMNs, and ongoing documentation of the medical management of the patient's oxygen use in the patient's record. You must have access to specific oxygen test results (a copy of the actual study) in case of an audit, you can reference the oxygen LCD for these testing requirements. Suppliers may include chart notes proving that the patient has been seen and reevaluated in the required timeframe according to the LCD.

Q: What exactly does the supplier need to do to verify the signature of the treating physician in the case of a CERT audit?

A: CERT will accept an attestation letter of signature verification. CERT will also use other records submitted to attempt to match the illegible signature.

Q: Are you going to start to adhere to legible doctor signatures when deciding to accept/not accept medical documentation?

A: Yes.

Q: Our National Company has a billing center and sometimes there are problems with the distribution sites receiving the CERT request. Is there a way to make sure the billing center receives the request?

A: A point of contact may be established with CERT. When calling the CERT contractor to confirm updated contact information, please ensure to have your DME MAC Contractor number ready.

Q: Why do claims still deny for medical necessity even though the CERT audits are answered? Why do the same patients get picked for CERT audits over and over?

A: Submitting medical records to CERT does not guarantee that they support the medical necessity for coverage criteria of the items billed. For example, a progress note sent may not contain the information necessary to meet an item's coverage criteria needed for the item. CERT selects claims randomly. The more claims a supplier submits, the higher the probability that a supplier's claim may get chosen.

Q: Does there need to be a specific number of refills on a prescription/order for diabetic supplies, or can they get the appropriate quantity (every 30 days or 3 months) for up to 12 months from the prescription date, after which a new prescription is required?

A: The prescription/order is valid for what the doctor prescribes, i.e. one month, 6 months, 12 months or lifetime, unless a policy specifies a specific time when a new order is required.

Q: When a person comes in with an appropriate prescription with diagnosis on it for DME (i.e., manual wheelchair, or semi-electric bed), can we call the ordering physician to ask the duration of need and document it on prescription? Do we have the beneficiary sign the ABN indicating the reasons the DME may not be covered per LCD? Do we not give the DME to the person until we get the required medical documentation (week/month) to ensure we will be paid and not have money taken back if we were audited because the person was not eligible?

A: Based on the initial order, suppliers can complete and send back to the physician to sign off on. The ABN must be provided prior to delivery of the item and suppliers would need to have knowledge if the patient does or does not meet medical necessity prior to having them sign the ABN.

Q: How should we handle requests for documents that are not a requirement of the LCD?

A: CERT asks for documentation beyond what is listed in the LCD. They also ask for information from CMS Manuals and regulations.

Q: Please explain the "Specialty Evaluation" and whether it includes ALL accessories to a power wheelchair.

A: The "Specialty Evaluation" is typically completed by a physical therapist (PT) or occupational therapist (OT) specializing in power wheelchairs. The evaluation should be a written document providing information on how the power options (such as; power tilt or recline) will address and aide the patient's mobility limitations as well as any other added feature to the basic power wheelchair.

Q: What documentation is needed for intermittent use of inotropic drugs on an E0781 ambulatory infusion pump?

A: The documentation needed would be a written order, physician records pertaining to the information as outlined in the Local Coverage Determination (LCD) and Policy Article including the before and after inotropic drug infusion values, request for refill, and proof of delivery.

Q: What is the supplier's responsibility for monitoring oxygen use? If patients are not using the oxygen for the hours prescribed, what is the supplier's responsibility regarding informing the prescribing physician?

A: We are all responsible for doing our part to protect the Medicare Trust Fund by ensuring that claims submitted to the Medicare Program for reimbursement meet the Medicare coverage criteria. If a supplier is aware that a beneficiary is not using oxygen for the hours prescribed, or that the beneficiary no longer meets medical necessity criteria, the supplier should inform the ordering physician. If the supplier is aware that the coverage criteria are not met, the supplier should not submit a claim to the Medicare program for payment.

Q: If the patient is not using oxygen, but still has saturation levels at rest of less than 89%, and the physician refuses to certify that the patient does not require oxygen, what is the supplier's responsibility for continuing to supply and bill for oxygen?

A: If the supplier is aware that the coverage criteria are not met, the supplier should not submit a claim to the Medicare program for payment. In the case of items which require a discontinue order from the ordering physician and the ordering physician does not find it in the patient's best interest to discontinue the item, suppliers should execute an ABN advising the patient of his or her financial liability for the items/services.

Q: What specific documents are you looking for when auditing a CPAP claim?

A: If the claim is for the first through third month(s) then initial coverage criteria would need to be met with the following documentation provided: written order, qualifying sleep study, documentation regarding the initial face to face examination, and proof of delivery. If the claim is for fourth and subsequent months, the supplier must provide initial coverage criteria documentation plus documentation regarding meeting compliance as outlined in the LCD, re-evaluation, and continued use of the equipment or supplies (request for refill).

Q: What do supplier's look for in physician records to support over-utilization for diabetic testing supplies? If patients are not testing their blood sugars, should they be eligible for diabetic shoes and inserts?

A: The physician records regarding supporting over-utilization for diabetic supplies should describe the patient's symptoms requiring an increase in testing frequency, how long they feel the patient will need to test at a higher frequency, what the patient's blood sugar readings are and changes being made with their diabetes management, and when their last HGB A1C and results was. Diabetic shoes and inserts are eligible for coverage if the patient has documented diabetes mellitus and meet one or more of the conditions as outlined in the local coverage determination (LCD) and policy article documented in the medical records by the certifying physician.

Q: What clinical documents are necessary to make a file complete for diabetic supplies, especially if a diabetic patient is not insulin dependent and provides a prescription written from M.D. for testing more than once a day.

A: The documentation that should be provided if requested for a non-insulin dependent diabetic testing above the typical allowed amount (once per day) would include; written order, physician progress notes regarding the patient's condition and need for testing above the allowed amount, patient's testing log showing they are in fact testing the prescribed amount of times, request for refill, and proof of delivery.

Q: How do you begin approaching the physician with the request to obtain the copies of his clinical notes especially now that everybody is concerned with HIPAA?

A: It is not against HIPPA law for physicians to provide suppliers with the medical record documentation to help support the need for their claims. Each of the four DME MAC Jurisdictions have documents available on their web sites (such as the "Dear Physician" letters) to educate and help obtain the necessary documentation from the physician.

Q: We have a lot of issues with patients not seeing their physician in several years and the physician is not able to provide medical records. We spend endless hours trying to obtain documentation, but are at a loss providing these records to CERT.

CERT CONT'D

A: This is a business decision on the supplier's part whether to obtain the supporting medical documentation up front or to wait until a request is received. If you wait until a request is received then you are taking a greater chance that you will not be able to obtain the supporting documentation and therefore holding you liable due to coverage criteria not being supported and an not having issued an ABN.

Q: How can we get doctors to sign their names legibly?

A: We are encouraging suppliers to start sending in signature keys. Some suggestions are having a log with the physicians name printed clearly and then their signature next to it. Also we have heard some suggestions about on the orders having the physician's name printed clearly underneath his signature.

Q: What is acceptable paperwork for the prescription and Detailed Product Description - is there a form that Medicare can provide so everything can be uniform Medical Documentation?

A: Medicare does not provide a document for suppliers to use regarding the written order or the detailed product description but provides what information must be on these documents.

Q: What avenues of recourse are there when the physician or physician offices do not respond to the audit documents requests and in fact refuse to collaborate with the suppliers?

A: Currently there is no recourse on the physicians if they do not respond to the Request from CERT regarding a DME supply. Suppliers should refer to the PIM citation Manual 100-8 Chapter 5 section 5.8 which states the following, "the supplier should also obtain as much documentation from the patient's medical record as they determine they need to assure themselves that coverage criteria for an item have been met. If the information in the patient's medical record does not adequately support the medical necessity for the item, the supplier is liable for the dollar amount involved unless a properly executed ABN of possible denial has been obtained."

Q: Are supplemental insurance required to pay according to how Medicare pays on a Home Sleep Study. We continue to receive denials where the supplemental insurance does not pay and they state it is non-covered even though Medicare found it to be medically necessary.

A: Not all supplemental insurances are considered Medigap policies; therefore they are not required to pay according to Medicare. A Medigap policy is health insurance sold by private insurance companies to fill the "gaps" in Original Medicare Plan coverage. Medigap policies help pay some of the health care costs that the Original Medicare Plan doesn't cover. If a beneficiary has the Original Medicare Plan and has a Medigap policy, then Medicare and the Medigap policy will each pay its share of covered health care costs. Within each Medigap policy are different levels of coverage.

Suppliers are encouraged to check with the supplemental insurance to determine if it a Medigap policy and to determine the level of coverage the beneficiary has. If the supplemental insurance the beneficiary has is not Medigap, the supplemental insurance is not required to cover the same services as Medicare covers. To report non-compliant Medigap insurances, suppliers should contact your local state insurance department. For additional information on Medigap coverage, please refer to the Centers for Medicare & Medicaid Services web site: http://www.cms.hhs.gov/Medigap/

Q: Recent CERT requests related to oxygen have asked for evidence of ongoing medical necessity after the time of the recertification CMN (that is the 2nd CMN signed by the physician as required in the LCD). Why is this, how should the supplier respond and is there basis for claims denial if no further testing or physicians documentation is available?

A: Suppliers should be checking on a continual basis with the beneficiary that they are in fact continuing to use the equipment and do need the supplies being provided to them. This would be checking for a "request for refill" which is outlined in the IOM 100-08, chapter 4, section 4.26.1. Some type of documentation regarding either contacting or being contacted by the beneficiary within one week prior to delivery that the beneficiary attests to using the equipment and needing the items and quantities to be delivered.

Q: Are ABN's appropriate when certain physicians, or other prescribing providers, have demonstrated they are not willing to provide the requested clinical/medical information to substantiate their prescription?

A: The supplier should obtain as much documentation from the patient's medical record as they determine they need to assure themselves that coverage criteria for an item have been met. If the information in the patient's medical record does not adequately support the medical necessity for the item, the supplier will be held liable for the dollar amount involved unless a properly executed ABN has been obtained. A supplier may not routinely issue ABNs to a particular physician who has a history of not providing the necessary documentation; the supplier may only issue the ABN after the supplier has attempted to obtain the necessary documentation and failed, and/or the documentation received does not support medical necessity.

Q: Why are suppliers being asked to provide medical records beyond the scope of what is outlined in the specific LCDs? Why are physicians and beneficiaries not held responsible for some of the fraud committed in the industry?

A: Suppliers are being asked to supply records in accordance with ALL Medicare Guidelines not just Local Coverage Determination and Policy Article. As it is stated in the PIM 100-8 Chapter 5 Section 5.7 "However, neither a physician's order nor a CMN nor a DIF nor a supplier prepared statement nor a physician attestation by itself provides sufficient documentation of medical necessity, even though it is signed by the treating physician or supplier. There must be information in the patient's medical record that supports the medical necessity for the item and substantiates the answers on the CMN (if applicable) or DIF (if applicable) or information on a supplier prepared statement or physician attestation (if applicable)."

Q: If a recertification CMN overlaps a revised CMN, how is this handled so it does not create a denial for CMNs?

A: When a change occurs that necessitates a revised CMN, and a recertification CMN is also due, the supplier must submit only the recertification CMN.

Q: What do you do if the MD does will not provide Progress notes? What do you do if the MD provides Progress notes, that are poorly written and do not pertain to the piece of equipment that was ordered and already given by DME.

A: It is the supplier's responsibility to obtain the documentation needed to support the medical necessity of the equipment being supplied. If the physician does not provide you with the documentation that you request you can explain to them that it is stated in the PIM Chapter 5 Section 5.7 "For any DMEPOS item to be covered by Medicare, the patient's medical record must contain sufficient documentation of the patient's medical condition to substantiate the necessity for the type and quantity of items ordered and for the frequency of use or replacement (if applicable). The information should include the patient's diagnosis and other pertinent information including, but not limited to, duration of the patient's condition, clinical course (worsening or improvement), prognosis, nature and extent of functional limitations, other therapeutic interventions and results, past experience with related items, etc" and "There must be information in the patient's medical record that supports the medical necessity for the item and substantiates the answers on the CMN (if applicable) or DIF (if applicable) or information on a supplier prepared statement or physician attestation (if applicable)". This is a business decision on the supplier's part whether to obtain the supporting medical documentation up front or to wait until a request is received. If you wait until a request is received then you are taking a greater chance that you will not be able to obtain the supporting documentation and cannot issue an Advance Beneficiary Notice of Non-coverage at that time holding you liable due to coverage criteria not being supported.

Q: How long after submitting CERT requested information should we receive a decision?

A: Once the CERT review is completed and if CERT has made a denial on your claim the DME MAC will adjust your claim. You will then receive a recoupment letter from the Overpayment Recovery Unit within 30 days.

Q: Please provide a list of important documentation needed for a Medicare patient on enteral formula with or without pump and supplies.

A: Please refer to the Documentation Requirements within the Local Coverage Determination and Policy Article for Enteral Nutrition.

Q: Does the Assignment of Benefit (AOB) from the patient have to be signed and dated before the date of service?

A: AOB must be signed and dated before or on the date of service.

Q: Could failure to include the KX modifier be a CERT trigger?

A: The CERT contractor randomly selects claims for review. Improper use of the KX should not "trigger" a CERT review.

Q: Can an respiratory therapist (RT) in an oxygen supplier's office do pulse oximetry spot checks on patients at rest to qualify them for home O2 if they have orders from a physician? Exactly who is considered "qualified" to provide this test?

A: No, a respiratory therapist in a supplier's office will not qualify a beneficiary for home oxygen under any circumstances. The rules governing who can qualify a patient are governed by the Oxygen and Oxygen Services LCD (L11446) under the "Testing Specifications" section.

Q: How do suppliers get reimbursed for oxygen tank delivery? When and how do we bill for maintenance for oxygen patients?

A: Medicare does not pay separately for the delivery of oxygen tanks, since it is included in the supplier's monthly rental reimbursement during the 36-month rental cap, and it is included in the reimbursement for contents after the 36-month cap is reached. The rules for maintenance and servicing of oxygen equipment for 2010 are outlined in detail in Medicare Learning Network Matters article 6716.

Q: Where do I find documentation requirements for diabetic shoes?

A: Documentation requirements for Diabetic Shoes are available in the Therapeutic Shoes for Diabetics LCD (L11525) and Policy Article.

Q: Do we need to have a copy of the face-to-face in our patient chart, or will documentation of the date and time be sufficient for billing purposes?

A: If the supplier is referring to Power Mobility devices, yes the face-to-face exam must be in the suppliers' files.

Q: Will LCD/fee schedules list the correct modifiers/ HCPC information for providers on January 1, 2010? I understand that as of January 1st, any errors with modifiers will not be able to be corrected through the reopening process anymore. Will Medicare provide correct modifiers/information on web site?

A: If supplier is referring to the proper use of the KX modifier, yes information is available on the contractor web sites regarding correct usage. Changes have recently been made to several Medicare policies regarding use of the KX, GA, GZ, and GY modifiers. Suppliers should refer to the LCD to determine proper use of those modifiers. For many modifier situations, when the modifiers are incorrectly billed, this may result in a return/reject. For those situations, suppliers must correct the claim line and resubmit the claim for processing – it is not necessary to go through the reopening process.

Q: Please provide information specific to filing post operative cataract glasses. How do we properly file for frame and lenses following cataract surgery? Are patients allowed 2 frames if they have surgery on both eyes? Do these benefits expire? Can a patient use their current frame but file for lenses only? What add-ons are allowed or are they all patient responsibility?

