Jurisdiction D News from Noridian Administrative Services, LLC.

Happenings

April 2009
Issue No. 20

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

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Don't be left in the dark. Sign up for the NAS e-mail listing to receive updates that contain the latest Medicare news. Visit the NAS Web site 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

Web site: www.noridianmedicare.com

Fax	
Reopenings and Redeterminations	888-408-7405
Administrative Simplification Compliance Act (ASCA)	888-523-8449
Refunds to Medicare	888-529-3666
MSP Inquires and Refunds	888-535-5114
ADMC Requests/Documentation	877-662-8445
Medical Review Medical Documentation	866-465-0213
CERT Medical Documentation	877-436-4479

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

Mailing Addresses	
Claims, Redetermination Requests, Correspondence and Medical Review Documentation Noridian Administrative Services PO Box 6727 Fargo ND 58108-6727	**Advance Determination of Medicare Coverage Requests** Noridian Administrative Services Jurisdiction D DME Medical Review PO Box 6747 Fargo ND 58108-6747
Administrative Simplification Compliance Act Exception Requests Noridian Administrative Services PO Box 6737 Fargo ND 58108-6737	**Benefit Protection** Noridian Administrative Services Benefit Protection-DME PO Box 6736 Fargo ND 58108-6736
Electronic Funds Transfer Forms / Overpayment Redeterminations Noridian Administrative Services PO Box 6728 Fargo ND 58108-6728	**Qualified Independent Contractor** RiverTrust Solutions, Inc. PO Box 180208 Chattanooga TN 37401-7208

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

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

Holiday Schedule

NAS offices will be closed on the days listed below except for the federal holidays noted with a (*). These federal holidays are days that the NAS offices will be open and the Contact Center representatives will be available from 12:00 - 5:30 p.m. CT.

Holiday	Date
Memorial Day	May 25, 2009
Independence Day	July 3, 2009
Labor Day	September 7, 2009
Columbus Day *	October 12, 2009
Veterans Day *	November 11, 2009
Thanksgiving	November 26 and 27, 2009
Christmas Eve **	December 24, 2009
Christmas Day	December 25, 2009
** Partial day closure	

Sources for "Jurisdiction D Happenings" Articles

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

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

Medicare Learning Network Matters Disclaimer Statement

Below is the 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."

Interactive Voice Response Tax Identification Number Implementation on April 6, 2009

In accordance with CR 6139, on April 6, 2009, suppliers are required to provide the last 5-digits of their Tax Identification Number (TIN) along with their National Provider Identifier (NPI) and Provider Transaction Access Number (PTAN) when accessing the Interactive Voice Response (IVR) line.

The IVR can be accessed by calling 1-877-320-0390. If you experience any difficulty accessing the IVR after 7:00 a.m., please call the Contact Center at 1-866-243-7272 to report the issue.

For instructions on using the IVR, please see the IVR Guide and IVR At-A-Glance brochure. These resources were updated on April 6, 2009, to reflect the new TIN requirement.

Implementation of New Provider Authentication Requirements for Medicare Contractor Provider Telephone and Written Inquiries

MLN Matters Number: MM6139 Revised
Related Change Request (CR) #: 6139
Related CR Release date: March 4, 2009
Related CR Transmittal #: R25COM
Effective Date: April 6, 2009
Implementation Date: April 6, 2009 for providers

Note: This article was revised on March 5, 2009 to reflect the revised CR 6139, which CMS re-issued on March 4, 2009. (The effective and implementation dates for providers were previously changed to April 6, 2009 by Transmittal R23COM on February 10.) In this revision of the article, the CR release date, transmittal number, and the Web address of the CR have been changed. All other information remains the same.

Provider Types Affected
CR 6139 impacts all physicians, providers, and suppliers (or their staffs) who make inquiries to Medicare contractors (carriers, Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), Medicare Administrative Contractors (A/B MACs), or Durable Medical Equipment Medicare Administrative Contractors (DME MACs)). Inquiries include written inquiries or calls made to Medicare contractor provider contact centers, including calls to Interactive Voice Response (IVR) systems.

What You Need to Know
CR 6139, from which this article is taken, addresses the necessary provider authentication requirements to complete IVR transactions and calls with a Customer Service Representative (CSR).

Effective April 6, 2009, when you call either the IVR system, or a CSR, the Centers for Medicare & Medicaid Services (CMS) will require you to provide three data elements for authentication: 1) Your National Provider Identifier (NPI); 2) Your Provider Transaction Access Number (PTAN); and 3) The last 5-digits of your tax identification number (TIN).

