Jurisdiction D News from Noridian Administrative Services, LLC.

Happenings

November 2010
Issue No. 29

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

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Educational

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

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Jurisdiction D DME MAC Supplier Contacts and Resources

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

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

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

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

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

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

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

Medicare Learning Network Matters Disclaimer Statement

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

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

Sources for "Jurisdiction D Happenings" Articles

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

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

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
15	RAC Overpayments	Changed RAC Redetermination Form to DME MAC Redetermination Request Form	10/20/10
2	Supplier Standards	Updated to 30 Supplier Standards	09/27/10
3	Supplier Documentation	Added "verbal" to the first bullet	09/27/10
3	Verbal and Preliminary Orders	Added "Dispensing" to the heading; Added the sentence "A verbal order, dispensing order and preliminary order are all considered the same item."; Added description of EY modifier	09/27/10
3	Proof of Delivery	Added "for every item provided"; Removed last paragraph under Exceptions	09/27/10
3	Advance Beneficiary Notice of Noncoverage	Added description of GA modifier	09/27/10
4	Certificate of Medical Necessity – Common Scenarios	Updated table and notes below	09/27/10
5	SNF Consolidated Billing – Capped Rental DME	Changed fourth example to a wheelchair	09/27/10
5	DMEPOS Claims During Inpatient Stay	Changed second example to a hospital bed	09/27/10
11	Medicare Secondary Payer Fact Sheet	Removed section	09/27/10
14	Fraud and Abuse	Changed PSC website address	09/27/10
17	Medicare Remittance Notice	Removed "Understanding the Remittance Advice – By Sections"	09/27/10
Appendix	Resources	Added e-mail address for DME Endeavor	09/27/10

2010 Holiday and Training Closures

NAS offices will be closed on the days listed below.

Supplier Contact Center

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

Telephone Reopenings

Holiday	Date
Thanksgiving	November 25 and 26
Training	December 9 from 8 - 9 a.m. CT
Training	December 15 from 9 - 11 a.m. CT
Christmas Eve	December 24
New Years Day	December 31

Overpayments Option on IVR Now Provides Spelling of Beneficiary's Name

Beginning Wednesday, November 10th, the spelling of the beneficiary's name can be obtained when using the financial menu option Overpayments on the Interactive Voice Response (IVR) System.

After the IVR has successfully obtained all the required information and plays back the information associated with each claim, an additional navigational option of "spell name" is offered. To hear the spelling of the name just provided simply say "spell name" or press "4" on the telephone keypad. The IVR will return the beneficiary's name as first name, middle initial, last name.

Example:

IVR– "Alright, I found # claims. Here is the first one. It is for John R Doe for the date of service MM/DD/YY. The overpayment amount is $XX.XX."

Say "repeat that", "next claim" or "spell name."

User– "Spell name"

IVR– "Ok, the beneficiary's first name is spelled J-O-H-N. The middle initial is R and the last name is spelled "D-O-E."

Say "repeat that", "next claim" or "spell name."

User– "Next claim"

IVR– "Here's the next one. It is for Jane R Doe for the date of service MM/DD/YY. The overpayment amount is $XX.XX."

For complete information on using the IVR, see the IVR User Guide and IVR-At-A-Glance.

IVR No Longer Requires Re-entry of NPI, PTAN, and TIN

Beginning Friday, October 22, 2010, the Interactive Voice Response System (IVR) no longer requires the re-entry of the supplier's National Provider Identifier (NPI), Provider Transaction Access Number (PTAN), and Tax Identification Number (TIN) combination when navigating through multiple menu options.

How It Works

The IVR will now carry the NPI, PTAN, and TIN combination obtained with the first inquiry throughout all the menu options the supplier navigates eliminating the need to re-enter this information. The menu options which previously allowed suppliers to change their NPI, PTAN, TIN combination after each inquiry will continue to do so. Those options are same and similar, claims, duplicate remittance and the three financial sub-menu options: checks, payment floor and overpayments. If the supplier elects to change their NPI, PTAN, TIN combination, the newly entered combination will be the one carried forward to the next menu option.

How to Change Menu Options

To change menu options say "main menu" at any time. The IVR will return to the main menu list. Speak or key the next menu option to be used. The IVR will move to the selected menu option but will not request the NPI, PTAN or TIN. The IVR will request the next required element. For example, if the next option selected is claims the first element the IVR will request is the beneficiary's Medicare Health Insurance Claim Number (HICN).

Navigating the IVR Using Multiple NPI, PTAN, and TIN Combinations

If a supplier needs to use multiple menu options for more than one supplier NPI, PTAN, and TIN combination, the supplier can change the combination being used by saying, "change NPI" when the navigation options play. The IVR will prompt the supplier to enter each element of the alternate combination. The IVR will assume the supplier wants to continue with another inquiry in the same menu option they were using but understands a change of supplier information has been made. The IVR will proceed to ask for the other required elements for that menu options. If the supplier does not wish to make another inquiry in that menu option but wants to navigate to a different option with the new supplier information, they must interrupt the IVR by saying "main menu" and selecting the IVR option that best fits their inquiry from the main menu list.

The following scenarios depict how a supplier could change menu options and/or NPI, PTAN, and TIN combinations on the IVR.

You Are Here	You Want to Be Here	Action
Claims for Initial NPI/PTAN/TIN	Overpayments for Initial NPI, PTAN, TIN	Say "Main Menu" Say "Overpayments"
Claims for Initial NPI/PTAN/TIN	Claims for Alternate NPI/ PTAN/TIN	Say "Change NPI" When prompted enter Alternate NPI/PTAN/TIN When prompted enter required elements for next claim (HICN, beneficiary name, date of service)
Claims for Initial NPI/PTAN/TIN	Financial/Overpayments for Alternate NPI/PTAN/TIN	Say "Change NPI" When prompted enter Alternate NPI/PTAN/TIN **When prompted to enter next required element for claims interrupt by saying, "Main Menu" Say "Financial" Say "Overpayments" When prompted enter required elements for the overpayment

Suppliers may substitute the IVR options same or similar, eligibility, pricing, claims, duplicate remittance advice, CMN status, and financial (checks, payment floor and overpayments) for the menu options represented by Claims and Financial/ Overpayments in the examples above.

For complete instructions on using the IVR, please see the IVR User Guide and IVR-At-A-Glance. NAS encourages the supplier community to have the IVR-At-A-Glance guide readily available to assist them in their IVR inquiries.

Eligibility Now Available on IVR 24 Hours/7 Days a Week

Beginning Friday, September 10, 2010, eligibility is available on the Jurisdiction D Interactive Voice Response (IVR) System 24 hours a day, 7 days a week.

As before, the National Provider Identifier (NPI), Provider Transaction Access Number (PTAN), Taxpayer Identification Number (TIN), beneficiary Medicare number, name, date of birth, and date of service are required; however, when accessing eligibility outside of 6 a.m. to 6 p.m. CT, the way in which the beneficiary's name is entered has changed.

Entering Beneficiary Name Outside of 6 a.m. to 6 p.m. CT

When calling outside of 6 a.m. to 6 p.m. CT, the IVR will request the first letter of the beneficiary's first name. Once this is successfully obtained it will request the first six letters of the beneficiary's last name. The information may be entered by keying or speaking the letters of the beneficiary's name. A three key combination must be used to key each letter. Below are some examples of how to key the name. Please see the IVR User Guide for complete instructions on keying and a three key conversion chart.

Example: John Doe
First initial: *51
First six letters of last name: *31*63*32

In the example below the beneficiary's last name consists of two names. An entry is not required for the space between hyphenated last names, etc. Enter the first six letters even if there is a space or hyphen between last names.

Example: John Doe Mason
First initial: *51
First six letters of last name: *31*63*32*61*21*73

Information Available

The IVR provides:

- Part A and B effective dates
- Part B deductible information – If it has been met for the year inquired upon or, if it is not met, the amount remaining
- Health Maintenance Organization (HMO) information - The IVR indicates whether the beneficiary is enrolled in a risk/cost HMO or other Managed Care Organization (preferred provider option (PPO), point of service (POS), or Indemnity plan). The name and phone number of the plan are also provided.
- Medicare Secondary Payer (MSP) information – If no indication is given, Medicare is primary. If there is an open MSP file for the date of service, the IVR will return a response of "Our files indicate that Medicare is secondary."

- Home health information (based on the date of service) - If there is a home health episode on file and our records indicate the episode has been discontinued, the date of discontinuance is provided. If there is not a discontinuation date on file, the IVR indicates the beneficiary may still be receiving home health.
- Hospice information (based on the date of service) - If there is an open hospice record, the IVR provides the date the beneficiary's most recent hospice period began and advises that they may still be enrolled in the hospice program. If the hospice period has been revoked, it provides the date the period began and the date it was revoked.
- When applicable, the IVR provides the new Medicare number assigned to the beneficiary.
- When applicable, the IVR provides a date of death on file notification.

Navigation

To make an inquiry on another beneficiary, simply key or speak the beneficiary's Medicare number or speak one of the options below to navigate:

- Repeat that
- Change the date
- Main Menu

Note: The availability of all other menu options requiring system access remains 6 a.m. to 6 p.m. CT. Please review the IVR User Guide and IVR-At-A-Glance for complete information on using the IVR.

Website Improvements 2010 – Share Your Thoughts In a Monthly Survey

NAS encourages suppliers to complete the randomly distributed ForeSee Results survey that pops up when navigating the webite. Enhancements to the NAS DME website, https://www.noridianmedicare.com/dme, are made based on comments received from this survey. Review the summary of the enhancements made during 2010, visit the website, take the survey, and continue sharing what works well and ideas for improvement.

Since January 2010, several enhancements have been made to improve the suppliers website visit, including:

- Website Redesign
  - NAS redesigned the website to assist suppliers in finding information quicker and easier. The left navigation provides the topics on each page, saving suppliers time on searching for information.
- Endeavor
  - Endeavor was added to the website to provide suppliers eligibility, claim status, and remittance advices through an online portal.
- Self-Paced Tutorials
  - Several general self-paced tutorials, which include interactive learning, surveys, and certificates of completion, are available (not all-inclusive):
    - Advance Beneficiary Notice of Noncoverage
    - DME Modifiers
    - Documentation Prior to DME Claim Submission
  - Policy specific tutorials are also offered to suppliers (not all-inclusive):
    - Refractive Lenses
    - Ostomy Supplies
    - Manual Wheelchair Bases
- View & Listen Presentations
  - The following topics are available to view the presentation while listening to the presenter:
    - Advance Beneficiary Notice of Noncoverage
    - Glucose Monitors and Testing Supplies
    - Ostomy Supplies
- Training/Events Page
  - The Training/Events page was redesigned to provide all of the training material used for web-based workshops and self-paced tutorials in one area.
- Policy Specific Pages
  - Additional topics added: Enteral Nutrition, Glucose Monitors and Testing Supplies, Positive Airway Pressure Devices, Power mobility devices)
  - These pages contain all of the publications regarding the topic on one page for quick and easy access to information.
- Claim Submission FAQs
  - FAQs regarding the top ten reasons for claim denials are provided in the FAQ database to assist suppliers in avoiding these errors.

All survey results are strictly confidential. NAS is provided only with the statistical survey results and comments; not visitor information. Those who participate and complete the survey will not see the survey again for 30 days. If you have responded to the survey previously, we would appreciate any new comments you have regarding the changes implemented since your last survey responses; feel free to take the survey more than once.

Modifier JW Use

The Medicare Claims Processing Manual (Internet Only publication 100-4), Chapter 17, Section 40 contains instructions for the use of the JW modifier for discarded drugs and biologicals. The descriptor for the JW modifier reads:

JW – DRUG AMOUNT DISCARDED/NOT ADMINISTERED TO ANY PATIENT

For NAS Durable Medical Equipment Medicare Administrative Contractor (DME MAC) claims, the JW modifier is not required for discarded drugs and biologicals.

Suppliers with additional questions should refer to MLN Matters articles MM6711 and MM7095 at:
http://www.cms.gov/MLNMattersArticles/downloads/MM7095.pdf
http://www.cms.gov/MLNMattersArticles/downloads/MM6711.pdf

Refunds to Medicare

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

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

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

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

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

Physician Documentation Responsibilities

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

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

Quarterly Provider Updates

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

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

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

Automatic Mailing/Delivery of DMEPOS Reminder

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

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

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

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

Call 1-800-MEDICARE

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

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

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

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

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

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

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

MLN Matters Update – MSP Fact Sheet

CMS notifies suppliers that the MSP Fact Sheet is now available in hardcopy from the Medicare Learning Network.

From the Medicare Learning Network: "Medicare Secondary Payer (MSP) Fact Sheet, for Provider, Physician, and Other Supplier Billing Staff"

The "Medicare Secondary Payer (MSP) Fact Sheet, for Provider, Physician, and Other Supplier Billing Staff" (revised May, 2010), is now available in hardcopy from the Medicare Learning Network®. This resource provides a general overview of the MSP provisions for individuals involved with admission or billing procedures in provider, physician, and other supplier settings. To order your copy, free of charge, please visit the MLN Products page at http://www.cms.gov/MLNProducts/01_Overview.asp on the Internet. From this page, scroll down to the "Related Links Inside CMS" section and select the "MLN Product Ordering Page" link. To view the online version, please visit http://www.cms.gov/MLNProducts/downloads/MSP_Fact_Sheet.pdf on the Internet.

Medicare Quarterly Provider Compliance Newsletter – First Edition Released

The Medicare Learning Network® (MLN) has developed a new educational tool, the ***Medicare Quarterly Provider Compliance Newsletter,*** to advise physicians, suppliers, and other FFS providers about how to avoid common billing errors and other erroneous activities when dealing with the Medicare Program. The newsletter will be issued on a quarterly basis and highlight the "top" issues of that particular quarter as identified through a variety of sources. In this first edition, a number of issues that impact a variety of provider types are presented in order to introduce the newsletter to a wide audience of providers. For more information, please read the first edition of the newsletter at http://www.cms.hhs.gov/MLNProducts/downloads/MedQtrlyComp_Newsletter_ICN904943.pdf on the CMS website.

New – Medicare Self-Referral Disclosure Protocol

Section 6409(a) of the Affordable Care Act (ACA) requires the Secretary of the Department of Health and Human Services, in cooperation with the Inspector General of the Department of Health and Human Services, to establish a Medicare self-referral disclosure protocol ("SRDP") that sets forth a process to enable providers of services and suppliers to self-disclose actual or potential violations of Section 1877 of the Social Security Act (the Act).

The SRDP requires health care providers of services or suppliers to submit all information necessary for CMS, on behalf of the Secretary, to analyze the actual or potential violation of Section 1877 of the Act. Section 6409(b) of the ACA, gives the Secretary of HHS the authority to reduce the amount due and owing for violations of Section 1877. The SRDP is located on the CMS website at http://www.cms.gov/PhysicianSelfReferral/.

Results of 2010 MCPSS

MLN Matters® Number: SE1030

Provider Types Affected

This article is informational only for all physicians, providers, and suppliers billing the Medicare program.

Provider Action Needed

No action is needed. This article is informational only and provides a summary of the findings from the annual MCPSS by the Centers for Medicare & Medicaid Services (CMS) to assess provider satisfaction with service from Medicare contractors (carriers, Fiscal Intermediaries (FIs), Medicare Administrative Contractors (MACs), and Durable Medical Equipment Medicare Administrative Contractors (DME MACs)).

Background

The MCPSS offers Medicare Fee-For-Service (FFS) providers an opportunity to give CMS feedback on their satisfaction, attitudes, perceptions, and opinions about the services provided by their respective contractor. The MCPSS elicits information from a sample of hospitals, physicians, Skilled Nursing Facilities (SNFs), home health agencies, clinical laboratories, and other providers and suppliers.

Survey questions focus on seven key business functions of the provider-contractor relationship: provider inquiries, provider outreach & education, claims processing, appeals, provider enrollment, medical review, and provider audit & reimbursement. The 2010 MCPSS survey questions used a new fully labeled rating scale of 1 to 5, "1" representing "very dissatisfied" and "5" representing "very satisfied".

CMS distributed the 2010 survey to approximately 33,000 randomly selected providers, including physicians and other health care practitioners, suppliers, and institutional facilities that serve Medicare beneficiaries across the country. Those health care providers selected to participate in this year's survey were notified in January.

In January 2011, the next MCPSS will be distributed to a new sample of approximately 33,000 Medicare providers. The views of each provider in the survey are important because they represent many other organizations similar in size, practice type and geographical location. If you are one of the providers randomly chosen to participate in the 2011 MCPSS implementation, you have an opportunity to help CMS improve service to all providers.

Key Points/2010 Results

- Of all providers who responded, more than 69 percent stated they were satisfied or very satisfied with their contractor's overall performance and 13 percent were dissatisfied or very dissatisfied with their contractor's overall performance.
- Audit & Reimbursement and Claims Processing business functions were rated with the highest level of provider satisfaction.
- High satisfaction was also expressed by hospices, End Stage Renal Disease (ESRD) providers, and Rural Health clinics; while low satisfaction was expressed by licensed practitioners and laboratories.
- Individual results were provided to Medicare contractors for their use in process improvement activities.
- CMS is gradually migrating to a fully Web-based survey. The migration to the Web mode of response this year reached an overall total of 65 percent.
- The public report may be found at http://www.cms.gov/MCPSS/ on the CMS website.

Additional Information

Remember, your Medicare contractor is available to assist you in providing services to Medicare beneficiaries and in being reimbursed timely for those services. Whenever you have questions, contact your contractor at their toll free number, which is available at http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip on the CMS website.

For more information about the MCPSS, please visit http://www.cms.gov/MCPSS/ on the CMS website.

2010 MCPSS Results Now Available

CMS has completed the administration of the 2010 Medicare Contractor Provider Satisfaction Survey (MCPSS). The 2010 results reflect the percentage of provider satisfaction as distributed on the new, fully labeled, 5-point scale:

1-very dissatisfied

2-dissatisfied

3-neither satisfied nor dissatisfied

4-satisfied

5-very satisfied

A random sample of over 33,000 providers was selected to participate in this year's survey. Providers were asked to rate their satisfaction with services provided by the Fee-for-Service (FFS) Medicare contractors. Of all providers who responded, more than 69 percent stated they were satisfied or very satisfied with their contractor's overall performance. Approximately 13 percent stated they were dissatisfied or very dissatisfied.

From the results, CMS is able to identify the contractor services that providers value the most, as well as areas that need improvement. CMS will use this information to encourage process improvements with the FFS Medicare contractors.

The 2010 MCPSS public report details findings from the survey and can be accessed at https://www.cms.gov/MCPSS.

Thank you for your interest in the MCPSS.

Updates from Medicare Learning Network: Revised Special Edition 7021 and MLN Matters 7064

CMS reminds suppliers that Revised Special Edition 7021, regarding accreditation and competitive bidding, and MLN Matters 7064 on End Stage Renal Disease (ESRD) are now available.

Medicare Learning Network: REVISED Special Edition MLN Matters Article #MM7021 - Guidance on Implementing Section 3109 of the Patient Protection and Affordable Care Act (ACA)

The Centers for Medicare & Medicaid Services (CMS) has revised Special Edition MLN Matters Article #MM7021 (Guidance on Implementing Section 3109 of the Patient Protection and Affordable Care Act) to add an updated hyperlink to the DMEPOS Accreditation webpage and to update the article's associated newsflash to be relevant to DMEPOS Competitive Bidding. This article is informational in nature and reinforces existing policy; it does not present new policy. For more details, please read the article at http://www.cms.gov/MLNMattersArticles/downloads/MM7021.pdf on the CMS website.

Medicare Learning Network: MLN Matters Article #MM7064 - ESRD Prospective Payment System (PPS) and Consolidated Billing for Limited Part B Services

The Centers for Medicare & Medicaid Services (CMS) has released MLN Matters Article #MM7064 to announce the implementation of an ESRD bundled prospective payment system (PPS). The ESRD PPS is effective for services on or after January 1, 2011; therefore, it is important that providers not submit claims spanning dates of service in 2010 and 2011. However, ESRD facilities may make a one-time election to be excluded from the transition period and have their payment based entirely on the payment amount under the ESRD PPS. Facilities wishing to exercise this option must do so on or before November 1, 2010. This article is based on Change Request (CR) 7064 and is available at http://www.cms.gov/MLNMattersArticles/downloads/MM7064.pdf on the CMS website.

Recently Released MLN Matters Articles

CMS has recently released the following Medicare Learning Network (MLN) Matters articles regarding competitive bidding and timely filing instructions.

MLN Matters Article #MM7014 - Home Health Agencies (HHAs) Providing Durable Medical Equipment (DME) in Competitive Bidding Areas

The Centers for Medicare & Medicaid Services (CMS) has released ***MLN Matters Article #MM7014*** to alert Home Health Agencies (HHAs) that edits will be in place, effective for services on or after January 1, 2011, to prevent them from billing competitively-bid DME items in competitive bidding areas and consequently, preventing the inappropriate payment of competitively-bid DME items to HHAs. For more details, please read the article at http://www.cms.gov/MLNMattersArticles/downloads/MM7014.pdf on the CMS website.

MLN Matters Article #MM7080 - Timely Claims Filing: Additional Instructions

The Centers for Medicare & Medicaid Services (CMS) has released ***MLN Matters Article #MM7080*** to expand the Medicare Fee-For-Service (FFS) reimbursement instructions outlined in Change Request 6960 that specified the basic timely filing standards established for FFS reimbursement. Those basic standards are a result of Section 6404 of the Patient Protection and Affordable Care Act of 2010 (ACA), which states that claims with dates of service on or after January 1, 2010, received later than one calendar year beyond the date of service will be denied by Medicare. For more details, please read the article at http://www.cms.gov/MLNMattersArticles/downloads/MM7080.pdf on the CMS website.

MLN Matters Article #MM6934 - Durable Medical Equipment National Competitive Bidding Implementation -- 10G: Paying for Oxygen Equipment when Grandfathered

The Centers for Medicare & Medicaid Services (CMS) has released MLN Matters Article #MM6934 to alert suppliers that a non-contract supplier who chose to be a grandfathered

supplier for oxygen and oxygen equipment should also furnish additional oxygen equipment when medically necessary after the start of a Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding Program to beneficiaries residing in a Competitive Bidding Area (CBA) who are already receiving oxygen equipment from the grandfathered supplier, as described in Change Request 6934. For more details, please read the article at http://www.cms.gov/MLNMattersArticles/downloads/MM6934.pdf on the CMS website.

Commercial Banking Services Contract Award Update

Update to Earlier Posted Article on April 8, 2010

NAS will be transitioning to US Bank for all Medicare lines of business. Suppliers will see no payment impact when this change occurs. Suppliers who receive paper checks will now see US Bank on the check instead of JP Morgan Chase but this will have no payment impact.

Transition Dates: DME - Jurisdiction D – August 30, 2010

Source: JSM/TDL – 10384 Dated July 30, 2010

CMS Is Here to Help in Transitions to Version 5010 and ICD-10

Have questions about the Version 5010 and ICD-10 transition? CMS is here to help!

We have resources for providers, vendors, and payers to prepare for the transition. Fact sheets available for educating staff and others about the transition include:

- The ICD-10 Transition: An Introduction
- ICD-10 Basics for Medical Practices
- Talking to Your Vendors About ICD-10 and Version 5010: Tips for Medical Practices
- Talking to Your Customers About ICD-10 and Version 5010: Tips for Software Vendors

Compliance timelines, materials from CMS-sponsored calls and conferences, and links to resources are available at http://www.cms.gov/ICD10/. Check back often for the latest information and updates.

Keep Up to Date on Version 5010 and ICD-10

Please visit http://www.cms.gov/ICD10/ for the latest news and sign up for Version 5010 and ICD-10 e-mail updates!

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

Closing in on 120 Days and Counting Until January 2011 Target Testing for Version 5010

Health care providers, health plans, clearinghouses and vendors should be finished with their internal testing of the Version 5010 HIPAA electronic health care transaction standards by the first recommended deadline for internal testing, **December 31, 2010**, and be ready to start testing with their external partners, beginning in **January 2011**, just about four months away.

Beginning January 2011, CMS' Medicare Fee-for-Service program will be ready to test Version 5010 transaction standards with its external partners, and other industry segments should be poised to follow suit. This recommended external testing start date will give the industry adequate time to ensure that their Version 5010 transactions are being conducted correctly, in preparation for mandatory Version 5010 compliance by **January 1, 2012**.

Don't fall behind on this important testing process. Make sure you communicate with your external partners about your Version 5010 testing plans. Incorporate your Version 5010 testing messages into your existing communication vehicles, including website links, customer service encounters, etc., to let everyone know when you will be ready to start testing Version 5010 transactions with them.

Keep Up to Date on Version 5010 and ICD-10

Please visit http://www.cms.gov/ICD10 for the latest news and sign up NOW for Version 5010 and ICD-10 e-mail updates!

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

Medicare Learning Network: Version 5010 and Timely Filing

CMS provides updates from the Medicare Learning Network on Version 5010 and timely filing requirements.

"5010: Taking Electronic Billing and Electronic Data Interchange (EDI) to the Next Level"

New! The Medicare Learning Network® has released a new educational tool titled "5010: Taking Electronic Billing and Electronic Data Interchange (EDI) to the Next Level." This educational tool is designed to provide education on the upcoming implementation of Versions 5010 and D.0, which will replace the current version that covered entities must use when conducting electronic HIPPA transactions. It includes a timeline and list of resources related to the implementation. This product is suggested for all Medicare Fee-For-Service Providers and is available in downloadable format at http://www.cms.hhs.gov/MLNProducts/downloads/5010EDI_RefCard_ICN904284.pdf.

Reminder about Important Timely Filing Requirement Information

If you are a Medicare Fee-For-Service physician, provider, or supplier submitting claims to Medicare for payment, this is very important information you need to know. Effective immediately, any Medicare Fee-For-Service claim with a

FYI CONT'D

date of service on or after Jan 1, 2010, must be received by your Medicare contractor no later than one calendar year (12 months) from the claim's date of service – or Medicare will deny the claim.

If you have Medicare Fee-For-Service claims with a service dates from Oct 1, 2009, through Dec 31, 2009, those claims MUST be received by Dec 31, 2010, or Medicare will deny them. Claims with services dates from Jan 1, 2009, to Oct 1, 2009, keep their original Dec 31, 2010, deadline for filing.

When claims for services require reporting a line item date of service, the line item date will be used to determine the date of service. CR 7080, issued on July 30, 2010, clarified that for institutional claims containing claim level span dates of service (ie. a "From" and "Through" date span on the claim), the "Through" date on the claim shall be used to determine the date of service for claims filing timeliness. Conversely, professional claims containing claim level span dates of service (ie. a "From" and "Through" date span on the claim), the "From" date on the claim shall be used to determine the date of service for claims filing timeliness.

For additional information about the new maximum period for claims submission filing dates, contact your Medicare contractor, or review the MLN Matters articles listed below related to this subject:

- MM6960 – "Systems Changes Necessary to Implement the Patient Protection and Affordable Care Act (PPACA) Section 6404 - Maximum Period for Submission of Medicare Claims Reduced to Not More Than 12 Months" – http://www.cms.gov/MLNMattersArticles/downloads/MM6960.pdf
- MM7080 – "Timely Claims Filing: Additional Instructions" – http://www.cms.gov/MLNMattersArticles/downloads/MM7080.pdf

You can also listen to a podcast on this subject by visiting http://www.cms.gov/CMSFeeds/02_listofpodcasts.asp.

Medicare Fee-For-Service Emergency Policies and Procedures: Q & A for All Types of Emergencies and Disasters

MLN Matters® Number: MM6837
Related Change Request (CR) #: 6837
Related CR Release Date: September 21, 2010
Related CR Transmittal #: R772OT
Effective Date: November 22, 2010
Implementation Date: November 22, 2010

Provider Types Affected

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

Provider Action Needed

This article is informational only and advises providers on where to find information regarding Medicare policies related to emergency guidance for the duration of the emergency, such as the H1N1 pandemic.

Background

As part of its preparedness efforts for an influenza pandemic, the Centers for Medicare & Medicaid Services (CMS) developed certain emergency guidance and procedures that may be implemented for the Medicare fee-for-service (FFS) program in the event of a pandemic or disaster.

Additional pandemic-specific preparedness guidance and procedures were issued in prior Change Requests (CRs). CR 6837 rescinds the CRs implementing selected influenza pandemic-specific guidance and procedures. Specifically, CR 6837 rescinds CRs 5099, 6146, 6164, 6174, 6209, 6256, 6280, 6284, and 6378.

The guidance and procedures (in the form of Questions & Answers (Qs & As)) previously implemented by the aforementioned CRs will, instead, be made available on the CMS "Emergency" website at http://www.cms.gov/Emergency/, and entitled:

- "Emergency Qs & As – no 1135 waivers required," and
- "Emergency Qs & As – applicable only when an applicable 1135 waiver has been granted."