A: Suppliers are required to have a National Supplier Clearinghouse number and submit claims to the appropriate DME MAC based on where the beneficiary is registered with Social Security. There are statutory limits; one pair of lenses and frames after each cataract surgery. This is not an accumulative benefit. If the beneficiary does not get lenses after the first surgery but waits unit after the second, only one pair is allowed. A patient may use their current frames and only replace the lenses, but frames at a later time will not be allowed. Please refer to the LCD and Policy Article for medically necessary options and how to appropriate bill for them, as well as all general coverage, coding and billing requirements.

Q: What key elements will the CERT Contractors be addressing during an audit?

A: Documentation to support medical necessity and proof that the coverage criteria are met as well as appropriate code guidelines are followed.

Q: What can be done to get more cooperation from doctors in providing DME companies with sufficient medical documentation so that we may better comply and feel confident that what we have obtained with be enough in case of an audit?

A: A vigorous intake process is recommended. Asking the appropriate questions once an order is received based on coverage criteria requirements, begins the documentation process. Partnering with the physician on behalf of the beneficiary is a must. If you are finding that difficult, please refer and utilize one of the many physician letters developed by the DME MAC Medical Directors, which discusses the ordering physician's roles, and responsibilities required by Medicare law.

Q: Are there any CERT documentation requirements specifically affecting orthotics and prosthetics?

A: Documentation requirements are the same regardless of what type of equipment is dispensed.

Q: How come the date of service in question gets recouped when there is not a doctor's note on that specific date but the need is still proved by doctor's notes around that date. What do we do when the doctor refuses to give the notes needed even when we give them the CERT audit and the letter Medicare made for this reason? How come a "pad Rx" is not considered part of the patient's medical record when the doctor signs it?

A: 1. An item cannot be dispensed before the medical need is determined. For example, if the physician documented the need in the beneficiary's medical record on 1-1-10, the item cannot be dispensed prior to that. 2. Suppliers should assure prior to dispensing an item that the medical records support the medical need and medical records are available upon request. 3. A "pad Rx" is just that, an order. The patient's medical record includes the ordering physicians patient's diagnosis and other pertinent information including, but not limited to, duration of the patient's condition, clinical course (worsening or improvement), prognosis, nature and extent of functional limitations, other therapeutic interventions and results, past experience with related items, etc. The "pad Rx" cannot provide this type of information and is not considered the patient's medical record.

Q: How are physicians in the hospital affected by the outcomes of the CERT program in regards to documentation/ordering?

A: The DME supplier is expected to know if there is appropriate documentation and a complete order for an item. If a DMEPOS item is dispensed, and a CERT audit is conducted that shows the documentation is not sufficient to support medical necessity, the DME supplier is affected by recoupment, not the ordering physician. The Local Part B and Part A contractors also receive CERT audits that may affect hospitals, and physicians within those hospitals reimbursements.

Q: Please explain compliance for CPAP documentation both before sleep study and after trial use. What is sufficient from the doctor before sleep study? If chart notes are not detailed, does the DME supplier deny delivery of CPAP machine to be covered by Medicare even though the sleep study definitely showed a medical need? It is hard for us as a supplier to determine if the medical chart notes are sufficient for an audit.

A: Before the sleep study the beneficiary must have received a face-to-face examination with a treating physician to assess the patient for obstructive sleep apnea. A thorough intake process in recommend to assure all the coverage criteria is met. Asking appropriate questions and gathering medical records prior to dispensing the device allows the supplier to know if coverage criteria is met, if the coverage criteria is not met, the supplier may want to consider executing an ABN to protect themselves from liability.

Q: What is included in the error rate calculation? Should entities use this calculation to track error rates? Is the expected error rate always 0%, or up to 5%?

A: The error rate is calculated for the Medicare contractor, not the individual suppliers.

Q: Why now do we have to have blood gas done when before it was pulse oximetry or blood gas? Do you have to have a special person to do a power wheelchair that is sold without special seating?

A: In the Oxygen LCD, the term blood gas study includes both an oximetry test and an arterial blood gas test. A Group 2, single power option power wheelchair and above requires the supplier to employ a RESNA-certified Assistive Technology Professional (ATP) who specializes in wheelchairs and who has direct, in-person involvement in the wheelchair selection for the patient.

Q: Who is supposed to train a patient on the usage of a glucometer — the doctor or the supplier? What kind of documentation do we need to keep in patient's file? What can we do if doctors are not willing to send progress notes, lab etc.?

A: Glucometer training can be completed by either the physician or the supplier. However, it is the responsibility of the supplier to ensure the training has been completed to be in compliance with the Glucose Monitors LCD. Per this LCD, the following documentation is required to be in the patient's file and made available upon request: verbal order (if item is dispensed based on a verbal order), written order, beneficiary authorization, proof of delivery, and documentation supporting the basic coverage criteria. Additional documentation must be included in the patient's medical record including the diagnosis, reason for frequency of testing, physician's evaluation, actual testing frequency, and evidence that the supplies are nearly exhausted prior to refilling the order. Refer to the Glucose Monitor LCD for detailed information. If a supplier is having issues retrieving appropriate documentation from the physician, there is Physician Letters on the DME MAC web sites to help in the collection of this required documentation.

Q: If a beneficiary is at a facility and we get a request for DME items and the beneficiary's address with Medicare is the same as the facility do we indicate the place of service as "home"?

A: If the beneficiary is in an Assisted Living Facility use POS 13, for a Nursing Home use 32. Refer to your Jurisdiction's supplier manual for appropriate POS codes.

Q: Prior to all the recent guidance to use ship date versus usage date for our enteral patients we were following the 7 day 5 day rule for contacting patient, however we used the documented next usage cycle as the bill date. For example, we have clear documentation that we have contacted the beneficiary, reviewed their inventory, asked our nutritional support questions to determine compliance, and informed beneficiary that we will be shipping their next month supply tomorrow (within the 5 day window). And it is documented that this shipment is for the next supply period e.g. January 5- February 4th. That is what we used for bill dates versus the current guidance to use the ship date as the bill date. What is our liability in this situation?

A: Date of service is either the ship date if the item is being shipped, or the date the supply was directly delivered to the beneficiary. If it differs, that may cause a CERT error.

Q: Why does it take so long to get results from CERT audits? We just received an overpayment request from 18 months ago.

A: The CERT reviews are usually completed within 60 days but after the CMS issued JSM/TDL-09225 dated 03-26-09 CERT was instructed to go back and re-review all of their previous determinations made after the OIG findings were released. What happened was the OIG (Office of Inspector General) performed quality review on the CERT claim determinations. The OIG findings determined that CERT was not reviewing the claims in accordance with CMS guidelines and regulations therefore claims that had been reviewed more than a year ago where re-reviewed for a determination.

Q: Could CMS make it as a policy or standard that every person in the DME or like be trained or possess some kind of health related certification or accredited college degree in an area dealing with DME as a provider, or open up a new DME business?

A: All Medicare statutory and regulatory requirements must be followed, to include Quality Standards, Accreditation and Supplier Standards. Supplier Standard # 1 states all applicable Federal and State licensure and regulatory requirements must be met.

Q: We have gotten requests for documentation that is not listed in the LCD, such as physician follow-up at 6 months when it is not a recertification. How do we deal with these?

A: CERT reviewers will ask for documentation to support the beneficiary is still needing and using the oxygen and is under the physicians care for oxygen. CERT needs to make sure the beneficiary is seeing a physician for their oxygen needs. All LCD's state in the documentation section:

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.

Q: When a doctor writes a prescription knowing that a patient does not qualify for the item prescribed, wouldn't that be a fraud?

A: This would not be considered fraudulent. Physicians may prescribe an item they believe is necessary for their patient without regard to DME statutes.

Q: Is a physician's assistant (PA) or nurse practitioner (NP) allowed to make corrections to an order signed off on by an MD or DO? How should additional information" or "changes" be documented on an order or chart note? Does it require date and initials or just initials?"

A: No, any corrections to documentation must be made by the physician. A physician must initial and date all corrections.

Q: Any suggestions on how we are to retrieve the extra documentation from the doctors.

A: All DME MACs offer resources such as the "Physician Documentation Letter" that can assist suppliers in obtaining medical records.

Q: What are the requirements for oxygen?

A: Please refer to the Oxygen LCD (L11446) and Policy Article (A33750).

Q: Why are ABN's not used or recognized by Medicare Fee for Service Insurance? If we cannot use them than what are we to do if our customer wishes to upgrade? Do they not have that right as a Fee for Service customer?

A: ABN's are used for Fee-for-Service Medicare. You can locate ABN information on the CMS web site and each DME MAC web site.

Q: What is CERT looking for in physician's progress notes? What date range of progress notes is CERT looking for?

A: Physician progress notes must support that the criteria outlined in the LCD are met. The date range would vary depending on the dates of service in the CERT request.

Q: Are there any direct changes affecting the Post/op Rx glasses?

A: No.

Q: It has been under our impression that our detail order which had the same as the 7 element order was ok. But now we are being denied because we don't have a separate 7 element order. When did the 7 element order take place?

A: The 7 element order was required as of 05/05/05 which was included in the archived motorized/power wheelchair base LCD. The Physician or PT/OT is able to complete the MRADL's but the treating physician must still sign off on these results.

Q: We have a terrible time getting physicians to respond to our requests for documentation. When they do respond, it is never with the documentation we have specifically asked for.

A: Since the provider receives payment for the item dispensed, it is up to the provider to be sure they have or have access to the required documentation. There are "Dear Physician" letters available on each DME MAC web site to help in obtaining the required documentation.

Q: What documentation must accompany a claim for continued CPAP or Bi-Level therapy after a patient has failed the initial 90-day period and additional 30-day period?

A: Documentation requirements are outlined in the LCD and Policy Article. The supporting documentation must be kept on file and does not have to be submitted with the claim.

Q: What is Medicare's role in educating physicians about the detail of documentation Medicare expects to find in the patient's medical record to justify equipment or on-going use of supplies?

A: The DME MACs are required to and funded to educate the supplier community. Therefore, we only provide limited education to the physician community. However, the DME MACs are working with Part A and Part B Medicare contractors regarding physician education pertaining to documentation requirements affecting the supplier community. The suppliers are expected to help educate the physician community on the documentation requirements.

Q: How do you get the Medicare members to go to Pedorthic or DME facilities with a prescription and physician's documentation/medical necessity? Everyone comes in with only a prescription and would have to go back to get physician's documentation.

A: The DME MACs are required to and funded to educate the supplier community. Therefore, we only provide limited education to the physician community. The suppliers are expected to help educate the physician community on the documentation requirements necessity

Q: What is being done to reduce offsets due to home health consolidated billing?

A: Home Health is given a timely filing limit similar to providers. Therefore, this issue cannot be corrected. It is up to the provider to be sure that their patient is not in a home health episode when supplying items to a beneficiary.

Q: What documentation is needed for intermittent use of inotropic drugs on an E0781 ambulatory infusion pump?

A: The documentation needed would be a written order, physician records pertaining to the information as outlined in the Local Coverage Determination (LCD) including the before and after inotropic drug infusion values, request for refill, and proof of delivery.

Q: Please explain exactly what types of documentation are required for each piece of equipment that you cover.

A: Suppliers must review the LCD regarding the type of equipment in question to determine what documentation is required. The documentation requirements in each LCD differ.

Q: How long will it take to get a determination on CERT audits? I am seeing overpayment determinations more than a year after the original audit documentation was submitted.

A: Most of the time there is a 60 day turn-around but during this report period the CERT contractor was re-reviewing the claims from the last report period so you may have seen results that were older than the normal timeframe.

Q: What is the average time it takes for negative pressure wound care claims to be paid?

A: Claims processing has a timeframe of up to 30 days for completion.

Q: If a supplier does not win the competitive bid, is the supplier barred from dispensing the item in question, or can it bill and accept the amount of the competitive bid winner. How large an area do we have to be able to deliver to, if we competitively bid?

A: The Medicare DMEPOS Competitive Bidding Program requires Medicare beneficiaries to obtain competitive bidding items from a contract supplier, unless an exception applies. Therefore, in some instances, a beneficiary may be required to change from a non-contract supplier to a contract supplier. However, the program does allow for certain suppliers to be "grandfathered." Grandfathered suppliers are allowed to continue to provide certain rented DME items and services even though they are not contract suppliers. Grandfathering only applies when the patient is renting DME or oxygen equipment at the time the competitive bidding program becomes effective and the rental period for the item began before the start of the competitive bidding program. Payment for grandfathered items furnished during the initial competitive bidding contract period (i.e., when the item is bid for the first time in a Competitive Bidding Area [CBA]) varies depending on the payment category to which the items belong. In all cases, assignment of claims is mandatory, and suppliers must accept the Medicare allowed payment amount as payment in full. Generally, if a non-contract supplier in a CBA furnishes a competitively bid item to any Medicare beneficiary regardless of whether that beneficiary maintains a permanent residence in the CBA or another area, and no applicable exceptions apply, Medicare will not make payment. In addition, the beneficiary is not liable for payment unless the non-contract supplier in a CBA obtains an ABN signed by the beneficiary. A CBA is defined by specific zip codes related to a metropolitan statistical area (MSA). The CBA may be concurrent with, larger than or smaller than the related MSA, depending on a variety of considerations, for example, the exclusion of low population-density areas within an MSA or the inclusion of areas outside of an MSA that are part of a normal service area for suppliers in that MSA. The CBA will be the area wherein only contract suppliers may furnish certain DMEPOS items to beneficiaries unless an exception is permitted by regulations. For information on competitive bidding areas and requirements, suppliers should contact the Competitive Bidding Implementation Contractor (CBIC). The CBIC is the contact point for bidder education. The CBIC has a dedicated web site, http://www.dmecompetitivebid.com, which includes comprehensive information for suppliers, including bidding rules, user guides, frequently asked questions, policy fact sheets, checklists, and bidding information charts. The CBIC toll-free help desk, 1-877-577-5331, is also available to help bidders with all of their questions and concerns.

Q: Is there a way to retrieve information from Medicare regarding whether the beneficiary has another active supplier?

A: Suppliers may use the Interactive Voice Response Unit (IVR) or the Claims Status Inquiry (CSI) system to determine if a beneficiary has previously rented or purchased the same or a similar piece of equipment. This information will assist the supplier in determining whether the beneficiary is currently receiving the item from another supplier.

Q: Does the TENS unit rental and purchase apply to the patient maximum?

A: If you are referring to fee allowance, then no. There is no reduction in the allowed amount for purchase due to the two months rental.

Q: Please explain the KX modifier as applies to L4360 and other foot and ankle orthoses.

A: The ankle-foot/knee-ankle-foot orthosis policy does require use of the KX modifier when the requirements specified in the medical policy have been met. Refer to the Local Coverage Determination and Policy Article for specific coverage requirements.

DME MAC CERT ACT Q&A – January 13, 2010

The following questions and answers were received during the DME MAC Comprehensive Error Rate Testing (CERT) Education Task Force Ask the Contractor Teleconference (ACT) on January 13, 2010.

Q: When the reasonable useful lifetime (RUL) for oxygen is reached, is a new Certificate of Medical Necessity (CMN) and new testing required? And, are the Comprehensive Error Rate Testing (CERT) reviewers familiar with the new oxygen requirements with regard to replacing oxygen equipment when the five year reasonable useful lifetime has been reached?

A: As stated in the Local Coverage Determination (LCD) for oxygen, a new initial CMN is required, but new testing is not required when oxygen equipment is replaced when the five year RUL is reached. The CERT contractor is aware of the Medicare regulations pertaining to the new oxygen requirements, including specific requirements regarding replacement of oxygen when the RUL is reached.

Q: We are receiving documentation requests from the CERT contractor, requesting physician medical record documentation that dates back more than ten years. We are being told by the physicians that they do not retain documentation that far back. What should suppliers do if we get a CERT request for documentation to support a claim, and the CERT is requesting physician documentation from more than ten years ago? When we get a CERT denial in this situation, can we appeal?