Make sure that your staffs are aware of this requirement for provider authentication.

Background
In order to comply with the requirements of the Privacy Act of 1974 and of the Health Insurance Portability and Accountability Act, customer service staff at Medicare fee-for-service provider contact centers must properly authenticate callers and writers before disclosing protected health information.

Because of issues with the public availability of previous authentication elements, CMS has addressed the current provider authentication process for providers who use the IVR system or call a CSR. To better safeguard providers' information before sharing information on claims status, beneficiary eligibility, and other provider related questions, CR 6139, from which this article is taken, announces that CMS has added the last 5-digits of the provider's TIN as an additional element in the provider authentication process. Your Medicare contractor's system will verify that the NPI, PTAN, and last 5-digits of the TIN are correct and belong to you before providing the information you request.

Note: You will only be allowed three attempts to correctly provide your NPI, PTAN, and last 5-digits of your TIN.

As a result of CR 6139, the Disclosure Desk Reference for Provider Contact Centers, which contains the information Medicare contractors use to authenticate the identity of callers and writers, is updated in the Medicare Contractor Beneficiary and Provider Communications Manual, Chapter 3 (Provider Inquiries), Section 30 (Disclosure of Information) and Chapter 6 (Provider Customer Service Program), Section 80 (Disclosure of Information) to reflect these changes.

New information in these manual chapters also addresses other authentication issues. This new information is summarized as follows:

- Authentication of Providers with No NPI
  Occasionally, providers will never be assigned an NPI (for example providers who are retired/terminated), or inquiries may be made about claims submitted by a provider who has since deceased.

  Most IVRs use the NPI crosswalk to authenticate the NPI and PTAN. The NPI is updated on a daily basis and does not maintain any history about deactivated NPIs or NPI/PTAN pairs. Therefore, if a provider enters an NPI or NPI/PTAN pair that is no longer recognized by the crosswalk, the IVRs may be unable to authenticate them; or if the claim was processed using a different NPI/PTAN pair that has since been deactivated, the IVR may not be able to find the claim and return claims status information.

  Since these types of inquiries are likely to result in additional CSR inquiries, before releasing information to the provider, CSRs will authenticate using at least two other data elements available in the provider's record, such as provider name, TIN, remittance address, and provider master address.

- **Beneficiary Authentication**
  Before disclosing beneficiary information (whether from either an IVR or CSR telephone inquiry), and regardless of the date of the call, four beneficiary data elements are required for authentication:

  1. Last name,
  2. First name or initial,
  3. Health Insurance Claim Number (HICN), and
  4. Either date of birth (eligibility, next eligible date, Durable Medical Equipment Medicare Administrative Contractor Information Form (DIF) (pre-claim)) or date of service (claim status, CMN/DIF (post-claim)).

- **Written Inquiries**
  In general, three data elements (NPI, PTAN, and last 5-digits of the TIN) are required for authenticating providers' written inquiries. This includes inquiries received without letterhead (including hardcopy, fax, email, pre-formatted inquiry forms or inquiries written on Remittance Advice (RAs) or Medicare Summary Notices (MSNs)).

  The exception to this requirement is written inquiries received on the provider's official letterhead (including emails with an attachment on letterhead). In this case, provider authentication will be met if the provider's name and address are included in the letterhead and clearly establish their identity. Therefore, the provider's practice location and name on the letterhead must match the contractor's file for this provider. (However, your Medicare contractor may use discretion if the file does not exactly match the letterhead, but it is clear that the provider is one and the same.) In addition, the letterhead information on the letter or email needs to match either the NPI, the PTAN, or last 5-digits of the TIN. Providers will also include on the letterhead either the NPI, PTAN, or last 5-digits of the TIN. Medicare contractors will ask you for additional information, if necessary.

- **Overlapping Claims**
  When claims overlap (that is, multiple claims with the same or similar dates of service or billing periods), the contractor that the provider initially contacts will authenticate that provider by verifying his/her name, NPI, PTAN, last 5-digits of the TIN, beneficiary name, HICN and date of service for post-claim information, or date of birth for pre-claim information.

Additional Information
You can find more information about the new provider authentication requirements for Medicare inquiries by going to CR 6139, located on the CMS Web site at http://www.cms.hhs.gov/Transmittals/downloads/R25COM.pdf.

Beneficiaries Call 1-800-MEDICARE

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

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

FYI CONT'D

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 Web site, http://www.medicare.gov/, where they can:

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

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

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

North Dakota Floods - State of Emergency Notice

As a consequence of severe storms and flooding in the State of North Dakota, the President has declared a major disaster, and the Acting Secretary of the U.S. Department of Health and Human Services has declared that a public health emergency exists and has existed since March 13, 2009, in the State of North Dakota. For more information, go to http://www.cms.hhs.gov/Emergency/12_StormFlood.asp on the CMS Web site.