Additional Information

The official instruction, CR 6837, issued to your carrier, FI, A/B MAC, RHHI, and DME MAC regarding this change may be viewed at http://www.cms.gov/Transmittals/downloads/R772OTN.pdf on the CMS website.

EDUCATIONAL

Exciting News for NAS Web-based Presentations and CEUs

NAS is pleased to announce Continuing Education Units (CEUs) approved by the American Academy of Professional Coders (AAPC) for the following web-based workshops. NAS does not require CEUs from our supplier community; however, these are offered by NAS for free as an opportunity for those suppliers/staff that need CEUs as part of their Certified Professional Coder education. NAS does not charge a fee for the training and/or CEUs offered to our workshop attendees.

- Putting the Pieces of DME Together Part 1: Background Knowledge*
- Putting the Pieces of DME Together Part 2: Documentation*
- Putting the Pieces of DME Together Part 3: Claims and Appeals*
- Documentation Prior to DME Claims Submission*
- Power Mobility Devices*
- Manual Wheelchair Bases*

- Wheelchair Options, Accessories, and Seating*
- Oxygen and Oxygen Equipment*

Please check the Training and Events page for scheduled events.

*This program has the prior approval of the American Academy of Professional Coders (AAPC) for 1 continuing education hour. Granting of prior approval in no way constitutes endorsement by the AAPC of the program content or the program sponsor.

Ask the Contractor Q&A – August 25, 2010

The following questions and answers are from the August 25, 2010, Ask-the-Contractor conference call. In some cases, the original answers given during the call may have been expanded to provide further detail. These were current as of this event. Please check our website for updates.

Prior to taking questions, NAS provided the following updates:

Endeavor

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

The hours of availability include:

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

Suppliers, billers and third parties may register for Endeavor. Each person accessing Endeavor must register for their own User ID. User IDs cannot be used by more than one person. To register, go to the claims page of our website. Many suppliers are already taking advantage of this tool and we highly encourage you all to do so as well!

Website Satisfaction Survey

NAS encourages suppliers to complete the randomly distributed Website Satisfaction Survey that pops up when navigating the website. Enhancements to the NAS DME website are made based on comments on this survey. Suppliers should let NAS know what they like about the website along with ideas for improvement. NAS appreciates and values suppliers' thoughts and opinions.

PECOS

NAS would like to remind suppliers that Phase 2 of CR6421 (Expansion of the Current Scope of Editing for Ordering/Referring Providers for DMEPOS Suppliers') is still delayed. Edits to deny claims for referring physician and non-physician practitioners who are not enrolled in PECOS (Provider Enrollment, Chain and Ownership System) will not be denied until January 3, 2011. Although enrolled in Medicare, some physicians and non-physician practitioners who are eligible to order items do not have current enrollment records in PECOS. Suppliers are encouraged to verify with their referral sources their legal names, National Provider Identifier (NPI), and that the physician or non-physician practitioner is not being excluded from the Medicare program.

IVR Updates

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

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

- **CEDI Updates**
  Forms are being processed forms within four days of receipt.
- An IVR has been implemented to let callers check the status of their Common Electronic Data Interchange (CEDI) enrollment forms.
  - Hours of availability: 24/7
  - Use record ID or request ID (RID) number printed on form after completion
- The Help Desk will be closed Labor Day however the gateway will be open to accept claims.
  - All claims received after 5 p.m. ET on Friday, September 3, 2010, through 5 p.m. ET Tuesday, September 7, 2010, will have Tuesday's date of receipt.
- CMS and Medicare contractors are working on the implementation of the Health Insurance Portability and Accountability Act (HIPAA) II, the 5010, and NCPDP D.0 transactions.
- Testing with vendors is scheduled to begin in January 2011 with everyone using 5010 and D.0 by January 2012.
- The EDI Gen Response Report and CEDI NCPDP Front End Report will be going away with 5010 and D.0. 5010 claims will receive the X12 999 and the 277 CA or Claims Acknowledgement transactions for their front-end reporting. The NCPDP D.0 claims will receive an NCPDP formatted transmission response transaction.
- Suppliers should be talking to their software vendors now to make sure their vendors are working on the programming changes for 5010 and D.0 and also that

they will be creating programs for suppliers to be able to translate those three new formatted reports into a readable report so you are able to tell which claims were accepted and rejected.

- Companion documents are being worked on and will be distributed to vendors and suppliers through the CEDI list serv.

Q1. We have beneficiaries who received a positive airway pressure (PAP) device from another supplier, but did not qualify for the equipment. Now they are coming to us for supplies. We tell them we cannot bill Medicare because the coverage criterion for continued need is not met and we give them an advance beneficiary notice of noncoverage (ABN) to protect ourselves from liability. This does not seem fair to the beneficiary.

A1. You are correct in obtaining the ABN. If the beneficiary does not have documentation supporting the continued use of the device, future supplies should not be paid by Medicare. The beneficiary must comply with the PAP usage guidelines for continued Medicare coverage for the device and related supplies.

Follow-up. For most cases, the other supplier has already billed up to the purchase price even though they were not suppose to since the beneficiary was not compliant with usage or the patient was provided the equipment and after three months could not use it so the supplier picked it up without telling them they had to sleep with it for 30 consecutive days for over four hours. The patient was not aware of the requirements. Then when we call the provider to get a copy of the physician notes and download, they do not have anything because the patient never used it. What can we do in these instances?

A. Going forward, make sure the patient goes through a new trial and is compliant. Otherwise, the only option is to inform the beneficiary that they did not meet coverage criteria and ask for an ABN if they still want the supplies. The supplier that did not follow the guidelines is using the KX modifier incorrectly and could potentially be audited. At that point, Medicare would recoup the monies paid.

Q2. I have a doctor that created his own mobility assistive equipment (MAE) list in his medical record system. Can he create such a checklist and use that part of the medical record to qualify someone for a walker, cane, or wheelchair?

A2. Medicare cannot dictate what format a physician chooses to use for their medical records. The reason that checklists are discourages is that checklists, by their nature, cannot answer the questions that are needed. They tend to reduce information to short, simplistic answers or to diagnoses or to conditions without giving sufficient information to understand the extent of a patient's capabilities or disability. We would encourage you to give the physician the Physician Letter written by all DME MAC Medical Directors to help him provide good documentation and prevent the use of checklists.

Q3. Regarding face-to-face chart notes for a PAP device, if the notes faxed to us did not have the doctor's information, such as their name, address, or phone number because it was copied directly out of the patient's file, but the fax coversheet includes the doctor's name and address, would that count as a qualifying face-to-face?

A3. The faxed coversheet may or may not be from the physician who saw the individual. For a note to be valid, it needs to be signed and dated by the treating physician. We encourage you to have someone refax the note from the doctor's office after it has been validated by the treating physician that they were indeed the physician who saw the patient.

Follow-up. Do all chart notes need to be signed and dated by a physician? Some physicians use stickers or stamp their name and address on the notes.

A. CMS indicated for chart notes to be valid, they must have a valid date and signature. Review MLN Matters 6698 for further clarification. CMS has broadly defined signature to include a recognizable identifier. Also keep in mind, signatures for orders or documentation cannot be a stamp per CR5971.

Q4. I delivered supplies to a patient for items to be used August 1st to August 31st and the claim has been submitted. It was for prospective billing. I received a phone call from the patient stating they were in the hospital August 10th to August 17th. There was no change in the order during this time. Now the patient has enough enteral nutrition until September 7th because of the seven days they were in the hospital. If the next delivery date is September 2nd for the usage date of September 8th to October 7th, what happens to the seven days that was already billed for the hospital dates of August 10th to August 17th?

A4. Per the Program Integrity Manual (PIM), you need to contact the patient seven days prior to the end of their expected usage and then not deliver any sooner than five days prior to the expected utilization. Because you have seven days left over, extending the delivery date to September 2nd would be correct billing. The date of service should reflect the date of shipping or delivery, not the date of usage.

Q5. How do I prove that a physician has ruled out other treatments for oxygen? It seems like most doctors go through an internal thought process and do not write down everything they ruled out before they decide on oxygen.

A5. There should be evidence in the medical record that any correctable cause of hypoxia and/or dyspnea, has been addressed. Despite appropriate management of the patient's primary pulmonary condition, the patient, while in the chronic, stable state is still sufficiently hypoxic to obtain the qualifying test results. There should not be oxygen prescribed for home use when review of the record indicates that the patient's signs and/or symptoms could reasonably be addressed by first treating an underlying congestive heart failure, bronchospasm, obstructing secretions, pneumonia or other correctable cause. Beyond this, a specific physician's statement affirming or addressing this fifth coverage condition is not required.

Q6. We have enteral patients who have order changes. If I dispensed a category one formula and then have an order

change to a category two formula, there will be overlap and I have already billed for the first formula. Do I still get paid for the first formula or am I required to pick it up?

A6. Examples were requested and not received. You would not pick up the first formula. If the medical necessity supports a different formula, the overlap should be allowed.

Q7. We made a delivery for enteral nutrition for August 1st to August 31st. The patient was hospitalized from August 5th to August 20th. When the patient was discharged, they were no longer on enteral therapy. What is the requirement for the delivery that was made for the services of August 1st through August 31st?

A7. One of the criteria for enteral requires the patient's condition be permanent. If the judgment of the attending physician, substantiated in the medical record, was that the condition was of long and indefinite duration (ordinarily at least three months), the test of permanence is considered met. However, permanence does not require a determination that there is no possibility that the patient's condition may improve sometime in the future. If permanency was documented and all other criteria met, the claim should be allowed. If permanency was never documented, an overpayment would be due to Medicare.

Q8. I'm been told that all infusion therapy (Deferoxamine) via pump is covered by Medicare yet I keep receiving denials. Why?

A8. Examples were requested and not received.

Q9. We have beneficiaries who contact us regarding their next usage two weeks prior to the end of their usage. Is it possible to take their refill order at that time and schedule the delivery in two weeks?

A9. NAS recommends documenting why the beneficiary called two weeks prior to running out, i.e., are on vacation, to make sure they don't run out, etc. as the PIM states contact should not be made until seven days prior to the end of usage. Even if this is directed towards a supplier making contact with the beneficiary, the supplier should be cautious in taking this information for the refill as something could potentially happen to the beneficiary in those two weeks.

Q10. Our question has to do with switching from a PAP to a Bi-level and starting a new capped rental on the BiPAP. We had a situation where we took it to redeterminations and they did not start a new capped rental period, rather they continued the rental for the PAP. We need something in writing stating that if we prove they cannot tolerate the PAP and the Bi-level was given, that a new capped rental will be started if all the guidelines are met.

A10. If the beneficiary switched from an E0601 to an E0470 because the E0601 has been tried and proven ineffective based on a therapeutic trial conducted in either a facility or in a home setting, a new capped rental period would begin.

Q11. I have a question on the new language in the article PAP Documentation Requirement Revision – Ineffective Therapy on E0601 posted last week and if the requirements are met in the following situation. I have a patient who was using a PAP and the mask worked just fine. They then switched to the bi-level using the same mask. A couple months later, they need to switch to a different mask. Do we have to continue documenting the mask changes or because the patient met the new portion of the policy, are we finished documenting the mask changes?

A11. If at the time of the transition you documented and accepted the same mask, and now you are making a change months later, you should document the reason for the change.

Q12. I have a question regarding the L4360 pneumatic walking cast. I receive denials that state "Claim contains incomplete or invalid information. No appeal rights." I contacted my clearinghouse that was sending the denial who said the procedure or modifier was not consistent. Did the modifiers change? I have billed with the RT or LT modifier with one for the number of units. I tried using the KX modifier and it still did not go through.

A12. If coverage criteria is met, the KX modifier is required along with the RT and/or LT modifier. Examples were requested and received. Education was given on using the appropriate modifiers. The claims are in the process of being resubmitted.

Q13. Per the PAP policy, documentation for adherence to PAP therapy shall be accomplished through direct download or visual inspection of usage data with documentation provided in a written report format to be reviewed by the treating physician and included in the beneficiary's medical records. Sometimes we see issues with getting the download from the patient or they use an older machine without the download feature. The patient may not use the data card correctly, it may get lost in the mail, or get wiped out. In those cases, I would like to utilize the visual inspection and written report. To be compliant, what format does this need to be in?

A13. There is not a prescribed format for the visual inspection and written report. Visual inspection may be documented by the supplier by contacting the beneficiary via telephone and asking them to read the values from the device, or the supplier or physician may read the values during a home or office visit. Daily contact with the beneficiary is advised during the compliance period to assure accurate records of usage are documented. If an accident happens with the data card where data is lost, and/or a visual inspection was not done, the compliance period may need to start over.

Q14. In regards to enteral nutrition being billed and then later finding out the patient was in the hospital, we see where the whole claim denies because there were hospital dates in the middle of billing. I know DME MACs used to pay for the dates prior to and after the hospital dates. Is it correct to be denying the entire claim?

A14. If a beneficiary using DMEPOS is at home on the "from" date or anniversary date, Medicare pays for the DMEPOS for the entire month.

Q15. I have been told in the past that commodes are noncovered items. If a patient has an order for a wheelchair and later comes in with an order for a commode, as long as all documentation is available and criteria is met, will both the commode and wheelchair be covered?

A15. Yes, as long as the coverage criteria within the Commode Local Coverage Determination (LCD) and Wheelchair LCD are met, both items will be considered for coverage. These are not considered same or similar pieces of equipment to where if the patient has one, they cannot have the other.

Q16. If I referred a situation to the NAS fraud department, do I ever find out the outcome of the referral?

A16. No. When issues are referred to the fraud department, there is no requirement for DME MACs to respond back to the individual who reported the issue.

Q17. The disposable filter used for PAP and RAD (A7038) comes packaged as two filters in one package. Do we bill this as one or two units of service?

A17. According to the definition, it is indicated as one filter so you would bill two units of service for the two filters you are supplying.

Q18. Do you know when the CMS-1500 claim form will be changing to allow more diagnosis codes?

A18. CMS has indicated that at this time the paper claim form will not be changed to allow more diagnosis codes before October 1, 2013.

Q19. Are we allowed to alter the Medicare ABN form and use it for other insurances?

A19. This form is approved for Medicare use. Whether or not another insurance company accepts this as a valid ABN is their decision.

Q20. If we properly fit a patient with a PAP mask they thought was most comfortable, but when they go home and sleep with it for eight hours and realize it is not the most comfortable, can they return the first mask? Do we have to refund Medicare for the first mask?

A20. There is a three month replacement period for masks. You will only receive payment for one mask in a three month period. The supplier may either refund payment for the first mask before billing for the second, or keep the payment for the first mask and not bill for the replacement.

Q21. Where can I find the process in writing regarding supplies that overlap five days?

A21. Refer to the PIM Publication 100-8 Chapter 4 Section 4.26.1.

Q22. If I deliver formula and supplies to a patient for one month and before I bill the claim, I find out the patient was in the hospital for 15 days out of the month, can I still bill for the entire month even if I know the patient was in the hospital?

A22. Per the IOM Publication 100-4 Chapter 20 Section 210, Medicare makes a separate payment for a full month for DMEPOS items, provided the beneficiary was in the home on the "from" date.

Q23. I am seeing a lot of our claims where our date of service date is being loaded as the initial Certificate of Medical Necessity (CMN) date on replacement oxygen concentrators. The customer service representatives say this is being done as a courtesy for us because we are saying the first date we billed should be our delivery date and CMN date, which is true. For some cases we billed contents that month. We would change our bill date for the next month but the CMN and delivery date are still the same. That does not change but because we had to change our billing because we do not want to bill for contents and replacement equipment in the same month, the date of service is being loaded as a CMN initial date causing denials a year later for a made up recertification.

A23. Examples were requested and not received.

Q24. We have an issue with PECOS. A physician is now married with all of her professional information still under her maiden name but her social security number is under her married name. When I check PECOS, everything is listed under her married name. When calling enrollment, we were told the names should cross-reference but they are not. It doesn't pass through CEDI. I did send in one claim under her married name like it shows in PECOS and it did pass through CEDI.

A24. The information was forwarded on to Enrollment for a follow-up call to the supplier.

Q25. Regarding hospital beds, we have been lead to believe that the patient had to have a respiratory or heart diagnosis as their primary diagnosis in order for a bed to be covered in order to alleviate pain. Would that also include a fractured hip and any type of pain as long as the doctor prescribed a hospital bed for the patient to be making frequent changes in their body position?

A25. The Hospital Beds and Accessories LCD has four specific criteria to be met for coverage and it does not state a requirement to be a respiratory or heart related primary diagnosis. One of the coverage criteria for a hospital bed is the patient requires positioning of the body in ways not feasible with an ordinary bed in order to alleviate pain. If the physician has ordered a bed for this reason for a patient with a fractured hip, they meet this coverage criterion. There is a coverage criterion that states a bed is covered for a patient that requires the head of the bed to be elevated more than 30 degrees most of the time due to congestive heart failure, chronic pulmonary disease, or problem with aspiration, but this is not the only coverage criteria.

Q26. We started billing for place of service (POS) 13 (assisted living). My claims are front-end rejecting for invalid zip code. When we called CEDI, we were told we had to put in a facility when billing POS 13. Why would a facility be needed?

A26. All claims with POS other than 12 (home) require information on where the services were provided. In order for the claim to get past CEDI, you will need to put the assisted living address information.

Q27. What documentation is needed for a seat for a walker (E0156)?

A27. The patient must meet coverage criteria for the walker. There also needs to be an order for the seat with documentation in the medical records describing the reason for the seat, such as knee buckling.

Q28. If I bill with a non-PECOS registered doctor for a shower chair expecting a denial so I can bill secondary insurance, will I receive a patient responsibility (PR) or contractual obligation (CO) denial?

A28. This claim will not reach the DME MACs for a denial as this is an unprocessable claim once the PECOS editing is implemented in January 2010 to reject claims. Once the edits become effective, this will be front-end rejected on the CEDI report, if you bill electronically. If you need to bill the claim for denial, per Change Request 6421, submit the EY modifier on all charge lines of the claim. This will bypass the CEDI edit that checks the PECOS record and the claim will go to the DME MACs for processing. The EY modifier lets the DME MACs know that you understand you are billing for denial.

Q29. I have a Comprehensive Error Rate Testing (CERT) review asking for evidence that the patient is mobile in the home for portable oxygen. Do you have any suggestions for what would be considered evidence that the patient is mobile in the home?

A29. Ask the appropriate questions during your intake process, such as if they are mobile in the home, and document their answer. Consult with the physician about their mobility in the home and if there is any conditions listed in the medical record that may suggest they are or are not mobile. Most medical records indicate evidence that the patient is mobile and not bed bound.

Follow-up: Would a home assessment we conduct that talks about what they can and cannot do be sufficient?

A. The physician needs to document in the patient's medical records their ability to be mobile in the home. This also needs to be documented on the Oxygen CMN under section B, which can only be completed by the physician or their employee.

Medicare Learning Network – Now Available – ABN Booklet, DMEPOS Competitive Bidding Fact Sheet, and Overpayment Collection Process

CMS notifies suppliers of information available to suppliers through the Medicare Learning Network.

Medicare Learning Network: Now Available in Hardcopy: Advanced Beneficiary Notice of Noncoverage (ABN) Booklet

The "Advanced Beneficiary Notice of Noncoverage (ABN)" booklet, which provides information on when providers should use an ABN, ABN policies, how to properly complete an ABN and ABN modifiers, is now available in hardcopy from the Medicare Learning Network(r). To order your copy, free of charge, please visit the MLN Products page at http://www.cms.gov/MLNProducts/01_Overview.asp on the internet.

Scroll down to the "Related Links Inside CMS" section and choose "MLN Product Ordering Page". To view the online version, please visit http://www.cms.gov/MLNProducts/downloads/ABN_Booklet_ICN006266.pdf on the internet.

Medicare Learning Network: Now Available in Hardcopy: DMEPOS Competitive Bidding Program: Fact Sheet for Referral Agents

Now available to order in hardcopy! The new Medicare Learning Network(r) (MLN) fact sheet "The DMEPOS Competitive Bidding Program: Fact Sheet for Referral Agents" is now available in both downloadable and hardcopy formats. The downloadable version is available at http://www.cms.gov/MLNProducts/downloads/DME_Ref_Agt_Factsheet_ICN900927.pdf.

To order a hardcopy, free of charge, please visit the MLN homepage at http://www.cms.gov/mlngeninfo on the internet. Click on "MLN Product Ordering Page" in the "Related Links Inside CMS" section.

Medicare Learning Network: Now Available for Download: The Medicare Overpayment Collection Process
The publication titled "The Medicare Overpayment Collection Process" (previously titled "What Physicians and Other Suppliers Should Know About Medicare Overpayments"), which provides the definition of an overpayment and information about the collection of Medicare physician and supplier overpayments, is now available in downloadable format from the Medicare Learning Network(r) at http://www.cms.gov/MLNProducts/downloads/OverpaymentBrochure508-09.pdf

Version 5010/D.0 National Calls

Throughout the implementation of Version 5010/D.0, CMS will be hosting a variety of national education calls that will inform the Medicare Fee-for-Service provider community of the steps that they need to take in order to be ready for implementation. These calls will also give participants an opportunity to ask questions of Medicare subject matter experts.

Please bookmark this link http://www.cms.gov/Versions5010andD0/V50/list.asp to the new 5010/D.0 National Calls web page to stay current on upcoming calls and view materials from past calls.

Keep Up to Date on Version 5010/D.0 and ICD-10

For the latest news and resources, please visit http://www.cms.gov/Versions5010andD0 for Version 5010 and http://www.cms.gov/ICD10/ for ICD-10 information.

CERT

CERT Error Rate at 65.13% for Enteral Nutrition

The Comprehensive Error Rate Testing (CERT) contractor has been identifying a significant number of errors on claims for enteral nutrition. NAS' most recent data shows an error rate at 65.13% with enteral nutrition as the seventh highest source of errors for Jurisdiction D. Most of the errors are due to insufficient documentation to support the medical necessity for the billed items. Based on reports received by NAS, the documentation that the CERT contractor is looking for includes:

- Signed and dated orders that contain all items billed (i.e. nutrition, mode of delivery, and supply kit)
- Clinical records supporting the beneficiary has either a permanent non-function or disease of the structures that normally permit food to reach the small bowel or disease of the small bowel which impairs digestion and absorption of an oral diet
- DME Information Forms (DIFs) that are both signed and dated by the supplier
- Justification for a pump if that is the mode of delivery over another type of delivery (i.e. gravity, syringe)
- Documentation justifying "special" enteral formulas (B4149, B4153-B4157, B4161, and B4162)

When suppliers receive a request from the CERT contractor on an enteral nutrition claim, it is important to assure that all of these documents are included in the response. If any of these documents is not provided, it will likely result in a request for overpayment on the claim.

CERT Documentation

This article is to remind suppliers they must comply with requests from the CERT Documentation Contractor for medical records needed for the Comprehensive Error Rate Testing program. An analysis of the CERT related appeals workload indicates the reason for the appeal is due to "no submission of documentation" and "submitting incorrect documentation."

Suppliers are reminded the CERT program produces national, contractor-specific and service-specific paid claim error rates, as well as a supplier compliance error rate. The paid claim error rate is a measure of the extent to which the Medicare program is paying claims correctly. The supplier compliance error rate is a measure of the extent to which suppliers are submitting claims correctly.

The CERT Documentation Contractor sends written requests for medical records to suppliers that include a checklist of the types of documentation required. The CERT Documentation Contractor will mail these letters to suppliers individually. Suppliers must submit documentation to the CERT Operations Center via fax, the preferred method, or mail at the number/address specified below.

The secure fax number for submitting documentation to the CERT Documentation Contractor is (240) 568-6222.

Mail all requested documentation to:

CERT Documentation Office
Attn: CID #:xxxxxx
9090 Junction Drive, Suite 9
Annapolis Junction, MD 20701

The CID number is the CERT reference number contained in the documentation request letter.

Suppliers may call the CERT Documentation Contractor at (301) 957-2380 with questions regarding specific documentation to submit.

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

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

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

CEDI

CEDI: Elimination of Direct Dial-Up Options

Attention All CEDI Trading Partners, Suppliers, Billing Services, Clearinghouses and Vendors

Please stop and read the following:
If you are currently accessing the National Government Services Common Electronic Data Interchange (CEDI) Gateway via one of the approved Network Service Vendors (NSVs), please ignore this message. The NSVs approved for connectivity to CEDI are: ECC Technologies, IVANS, McKesson CareBridge, MedXpress, NEBO, and VisionShare.

If you are **not** using an NSV to connect to the CEDI Gateway, please read this important message that will impact your ability to submit your electronic transactions.

In response to concerns with the security of existing direct dial-up and Point-to-Point Protocol (PPP) File Transfer Protocol (FTP) service, National Government Services is eliminating the direct dial-up options and is requiring the use of a NSV for access to the CEDI Gateway.

Beginning November 1, 2010, all **new** CEDI Trading Partners being setup with CEDI will be required to connect to the CEDI Gateway via an NSV.

As of April 30, 2011, the direct dial-up connections and protocols to the CEDI Gateway will no longer be supported.

NSVs provide a variety of connectivity options including internet, Secure FTP, and dial-up service should a trading partner wish to continue with the dial-up option. In addition to the added security, NSVs offer faster and more

reliable connections than the direct dial-up methods. This connectivity solution aligns our Trading Partner community with CMS direction for connectivity to the Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for online Claim Status Inquiry (CSI) access and to submit 270/271 eligibility transaction to the CMS Data Center.

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

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

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

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

MedXpress
Website: http://www.icssoftware.net/MedXpress
Customer Service: 877-624-3250

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

VisionShare
Website: http://www.visionshareinc.com
Customer Service: 888-895-2649/612-460-4327

We encourage you to begin your research with our NSVs as quickly as possible to ensure your transition is completed with no disruption of service.

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

Updating Address and Contact Information with CEDI

For CEDI Trading Partners who need to update address or contact information, please complete the CEDI Address and Contact Information Change Form from the CEDI website, http://www.ngscedi.com under EDI Enrollment. Changes made with the National Supplier Clearinghouse (NSC) or the National Plan & Provider Enumeration System (NPPES) will not automatically filter into the CEDI system. Change requests will take five to seven business days to process and an e-mail confirmation will be sent to the e-mail address entered on the form.

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

CEDI Enrollment IVR System

The Common Electronic Data Interchange (CEDI) Enrollment Interactive Voice Response (IVR) is available 24 hours a day and can be used to check the status of CEDI enrollment forms submitted on-line. Once an enrollment form is submitted electronically through the CEDI website, it will be issued a unique Request ID (RID) number which will appear on the printed copy of the form. An acknowledgement e-mail will also be sent to the e-mail address on the enrollment form to notify of the online submission as well as the RID.

To access the IVR, call 866-311-9184 and select Option 2 from the main menu. The IVR will first request that you indicate which enrollment form you are requesting status for. You can either say the name of the form or select the number of the form to proceed.

- Press 1 for the CEDI Supplier Authorization Form
- Press 2 for the CEDI Submitter Action Request Form
- Press 3 for the CEDI Enrollment Agreement Form

The system will then ask for the RID. This can either be spoken or entered using the touch tone key pad on your phone. The RID can be found in the e-mail notification of the online submission as well as on the printed copy of the forms.

Note: If you are unable to locate the RID, you can check by the National Provider Identifier (NPI), Provider Transaction Access Number (PTAN), and date of online submission by saying "Check by NPI."

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

CEDI Password Requirement Change

The Common Electronic Data Interchange (CEDI) Gateway will be implementing additional security measures on December 30, 2010.

Currently, the CEDI Gateway passwords expire every 90 days. With the change, the password will expire every 60 days. **This will impact existing passwords on December 30, 2010, that are in the 60-90 day time period.** These passwords will need to be changed upon login to the CEDI Gateway when the changes are implemented on December 30, 2010.

As a reminder

- All CEDI Gateway Login IDs will be suspended after 90 days of inactivity. The Trading Partner must contact the CEDI Help Desk to have the password reset to be able to login to CEDI.
- All CEDI Gateway Login IDs will be removed after 13 months of inactivity and the Trading Partner must re-enroll with CEDI.

Top 10 CEDI Edits for Third Quarter 2010

National Government Services Common Electronic Data Interchange (CEDI) has identified the following edits as the top ten edits that were received on the CEDI GenResponse Report (GENRPT) during the third quarter. The edit, its description and tips to resolve the error are provided below.

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

For questions regarding the edits, please contact the CEDI Help Desk at 866-311-9184 or by e-mail at ngs.cedihelpdesk@wellpoint.com.

1. **C202 Ordering Provider Not Authorized**

   The edit C202 is a warning edit. It will not reject the claims until it becomes a rejection in January 2011. The edit indicates that the ordering provider submitted in the claim is not found on the Centers for Medicare & Medicaid Services (CMS) supplied Provider Enrollment Chain & Ownership System (PECOS) file of providers/suppliers who are authorized to order durable medical equipment (DME) supplies. Contact the ordering provider identified in the edit to verify their information, including their National Provider Identifier (NPI), and eligibility with PECOS.