A: Claims denied by the CERT contractor may be appealed through the appeal process. Note that CMS is researching this issue and will provide a response to the Durable Medical Equipment Medicare Administrative Contractors (DME MACs). When a response is received, the DME MACs will post the information to their web sites.

Q: When CERT makes a denial based upon insufficient documentation, does the CERT contractor explain which piece of documentation/information was missing?

A: Yes, the CERT reviewer informs the Medicare contractor of the documentation that is missing. If the supplier wants specific detail, the supplier should contact the CERT coordinator in their district.

Q: Suppliers are instructed to retain documentation for seven years. If CERT is asking for medical record documentation, that dates back longer than seven years, how can we control the fact that a physician no longer has that documentation? Is the supplier legally required to have documentation that is requested when it has been greater than seven years?

A: Suppliers are strongly encouraged to obtain all information necessary to support medical necessity of an item during the intake process. Make sure that you have the documentation and the information to support medical necessity of the equipment that you are providing to that beneficiary. Note that CMS is researching this issue and will provide a response to the Durable Medical Equipment Medicare Administrative Contractors (DME MACs). When a response is received, the DME MACs will post the information to their web sites.

Q: How can suppliers be held accountable for what is documented in the physician's medical record when physicians have not been educated about supplier's policies and procedures related to medical equipment and what their progress note should include?

A: While suppliers cannot reasonably control what a physician documents in the beneficiary's record, suppliers are responsible for ensuring that the item they are providing to the beneficiary meets medical necessity criteria outlined in the LCD and that the documentation supports the medical necessity of the item. To ensure the documentation supports the medical necessity for the item, we encourage the supplier to request the supporting documentation prior to dispensing the item.

To educate physicians on the documentation requirements, suppliers may provide the ordering physician with a copy of the documentation requirements that are outlined in the LCD. This practice will help the physician gain an understanding of the Medicare requirements placed on the suppliers. Additionally, to assist suppliers, the DME MACs are working with the Part A and Part B carriers to educate physicians on the documentation needs of the supplier community.

Q: When the CERT contractor requests documentation, how many days is the supplier given in which to return the requested documentation?

A: The initial request sent to the supplier by the CERT contractor allows 30 days for the supplier to submit the requested documentation to the CERT contractor. If the supplier does not submit the requested documentation within 30 days, additional contacts will be made in an attempt to obtain the documentation. The supplier has up to 75 days in which to submit the documentation. If the documentation is not received within 75 days, the claim will be denied and the DME MAC will be notified to recoup its payment from the supplier.

Q: When we send in our physician's notes for patients who are seeing their physicians during the day and showing a 90 percent oxygen saturation or oxygen saturation that is in normal range because they are being tested in a doctor's office during the day, our claim are getting rejected because the patients have qualifying stats. However, the patients are actually de-sating down into the 50s and the 60s when they are sleeping. We're having difficulty getting that understood. Is that something that is commonly misunderstood?

A: The CERT review contractor is staffed with medically trained personnel so they are familiar with the medical policy and coverage requirements for oxygen. Suppliers must make sure to submit documentation that justifies the need for the oxygen based upon why the patient has the oxygen. If there

are no notes and no records from the physician that justify the need for the oxygen as it is billed to Medicare the claim will be denied. Make sure that the documentation provided to the CERT contractor justifies the need for the oxygen as the patient is using it in the home. If you believe that the CERT contractor is denying the claims in error, you should request an appeal.

Q: To constitute continued use, particularly as with a nebulizer and nebulizer medications, doesn't the ongoing annual prescriptions and continued shipment of nebulizer drugs indicate continued use?

A: It is the beneficiary's medical record and medical documentation from a physician that would indicate the continued need for an item.

Q: If a beneficiary has an order for oxygen, and the physician's documentation does not support the medical necessity for the oxygen, or the physician does not provide the supplier with adequate documentation, so the supplier refuses to provide the beneficiary with oxygen, who is responsible if the beneficiary dies?

A: That is more of a legal issue. If you determine that the beneficiary doesn't meet the coverage criteria based upon the documentation provided and you do not want to provide service to that beneficiary, suppliers can execute an ABN, refer the beneficiary to another supplier, or handle according to your company's best interest.

Q: The CERT contractor is asking for documentation from 11 years ago but suppliers are only required to keep information on file for seven. Is CERT going to continue to ask for documentation past seven years?

A: The CMS will research this issue and provide an update to the DME MACs. Once a response is received from CMS, the DME MACs will post the information to the web site.

Q: Are electronic patient signatures acceptable on delivery tickets?

A: For proof of delivery, the beneficiary's electronic signature, such as the electronic box used by FedEx, is acceptable.

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.

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.

Reminder: Express Plus Transitioning to PC-ACE Pro32

The Common Electronic Data Interchange (CEDI) currently supports both Express Plus and PC-ACE Pro32 for billing durable medical equipment (DME) electronic claims. After careful consideration, CEDI has decided to transition support to one free software; PC-ACE Pro32. As of April 1, 2010, the CEDI Help Desk will no longer support the Express Plus software. CEDI feels this will best meet the needs of the DME supplier community.

To prevent the loss of information for Express Plus users, a tool has been created to copy database information from Express Plus into the PC-ACE Pro32 software. The conversion tool and instructions to assist in copying the information and completing the conversion to PC-ACE Pro32 can be accessed from the CEDI web site at the following link http://www.ngscedi.com/downloads/Downloadindex.htm.

Note: This conversion will not erase or delete any information currently stored in the Express Plus software. The conversion will not transfer claim information, but will transfer the setup (submitter) information, provider, physician, facility, and patient information.

Benefits offered by the PC-ACE Pro32 software include:

- Stores and maintains the code lists including Diagnosis Codes, Procedure Codes, and Modifiers and receives quarterly updates for these code sets;

CEDI CONT'D

- Checks the claims for missing or invalid information and provides for easy editing by highlighting the missing or invalid information;
- Claim data entry is numbered according to the 1500 paper claim form;
- Will be updated for version 5010 and be made available to PC-ACE Pro32 users.

For more information about the PC-ACE Pro32 software, access the User Guide and help documents located on the CEDI web site at the following link http://www.ngscedi.com/downloads/Downloadindex.htm.

Express Plus users are not required to make the conversion to PC-ACE Pro32. If you would like to use a different approved software vendor, the Approved Entities List is available at the following link http://www.ngscedi.com/outreach_materials/outreachindex.htm.

If you are having difficulties with the conversion and additional assistance is needed, contact the CEDI Help Desk at ngs.cedihelpdesk@wellpoint.com or 866-311-9184.

Update: Ordering/Referring Provider Front-End PECOS Warning Edits at CEDI

Common Electronic Data Interchange (CEDI) errors C200, C201 and C202 are warning errors/edits indicating the ordering/referring provider submitted on the claims was not eligible to order/refer for the service billed according to the Medicare Part A and Part B Provider Enrollment, Chain and Ownership System (PECOS). These edits will generate as a warning on the CEDI GENRPT until April 5, 2010. These errors/edits are in place as part of CMS Change Request 6421 and related Medicare Learning Network (MLN) article MM6421 implemented with the October 2009 Release.

CMS has completed the systematic loading of National Provider Identifiers (NPIs) to the existing records in PECOS that did not contain an NPI. With this update to the PECOS records, CEDI has seen a drop in the number of warning messages being produced on the supplier's GENRPT.

Prior to April 5, 2010, CMS will make publicly available on the Internet the names and NPIs of the Medicare physicians and non-physician practitioners who are eligible to order or refer in the Medicare program. CEDI will provide notification when this has been completed.

Should a supplier receive one of these warning errors/edits on a claim, CEDI recommends they contact the ordering/referring provider submitted on the claim and have them verify their eligibility with PECOS. The supplier should also verify with the ordering/referring provider how their name is listed with their PECOS enrollment and ensure the name submitted on the claim matches the PECOS record.

Ordering/referring providers may use the following web site to obtain information in relation to PECOS and to enroll and/or access the PECOS system to ensure they are listed and authorized to order/refer services for Medicare: http://www.cms.hhs.gov/MedicareProviderSupEnroll/04_InternetbasedPECOS.asp.

Providers may also contact their Medicare Part A and/or Part B contractor's enrollment team in regards to their enrollment file as reflected in PECOS.

If DME Jurisdiction D suppliers have questions, please call the Supplier Contact Center at 1-866-243-7272.

Avoid Diagnosis Code CEDI Rejections

There were 61,095 ICD-9-CM diagnosis code errors submitted on DME electronic claims during October. This article relays the errors and offers suggestions to assist suppliers in submitting claims properly and improving their claims processing timeliness.

1. Use the diagnosis code that was applicable for the date of service (DOS). http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/07_summarytables.asp.
2. Code the diagnosis to the highest level of specificity. Diagnosis codes range from three to five digits. Rejections are caused when all five digits are required but not submitted.
3. Diagnosis code pointers are a single character in length. Currently the numbers one through eight are valid. The diagnosis code pointers are entered in the 2400 Loop SV107-1 through SV107-4. The pointer in SV107-1 is used for the first diagnosis code pointer (primary diagnosis for this service line). Use remaining diagnosis pointers in declining level of importance to service line. The primary diagnosis code should indicate the primary condition for the item/service billed.
4. Referencing multiple diagnosis codes in a single SV107 position or re-entering the diagnosis code as a pointer in SV107 will result in a claim rejection.
5. The primary diagnosis code on the claim appears in the 2300 Loop HI01-2. The qualifier BK should be used in HI01-1 to indicate the diagnosis code in HI01-2 is primary.
6. If additional diagnosis codes are required on a claim, they may also be submitted in the 2300 Loop HI02-2, HI03-2, HI04-2, HI05-2, HI06-2, HI07-2, and HI08-2. A qualifier of BF is used to indicate supporting diagnosis codes. Supporting diagnosis codes must be entered in each of the HI elements in sequential order. If HI02-2 and HI04-2 are filled in, but HI03-2 is blank, the claim will reject.
7. If a pointer in any SV107 element points to a blank HI element, the claim will reject.

The diagnosis specific edit descriptions and occurrences for each edit that occurred during the month of October, as reported by the CEDI contractor, are provided below. Visit the CEDI web site for more information regarding electronic billing.

Edit Description	Edit Count
Diagnosis Code Invalid - Pointer 1	20,643
Diagnosis Code 2 Invalid for DOS	8,624
Diagnosis Code Invalid - Pointer 2	7,715
Diagnosis Code 3 Invalid for DOS	6,487
Diagnosis Code Invalid - Pointer 3	4,204

CEDI CONT'D

Diagnosis Pointer points to blank Dx code	2,230
Diagnosis Code 4 Invalid for DOS	2,205
Diagnosis Code 1 Invalid	1,811
Diagnosis Code Invalid - Pointer 4	1,694
Diagnosis Code 1 Invalid for DOS	1,422
Diagnosis Code 2 Invalid	1,103
Acceptable pointer values are 1 - 4, inclusive	1,079
Diagnosis Code 3 Invalid	749
Line Level Dx Code Pointer must be present	313
Diagnosis Code 5 Invalid for DOS	256
Diagnosis Code 4 Invalid	229
Claim Level Dx Code must be present	103
Diagnosis Code 6 Invalid for DOS	93
A 3rd Diagnosis submitted w/o a 2nd Diagnosis	55
Diagnosis Code 8 Invalid for DOS	37
A 4th Diagnosis submitted w/o a 3rd Diagnosis	20
A 5th Diagnosis submitted w/o a 4th Diagnosis	18
Diagnosis Code 5 Invalid	2
Diagnosis Code 7 Invalid	2
Diagnosis Code 6 Invalid	1
Total Diagnosis Related Errors / Edits	**61,095**

COMPETITIVE BIDDING

Medicare's Competitive Bidding Program for DMEPOS

Medicare's Competitive Bidding Program for durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) is designed to ensure beneficiaries with Original Medicare continue to receive quality medical equipment and related services from accredited suppliers, while reducing out-of-pocket expenses for Medicare beneficiaries and saving the Medicare program money.

Medicare's current fee schedule rates for DMEPOS items are overpriced and based on outdated, inflated supplier charges from over 20 years ago. Competitive bidding among suppliers will establish new, lower Medicare payment amounts for DMEPOS items.

The DMEPOS Competitive Bidding Program:

- Starts January 1, 2011 in nine areas of the country and will be phased into other areas in future years;
- Applies to Medicare beneficiaries who live in (or travel to) these areas and who buy or rent certain items of durable medical equipment and supplies;
- Includes items such as oxygen equipment and supplies, certain power wheelchairs, walkers, mail order diabetic supplies and hospital beds; and
- Selects enough qualified, accredited contract suppliers to meet Medicare beneficiaries' needs for competitively bid items and services.

The nine initial competitive bidding areas are:

1. Charlotte-Gastonia-Concord (North Carolina and South Carolina)
2. Cincinnati-Middletown (Ohio, Kentucky and Indiana)
3. Cleveland-Elyria-Mentor (Ohio)
4. Dallas-Fort Worth-Arlington (Texas)
5. Kansas City (Missouri and Kansas)
6. Miami-Fort Lauderdale-Pompano Beach (Florida)
7. Orlando (Florida)
8. Pittsburgh (Pennsylvania)
9. Riverside-San Bernardino-Ontario (California)

In order to help you stay fully and accurately informed about Medicare's DMEPOS Competitive Bidding Program, CMS has prepared the first in a series of "program preview" documents, which can be found at http://www.cms.hhs.gov/Partnerships/03_DMEPOS_Toolkit.asp. We encourage you to share this information with your local affiliates throughout the country, particularly in the nine initial competitive bidding areas. Please note that "program preview" documents are not intended for distribution to Medicare beneficiaries. We'll be forwarding materials for you to share with beneficiaries later this year when DMEPOS users may need to take action.

Medicare's DMEPOS Competitive Bidding Program - A Better Way for Medicare to Pay for Medical Equipment

MLN Matters® Number: SE1007

Provider Types Affected

This MLN Matters® article is informational for physicians, providers, and suppliers submitting claims to the Medicare Program. The article provides an overview of and the rationale for Medicare's Competitive Bidding Program for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) being implemented by the Centers for Medicare & Medicaid Services (CMS).

What You Need to Know

Medicare's Competitive Bidding Program for durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) is an important step towards paying appropriately for medical items and services. The program will reduce out-of-pocket expenses for Medicare beneficiaries and save the Medicare program money while ensuring beneficiaries continue to receive quality products from accredited suppliers.

Background

Examples of DMEPOS include oxygen equipment, walkers, wheelchairs, devices used to treat sleep disorders, and hospital beds. Medicare generally pays 80 percent of the "fee schedule" payment amount for DMEPOS items used in the home by beneficiaries under Part B of Original Medicare, and beneficiaries pay the remaining 20 percent. For most of these items, the "fee schedule" payment amounts are based on historical charges, adjusted for inflation at times, and not on current market prices. Numerous studies by the Office of the Inspector General and the Government Accountability Office have found that the prices paid by Medicare for certain DMEPOS items are excessive - sometimes three or four times retail prices and the amounts paid by commercial insurers. Clearly, Medicare needs a better way to pay for DMEPOS items.

Under the DMEPOS Competitive Bidding Program, Medicare beneficiaries with Original Medicare who live in competitive bidding areas (CBAs) will pay less for certain

COMPETITIVE BIDDING CONT'D

DMEPOS items and services. DMEPOS suppliers compete to become Medicare contract suppliers by submitting bids to furnish certain medical equipment and supplies in the CBAs. Medicare will use these bids to set a "single payment amount," which will replace the "fee schedule" amount as payment for those items. The "single payment amount" must be lower than the "fee schedule amount." All suppliers are thoroughly screened to make sure they meet Medicare requirements before they are awarded contracts. In certain situations, beneficiaries in CBAs who rent oxygen or certain other durable medical equipment may continue renting these items from their current suppliers when the program takes effect, regardless of whether the supplier is a contract supplier. Beneficiaries who start using competitive bid DMEPOS items after the program begins or who do not continue renting equipment from their current suppliers will need to use contract suppliers in most cases.