This CMS Web site includes "downloads" that outline Medicare FFS policy during this emergency.

Please refer to the NAS and the CMS Web sites for future updates and guidance.

Minnesota Floods - A State of Emergency Notice

As a consequence of severe storms and flooding in the State of Minnesota, the President has declared a major disaster, and the Acting Secretary of the U.S. Department of Health and Human Services has declared that a public health emergency exists and has existed since March 16, 2009, in the State of Minnesota. For more information, go to http://www.cms.hhs.gov/Emergency/12_StormFlood.asp on the CMS Web site.

This CMS Web site includes "downloads" that outline Medicare FFS policy during this emergency.

Please refer to the NAS and the CMS Web sites for future updates and guidance.

Individuals Authorized Access to CMS Computer Services - Provider/ Supplier Community: The First in a Series of Articles

MLN Matters Number: SE0747 Revised

Note: This article was revised on February 20, 2009, to reflect current terminology and processes as reflected on the Individuals Authorized Access to CMS Computer Services (IACS) Web site. Please note that CMS will notify providers as CMS applications integrated with IACS become available, and provide clear instructions that specify which providers should register in IACS to access those applications. For example, MLN Matters articles SE0830 and SE0831 inform physicians how to register in IACS to access their Physician Quality Reporting Initiative (PQRI) feedback reports. Do not register until you are notified to do so by CMS or one of its contractors and only if you meet the criteria in the notice.

These articles will help providers to register for access to CMS online computer services when directed to do so by CMS. This article contains:

- 11 questions and answers to get you started and
- Overview of the registration process for IACS defined provider/supplier organization users.

Provider Types Affected

Medicare physicians, providers, and suppliers who

submit fee-for-service claims to Medicare contractors (carriers, fiscal intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), and Medicare Administrative Contractors (A/B MACs)).

Special Note: Durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers should not register for IACS at this time. DMEPOS suppliers may want to review question # 11 below.

What Providers Need to Know
The Centers for Medicare & Medicaid Services (CMS) will be announcing new online enterprise applications that will allow Medicare fee-for-service providers to access, update, and submit information over the Internet. CMS enterprise applications are those hosted and managed by CMS and do not include FI/Carrier/MAC-supplied Internet applications. Details of these provider applications that are integrated with IACS will be announced as they become available.

CMS will inform providers or appropriate staff when they should begin to register for access in the CMS security system known as the Individuals Authorized Access to CMS Computer Services (IACS). The IACS Web page is at http://www.cms.hhs.gov/IACS on the CMS Web site. The specific community for providers can be accessed by clicking on the "Provider/Supplier Community" in the left margin of the aforementioned Web site. Or, you can go directly to the "Provider/Supplier Community" page at http://www.cms.hhs.gov/IACS/04_Provider_Community.asp on the CMS Web site.

Provider Action Needed
CMS will notify providers as internet applications integrated with IACS become available, and provide clear instructions that specify which providers should register in IACS. **Do not register until you are informed to do so by CMS or one of its contractors and only if you meet the criteria in the notice.** This article and other articles in the IACS series will help you navigate this process when directed to do so by CMS. The other articles available to help with general navigation are:

- SE0753 at http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0753.pdf on the CMS Web site; and
- SE0754 at http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0754.pdf on the CMS Web site.

11 Questions and Answers to Get You Started

1. What is IACS?
IACS is a security system CMS uses to control issuance of electronic identities and access to new CMS provider Web-based applications. Through IACS, provider organizations (and other communities), as defined by IACS (See question # 7 below), and their staff, as well as individual practitioners, will be able to access new CMS applications. Through IACS, provider organizations will also be able to manage users whom they authorize to conduct transactions on their behalf, which may include staff and contractors.

Note: IACS is not applicable to FI/Carrier/MAC-sponsored internet applications.

2. Who can use this system?
Medicare providers and their designated representatives (e.g. clearinghouses, credentialing departments) may request access to CMS enterprise applications. At this time, the software used for DMEPOS Competitive Bidding has a dedicated version of IACS. (See question # 11 below.)

3. When should I register?
CMS will notify providers as Web-based applications integrated with IACS become available and provide clear instructions that specify which providers should register in IACS.

Do not register unless you fit the criteria in the CMS notice. For example, DMEPOS suppliers interested in becoming a contract supplier under the Medicare Competitive Bidding Program will receive explicit instructions on how and when to register for access to bidding software.