   More information can be located at http://www.cms.gov/MedicareProviderSupEnroll/04_InternetbasedPECOS.asp.

2. **C200 Referring Provider Not Authorized**

   The edit C200 is a warning edit. It will not reject the claims until it becomes a rejection in January 2011. The edit indicates that the referring provider submitted in the claim is not found on the CMS supplied PECOS file of providers/suppliers who are authorized to refer DME supplies. Contact the referring provider identified in the edit to verify their information, including their NPI, and eligibility with PECOS.

   The referring provider does not need to be sent on DME claims. The referring provider may be removed from the submitted claim. However, if the information is sent, it will be checked as part of the CEDI front-end edits.

   For more information, visit the CMS website at: http://www.cms.gov/MedicareProviderSupEnroll/04_InternetbasedPECOS.asp.

3. **C201 Referring Provider Not Authorized**

   The edit C201 is a warning edit. It will not reject the claims until it becomes a rejection in January 2011. The edit indicates that the referring provider submitted in the claim is not found on the CMS supplied PECOS file of providers/suppliers who are authorized to refer DME supplies. Contact the referring provider identified in the edit to verify their information, including their NPI, and eligibility with PECOS.

   The referring provider does not need to be sent on DME claims. The referring provider may be removed from the submitted claim. However, if the information is sent, it will be checked as part of the CEDI Front-end edits.

   For more information, visit the CMS website at: http://www.cms.gov/MedicareProviderSupEnroll/04_InternetbasedPECOS.asp.

4. **C172 Invalid Procedure Code and/or Modifier**

   The procedure code, modifier, or procedure code and modifier combination is invalid. To resolve this error, verify the Healthcare Common Procedure Coding System (HCPCS) and modifier combination is valid.

   If the procedure code, modifier, or combination is valid, verify the first position does not contain a space.

   Helpful Tips to verify a Procedure Code/HCPCS and modifier combination:

   - Check the validity of the procedure code/modifier combination by using the Pricing, Data Analysis and Coding (PDAC) website www.dmepdac.com.
   - Check the local coverage determination (LCD) at the DME Medicare administrative contractors (MACs) for guidelines on procedure codes and modifier usage for that LCD.
   - Reference the supplier manual at the DME MAC Jurisdiction(s).
   - Contact the Customer Care department at the appropriate Jurisdiction:
     - Jurisdiction A: 866-590-6731
     - Jurisdiction B: 866-590-6727
     - Jurisdiction C: 866-270-4909
     - Jurisdiction D: 866-243-7272

5. **C095 Diagnosis Code Invalid – Pointer 1**

   The diagnosis code pointed to as the first relevant diagnosis on the claim was not valid for the date of service. This is usually, but not always, the first diagnosis code on the claim. Contact the DME MAC jurisdiction where the claim would be processed based on the beneficiary state code for assistance with the diagnosis code entered.

6. **1001 Required Loop Not Found**

   This edit indicates a required loop was not found in the file received by CEDI. This typically occurs when loop 2420E (ordering provider info) is omitted as it is required on every charge line for Medicare DME. Contact your software vendor for assistance in resolving this edit.

7. **C044 Subscriber Primary ID Invalid**

   The patient's Medicare ID (HICN) is invalid. Verify the number on the patient's red, white, and blue Medicare card.

8. **C008 EIN/SSN Not on File with NPI**

   When C008 fires on its own, it can indicate the Tax ID (Employer Identification Number/Social Security Number) submitted on the claim does not match what

is on file with National Plan and Provider Enumeration System (NPPES) or the National Supplier Clearinghouse (NSC).

Verify the information entered on the NPPES website matches what you are submitting. The NPPES website can be accessed at https://nppes.cms.hhs.gov/NPPES/StaticForward.do?forward=static.npistart.

Note: This edit can fire with the C003 Billing NPI Not on Crosswalk. If this occurs, the Tax ID (Employer Identification Number/Social Security Number) may have been entered correctly in the claim; however, with the NPI not on the crosswalk, the Tax ID could not be verified. Please refer to edit C003 for more information for resolving this error.

9. C003 Billing NPI Not on Crosswalk

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

For Individuals:

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

For Organizations:

- The Tax ID number (EIN), PTAN/NSC and Practice Address ZIP Code at NPPES must match the EIN, PTAN/NSC and Practice Address ZIP Code at the NSC.
- If the match cannot be found, an active crosswalk record will not be created.

The NPPES website can be accessed at https://nppes.cms.hhs.gov/NPPES/StaticForward.do?forward=static.npistart.

10. C171 Capped Rental – Modifier Missing

The item (whether for purchase or rental) is classified as a capped rental item (or possibly a pen pump item), and the required KH, KI, or KJ modifier (whichever is appropriate) was not submitted.

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

For questions regarding the edits, please contact the CEDI Help Desk at 866-311-9184 or by e-mail at ngs.cedihelpdesk@wellpoint.com.

CEDI Network Service Vendor Requirement Frequently Asked Questions

In response to concerns with the security of existing direct dial-up and Point-to-Point Protocol (PPP) File Transfer Protocol (FTP) service, National Government Services is eliminating the direct dial-up options and is requiring the use of a Network Service Vendor (NSV) for access to the CEDI Gateway. NSVs provide faster and more reliable connections in a secure environment.

CEDI has prepared a list of Frequently Asked Questions (FAQ) for vendors, billing services, clearinghouses and Trading Partners/Submitters.

As a Reminder
Beginning November 1, 2010, all **new** CEDI Trading Partners being setup with CEDI will be required to connect to the CEDI Gateway via an NSV.

As of April 30, 2011, the direct dial-up connections and protocols to the CEDI Gateway will no longer be supported.

Please visit the CEDI website at http://www.ngscedi.com/telecomm/teleindex.htm for the FAQ and a list of the NSVs.

HHS Publishes X12 Version 5010 and NCPDP Version D.0 Errata Notification

On Wednesday, October 13, 2010, the Department of Health and Human Services (HHS) published in the Federal Register a notification announcing maintenance changes to the standards adopted in our regulation entitled "Health Insurance Reform; Modifications to the Health Insurance Portability and Accountability Act (HIPAA) Electronic Transaction Standards," published in the Federal Register on January 16, 2009. These standards include the ASC X12 5010 (Version 5010) HIPAA electronic health care transactions; and the National Council of Prescription Drug Programs (NCPDP) Telecommunications Version D.0 standard. This notice also instructs interested persons on how to obtain the corrections, and advises HIPAA covered entities to be sure to use the HIPAA compliant version of each respective standard that includes these error corrections.

For the complete Federal Register notice, please go to http://edocket.access.gpo.gov/2010/pdf/2010-25684.pdf.

Medicare FFS Implementation of HIPAA 5010/D.0 – Errata Impacts

The purpose of this message is to clearly communicate the approach that Medicare Fee-For-Service (FFS) is taking to ensure compliance with the Health Insurance Portability and Accountability Act's (HIPAA's) new versions of the Accredited Standards Committee (ASC) X12 and the National Council for Prescription Drug Programs (NCPDP) Electronic Data Interchange (EDI) transactions.

The Standards Development Organizations have made corrections to the 5010 and D.0 versions of certain transactions. The Errata versions replace the Base versions for HIPAA compliance. Per the Federal Register (Vol. 75, No. 197, October 13, 2010, 62684–62686 [2010–25684] found at http://www.access.gpo.gov/su_docs/aces/fr-cont.html), HIPAA compliance will require the implementation of the Errata versions and the Base versions for those transactions not affected by the Errata, as listed below. Compliance with the Errata must be achieved by the original regulation compliance date of January, 2012.

Table 1. Transactions Affected by the Errata - List of Base and Errata Versions for 5010 and D.0.

Transactions Affected by the Errata Version	Base Version	Errata Version
270/ 271 Health Care Eligibility Benefit Inquiry and Response	005010X279	005010X279A1
837 Health Care Claim: Professional	005010X222	005010X222A1
837 Health Care Claim: Institutional	005010X223	005010X223A2
999 Implementation Acknowledgment For Health Care Insurance	005010X231	005010X231A1
835 Health Care Claim Payment/Advice	005010X221	005010X221A1
276/277 Status Inquiry and Response	005010X212	N/A
277CA Claim Acknowledgement	005010X214	N/A
National Council for Prescription Drug Programs (NCPDP) Version D.0 of the Telecom Standard	D.0	D.0 April 2009

Medicare FFS will implement the Errata versions to meet HIPAA compliance requirements. Also in compliance with the published regulation (RIN 0938-AM50 of 45 CFR Part 162), Medicare FFS testing with external trading partners must begin in January of 2011.

Testing

Medicare FFS contractors will be ready to test the Base versions of all transactions in January 2011, and the 5010/D.0 Errata versions in April 2011. Trading Partners should contact their local Medicare FFS contractor for specific testing schedules. See http://www.cms.gov/ElectronicBillingEDITrans/ under downloads, to find a Medicare FFS contractor in your state.

Production

The Errata versions will be available for Medicare FFS production in April 2011. The Errata transactions must be tested before using them for production. As a result, Medicare FFS 5010/D.0 test-to-production transition will begin in April 2011.

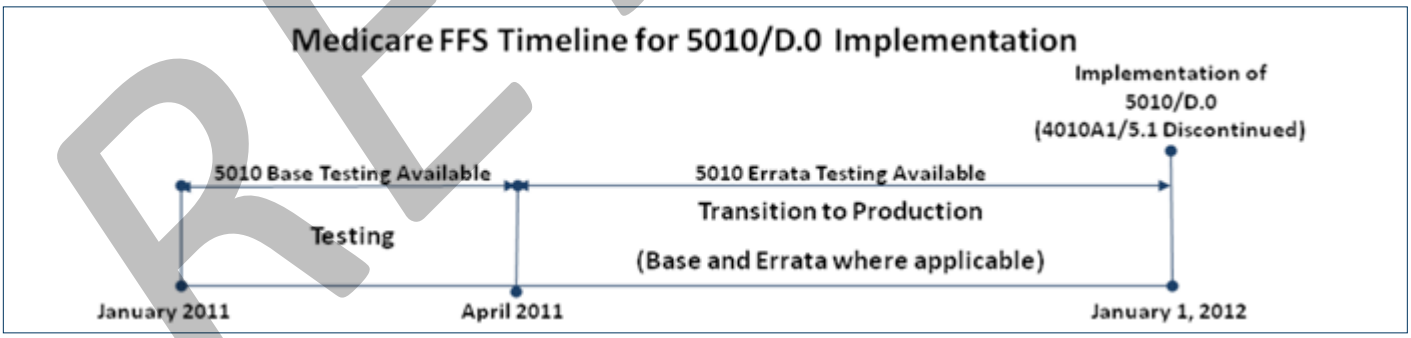


Figure 1. Medicare FFS Timeline for 5010/D.0 Implementation: 1) Testing on Base Versions to begin in January 2011, 2) Testing and transition to production on Errata version to begin in April 2011, and 3) Implementation of 5010/D.0 on January 1, 2012.

Internet-based PECOS for DMEPOS Suppliers

Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) suppliers can use Internet-based Provider Enrollment, Chain and Ownership System (PECOS) to enroll, make a change in their enrollment record, view their Medicare enrollment information on file with Medicare, and check on the status of a Medicare enrollment application via the Internet.

Using Internet-based PECOS

Before you begin to use Internet-based PECOS, you:

- Should review the document titled, "Internet-based PECOS -- Getting Started Guide for Suppliers of DMEPOS" to obtain access to Internet-based PECOS. This document can be found at: http://www.cms.gov/MedicareProviderSupEnroll/04_InternetbasedPECOS.asp
- Must obtain and designate a unique National Provider Identifier for each business/practice location that you are enrolling or have enrolled with the National Supplier Clearinghouse (NSC). Note: there is an exception for sole proprietorships.
- Enter the "legal business name" for the supplier of DMEPOS as it shown on the IRS documentation and on the National Plan and Provider Enumeration System (NPPES). Both PECOS and NPPES require the submission of the "legal business name".

Finalizing Submission and Responding to Development Request

After submitting an enrollment application via Internet-based PECOS, you:

- Must print, sign and date (blue ink recommend) the Certification Statement(s) and mail the Certification Statement(s) and supporting documentation to the NSC within 7 days. The NSC will not begin to process your enrollment application until it receives a signed and dated Certification Statement.
- May be asked to make corrections or submit additional documents by the NSC. In order for your application to be processed, you must submit this information promptly.

Pending Paper Enrollment Application

If a DMEPOS supplier has a pending paper enrollment application, the supplier should not submit an Internet-based PECOS enrollment application for the same enrollment or change of information.

More Information

For more information about Internet-based PECOS, including contact information for the External User Services (EUS) Help Desk, go to http://www.cms.gov/MedicareProviderSupEnroll/ and select the "Internet-based PECOS" tab on the left side of screen. The EUS Help Desk provides assistance to providers and suppliers if they encounter an application navigation or systems problem with Internet-based PECOS.

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

Medicare Learning Network – Basics of Internet-based PECOS for DMEPOS Suppliers

The Basics of Internet-based PECOS for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Suppliers educates DMEPOS suppliers on how to enroll in the Medicare Program and maintain their enrollment information using Internet-based PECOS. This fact sheet is available at http://www.cms.gov/MLNProducts/downloads/MedEnroll_PECOS_DMEPOS_FactSheet_ICN904283.pdf on the CMS website.

Reminders About NPI and PECOS

Listed below are a few reminders regarding the National Provider Identifier (NPI) and the Provider Enrollment, Chain and Ownership System (PECOS):

- With the exception of sole proprietorships, each enrolled supplier of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) must obtain and designate a unique NPI for each practice location if it has more than one enrolled with the National Supplier Clearinghouse
- The Centers for Medicare & Medicaid Services will soon provide access to Internet-based PECOS to suppliers of DMEPOS who are enrolled or who are eligible to enroll in the Medicare program
- Internet-based PECOS is the online Medicare provider and supplier enrollment system that may be used by providers and suppliers to submit enrollment applications, view enrollment information, update enrollment information, complete the re-enrollment process, voluntarily terminate from the Medicare program, and track the status of an application submitted via the Internet
- Internet-based PECOS is an alternative to completing and mailing a paper DMEPOS supplier enrollment application (CMS-855S)
- With the implementation of the Internet-based PECOS for suppliers of DMEPOS in October 2010, all suppliers of DMEPOS are encouraged to review the 'Internet-based PECOS – Getting Started Guide for DMEPOS suppliers'

Source: National Supplier Clearinghouse (NSC)

Notifying NSC of Deceased Owners or Authorized and Delegated Officials

DMEPOS suppliers are reminded to notify the National Supplier Clearinghouse (NSC) within 30 days of deceased owners, or authorized and delegated officials. This rule is published in 100-08 of the Program Integrity Manual (PIM), Chapter 10, Section 16, Subsection D. Please submit this information to decease.notification@palmettogba.com.

Source: National Supplier Clearinghouse

Chain DMEPOS Supplier Closing a Practice Location

All DMEPOS suppliers, including a chain supplier, are required to notify the National Supplier Clearinghouse (NSC) regarding the closure of a Medicare enrolled supplier practice location within 30 days of the closure. Accordingly, if a chain DMEPOS supplier is closing a practice location enrolled in the Medicare program, then the chain supplier must notify the NSC about this change (voluntary termination) by submitting the Medicare enrollment application (CMS-855S) within 30 days of the closure.

Any DMEPOS supplier, including a chain supplier, that does not comply with its reporting responsibilities is subject to a Medicare revocation and the loss of Medicare billing privileges. In addition, the imposition of Medicare revocation requires that the NSC establish a Medicare enrollment bar for a period of not less than one year. A Medicare enrollment bar will prohibit a revoked supplier, including a chain supplier, from enrolling new practice locations under the same legal business name or with the same authorized or delegated officials. Finally, the imposition of a Medicare revocation may impact the cost associated with obtaining a surety bond.

Source: National Supplier Clearinghouse

Medicare Imposes Stronger Protections on Medical Equipment Suppliers

New Rule Strengthens Supplier Enrollment Standards to Help Prevent Fraud

The Centers for Medicare & Medicaid Services (CMS) issued a final rule representing another step to increase protections for Medicare and beneficiaries from potentially fraudulent suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS).

The new regulation enhances Medicare enrollment standards for DMEPOS suppliers by adding several new standards and strengthening existing standards that suppliers must meet before being able to furnish equipment and supplies to Medicare beneficiaries. These new and stronger standards will help to reduce fraud in Medicare and provide beneficiaries with additional assurance that they are being served by legitimate suppliers who meet Medicare's standards.

The final rule also clarifies and expands the existing enrollment requirements that DMEPOS suppliers must meet to establish and maintain billing privileges in the Medicare program.

To read the entire CMS press release click here: https://www.cms.gov/apps/media/press_releases.asp

For directions on how to download the final regulation in text or PDF format: http://www.cms.gov/MedicareProviderSupEnroll/09_ProviderEnrollmentRegulation.asp

IHS Facilities and Tribal Provider's Use PECOS

MLN Matters® Number: MM7174
Related Change Request (CR) #: 7174
Related CR Release Date: October 28, 2010
Related CR Transmittal #: R358PI
Effective Date: November 29, 2010
Implementation Date: November 29, 2010

Provider Types Affected

Tribal or Indian Health Service (IHS) providers wanting to enroll or who are currently enrolled in the Medicare program.

Provider Action Needed

This article is based on Change Request (CR) 7174, which informs Indian Health Service (IHS) facilities and Tribal providers initially enrolling in the Medicare program or submitting changes of enrollment information that they may use the Internet-based Provider Enrollment, Chain and Ownership System (PECOS) to do so.

Background

Currently, Indian Health Service (IHS) facilities and Tribal providers are permitted to enroll in Medicare Part A and B using the paper enrollment process only. The Internet-based Provider Enrollment, Chain and Ownership System (PECOS) routes enrollment applications to the correct Medicare contractor based on the provider/supplier type and their practice location, but it is not currently designed to route IHS and tribal enrollment applications to Trailblazer Health Enterprises, LLC (TrailBlazer), the single designated Medicare contractor responsible for enrolling this provider type. For this reason, IHS facilities and tribal providers have not been able to use Internet-based PECOS.

Change Request (CR) 7174 is establishing an interim process to allow IHS facilities and tribal providers to use Internet-based PECOS to initially enroll in the Medicare program or submit changes of information.

If IHS facilities or tribal providers choose to use Internet-based PECOS, they will be responsible for mailing to TrailBlazer the following as part of the interim process:

- A cover letter to indicate they are seeking to enroll as an IHS facility or tribal provider or updating their current enrollment information;
- The Internet-based PECOS certification statement; and
- Any other applicable supporting documentation.

The Trailblazers addresses are as follows:

Part A
Part A Provider Enrollment
TrailBlazer Health Enterprises, LLC
Provider Enrollment
P.O. Box 650458
Dallas, TX 75265-0458

Part B
Part B Provider Enrollment
TrailBlazer Health Enterprises, LLC
Provider Enrollment
P.O. Box 650544
Dallas, TX 75265-0544

ENROLLMENT CONT'D

This interim process shall remain in effect until PECOS system changes are implemented to route all electronic enrollment applications received from IHS facilities and tribal providers directly to Trailblazers.

Additional Information

The official instruction, CR 7174, issued to your carriers, Fiscal Intermediaries (FIs), and Part A/Part B Medicare Administrative Contractors (A/B MACs) regarding this change may be viewed at http://www.cms.gov/Transmittals/downloads/R358PI.pdf on the CMS website.

ACCREDITATION

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

MLN Matters® Number: MM7021 Revised
Related Change Request (CR) #: 7021
Related CR Release Date: June 25, 2010
Related CR Transmittal #:R346PI
Effective Date: January 1, 2011
Implementation Date: January 3, 2011

Note: This article was re-issued on August 27, 2010, to include the above news flash as a reminder of the upcoming DMEPOS Competitive Bidding Program and to add a Web link to the Provider/Supplier Accreditation page on the CMS website. That link is in the "Additional Information" section of the article. All other information is the same.

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 7021, which revises the Medicare Program Integrity Manual (Chapter 15 (Medicare Provider/Supplier Enrollment)) to include Section 38.6.1 (Compliance Standards for Pharmacy Accreditation). This article explains the revised requirements for pharmacies as a result of Section 3109 (a) of the Patient Protection and Affordable Care Act (ACA). That section states that certain pharmacies are not required to have submitted evidence of accreditation to the Secretary of Health and Human services prior to January 1, 2011. See the Background section of this article for complete details.

Background

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

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

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

1. Also, with respect to items and services furnished on or after January 1, 2011, the ACA (section 3109 (a)) provides that the quality standards and accreditation requirements set forth in MIPPA (Section 1834(a)(20)(F)) will not apply to such pharmacies if the pharmacy meets each of the following:
2. The total billings by the pharmacy for such items and services under this title are less than 5 percent of total pharmacy sales for the previous 3 calendar years, 3 fiscal years, or other yearly period specified by the CMS;
3. The pharmacy has been enrolled under Section 1866(j) of the Social Security Act as a supplier of DMEPOS, and has been issued a provider number for at least 5 years;
4. No final adverse action (as defined in Section 424.579a) of title 42, Code of Federal Regulations) has been imposed in the past 5 years;
5. The pharmacy submits an attestation that the pharmacy meets the first three criteria listed above; and
6. The pharmacy agrees to submit materials as requested during the course of an audit conducted on a random sample of pharmacies selected annually.

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

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

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

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

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

By June 30, 2011, the NSC-MAC will send a notice of revocation to all enrolled pharmacies that were sent an audit verification letter who did not submit satisfactory evidence that they were in compliance with the requirements to obtain an accreditation exemption. The notice of revocation will cite that the revocation is for a lack of required accreditation.

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

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

Partial Code Freeze Prior to ICD-10 Implementation

At the ICD-9-CM Coordination & Maintenance Committee Meeting (September 15, 2010), it was announced that the committee had finalized the decision to implement a partial freeze for both ICD-9-CM codes and ICD-10-CM and ICD-10-PCS codes prior to implementation of ICD-10 on October 1, 2013. There was considerable support for this partial freeze.

The partial freeze will be implemented as follows:

- The last regular annual update to both ICD-9 and ICD-10 code sets will be made on October 1, 2011.
- On October 1, 2012, there will be only limited code updates to both ICD-9- CM and ICD- 10 code sets to capture new technology and new diseases.
- There will be no updates to ICD-9 -CM on October 1, 2013, as the system will no longer be a HIPAA standard.

On October 1, 2014, regular updates to ICD-10 will begin. The ICD-9 Coordination & Maintenance Committee will continue to meet twice a year during the freeze. At these meetings the public will be allowed to comment on whether or not requests for new diagnosis and procedure codes should be created based on the need to capture new technology or disease. Any code requests that do not meet the criteria will be evaluated for implementation within ICD-10 on or after October 1, 2014, once the partial freeze is ended.

To view the transcript of the meeting, go to: http://www.cms.gov/ICD9ProviderDiagnosticCodes/03_meetings.asp. From there, select the September 15-16, 2010, meeting transcript in the download section, and then from the ZIP files, select the 091510_Morning_Transcript file. This section appears on page 4 of the 78-page proceeding.

Audio Transcript Now Available: September ICD-10 Implementation in a 5010 Environment Call

The audio transcript of the CMS Monday, September 13, 2010, follow-up national provider conference call, "ICD-10 Implementation in a 5010 Environment," is now available. To access the audio transcript, go to http://www.cms.gov/ICD10/02c_CMS_Sponsored_Calls.asp on the CMS website. Scroll to the bottom of the web page to the Downloads section to locate the audio file. The audio transcript is approximately 1 hour and 28 minutes in length. The written transcript will be available soon.

Transcript Now Available: ICD-10 Implementation in a 5010 Environment Follow-up Call

Now Available from CMS: Written Transcript of the Mon Sep 13 "ICD-10 Implementation in a 5010 Environment Follow-Up" Conference Call

The written transcript of the Centers for Medicare & Medicaid Services' Mon Sep 13 national provider conference call, "ICD-10 Implementation in a 5010 Environment Follow-Up," is now available. To access the written transcript, visit http://www.cms.gov/ICD10/02c_CMS_Sponsored_Calls.asp. Scroll to the bottom of the web page to the Downloads section to locate the written transcript PDF file.

Implementation of PWK (Paperwork) Segment for X12N Version 5010

MLN Matters® Number: MM7041
Related Change Request (CR) #: 7041
Related CR Release Date: August 27, 2010
Related CR Transmittal #: R763OTN
Effective Date for Providers: April 1, 2011
Implementation Date: April 4, 2011

Provider Types Affected

This article is for physicians, suppliers, and providers billing Medicare contractors (carriers, Part A/B Medicare Administrative Contractors (MACs), Durable Medical Equipment Medicare Administrative Contractors, and fiscal intermediaries (FIs) including regional home health intermediaries).

Provider Action Needed

This article is based on Change Request (CR) 7041 which announces the implementation of the PWK (paperwork) segment for X12N Version 5010. Be sure your billing staff is aware of these changes.

Background

Since 2003, the Centers for Medicare & Medicaid Services (CMS) has believed that a complete Health Insurance Portability & Accountability Act of 1996 (HIPAA) implementation involves implementing the PWK (paperwork) segment. The PWK is a segment within the 837 Professional and Institutional electronic transactions. The PWK segment provides the "linkage" between electronic claims and additional documentation which is needed for claims adjudication. Although the PWK segment allows for an electronic submission of the additional documentation, this preliminary implementation will only allow for submission of additional documentation via mail and fax.

The implementation of a dedicated PWK process, involving OCR/imaging technology, allows providers to continue using cost effective electronic data interchange (EDI) technology as well as providing cost savings for the Medicare program. Medicare contractors will be responsible for imaging, storage, and retrieval of the additional documentation for their claims examiners. Having the documentation available to claims examiners eliminates the need for costly automated development.

Key Points for Medicare Billers

- Your Medicare contractor will implement the appropriate PWK fax/mail cover sheet for their line of business which must be used by trading partners when mailing or faxing additional documentation which is indicated in the PWK segment. Sample versions of the fax/mail cover sheets are attached to CR 7041, which is available at http://www.cms.gov/Transmittals/downloads/R763OTN.pdf on the CMS website.
- Your Medicare contractor will provide the cover sheet to their trading partners via hardcopy and/or electronic download.
- Submitters must send the additional documentation AFTER the claim has been electronically submitted with the PWK segment.
- Submitters will need to accurately and completely record data on the fax/mail cover sheet that relates the faxed/mailed data to the PWK Loop on the claim.
- Medicare contractors will manually return PWK data submissions (cover sheet and attached data) which are incomplete or incorrectly filled out.
- Medicare contractors will allow seven calendar "waiting" days (from the date of receipt) for additional information to be faxed or ten calendar "waiting" days for additional information to be mailed.
- Submitters must send ALL relevant PWK data at the same time for the same claim.
- If the additional documentation is not received within the seven calendar waiting days (fax) or ten calendar waiting days for mailed submissions, your contractor will begin normal processing procedures on your claim.
- Medicare will not crossover PWK data to the Coordination of Benefits contractor.

Additional Information

If you have questions, please contact your Medicare MAC and/or FI/carrier at their toll-free number which may be found at http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip on the CMS website.

The official instruction (CR 7041) issued to your Medicare MAC and/or FI/carrier is available at http://www.cms.gov/Transmittals/downloads/R763OTN.pdf on the CMS website.

Medicare DMEPOS Rules to Take Effect in 2011 – Competitive Bidding

The Centers for Medicare & Medicaid Services (CMS) has announced that the following final rule is on display at the *Federal Register:* Medicare Program; Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2011

The rule (CMS-1503-FC) can be viewed at: http://www.cms.gov/PhysicianFeeSched/PFSFRN/list.asp.

This final rule includes provisions regarding the following DMEPOS subjects that impact the Medicare DMEPOS Competitive Bidding Program:

- The establishment of an appeals process for competitive bidding contract suppliers that are notified that they are in breach of contract.
- The subdivision of metropolitan statistical areas (MSAs) with populations over 8,000,000 into smaller competitive bidding areas (CBAs), in particular Chicago, New York and Los Angeles.
- The addition of 21 MSAs to the 70 MSAs already included in the Round 2 Competitive Bidding program, for a total of 91 MSAs.
- The addition of the following policies affecting future competitions for diabetic testing supplies following Round 1:
  - Revision of the definition of a "mail order" item to include any item shipped or delivered to a beneficiary's home, regardless of the method of delivery;
  - Requirement that bidding suppliers demonstrate that their bid covers types of diabetic testing strip products that, in the aggregate and taking into account volume for the different products, cover at least 50 percent of the types of test strips products on the market; and
  - Prohibition of contract suppliers from influencing or incentivizing beneficiaries to switch types of test strips or glucose monitors.
- The exemption of off-the shelf orthotics from competitive bidding when provided by a physician to his or her own patients or a hospital to its own patients.
- The elimination of the lump sum purchase option for standard power wheelchairs furnished on or after January 1, 2011, and adjustments to the amount of the capped rental payments for both standard and complex rehabilitative power wheelchairs.