Competitive bidding:

- Creates incentives for suppliers to continue to provide quality products and services efficiently and at a reasonable cost.
- Lowers the costs to beneficiaries and to taxpayers. Once fully implemented across the country, total savings are projected to be in the billions of dollars each year.
- Requires that all suppliers in the program meet strict quality and financial standards and be accredited by a Medicare-deemed national accreditation organization.
- Selects multiple winning contract suppliers, both small and large, to ensure beneficiaries have access to quality medical equipment and supplies with a choice of suppliers.

Proven Results

Competitive bidding for DMEPOS is proven to save money for taxpayers and Medicare beneficiaries while maintaining access to quality DMEPOS items and services. The Balanced Budget Act of 1997 required Medicare to test competitive bidding for DMEPOS items as a new way to set fees. Medicare implemented two demonstration projects in Polk County, Florida and San Antonio, Texas to determine if competitive bidding among suppliers would be successful in driving down costs to a fair market value while maintaining product quality. The demonstration projects showed that competition helps Medicare beneficiaries receive quality medical equipment and supplies at fair and reasonable prices. At the completion of the demonstration projects in 2002, Medicare found that:

- 77 percent of winning bidders were small suppliers;
- Beneficiaries saved 20 percent through the competitive model;
- Access to quality equipment and supplies was maintained; and
- Beneficiary satisfaction remained high.

Implementation Overview

After the successful demonstrations, the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) mandated that Medicare phase in the DMEPOS Competitive Bidding Program. Round One of the program was implemented on July 1, 2008 in 10 CBAs and resulted in a projected average savings of 26 percent compared to Medicare's fee schedule amounts. Two weeks after implementation, Congress enacted a temporary delay of the program as part of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) which mandated certain program modifications but did not fundamentally change the nature of the program required by the MMA.

The MIPPA required CMS to terminate supplier contracts awarded in Round One and to conduct a new competition in nine CBAs in 2009. Together with its Competitive Bidding Implementation Contractor, Medicare is currently evaluating bids suppliers submitted in 2009 and expects to announce the competitive bidding payment rates resulting from the competition in June 2010. Medicare plans to announce the contract suppliers in September 2010, and the program is scheduled to go into effect in the nine Round One Rebid areas on January 1, 2011. Medicare will begin the supplier competition for the next phase (Round Two) of the program in 2011.

Round One Rebid Areas and Product Categories

The Round One Rebid Areas are:

- Charlotte-Gastonia-Concord (North Carolina and South Carolina);
- Cincinnati-Middletown (Ohio, Kentucky and Indiana);
- Cleveland-Elyria-Mentor (Ohio);
- Dallas-Fort Worth-Arlington (Texas);
- Kansas City (Missouri and Kansas);
- Miami-Fort Lauderdale-Pompano Beach (Florida);
- Orlando (Florida);
- Pittsburgh (Pennsylvania); and
- Riverside-San Bernardino-Ontario (California).

The Round One Rebid Product Categories are:

- Oxygen supplies and equipment;
- Standard power wheelchairs, scooters, and related accessories;
- Complex rehabilitative power wheelchairs and related accessories (Group 2 only);
- Mail-order diabetic supplies;
- Enteral nutrients, equipment, and supplies;
- Continuous Positive Airway Pressure (CPAP) machines and Respiratory Assist Devices (RADs) and related supplies and accessories;
- Hospital beds and related accessories;
- Walkers and related accessories; and
- Support surfaces (Group 2 mattresses and overlays in Miami only).

Additional Information

To learn more about Medicare's DMEPOS Competitive Bidding Program, visit http://www.cms.hhs.gov/DMEPOSCompetitiveBid/ and http://www.cms.hhs.gov/Partnerships/03_DMEPOS_Toolkit.asp#TopOfPage on the CMS web site.

ENROLLMENT

Enrollment Reminders for Suppliers

Suppliers are reminded to promptly inform the National Supplier Clearinghouse (NSC) of the death of DMEPOS supplier associates such as owners, authorized officials or delegated officials of DMEPOS suppliers.

Also, Supplier Standard #2 states: A supplier must provide complete and accurate information on the DMEPOS supplier application. Any changes to this information must be reported to the National Supplier Clearinghouse within 30 days.

National Supplier Clearinghouse:
Phone: 1-866-238-9652
web site: http://www.palmettogba.com/nsc

Source: Change Request 6714 and the NSC Supplier Standards

NSC Corrective Action Plan and Reconsideration Process

Please be advised that submitting a Corrective Action Plan (CAP)/Reconsideration request prior to the scheduled revocation date will not necessarily circumvent the revocation of your Medicare billing privileges. All Appeals are processed in the order in which they are received. While there is not an estimated timeframe of completion, our staff is working to process requests in a fair and reasonable manner. Please allow time for your CAP/Reconsideration to be reviewed. Once a determination has been made, you will receive written notification.

There is no specific form that must be completed to request a CAP or reconsideration. Suppliers must submit a cover letter signed by the authorized or delegated official on file with the NSC stating the purpose of the submission.

For more information regarding the CAP/reconsideration process click here.

Source: National Supplier Clearinghouse (NSC)

CMS Processing Pharmacy DME Accreditation Determinations

CMS will continue to process accreditation determinations for pharmacies after January 1, 2010. The revocation process for those who do not meet the accreditation requirement will be prioritized based on any potential beneficiary access issues as well as the Agency's workload. Pharmacies should proceed with their accreditation activities and the accrediting organization will notify the National Supplier Clearinghouse of any newly processed accreditations.

CMS encourages pharmacies to complete their accreditation applications as soon as possible and will notify pharmacies that furnish DME items of any changes in the accreditation requirements.

FORMS

Change to DME CSI User Request Form Instructions

NAS Data Security has updated the instructions for the Part A Direct Data Entry (DDE), Part B Professional Provider Telecommunication Network (PPTN), & DME Claim Status Inquiry (CSI) User Request Form. The updated instructions apply to the DME CSI users only.

The "Access Information section, State(s) Requesting Access" box has been updated in the instructions. When submitting a Medicare Claims Processing System (MCPS) request, please indicate Jurisdiction D (ex: "Jurisdiction D", "JD", or "Jur D") in this box rather than listing the state or states you are requesting access to.

This change is effective December 15, 2009. Any forms submitted after this date will be returned to the contact person for correction if the "State(s) Requesting Access" box is left blank or does not indicate Jurisdiction D (ex: "Jurisdiction D", "JD", or "Jur D").

For more information, please contact Trent Cable at 701-277-6779, Jamie Larson at 701-277-2843, Pat Schrock at 701-277-2155, Rob Schobinger at 701-277-5128 or Michelle Jastram at 701-277-5120.

REIMBURSEMENT

January 2010 ASP File Now Available

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

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

MLN Matters® Number: MM6804
Related Change Request (CR) #: 6804
Related CR Release Date: January 29, 2010
Related CR Transmittal #: R1899CP
Effective Date: April 1, 2010
Implementation Date: April 5, 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) 6804 which instructs Medicare contractors to download and implement

REIMBURSEMENT CONT'D

the April 2010 ASP drug pricing file for Medicare Part B drugs; and if released by the Centers for Medicare & Medicaid Services (CMS), also the revised January 2010, October 2009, July 2009, and April 2009 files. Medicare will use the April 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 April 5, 2010, with dates of service April 1, 2009, through June 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
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
April 2009 ASP and NOC files	April 1, 2009, through June 30, 2009

Additional Information

The official instruction (CR6804) issued to your Medicare MAC, carrier, and/or FI may be found at http://www.cms.hhs.gov/Transmittals/downloads/R1899CP.pdf on the CMS web site.

CODING

HCPCS Code Update – 2010

The following list identifies changes to level II Healthcare Common Procedure Coding System (HCPCS) codes for 2010.

Added Codes/Added Modifiers: New codes and modifiers are effective for dates of service on or after January 1, 2010.

Discontinued Codes/Deleted Modifiers: Codes or modifiers that are discontinued/deleted will continue to be valid for claims with dates of service on or before December 31, 2009, regardless of the date of claim submission. If there is a direct crosswalk for a discontinued/deleted code or modifier, it is listed in the table. The crosswalked codes are also "added" codes effective for dates of service on or after January 1, 2010.

There is no grace period that would allow submission of the discontinued code for dates of service in 2010.

Narrative Changes/Revised Modifiers: A description change for an existing code or modifier is effective for dates of service on or after January 1, 2010.

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

Ankle-Foot and Knee-Ankle-Foot Orthoses

Code	Added Code Narrative
A4466	GARMENT, BELT, SLEEVE OR OTHER COVERING, ELASTIC OR SIMILAR STRETCHABLE MATERIAL, ANY TYPE, EACH (*Note: Noncovered)*

Code	Narrative Changes Old Narrative	New Narrative
L4396	STATIC ANKLE FOOT ORTHOSIS, INCLUDING SOFT INTERFACE MATERIAL, ADJUSTABLE FOR FIT, FOR POSITIONING, PRESSURE REDUCTION, MAY BE USED FOR MINIMAL AMBULATION, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	STATIC OR DYNAMIC ANKLE FOOT ORTHOSIS, INCLUDING SOFT INTERFACE MATERIAL, ADJUSTABLE FOR FIT, FOR POSITIONING, MAY BE USED FOR MINIMAL AMBULATION, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT

External Breast Prostheses

Code	Added Code Narrative
L8031	BREAST PROSTHESIS, SILICONE OR EQUAL, WITH INTEGRAL ADHESIVE
L8032	NIPPLE PROSTHESIS, REUSABLE, ANY TYPE, EACH

Code	Narrative Changes Old Narrative	New Narrative
L8030	BREAST PROSTHESIS, SILICONE OR EQUAL	BREAST PROSTHESIS, SILICONE OR EQUAL, WITHOUT INTEGRAL ADHESIVE

Facial Prostheses

Code	Added Code Narrative
A4456	ADHESIVE REMOVER, WIPES, ANY TYPE, EACH

Code	Discontinued Code Narrative	Crosswalk to Code
A4365	ADHESIVE REMOVER WIPES, ANY TYPE, PER 50	A4456

Knee Orthoses

Code	Added Code Narrative
A4466	GARMENT, BELT, SLEEVE OR OTHER COVERING, ELASTIC OR SIMILAR STRETCHABLE MATERIAL, ANY TYPE, EACH (*Note: Noncovered)*

Code	Discontinued Code Narrative	Crosswalk to Code
L1800	KNEE ORTHOSIS, ELASTIC WITH STAYS, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	A4466
L1815	KNEE ORTHOSIS, ELASTIC OR OTHER ELASTIC TYPE MATERIAL WITH CONDYLAR PAD(S), PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	A4466
L1825	KNEE ORTHOSIS, ELASTIC KNEE CAP, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	A4466
L1901	ANKLE ORTHOSIS, ELASTIC, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT (E.G. NEOPRENE, LYCRA)	A4466
L2770	ADDITION TO LOWER EXTREMITY ORTHOSIS, ANY MATERIAL - PER BAR OR JOINT	None

Lower Limb Prostheses

Code	Added Code Narrative
L5973	ENDOSKELETAL ANKLE FOOT SYSTEM, MICROPROCESSOR CONTROLLED FEATURE, DORSIFLEXION AND/OR PLANTAR FLEXION CONTROL, INCLUDES POWER SOURCE

Miscellaneous

Code	Added Code Narrative
A4466	GARMENT, BELT, SLEEVE OR OTHER COVERING, ELASTIC OR SIMILAR STRETCHABLE MATERIAL, ANY TYPE, EACH (*Note: Noncovered)*

Code	Narrative Changes Old Narrative	New Narrative
E0700	SAFETY EQUIPMENT (E.G., BELT, HARNESS OR VEST)	SAFETY EQUIPMENT, DEVICE OR ACCESSORY, ANY TYPE
E0249	PAD FOR WATER CIRCULATING HEAT UNIT	PAD FOR WATER CIRCULATING HEAT UNIT, FOR REPLACEMENT ONLY

Code	Discontinued Code Narrative	Crosswalk to Code
E1340	REPAIR OR NONROUTINE SERVICE FOR DURABLE MEDICAL EQUIPMENT REQUIRING THE SKILL OF A TECHNICIAN, LABOR COMPONENT, PER 15 MINUTES (*Note: Invalid for claim submission to Medicare for DOS on/after 4/1/09)*	K0739 or K0740 (*Note: Effective 4/1/09)*
L0210	THORACIC, RIB BELT	A4466
L3651	SHOULDER ORTHOSIS, SINGLE SHOULDER, ELASTIC, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT (E.G. NEOPRENE, LYCRA)	A4466
L3652	SHOULDER ORTHOSIS, DOUBLE SHOULDER, ELASTIC, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT (E.G. NEOPRENE, LYCRA)	A4466
L3700	ELBOW ORTHOSIS, ELASTIC WITH STAYS, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	A4466
L3701	ELBOW ORTHOSIS, ELASTIC, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT (E.G. NEOPRENE, LYCRA)	A4466
L3909	WRIST ORTHOSIS, ELASTIC, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT (E.G. NEOPRENE, LYCRA)	A4466
L3911	WRIST HAND FINGER ORTHOSIS, ELASTIC, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT (E.G. NEOPRENE, LYCRA)	A4466
L6639	UPPER EXTREMITY ADDITION, HEAVY DUTY FEATURE, ANY ELBOW	None

Nebulizers

Code	Added Code Narrative
Q4074	ILOPROST, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, UNIT DOSE FORM, UP TO 20 MICROGRAMS

Code	Discontinued Code Narrative	Crosswalk to Code
Q4080	ILOPROST, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, UNIT DOSE FORM, 20 MICROGRAMS	Q4074

Ostomy Supplies

Code	Added Code Narrative
A4456	ADHESIVE REMOVER, WIPES, ANY TYPE, EACH

Code	Discontinued Code Narrative	Crosswalk to Code
A4365	ADHESIVE REMOVER WIPES, ANY TYPE, PER 50	A4456

Oxygen and Oxygen Equipment

Code	Added Code Narrative
E0433	PORTABLE LIQUID OXYGEN SYSTEM, RENTAL; HOME LIQUEFIER USED TO FILL PORTABLE LIQUID OXYGEN CONTAINERS, INCLUDES PORTABLE CONTAINERS, REGULATOR, FLOWMETER, HUMIDIFIER, CANNULA OR MASK AND TUBING, WITH OR WITHOUT SUPPLY RESERVOIR AND CONTENTS GAUGE

Code	Narrative Changes Old Narrative	New Narrative
E0441	OXYGEN CONTENTS, GASEOUS (FOR USE WITH OWNED GASEOUS STATIONARY SYSTEMS OR WHEN BOTH A STATIONARY AND PORTABLE GASEOUS SYSTEM ARE OWNED), 1 MONTH'S SUPPLY = 1UNIT	STATIONARY OXYGEN CONTENTS, GASEOUS, 1 MONTH'S SUPPLY = 1 UNIT
E0442	OXYGEN CONTENTS, LIQUID (FOR USE WITH OWNED LIQUID STATIONARY SYSTEMS OR WHEN BOTH A STATIONARY AND PORTABLE GASEOUS SYSTEM ARE OWNED), 1 MONTH'S SUPPLY = 1 UNIT	STATIONARY OXYGEN CONTENTS, LIQUID, 1 MONTH'S SUPPLY = 1 UNIT
E0443	PORTABLE OXYGEN CONTENTS, GASEOUS (FOR USE ONLY WITH PORTABLE GASEOUS SYSTEMS WHEN NO STATIONARY GAS OR LIQUID SYSTEM IS USED), 1 MONTH'S SUPPLY = 1 UNIT	PORTABLE OXYGEN CONTENTS, GASEOUS, 1 MONTH'S SUPPLY = 1 UNIT
E0444	PORTABLE OXYGEN CONTENTS, LIQUID (FOR USE ONLY WITH PORTABLE LIQUID SYSTEMS WHEN NO STATIONARY GAS OR LIQUID SYSTEM IS USED), 1 MONTH'S SUPPLY = 1 UNIT	PORTABLE OXYGEN CONTENTS, LIQUID, 1 MONTH'S SUPPLY = 1 UNIT