4. How long is my password valid?
Passwords expire every 60 days. After that point, when you log into IACS, you will be prompted to create a new password to re-activate your account. Therefore, we recommend that once registered, you sign on periodically into IACS to keep your password active.

5. How do I register as an IACS user?
IACS uses a self-registration process. The self-registration process you will follow depends on the type of IACS user you select. There are two categories of user types: individual practitioners and provider organizations. There are step-by-step registration instructions to help you through this process.

Note: User guides for the IACS community may be found at http://www.cms.hhs.gov/IACS/04_Provider_Community.asp#TopOfPage on the CMS Web site.

The External User Services (EUS) Help Desk will support this process for IACS It may be reached by email at EUSSupport@cgi.com or by phone on 1-866-484-8049 or TTY/TDD on 1-866-523-4759.

6. When would I register as an individual practitioner?
An individual practitioner (IP) is defined by IACS as a solo physician or non- physician practitioner; who has not reassigned Medicare payments to a group practice. This designation is intended for practitioners who will be conducting transactions with online applications personally and who have NO staff that will be directed to access the applications on their behalf. If you will have staff or other practitioners who will need to access CMS applications, you should register as a provider Organization (not as an individual practitioner). Please see #7.

CMS will match your IACS registration with Medicare enrollment data before allowing you to access a CMS application. Those providers registering as an individual practitioner who have not submitted a Medicare enrollment application (CMS-855) since November 2003 will need to update their CMS-855 form.

Note: See http://www.cms.hhs.gov/MedicareProviderSupEnroll/ for more information about the Medicare enrollment process. To facilitate your enrollment into the Medicare program or updating your enrollment with Medicare, you should review the following downloadable file at http://www.cms.hhs.gov/MedicareProviderSupEnroll/downloads/Enrollmenttips.pdf before submitting an enrollment application to a Medicare contractor.

If you enrolled in Medicare after November 2003, or

have updated your enrollment since then, register as an individual practitioner following the steps in the IACS Individual Practitioner Quick Reference Guide, which can be found in the Downloads section of http://www.cms.hhs.gov/IACS/04_Provider_Community.asp#TopOfPage on the CMS Web site. (Once at the Web site, scroll down to the Downloads section.)

7. When would I register as an IACS provider organization?
The term "organization", as defined by IACS, should not be confused with the term organization as it applies to provider enrollment or the NPI.

For IACS registration purposes, "organization" includes providers and suppliers such as hospitals, home health agencies, skilled nursing facilities, independent diagnostic testing facilities, ambulance companies, ambulatory surgical centers and physician group practices.

It also includes individual physicians and non- physician practitioners who want to delegate staff or surrogates to conduct transactions on their behalf (office staff, administration support etc.). In this case, for IACS registration purposes, registration must be as an organization.

IACS provider organizations require Security Officials (see question # 9 below) that establish the provider organization in IACS. All users will then be grouped together within IACS under the provider organization's Security Official.

8. What should I have in hand before I register as an IP?
An individual practitioner (who will be conducting transactions with online applications personally and who will have no additional staff directed to access the applications) will need to know their:

- Social Security Number and
- Correspondence Information.

9. What should I have in hand before I register as a Security Official of a Provider Organization?
For an IACS provider organization, the Security Official (SO) of that organization will be the first person to register within IACS and will need to create their organization. The SO should have the following organizational information available before they sign on to register:

- Taxpayer Identification Number (TIN);
- Legal Business Name;
- Corporate Address; and
- Internal Revenue Service (IRS) Issued CP-575 hard copy form.

If the SO does not have the CP-575, a copy of other official IRS documentation may be submitted. An official IRS document should have the following information:

Required:

- IRS letterhead;
- Legal Business Name (not handwritten); and
- TIN/EIN (not handwritten).

Examples of acceptable IRS documents include, but are not limited to:

- Copy of IRS CP-575;
- Copy of IRS 147C Letter; or
- Copy of Federal Tax Deposit Coupon.

All documents received must be legible.

10. How do I register my provider organization in IACS?
IACS is based on a delegated authority model. Each organization must designate an SO who will register the organization via IACS and then be accountable for users in the organization. Using information supplied via the IACS registration as well as a mailed-in copy of the organization's IRS documentation, CMS will verify the SO's role in the organization, the TIN and the Legal Business Name of the organization. This can take several weeks. Once approved, the SO then has the ability to approve other registrants under the provider organization. For more details, please read the Overview section, which follows question #11.