Appeals Process

We finalized, in the final rule, an appeals process for suppliers who have been notified that they are in breach of their DMEPOS competitive bidding contract. Depending on the circumstances, suppliers initially will either be afforded a process for submitting a corrective action plan or request a hearing prior to termination of the contract. The appeals process will ensure that suppliers have appeal rights and that they receive an opportunity to be heard before their contract is terminated.

Subdivision of the Metropolitan Statistical Areas (MSA)

Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) allows us to subdivide MSAs with populations over 8,000,000 into smaller CBAs. We will subdivide the three largest MSAs: Chicago-Naperville-Joliet, IL-IN-WI; Los Angeles-Long Beach-Santa Ana, CA; and New York-Northern New Jersey-Long Island, NY-NJ-PA. We finalized the regulation to subdivide MSAs along county lines as we believe county lines are well-defined and more static.

Addition of 21 MSAs to 70 MSAs

The Affordable Care Act requires that we expand Round 2 of the competitively bidding program by adding an additional 21 of the largest MSAs based on total population to the original 70 already selected for Round 2. We have included this requirement in the regulation.

Diabetic Testing Supplies

MIPPA specifies that a national competition for mail order items and services is to be phased in after 2010. The regulation includes provisions to implement a national mail order competition for diabetic supplies in 2011 that includes all home deliveries while maintaining the local pharmacy pickup choice for beneficiaries. We are also implementing the special "50 percent rule" mandated by MIPPA and implementing an anti-switching requirement as part of the terms of the competitive bidding contract.

Exemption of Off-the Shelf (OTS) Orthotics from CBP

This regulation implements the MIPPA requirement to extend the competitive bidding exception to OTS orthotics furnished by: (1) a physician or other practitioner (as defined by the Secretary) to the physician's or practitioner's own patients as part of the physician's or practitioner's professional service; or (2) a hospital to the hospital's own patients during an admission or on the date of discharge from the hospital.

Elimination of Additional Rental Payments

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

We received nine public comments on this rule and will take them under consideration for future proposed rulemaking.

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

Lump Sum Purchase Option for Standard Power Wheelchairs

Sections 3136(a)(1) and (2) of the Affordable Care Act required revisions to the regulations to eliminate lump sum (up-front) purchase payment for standard power-driven wheelchairs and permit payment only on a monthly rental basis for standard power-driven wheelchairs. For complex rehabilitative power-driven wheelchairs, the regulations will continue to permit payment to be made on a lump sum purchase method or a monthly rental method. Also, payment adjustments required by the statute were made for power-driven wheelchairs under the Medicare Part B DMEPOS fee schedule to pay 15 percent (instead of 10 percent) of the purchase price for the first three months under the monthly

rental method and 6 percent (instead of 7.5 percent) for remaining rental months. Payment is based on the lower of the supplier's actual charge and the fee schedule amount. These changes do not apply to power-driven wheelchairs furnished pursuant to contracts entered into prior to January 1, 2011, as part of the Medicare DMEPOS Competitive Bidding Program.

Oxygen and Oxygen Equipment

We have decided not to finalize this proposed revision for situations where a beneficiary relocates on or after the 18th month rental payment and before the 36-month rental at this time due to evidence that beneficiaries who relocate before the 36th month find suppliers to furnish the oxygen and oxygen equipment. We will consider implementing this regulatory change in the future if we determine that beneficiaries are having difficulty locating suppliers when they relocate during the 36-month rental period

These provisions are found in Sections H, N, P, Q, and R of the 2011 Physician Fee Schedule final rule, which is now on display at the Office of the Federal Register. The final rule (CMS-1503-FC) is available at http://www.cms.gov/PhysicianFeeSched/PFSFRN/list.asp.

Round One Rebid of DMEPOS Competitive Bidding Program – Phase 8A: Hospital Exception

MLN Matters® Number: MM6677 Revised
Related Change Request (CR) #: 6677
Related CR Release Date: November 6, 2009
Related CR Transmittal #: R590OTN
Effective Date: April 1, 2010
Implementation Date: April 5, 2010

Note: This article was revised on September 21, 2010 to remove a reference to the National Competitive Billing Indicator from the fourth bullet point on page 2. Providers are not responsible for coding that indicator. All other information remains the same.

Provider Types Affected

This article is for hospitals that bill Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for specific allowed competitively bid items (crutches, canes, walkers, folding manual wheelchairs, blood glucose monitors, and infusion pumps) to their patients on the day of discharge.

What You Need To Know

The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 6677 to announce that hospitals may furnish certain competitively bid Durable Medical Equipment (DME) items to their patients on the date of discharge without submitting a bid and being awarded a contract under the Competitive Bidding Program Round 1 Rebid. The DME competitive bid items that a hospital may furnish upon discharge as part of this exception **for Round 1 Rebid** are walkers and related accessories. Note that this applies to claims received upon implementation of the DMEPOS Competitive Bidding Program Round One. That date is January 1, 2011, but the date is subject to change.

Key Points of CR6677

- Hospitals may furnish walkers and related accessories to their patients on the date of discharge whether or not the hospital has a contract under the DMEPOS Competitive Bidding Program.
- Separate payment is not made for walkers and related accessories furnished by a hospital **on the date of admission** as payment for these items is included in the Part A payment for inpatient facility services.
- Hospitals as defined below may furnish walkers and related accessories to their patients for use in the home on the date of discharge and receive payment at the applicable single payment amount, regardless of whether the hospital is a contract supplier.
- To be paid for walkers and accessories as a non-contract supplier, hospitals should **use the modifier "J4"** on the claim line in combination with the following **HCPCS codes: A4636, A4637, E0130, E0135, E0140, E0141, E0143, E0144, E0147, E0148, E0149, E0154, E0155, E0156, E0157, E0158, and E0159.**
- Hospital claims submitted for these items, for which Medicare does not find a matching date of discharge will be denied with remittance advice messages B15 (Payment adjusted because this service/procedure requires that a qualifying service/procedure be received and covered. The qualifying service/procedure had not been received/adjudicated.), M114 (This service was processed in accordance with rules and guidelines under the DMEPOS Competitive Bidding Program or other Demonstration Project. For more information regarding these projects, contact your local contractor.), and MA13 (Alert: you may be subject to penalties if you bill the patient for amounts not reported with the PR (patient responsibility) group code.). Prior to denying these DME claims, Medicare will hold the claim for up to 15 business days to await the arrival of the hospital claim with the related discharge date. If such discharge is not processed by the end of the 15 business days, the DME claim will be denied.

Background

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

On July, 15, 2008, section 154 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) amended the MMA and mandated certain changes to the competitive bidding program. One of these changes established an exception for hospitals from the competitive bidding program when they are furnishing certain items to their own patients during an admission or on the date of discharge.

A hospital under this exception **does not include a hospital-owned DME supplier**. Instead, a hospital is defined in accordance with section 1861(e) of the Social Security Act. A DME supplier that furnishes the DME item to the hospital, which then furnishes the item to the patient on the date of discharge, must be a contract supplier in the competitive bidding program.

Additional Information

For discussion of the program instructions designating the competitive bidding areas and product categories included in the DMEPOS competitive bidding program round one rebid in CY 2009 you may review MM6571 at http://www.cms.gov/MLNMattersArticles/downloads/MM6571.pdf on the CMS website.

The MSAs and product categories that are included in the DMEPOS Competitive Bidding Round I rebid in 2009 can also be found at http://www.cms.gov/DMEPOSCompetitiveBid/01_overview.asp on the CMS website. Further information on the boundaries and list of zip codes for each competitive bid area (CBA) and the Healthcare Common Procedure Coding System (HCPCS) codes for each product category are available by visiting http://www.cms.gov/DMEPOSCompetitiveBid/01_overview.asp on the CMS website and following the link to the Competitive Bidding Implementation Contractor (CBIC).

DME National Competitive Bidding Implementation – Phase 11E: RA and MSN Messages for Round One

MLN Matters® Number: MM7066
Related Change Request (CR) #: 7066
Related CR Release Date: September 24, 2010
Related CR Transmittal #: R777OTN
Effective Date: January 1, 2011
Implementation Date: January 3, 2011

Provider Types Affected

Providers and suppliers billing Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for services provided to Medicare beneficiaries who reside in Competitive Bidding Areas (CBAs).

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 7066 to alert providers that Medicare contractors are required to use the appropriate remark, reason and Medicare Summary Notice (MSN) messages when processing National Competitive Bidding (NCB) claims for the Round One Rebid, as noted in the Key Points section below. Make certain your billing staffs are aware of these changes.

Background

Round One of the DMEPOS Competitive Bidding Program was implemented on July 1, 2008, in 10 competitive bidding areas, as mandated by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). As part of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), Congress enacted a temporary delay in the competitive bidding program for Round One Competitive Bidding Areas. The law required CMS to terminate the existing contracts that were awarded in Round One and re-compete the contracts in 2009. MIPPA also excluded certain DMEPOS items and areas from competitive bidding and provided an exemption to the program for hospitals that furnish certain types of DMEPOS items to their own patients.

On January 16, 2009, CMS issued an interim final regulation with comment period that incorporates changes required by the MIPPA. This rule implements certain MIPPA provisions that delay implementation of Round One of the Competitive Bidding Program and required CMS to conduct a second Round One competition (the Round One rebid) in 2009 and mandated certain changes for both the Round One rebid and subsequent rounds of the program. CR 7066 instructs Medicare contractors to use specific Medicare Summary Notices (MSN), which go to beneficiaries, and Remittance Advice (RA) messages for providers/suppliers for specific circumstances when processing NCB claims. Those RA messages are the subject of this article.

Key Points of CR 7066

The following points detail the messages that providers and suppliers may receive as a result of the DME NCB implementation as discussed in CR 7066:

1. **On remittance advices on claims paid for beneficiaries residing in CBA and obtaining an item from contract supplier in their CBA, you will receive the following, as appropriate:**
   - M112 - Reimbursement or this item is based on the single payment amount required under the DMEPOS Competitive Bidding Program for the area where the patient resides.
   - MA13 – Alert: You may be subject to penalties if you bill the patient for amounts not reported with the PR (patient responsibility) group code.
   - 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
2. **When denying a claim for a beneficiary who resides in a CBA who obtains an item from a non-contract supplier that has not obtained a signed Advance Beneficiary Notice (ABN), you will receive the following:**
   - M115 – This item is denied when provided to this patient by a non-contract or non-demonstration supplier.
   - M114 – This service was processed in accordance with rules and guidelines under the DMEPOS Competitive Bidding Program or other Demonstration Project. For more information regarding this project, contact your local contractor.
   - 96 – Non-covered charge(s).
   - N211 – Alert: You may not appeal this decision.
   - MA13 – Alert: You may be subject to penalties if you bill the patient for amounts not reported with the PR (patient responsibility) group code.

3. **When a supplier has collected more than the 20 percent co-pay and any remaining deductible for an NCB claim, you will receive the following:**
   - MA59 - Alert: The patient overpaid you for these services. You must issue the patient a refund within 30 days for the difference between his/her payment and the total amount shown as patient responsibility on this notice.
   - M114 – This service was processed in accordance with rules and guidelines under the DMEPOS Competitive Bidding Program or other Demonstration Project. For more information regarding this project, contact your local contractor.
   - 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
   - N211 – Alert: You may not appeal this decision.
4. **When a claim is denied for an NCB item obtained from a non-contract supplier when the supplier has obtained an ABN, the following messages are used:**
   - M115 – This item is denied when provided to this patient by a non-contract or non-demonstration supplier.
   - M114 – This service was processed in accordance with rules and guidelines under the DMEPOS Competitive Bidding Program or other Demonstration Project. For more information regarding this project, contact your local contractor.
   - 96 – Non-covered charge(s).
   - N211 – Alert: You may not appeal this decision.
   - M38 - The patient is liable for the charges for this item/service. The patient was informed in writing before the service was furnished that CMS would not pay for the item/service, and the patient agreed to pay by signing the Advanced Beneficiary Notice (ABN).
5. **When a beneficiary from a CBA travels to a different CBA and obtains an NCB item from a contract supplier in that CBA, the following messages are returned for the paid claim:**
   - M112 - Reimbursement or this item is based on the single payment amount required under the DMEPOS Competitive Bidding Program for the area where the patient resides.
   - M114 – This service was processed in accordance with rules and guidelines under the DMEPOS Competitive Bidding Program or other Demonstration Project For more information regarding this project, contact your local contractor.
   - MA13 – Alert: You may be subject to penalties if you bill the patient for amounts not reported with the PR (patient responsibility) group code.
   - 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
6. **When a beneficiary from a CBA travels to an area that is not designated as a CBA, the following messages accompany the paid claim:**
   - M112 - Reimbursement or this item is based on the single payment amount required under the DMEPOS Competitive Bidding Program for the area where the patient resides.
   - M114 – This service was processed in accordance with rules and guidelines under the DMEPOS Competitive Bidding Program or other Demonstration Project. For more information regarding this project, contact your local contractor.
   - MA13 – Alert: You may be subject to penalties if you bill the patient for amounts not reported with the PR (patient responsibility) group code.
   - 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
7. **When Medicare makes payment to a non-contract supplier at the bid price on a grandfathered claim, the following messages are used:**
   - M112 - Reimbursement or this item is based on the single payment amount required under the DMEPOS Competitive Bidding Program for the area where the patient resides.
   - M113 – Our records indicate that this patient began using this item/service prior to the current contract period for DMEPOS Competitive Bidding Program.
   - MA13 – Alert: You may be subject to penalties if you bill the patient for amounts not reported with the PR (patient responsibility) group code.
   - 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
8. **The following messages are used when payment is made to a non-contract supplier at the fee schedule amount on a grandfathered claim for inexpensive and routinely purchased (IRP) items or capped rental base equipment:**
   - M113 – Our records indicate that this patient began using this item/service prior to the current contract period for DMEPOS Competitive Bidding Program.
   - M114 – This service was processed in accordance with rules and guidelines under the DMEPOS Competitive Bidding Program or other Demonstration Project. For more information regarding this project, contact your local contractor.
   - MA13 – Alert: You may be subject to penalties if you bill the patient for amounts not reported with the PR (patient responsibility) group code.
   - 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.

9. **When claims from physicians or hospitals acting as DMEPOS suppliers and there is no matching office visit found in Medicare claims history, the claims are denied using the following:**
   - B15 - Payment adjusted because this service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated.
   - M114 – This service was processed in accordance with rules and guidelines under the DMEPOS Competitive Bidding Program or other Demonstration Project. For more information regarding this project, contact your local contractor.
   - MA13 – Alert: You may be subject to penalties if you bill the patient for amounts not reported with the PR (patient responsibility) group code.
10. **When beneficiary-submitted claims that are subject to NCB are denied, the following messages are used:**
    - 111 – Not covered unless the provider accepts assignment.
    - M114 – This service was processed in accordance with rules and guidelines under the DMEPOS Competitive Bidding Program or other Demonstration Project. For more information regarding this project, contact your local contractor.
    - MA13 – Alert: You may be subject to penalties if you bill the patient for amounts not reported with the PR (patient responsibility) group code.
    - N211 – Alert: You may not appeal this decision.
11. **Paper claims subject to NCB are denied using the following messages:**
    - A1 – Claim/Service Denied.
    - M117 – Not covered unless submitted via electronic claim.
    - M114 – This service was processed in accordance with rules and guidelines under the DMEPOS Competitive Bidding Program or other Demonstration Project. For more information regarding this project, contact your local contractor.
    - MA13 – Alert: You may be subject to penalties if you bill the patient for amounts not reported with the PR (patient responsibility) group code.
    - N211 – Alert: You may not appeal this decision.
12. **Medicare will deny claims from Skilled Nursing Facilities (SNF) when the SNF acts as a limited contract supplier, but the place of service does not indicate a SNF. In denying such claims, the following messages are used:**
    - 170 – Payment is denied when performed/billed by this type of provider.
    - M77 – Missing/incomplete/invalid place of service.
    - M114 – This service was processed in accordance with rules and guidelines under the DMEPOS Competitive Bidding Program or other Demonstration Project. For more information regarding this project, contact your local contractor.
    - MA13 – Alert: You may be subject to penalties if you bill the patient for amounts not reported with the PR (patient responsibility) group code.
13. **The following messages are used by Medicare when making payments for oxygen in situations where the beneficiary does not use a grandfathered supplier, so that when the 36-month payment cap under the Deficit Reduction Act (DRA) has been reached, the cap must be increased for a total of up to 45 payments:**
    - M114 – This service was processed in accordance with rules and guidelines under the DMEPOS Competitive Bidding Program or other Demonstration Project. For more information regarding this project, contact your local contractor.
    - MA13 – Alert: You may be subject to penalties if you bill the patient for amounts not reported with the PR (patient responsibility) group code.
    - 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
14. **The following messages are used by Medicare when denying claims under NCB where a supplier submits a claim for oxygen equipment when the payment cap has been reached:**
    - MA13 – Alert: You may be subject to penalties if you bill the patient for amounts not reported with the PR (patient responsibility) group code.
    - B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.
    - N211 – Alert: You may not appeal this decision.
    - N370 – Billing exceeds the rental months covered/approved by the payer.
    - M114 – This service was processed in accordance with rules and guidelines under the DMEPOS Competitive Bidding Program or other Demonstration Project. For more information regarding this project, contact your local contractor.
15. **The following messages are used by Medicare when making payments for capped rental situations where the beneficiary does not use a grandfathered supplier, so that a total maximum of up to 25 payments will be made:**
    - M114 – This service was processed in accordance with rules and guidelines under the DMEPOS Competitive Bidding Program or other Demonstration Project. For more information regarding this project, contact your local contractor.
    - MA13 – Alert: You may be subject to penalties if you bill the patient for amounts not reported with the PR (patient responsibility) group code.
    - 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.

16. **The following message is used when Medicare returns unassigned NCB claims as unprocessable:**
    - 111 – Not covered unless the provider accepts assignment.
17. **The following messages are used by Medicare when denying claims under NCB where a supplier submits a claim for a capped rental item when the payment cap has been reached :**
    - B7: This provider was not certified/eligible to be paid for this procedure/service on this date of service.
    - N370: Billing exceeds the rental months covered/ approved by the payer.
    - M114 – This service was processed in accordance with rules and guidelines under the DMEPOS Competitive Bidding Program or other Demonstration Project. For more information regarding this project, contact your local contractor.
    - MA13 – Alert: You may be subject to penalties if you bill the patient for amounts not reported with the PR (patient responsibility) group code.
18. **Medicare uses the following messages to deny claims when a modifier required for NCB is missing from a claim line:**
    - 4 – The procedure code is inconsistent with the modifier use or a required modifier is missing.
    - M114 – This service was processed in accordance with rules and guidelines under the DMEPOS Competitive Bidding Program or other Demonstration Project. For more information regarding this project, contact your local contractor.
    - MA13 – Alert: You may be subject to penalties if you bill the patient for amounts not reported with the PR (patient responsibility) group code.
19. **Medicare uses the following messages when denying claims for a beneficiary residing in a CBA for both the base oxygen equipment and the related oxygen contents received from a non-contract supplier when the rental period for the base oxygen equipment began on or after the start date of the Round One Rebid:**
    - 96 – Non-covered charge(s).
    - M115 – This item is denied when provided to this patient by a non-contract or non-demonstration supplier.
    - M114 – This service was processed in accordance with rules and guidelines under the DMEPOS Competitive Bidding Program or other Demonstration Project. For more information regarding this project, contact your local contractor.
    - N211 – Alert: You may not appeal this decision.
    - MA13 – Alert: You may be subject to penalties if you bill the patient for amounts not reported with the PR (patient responsibility) group code.
20. **Medicare uses the following messages when denying oxygen content claims from a non-contract supplier that is not the same non-contract supplier that received the 36th month base oxygen equipment rental payment, when the initial date on the Certificate of Medical Necessity (CMN) for the base oxygen equipment is prior to the start date of the Round One Rebid and the CBA-residing beneficiary is not traveling:**
    - B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.
    - N211 – Alert: You may not appeal this decision.
    - M115 – This item is denied when provided to this patient by a non-contract or non-demonstration supplier.
    - M114 – This service was processed in accordance with rules and guidelines under the DMEPOS Competitive Bidding Program or other Demonstration Project. For more information regarding this project, contact your local contractor.
    - MA13 – Alert: You may be subject to penalties if you bill the patient for amounts not reported with the PR (patient responsibility) group code.
21. **Medicare uses the following messages when denying claims for a beneficiary residing in a CBA for portable oxygen equipment that is acquired on or after the start date for the Round One Rebid, when submitted by a non-contract supplier, if the supplier did not furnish the stationary oxygen equipment prior to the start of the National Competitive Bid Round One Rebid (the stationary oxygen equipment is not a grandfathered item):**
    - 96 – Non-covered charge(s).
    - M115 – This item is denied when provided to this patient by a non-contract or non-demonstration supplier.
    - M114 – This service was processed in accordance with rules and guidelines under the DMEPOS Competitive Bidding Program or other Demonstration Project. For more information regarding this project, contact your local contractor.
    - N211 – Alert: You may not appeal this decision.
    - MA13 – Alert: You may be subject to penalties if you bill the patient for amounts not reported with the PR (patient responsibility) group code.
22. **Medicare uses the following messages when denying claims for a beneficiary residing in a CBA for stationary oxygen equipment that is acquired on or after the start date for the Round One Rebid, when submitted by a non-contract supplier, if the supplier did not furnish the portable oxygen equipment prior to the start of the National Competitive Bid Round One Rebid (the portable oxygen equipment is not a grandfathered item):**
    - 96 – Non-covered charge(s).
    - M115 – This item is denied when provided to this patient by a non-contract or non-demonstration supplier.

- M114 – This service was processed in accordance with rules and guidelines under the DMEPOS Competitive Bidding Program or other Demonstration Project. For more information regarding this project, contact your local contractor.
- N211 – Alert: You may not appeal this decision.
- MA13 – Alert: You may be subject to penalties if you bill the patient for amounts not reported with the PR (patient responsibility) group code.

23. Medicare uses the following messages when denying claims for replacement of an item that is subject to the DMEPOS Competitive Bidding Program when submitted by non-contract suppliers, even when submitted with the "RA" modifier:

- 96 – Non-covered charge(s).
- M115 – This item is denied when provided to the patient by a non-contract or non-demonstration supplier.
- M114 – This service was processed in accordance with rules and guidelines under the DMEPOS Competitive Bidding Program or other Demonstration Project. For more information regarding this project, contact your local contractor.
- N211 – Alert: You may not appeal this decision.
- MA13 – Alert: You may be subject to penalties if you bill the patient for amounts not reported with the PR (patient responsibility) group code.

Note: For all the above situations, Medicare contractors assign a Group Code of "CO" – Contractual Obligation.

Additional Information

- The official instruction associated with this CR7066 issued to your Medicare DME MAC regarding this change may be viewed at http://www.cms.gov/Transmittals/downloads/R777OTN.pdf on the CMS website.
- To review the CMS DME website that provides a complete listing of links to DME related information you may go to http://www.cms.gov/center/dme.asp on the CMS website.
- For discussion of the program instructions designating the competitive bidding areas and product categories included in the DMEPOS competitive bidding program round one rebid in CY 2009 you may review MM6571 at http://www.cms.gov/MLNMattersArticles/downloads/MM6571.pdf on the CMS website
- The MSAs and product categories that are included in the DMEPOS Competitive Bidding Round I rebid in 2009 can also be found at http://www.cms.gov/DMEPOSCompetitiveBid/01_overview.asp on the CMS website.
- Further information on the boundaries and list of zip codes for each CBA and the Healthcare Common Procedure Coding System (HCPCS) codes for each product category are available by visiting http://www.cms.gov/DMEPOSCompetitiveBid/01_overview.asp on the CMS website and following the link to the Competitive Bidding Implementation Contractor (CBIC).
- To review *Round One Rebid of the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program - Phase 8A: Hospital Exception* you may go to http://www.cms.gov/MLNMattersArticles/downloads/MM6677.pdf on the CMS website.

Competitive Bidding Fact Sheets

The following new fact sheets related to the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program are now available in downloadable format from the Medicare Learning Network®.

- DMEPOS Competitive Bidding Program Traveling Beneficiary Fact Sheet
- DMEPOS Competitive Bidding Program Physicians and Other Treating Practitioners Who Are Enrolled Medicare DMEPOS Suppliers Fact Sheet
- DMEPOS Competitive Bidding Program Hospitals That Are Not Contract Suppliers Fact Sheet

On January 1, 2011, when the DMEPOS Competitive Bidding Program goes into effect in nine competitive bidding areas (CBAs), beneficiaries with Original Medicare who obtain competitively bid items in CBAs must obtain those items from a contract supplier in order for Medicare to pay, unless an exception applies.

To learn more, view the fact sheets at http://www.cms.gov/DMEPOSCompetitiveBid/04_Educational_Resources.asp on the CMS website and click on the appropriate links in the "Downloads" section.

For more information about the DMEPOS Competitive Bidding Program, including a list of the first nine CBAs and items included in the program, visit http://www.cms.gov/DMEPOSCompetitiveBid on the CMS website.

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

The Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program is scheduled to begin in nine competitive bidding areas (CBAs) on January 1, 2011. The competitive bidding program will offer beneficiaries in the designated CBAs access to quality DMEPOS products and services with lower out-of-pocket costs. When the program starts, beneficiaries located in the CBAs must obtain these items from a contract supplier unless an exception applies.

CMS is now in the process of contracting with suppliers to become contract suppliers in the nine CBAs. All suppliers being offered contracts went through a thorough vetting process, are licensed and accredited, and meet financial standards. This means that Medicare beneficiaries will continue to receive quality items and services from DMEPOS suppliers they can trust.

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

More information for referral agents can be found in the new Medicare Learning Network® (MLN) fact sheet "The DMEPOS Competitive Bidding Program: Fact Sheet for Referral Agents" located at http://www.cms.gov/DMEPOSCompetitiveBid/04_Educational_Resources.asp.

This fact sheet is also now available to order in hardcopy, free of charge, from the MLN. To order your copy, please visit the MLN homepage at http://www.cms.gov/mlngeninfo on the internet. Click on "MLN Product Ordering Page" in the "Related Links Inside CMS" section.

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

Medicare Learning Network Releases Three New Fact Sheets for DMEPOS Competitive Bidding Program

The Medicare Learning Network® has released three new fact sheets related to the Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding program:

- "The DMEPOS Competitive Bidding Program Non-Contract Supplier Fact Sheet," which is designed to educate suppliers on a broad variety of requirements for non-contract suppliers under the DMEPOS competitive bidding program;
- "The DMEPOS Competitive Bidding Program Enteral Nutrition Fact Sheet," which is designed to educate suppliers on rules for providing enteral nutrition under the DMEPOS competitive bidding program; and
- "The DMEPOS Competitive Bidding Program Mail Order Diabetic Supplies Fact Sheet," which is designed to educate suppliers on rules regarding providing mail order diabetic supplies under the DMEPOS competitive bidding program.

To learn more, please visit the DMEPOS Competitive Bidding Educational Resources page at http://www.cms.gov/DMEPOSCompetitiveBid/04_Educational_Resources.asp on the Centers for Medicare & Medicaid Services website, then select the "DMEPOS Competitive Bidding Fact Sheets" link in the "Downloads" section.

Also, CMS would like to remind all non-contract suppliers that furnish competitively bid rented durable medical equipment (DME) or oxygen and oxygen equipment to beneficiaries in competitive bidding areas (CBAs) of the following upcoming deadlines:

- A non-contract supplier that elects to become a grandfathered supplier must provide a 30-day written notification to each Medicare beneficiary who resides in a CBA and is currently renting competitively bid oxygen and oxygen equipment or DME from that supplier. These notifications must be sent by Wed Nov 17, 2010. A non-contract supplier that elects to become a grandfathered supplier must also provide written notification to the Centers for Medicare & Medicaid Services (CMS) of this decision by Wed Nov 17, 2010.
- A non-contract supplier that elects not to become a contract supplier is required to pick-up the item it is currently renting to the beneficiary from the beneficiary's home after proper notification. Proper notification includes a 30-day, a 10-day, and a 2-day notice of the supplier's decision not to become a grandfathered supplier to its Medicare beneficiaries who are currently renting competitively bid DME or oxygen and oxygen equipment and who reside in a CBA. The 30-day notification to the beneficiary must be sent by Wed Nov 17, 2010, and must be in writing.

For more information on grandfathering requirements, please see the "DMEPOS Competitive Bidding Program Grandfathering Requirements for Non-Contract Suppliers Fact Sheet," which is now available, free of charge, from the Medicare Learning Network® at http://www.cms.gov/DMEPOSCompetitiveBid/04_Educational_Resources.asp in the "Downloads" section.