Patient Lifts

Code	Added Code Narrative
E1036	MULTI-POSITIONAL PATIENT TRANSFER SYSTEM, EXTRA-WIDE, WITH INTEGRATED SEAT, OPERATED BY CAREGIVER, PATIENT WEIGHT CAPACITY GREATER THAN 300 LBS

Spinal Orthoses

Code	Added Code Narrative
A4466	GARMENT, BELT, SLEEVE OR OTHER COVERING, ELASTIC OR SIMILAR STRETCHABLE MATERIAL, ANY TYPE, EACH (*Note: Noncovered)*

Surgical Dressings

Code	Narrative Changes Old Narrative	New Narrative
A6549	GRADIENT COMPRESSION STOCKING, NOT OTHERWISE SPECIFIED (*Note: Noncovered)*	GRADIENT COMPRESSION STOCKING/ SLEEVE, NOT OTHERWISE SPECIFIED

Code	Discontinued Code Narrative	Crosswalk to Code
A6200	COMPOSITE DRESSING, PAD SIZE 16 SQ. IN. OR LESS, WITHOUT ADHESIVE BORDER, EACH DRESSING (*Note: Invalid for claim submission to Medicare for DOS on/after 1/1/07)*	A6251 (*Note: Effective 1/1/07)*

A6201	COMPOSITE DRESSING, PAD SIZE MORE THAN 16 SQ. IN. BUT LESS THAN OR EQUAL TO 48 SQ. IN., WITHOUT ADHESIVE BORDER, EACH DRESSING (*Note: Invalid for claim submission to Medicare for DOS on/after 1/1/07)*	A6252 (*Note: Effective 1/1/07)*
A6202	COMPOSITE DRESSING, PAD SIZE MORE THAN 48 SQ. IN., WITHOUT ADHESIVE BORDER, EACH DRESSING (*Note: Invalid for claim submission to Medicare for DOS on/after 1/1/07)*	A6253 (*Note: Effective 1/1/07)*
A6542	GRADIENT COMPRESSION STOCKING, CUSTOM MADE	A6549
A6543	GRADIENT COMPRESSION STOCKING, LYMPHEDEMA	A6549

Urological Supplies

Code	Added Code Narrative
A4336	INCONTINENCE SUPPLY, URETHRAL INSERT, ANY TYPE, EACH
A4360	DISPOSABLE EXTERNAL URETHRAL CLAMP OR COMPRESSION DEVICE, WITH PAD AND/OR POUCH, EACH (*Note: Noncovered)*
A4456	ADHESIVE REMOVER, WIPES, ANY TYPE, EACH

Code	Discontinued Code Narrative	Crosswalk to Code
A4365	ADHESIVE REMOVER WIPES, ANY TYPE, PER 50	A4456

Wheelchair Options and Accessories

v Code	Discontinued Code Narrative	Crosswalk to Code
E2223	MANUAL WHEELCHAIR ACCESSORY, VALVE, ANY TYPE, REPLACEMENT ONLY, EACH	None
E2393	POWER WHEELCHAIR ACCESSORY, VALVE FOR PNEUMATIC TIRE TUBE, ANY TYPE, REPLACEMENT ONLY, EACH	None
E2399	POWER WHEELCHAIR ACCESSORY, NOT OTHERWISE CLASSIFIED INTERFACE, INCLUDING ALL RELATED ELECTRONICS AND ANY TYPE MOUNTING HARDWARE	K0108

Modifiers

Modifier	Added Modifiers Narrative
J4	DMEPOS ITEM SUBJECT TO DMEPOS COMPETITIVE BIDDING PROGRAM THAT IS FURNISHED BY A HOSPITAL UPON DISCHARGE

Modification to HCPCS Code Set

CMS has released a modification to the Healthcare Common Procedure Coding System (HCPCS) code set. CMS has revised the definition for HCPCS code L8680 to "IMPLANTABLE NEUROSTIMULATOR ELECTRODE, EACH". In making this change, the CY 2010 definition for L8680 reverts to the definition reflected in the CY 2009 HCPCS code set. This change has been posted to the 2010 HCPCS Corrections document located on the HCPCS web page at http://www.cms.hhs.gov/HCPCSReleaseCodeSets/ANHCPCS/list.asp.

Scheduled Release of Modifications to HCPCS Code Set

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

Letter to Physicians – PECOS

Suppliers may provide this letter to physicians as a reminder to confirm their PECOS enrollment.

NORIDIAN® Administrative Services LLC

Medicare

January, 2010

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

Dear Colleague:

Providers of laboratory and radiologic services and suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) are partners in caring for your patient(s). Effective, April 5, 2010, they will not receive payment from Medicare for the items or services ordered **if you do not have a current enrollment in the Medicare Provider Enrollment, Chain and Ownership System (PECOS)**. This may also result in your patient not receiving the service or item needed, or potentially being held financially responsible and **may result in your office being swamped with calls as others seek this information**. Please help avoid these difficulties by **confirming now that you are enrolled in PECOS** if you have not already done so, or updating your Medicare enrollment if you have not done so since November 2003.

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

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

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

For additional information regarding the Medicare enrollment process, including Internet-based PECOS, go to http://www.cms.hhs.gov/MedicareProviderSupEnroll on the CMS Web site.

Sincerely,

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

CMS Centers for Medicare & Medicaid Services

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

HCPCS A4253 and A4259 - Notification of Prepayment Review

NAS Jurisdiction D DME MAC Medical Review will be initiating a widespread prepayment probe review of claims for HCPCS A4253 (Blood glucose test or reagent strips for home blood glucose monitor, per 50 strips) and A4259 (Lancets, per box of 100). Widespread reviews are used to determine the extent of potential problem areas across multiple suppliers. This review is being initiated based on the results of Comprehensive Error Rate Testing (CERT) analysis.

In order to evaluate compliance with Medicare coverage and coding rules, all suppliers billing Jurisdiction D for HCPCS code A4253 and A4259 are subject to this review. Suppliers of the selected claims will receive an *Additional Documentation Request* (ADR) letter asking for specific information to determine if the item billed complies with the existing reasonable and necessary criteria. Failure to supply the requested information within **30 days** of the date on the letter will result in the claim being denied as not medically necessary. The ADR letter will provide instruction for submitting documentation.

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Local Coverage Determination (L196) and Policy Article (A33673) for Glucose Monitors effective October 2008. Suppliers can review the Glucose Monitors and Supplies documentation checklist on the NAS web site at: https://www.noridianmedicare.com/dme/coverage/docs/checklists/glucose_monitors_and_supplies.pdf.

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

HCPCS K0004 - Notification of Prepayment Review

NAS Jurisdiction D DME MAC Medical Review will be initiating a widespread prepayment probe review of claims for HCPCS K0004 (High strength, lightweight wheelchair). Widespread reviews are used to determine the extent of potential problem areas across multiple suppliers. This review is being initiated based on the results of Comprehensive Error Rate Testing (CERT) analysis.

In order to evaluate compliance with Medicare coverage and coding rules, all suppliers billing Jurisdiction D for HCPCS code K0004 are subject to this review. Suppliers of the selected claims will receive an *Additional Documentation Request* (ADR) letter asking for specific information to determine if the item billed complies with the existing reasonable and necessary criteria. Failure to supply the requested information within **30 days** of the date on the letter will result in the claim being denied as not medically necessary. The ADR letter will provide instruction for submitting documentation.

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in Local Coverage Determination (L11454) and Policy Article (A25378) for Manual Wheelchair Bases effective October 2009.

Suppliers can review the Manual Wheelchair Bases documentation checklist on the NAS web site at http://www.noridianmedicare.com/dme/coverage/docs/checklists/manual_wheelchairs.pdf

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

What Billing the KX Modifier Means

The KX modifier states that requirements specified in the applicable medical policy have been met. Supporting medical documentation that corroborates those requirements must be available to the DME MAC upon request. Simply applying the KX modifier without understanding what it represents is improper billing.

Currently there are 54 Local Coverage Determinations (LCDs) and Policy Articles (PAs) in effect for DMEPOS. Thirty-two reference use of the KX modifier. NAS encourages suppliers to review and have a working knowledge of the specific documentation requirements for items being dispensed before appending the KX modifier to a claim, as outlined in the LCD and PA.

NAS monitors the usage of the KX modifier and continues to establish edits that will deny claims when this modifier is not reported on the claim. Therefore, if the KX modifier is referenced in an LCD, and the item being billed meets the coverage criteria, the KX must be appended to the Healthcare Common Procedure Coding System (HCPCS) code or the code may be denied.

Policies that reference the KX modifier are being updated to require the KX, GA, GZ modifiers, or for items with statutory requirements, the GY modifier. These instructions are listed in the Documentation section of the LCD. Claims that do not follow these new guidelines will be rejected as missing information and must be corrected and resubmitted.

Listed below are the medical policies that reference using the KX modifier.

- L142: Ankle-Foot/Knee-Ankle-Foot Orthosis
- L13577: Automatic External Defibrillators
- L15300: Cervical Traction Devices
- L11486: Commodes
- L171: PAP (CPAP)
- L11452: Epoetin
- L11570: External Infusion Pumps
- L196: Glucose Monitors (also references KS modifier usage)
- L12739: High Frequency Chest Wall Oscillation Devices
- L11487: Home Dialysis Supplies and Equipment
- L11572: Hospital Beds

- L68: Immunosuppressive Drugs
- L27058: Knee Orthoses
- L11454: Manual Wheelchair Bases
- L11488: Nebulizers
- L11489: Negative Pressure Wound Therapy Pumps
- L11575: Oral Antiemetic Drugs
- L11456: Orthopedic Footwear
- L11577: Patient Lifts
- L23598: Power Mobility Devices
- L11578: Pressure Reducing Support Surfaces Group 1
- L11579: Pressure Reducing Support Surfaces Group 2
- L11580: Pressure Reducing Support Surfaces Group 3
- L51: Refractive Lenses
- L11493: Respiratory Assistive Devices
- L108: Speech Generating Devices
- L157: Therapeutic Shoes for Persons with Diabetes
- L11495: Transcutaneous Electrical Nerve Stimulators (TENS)
- L11581: Urological Supplies
- L11461: Walkers
- L11462: Wheelchair Options/ Accessories
- L15670: Wheelchair Seating

The LCDs and Policy Articles are housed in the Medicare Coverage Database and can also be accessed in the Coverage/MR section of the DME web site.

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

MLN Matters® Number: 6421 Revised
Related Change Request (CR) #: 6421
Related CR Release Date: April 24, 2009
Related CR Transmittal #: R480OTN
Effective Dates: Phase 1 – October 1, 2009, Phase 2 – April 1, 2010
Implementation Date: Phase 1 – October 5, 2009, Phase 2 – April 5, 2010

Note: This article was revised on December 11, 2009 to reflect an extension of phase 1 and a delay in implementing phase 2 of CR 6417. All other information remains the same.

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-April 4, 2010): 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, (April 5, 2010 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 web site. Before using Internet-based PECOS, providers should read the educational material about Internet-based PECOS that is available at http://www.cms.hhs.gov/MedicareProviderSupEnroll/04_InternetbasedPECOS.asp on the CMS web site. 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.hhs.gov/Transmittals/downloads/R480OTN.pdf on the CMS web site.

"DR" Condition Code and "CR" Modifier

As part of its response to the 2005 *Katrina* hurricane emergency, CMS developed the "DR" condition code and the "CR" modifier to facilitate the processing of claims affected by that emergency (See Transmittal 184 (CR 4106), issued on October 15, 2005). Use of these indicators was also authorized for claims affected by subsequent emergencies. The discretionary use of these indicators by a provider or supplier was permitted and such use signified not only that the item or service was affected by an emergency or disaster, but also that the provider or supplier had met all of CMS' requirements related to the furnishing of such item or services during the emergency or disaster.

Subsequently, on July 31, 2009, CMS issued Transmittal 1784 (CR 6451) which, among other things, narrowed the scope of permitted uses of these indicators. In particular, it eliminated the discretionary use of both the "DR" condition code and the "CR" modifier by providers and suppliers.

For the H1N1 pandemic emergency, CMS has authorized the use of the "DR" condition code and the "CR" modifier only by providers that have been granted a formal waiver under Section 1135 of the Social Security Act and then only for services affected by the emergency and while the waiver remains in effect. No other provider or supplier may use either indicator at this time.

Providers and suppliers who have been annotating their claims with one or both indictors should cease doing so (unless they are operating under a formal 1135 waiver). Processing of claims annotated with these indicators, that are submitted by providers and suppliers that have not been granted an 1135 waiver, may be delayed.

Please contact your local CMS Regional Office if you have questions or need more information. You may also visit the H1N1 web page at http://www.cms.hhs.gov/H1N1.

Healthcare Provider Taxonomy Codes April 2010 Update

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

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

Valid HPTCs are those codes approved by the NUCC for current use. Terminated codes are not approved for use after a specific date and newly approved codes are not approved for use prior to the effective date of the code set update in which each new code first appears. Although the NUCC generally posts their updates on the WPC web page 3 months prior to the effective date, changes are not effective until April 1 or October 1 as indicated in each update. Specialty and/or provider type codes issued by any entity other than the NUCC are not valid and Medicare would be guilty of non-compliance with HIPAA if Medicare contractors accepted claims that contain invalid HPTCs.

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

The HPTC list is available from the Washington Publishing Company (WPC). To view the April 2010 changes, visit the WPC web site at: http://www.wpc-edi.com/codes/taxonomy, then select "New Codes" for a listing of new HPTCs or "Modifications" for a listing of modified HPTCs.

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

Claim Status Category Code and Claim Status Code Update

MLN Matters® Number: 6723 Revised
Related Change Request (CR) #: 6723
Related CR Release Date: December 14, 2009
Related CR Transmittal #: R1874CP
Effective Date: January 1, 2010
Implementation Date: January 4, 2010

Note: This article was revised on December 15, 2009, to reflect a revised CR 6723 that was issued on December 14. The CR release date, transmittal number, and the web address for accessing CR 6723 were revised. All other information remains the same.

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 CR6723, 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 September 2009 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 November 1, 2009. All providers should ensure that their billing staffs are aware of the updated codes.

Background

The Health Insurance Portability and Accountability Act (HIPAA) requires all health care benefit payers to use only Claim Status Category Codes and Claim Status Codes approved by the national Code Maintenance Committee in the X12 276/277 Health Care Claim Status Request and Response format adopted as the standard for national use (004010X093A1). These codes explain the status of submitted claim(s). Proprietary codes may not be used in the X12 276/277 to report claim status. All code changes approved during the September 2009 committee meeting were posted at http://www.wpc-edi.com/content/view/180/223/ on November 1, 2009. Medicare will implement those changes on January 4, 2010 as a result of CR6723.

Additional Information

The official instruction issued to your Medicare contractor regarding this change may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R1874CP.pdf on the CMS web site.