Once you understand IACS user roles, and have designated an SO, the SO should register using the instructions in the IACS Quick Reference Guide, which is available at http://www.cms.hhs.gov/IACS/04_Provider_Community.asp#TopOfPage on the CMS Web site.

The next MLN article in this series of articles provides instructions for additional users to register in IACS.

11. Why is registration not available at this time for DMEPOS suppliers in IACS?
DMEPOS suppliers should not register in IACS because CMS does not have new online applications at this time. DMEPOS suppliers interested in DMEPOS competitive bidding should follow CMS DMEPOS Competitive Bid instructions which would be released closer to the bidding window.

Overview: Registering in IACS as a Provider Organization or a Provider Organization User
For IACS registration purposes, "organization" includes providers and suppliers such as hospitals, home health agencies, skilled nursing facilities, independent diagnostic testing facilities, ambulance companies, ambulatory surgical centers, and physician group practices. It also includes individual physicians and non- physician practitioners who want to delegate employees to conduct transactions on their behalf.

I. The Registration Process
IACS is based on a delegated authority model. Each user self-registers and is approved as shown below. The system is designed for flexibility to meet provider needs while assuring security of computer systems and privileged information. At this time, a provider organization must have at least 2 users, one of whom will be able to access CMS applications integrated with IACS.

The "delegated authority model" previously described is shown below. The EUS Help Desk will be responsible for approving the organization's Security Official. Then the Security Official may approve the Backup Security Official(s) etc.

II. Registration Roles

1. The first person to register must be the Security Official.
The Security Official is the person who registers their organization in IACS and establishes the organization profile

information in IACS. There can be only one Security Official for an organization. The Security Official is trusted to approve the access request of Backup Security Official(s) and can approve the access requests of User Group Administrators. The Security Official will be approved by CMS through its EUS Help Desk. The Security Official is held accountable by CMS for the behavior of those approved in the organization, including End Users. The –IACS SO Quick Reference Guide may be found at http://www.cms.hhs.gov/IACS/04_Provider_Community.asp#TopOfPage on the CMS Web site.

Note: Additional employee and contractor users cannot be approved until the security official has been approved by the EUS Help Desk.

2. An organization may choose to have one or more Backup Security Officials. (Optional)
This is an optional role. You need not have a Backup Security Official. The Backup Security Official is approved by the Security Official. A Backup Security Official performs the same functions as a Security Official in an organization, with the exception of approving other Backup Security Officials and updating the organization profile. There can be one or more Backup Security Officials in an organization. The Backup Security Official can approve the access requests of User Group Administrators and may aid the Security Official with the administration of User Groups and User Group Administrators' accounts.

3. The next registrant must be a User Group Administrator (UGA).
The UGA is approved by the Security Official or Backup Security Official. The UGA is trusted to approve the access requests of End Users for that User Group.

A UGA registers the User Group within an organization in IACS and updates the User Group profile information in IACS. There can be multiple UGAs for the same User Group within an organization.

If the UGA is a surrogate user (not part of the organization, but rather a contractor company working on behalf of the organization), they should select the option to create a "Surrogate User Group"- See Section III. Note that surrogates will not have access to the Provider Statistical and Reimbursement (PS & R) System.

4. The Next Registrants are End Users.
An End User is a staff member who is trusted to perform Medicare business and conduct transactions for the provider organization. An End User is part of a User Group within the provider organization. An End User may be an employee of a provider/supplier/practitioner or a contractor working on the behalf of one of these entities. An End User may belong to multiple groups in one or more organizations. The End User is approved by the UGA.

Note: End Users cannot register in User Groups until after the User Group Administrator has been approved.

III. SURROGATE USER GROUPS

This applies to provider organizations that want to delegate online work to individuals or a company outside of the provider organization. Under this scenario, those working on behalf of the provider organization register as a Surrogate User Group. Examples include clearinghouses, credentialing departments, independent contractors. A Surrogate User Group has a direct contractual business relationship with the Medicare provider/supplier, but not with CMS. A Surrogate User Group may be associated with multiple provider organizations. As noted above, surrogates will not have access to the PS & R system.

1. The first contractor employee to register in a Surrogate User Group must be the UGA.
If there will be only one user in a Surrogate Group, that user must register as a UGA. The UGA for the Surrogate User Group will register the Surrogate User Group and update the User Group profile information in IACS. There can be multiple UGAs within the same Surrogate User Group. The UGA is trusted to approve the access requests of End Users for their user group.

The UGA of the Surrogate User Group must be approved by the Security Official or Backup Security Official in the provider organization on whose behalf it performs work. Once approved, the UGA of a Surrogate Group may request to associate with other provider organizations for which it performs work without registering again.