DMEPOS Contract Suppliers Announced

The Centers for Medicare & Medicaid Services (CMS) has announced the contract suppliers for the Round 1 Rebid of the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding Program.

The list of contract suppliers is now available at http://www.cms.gov/DMEPOSCompetitiveBid/01A2_Contract_Supplier_Lists.asp.

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

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

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

New Medicare DME MAC Redetermination Request Form

On September 15, 2010, a new Redetermination Request Form will be available for all DMEPOS suppliers to use in order to submit a redetermination request. The new form is designed so that you can easily include all of the basic information needed to submit a redetermination request and will be valid in all four DME MAC Jurisdictions, meaning that suppliers who submit claims across multiple jurisdictions will only need to deal with one Redetermination Request Form regardless of which DME MAC to whom you are submitting your request. Representatives from all four DME MACs collaborated to create the new form in order to ensure consistency in redetermination requests across all jurisdictions. Using the new form will help to streamline your redetermination submission process and will help the DME MACs to ensure that your request is processed timely and accurately.

Illegible Documentation Guidelines

Incomplete or illegible documentation can result in a denial of payment for services billed to Medicare. When documentation is faxed, it can often come in smudged or darkened, which makes that documentation illegible. Illegible documentation can include, but not limited to, documentation sent via fax or handwritten medical notes.

If medical documentation is unable to be faxed due to poor quality or readability, it can be mailed to:

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

If the medical notes are handwritten and illegible, the appeal will remain denied as there is no medical documentation to review. If some of the medical documentation submitted is illegible, that documentation will be excluded and only the legible pieces will be considered as part of the appeals process.

Top Ten Reopenings: January – June 2010

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

1. Maximum Amount Paid (MA18, MA01)
This is the maximum approved amount for this item.

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

2. Medical Necessity (MA13, MA67)
These are 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.

3. Non-Covered Charges (MA13, MA01)
Non-covered charges.

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

4. Frequency (MA13, MA01)
Payment denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, this dosage or this day's supply.

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

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

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

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

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

5. Billing Over Months Covered (MA18, MA13, MA67)
Billing exceeds the rental months covered/approved by the payer.

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

6. Recertification of Medical Necessity Needed (MA13, MA01)
No recertification or revision of medical necessity was received for this equipment.

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

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

7. Certification of Medical Necessity Needed (MA13, MA01)
No Certification of Medical Necessity was received for this equipment.

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

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

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

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

8. Same/Similar (MA18, MA13, MA01)
Either you or another supplier is already furnishing the same or similar equipment to this patient.

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

9. Procedure Code Invalid on Date of Service (MA13, MA01)
Procedure code was invalid on the date of service.

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

10. Duplicate (MA13, MA01)
This service was included in a claim that was previously billed and adjudicated. No appeal rights attached except with regard to whether the service/item is a duplicate.

Common types of services that deny for duplicate include, but are not limited to:

- Drugs: Specify different drug names in the narrative of the claim.
- Wheelchair accessories not otherwise specified: Add a narrative in the comment section of the line item specifying what the accessory is.

This will help to avoid the frequency of duplicate denials.

Another way to minimize duplicate claim denials is to use the IVR system to check on the status of any outstanding claims. The IVR can provide the remittance advice date, check number, and amount paid on these items.

If the claim was previously denied, review the denial reason to determine if a reopening or redetermination should be done before resubmitting.

Top Ten Redeterminations: January – June 2010

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

1. Maximum Amount Paid (MA18, MA01)
This is the maximum approved amount for this item.

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

2. Medical Necessity (MA13, MA67)
These are 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.

3. Certification of Medical Necessity Needed (MA13, MA01)
No Certification of Medical Necessity was received for this equipment.

Suppliers should be knowledgeable regarding the medical policies for items requiring a Certificate of Medical Necessity (CMN) or a DME Information Form (DIF). Ensure the

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

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

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

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

4. Same/Similar (MA18, MA13, MA01)
Either you or another supplier is already furnishing the same or similar equipment to this patient.

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

5. Frequency (MA13, MA01)
Payment denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, this dosage or this day's supply.

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

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

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

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

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

6. Billing Over Months Covered (MA18, MA13, MA67)
Billing exceeds the rental months covered/approved by the payer.

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

7. Non-Covered Charges (MA13, MA01)
Non-covered charges.

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

8. Recertification of Medical Necessity Needed (MA13, MA01)
No recertification or revision of medical necessity was received for this equipment.

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

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

9. Duplicate (MA13, MA01)
This service was included in a claim that was previously billed and adjudicated. No appeal rights attached except with regard to whether the service/item is a duplicate.

Common types of services that deny for duplicate include, but are not limited to:

- Drugs: Specify different drug names in the narrative of the claim.
- Wheelchair accessories not otherwise specified: Add a narrative in the comment section of the line item specifying what the accessory is.

This will help to avoid the frequency of duplicate denials.

Another way to minimize duplicate claim denials is to use the IVR system to check on the status of any outstanding claims. The IVR can provide the remittance advice date, check number, and amount paid on these items.

If the claim was previously denied, review the denial reason to determine if a reopening or redetermination should be done before resubmitting.

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

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

Telephone Reopenings: What Can and Cannot be Requested

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

What Can be Done as a Reopening

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

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

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

What Can Not be Done as a Reopening

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

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

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

RAC Demonstration High-Risk Vulnerabilities – No Documentation or Insufficient Documentation Submitted

MLN Matters® Number: SE1024 Revised

This is the first in a series of articles that will disseminate information on RAC high dollar improper payment vulnerabilities. The purpose of this article is to provide education regarding RAC demonstration-identified vulnerabilities in an effort to prevent these same problems from occurring in the future. With the expansion of the RAC Program and the initiation of complex medical review (coding and medical necessity) in all four RAC regions, it is essential that providers understand the lessons learned from the demonstration and implement appropriate corrective actions.

Note: This article was revised on October 13, 2010, to correct the Web address for Diversified Collection Services on page 4. All other information is the same.

Provider Types Affected

This article is for all Inpatient Hospital and Skilled Nursing Facility providers that submit fee-for-service claims to Medicare Fiscal Intermediaries (FIs) or Part A/B Medicare Administrative Contractors (MACs).

Provider Action Needed

Review the article and take steps, if necessary, to meet Medicare's documentation requirements to avoid unnecessary denial of your claims.

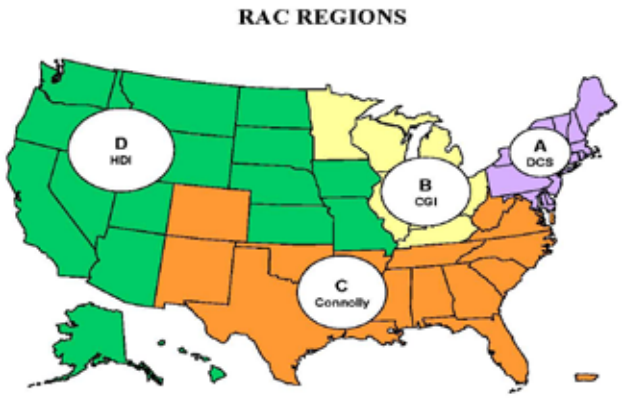
Background

The *Medicare Modernization Act of 2003* (MMA) mandated that the Centers for Medicare & Medicaid Services (CMS) establish the Recovery Audit Contractor (RAC) program as a three-year demonstration. The demonstration began March 2005 in California, Florida, and New York. In 2007, the program expanded to include Massachusetts, Arizona, and South Carolina before ending on March 27, 2008.

RECOVERY AUDIT CONTRACTOR CONT'D

The success of the demonstration resulted in the passage of legislation in the *Tax Relief and Healthcare Act of 2006, Section 302,* which required CMS to establish a National RAC Program by January 1, 2010. CMS uses four RACs to implement the National RAC program. Each RAC is responsible for identifying overpayments and underpayments in approximately one quarter of the country. Figure 1 displays each of the four RAC regions and identifies the RAC responsible for recovery activities in that region.

Figure 1:



The primary goal of the RAC demonstration was to determine if recovery auditing could be effective in Medicare. While the demonstration proved recovery auditing was successful identifying and correcting improper payments in Medicare, it also provided best practices for developing a national program and allowed CMS to identify high risk vulnerabilities. Two of the high risk vulnerabilities identified during the RAC demonstration include:

- Provider non-compliance with timely submission of requested medical documentation; and
- Insufficient documentation that did not justify that the services billed were covered, medically necessary, or correctly coded.

Medical Documentation Reminders

CMS reminds providers that medical documentation must be submitted within 45 days of the date of the Additional Documentation Request (ADR) letter. Medicare contractors, including RACs, have the legal authority to review any information, including medical records, pertaining to a Medicare claim. If a provider fails to submit documentation, there is no justification for the services or the level of care billed. Failure to submit medical records (unless an extension has been granted) results in denial of the claim.

Submission of incomplete or illegible medical records can also result in denial of payment for services billed. Claim payment decisions that result from a medical review of records are based on the documentation that Medicare contractors received. For a Medicare claim to be paid, there must be sufficient documentation in the provider's records to verify that the services were provided to eligible beneficiaries, met Medicare coverage and billing requirements, including being reasonable and necessary, were provided at an appropriate level of care and correctly coded. If there is insufficient documentation for the services billed, the claim may be considered an overpayment and the provider may be requested to repay the claim paid amount to Medicare.

Actions to Assist Providers

The following requirements have been developed to assist providers in ensuring the timely submission of sufficient documentation to justify the services billed:

- RACs must clearly indicate deadlines for submission of medical records in ADR letters;
- RACs must initiate one additional contact with the provider before issuing a denial for a failure to submit documentation;
- RACs must accept and review extensions requests if providers are unable to submit documentation timely;
- RACs must clearly indicate in ADR letters suggested documentation that will assist them in adjudicating the claim;
- RACs must allow providers to submit medical records on CD/DVD or to fax the needed medical records;
- RACs must implement the RAC look back date of 3 years with a maximum look back date of October 1, 2007;
- RACs must limit the number of medical records requests every 45 days;
- RACs must indicate the status of a provider's additional documentation requests on their claim status websites;
- RACs must establish a provider web-portal so providers can customize their address and identify an appropriate point of contact to receive ADR letters; and
- RACs must post all approved issues under review on their websites.

Preparing for RAC Audits

CMS recommends providers implement a plan of action for responding to RAC ADR letters. This could involve developing a RAC team to coordinate all RAC activities that may include tracking audit and appeal findings, identifying patterns of error, implementing corrective actions, etc. Providers should consider assigning a point of contact and, if necessary, an alternate, who will be responsible for tracking and responding to RAC ADR letters. Providers should tell the RAC the precise address and contact person to use when sending ADR letters. Providers may submit this information to the RAC. Additional information on how to identify a point of contact can be found on the individual RAC web pages listed at the end of this article. Providers can also check the status of the submitted documentation by accessing the applicable RAC website. This allows providers to track whether the RAC received the documentation. Providers should consult the individual RAC web pages to determine the proper method for accessing this information. Providers should also consider monitoring their RAC websites for updates on approved new issues. This will assist providers in better understanding what audits are taking place so they can prepare to respond to ADR letters.

CMS RAC Website Information

The following list identifies information unique to each of the four RACs, the States they cover, their subcontractor(s), and

includes website information to assist providers in preparing for RAC audits:

RAC Region A- Diversified Collection Services (DCS), Inc. of Livermore, California:

- States in Region: Maryland (MD), Washington, D.C., Delaware (DE), New Jersey (NJ), Pennsylvania (PA), New York (NY), Maine (ME), Vermont (VT), New Hampshire (NH), Massachusetts (MA), Connecticut (CT), and Rhode Island (RI).
- Subcontractors: PRGX (formerly PRG Schultz), Federal Review Services, and iHealth Technologies
- Email: Info@dcsrac.com
- Website: http://www.dcsrac.com/PROVIDERPORTAL.aspx

RAC Region B- CGI Technologies and Solutions, Inc. of Fairfax, Virginia:

- States in Region: Michigan (MI), Minnesota (MN), Wisconsin (WI), Illinois (IL), Indiana (IN), Kentucky (KY), and Ohio (OH).
- Subcontractor: PRGX
- Email: racb@cgi.com
- Website: http://racb.cgi.com/

RAC Region C- Connolly, Inc. of Philadelphia, Pennsylvania:

- States in Region: Colorado (CO), New Mexico (NM), Texas (TX), Oklahoma (OK), Arkansas (AR), Louisiana (LA), Mississippi (MS), Tennessee (TN), Alabama (AL), Georgia (GA), North Carolina (NC), South Carolina (SC), West Virginia (WV), Virginia (VA), Florida (FL), US Virgin Islands (VI) and Puerto Rico (PR).
- Subcontractor: Viant
- Email: racinfo@connollyhealthcare.com
- Website: http://www.connollyhealthcare.com/RAC/

RAC Region D- HealthDataInsights (HDI), Inc. of Las Vegas, Nevada

- States in Region: Washington (WA), Oregon (OR), California (CA), Alaska (AK), Hawaii (HI), Nevada (NV), Idaho (ID), Montana (MT), Utah (UT), Arizona (AZ), Wyoming (WY), North Dakota (ND), South Dakota (SD), Nebraska (NE), Kansas (KS), Iowa (IA), and Missouri (MO).
- Subcontractor: PRGX
- Email: racinfo@emailhdi.com
- Website: https://racinfo.healthdatainsights.com/

Additional Information

Providers are also encouraged to visit the CMS RAC website at http://www.cms.gov/RAC for updates on the National RAC Program. On that website, you can register to receive email updates and view current RAC activities nationwide.

Tips for Submitting Offsets

This article provides tips on submitting offsets to ensure quick and accurate processing.

1. The quickest way to request an offset is to use the Immediate Offset check box on the Refunds to Medicare form when initially submitting a voluntary refund request.
2. Do NOT use the Refunds to Medicare form to request offset AFTER receiving an overpayment demand letter from either NAS or HealthDataInsights (HDI). This delays processing and can result in interest being accrued to the Account Receivable (AR). The interest may not be refunded.
3. Every offset request should include the following three elements. If all three are not included, processing may be delayed.
   a. Supplier's Provider Transaction Access Number (PTAN)
   b. Document Control Number (DCN), Financial Control Number (FCN), or Account Receivable (AR) number from the NAS or HDI overpayment demand letter
   c. The word "Offset" or "Offset Request."
4. When requesting an offset on a Recovery Audit Contractor (RAC) overpayment after receiving an overpayment demand letter, write "Offset" on the Audit Detail pages or use the RAC Offset Request form and fax to 1-866-640-9459.
5. When requesting offset on a non-RAC overpayment after receiving an overpayment demand letter, write "Offset" and the PTAN/NSC number on the first page of the demand letter and fax only that page to 1-888-529-3666.
6. RAC offset requests and non-RAC offset requests have separate fax numbers. To speed processing, use the correct fax numbers.
   a. RAC offset fax number: 1-866-640-9459.
   b. Non-RAC offset fax number: 1-888-529-3666.
7. Submit post-demand letter offset requests within ten days of receipt of the overpayment demand letter. This allows more time for the overpayment to collect without accruing interest.
8. In order to avoid interest, claim payments must be available to use for offset. If the overpayment is not repaid in full by the 30th day, interest will accrue on the balance. This interest will not be refunded, even if additional claim payments become available after the 30th day.

Submitting Offset Requests

This article explains offsets and how suppliers can properly request offsets.

Offset is a method of repayment to Medicare, where claim payments are withheld to staisfy unpaid debt.

If sufficient claim payments are available to cover the amount owed within 30 days of the overpayment demand letter date, interest charges may be avoided. **Note: It is the supplier's responsibility to make payment in full within 30 days to avoid interest.** If there are not sufficient claim payments available to repay the debt in full, interest will accrue on the balance remaining unpaid on the 31st day. This interest will not be refunded, even if further claim payments become available after the 31st day.

Requested Offset and Automatic Offset

Requested Offset:

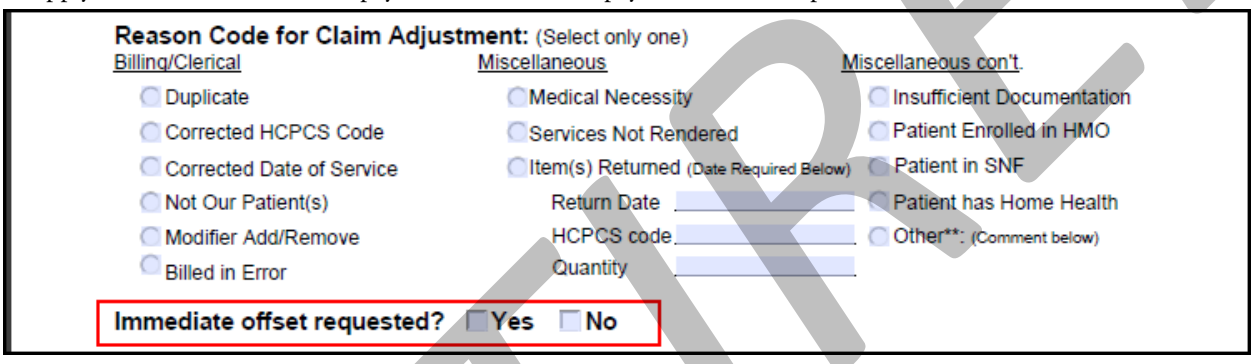
There are two ways that suppliers may request an offset:

- Pre-Demand
- Post-Demand

Pre-Demand Offsets

Pre-Demand offsets may be requested when a supplier submits the Refunds to Medicare form to Medicare.

- Select "Yes" in the checkbox for "Immediate Offset" located below the Reason Code for Claim Adjustment section. NAS will apply the next available claim payment(s) to the overpayment until it is paid in full.



- The Remittance Advice will be sent to the supplier, regardless of offset status.
- An overpayment demand letter is sent to the supplier. This letter contains detailed information about the recoupment and outlines the supplier's appeal rights.

Post-Demand Offsets

Post-Demand Offsets are requested after the supplier receives the overpayment demand letter. NAS requests that three elements be included in every offset request:

1. Supplier's Provider Transaction Authentication Number (PTAN), also known as the National Supplier Clearinghouse (NSC) number.
2. Financial Control Number (FCN)/Document Control Number (DCN) printed on the first page of the overpayment demand letter.
3. Request to offset, which may be indicated on a fax cover sheet or written directly on the first page of the letter.

NAS recommends that suppliers use the overpayment demand letter to request offset for post-demand requests. The FCN/DCN is printed on the first page of the overpayment letter. Write "Offset" and the supplier's PTAN/NSC number on the first page of the letter and fax only the first page to NAS at 1-888-529-3666. To avoid delays in processing, use the correct fax number.

Suppliers may send multiple offset requests in the same fax.

A Recovery Audit Contractor (RAC) offset is a type of Post-Demand offset request. HealthDataInsights (HDI), the RAC for DME Jurisdiction D, is responsible for mailing overpayment demand letters for RAC recoupments. The HDI letter is formatted differently than the NAS overpayment demand letter and displays the HDI logo in the upper right corner.

When submitting a RAC offset request, suppliers may send the Audit Detail pages from the HDI overpayment demand letter, with "Offset" written on the pages. The PTAN/NSC number and FCN/DCN number are already printed on the Audit Detail (the AR Number on the Audit Detail corresponds to the FCN/DCN number on the NAS overpayment letter).

For multiple offset requests, it may be easier to itemize the information on the RAC Offset form located at https://www.noridianmedicare.com/dme/forms/docs/immediate_offset.pdf. The fax number for RAC offsets is 1-866-640-9459 and NAS

OFFSETS CONT'D

processes all RAC offset requests. To avoid delays in processing, use the correct fax number.

Important: It is in the supplier's interest to submit post-demand offset requests as soon as possible to maximize the availability of claim payments prior to the interest accrual date. If a request to offset is received, but no claim payments are available between the date offset is requested and the 30th day, interest will accrue. This interest will not be refunded, even if claim payments become available for offset at a later date.

Automatic Offset

CMS guidelines require NAS to automatically begin an offset when a recoupment becomes 41 days old. There is no need for a supplier to request an offset on any recoupment after the 41st day from the overpayment demand letter date. However, since interest accrues on the 31st day after the overpayment demand letter date, suppliers may elect to request offset sooner.

BILLING

Timely Filing Requirements for Medicare Fee-For-Service Claims

Attention: Electronic Trading Partners

Due to the change in the timely filing limits for Medicare fee-for-service claims, if you need a claim receipt date prior to January 1, 2011, you must have your claims submitted to Common Electronic Data Interchange (CEDI) no later than 3 p.m. eastern time (ET) on Thursday, December 30, 2010.

Because Friday, December 31, 2010, is a holiday for CEDI and the durable medical equipment Medicare administrative contractors (DME MACs), electronic submitters must know the following:

- Claims submitted to CEDI **before** 3 p.m. ET on December 30, 2010, will receive a date of receipt of December 30, 2010.
- Claims submitted to CEDI **after** 3 p.m. ET on December 30, 2010, and before 5 p.m. (ET) on January 3, 2011, will receive a date of receipt of January 3, 2011.

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

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

As a result of the PPACA, the timely filing limits for submitting claims for Medicare fee-for-service (FFS) reimbursement have changed.

- Claims with dates of service prior to 10/01/2008 are past timely filing for Medicare.
- Claims with dates of service 10/01/2008–12/31/2009 must be submitted to Medicare by 12/31/2010.
- Claims with dates of service 01/01/2010 and after have to be submitted to Medicare within one year after the date of service.

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

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

Medicare Contractor Annual Update of ICD-9-CM

MLN Matters Number: MM7006 Revised
Related Change Request (CR) #: 7006
Related CR Release Date: August 4, 2010
Related CR Transmittal #: R2017CP
Effective Date: October 1, 2010
Implementation Date: October 4, 2010

Note: This article was revised on August 4, 2010, to reflect the revised CR 7006, which was revised on August 4. In this article, the CR release date and Transmittal number (see above) were changed and the Web address for accessing CR 7006 was also changed. All other information is the same.

Provider Types Affected

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

Provider Action Needed

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

You can see the new, revised, and discontinued ICD-9-CM diagnosis codes on the Centers for Medicare & Medicaid Services (CMS) website at http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/07_summarytables.asp#TopOfPage, or at the National Center for Health Statistics (NCHS) website at http://www.cdc.gov/nchs/icd9.htm in June of each year. You are also encouraged to purchase a new ICD-9-CM book or CD-ROM on an annual basis.

Background

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

CMS issued CR 7006 as a reminder that the annual ICD-9-CM coding update will be effective for dates of service on or

after October 1, 2010 (for institutional providers, effective for discharges on or after October 1, 2010).

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

Additional Information

For complete details regarding this CR, please see the official instruction (CR7006) issued to your Medicare contractor, which may be found at http://www.cms.gov/Transmittals/downloads/R2017CP.pdf on the CMS website.

CO-4 Denials – Wrong or Missing Modifier

Did you know that most CO-4 denials could be prevented by reviewing the Local Coverage Determination (LCD) and Policy Article?

What does CO-4 mean?

> "The procedure code is inconsistent with the modifier used or a required modifier is missing."

During the months of April – June 2010, CO-4 denials were related to HCPCS codes billed that are addressed in the following policies:

Title	LCD	Policy Article
Ankle Foot Orthosis	L142	A19800
Hospital Beds	L11572	A37079
Positive Airway Pressure Devices	L171	A19827
Pressure Reducing Support Surfaces Group I	L11578	A33678
Refractive Lenses	L51	A23900
Therapeutic Shoes	L157	A37076

The most common missing modifiers and definitions are:

- LT – Left side (Used to identify item provided for the left side of the body)
- RT – Right side (Used to identify item provided for the right side of the body)
- KX – All required coverage criteria are met and documentation is on file
- GA – Valid Advance Beneficiary Notice of Noncoverage (ABN) is on file
- GY – Item or service statutorily excluded or does not meet the definition of any Medicare benefit
- GZ – Item or service expected to be denied as not reasonable or necessary and no valid ABN on file

Supplies and Accessories Used With Beneficiary Owned Equipment

This article discusses supplies and accessories used with beneficiary owned equipment that was not paid for by Medicare Fee-for-Service (FFS) i.e., equipment paid for by other insurance or the beneficiary. These items deny with remark code M124 (missing indication of whether the patient owns the equipment that requires the part or supply) and reason code CO-96 (contractual obligation) (noncovered charges) on the remittance advice.

Initial Claim Submission

The following elements need to be submitted for beneficiary owned equipment on the initial claim in Item 19 on the CMS-1500 claim form or in the 2400 loop NTE segment for electronic claims:

- HCPCS code of base equipment; and,
- A notation that this equipment is beneficiary-owned; and,
- Date (month, year) the patient obtained the equipment.

Claims for supplies and accessories for beneficiary owned equipment must include all information listed above. In addition, use the appropriate modifiers to ensure that the claim does not return/reject for invalid/missing information. Refer to the Local Coverage Determination (LCD) and Policy Article for more information.

Redetermination Submission

In addition to the above, the following elements need to be submitted with the request for redetermination for equipment that is beneficiary owned:

- Medical documentation to support the need for the base equipment as outlined in the LCD and/or Policy Article for the item; and
- Make/model/serial number of the base equipment; and
- Who purchased the base equipment (examples include: Blue Cross/Blue Shield, Medicaid, the beneficiary)

Medicare requires that supplies and accessories only be provided for equipment that meets existing coverage criteria for the base item. In addition, if the supply or accessory has additional, separate criteria, these must also be met.

Suppliers are also reminded stay attuned to atypical utilization patterns.

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

"Contact with the beneficiary or designee regarding refills should take place no sooner than approximately 7 days prior to the delivery/shipping date. For subsequent deliveries of refills, the supplier should deliver the DMEPOS product no sooner than approximately 5 days prior to the end of usage for the current product."

Reference the *Program Integrity Manual*, located on the CMS website, Internet Only Manual, 100-8, Chapter 4.26.1 for more information on refills.

PR-204 Denials – Noncovered

In order for an item to be covered by the Durable Medical Equipment Medicare Administrative Contractor (DME MAC) it must fall within one of ten benefit categories as outlined in Chapter 9 of the Jurisdiction D Supplier Manual.

The table below indicates the top 10 HCPCS codes receiving a noncovered denial with the remark code PR-204 (patient responsibility) over the past three months. Many of the items are specific to refractive lenses; refer to policy L51 for full coverage guidelines. Although frames and lenses are generally covered, personal preference items such as scratch resistant coating and tint are not.

Reason Remark Code PR-204 Denials

HCPCS	Description	Received by Month			Total
		Apr	May	Jun	
A9270	Noncovered item or service	3,526	2,794	3,195	9,515
A4223	Infusion supplies not used with external infusion pump, per cassette or bag	2,248	2,034	2,794	7,076
A4927	Gloves, nonsterile, per 100	2,198	1,907	2,318	6,423
V2025	Deluxe frame	1,954	1,795	1,945	5,694
A4520	Incontinence garment, any type	1,849	1,774	1,844	5,467
V2781	Progressive lens, per lens	1,536	1,373	1,545	4,454
V2760	Scratch resistant coating, per lens	802	717	713	2,232
A4245	Alcohol wipes, per box	681	589	706	1,976
A6402	Gauze, nonimpregnated, sterile, pad size 16 sq in or less, without adhesive border, each dressing	553	662	641	1,856
E1399	Durable Medical Equipment, miscellaneous	599	564	571	1,734

Claims Denied with M18 Code-SNF Denials

Due to new Common Working File (CWF) editing implemented on July 12, there were some claims processed in July, 2010 which denied in error with reason code 96 and remark code M18.

> Reason code 96: Non-covered charges
>
> Remark code M18: Certain services may be approved for home use. Neither a hospital nor a Skilled Nursing Facility (SNF) is considered to be a patient's home.

The CWF editing implemented was for beneficiaries who had a SNF claim in their billing history, however, upHowever, uponon further evaluation of the editing criteria, it was determined that some claims denied in error. NAS will be adjusting all claims denied due to this CWF editing, starting the week of August 2.

The adjusted claim may deny appropriately if the services were provided while the patient was in a SNF stay. In this situation, the remittance advice codes on these denied claims will be reason code 109 and remark code MA101.

> Reason code 109: Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.
>
> Remark code: MA101 A Skilled Nursing Facility (SNF) is responsible for payment of outside providers who furnish these services/supplies to residents.

Please note that some claims have not yet finalized and NAS will continue to identify and adjust the claims denied in error in the next few weeks.

2010 DMEPOS HCPCS Code Jurisdiction List

MLN Matters® Number: MM7110
Related Change Request (CR) #: 7110
Related CR Release Date: September 17, 2010
Related CR Transmittal #: R2056CP
Effective Date: December 22, 2010
Implementation Date: December 22, 2010

Provider Types Affected

Suppliers submitting claims to Medicare Contractors (DME Medicare Administrative Contractors (DME MACs), Part B carriers, and Medicare Administrative Contractors (A/B MAC)) for DMEPOS services provided to Medicare beneficiaries are affected.