New POS Code for Walk-in Retail Health Clinic

MLN Matters® Number: MM6752
Related Change Request (CR) #: 6752
Related CR Release Date: December 11, 2009
Related CR Transmittal #: R1869CP
Effective Date: March 11, 2010
Implementation Date: March 11, 2010

Provider Types Affected

This article is for physicians; non-physician practitioners; Ambulatory Surgical Centers (ASC); Independent Diagnostic Testing Facilities (IDTFs); Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) suppliers; and Clinical Diagnostic Laboratories submitting claims to Medicare carriers, Parts A and B Medicare Administrative Contractors (A/B MACs) and DME MACs.

Provider Action Needed

This article, based on CR 6752, advises you that the current place of service (POS) code set has been updated to add a new code of 17 (Walk-in Retail Health Clinic). The code's description is as follows: "a walk-in health clinic, other than an office, urgent care facility, pharmacy or independent clinic and not described by any other Place of Service code, that is located within a retail operation and provides, on an ambulatory basis, preventive and primary care services."

Note: For the health care industry, the HIPAA effective date of the new POS code for walk-in retail health clinics is no later than May 1, 2010, with covered entities permitted to use it at any time after which the new code is posted to the Centers for Medicare & Medicaid Services (CMS) POS web page.

You need to know that Medicare has not identified a need for this new code. Therefore, you should continue to use the billing instructions for immunizations described in the *Medicare Claims Processing Manual*, Chapter 18, Section 10.

Background

As an entity covered under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Medicare must comply with standards and their implementation guides adopted by regulation under this statute. The currently adopted professional implementation guide for the ASC X12 837 standards requires that each electronic claim transaction include a POS code from the POS code set maintained by CMS. As a payer, Medicare must be able to recognize as valid any valid code from the POS code set that appears on the HIPAA standard claim transaction. In accordance with HIPAA, Medicare will be able to recognize POS code 17 as valid by May 1, 2010, with plans to do so by March 11, 2010.

The new code 17 was established because industry entities other than Medicare identified a need to track the suppliers and settings of immunizations in greater detail than afforded through the current POS code set; these entities specifically wished to capture the walk-in retail health clinic, which they believe will be a common setting for immunizations.

Medicare has not identified a need for this new code, and physicians and other providers/suppliers are instructed to continue to use the billing instructions for immunizations described in the *Medicare Claims Processing Manual*, Chapter 18, Section 10.

Additional Information

The official instruction, CR 6752, issued to your carrier, A/B MAC, or DME MAC regarding this change, may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R1869CP.pdf on the CMS web site.

Medically Unlikely Edits

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 617	Date: January 8, 2010 Change Request 6712

Transmittal 178, Change Request 5402, dated December 8, 2006, is being rescinded and replaced with Transmittal 617. This change request replaces the file format and some of the process and is denying FISS lines; and updates how CMS handles modifier 55. All other material remains the same.

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: 617	Date: January 8, 2010	Change Request 6712

Transmittal 178, Change Request 5402, dated December 8, 2006, is being rescinded and replaced with Transmittal 617. This change request replaces the file format and some of the process and is denying FISS lines; and updates how CMS handles modifier 55. All other material remains the same.

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 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.

CONTINUED ON NEXT PAGE.

II. BUSINESS REQUIREMENTS

Number	Requirement	A/B MAC	DME MAC	FI	CARRIER	RHHI	FISS	MCS	VMS	CWF	OTHER
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							
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. MCS and VMS are not checked because the MCS and VMS systems already meet this requirement.						X				
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					
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					
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.										*
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 MUE value and assign MSN message # 15.6 and ANSI reason code XX, Payment denied/reduced because the payer deems the information submitted exceeds the number of medically likely services, group code CO (contractual obligation), and remark codes # N362 and MA01 to claims that fail the MUEs.	X	X	X	X	X					
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.	X	X	X	X	X	X	X	X		1
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					2
6712.13.2	The MUE denials shall have "provider liability."	X	X	X	X	X					
6712.13.3	The MUE denials cannot be waived nor subject to an ABN.	X	X	X	X	X					
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			
6712.5	Contractors shall refer providers to the web site: "http://www.cms.hhs.gov/ National CorrectCodInitEd/08_MUE. asp#TopOfPage" for current information on the MUE program.	X	X	X	X	X					

* NCCI/MUE Contractor and CMS/MUE Workgroup
1 BDC, EDC, and CDCs
2 Providers

III. PROVIDER EDUCAITON TABLE

Number	Requirement	A/B MAC	DME MAC	FI	CARRIER	RHHI	FISS	MCS	VMS	CWF	OTHER
6712.16	Contractors shall post this entire instruction, or a direct link to this instruction, on their web sites 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					

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:

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 web site: "http://www.cms.hhs.gov/NationalCorrectCodInitEd/08_MUE.asp#TopOfPage." A "1" indicates that CMS will publish the MUE units on the CMS web site.

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/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 VMS 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

Guidance on Implementing System Edits for Certain DMEPOS

MLN Matters® Number: MM6566
Related Change Request (CR) #: 6566
Related CR Release Date: December 23, 2009
Related CR Transmittal #: R614OTN
Effective Date: July 1, 2010
Implementation Date: July 6, 2010

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 mandatory quality requirements that may apply. DMEPOS suppliers should be aware that if they are not identified by the National Supplier Clearing House-Medicare Administrative Contractor (NSC-MAC) as being accredited to supply the specific product/service AND they are not exempt from accreditation, their claims will be automatically denied by Medicare.

Background

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

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

Section 154(b) of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) added a new subparagraph (F) to Section 1834(a)(20) of the Act. In implementing quality standards under this paragraph the Secretary will require suppliers furnishing items and services directly, or as a subcontractor for another entity, to have submitted evidence of accreditation by an accreditation organization designated by the Secretary. This subparagraph states that eligible professionals and other persons (defined below) are exempt from meeting the accreditation deadline unless CMS determines that the quality standards are specifically designed to apply to such 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. 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, E0444
R09	Respiratory Assist Devices	E0470, E0471, E0472
DM20 (Miami Only)	Support Surfaces: Pressure Reducing Beds/Mattresses/ Overlays/Pads	E0277, E0372, E0373, E0371, E0193
M05	Walkers	E0143, E0135, E0156, E0149, E0154, E0141, E0147, E0155, E0148, E0140, E0144, E0130, E0158, E0159, E0157, A4637
M09 M09A	Wheelchairs – Complete Rehabilitative Power Wheelchairs Wheelchairs – Complete Rehabilitative Power Wheelchair Related Accessories	K0835, K0836, K0841, K0838, K0837, K0842, K0843, K0839, K0840
M07 M07A	Wheelchairs – Standard Power Wheelchairs – Standard Power Related Accessories	K0823, K0822, K0825, K0800, K0824, K0814, K0821, K0801, K0816, K0827, K0815, K0826, K0813, K0806, K0807, K0828, K0802, K0829, K0820, K0808

Additional Information

The official instruction (CR6566) issued to your Medicare DME MAC is available at http://www.cms.hhs.gov/Transmittals/downloads/R614OTN.pdf on the CMS web site.

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.hhs.gov/mlnmattersarticles/downloads/MM6282.pdf on the CMS web site.

Implementation of HIPAA Version 5010 276/277 Claim Status Second Phase

MLN Matters ® Number: 6721 Revised
Related Change Request (CR) #: 6721
Related CR Release Date: January 15, 2010
Effective Date: April 1, 2010 (except July 1, 2010 for Jurisdiction 9 MAC)
Related CR Transmittal #: R623OTN
Implementation Date: April 5, 2010 (except July 6, 2010 for Jurisdiction 9 MAC)

Note: This article was revised on January 19, 2010, to reflect a revised CR 6721 that was issued on January 15, 2010. The CR was revised to correct the definition of a data element (SVC07) in the 277 Flat File Standard attached to CR 6721. The corrected definition is in the attachment of the revised CR 6721. In this article, the CR release date, transmittal number, and the web address for accessing CR 6721 have been changed. All other information remains the same.

Provider Types Affected

Physicians, providers, and suppliers submitting claims to Medicare contractors (Carriers, Fiscal Intermediaries (FIs), DME Medicare Administrative Contractors (DME MACs), A/B Medicare Administrative Contractors (A/B MACs), and/or Regional Home Health Intermediaries (RHHIs)) for services provided to Medicare beneficiaries should be aware of this issue.

Provider Action Needed

This article is based on Change Request (CR) 6721 which provides technical directions to Medicare Shared System Maintainers and Medicare Contractors regarding the implementation of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 for the Accredited Standards Committee (ASC) X12 Version 005010 Health Care Claim Status Request and Response (276/277) transaction sets. Providers need to be aware of their own requirements to be fully compliant with the X12 5010 standards by January 1, 2012. Extensive information regarding the standards, along with helpful guidance for providers, is available at http://www.cms.hhs.gov/Versions5010andD0/ on the Centers for Medicare & Medicaid Services (CMS) web site. Note that the above implementation dates relate only to

Medicare contractors completion of work on this particular phase of the implementation.

Background

Change Request (CR) 6721 provides technical direction to the following Medicare Shared System Maintainers and Medicare Contractors for implementing the second phase of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 for the Accredited Standards Committee (ASC) X12 Version 005010 Health Care Claim Status Request and Response (276/277) transaction sets. The CR also contains details on the Common Edits and Enhancement Module (CEM) software for the inbound Claim Status Inquiry process.

CMS has prepared a comparison of the current X12 HIPAA Electronic Data Interchange (EDI) standards (Version 4010/4010A1) with Version 5010 and the National Council for Prescription Drug Programs (NCPDP) EDI standards Version 5.1 to Version D.0. The 4010A1 Implementation Guides and the 5010 Technical Report 3 (TR3) documents served as reference materials during the preparation of the comparison excel spreadsheets. CMS is making the side-by-side comparison documents available for download in both Microsoft Excel and PDF formats. The comparisons were performed for Medicare Fee-for-Service business use and while they may serve other uses, CMS does not offer to maintain this product for purposes other than Medicare Fee-for-Service. You can find these documents at http://www.cms.hhs.gov/MFFS5010D0/20_Technical%20Documentation.asp#TopOfPage on the CMS web site.

Additional Information

The official instruction, CR 6721, issued to your carrier, FI, A/B MAC, RHHI, and DME MAC regarding this change may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R623OTN.pdf on the CMS web site.

You can also review the Final Rule as published in the Federal Register on January 16, 2009 by the Department of Health and Human Services 45 CFR Part 162, Subpart N—Health Care Claim Status at http://edocket.access.gpo.gov/2009/pdf/E9-740.pdf on the Internet.

You can find more information about HIPAA Version 5010 and NCPDP Version D.0. at http://www.cms.hhs.gov/ElectronicBillingEDITrans/18_5010D0.asp on the CMS web site. A special edition MLN Matters® article, SE0832, on the ICD-10 code set is available at http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0832.pdf on the CMS web site.

Instructions on How to Process Negative CARC Adjustment Amounts When Certain CARCs Appear on MSP Claims

MLN Matters® Number: MM6736
Related Change Request (CR) #: 6736
Related CR Release Date: February 5, 2010
Related CR Transmittal #: R73MSP
Effective Date: July 1, 2010
Implementation Date: July 6, 2010

Provider Types Affected

This article applies to all physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), Medicare Administrative Contractors (MACs), and durable medical equipment Medicare Administrative Contractors (DME MACs)) for services provided to Medicare beneficiaries.

Provider Action Needed

This article is based on CR 6736, which provides Medicare contractors with processing instructions for claim adjustment reason code (CARC) adjustment amounts that are negative when certain CARCs appear on incoming Medicare Secondary Payer (MSP) claims.

You should know that Medicare contractors will automatically reprocess any MSP claims retroactive to July 5, 2009, and remove the positive Claim Adjustment Segment (CAS) CARC adjustment from the primary payer payment amount where a CARC adjustment was added to the primary payer payment amount when the same CAS CARC adjustment was received as a negative adjustment. Please be sure your billing staffs are aware of these changes.

Background

CRs 6426 and 6427 instruct Medicare contractors to take into consideration the CARCs and the applicable adjustment amounts when processing MSP claims. Business requirements (BRs) 6426.6 and 6427.6 instruct shared systems to add certain CARC adjustment amounts to the paid amounts when these CARCs are received on a claim. There have been rare circumstances where the CARCs found in BR 6426.6 and 6427.6 on incoming MSP claims include a negative adjustment amount and the shared systems mistakenly added the same adjustment amount to the claim based on instructions found in CR 6426 and 6427.

CR 6736 provides instructs Medicare contractors not to add the CARCs when the adjustment amounts on incoming MSP claims are negative. Medicare systems will automatically reprocess any MSP claims retroactive to July 5, 2009, and remove the positive CAS CARC adjustment from the primary payer payment amount where a CARC adjustment was added to the primary payer payment amount when the same CAS CARC adjustment was received as negative adjustment.

Additional Information

CR 6426 is available at http://www.cms.hhs.gov/transmittals/downloads/R70MSP.pdf on the CMS web site. CR 6427 is available at http://www.cms.hhs.gov/transmittals/downloads/R67MSP.pdf on the CMS web site.

The official instruction, CR 6736, issued to your Medicare contractor regarding this change, may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R73MSP.pdf on the CMS web site.

CR 6736 includes the revisions that will be made to the Medicare Secondary Payer (MSP) Manual, Chapter 5 (Contractor Prepayment Processing Requirements), Section 40.7.5, Effect of Failure to File Proper Claim, as an attachment to that CR.

CARC, RARC, and MREP Update

MLN Matters® Number: MM6742
Related Change Request (CR) #: 6742
Related CR Release Date: November 27, 2009
Related CR Transmittal #: R1862CP
Effective Date: January 1, 2010
Implementation Date: January 4, 2010

Provider Types Affected

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

Provider Action Needed

CR 6742, from which this article is taken, announces the latest update of Remittance Advice Remark Codes (RARCs) and Claim Adjustment Reason Codes (CARCs). The CR is effective January 1, 2010.. Be sure billing staff are aware of these changes.

Background

The reason and remark code sets must be used to report payment adjustments in remittance advice transactions. The reason codes are also used in coordination-of-benefits (COB) transactions. The RARC list is maintained by the Centers for Medicare & Medicaid Services (CMS), and used by all payers; and additions, deactivations, and modifications to it may be initiated by any health care organization. The RARC list is updated 3 times a year – in early March, July, and November although the Committee meets every month. A national code maintenance committee maintains the CARCs. That Committee meets at the beginning of each X12 trimester meeting (January/February, June and September/October) and makes decisions about additions, modifications, and retirement of existing reason codes. The updated list is posted 3 times a year around early March, July, and November. Both code lists are posted at http://www.wpc-edi.com/Codes on the Internet. The lists at the end of this article summarize the latest changes to these lists, as announced in CR 6742.

CMS has also developed a tool to help you search for a specific category of code and that tool is available at http://www.cmsremarkcodes.info on the Internet. Note that this web site does not replace the Washington Publishing Company (WPC) site. That site is http://www.wpc-edi.com/Codes and, should there be any discrepancies in what is posted at the CMS site and the WPC site, consider the WPC site to be correct.

Additional Information

To see the official instruction (CR6742) issued to your Medicare Carrier, RHHI, DME/MAC, FI and/or MAC refer to http://www.cms.hhs.gov/Transmittals/downloads/R1862CP.pdf on the CMS web site.