2. A contractor employee may also register as an End User.
An End User is approved to perform Medicare business for a surrogate or provider User Group by their UGA. An End User may belong to multiple groups in one or more organizations.

Additional Help
The EUS Help Desk will support the provider/supplier community with this process for IACS. It may be reached by email at EUSSupport@cgi.com or by phone on 1-866-484-8049 or TTY/TDD on 1-866-523-4759.

Information on the steps needed for individual eligible professionals to access their 2007 Physician Quality Reporting Initiative (PQRI) Feedback Reports personally is available in MLN Matters article SE0830 at http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0830.pdf on the CMS Web site. Information on the steps for IACS defined "organizations" to access their PQRI Feedback Report is available at http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0831.pdf on the CMS Web site.

Individuals Authorized Access to CMS Computer Services – Provider/Supplier Community: The Second in a Series of Articles

MLN Matters Number: SE0753 Revised

Note: This article was revised on February 20, 2009, to reflect current terminology and processes as reflected on the Individuals Authorized Access to CMS Computer Serivces (IACS) Web site. Please note that CMS will notify providers as internet applications become available, and provide clear instructions that specify which providers should register in IACS to access those applications. For example, MLN Matters articles SE0830 and SE0831 inform physicians how to register in IACS to access their Physician Quality Reporting Initiative (PQRI) feedback reports. Do not register until you are notified to do so by CMS or one of its contractors and only if you meet the criteria in the notice.

This article contains:

- Three questions and answers about the registration process for provider organizations.
- Links to the Quick Reference Guides for completing the registration process for provider organizations.

Provider Types Affected
Medicare physicians, providers, and suppliers (collectively referred to as providers) who submit fee-for-service claims to Medicare contractors (carriers, fiscal intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), and Medicare Administrative Contractors (A/B MACs)).

Special Note for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) suppliers. Do not register for IACS at this time. DMEPOS suppliers may want to review the first MLN Matters article in this new series on IACS, which can be found at http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0747.pdf on the Centers for Medicare & Medicaid Services (CMS) Web site.

Provider Action Needed
CMS will inform providers as internet applications become available, and provide clear instructions that specify which providers should register in IACS. Do not register until you are notified to do so by CMS or one of its contractors and only if you meet the criteria in the notice. This article and other articles in the IACS series will help you navigate this process when directed to do so by CMS.

What Providers Need to Know
The CMS will be announcing new online enterprise applications that will allow Medicare fee-for-service providers to access, update, and submit information over the Internet. CMS enterprise applications are those hosted and managed by CMS and do not include FI/Carrier/MAC Internet applications that are hosted/managed by those entities. Details of these provider applications will be announced as they become available.

Registering in IACS
IACS protects and allows access to CMS enterprise applications. Communities (e.g., the IACS provider/supplier community) are comprised of groups of users who provide a similar service to CMS and who need access to similar applications (For example, providers need access to provider-related CMS applications). The next community which will become available is the FI/Carrier/MAC community. It will be comprised of users who work within Medicare Fee-for-Service contracting organizations (FI's, Carriers and MACs). Since many IACS communities will be added in the future, the IACS community's user instructions are generic to allow use by multiple communities. The rules and concepts across communities are very similar.

When given a choice in IACS to select your community, Medicare providers should select the "Provider/Supplier Community".

The first MLN Matters article in this series provided an overview of the IACS registration process as well as registration instructions for Security Officials (SOs) of provider organizations and individual practitioners using IACS personally. This article can be found at http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0747.pdf on the CMS Web site.

Three Questions and Answers about the Provider Organization Registration Process

1. How can I get registered in IACS? Can I just figure it out by myself?
We recommend that you use the reference guides as they contain detailed explanations of the role responsibilities, acceptable data formats and interpretations of error messages. To directly access IACS, go to https://applications.cms.hhs.gov and then click on Enter CMS Applications Portal.

2. I will work for more than one provider, or serve in multiple roles in the same organization. Do I need to register in IACS separately for each organization or role?
No, only register once. Each user will receive only one IACS User ID and password. Once you receive approval and your user ID and password, you can add additional roles to your account.

Instructions for modifying your IACS account profile will be released shortly. In the meantime, questions may be directed to the help desk as shown in the "Additional Help"section at the end of this article.

3. My organization is too small to fill all these roles. What should I do?
As few as two staff can be registered in IACS for a provider organization to access CMS enterprise applications. The first person must register as a Security Official (SO), the second registers as a User Group Administrator (UGA). The UGA may access CMS applications as approved by the SO. The Backup Security Official is an optional role.