Provider Action Needed

This article is informational and based on Change Request (CR) 7110 that notifies providers that the spreadsheet containing an updated list of the HCPCS codes for DME MAC, Part B carrier, or A/B MAC jurisdictions is updated annually to reflect codes that have been added or discontinued (deleted) each year. The spreadsheet is helpful to billing staff by showing the appropriate Medicare contractor to be billed for HCPCS appearing on the spreadsheet. The spreadsheet for the 2010 Jurisdiction List is an Excel® spreadsheet and is available at http://www.cms.gov/center/dme.asp on the Centers for Medicare &.Medicaid Services (CMS) website.

Additional Information

To see the official instruction (CR7110) issued to your Medicare DME MAC, carrier, or A/B MAC, visit http://www.cms.gov/Transmittals/downloads/R2056CP.pdf on the CMS website. The 2010 Jurisdiction List is attached to CR 7110.

Common Working File Unsolicited Response Adjustments for Certain Claims Denied Due Open MSP GHP Record

MLN Matters® Number: MM6625
Related Change Request (CR) #: 6625
Related CR Release Date: July 30, 2010
Related CR Transmittal #: R2014CP
Effective Date: April 1, 2011
Implementation Date: April 4, 2011

Provider Types Affected

Physicians, providers, and suppliers who bill Medicare contractors (fiscal intermediaries (FI), Regional Home Health Intermediaries (RHHI), carriers, Medicare Administrative Contractors (A/B MAC), or Durable Medical Equipment Contractors (DME MAC) for services provided, or supplied, to Medicare beneficiaries.

What You Need to Know

CR 6625, from which this article is taken, instructs Medicare contractors (FIs, RHHIs, carriers, A/B MACS, and DME MACs) and shared system maintainers (SSM) to implement (effective April 1, 2011) an automated process to reopen Group Health Plan (GHP) Medicare Secondary Payer (MSP) claims when related MSP data is deleted or terminated after claims were processed subject to the beneficiary record on Medicare's database. Make sure that your billing staffs are aware of these new Medicare contractor instructions. Please see the Background section, below, for more details.

Background

MSP GHP claims were not automatically reprocessed in situations where Medicare became the primary payer after an MSP GHP record had been deleted or when an MSP GHP record was terminated after claims were processed subject to MSP data in Medicare files. It was the responsibility of the beneficiary, provider, physician or other suppliers to contact the Medicare contractor and request that the denied claims be reprocessed when reprocessing was warranted. However, this process places a burden on the beneficiary, physician, or other supplier and CR 6625 eliminates this burden. As a result of CR 6625, Medicare will implement an automated process to:

1. Reopen certain MSP claims when certain MSP records are deleted, or
2. Under some circumstances when certain MSP records are terminated and claims are denied due to MSP or Medicare made a secondary payment before the termination date is accreted.

Basically, where Medicare learns, retroactively, that Medicare Secondary Payer data for a beneficiary is no longer applicable, Medicare will require its systems to search claims history for claims with dates of service within 180 days of a MSP GHP deletion date or the date the MSP GHP termination was applied, which were processed for secondary payment or were denied (rejected for Part A only claims). If claims were processed, the Medicare contractors will reprocess them in view of the more current MSP GHP information and make any claims adjustments that are appropriate. If providers, physicians or other suppliers believe some claim adjustments were missed please contact your Medicare contractor regarding those missing adjustments.

Additional Information

You can find the official instruction, CR6625, issued to your FI, RHHI, carrier, A/B MAC, or DME MAC by visiting http://www.cms.gov/Transmittals/downloads/R2014CP.pdf on the Centers for Medicare & Medicaid Services (CMS) website.

ESRD PPS and Consolidated Billing for Limited Part B Services

MLN Matters® Number: MM7064
Related Change Request (CR) #: 7064
Related CR Release Date: August 20, 2010
Related CR Transmittal #: R2033CP
Effective Date: January 1, 2011
Implementation Date: January 3, 2011

Provider Types Affected

Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, DME Medicare Administrative Contractors (DME MACs), Fiscal Intermediaries (FIs), and/or A/B Medicare Administrative Contractors (A/B MACs)) for ESRD services provided to Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 7064 which announces the implementation of an End Stage Renal Disease (ESRD) bundled prospective payment system (PPS) effective January 1, 2011.

Once implemented, the ESRD PPS will replace the current basic case-mix adjusted composite payment system and the methodologies for the reimbursement of separately billable outpatient ESRD related items and services. The ESRD PPS will provide a single payment to ESRD facilities, i.e., hospital-based providers of services and renal dialysis facilities, that will cover all the resources used in providing an outpatient dialysis treatment, including supplies and equipment used to administer dialysis in the ESRD facility or at a patient's home, drugs, biologicals, laboratory tests, training, and support services. The ESRD PPS provides ESRD facilities a 4-year phase-in (transition) period under which they would receive a blend of the current payment methodology and the new ESRD PPS payment. In 2014, the payments will be based 100 percent on the ESRD PPS payment.

Since the ESRD PPS is effective for services on or after January 1, 2011, it is important that providers not submit claims spanning dates of service in 2010 and 2011. ESRD facilities have the opportunity to make a one time election to be excluded from the transition period and have their payment based entirely on the payment amount under the ESRD PPS as of January 1, 2011. Facilities wishing to exercise this option must do so on or before November 1, 2010. See the Background and Additional Information Sections of this article for further details regarding the ESRD PPS.

Background

The Medicare Improvements for Patients and Providers Act (MIPPA); Section 153(b); see http://www.govtrack.us/congress/billtext.xpd?bill=h110-6331 on the Internet) requires the Centers for Medicare & Medicaid services (CMS) to implement an End Stage Renal Disease (ESRD) bundled prospective payment system (PPS) effective January 1, 2011. Once implemented, the ESRD PPS will replace the current basic case-mix adjusted composite payment system and the methodologies for the reimbursement of separately billable outpatient ESRD related items and services.

Specifically, the ESRD PPS combines payments for composite rate and separately billable services into a single base rate. The per dialysis treatment base rate for adult patients is subsequently adjusted to reflect differences in:

- Wage levels among the areas in which ESRD facilities are located;
- Patient-level adjustments for case-mix;
- An outlier adjustment (if applicable);
- Facility-level adjustments;
- A training add-on (if applicable); and
- A budget neutrality adjustment during the transition period through 2013.

Patient-level Adjustments

The patient-level adjustments are patient-specific case-mix adjusters that were developed from a two-equation regression analysis that encompasses composite rate and separately billable items and services. Included in the case-mix adjusters for adults are those variables that are currently used in basic case-mix adjusted composite payment system, that is, age, body surface area (BSA), and low body mass index (BMI). In addition to those adjusters that are currently used, the ESRD PPS will also incorporate adjustments for six co-morbidity categories and an adjustment for the onset of renal dialysis.

Outlier Adjustment

ESRD facilities that are treating patients with unusually high resource requirements, as measured through their utilization of identified services beyond a specified threshold, will be entitled to outlier payments. Such payments are an additional payment beyond the otherwise applicable case-mix adjusted prospective payment amount.

ESRD outlier services are the following items and services that are included in the ESRD PPS bundle:

1. ESRD-related drugs and biologicals that were or would have been, prior to January 1, 2011, separately billable under Medicare Part B;
2. ESRD-related laboratory tests that were or would have been, prior to January 1, 2011, separately billable under Medicare Part B;
3. Medical/surgical supplies, including syringes, used to administer ESRD-related drugs that were or would have been, prior to January 1, 2011, separately billable under Medicare Part B; and
4. Renal dialysis service drugs that were or would have been, prior to January 1, 2011, covered under Medicare Part D, notwithstanding the delayed implementation of ESRD-related oral-only drugs effective January 1, 2014.

Note: Services not included in the PPS that remain separately payable, including blood and blood processing, preventive vaccines, and telehealth services, are not considered outlier services.

Facility-level Adjustments

The facility-level adjustments include adjusters to reflect urban and rural differences in area wage levels using an area wage index developed from Core Based Statistical Areas (CBSAs). The facility-level adjustments also include

an adjuster for facilities treating a low-volume of dialysis treatments.

Training Add-On

Facilities that are certified to furnish training services will receive a **training add-on payment amount of $33.44**, which is adjusted by the geographic area wage index to account for an hour of nursing time for each training treatment that is furnished. The training add-on applies to both peritoneal dialysis (PD) and hemodialysis (HD) training treatments.

Adjustments Specific to Pediatric Patients

The pediatric model incorporates separate adjusters based on two age groups (<13, 13-17) and dialysis modality (hemodialysis, peritoneal dialysis). The per-treatment base rate as it applies to pediatric patients is the same base rate that applies for adult patients, which is also adjusted by the area wage index. However, due to the lack of statistical robustness, the base rate for pediatric patients is not adjusted by the same patient-level case-mix adjusters as for adult patients. Instead, the pediatric payment adjusters reflect the higher total payments for pediatric composite rate and separately billable services, compared to that of adult patients.

Treatments furnished to pediatric patients:

- Can qualify for a training add-on payment (when applicable), and
- Are eligible for an outlier adjustment.

Note: Pediatric dialysis treatments are not eligible for the low-volume adjustment.

ESRD PPS 4-year Phase-in (Transition) Period

The ESRD PPS provides ESRD facilities with a 4-year transition period under which they would receive a blend of payments under the prior case-mix adjusted composite payment system and the new ESRD PPS as noted in the following table:

The ESRD PPS 4-year Transition Period Blended Rate Determination

Calendar Year	Blended Rate
2011	75 percent of the old payment methodology, and 25 percent of new PPS payment
Calendar Year Blended Rate 2012	50 percent of the old payment methodology, and 50 percent of the new PPS payment
2013	25 percent of the old payment methodology, and 75 percent of the new PPS payment
2014	100 percent of the PPS payment

For Calendar Year (CY) 2011, CMS will continue to update the basic case-mix composite payment system for purposes of determining the composite rate portion of the blended payment amount. CMS updated the composite payment rate, the drug add-on adjustment to the composite rate, the wage index adjustment, and the budget neutrality adjustment.

The ESRD PPS base rate is $229.63, which is applicable for both adult and pediatric ESRD patients effective January 1, 2011. This base rate will be wage adjusted as mentioned above where

- The labor-related share of the base rate from the ESRD PPS market basket is 0.41737, and
- The non labor-related share of the base rate is $133.79 ((229.63 X (1 - 0.41737) = $133.79).

During the transition, the labor-related share of the case-mix adjusted composite payment system will remain 0.53711.

The payment rate for a dialysis treatment is determined by wage adjusting the base rate and then applying any applicable:

- Patient-level adjustments;
- Outlier adjustments;
- Facility-level adjustments; and
- Training add-on payments (adjusted for area wage levels)

Once the payment rate for the dialysis treatment is determined, the last item in the computation to determine the final payment rate is the application of the transition budget neutrality factor of .969, that is, a 3.1 percent reduction.

The ESRD PRICER will provide the payment for existing composite rate, the new ESRD PPS payment rate, and the outlier payment (when applicable). These reimbursement amounts must be blended during a transition period for all ESRD facilities except those facilities opting out of the transition and electing to be paid 100 percent of the payment amount under the new ESRD PPS.

Note: Providers wishing to opt out of the transition period blended rate must notify their Medicare Contractor on or before November 1, 2010. Providers shall not submit claims spanning date of service in 2010 and 2011.

Three New Adjustments Applicable to the Adult Rate

1. Comorbid Adjustments: The new ESRD PPS provides for 3 categories of chronic comorbid conditions and 3 categories for acute comorbid conditions. A single adjustment will be made to claims containing one or more of the comorbid conditions. The highest comorbid adjustment applicable will be applied to the claim. The acute comorbid adjustment may be paid no greater than 4 consecutive months for any reported acute comorbid condition, unless there is a reoccurrence of the condition. The 3 chronic comorbid categories eligible for a payment adjustment are:
   - Hereditary hemolytic and sickle cell anemia;
   - Monoclonal gammopathy (in the absence of multiple myeloma); and
   - Myelodysplastic syndrome.

   The 3 acute comorbid categories eligible for a payment adjustment are:
   - Bacterial Pneumonia;
   - Gastrointestinal Bleeding; and
   - Pericarditis.

2. Onset of Dialysis Adjustment: An adjustment will be made for patients that have Medicare ESRD coverage during their first 4 months of dialysis. This adjustment will be determined by the dialysis start date in Medicare's Common Working File as provided on the CMS Form 2728, completed by the provider. When the onset of dialysis adjustment is provided, the claim is not entitled to a comorbid adjustment or a training adjustment.
3. Low-Volume Facility Adjustment: Providers will receive an adjustment to their ESRD PPS rate when the facility furnished less than 4,000 treatments in each of the three years preceding the payment year and has not opened, closed, or received a new provider number due to a change in ownership during the three (3) years preceding the payment year. The 3 years preceding treatment data should be reflected on the last 2 settled cost reports and the most recent must be filed. The provider must notify their Medicare Contractor if they believe they are eligible for the low-volume adjustment.

Change in Processing Home Dialysis Claims

For claims with dates of service on or after January 1, 2011, the payment of home dialysis items and services furnished under Method II, regardless of home treatment modality, are included in the ESRD PPS payment rate.

Therefore, all home dialysis claims:

- Must be submitted by a renal dialysis facility and
- Will be processed as Method I claims.

Note: CR 7064 instructs the DME MACs to stop separate payment to suppliers for Method II home dialysis items and services for claims with dates of service on or after January 1, 2011. Medicare will, however, allow separate billing for ESRD supply HCPCS codes (as shown on attachment 4 of CR 7964) by DME suppliers when submitted for services not related to the beneficiary's ESRD dialysis treatment and such services are billed with the AY modifier.

Consolidated Billing

CR 7064 provides an ESRD consolidated billing requirement for limited Part B services included in the ESRD facility bundled payment. Certain laboratory services and limited drugs and supplies will be subject to Part B consolidated billing and will no longer be separately payable when provided for ESRD beneficiaries by providers other than the renal dialysis facility. Should these lab services, and limited drugs be provided to a beneficiary, but are not related to the treatment for ESRD, the claim lines must be submitted by the laboratory supplier or other provider with the new AY modifier to allow for separate payment outside of ESRD PPS. ESRD facilities billing for any labs or drugs will be considered part of the bundled PPS payment unless billed with the modifier AY. In addition, as noted above, Medicare will, however, allow separate billing for ESRD supply HCPCS codes (as shown on attachment 4 of CR 7964) by DME suppliers when submitted for services not related to the beneficiary's ESRD dialysis treatment and such services are billed with the AY modifier.

Other Billing Reminders

- Note that with the ESRD PPS changes, Medicare systems will also reject any lines reporting revenue code 0880 as of January 1, 2011. These rejections will be made with remittance advice remark code (RARC) M81 (You are required to code to the highest level of specificity), and assign a group code of CO (provider liability) to such lines.
- Medicare will return claims to the provider with dates of service spanning 2010 and 2011.
- Telehealth services billed with HCPCS Q3014, preventive services covered by Medicare, and blood and blood services are exempt from the ESRD PPS and will be paid based on existing payment methodologies.
- When claims are received without the AY modifier for items and services that are not separately payable due to the ESRD PPS consolidated billing process, the claims will be returned with claim adjustment reason code (CARC) 109 (Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.), RARC N538 (A facility is responsible for payment to outside providers who furnish these services/supplies/drugs to its patients/residents.), and assign Group code CO.
- All 72X claims from Method II facilities with condition code 74 will be treated as Method I claims as of January 1, 2011. Effective that same date, Medicare will no longer enter Method selection forms data into its systems.
- Services included in the existing composite rate continue to not be reported on the claim unless they are clinical lab services subject to the 50/50 rule. The only additional data that must be reported on or after January 1, 2011 are any oral and other equivalent forms of injectable drugs identified as outlier services. Oral and other equivalent forms of injectable drugs should be reported with the revenue code 0250. The drug NDC code must be reported with quantity field reflecting the smallest available unit.
- Payment for ESRD-related Aranesp and ESRD-related Epoetin Alfa (EPO) is included in the ESRD PPS for claims with dates of service on or after January 1, 2011.
- Effective January 1, 2011, section 153b of the MIPPA requires that all ESRD-related drugs and biologicals are included in the ESRD PPS and must be billed by the renal dialysis facility.

Additional Information

The official instruction, CR 7064, issued to your carriers, DME MACs, FIs and/or A/B MACs regarding this change may be viewed at http://www.cms.gov/Transmittals/downloads/R2033CP.pdf on the CMS website. Attached to CR 7064, you may find the following documents to be helpful:

- Attachment 3, which is a list of outlier services;
- Attachment 4, which is a list of DME ESRD Supply HCPCS codes used in for ESRD PPS consolidated billing edits;
- Attachment 5, which contains a list of DME ESRD Supply HCPCS codes that are NOT payable to DME suppliers;

- Attachment 6, which is a list of laboratory CPT/HCPCS codes subject to ESRD consolidated billing;
- Attachment 7, which lists the drug codes subject to ESRD consolidated billing; and
- Attachment 8, which lists by ICD-9-CM codes, the comorbid categories and diagnosis codes.

Healthcare Provider Taxonomy Codes October 2010 Update

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

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

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

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

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

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

Claim Status Category and Claim Status Codes Update

MLN Matters® Number: MM7158
Related Change Request (CR) #: 7158
Related CR Release Date: September 17, 2010
Related CR Transmittal #: R2049CP
Effective Date: January 1, 2011
Implementation Date: January 3, 2011

Provider Types Affected

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

Provider Action Needed

This article, based on CR 7158, explains that the Claim Status Codes and Claim Status Category Codes for use by Medicare contractors with the Health Claim Status Request and Response ASC X12N 276/277 along with the 277 Health Care Claim Acknowledgement updated during the October 2010 meeting of the national Code Maintenance Committee and code changes approved at that meeting are to be posted at http://www.wpc-edi.com/content/view/180/223/ on or about November 1, 2010. Included in the code lists are specific details, including the date when a code was added, changed, or deleted. Medicare contractors will implement these changes on January 3, 2011. All providers should ensure that their billing staffs are aware of the updated codes and the timeframe for implementations.

Background

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

Additional Information

The official instruction, (CR 7158), issued to your Medicare contractor regarding this change may be viewed at http://www.cms.gov/Transmittals/downloads/R2049CP.pdf on the CMS website.

HCPCS Annual Update for SNF CB – 2011

MLN Matters® Number: MM7159
Related Change Request (CR) #: 7159
Related CR Release Date: September 10, 2010
Related CR Transmittal #: R2048CP
Effective Date: January 1, 2011
Implementation Date: January 3, 2011

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 7159 which provides the 2011 annual update of Healthcare Common Procedure Coding System (HCPCS) Codes for Skilled Nursing Facility Consolidated Billing (SNF CB) and how the updates affect edits in Medicare claims processing systems.

Physicians and providers are advised that, by the first week in December 2010, new code files will be posted at http://www.cms.hhs.gov/SNFConsolidatedBilling/ on the Centers for Medicare & Medicaid Services (CMS) website. Note that this site will include new Excel® and PDF format files. It is important and necessary for the provider community to view the "General Explanation of the Major Categories" PDF file located at the bottom of each year's FI/A/B MAC update listed at http://www.cms.hhs.gov/SNFConsolidatedBilling/ on the CMS website in order to understand the Major Categories, including additional exclusions not driven by HCPCS codes.

See the Background and Additional Information Sections of this article for further details regarding these changes.

Background

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

Additional Information

The official instruction, CR 7159, issued to your carriers, DME MACs, FIs, and A/B MACs regarding this change may be viewed at http://www.cms.gov/Transmittals/downloads/R2048CP.pdf on the CMS website.

HCPCS Code Set Update

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

Updated from CMS Medicare Learning Network: Podcast and Revised MREP Brochure

CMS announces a new podcast, "New Maximum Period for the Submission of Medicare Claims" and a revised Medicare Remit Easy Print (MREP) brochure is now available.

Just Released! The Medicare Learning Network is now podcasting! Our premier production – "New Maximum Period for the Submission of Medicare Claims", which reminds Medicare Fee-for-Service providers of the current claims submission deadline, is now available. To access the podcast, go to http://www.cms.gov/CMSFeeds/02_listofpodcasts.asp on the CMS website.

Revised! ***The Medicare Remit Easy Print Brochure*** (revised May 2010), which provides information about free software that enables professional providers and suppliers to view and print remittance information, is now available in print format from the **Medicare Learning Network**. To place your order, visit http://www.cms.gov/MLNGenInfo/, scroll down to "Related Links Inside CMS" and select "MLN Product Ordering Page."

CARC, RARC, and MREP Update

MLN Matters® Number: MM7089
Related Change Request (CR) #: 7089
Related CR Release Date: August 6, 2010
Related CR Transmittal #: R2019CP
Effective Date: October 1, 2010
Implementation Date: October 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 7089, from which this article is taken, announces the latest update of Remittance Advice Remark Codes (RARCs) and Claim Adjustment Reason Codes (CARCs), effective October 1, 2010 for Medicare. These are the changes that have been added since CR 6901. Be sure billing staff are aware of these changes.

Background

The reason and remark code sets must be used to report payment adjustments in remittance advice transactions. The reason codes are also used in some coordination-of-benefits

(COB) transactions. The RARC list is maintained by the Centers for Medicare & Medicaid Services (CMS), and used by all payers; and additions, deactivations, and modifications to it may be initiated by any health care organization. The RARC list is updated 3 times a year – in early March, July, and November although the Committee meets every month.

The CARC list is maintained by the Claim Adjustment Status Code Maintenance Committee, and used by all payers. This committee meets 3 times a year, and this code list also gets updated 3 times a year – in 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 7089.

Additional Information

To see the official instruction (CR7089) issued to your Medicare Carrier, RHHI, DME/MAC, FI and/or MAC refer to http://www.cms.gov/Transmittals/downloads/R2019CP.pdf on the CMS website.

New Codes - CARC

Code	Current Narrative	Effective Date Per WPC Posting
235	Sales Tax.	6/6/2010

Modified Codes – CARC
None

Deactivated Codes – CARC
None

New Codes – RARC

Code	Current Narrative	Medicare Initiated
N533	Services performed in an Indian Health Services facility under a self-insured tribal Group Health Plan.	NO
N534	This is an individual policy, the employer does not participate in plan sponsorship.	NO
N535	Payment is adjusted when procedure is performed in this place of service based on the submitted procedure code and place of service.	YES
N536	We are not changing the prior payer's determination of patient responsibility, which you may collect, as this service is not covered by us.	NO
N537	We have examined claims history and no records of the services have been found.	NO
N538	A facility is responsible for payment to outside providers who furnish these services/supplies/drugs to its patients/residents.	NO
N539	Alert: We processed appeals/waiver requests on your behalf and that request has been denied.	NO

Modified Codes – RARC

Code	Modified Narrative	Medicare Initiated
N104	This claim/service is not payable under our claims jurisdiction area. You can identify the correct Medicare contractor to process this claim/service through the CMS website at www.cms.gov.	YES
N115	This decision was based on a Local Coverage Determination (LCD). An LCD provides a guide to assist in determining whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd, or if you do not have web access, you may contact the contractor to request a copy of the LCD.	YES
N386	This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.ms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NDC.	YES
N528	Patient is entitled to benefits for Institutional Services only.	NO
N529	Patient is entitled to benefits for Professional Services only.	NO
N530	Not Qualified for Recovery based on enrollment information.	NO

Deactivated Codes – RARC

Code	Current Narrative	Note
M118	Letter to follow containing further information.	Consider using N202
MA101	A Skilled Nursing Facility (SNF) is responsible for payment of outside providers who furnish these services/supplies to residents.	Consider using N538
N201	A mental health facility is responsible for payment of outside providers who furnish these services/supplies to residents.	Consider using N538
N514	Consult plan benefit documents/guidelines for information about restrictions for this service.	Consider using N130

MREP Software Code Updates

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.gov/AccesstoDataApplication/02_MedicareRemitEasyPrint.asp on the CMS website.

MREP Enhancement

MLN Matters® Number: MM7178
Related Change Request (CR) #: 7178
Related CR Release Date: October 8, 2010
Related CR Transmittal #: R2064CP
Effective Date: January 1, 2011
Implementation Date: January 3, 2011

Provider Types Affected

This article is for physicians, providers, and suppliers using the MREP Software supplied through Medicare contractors (carriers, Fiscal Intermediaries (FIs), DME Medicare Administrative Contractors (DME MACs) and/or Part A/B Medicare Administrative Contractors (MACs)).

What You Need to Know

The Centers for Medicare & Medicaid Services (CMS) announces in CR 7178, the following list of enhancements to the MREP:

- The MREP Demo function has been updated to reflect current functionalities; and
- A report can be run now for Medicare Secondary Payer (MSP) Claims to distinguish the Medicare secondary payments from the primary payments.

If you use the MREP software, be sure to obtain the new version in January and install it to begin benefiting from these enhancements.

Background

CMS developed the free MREP software to enable providers/suppliers to read and print the HIPAA-compliant Electronic Remittance Advice (ERA), also known as Transaction 835. MREP was first implemented in October 2005, and MREP has been enhanced continuously based on requests/comments received from users. These enhancements are based on requests received either through the carriers, MACs, DME MACs or through the CMS MREP website.

Additional Information

The official instruction, CR 7178 issued to your carrier, A/B MAC, and DME/MAC regarding this change may be viewed at http://www.cms.gov/Transmittals/downloads/R2064CP.pdf on the CMS website.

Submitting Diabetic Shoe Inserts for Coding

Diabetic inserts coded as A5512 and A5513 must meet the material thickness and Shore A durometer scale hardness measurements outlined in the Local Coverage Determination and Policy Articles for Therapeutic Shoes for Persons with Diabetes.

For inserts to be coded as A5512, the product must be a heat moldable "base layer" with a material thickness of at least 1/4 of an inch of 35 Shore A or higher or at least 3/16 of an inch of 40 Shore A or higher, be coded by the Pricing, Data Analysis and Coding (PDAC), and be listed on the Product Classification List. **A sample pair of inserts must be submitted with the Coding Verification Application.** Applications are available on the PDAC website at https://www.dmepdac.com.

For inserts to be coded as A5513, the product must retain its shape during use for the life of the insert. The base layer material must be 35 Shore A or higher. The central portion of the base layer of the heel must be at least 1/16 of an inch on the finished product, be coded by the PDAC, and be listed on the Product Classification List. **Manufacturers/ central fabrication facilities must submit a 4 x 4 x ½ inch sample of base layer material(s), a sample pair of inserts, a narrative description and pictures of the manufacturing process, and a completed Coding Verification Application.** Applications are available on the PDAC website at https://www.dmepdac.com. A copy of the original Coding Verification Letter to the manufacturer/ central fabrication facility, approving the product as A5513, must be kept on file and available to distributors, suppliers, and CMS contractors upon request.

Practitioners who create custom fabricated inserts from raw materials for dispensing directly to the end user (the beneficiary) are not required to have their insert listed on the PDAC website in order to bill using code A5513. However, a coding verification request may be submitted to the PDAC to ensure accuracy of the code for the item provided. **If a Coding Verification Review is requested, a 4 x 4 x ½ inch sample of base layer material(s), a sample pair of inserts, a narrative description and pictures of the manufacturing process, and a completed Coding Verification Application must be submitted.**

Coding verification results are subject to review and observation by CMS and its contractors, including the PDAC, DME MAC, Program Safeguard Contractor (PSC), and Zone Program Integrity Contractor (ZPIC).

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

Pneumatic Knee Splint – Coding Verification Review Requirement

Effective for claims with dates of service on or after January 1, 2011, the only products which may be billed using code L4380 (Pneumatic knee splint, prefabricated, includes fitting and adjustment) are those for which a written coding verification has been made by the Pricing, Data Analysis, and Coding (PDAC) contractor.

Information concerning the documentation that must be submitted to the PDAC for a Coding Verification Request can be found on the PDAC website https://www.dmepdac.com/review/index.html or by contacting the PDAC Contact Center at 877-735-1326. Once the products are coded by the PDAC they will be listed on the Product Classification List.

Ultrasonic/Electronic Aerosol Generator with Small Volume Nebulizer – Coding Verification Review Requirement

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

Products currently coded with E0574 which are listed on DMECS will be end dated as of December 31, 2010.

The PDAC coding verification application required for these products is the DME and Supplies application. This application is located on the PDAC website here: https://www.dmepdac.com/review/apps_check.html. If you have questions please contact the PDAC Contact Center at 1-877-735-1326 during the hours of 8:30 a.m. to 4 p.m. CT, Monday through Friday, or e-mail the PDAC by completing the DME PDAC Contact Form located on the PDAC website here: https://www.dmepdac.com.

Once products are coded by the PDAC, they will be listed in the Product Classification Matrix on DMECS.