New Codes – CARC

Code	Current Narrative	Effective Date Per WPC Posting
232	Institutional transfer amount. Note: Applies to Institutional claims only and explains the DRG amount differences when patients care crosses multiple institutions.	11/1/2009
D23	This dual eligible patient is covered by Medicare Part D per Medicare Retro-Eligibility – Must also include Remittance Advice Remark Code	11/1/2009

Modified Codes – CARC

Code	Current Modified Narrative	Effective Date Per WPC Posting
4	The procedure code is inconsistent with the modifier used or a required modifier is missing. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
5	The procedure code/bill type is inconsistent with the place of service. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
6	The procedure/revenue code is inconsistent with the patient's age. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010

Code	Current Modified Narrative	Effective Date Per WPC Posting
7	The procedure/revenue code is inconsistent with the patient's gender. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
8	The procedure code is inconsistent with the provider type/specialty (taxonomy). Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
9	The diagnosis is inconsistent with the patient's age. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
10	The diagnosis is inconsistent with the patient's gender. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
11	The diagnosis is inconsistent with the procedure. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
12	The diagnosis is inconsistent with the provider type. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
49	These are non-covered services because this is a routine exam or screening procedure done in conjunction with a routine exam. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
51	These are non-covered services because this is a pre-existing condition. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
61	Penalty for failure to obtain second surgical opinion. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance AdviceRemark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
107	Related or qualifying claim/service was not identified on the claim. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
108	Rent/purchase guidelines were not met. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
152	Payer deems the information submitted does not support this length of service.	7/1/2010
167	This (these) diagnosis(es) is (are) not covered. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010

Code	Current Modified Narrative	Effective Date Per WPC Posting
170	Payment is denied when performed/billed by this type of provider. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
171	Payment is denied when performed/billed by this type of provider in this type of facility. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
172	Payment is adjusted when performed/billed by a provider of this specialty. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
179	Patient has not met the required waiting requirements. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
183	The referring provider is not eligible to refer the service billed. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
184	The prescribing/ordering provider is not eligible to prescribe/order the service billed. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
185	The rendering provider is not eligible to perform the service billed. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
222	Exceeds the contracted maximum number of hours/days/units by this provider for this period. This is not patient specific. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
B8	Alternative services were available, and should have been utilized. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an "Alert".)	7/1/2010
125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an "Alert".)	7/1/2010
148	Information from another provider was not provided or was insufficient/ incomplete. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an "Alert".)	7/1/2010

Code	Current Modified Narrative	Effective Date Per WPC Posting
226	Information requested from the Billing/Rendering Provider was not provided or was insufficient/incomplete. At least one Remark Code must be provided ((may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an "Alert".)	7/1/2010
227	Information requested from the patient/insured/responsible party was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an "Alert".)	7/1/2010
A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an "Alert".)	7/1/2010
40	Charges do not meet qualifications for emergent/urgent care. This change to be effective 07/01/2010: Charges do not meet qualifications for emergent/urgent care. Note: Refer to the 835 REF Segment: Healthcare Policy Identification, if present.	7/1/2010

Deactivated Codes – CARC

Code	Current Narrative	Effective Date
87	Transfer Amount	1/1/2012
D23	This dual eligible patient is covered by Medicare Part D per Medicare Retro-Eligibility – Must also include Remittance Advice Remark Code	1/1/2012

New Codes – RARC

N521	Mismatch between the submitted provider information and the provider information stored in our system.	NO
N522	Duplicate of a claim processed as a crossover claim.	NO

Modified Codes – RARC

Code	Modified Narrative	Medicare Initiated
M39	The patient is not liable for payment for this service as the advance notice of non-coverage you provided the patient did not comply with program requirements.	NO
M118	Letter to follow containing further information.	NO
N59	Please refer to your provider manual for additional program and provider information.	NO
N130	Consult plan benefit documents/guidelines for information about restrictions for this service.	NO
N202	Additional information/explanation will be sent separately.	NO

Deactivated Codes – RARC

None

Expiration of Medicare Processing of Certain IHS Part B Claims

MLN Matters® Number: SE0912 Replaced

Note: This article has been replaced by article SE0930, which is available at http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0930.pdf on the Centers for Medicare & Medicaid Services web site.

Sunset of Section 630 of MMA of 2003 for Payment of IHS

MLN Matters® Number: SE0930

Provider Types Affected

Indian Health Service (IHS) tribe and tribal organizations and facilities submitting claims to Medicare contractors

Provider Action Needed

This special edition article is being issued by the Centers for Medicare & Medicaid Services (CMS) to notify affected IHS physicians, IHS providers, and IHS suppliers that, per the provisions of section 630 of the MMA, certain Part B services will no longer be covered for Medicare payment when the provisions sunset as of December 31, 2009.

However, Congress is considering new legislation that may extend this provision beyond December 31, 2009. If such legislation is enacted, Medicare will notify contractors to again process claims for these IHS services.

These services include the following:

- Durable Medical Equipment, prosthetics, and orthotics;
- Therapeutic shoes;
- Clinical laboratory services;
- Surgical dressings, splints and casts;
- Drugs (those processed by the J4 A/B Medicare Administrative Contractor (MAC) and the DME MACs);
- Ambulance services;
- Influenza and pneumonia vaccinations; and
- Screening and preventive services.

Claims for services furnished on or before December 31, 2009, will be processed under normal conditions.

For services provided on or after January 1, 2010, health care providers may choose, to the extent possible, to hold their claims (that is, not submit their claims to Medicare) until it becomes clearer as to whether new legislation will be enacted to extend this provision. If legislation is enacted, claims submission for these items and services may resume. Otherwise, claims for these items and services, submitted with dates of service on or after January 1, 2010, will be denied because there would no longer be any statutory basis for such payment.

Depending on the effective date of possible legislation which extends coverage of these items and services, claims which were originally submitted and denied may be eligible for payment. If this has occurred, the submitter must contact the entity that processes their claims to have the claims adjusted. Affected providers need not resubmit their claims nor appeal the original denial.

CMS is committed to maintaining open lines of communication with all affected providers and stakeholders on this issue. Finally, be on the alert for possible action by Congress to extend this provision.

LCD and Policy Article Revisions - Summary for January 22, 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.

Ankle Foot/Knee Ankle Foot Orthosis
LCD
Revision Effective Date: 01/01/2010
HCPCS CODES AND MODIFIERS:
Added: A4466
Deleted: L1901
Revised Description: L4396

Policy Article
Revision Effective Date: 01/01/2010
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: Information on code A4466
CODING GUIDELINES
Deleted: Reference to invalid code L2770

Ostomy Supplies
LCD
Revision Effective Date: 01/01/2010
INDICATIONS AND LIMITATIONS OF COVERAGE:
Added: Requirements concerning request for refill
HCPCS CODES AND MODIFIERS:
Deleted: A4365
Added: A4456

Policy Article
Revision Effective Date 01/01/2010
CODING GUIDELINES:
Relocated: Faceplate Column I Column II table
ICD-9 CODES THAT ARE NOT COVERED:
Deleted: A4365
Added: A4456

Respiratory Assist Devices
LCD
Revision Effective Date: 02/01/2010
INDICATIONS AND LIMITATIONS OF COVERAGE:
Removed: Term "progressive" from general coverage criteria of neuromuscular diseases
Moved: Definitions contained in section III to the GENERAL section with the other definitions
Changed: Term "usual" to "prescribed" in the descriptor for FIO2 testing throughout
Added: Early coverage criteria for E0471 to COPD section
Moved: Late coverage criteria for E0471 to COPD section from CONTINUED COVERAGE section
Added: Hypoventilation Syndrome as a covered indication
Removed: Medicare Beneficiary Statement requirement
Added: Supply/accessory quantity monitoring requirement
DOCUMENTATION REQUIREMENTS:

Removed: Beneficiary Statement requirements

Surgical Dressings
LCD
Revision Effective Date: 01/01/2010
INDICATIONS AND LIMITATIONS OF COVERAGE:
Removed: A6200-A6202 from composite dressing reference
Clarified: Usual dressing changes for gauze with zinc paste
HCPCS CODES:
Deleted: A6200, A6201, A6202, A6542, A6543

Policy Article
Revision Effective Date: 01/01/2010
CODING GUIDELINES:
Deleted: References to A6200, A6201, A6202

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 January 28, 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.

Enteral Nutrition
LCD
Revision Effective Date: 04/01/2005 (January 2010 publication)
INDICATIONS AND LIMITATIONS OF COVERAGE:
Included: Statement regarding payment of special enteral formulas if the medical necessity for such formula is not substantiated, to the least costly medically appropriate, code B4150. This statement was inadvertently omitted from the LCD when the LMRP was converted to an LCD.

Knee Orthoses
LCD
Revision Effective Date: 01/01/2010
INDICATIONS AND LIMITATIONS OF COVERAGE:
Added: Coverage criteria for L1810, L1820
Added: Definition for knee instability
Revised: Coverage criteria for L1832
HCPCS CODES AND MODIFIERS:
Deleted: L1800, L1815, L1825
Added: A4466
ICD-9 CODES THAT SUPPORT MEDICAL NECESSITY:
Revised: Covered diagnoses for L1832

Policy Article
Revision Effective Date: 01/01/2010
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: Reference to code A4466
CODING GUIDELINES:
Deleted: Definitions for L1800, L1815, and L1825
Deleted: Reference to code L2770

Positive Airway Pressure Devices
LCD
Revision Effective Date: 01/01/2010
INDICATIONS AND LIMITATIONS OF COVERAGE:
Revised: PAP device coverage when based on facility-based PSG – coverage based on date of PSG not DOS of device for credentialing requirement.

Power Mobility Devices
LCD
Revision Effective Date: 10/01/2009 (January 2010 Revision)
DOCUMENTATION REQUIREMENTS:
Revised: Wording of one element of the detailed product description

Wheelchair Options and Accessories
LCD
Revision Effective Date: 04/01/2010
HCPCS CODES AND MODIFIERS:
Added : GA, GZ
Deleted: E2223, E2393, E2399 (effective 01/01/2010)
DOCUMENTATION REQUIREMENTS:
Revised: Requirements for the detailed product description
Added: Instructions for use of the GA, GY, and GZ modifiers
Revised: Requirements for use of the KX modifier

Policy Article
Revision Effective Date: 01/01/2010
CODING GUIDELINES:
Revised: Changed references from code E2399 to K0108
Deleted: References to codes E2223, E2393

Wheelchair Seating
LCD
Revision Effective Date: 04/01/2010
HCPCS CODES AND MODIFIERS:
Added: GY
Revised: GA
DOCUMENTATION REQUIREMENTS:
Added: Requirements for use of the GY modifier
Revised: Requirements for detailed product description
Revised: Requirements for use of the KX modifier
Revised: Requirements for use of GA and GZ modifiers

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 4, 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 Infusion Pumps
LCD
Revision Effective Date: 04/01/2010
INDICATIONS AND LIMITATIONS OF COVERAGE:
Revised: Physician assessment interval for insulin pumps from every 6 months to every 3 months

COVERAGE CONT'D

HCPCS CODES AND MODIFIERS:
Added: GA and GZ modifiers
Revised: KX modifier
DOCUMENTATION REQUIREMENTS:
Removed: KX modifier requirement for supplies billed with external insulin infusion pumps and insulin.
Revised: Requirements for use of KX modifier with external insulin infusion pumps and insulin to meet either the C-Peptide level criteria or beta cell autoantibody criterion.
Added: Instructions for the use of GA and GZ modifiers.
Added: Instructions for use of GY modifier from Policy article to LCD.

Facial Prosthesis
LCD
Revision Effective Date: 01/01/2010
HCPCS CODES AND MODIFIERS:
Replaced: A4365 with A4456

Policy Article
Revision Effective Date: 01/01/2010
CODING GUIDELINES:
Replaced: A4365 with A4456

Nebulizers
LCD
Revision Effective Date: 01/01/2010
INDICATIONS AND LIMITATIONS OF COVERAGE:
Replaced: Q4080 with Q4074 in the Iloprost coverage indications
HCPCS CODES AND MODIFIERS:
Replaced: Q4080 with Q4074
ICD-9 CODES
Replaced: Q4080 with Q4074 in the ICD-9 requirements
DOCUMENTATION REQUIREMENTS:
Replaced: Q4080 with Q4074 in the KX, GA and GZ modifiers requirements

Policy Article
Revision Effective Date: 01/01/2010
CODING GUIDELINES:
Replaced: Q4080 with Q4074 in the Inhalation Drug Requirements
Deleted: J7649 and J7659 from the Inhalation Drug Requirements

Oral Antiemetic Drugs
Policy Article
Revision Effective Date: 01/01/2010
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Changed: Timing in criterion 4 to match IOM 100-02, Chapter 15, Section 50-5-4
ICD-9 CODES THAT ARE COVERED:
Deleted: V58.0-V58.12 and replaced with V58.11 to match IOM 100-02, Chapter 15, Section 50-5-4.

Spinal Orthoses - TLSO and LSO
LCD
Revision Effective Date: 01/01/2010
HCPCS CODES AND MODIFIERS:
Added: A4466
Deleted: GY
DOCUMENTATION REQUIREMENTS:
Deleted: Use of GY modifier with elastic spinal orthoses (Refer to Policy Article for coding guidelines for elastic and nonelastic spinal orthoses.)

Policy Article
Revision Effective Date: 01/01/2010
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: Revised code reference (A4466) for elastic spinal orthoses
CODING GUIDELINES:
Added: Instructions for coding elastic and nonelastic flexible spinal orthoses
Added: Requirement for Coding Verification Review effective 7/1/2010.

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.

Coverage Reminder – Automatic External Defibrillators

The Durable Medical Equipment Medicare Administrative Contractors (DME MACs) have recently become aware of marketing material that suggests that coverage for a wearable automatic external defibrillator (AED) (K0606) is available immediately following a myocardial infarction and in several clinical situations that are not specified in the LCD. Suppliers are reminded that reimbursement is available only under the criteria listed in the LCD.

Wearable automatic external defibrillators (AED) (K0606) are covered as an alternative to implanted defibrillators when criteria specified in the Automatic External Defibrillator Local Coverage Determination (LCD) are met. Wearable AEDs are covered for patients if they meet one of the following criteria:

1. A documented episode of ventricular fibrillation or a sustained, lasting 30 seconds or longer, ventricular tachyarrhythmia. These dysrhythmias may be either spontaneous or induced during an electrophysiologic (EP) study, but may not be due to a transient or reversible cause and not occur during the first 48 hours of an acute myocardial infarction (ICD-9 427.1, 427.42, 427.5); or
2. Familial or inherited conditions with a high risk of life-threatening ventricular tachyarrhythmia's such as long QT syndrome (ICD-9 426.82) or hypertrophic cardiomyopathy (ICD-9 425.1); or
3. Either documented prior myocardial infarction (ICD-9 410.00-410.92, 412) or dilated cardiomyopathy (ICD -9 425.0-425.9) and a measured left ventricular ejection fraction less than or equal to 0.35; or
4. A previously implanted defibrillator now requires explantation (ICD-9 996.04, 996.61

Nonwearable AEDs (E0617) have different coverage criteria. Refer to the LCD for additional information.

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
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

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, recognized 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 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 compendia by going to CR 6806, located at http://www.cms.hhs.gov/Transmittals/downloads/R120BP.pdf on the CMS web site.

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 MLN Matters® article 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 web site.

CMS Manual System Pub 100-02 Medicare Benefit Policy	Department of Health & Human Services (DHHS) Centers for Medicare & Medicaid Services (CMS)
Transmittal 120	Date: January 29, 2010 Change Request 6806

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

I. SUMMARY OF CHANGES: Effective January 1, 2010, pursuant to section 182(b) of MIPPA, CMS is making corresponding revisions in Pub. 100-02, Medicare Benefit Policy Manual, chapter 15, section 50.4.5, for use in the determination of a medically-accepted indication of drugs and biologicals used off-label in an anti-cancer chemotherapeutic regimen.