If you are an individual professional who will be using IACS personally, you may register for the single role of individual practitioner. Please refer to the first MLN article which may be found at http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0747.pdf on the CMS Web site.

IACS Quick Reference Guides for Completing the Provider Organization Registration Process

IACS Registration Approval Process

1. Backup Security Official (BSO) Guide
BSOs will request access to an organization using the IACS BSO Quick Reference Guide found at http://www.cms.hhs.gov/IACS/04_Provider_Community.asp#TopOfPage on the CMS Web site.

2. User Group Administrator (UGA) Guide
UGAs are the first user type able to request access to CMS Web-based applications. Their task, during the registration process, is to create a provider or surrogate user group, or associate with an existing provider or surrogate user group. A provider user group is a group that can be created by a UGA within an existing provider organization.

Once the user group is created and approved by the SO/BSO, end users can then submit a request to register in IACS and join that user group. The UGA will either approve or deny their request to join their user group. This is a way for users within an organization to form groups that align with business needs or any other logical grouping that is appropriate for that organization and ensure that the UGA

appropriately approves each end user into their user group. The important thing to keep in mind is that the UGA will need to approve the end users in the user group for which s/he is responsible, for this reason they should know everyone in their user group.

The IACS UGA Quick Reference Guide may be found at http://www.cms.hhs.gov/IACS/04_Provider_Community.asp#TopOfPage on the CMS Web site.

Special note for UGAs of Surrogate User Groups
A surrogate user group is established by individuals or a company outside of the provider organization which performs Medicare work on behalf of the provider organization (a contractor for a provider organization, billing company, etc.). If you will be creating a surrogate user group, the UGA of the surrogate user group must be approved by the SO or BSO in the provider organization on whose behalf it performs work. For example: Surrogate Billing Company ABC will work on behalf of Provider Organization XYZ. Once the Provider Organization XYZ is approved in IACS, the Surrogate Billing Company ABC can register in IACS and request to create a surrogate user group under the Provider Organization XYZ. Once approved, the UGA of a surrogate user group is issued an IACS user ID that enables the UGA to associate with other provider organizations for which it performs work without registering again.

At this time, a new surrogate user group must be created for each provider organization with which a UGA wishes to associate. If a surrogate user group performs work on behalf of 3 different provider organizations, the UGA for the surrogate user group will need to make 3 different requests to create 3 different surrogate user groups, one for each provider organization with which the UGA needs to associate. If a provider organization does not appear in IACS, they have not yet registered/been approved and you should contact them. You will not be able to associate with them until the provider organization appears in IACS.

If the provider organization does appear in IACS, each provider's SO or BSO must approve the request to associate that surrogate user group with their organization. Remember, as a surrogate user group, you will only be able to associate with provider organizations after those respective provider organizations and SOs have been approved in IACS.

In the future, CMS will explore options for simplifying this process for contractors that perform work on behalf of more than one provider organization and also to allow surrogate user groups to associate to Individual Practitioners within IACS.

3. An IACS End User Quick Reference Guide may be found at http://www.cms.hhs.gov/IACS/04_Provider_Community.asp#TopOfPage on the CMS Web site.

4. IACS User Guide for Approvers
The IACS User Guide for Approvers provides step-by-step instructions that SOs, BSOs and UGAs will use to approve or deny user requests to register in IACS. The IACS User Guide for Approvers can be found by going to the downloads section of http://www.cms.hhs.gov/IACS/03_General_User_Guides_and_Resources.asp on the CMS Web site.

Next Steps in Accessing a CMS Enterprise Application
A third MLN article discussing the final steps for using IACS to access CMS enterprise applications may be found at http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0754.pdf on the CMS Web site.

Additional Help
The CMS has established an External User Services (EUS) Help Desk to assist with your access to IACS. The EUS Help Desk may be reached by E-mail at EUSSupport@cgi.com or by phone on 1-866-484-8049 or TTY/TDD on 1-866-523-4759.

In addition, you can find an informative reference chart outlining the steps for accessing CMS enterprise applications at http://www.cms.hhs.gov/MLNProducts/downloads/IACSchart.pdf on the CMS Web site.

Individuals Authorized Access to CMS Computer Services – Provider/ Supplier Community: The Third in a Series of Articles

MLN Matters Number: SE0754 Revised

Note: This article was revised on February 20, 2009, to reflect current terminology and processes as reflected on the Individuals Authorized Access to CMS Computer Services (IACS) Web site. Please note that CMS will notify providers as internet applications become available, and provide clear instructions that specify which providers should register in IACS to access those applications. For example, MLN Matters articles SE0830 and SE0831 inform physicians how to register in IACS to access their Physician Quality Reporting Initiative (PQRI) feedback reports. Do not register until you are notified to do so by CMS or one of its contractors and only if you meet the criteria in the notice.