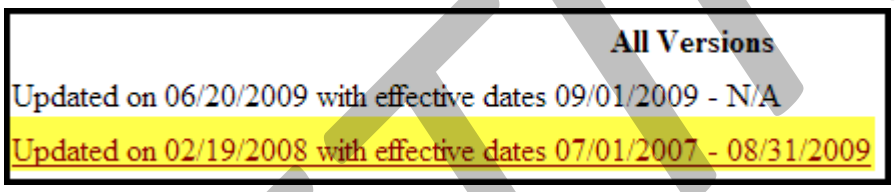
Archived LCDs Now Available on NAS DME Website

NAS now offers an Archived Local Coverage Determinations (LCDs) and Policy Articles webpage, accessible from the Current LCD and Policy Article page. The Archived documents are provided by date on the Archived LCDs and Policy Articles page and from the All Version section located at the end of the Current LCDs and Policy Articles.

These Archived LCDs and Policy Articles are not searchable through the search engine. This is to assist suppliers in searching for the most up-to-date information.

Archived LCDs and Policy Articles Page

All Versions Section in Current LCDs and Policy Articles



NAS encourages suppliers to complete the randomly distributed Website Satisfaction Survey that pops up when navigating the website. Let us know if you notice improvements in your policy research with the addition of this Archived LCD and Policy Article page. All survey results are strictly confidential. NAS is provided only with the statistical survey results and comments; not visitor information. Those who participate and complete the survey will not see the survey again for 30 days. If you have responded to the survey previously, we would appreciate any new comments you have regarding the changes implemented since your last survey responses; feel free to take the survey more than once.

Request for Refill – Documentation

For all DMEPOS items that are provided on a recurring basis, suppliers are required to have contact with the beneficiary prior to dispensing a new supply of items. (Contact with a caregiver/ designee also meets the requirements that are specified in this article.)

For items that the patient obtains at a retail store site, the signed delivery slip is sufficient documentation of a request for refill.

For items that are delivered to the beneficiary's home or nursing home by the supplier or third party delivery service, documentation of a request for refill must be either a written document received from the beneficiary or a contemporaneous written record of a phone conversation/contact between the supplier and beneficiary. A retrospective attestation statement by the supplier or beneficiary is not sufficient.

If it is a written document received from the beneficiary, the documentation should contain the following or equivalent information:

- Beneficiary's name
- A description of each item or of each type of item that is being requested (e.g., diabetic testing supplies, inhalation drugs, nebulizer accessories, etc.); a list of each separate item is not required

- A statement that the beneficiary is requesting a refill of the items
- Beneficiary signature (If signed by a caregiver, indicate relationship to beneficiary)
- Date of signature

If it is a record of a phone conversation, the documentation should contain the following or equivalent information:

- Beneficiary's name
- Person contacted (i.e., beneficiary or caregiver [list name])
- A description of each item or of each type of item that is being requested; a list of each separate item is not required
- A statement that the beneficiary is requesting a refill of the items
- Date of contact

If the phone contact involves use of an automated response system, the record of that contact should contain similar information.

Other useful information that might be obtained at the time of contact with the beneficiary includes but is not limited to:

- Quantity of supplies that the beneficiary still has
- How often the beneficiary has been testing/taking a drug/using or replacing an item
- Whether the beneficiary is also receiving the items from another supplier

Additional information on requests for refill:

- Medicare Coverage Database, article, March 2009 – Beneficiary Request for Refill of Supplies, Accessories, and Drugs
- Jurisdiction D DME Happenings, Issue 21, June 2009 – Beneficiary Request for Refill of Supplies, Accessories, and Drugs
- Medicare Program Integrity Manual, Pub 100-08, Chapter 4, Section 4.26.1
- Medicare Claims Processing Manual, Pub 100-04, Chapter 20, Section 200

Patient Documentation Form for Persons with Diabetes

In 2009 NAS published Patient Documentation Forms for insulin and non-insulin dependent diabetic patients. The purpose of the forms was to assist suppliers with educating physicians on clearly documenting in the patient's clinical record the need for a patient to test more than the average frequency.

Since that time, NAS has received numerous questions regarding to whom that form should be returned. NAS has also learned that suppliers have taken the NAS form and modified it with lines, which leads physicians to believe it is to be completed and returned to Medicare. **It was never the intention of NAS to have this form completed by a physician and returned to Medicare.** Therefore, NAS is asking those suppliers who have modified the form from the NAS website to **stop** distributing their modified versions.

In addition, suppliers providing the forms located on the NAS website to their patients should advise the patients that the forms are informational only and are not to be returned to Medicare.

Suppliers are expected to read and understand the Local Coverage Determination (LCD) and Policy Article for Glucose Monitors for additional coverage, coding and documentation requirements.

Medicare Policy Regarding Pressure Reducing Support Surfaces

MLN Matters Number: SE1014 Revised

Note: This article was revised and re-issued in its entirety on August 17, 2010.

Provider Types Affected

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

Provider Action Needed

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

Background

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

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

- **Group 1** support surfaces are generally designed to either replace a standard hospital or home mattress or as an overlay placed on top of a standard hospital or home mattress. Products in this category include mattresses, pressure pads and mattress overlays (foam, air, water, or gel).

- **Group 2** support surfaces are generally designed to either replace a standard hospital or home mattress or as an overlay placed on top of a standard hospital or home mattress. Products in this category include powered air flotation beds, powered pressure reducing air mattresses, and non-powered advanced pressure reducing mattresses.
- **Group 3** support surfaces are complete bed systems, known as air-fluidized beds, which use the circulation of filtered air through silicone beads.

Although LCDs are published by the four DME MAC contractors, inappropriate payments are still being made, and other problems continue to adversely affect Medicare reimbursement for this equipment. Therefore, CMS is taking additional steps listed here to reduce the extent of inappropriate support surface payments.

Required Documentation in Patient's Medical Record

- For any DMEPOS item to be covered by Medicare, the patient's **medical record must contain sufficient documentation** of the patient's medical condition to substantiate the necessity for the type and quantity of items ordered and for the frequency of use or replacement (if applicable). The information should include the patient's diagnosis and other pertinent information including, but not limited to, duration of the patient's condition, clinical course (worsening or improvement), prognosis, nature and extent of functional limitations, other therapeutic interventions and results, past experience with related items, etc.
- Suppliers should note that neither physicians' orders, nor supplier-prepared statements, nor physician attestations by themselves provide sufficient documentation of medical necessity, even though they may be signed by the treating physician or supplier. **There must be information in the patient's medical record that supports the medical necessity for the item and substantiates the answers on the CMN** (if applicable) or DIF (if applicable) or information on a supplier prepared statement or physician attestation (if applicable). (See *Medicare's Program Integrity Manual* (PIM), Chapter 3 (http://www.cms.gov/manuals/downloads/pim83c03.pdf), Section 3.4.1.1, for additional instructions, regarding review of documentation during pre- and post-payment)
- The patient's medical record is not limited to the physician's office records. It may include hospital, nursing home, or home health agency (HHA) records and records from other health care professionals.
- The documentation in the patient's medical record does not have to be routinely sent to the supplier or to the DME MACs, DME Program Safeguard Contractors (PSCs), or Zone Program Integrity Contractors (ZPICs). However, the DME MACs, DME PSCs, or ZPICs may request this information in selected cases.

Required Supplier's Documentation

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

Medicare Coverage of Support Surfaces

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

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

- **GROUP 1 -** A group 1 support surface is covered if the patient is completely immobile. Otherwise, he or she must be partially immobile, or have any stage pressure ulcer and demonstrate one of the following conditions: impaired nutritional status, incontinence, altered sensory perception, or compromised circulatory status. A physician order must be obtained prior to delivery of the equipment and should be kept on file by the supplier.
- **GROUP 2 -** A group 2 support surface is covered if the patient has a stage II pressure sore located on the trunk or pelvis, has been on a comprehensive pressure sore treatment program (which has included the use of an appropriate group 1 support surface for at least one month), and has sores which have worsened or remained the same over the past month. A group 2 support surface is also covered if the patient has large or multiple stage III or IV pressure sores on the trunk or pelvis, or if he or she has

had a recent mycutaneous flap or skin graft for a pressure sore on the trunk or pelvis and has been on a group 2 or 3 support surface.

- **GROUP 3 –** A group 3 support surface is covered if the patient has a stage III or stage IV pressure ulcer, is bedridden or chair-bound, would be institutionalized without the use of the group 3 support surface, the patient is under the close supervision of the patient's treating physician, at least one (1) month of conservative treatment has been administered (including the use of a group 2 support surface), a caregiver is available and willing to assist with patient care and all other alternative equipment has been considered and ruled out.

Additional Information

For more information regarding Documentation, refer to the *PIM*, Chapter 5 (http://www.cms.gov/manuals/downloads/pim83c05.pdf) on the CMS website. In addition, the DME MAC LCDs - Pressure Reducing Support Surface – Group 1, Pressure Reducing Support Surface – Group 2, Pressure Reducing Support Surface – Group 3 may be found on the CMS Medicare Coverage Database at http://www.cms.gov/mcd (search "support surfaces").

Providers may also want to review the Office of Inspector General (OIG) report, Inappropriate Payments for Pressure Reducing Support Surfaces OEI-02-07-00420. This report may be viewed at http://www.oig.hhs.gov/oei/reports/oei-02-07-00420.pdf.

Therapeutic Shoes – Policy Revision / Documentation Requirements

A revision of the Therapeutic Shoes Policy Article (PA) has been released. In addition, the following revision to the Documentation Requirements section of the LCD is being made. It will be incorporated in a subsequent revision of the Therapeutic Shoes LCD.

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

If the prescribing physician is the supplier, a separate order is not required, but the item provided must be clearly noted in the patient's record.

A new order is not required for the replacement of an insert or modification within one year of the order on file. However, the supplier's records should document the reason for the replacement. A new order is required for the replacement of any shoe. A new order is also required for the replacement of an insert or modification more than one year from the most recent order on file. For claims with dates of service on or after January 1, 2011, the detailed written order must be signed on or after the date of the visit with the Prescribing Physician (see related Policy Article for information about the visit with the Prescribing Physician).

The supplier must obtain a signed statement from the physician who is managing the patient's systemic diabetes condition (i.e., the certifying physician) specifying that the patient has diabetes mellitus, has one of conditions 2a–2f listed in the related Policy Article, is being treated under a comprehensive plan of care for his/her diabetes, and needs diabetic shoes. The certifying physician must be an M.D. or D.O and may not be a podiatrist, physician assistant, nurse practitioner, or clinical nurse specialist. The "Statement of Certifying Physician for Therapeutic Shoes" form (see LCD Attachments section below) is recommended. Whatever form is used must contain all of the elements contained on the recommended form attached to this LCD. This statement must be completed, signed, and dated by the certifying physician and must be received by the supplier prior to claim submission. A new Certification Statement is required for a shoe, insert or modification provided more than one year after the most recent Certification Statement on file.

There must be information in the medical records of the certifying physician that:

a. Documents management of the patient's diabetes; and

b. Documents detailed information about the condition (2a–2f listed in the related Policy Article) that qualifies the patient for coverage.

The Certification Statement by itself does not meet this requirement for documentation in the medical records.

The in-person evaluation of the patient by the supplier at the time of selecting the items that will be provided (refer to related Policy Article, Non-Medical Necessity Coverage and Payment Rules, criterion 4) must include at least the following:

1. An examination of the patient's feet with a description of the abnormalities that will need to be accommodated by the shoes/inserts/modifications.
2. For all shoes, taking measurements of the patient's feet.
3. For custom molded shoes (A5501) and inserts (A5513), taking impressions, making casts, or obtaining CAD-CAM images of the patient's fee that will be used in creating positive models of the feet.

The in-person evaluation of the patient by the supplier at the time of delivery (refer to related Policy Article, Non-Medical Necessity Coverage and Payment Rules, criterion 5) must be conducted with the patient wearing the shoes and inserts and must document that the shoes/inserts/modifications fit properly.

The ICD-9 code that justifies the need for these items must be included on the claim.

These revisions address two main areas:

- In-person fitting and delivery. This requirement is included in the DMEPOS Quality Standards published in October 2008. This policy revision incorporates information that was published in an article in May 2010.

COVERAGE CONT'D

- Certification statement. The Medicare statute – Social Security Act, Title XVIII, Section 1861(s)(12) – states that the physician who is managing the individual's diabetic condition must (1) document that the patient has one of several specified conditions that predispose the patient to diabetic ulcers of the feet and (2) certify that the individual needs therapeutic shoes and inserts under a comprehensive plan of care related to their diabetes. The DME MACs have received a number of questions relating to the timing and sequencing of visits and other activities related to this requirement. The policy revision clarifies these requirements.

The statute, national policy, and LCD/PA identify three entities involved in the provision of therapeutic shoes: Certifying Physician, Prescribing Physician, and Supplier. Definitions of these entities are found in the Therapeutic Shoes Policy Article. The following table summarizes the sequence and timing of the various steps required for the coverage of therapeutic shoes and inserts.

Note: The information contained in this article is only a summary of requirements. For complete information, you must review the entire LCD and Policy Article

	Activity	Responsible Person	Requirements[1]
1	Visit to document diabetes management2	Certifying MD/DO	Within 6 months prior to delivery
2	Visit to document qualifying foot condition2	Certifying MD/DO, other MD/DO, DPM, PA, NP, CNS	Within 6 months prior to delivery
3	Completing Certification Statement	Certifying MD/DO	After visit(s) to document diabetes management and qualifying foot condition[2] After Certifying Physician reviews and signs report of visit documenting qualifying foot condition by other MD/DO, DPM, PA, NP, CNS – if applicable[3] Prior to initial provision of shoes and inserts For subsequent provision of shoes and inserts, required if delivery is more than 1 year after most recent Certification Statement
4	Providing dispensing order to supplier[4]	Prescribing physician	After visit with Prescribing physician Before delivery
5	Signing detailed written order	Prescribing physician	After visit with Prescribing physician
6	Selection visit	Supplier	
7	Delivery visit	Supplier	After selection visit After receiving dispensing order or detailed written order
8	Submitting claim	Supplier	After delivery After receiving detailed written order After receiving Certification Statement

1. If the table states that one event needs to occur "before" or "after" another event, both could occur on the same date if that sequence was followed
2. Effective for dates of service on/after 01/01/2011
3. Applicable if qualifying foot condition is not documented on visit with Certifying Physician
4. Separate dispensing order not needed if detailed written order received by supplier prior to delivery

Urethral Inserts – A4336 – Coverage and Documentation

Urethral inserts (A4336) are covered for adult females with stress incontinence when basic coverage criteria are met and the patient or caregiver can perform the procedure. They are not indicated for women:

- With bladder or other urinary tract infections (UTI)
- With a history of urethral stricture, bladder augmentation, pelvic radiation or other conditions where urethral catheterization is not clinically advisable
- Who are immunocompromised, at significant risk from UTI, interstitial cystitis, or pyleonephritis, or who have severely compromised urinary mucosa
- Unable to tolerate antibiotic therapy
- On anticoagulants
- With overflow incontinence or neurogenic bladder

If requested, the medical record must contain information that substantiates the need for this item.

This coverage expansion will be incorporated into the next revision of the Urological Supplies LCD.

Refer to the Urological supplies LCD and Policy Article for additional information.

October 2010 ASP Files and Updated 2009 and 2010 ASP Files Now Available

CMS has posted the October 2010 Average Sales Price (ASP) and Not Otherwise Classified (NOC) pricing files and crosswalks.

CMS has also posted the updated pricing files for July 2010, April 2010, January 2010, and October 2009.

All are available for download at: http://www.cms.gov/McrPartBDrugAvgSalesPrice/ (see left menu for year-specific links).

Notification of Immunosuppressive Drug Prepayment Review

NAS Jurisdiction D DME MAC Medical Review will be initiating a widespread prepayment review of claims for HCPCS codes J7507 (Tacrolimus), J7517 (Mycophenolate Mofetil), J7518 (Mycophenolate Acid), and J7520 (Sirolimus). 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 codes J7507, J7517, J7518, and J7520 are subject to this review. Suppliers who submitted the claims randomly selected in the review 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 Immunosuppressive Drugs Local Coverage Determination (LCD) L68 and Immunosuppressive Drugs Policy Article A25366. Suppliers can review the Immunosuppressive Drug documentation checklist on the NAS website at https://www.noridianmedicare.com/dme/coverage/checklists.html.

Information about 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.

Budesonide (J7626) and Arformoterol (J7605) – Notification of Prepayment Review

NAS Jurisdiction D DME MAC Medical Review is initiating a widespread prepayment review of claims for HCPCS J7626 (Budesonide) and J7605 (Arformoterol). Widespread reviews are used to determine the extent of potential problem areas across multiple suppliers. This review is being initiated based on the analysis of Comprehensive Error Rate Testing (CERT) errors.

In order to evaluate compliance with Medicare coverage and coding rules, all suppliers billing J7626 or J7605 to Jurisdiction D are subject to this review. Suppliers of the selected claims for review will receive an *Additional Documentation Request* (ADR) letter asking for specific information to determine if the item billed complies with the 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 instructions for submitting documentation.

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

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

Oral Anticancer Drugs – Covered Diagnoses

In March 2010, a revised medical policy on Oral Anticancer Drugs was published with an effective date of June 1, 2010. That policy revision defined the ICD-9 diagnosis codes for which each drug would be covered. The policy was revised to be consistent with Medicare's national coverage policy for Off-Label Use of Drugs and Biologicals in an Anti-Cancer Chemotherapeutic Regimen. That policy is found in the Medicare Benefit Policy Manual, Publication # 100-02, Chapter 15, Section 50.4.5: http://www.cms.gov/Manuals/IOM/list.asp.

That policy states that off-label indications are covered in two general situations:

1. The use is (a) supported in any of the following four compendia:
   - National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium – Category 1 or 2A
   - American Hospital Formulary Service – Drug Information
   - Thomson Micromedex DrugDex – Class I, IIa, or IIb
   - Clinical Pharmacology

   and (b) not listed as unsupported/ not medically accepted in any of the compendia (e.g., Category 3 in NCCN or Class III in DrugDex).
2. The Medicare contractor makes a determination based on its analysis of the published literature from one or more of the 26 journals listed in that section.

A further revision of the Oral Anticancer Drugs Policy Article is being released with the addition of a number of ICD-9 codes. The effective date of this expanded list of diagnosis codes is retroactive to June 1.

If suppliers or physicians think that there are additional diagnoses that meet the criteria defined in the Medicare Benefit Policy Manual, they may send documentation to:

Richard W. Whitten, MD, FACP
Medical Director, DME MAC Jurisdiction D
Noridian Administrative Services
PO Box 6727
Fargo, ND 58108-6727

The documentation should be copies of either the pertinent sections of one of the four compendia or full text versions of published articles from the specified journals. The preference is that these be electronic documents submitted on a disc; however, hard copy printouts are also acceptable.

Suppliers should refer to the Oral Anticancer Drugs Local Coverage Determination and Policy Article for complete information concerning coverage criteria, coding guidelines, and documentation requirements.

Oral Anticancer Drugs – Covered Diagnoses

In March 2010, a revised Oral Anticancer Drugs Policy Article was published with an effective date of June 1, 2010. That policy revision defined the ICD-9 diagnosis codes for which each drug would be covered. A revision of the Policy Article with a significantly expanded list of covered diagnoses is planned for release on August 12. NAS had not yet implemented these system changes so there were no denials for NAS claims based on this Policy Article. NAS will make these system changes at one time after the revised, expanded list of diagnoses is available for the revised Policy Article next week.

If suppliers have submitted claims for oral anticancer drugs with dates of service on or after June 1 that have been denied as noncovered by any of the other DME MACs (since NAS had not yet implemented these changes), once the revised policy is finalized the DME MAC will identify those claims and will adjust them if appropriate based on the additional diagnoses in the revised policy. Suppliers should not submit redetermination requests for those claims.

Pharmacies are encouraged to assure that beneficiaries continue to receive the chemotherapy drugs that are ordered by their physicians.

Treprostinil Inhalation Solution (Tyvaso®) - Coding and Coverage

Effective for dates of service on or after July 31, 2009, treprostinil inhalation solution and the nebulizer and related accessories used to administer it are covered for the treatment of patients with primary pulmonary hypertension (ICD-9 diagnosis codes 416.0 and 416.8) and who meet the criteria for iloprost as described in the Nebulizers LCD.

Treprostinil inhalation solution is coded J7699KO. One unit of service equals one ampule. The claim should identify the name of the drug and the number of ampules dispensed. The submitted charge for J7699KO should just reflect the drug itself - not the nebulizer or accessories.

The Optineb® ir (Nebu-tec) nebulizer used to administer treprostinil inhalation should be billed with code E0574 (ultrasonic nebulizer). Because E0574 is in the capped rental category, in order for it to be paid by Medicare, it must be billed as a rental (RR modifier). If the Optineb® ir nebulizer is billed as a purchase (NU modifier), it will be denied and the drugs and accessories will also be denied. The submitted charge for code E0574 should just reflect the charges for the nebulizer - not the drug or accessories.

If two Optineb® ir nebulizers are provided and the submitted charges reflects two nebulizers, you must bill 2 units of service on the claim line for E0574RR. Medicare will only pay for one nebulizer.

Accessories used in conjunction with the Optineb® ir nebulizer should be billed on separate claim lines. The dome and mouthpiece should be billed with code A7016. Other accessories should be billed with code A9999. When code A9999 is used, the claim must clearly describe the type and quantity of accessories provided.

This information will be added to the next revision of the Nebulizers policy. For additional coverage, coding, and documentation requirements, suppliers should refer to the Nebulizer LCD and related Policy Article on the DME MAC websites.

Discarded Drugs and Biologicals Policy at Contractor Discretion

MLN Matters® Number: MM7095
Related Change Request (CR) #: 7095
Related CR Release Date: August 20, 2010
Related CR Transmittal #: R758OTN
Effective Date: July 30, 2010
Implementation Date: September 21, 2010

Provider Types Affected

Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs), A/B Medicare Administrative Contractors (A/B MACs) and/or durable medical equipment (DME) MACs) for drugs or biologicals administered to Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 7095 which is being issued in response to inquiries related to CR 6711 pertaining to the use of the JW modifier (drug or biological amount discarded/not administered to any patient) for discarded drugs and biologicals.

CR 7095 instructs that each Medicare contractor 1) has the individual discretion to determine whether the JW modifier is required for any claims with discarded drugs including the specific details regarding how the discarded drug information should be documented and applied on the claim; and 2) will notify their respective providers of such requirements associated with the use of the JW modifier.

Your Medicare contractor will provide you with details concerning the use of the JW modifier for discarded drugs and biological. Be sure to follow those requirements.

Background

Previously, the Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 6711 (see the MLN Matters® article related to CR 6711 at http://www.cms.gov/MLNMattersArticles/downloads/MM6711.pdf on the CMS website)) which updated the Medicare Claims Processing Manual (Chapter 17, Section 40) and provided policy on the appropriate use of the JW modifier (drug or biological amount discarded/not administered to any patient) for discarded drugs or biologicals. After issuing CR 6711, CMS received several inquiries from various providers regarding how the JW modifier is to be used for their Medicare Part B drug claims.

CR 7095 is being issued in response to these inquiries, and it instructs that each Medicare contractor:

- Has the individual discretion to determine whether the JW modifier is required for any claims with discarded drugs including the specific details regarding how the discarded drug information should be documented and applied on the claim; and
- Will notify their respective providers of such requirements associated with the use of the JW modifier.

Additional Information

The official instruction, CR 7095, issued to your carrier, FI, A/B MAC, or DME MAC regarding this change may be viewed at http://www.cms.gov/Transmittals/downloads/R758OTN.pdf on the CMS website.

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

MLN Matters® Number: MM7188
Related Change Request (CR) #: 7188
Related CR Release Date: October 15, 2010
Related CR Transmittal #: R2067CP
Effective Date: January 1, 2011
Implementation Date: January 3, 2011

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 7188 and instructs Medicare contractors to download and implement the January 2011 ASP drug pricing file for Medicare Part B drugs; and, if released by the Centers for Medicare & Medicaid Services (CMS), also the revised October 2010, July 2010, April 2010, and January 2010 files. Medicare will use these files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after January 3, 2011, with dates of service January 1, 2011, through March 31, 2011. See the Background and Additional Information Sections of this article for further details regarding these changes.

Background

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

DRUGS/BIOLOGICALS CONT'D

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

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

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

Additional Information

The official instruction (CR 7188) issued to your Medicare MAC, carrier, and/or FI may be found at http://www.cms.gov/Transmittals/downloads/R2067CP.pdf on the CMS website.

PAP DEVICES

PAP Documentation Requirement Revision – Ineffective Therapy on E0601

Recently questions have been received by the Durable Medical Equipment Medicare Administrative Contractor (DME MAC) medical directors regarding the requirements in the Positive Airway Pressure (PAP) local coverage determination (LCD) for documentation of ineffective therapy while on an E0601 device. To clarify when a patient may switch from an E0601 to an E0470 device, the following language will replace the current verbiage in the Documentation Requirements section in an upcoming revision of the PAP LCD. The change will be effective for dates of service on or after August 1, 2010.

Revised Language:

For beneficiaries changing from an E0601 to E0470 due to ineffective therapy while on E0601 (either during a facility-based titration or in the home setting), the treating physician must document that both of the following issues were addressed prior to changing to an E0470 device:

A. Interface fit and comfort. An appropriate interface has been properly fit and the beneficiary is using it without difficulty. This properly fit interface will be used with the E0470 device; and,

B. E0601 pressure settings. The current pressure setting of the E0601 prevents the beneficiary from tolerating the therapy and lower pressure settings of the E0601 were tried but failed to:

1. Adequately control the symptoms of OSA; or,
2. Improve sleep quality; or,
3. Reduce the AHI/RDI to acceptable levels.

For additional coverage, coding and documentation requirements, suppliers should refer to the PAP LCD and related Policy Article on the DME MAC web sites.

OXYGEN

Break in Need/Break in Billing for Oxygen

The differences between break in need and break in billing for oxygen are described. Claim submission suggestions are also provided.

Break in Medical Necessity (Break in Need)

- If need /use of oxygen ends for less than 60 days plus the remainder of the rental month of discontinuation and then resumes, payment resumes where it left off.
- During the 36-month rental period, if need/use of oxygen ends for more than 60 days plus the remainder of the rental month of discontinuation and new medical necessity is established, a new 36 month rental period would begin. A new initial Certificate of Medical Necessity (CMN) is required to be submitted.
- During months 37-60, if need/use of oxygen ends and new medical necessity is established, a new rental period does not begin. The supplier who provided the oxygen equipment during the 36th rental month must provide all necessary items and services for the duration of the reasonable useful lifetime.

Break in Billing

If the patient enters a hospital, Skilled Nursing Facility (SNF), or joins a Medicare Advantage Plan, i.e., an Health Maintenance Organization (HMO), and continues to need/use oxygen when the patient returns or rejoins Medicare Fee-for Service (FFS), payment resumes where it left off. A new initial CMN is not required and should not be submitted.

Claim Submission

Use the tips below to assist in claim processing:

- Add a comment on the claim line stating "BIN" to indicate break in need, along with an explanation of the change in medical condition and submit a new initial CMN.
- Add a comment on the claim line stating "BIB" to indicate break in billing, along with an explanation for the break in billing.

Billing for Portable Oxygen Contents when Stationary Oxygen has been Discontinued

Noridian Administrative Services (NAS) requests that suppliers include a narrative on claims billed for portable oxygen contents when use of stationary oxygen equipment has been discontinued.

Per the Oxygen Policy Article (A33677), payment for contents (stationary and/or portable) is included in the allowance for stationary equipment. Therefore, if the patient currently has stationary equipment on file that has not yet reached its 36 month cap, contents will be denied as included in the payment for stationary equipment. NAS cannot conclusively identify that the use of stationary equipment has been discontinued prior to its cap unless indicated by the billing supplier. Please include a narrative when billing for portable contents stating, "Stationary Use Discontinued on MM/YYYY". The addition of this narrative will expedite correct claims processing and may prevent denials of oxygen contents.

Oxygen and Oxygen Equipment ACT Q&A July 14, 2010

Prior to taking questions during the July 14, 2010, Ask the Contractor Teleconference (ACT), NAS provided the following updates:

Interactive Voice Response System

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

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

Endeavor

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

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

Suppliers, billers and third parties may register for Endeavor. **Important Note:** Each person accessing Endeavor must register for their own User ID. User IDs cannot be used by more than one person. To register, all you have to do is go to the claims page of our website. Many suppliers are already taking advantage of this new tool and we highly encourage you all to do so as well!