New / Revised Material
Effective Date: January 1, 2010
Implementation Date: March 1, 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
R	15/50.4.5.1/Process for Amending the List of Compendia for Determination of Medically-Accepted Indications for Off-Label Uses of Drugs and Biologicals in an Anti-Cancer Chemotherapeutic Regimen

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:
Business Requirements
Manual Instruction
Unless otherwise specified, the effective date is the date of service.

Attachment – Business Requirements

Pub. 100-02	Transmittal: 120	Date: January 29, 2010	Change Request: 6806

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

Effective Date: January 1, 2010

Implementation Date: March 1, 2010

I. GENERAL INFORMATION

a. Background: 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-- American Medical Association Drug Evaluations (AMA-DE), United States Pharmacopoeia-Drug Information (USP-DI) or its successor publication, and American Hospital Formulary Service-Drug Information (AHFS-DI)—plus other authoritative compendia as identified by the Secretary, 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, 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 Physician Fee Schedule final rule for calendar year 2008, CMS established a process for revising the list of compendia, as authorized under section 1861(t)(2) of the Act, and also established a definition for "compendium." Under 42 CFR 414.930(a), 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." 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; and, (2) is indexed by drug or biological. In addition, CMS 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 at the end 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.' For additional background information, consult CR 6191, Transmittal 96, issued October 24, 2008.

b. Policy: Effective January 1, 2010, pursuant to section 182(b) of MIPPA, CMS is making corresponding revisions in Pub. 100-02, Medicare Benefit Policy Manual, chapter 15, section 50.4.5.1, for use in the determination of medically-accepted indications of drugs and biologicals used off-label in anti-cancer chemotherapeutic regimens. See 74 FR 61901.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	A/B MAC	DME MAC	FI	CARRIER	RHHI	FISS	MCS	VMS	CWF	OTHER
6806.1	Effective January 1, 2010, contractors shall be aware that the definition of "compendia" has been revised to include a publicly transparent process for evaluating therapies and for identifying potential conflicts of interest. No compendia may be included on the list of compendia without the above criteria being met.	X	X	X	X	X					

III. PROVIDER EDUCATION TABLE

Number	Requirement	A/B MAC	DME MAC	FI	CARRIER	RHHI	FISS	MCS	VMS	CWF	OTHER
6806.2	Contractors shall post this entire instruction, or a direct link to this instruction, on their web site and include information about it in a listserv message within 1 week of the release of this instruction. In addition, the entire instruction must be included in your next regularly scheduled bulletin. Contractors are free to supplement it with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X	X	X	X	X					

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below:
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendation or other supporting information:

Section B: For all other recommendations and supporting information, use this space:

V. CONTACTS

Pre-Implementation Contact(s): Brijet Burton, coverage, 410-786-7364, brijet.burton2@cms.hhs.gov, Pat Brocato-Simons, coverage, 410-786-0261, patricia.brocatosimons@cms.hhs.gov

Post-Implementation Contact(s): CMS ROs

VI. FUNDING

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

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.

50.4.5.1 - Process for Amending the List of Compendia for Determination of Medically-Accepted Indications for Off-Label Uses of Drugs and Biologicals in an Anti-Cancer Chemotherapeutic Regimen
(Rev.120, Issued: 01-29-10, Effective:01-01-10, Implementation: 03-01-10)

A. Background

In the Physician Fee Schedule final rule for calendar year *(CY)* 2008, the CMS established a process for revising the list of compendia, as authorized under section 1861(t)(2) of the Social Security Act, and also established a definition for "compendium." At 42 CFR 414.930(a), 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." 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) effective January 1, 2010, pursuant to section 182(b) of the Medicare Improvements for Patients and Providers Act (MIPPA), has a publicly transparent process for evaluating therapies and for identifying potential conflicts of interests*. See 42 CFR 414.930(a); 72 FR 66222, 66404, *and 74 FR 61901.*

B. Desirable Characteristics of Compendia

CMS 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) as criteria for decision-making. The list of desirable compendium characteristics was developed by the MedCAC during a public session on March 30, 2006. T he goal of this session was to review the evidence and advise CMS on the desirable characteristics of compendia for use in the determination of medically accepted indications of drugs and biologicals in anti-cancer therapy. As a result of this meeting, the MedCAC generated the following list of desirable characteristics:

- Extensive breadth of listings,
- Quick processing from application for inclusion to listing,
- Detailed description of the evidence reviewed for every individual listing,
- Use of pre-specified published criteria for weighing evidence,
- Use of prescribed published process for making recommendations,
- Publicly transparent process for evaluating therapies,
- Explicit "Not Recommended" listing when validated evidence is appropriate,
- Explicit listing and recommendations regarding therapies, including sequential use or combination in relation to other therapies,
- Explicit "Equivocal" listing when validated evidence is equivocal, and,
- Process for public identification and notification of potential conflicts of interest of the compendias' parent and sibling organizations, reviewers, and committee members, with an established procedure to manage recognized conflicts.

Furthermore, the provisions discussed in section 182(b) of MIPPA bring more uniformity in compendia conflict of interest disclosure practices and allow the public the ability to monitor how these policies impact compendia off-label recommendations.

C. Process for Changing List of Compendia

CMS will provide an annual 30-day open request period starting January 15 for the public to submit requests for additions or deletions to the compendia list contained on the CMS web site at http://www.cms.hhs.gov/CoverageGenInfo/02_compendia.asp.

Complete requests as defined in section 50.4.5.1.D will be posted to the web site *annually* by March 15 for public notice and comment. The request will identify the requestor and the requested action *CMS is being asked to make* to the list. Public comments will be accepted for a 30-day period beginning on the day the request is posted on the web site. In addition to the annual process, CMS may generate a request for changes to the list at any time an urgent action is needed to protect the interests of the Medicare program and its beneficiaries.

D. Content of Requests

For a request to be considered complete, and therefore accepted for review, it must include the following information:

- The full name and contact information (including the mailing address, e-mail address, and telephone number) of the requestor. If the requestor is not an individual person, the information shall identify the officer or other representative who is authorized to act for the requestor on all matters related to the request.
- Full identification of the compendium that is the subject of the request, including name, publisher, edition if applicable, date of publication, and any other information needed for the accurate and precise identification of the specific compendium.
- A complete, written copy of the compendium that is the subject of the request. If the complete compendium is available electronically, it may be submitted electronically in place of hard copy. If the compendium is available online, the requestor may provide CMS with electronic access by furnishing at no cost to the Federal Government sufficient accounts for the purposes and duration of the review of the application in place of hard copy.
- The specific action that the requestor wishes CMS to take, for example to add or delete a specific compendium.
- Detailed, specific documentation that the compendium that is the subject of the request does or does not comply with the conditions of this rule. Broad, nonspecific claims without supporting documentation cannot be efficiently reviewed; therefore, they will not be accepted.
- *A publicly transparent process for evaluating therapies, which includes the following: (1) internal or external request for listing of a therapy recommendation, including criteria used to evaluate the request (the complete application), (2) listing of all the evidentiary materials reviewed or considered for inclusion in the compendium (3) listing of all individuals who substantively participated in the review and development of the request, and (4) minutes and voting records of meetings for the review and disposition of the request. The information from an internal or external request for inclusion of a therapy in a compendium are available to the public for a period*

of not less than 5 years, which includes availability on the compendium's web site for a period of not less than 3 years, coincident with the compendium's publication.

- *A publicly transparent process for identifying potential conflicts of interests that provides: (1) direct or indirect financial relationships, and (2) ownership or investment interests that exist between individuals or the spouse or minor child of individuals who have substantively participated in the development or disposition of compendia recommendations, and the manufacturer or seller of the drug or biological being reviewed by the compendium. This information shall be identified and made timely available in response to a public request for a period of not less than 5 years, which includes availability on the compendium's web site for a period of not less than 3 years, coincident with the compendium's publication.*

A request may have only a single compendium as its subject. This will provide greater clarity to the scope of the Agency's review of a given request. A requestor may submit multiple requests, each requesting a different action.

E. Submission of Requests

Requests must be in writing and submitted in one of the following two ways (no duplicates please):

1. Electronic requests are encouraged to facilitate administrative efficiency. Each solicitation will include the electronic address for submissions.
2. Hard copy requests can be sent to: Centers for Medicare & Medicaid Services, Coverage and Analysis Group, Mailstop C1–09–06, 7500 Security Boulevard, Baltimore, MD 21244.

Allow sufficient time for hard copies to be received prior to the close of the open request period.

F. Review of Requests

CMS will consider a compendium's attainment of the desirable characteristics specified in 50.4.5.1.B when reviewing requests. CMS may consider additional, reasonable factors in making a determination. For example, CMS may consider factors that are likely to impact the compendium's suitability for this use, such as a change in the compendium's ownership or affiliation, and the standards applicable to the evidence considered by the compendium. CMS may consider that broad accessibility by the general public to the information contained in the compendium may assist beneficiaries, their treating physicians, or both, in choosing among treatment options. CMS will also consider a compendium's grading of evidence used in making recommendations regarding off-label uses, and the process by which the compendium grades the evidence. CMS may, at its discretion, combine and consider multiple requests that refer to the same compendium, even if those requests are for different actions. This facilitates administrative efficiency in the review of requests.

G. Publishing Review Results

CMS will publish decisions on the CMS web site within 90 days after the close of the public comment period.

(This instruction was last reviewed by CMS in *December* 2009.)

Maintenance and Servicing Payments for Certain Oxygen Equipment After July 1, 2010

MLN Matters® Number: MM6792
Related Change Request (CR) #: 6792
Related CR Release Date: February 5, 2010
Related CR Transmittal #: R635OTN
Effective Date: July 1, 2010
Implementation Date: July 6, 2010

Provider Types Affected

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

What You Need to Know

CR 6792, from which this article is taken, announces instructions regarding payment for maintenance and servicing of oxygen equipment furnished for dates of service on or after July 1, 2010. Please see the Background section, below, for details.

Background

Section 1834(a)(5)(F)(ii)(III) of the Social Security Act provides for the payment of charges for reasonable and necessary maintenance of, and servicing of, oxygen equipment that you furnish after the 36-month rental payment cap for parts and labor that are not covered by the supplier's or manufacturer's warranty.

CR 6716, titled Continuation of Maintenance and Servicing Payments in CY 2010 for Certain Oxygen Equipment as a Result of the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 and released November 2, 2009, provides instructions relating to the maintenance and servicing payments for oxygen equipment furnished through June 30, 2010. (You can find the related MLN Matters® Article at http://www.cms.hhs.gov/mlnmattersarticles/downloads/MM6716.pdf on the Centers for Medicare & Medicaid Services (CMS) web site.)

CR 6792, from which this article is taken, is a one-time notification that announces instructions regarding the payment for maintenance and servicing of oxygen equipment furnished for dates of service on or after July 1, 2010.

Specifically, CR 6792 provides that (effective for oxygen equipment, other than stationary or portable gaseous or liquid oxygen equipment, furnished on or after July 1, 2010) a maintenance and servicing fee of $66 is paid every 6 months, either beginning: 1) 6 months after the 36th paid rental month; or 2) when the item is no longer covered under the supplier's or manufacturer's warranty (whichever is later).

The maintenance and servicing fee, which will be updated annually through program instructions that are based on the covered item update for DME, covers all maintenance and servicing through the following 6 months that are needed in order to keep the oxygen equipment in good working order.

A single payment ($66 for dates of service July 1, 2010 through December 31, 2010) is made per beneficiary regardless of:

- The number of pieces of equipment serviced (stationary concentrator, portable concentrator, and/or transfilling equipment);
- When the maintenance and servicing is performed during each 6-month period; or
- How often the equipment must be maintained and serviced.

You must make at least one maintenance/servicing visit to inspect the equipment and provide any maintenance and servicing needed at the time of the visit during the first month of each 6-month period. For example:

- 36th monthly payment amount made for month ending July 31, 2010;
- 6-month period with no payment ends December 31, 2010;
- Maintenance and servicing payment may begin on January 1, 2011, provided warranty coverage ended on July 31, 2010, or earlier;
  - You must make at least one in-home visit during January 2011; and
  - Payment covers all maintenance and servicing through June 30, 2011.
- Second maintenance and servicing payment may be made on July 1, 2011;
  - You must make at least one in-home visit during July 2011, and
  - Payment covers all maintenance and servicing through December 31, 2011.

Note: You will not receive payment for maintenance and servicing of gaseous or liquid oxygen equipment (stationary or portable), or for maintenance and servicing of beneficiary-owned oxygen equipment.

Billing Guidance

You should use:

- Healthcare Common Procedure Coding System (HCPCS) codes E1390, E1391, E0433, or K0738 along with the MS modifier to bill and receive payment for maintenance and servicing of oxygen equipment other than gaseous or liquid oxygen equipment;
- HCPCS code E1390 for maintenance and servicing for a beneficiary using a single delivery port stationary oxygen concentrator or portable concentrator, and for maintenance and servicing for beneficiaries renting a combination of single delivery port stationary oxygen concentrators and gaseous or liquid oxygen transfilling equipment;
- HCPCS code E1391 for maintenance and servicing for a beneficiary using a dual delivery port stationary oxygen concentrator or for beneficiaries renting a combination of dual delivery port stationary oxygen concentrators and gaseous or liquid oxygen transfilling equipment;
- HCPCS code K0738 only in situations in which the beneficiary owns stationary oxygen equipment, but rents gaseous oxygen transfilling equipment; and
- HCPCS code E0433 only in situations in which the beneficiary owns stationary equipment but rents liquid oxygen transfilling equipment.

Notes: 1) Use HCPCS code E1390 (and not E1392) for maintenance and servicing of portable oxygen concentrator equipment; and 2) Bill the appropriate HCPCS code for the equipment or combination of equipment, as applicable, with the "MS" modifier.

You should remember that only one maintenance and servicing payment can be made for any combination of oxygen equipment used by the beneficiary that is classified under HCPCS codes E1390, E1391, E1392, E0433 or K0738.

For example, if maintenance and servicing is billed for a column I code/modifier, additional payment for the maintenance and servicing of any of the column II codes/modifiers will not be made.

Column I	Column II
E1390MS	E1391MS, K0738MS, E0433MS
E1391MS	E1390MS, K0738MS, E0433MS
K0738MS	E1390MS, E1391MS, E0433MS
E0433MS	E1390MS, E1391MS, K0738MS

Further, the maintenance and servicing payments following the 36th month rental cap for oxygen concentrators and transfilling equipment terminate if the stationary oxygen equipment is replaced and a new 36-month rental period commences.

Finally, be aware that your RHHI, MAC, or DME MAC will deny your claims for the maintenance and servicing of beneficiary-owned oxygen equipment or equipment that you bill with HCPCS codes E0424, E0439, E0431, E0434, E1405, E1392 or E1406 and the "MS" modifier. They will also deny claims for more than one payment per beneficiary, regardless of the combination of oxygen concentrator equipment and/or transfilling equipment used by the beneficiary, for any 6-month period for either HCPCS code E1390, E1391, E0433, or K0738, billed with the "MS" modifier.

When denying such claims, they will:

- Use the following remittance advice reason and remark codes:
  - Reason code A1: Claim/Service denied;
  - Remark Code M6 (revised) – Alert: You must furnish and service this item for any period of medical need for the remainder of the reasonable useful lifetime of the equipment.
  - Remark Code N372: Only reasonable and necessary maintenance/service charges are covered.
  - Assign group code CO (contractual obligation); and
  - Use the following Medicare Summary Notice (MSN) messages for denied claims:
  - 8.28 - Maintenance, servicing, replacement, or repair of this item is not covered;
  - 16.35: You do not have to pay for this amount.

Additional Information

You can find more information about the maintenance and servicing payments for certain oxygen equipment after July 1, 2010 by going to CR 6792, located at http://www.cms.hhs.gov/Transmittals/downloads/R635OTN.pdf on the CMS web site.