Self-Paced Tutorials

Self-paced tutorials and audio courses are now available on the NAS website on the Training/Events page. There are twelve tutorials which include:

- Advance Beneficiary Notice of Noncoverage (ABN)
- DME Modifiers
- Documentation Prior to DME Claim Submission
- Enteral Nutrition
- Glucose Monitor and Testing Supplies
- Hospital Beds
- Manual Wheelchairs
- Ostomy Supplies
- Basics of Medicare and DME
- DME Email Updates
- Upgrades
- Refractive Lenses

Three audio courses have been developed:

- ABN
- Glucose Monitors and Testing Supplies
- Ostomy Supplies

Additional tutorials are being developed based on data analysis, CERT errors, and supplier input.

Email Updates

NAS encourages everyone to have Medicare DME information delivered to you in a timely, categorized, summarized, convenient format by signing up for our DME email listserv. Benefits of becoming a subscriber include having the latest information from NAS and CMS delivered to you each Tuesday and Friday. This is a great way to keep current with Medicare regulations, workshop and educational events, Medical policy updates, and payment/reimbursement updates. https://www.noridianmedicare.com/dme/news/docs/email_brochure.pdf

PECOS

NAS would like to remind suppliers that Phase 2 of CR6421 (Expansion of the Current Scope of Editing for Ordering/Referring Providers for DMEPOS Suppliers') is still delayed. Edits to deny claims for referring physician and non-physician practitioners who are not enrolled in PECOS will not be denied until January 3, 2011. Although enrolled in Medicare, some physicians and non-physician practitioners who are eligible to order items do not have current enrollment records in PECOS. Suppliers are encourage to verify with their referral sources their legal names, NPI and that the physician or non-physician practitioner is not being excluded from the Medicare program.

Questions received prior to the call:

Q1. To bill for maintenance and servicing of oxygen concentrators and/or transfill equipment, at what point in the 6-month period must I have actually serviced the equipment?

A1. Effective July 1, 2010, the supplier must service the equipment in the first month, six months after the 36-month cap or at the end of the warranty period, whichever is later. Please refer to MLN Matters Article 6990 posted to the NAS website on June 18, 2010 This article provides clarification regarding date of service (DOS) for maintenance and servicing (M&S) to eligible pieces of equipment and further discusses unavoidable delays in servicing due to hospitalization or the beneficiaries being out of the service area.

Q2. Does Medicare pay for E1392 (Portable concentrator) or is it considered a convenience item?

A2. If ordered by the treating physician, all coverage criteria have been met and the qualifying blood gas study was taken at rest or during exercise (not during sleep), Medicare coverage is allowed for the E1392.

Q3. If one of my Kansas oxygen patients moves to Florida after I've received the 36-month cap payment, I still have to provide oxygen content for liquid or gas systems and any other necessary supplies to the beneficiary in Florida. What if I am not licensed in Florida?

A3. The supplier who received the 36-month payment must make arrangements for the beneficiary in Florida. The Kansas supplier can either deliver the items or have a different supplier deliver the content and supplies and bill Medicare themselves.

Q4. The following Q&A was published from the ACT in February 2010, but I find it confusing:

> **Q26. I have a patient whose oxygen portable system capped on January 9, 2009, and also reached it's RUL in March 2009. He added an oxygen concentrator in August 2008. When is a recertification required on the concentrator? Is this separate now that the portable is capped?**
>
> **A26. A recertification for the concentrator would not be required. The portable recertification that is already on file would also recertify the concentrator that was added at a later date.**
>
> **If an oxygen concentrator was added in August 2008, then a revised Certificate of Medical Necessity (CMN) would be required. But if the portable system reached its reasonable userful lifetime (RUL) in March 2009, then the portable recertification would have occurred March 2005 or so. If I follow the logic of the question and the answer, then essentially there is no CMN on file that lists the concentrator. Is that correct?**

A4. The answer is correct; a **recertification** would not be required. As indicated in your question, in order for the supplier to have been paid for the concentrator, a revised CMN would have been required but the Recertification requirement would have been satisfied with the previous dispensed portable system.

Q5. Does Medicare pay for A4615 (Nasal cannulas) or A4616 (Tubing) separately or is this always a bundled charge?

A5: All accessories are included in the allowance for rented oxygen equipment. The supplier must provide any accessory ordered by the physician. Accessories used with patient-owned oxygen equipment will be denied as noncovered.

Q6. Does Medicare only pay for one unit of E0431 (Portable gaseous oxygen system) regardless of how many tanks are dispensed? Is there a limit of tanks?

A6: Yes, only one unit of E0431 per month is allowed which includes all the tanks the beneficiary uses.

Q7. We need clarification on the requirements for a revised CMN when the length of need expires. The current Local Coverage Determination (LCD) states that a revised CMN is required when length of need (LON) expires if the physician specified less than lifetime on the most recent CMN. However, we are being told that a recertification CMN is required. Is that correct?

A7. No a recertification is not required to extend the LON. The correct CMN is a Revised. However if the Revised CMN is due at the same time as a Recertification, only a Recertification is required. For example, Recertification is required at 12 months for a Group I beneficiary, if the LON is for 12 months, then the supplier only needs to submit a Recertification.

Q8. If we submitted an electronic initial CMN with errors, but they are not on our hard copy CMN, what do we need to do to correct?

A8. Minor errors and omissions can be corrected through the reopening process. This would need to be sent to NAS as a written Reopening so the hardcopy CMN can be verified.

Q9. Is 12 months a valid LON on a Recertification for a Group I patient? Some representatives tell us to count from the initial date, so if the physician wants the CMN to be for an additional 12 months we must enter 24 months as the LON on the Recertification CMN?

A9. LON is based on the initial date. If the initial CMN originally had 12 months for a Group I patient, and the physician wanted to extend an additional 12 months, he/she should enter 24 months.

Questions and answers taken during the call:

Q10. I have three physicians who are showing up on the PECOS list, but I'm still showing them rejecting on my claims. Is there a way to report these or is there somebody working on that?

A10. PECOS error warning messages that suppliers receive when their physician/referral source is on the CMS Ordering Referring Report should be directed to the Common Electronic Data Interchange (CEDI) Contractor's help desk at 866-311-9184. This allows CEDI to research the actual name and NPI submission.

Q11. We have patients who in the past had a stationary oxygen system but are currently only on a portable system. We begin billing for portable contents once the stationary system is discontinued, but the portable contes were denied. We have been told that we didn't put a narrative on

the claim indicating the concentrator was discontinued. I find nothing in the manual that tells us to do that. What wording is required when this occurs? What is the correct process for this and when will it be included in the manual?

A11. NAS needs to know when the concentrator was discontinued so portable contents can be paid. The LCD does not require a Revised CMN in this case; therefore the supplier must provide a narrative on the first portable oxygen content claim that states "stationary use discontinued as of DATE". NAS will post an educational article informing suppliers the importance of that narrative statement and will include this article in our Oxygen Manual.

Q12. When I bill for an oxygen regulator it denies PR108. Regulators are part of the oxygen equipment I rent. Can I get paid for that item separately? Are conserving devices ever paid?

A12. Accessories, including but not limited to, transtracheal catheters (A4608), cannulas (A4615), tubing (A4616), mouthpieces (A4617), face tent (A4619), masks (A4620, A7525), oxygen conserving devices (A9900), oxygen tent (E0455), humidifiers (E0555), nebulizer for humidification (E0580), regulators (E1353), and stand/rack (E1355) are included in the allowance for rented oxygen equipment. The supplier must provide any accessory ordered by the physician. Accessories used with patient-owned oxygen equipment will be denied as noncovered.

Q13. If a patient lives in Jurisdiction D, but the address that the patient has on file is for Jurisdiction C and the patient chooses not to update their address with Social Security are we still able to use a Jurisdiction C address and bill Jurisdiction C?

A13. Yes. The address submitted on the claim should be the same address on file with Social Security. If the beneficiary's permanent address on file is within Jurisdiction C, that is where the claim should be submitted.

Q14. We have an E1390 and E0431 that has reached the 36-month cap. We are now trying to bill for the portable contents (E0443). The E0443 is being denied for no CMN on file. Do we actually have to have a separate CMN for the contents?

A14. A separate CMN is not needed for portable contents. If claims have been denied, the supplier can contact Reopenings to have them reprocessed. These claims were denied in error.

Q15. When a beneficiary is using and renting a portable system only, or when they own their stationary, can we bill for the contents?

A15. Yes, as long as the beneficiary qualifies for the portable system.

Q16. Oxygen testing during exercise requires three separate saturation or blood gas levels; one at rest, one during exercise, and one during exercise with oxygen applied to show improvement. Could you define improvement? If the saturation went up 1% is that acceptable?

A16. Yes. The policy language indicates there must be improvement; it is not further defined. It may not be clinically sufficient to get where you want to go, but that's left to the treating physician's judgment to determine the appropriate course of treatment.

Q17. My oxygen business is in Missouri. I have a beneficiary that moves to Nevada after the 36-month cap has been paid. If I find another company to provide oxygen and that company bills me and I continue to bill Medicare, am I not in breach of having licensing for that state if I'm billing Medicare for a patient residing in Nevada, a state in which I am not licensed?

A17. NAS would suggest posing this question to your legal counsel. If the beneficiary relocates outside the supplier's service area (either short-term travel, extended temporary relocation, or permanent relocation), the home supplier (the supplier who received the 36th month payment) is required to either provide the equipment and related items/services itself or make arrangements with a different supplier to provide the equipment and related items/services. The only items that can be billed to Medicare are contents and/or Maintenance and Servicing. It is acceptable for the supplier who is providing those items/services to bill Medicare.

Q18. How often is the PECOS physician list on the CMS website updated?

A18. That list is updated periodically by CMS. The most up-to-date information regarding referring physician enrollment status in PECOS can be accessed through the NAS IVR system by selecting provider enrollment (option 7).

Q19. Once the reasonable useful lifetime for oxygen equipment has been reached and the beneficiary agrees to the replacement equipment, is a new prescription required before dispensing the equipment?

A19. A new detailed written order and new initial replacement CMN is required prior to billing for the replacement equipment, not prior to dispensing.

Q20. CR6990 clarified <u>unavoidable</u> delays in M&S of oxygen equipment. Can a supplier decide based on their own scheduling to make the M&S visit after the first month of the six-month period and be reimbursed for that six month period?

For example, four months after the 36-month cap the supplier replaces the beneficiary's current equipment based on the supplier's internal policy to maintain and refurbish equipment after different intervals. The first month 6 months after the 36-month cap would only be two months after that replacement and we feels that would be unnecessary:

- **1/1/2010 36-month cap is reached**
- **5/1/2010 supplier swapped out equipment. (cannot bill M&S because it's within 6 months of the cap)**
- **July would be the first month 6 months after the 36-month cap which instructions indicate is the scheduled month for M&S. However M&S may not be needed until October or November of 2010.**

Can the supplier use the same instructions in this case as indicated below for unavoidable delays?

A20. The exception to making the M&S visit in the first month of a M&S period as set forth in the regulations **only** applies to situations where the visit is delayed beyond the first month for **unavoidable** reasons. The supplier should maintain detailed documentation in their records regarding why the delay was unavoidable. The oxygen equipment M&S regulation at 414.210(e)(5)(iv) requires the supplier to visit the home and inspect the equipment during the first month of each 6-month period. This policy establishes a timeframe so that the equipment is checked at least once every 6 months to ensure that the equipment is functioning properly. The M&S payment is made contingent on the fact that the supplier visits the home in the first month of the 6-month period. Thus, the supplier should make every attempt to make the first month equipment inspection visit during the 6-month periods in accordance with the timeframe set forth in the regulation (i.e., first 6-month period begins 6 months after the last day of the 36th month of the rental payment period or after the warranty coverage expires, whichever is later.) However, in the event of an unavoidable delay (i.e. beneficiary is out-of-town or hospitalized) and the visit occurs sometime after the first month of the original 6-month period or subsequent 6-month periods, the supplier must document the reason for the delay and bill for the M&S payment after the visit is made. Supplier convenience or recent replacement of supplier-owned equipment would not be considered an unavoidable delay and reason to establish a new sequence of 6-month M&S periods outside the regulatory timeframe.

Q21. When a patient has met their five year RUL and they have agreed to a new rental period, a face-to-face visit for the new replacement initial CMN is not required? I know a test isn't required, but don't I have to have a patient chart note to go with the new replacement initial CMN?

A21. There is no requirement for a physician visit that is specifically related to the completion of the Initial or Recertification CMN for replacement equipment. As stated, repeat testing also is not required. Enter the most recent qualifying value and test date. This test does not have to be within 30 days prior to the Initial Date for the replacement equipment. It could be the test result reported on the most recent prior CMN.

Q22. If a range is reported on a beneficiary test, for example oximetry is documented between 87-91 what would the reported number be on the CMN?

A22. The lowest value would be reported, 87.

Q23. In regards to testing during exercise, I understand the policy requires three tests but I thought the third test was to define what liter flow the patient would be prescribed. Is that not true?

A23. Although the prescribed liter flow may be determined, the third test is to demonstrate the improvement of the hypoxemia while exercising with oxygen.

Q24. If a patient is initially tested on four liters of oxygen and they have an 86% SAT, do they also need to be tested on room air for the CMN even if at four liters they're still at 86%?

A24. No, the qualifying blood gas study may be performed while the patient is on oxygen as long as the reported blood gas values meet the Group I or Group II criteria.

Q25. Do contents need to be billed on the anniversary date each month or can it be billed at any time during the following month?

A25. For gas or liquid contents, the date of service should be the day after the end of the 36 month cap, the anniversary date.

Q26. The DOS for contents does not have to be the delivery date?

A26. No. Suppliers must maintain proof of delivery and may deliver up to a three month supplier, but the DOS should remain the anniversary date.

Q27. We sent some oxygen claims electronically and for some reason the CMN wasn't received by Medicare. The claims were denied. Do those have to go through redeterminations/reopenings, or can they just be resubmitted with the CMN attached?

A27. It would depend on the type of denial received. If a "not medically necessary" denial is received (CO50), those cannot be resubmitted, but must go through the Redetermination process. If you received a rejection that indicated missing or invalid information, those can be resubmitted.

Q28. Is there a CMS proposal that once a patient meets 18 months of rental if that patient moves out of our jurisdiction that we're still required to provide oxygen?

A28. NAS is not aware of any specific recommendation.

Q29. Please comment on what charts notes are required for a post-payment review, in addition to the CMNs.

A29. The treating physician answers a series of questions in section B of the CMN. The answers to those questions should be found in the patient's medical record. The patient's medical record may be from the physician's office, the hospital, or other facility. Chart notes from the physician and other clinical personal are found in the medical record. The medical records need to support all the information that is listed on a CMN.

Follow-up question: Is a form the physician fills out a good substitute for medical records? Is there any recourse we can take if a physician is not willing to provide the medical records, saying that nobody else requires that?

Follow-up answer: During a review, clear, thorough medical records are required. NAS has a physician resource page on our website that contains letters written by Dr. Whitten, our Medical Director, designed to help educate physicians regarding documentation requirements to ensure their patients receive Medicare payment for the equipment they are prescribing.

Q30. When a patient moves out of our service area after their 36-month cap and we are unable to find a supplier in their area to service them, what are our options?

A30. The supplier who received the 36-month payment is responsible. You must make arrangements for that beneficiary.

Q31. When a recertification CMN is due, the LCD state a re-evaluation by the physician is required. What information should be included in the doctor's notes for this re-evaluation?

A31. The chart note from the physician visit should indicate the beneficiary still requires the oxygen and is benefiting from home oxygen therapy.

Q32. If a re-evaluation is not required for a replacement CMN, how are we to have chart notes for continued used?

A32. The re-evaluation is not a requirement for the replacement CMNs. The beneficiary may have seen their physician for their annual physical or for another issue where continued use of oxygen was documented. Asking the beneficiary the last time they saw their physician and recommending following up with their physician every year regarding their oxygen for continued use may be a good business practice.

Q33. When a patient is inpatient or in a Skilled Nursing Facility (SNF) and we have to change the anniversary date to their discharge date, how does that affect the recertification date, if it does at all?

A33. It doesn't. The Recertification date is always based on the Initial CMN date. If the patient is inpatient or in a SNF on the anniversary date, the DOS will need to be changed to the date of discharge.

Policy Article Revision – Summary for August 12, 2010

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

Oxygen and Oxygen Equipment
Policy Article
Revision Effective Date: 07/01/2010
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Revised: Coverage for maintenance and servicing, months 37-60.

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

Payment for Replacement of Oxygen Equipment in Bankruptcy Situations

MLN Matters Number: MM6838
Related Change Request (CR) #: 6838
Related CR Release Date: April 30, 2010
Related CR Transmittal #:1961CP
Effective Date: October 1, 2010
Implementation Date: October 4, 2010

Provider Types Affected

Suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) submitting claims to Medicare contractors (Regional Home Health Intermediaries (RHHIs), A/B Medicare Administrative Contractors (MACs) and DME MACs) for oxygen and oxygen equipment provided to Medicare beneficiaries are affected.

Provider Action Needed

This article is based on Change Request (CR) 6838 and informs suppliers of DMEPOS that Medicare contractors may make payment for replacement oxygen equipment in the event that a supplier files for Chapter 7 or 11 bankruptcy in a United States Bankruptcy Court. Please be sure that your billing staffs are aware of this change.

Background

CR 6838 adds Section 50.4 to Chapter 20 of the *Medicare Claims Processing Manual* to provide instructions, regarding payment for the replacement of oxygen equipment in the event that a supplier files for Chapter 7 or 11 bankruptcy under Title 11 of the United States Code and is unable to continue furnishing oxygen and oxygen equipment to patients.

In accordance with 42 CFR Sections 414.210(f) and 414.226(g), payment can be made for replacement of oxygen equipment if the equipment has been in continuous use by the patient for the equipment's reasonable useful lifetime or has been lost, stolen or irreparably damaged, resulting in a new reasonable useful lifetime period and a new 36 month rental payment period.

Payment Documentation Requirements

Medicare contractors are to verify supporting documentation and consider oxygen equipment as lost in certain bankruptcy situations. Payment may then be provided for the replacement of oxygen equipment and a new reasonable useful lifetime period and a 36 month rental payment period may begin on the date that the new, replacement equipment is furnished.

Similar to other situations where oxygen equipment is lost, stolen, or irreparably damaged, the contractor must verify that following claims information is included and valid with the claim:

- The most recent test date and blood gas testing result,
- Oxygen Certificate of Medical Necessity (CMN),
- The Healthcare Common Procedure Coding System (HCPCS) code for the new oxygen equipment (Stationary oxygen equipment - E0424, E0439, E1390, E1391, E1405 or E1406 or Portable oxygen equipment - E0431, E0433, E0434, E1392, or K0738),

- The HCPCS modifier RA (*Replacement of a DME Item*), and
- A narrative describing why the equipment was replaced. **Note:** Proof-of-delivery documentation from the previous supplier is not required.

In addition, the contractor must verify the following information is included and valid to support the supplier declared Chapter 7 or 11 bankruptcy under Title 11 of the United States Code bankruptcy and is unable to continue furnishing oxygen and oxygen equipment to patients:

a. For a Chapter 7 bankruptcy, supporting documentation must include court records documenting that the previous supplier filed a petition for a Chapter 7 bankruptcy in a United States Bankruptcy Court; and

b. For a Chapter 11 bankruptcy, supporting documentation must include court records documenting that the previous supplier filed a petition for a Chapter 11 bankruptcy in a United States Bankruptcy Court, **and** documents filed in the bankruptcy case confirming that the equipment was sold or is scheduled to be sold as evidenced by one of the following:

   - The court order authorizing and/or approving the sale; **or**
   - Supporting documentation that the sale is scheduled to occur or has occurred (e.g., a bill of sale, or an asset purchase agreement signed by the seller and the buyer); **or**
   - A court order authorizing abandonment of the equipment.

Messages for Denied Claims

Contractors will deny claims for replacement oxygen equipment due to bankruptcy if verification of the above supporting documentation is unsuccessful.

When denying claims for replacement oxygen equipment due to insufficient supporting documentation, the following reason and remark codes and messages will be used:

- Group Code CO (Contractual Obligation),
- A1 - Claim/Service Denied,
- N225 - Incomplete/invalid documentation/orders/notes/summary/report/chart, and
- MSN 9.2 - This item or service was denied because information required to make payment was missing. (Este artículo o servicio fue denegado porque la información requerida para hacer el pago fue omitida.).

Note: No payment will be made for replacement equipment when the original supplier divests business and equipment outside of the court bankruptcy process.

Additional Information

The official instruction (CR 6838) issued to your Medicare contractor, regarding this change, may be viewed at http://www.cms.gov/transmittals/downloads/R1961CP.pdf on the CMS website.

Wheelchair Options and Accessories – LT and RT Modifiers

The Wheelchair Options and Accessories Policy Article currently states:

> The right (RT) and left (LT) modifiers must be used when appropriate. If bilateral items (left and right) are provided as a purchase and the unit of service of the code is "each" bill both items on the same claim line using the LTRT modifiers and 2 units of service. If bilateral items are provided as a rental and the unit of service is "each", bill the items on two separate claim lines with the RT modifier on one line and the LT modifier on the other. If bilateral items are provided as a purchase or rental and the unit of service is "pair", bill both items on the same claim line using the LTRT modifiers and 1 unit of service.

The Policy Article is being revised to remove the requirement to report the LT and RT modifiers when the unit of service of the code is "pair". The revised last sentence will state:

> If bilateral items are provided and the unit of service is "pair", the LT and RT modifiers do not need to be reported.

This applies to HCPCS codes E1010 (power leg elevation system), K0020 (fixed, adjustable height armrests), and K0195 (elevating legrests – for use with capped rental wheelchair base).

This change is effective immediately and will be incorporated in a future revision of the Wheelchair Options and Accessories Policy Article.

FAQ – Power Mobility Devices – Supplier ATP Involvement (Revised July 2010)

This is a revision of an article originally published in 2008 and revised in December 2009. It clarifies the requirement in the Power Mobility Devices (PMD) Local Coverage Determination (LCD) that the supplier of a rehab PMD must 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. The term rehab PMD includes Group 2 power wheelchairs (PWCs) with power seating options, all Group 3, 4, and 5 PWCs, and push-rim power assist devices. The response to Q3 has been revised to clarify supplier requirements relating to the DMEPOS Quality Standards.

Q1. What is an ATP?

A. An Assistive Technology Professional (ATP) is a designation of certification by the Rehabilitation Engineering and Assistive Technology Society of North America (RESNA). Prior to January 1, 2009, RESNA maintained two certifications – Assistive Technology Supplier (ATS) and Assistive Technology Practitioner (ATP). Those certifications were combined into one – Assistive Technology Professional (ATP) – with a single certification examination after January 1, 2009. An ATP is a

service provider who analyzes the needs of individuals with disabilities, assists in the selection of appropriate equipment and trains the consumer on how to properly use the specific equipment.

Q2. Why does Medicare require "in-person" involvement in the selection of a rehab wheelchair?

A. As one can see from the description of the ATP in Question 1, the sATP with experience and training in proper assistive technology selection is in an ideal situation to translate the functional information from the licensed certified healthcare professional (LCMP) specialty examination into a specific equipment selection for the beneficiary.

Q3. Clarify "employ" as it relates to an ATP within this policy.

A. The DMEPOS Quality Standards require that a supplier of complex rehab wheelchairs employ (W-2 employee) an individual who has one of the following credentials: ATP or CRTS (Certified Rehabilitative Technology Supplier). This individual may not be a "contract" employee.

However, the supplier could employ additional ATPs to meet the sATP requirement in the PMD LCD. Those additional sATPs could be employed in a full-time, part-time, or contracted capacity, as is acceptable by state law. Those sATPs, if part-time or contracted, must be under the direct control of the supplier when participating in the wheelchair selection.

Q4. If a supplier has a part time or contracted ATP on staff, what type of special documentation would be needed in an audit to prove the credential?

A. A supplier must show that the employee was working under the supplier's control and guidance. The supplier should also be able to provide evidence of the sATP certification upon request.

Q5. Would a supplier be asked to provide employment records in an MR audit?

A. Yes, employment records, contracting agreements or credential records could be requested. These types of records do not need to be routinely submitted with a claim but must be available upon request.

Q6. What does it mean for the sATP to have direct, in-person involvement in the wheelchair selection process?

A. It means to physically see and interact with the patient and to document that involvement. It is important that the record show how the sATP was involved.

Q7. Can the sATP sign off on the licensed/certified medical professional (LCMP) evaluation, detailed product description, or some other attestation to demonstrate compliance with the requirement?

A. The medical policy does not mandate how suppliers document compliance with the ATP requirement. There must be evidence in the supplier's file of direct in-person interaction with the patient by the sATP in the wheelchair selection process. The supplier, LCMP or treating physician must document how the sATP is involved with the patient. The documentation must be complete and detailed enough so a third party would be able to understand the nature of the sATP involvement and to show that the standard was met. Just "signing off" on a form completed by another individual would not adequately document direct, in-person involvement. For example, if the sATP participates in the specialty evaluation conducted in a multi-specialty clinic, the sATP could request that the person conducting and documenting the specialty evaluation include their name and credentials in the final report - "Ms. Jones was evaluated today for a power mobility device. Taking part in the evaluation was Dr. Smith, Ann Jones, PT, and Bill Doe, ATP from XYZ Mobility." As an alternative, the sATP can create a note documenting their involvement in the specialty evaluation process and that the recommendations reflect their input.

Q8. If the sATP is not present at the specialty evaluation with the therapist or physiatrist, but does assess the patient "in person" following the evaluation by the LCMP, such as during the home evaluation, does this fulfill the requirement for "involvement with the selection process"?

A. If the sATP has direct contact with the patient and has been involved in the wheelchair selection process, the requirement is met, providing that the sATP interaction is clearly documented within the patient's file. If the sATP has not had direct in-person involvement in the wheelchair selection process, the requirement is not met and the KX modifier must NOT be added to the code.

Q9. How should the sATP document their involvement if their evaluation takes place at the office or the beneficiary's home?

A. A critical component in the provision of a PMD is ensuring that the wheelchair and accessories selected are appropriate for the beneficiary and meet their unique, individual needs. This often includes taking trunk and limb measurements, seating and positioning needs, and other observations about the beneficiary and their ability to use a PMD. This interaction should be documented by the sATP conducting the evaluation and signed and dated by the sATP, including their credentials.

Q10. Must the sATP be present for the delivery, fitting, and/or patient training for the wheelchair provided?

A. The policy states that the credentialed sATP must have direct, in-person involvement with the equipment selection process. The policy does not require that the sATP be present for delivery, fitting, and/or patient training for the wheelchair.

Q11. Can the sATP evaluation be conducted at the time of the PMD delivery to the beneficiary?

A. No. The purpose of the sATP evaluation is determining the proper seating, accessories and other components of the PMD prior to ordering and delivery; therefore, conducting this evaluation at the time of delivery of the device to the beneficiary's residence is not consistent with the intent of this requirement.

Q12. A company employs an ATP, as well as a number of non-credentialed staff who have direct, in-person involvement with the selection process. Is it permissible for the sATP to review the staff's recommendations and sign concurrence to meet the requirement?

A. The sATP must have direct in-person involvement with the wheelchair selection process. An sATP cannot simply "review" and "sign off" on non-credentialed staff work in order to meet the requirement.

Q13. Can the sATP select a product prior to the face-to-face (F2F) examination by the physician and/or prior to the specialty evaluation by the LCMP?

A. Since the role of the sATP is to assure that the equipment selected is appropriate to address the medical needs identified during the F2F examination and specialty evaluation process, it would be inappropriate to begin product selection prior to completion of the F2F examination or specialty evaluation. Any in-person sATP/beneficiary interactions prior to the F2F examination or specialty evaluation would not be considered sufficient to meet the LCD requirement.

Q14. An ATP candidate has taken the RESNA exam but at the time of the in-person evaluation has not yet received the credential. In the event of an audit, will the pending receipt of the sATP credential, retroactively dated to the day the test was taken, be considered compliant?

A. The LCD requires that there must have been an evaluation by a properly credentialed, supplier-employed ATP. The sATP must have been certified as of the date he/she performed the in-person evaluation of the patient. The sATP is not a credentialed ATP until receipt of the credential from RESNA. The RESNA document will specify the effective date of the credential.

Q15. If an ATP employed by a supplier who has had direct in-person involvement in the wheelchair selection process for a patient leaves a company before the wheelchair is delivered, will the claim be considered compliant?

A. Leaving the company employment would not invalidate what that person did while working as a RESNA-certified ATP. The patient's record must illustrate the previously employed sATP had in-person involvement with the wheelchair selection process.

Q16. Can an sATP perform any part of the F2F examination process required for all PMDs or the specialty evaluation required for rehab wheelchairs?

A. No.

Q17. If the sATP participated in the evaluation by means of a live video feed, would that be acceptable?

A. Yes. Involvement of the sATP in the evaluation of the patient via a live video feed is acceptable for beneficiaries who reside in remote locations as long as the evaluation is conducted in accordance with the Telehealth requirements outlined in the Centers for Medicare and Medicaid Services (CMS) Benefit Policy Manual (Internet-Only Manual 100-2), Chapter 15, Section 270.