This article describes the three steps providers must take to access a CMS Enterprise Provider Application including how to request a provider application role in IACS (See step 2).

Provider Types Affected
Medicare physicians, providers, and suppliers (collectively referred to as providers) who submit fee-for-service claims to Medicare contractors (carriers, fiscal intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), and Medicare Administrative Contractors (A/B MACs)).

Special Note for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) suppliers: Do not register for IACS at this time. DMEPOS suppliers may want to review the first MLN Matters article in the series on IACS which can be found at: http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0747.pdf on the Centers for Medicare & Medicaid Services (CMS) Web site.

Provider Action Needed
CMS will notify providers as internet applications become available, and will provide clear instructions that specify which providers should register in Individuals Authorized Access to CMS Computer Services (IACS) - Provider/ Supplier Community. Do not register until you are notified to do so by CMS or one of its contractors and only if you meet the criteria in the notice.

What Providers Need to Know
The CMS will announce new online enterprise applications that will allow Medicare Fee-For-Service (FFS) providers to access, update, and submit information over the Internet.

CMS enterprise applications are those hosted and managed by CMS and for the most part do not include internet applications offered, hosted, and managed by FIs/carriers/MACs. Details of these provider applications will be announced as they become available.

CMS will inform providers or appropriate staff when they should begin to register for access through the CMS security system known as IACS. The IACS Web page is at http://www.cms.hhs.gov/IACS on the CMS Web site. The specific community for providers can be accessed by clicking on the "Provider/Supplier Community" in the left margin of the aforementioned Web site. Or, you can go directly to the "Provider/Supplier Community" page at http://www.cms.hhs.gov/IACS/04_Provider_Community.asp on the CMS Web site.

The first article in this series provided an overview of the IACS registration process as well as registration instructions for Security Officials (SOs) and individual practitioners. This article can be found at http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0747.pdf on the CMS Web site.

Note: Individual practitioners must use a different registration process depending on whether they will have employees use IACS and/or the CMS application on their behalf. Those using employees must register in IACS as an "Organization". See the MLN Matters SE 0747 for more information.

The second article in this series addressed common questions and gave follow-up instructions for registering provider organizations including registration as Backup Security Officials (BSOs), User Group Administrators (UGAs), and End Users (EUs). It also provided instructions SOs, BSOs, and UGAs can use to approve user registration requests. This article can be found at http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0753.pdf on the CMS Web site.

The 3 Steps to Access a CMS Enterprise Provider Application
Provider IACS users must take 3 steps to access a CMS enterprise application.

Step 1: Be Approved for an IACS Role.
The first two MLN Matters Articles in this series discussed how to register in IACS.

The purpose of the IACS registration process is to:

- Confirm the identity of the person requesting registration;
- Assure registrants have a legitimate business need to access CMS provider systems;
- Provide the registrant an IACS role (e.g., SO, BSO, UGA, or End User) that defines their responsibilities (if any) for approving the registration requests of others in their organization; and
- Provide the registrant a User ID and Password for IACS.

Step 2: Be Approved for an Application Role
After receiving approval for an IACS role, and obtaining an IACS User ID and password, the registered user in a Provider Organization may then request access to CMS provider applications. This requires specifying a role for specific applications. For example, the role may be an "Application Approver" or an "Application User."

This application role determines:

- Their responsibilities (if any) to approve application access requests from others in their organization;
- What CMS enterprise applications (if any) to which they have a legitimate need to access, and
- The appropriate level of access to each application for their job function (which application "role" they require).

Users who received approval in IACS in Step 1 can then request access to specific CMS enterprise applications using their IACS User ID account.

This requires requesting either an "Application Approver" or an application "User" role for each application needed to perform Medicare related job functions. For provider applications, there are specific roles within the application that define what the user can do. For example, some application users may be limited to viewing information and printing reports, while others can enter, edit and submit information to CMS.

Note: Each user must request a specific application role in IACS for each CMS enterprise provider application they wish to use. Roles will be specific to each application.

The "IACS Request Access to CMS Application Quick Reference Guide" provides instructions for requesting an application role. It may be found at http://www.cms.hhs.gov/IACS/04_Provider_Community.asp#TopOfPage on the CMS Web site.

Application Approvers
Organizations must have designated persons that approve each user's request for an application role. The person who performs this task is an "Application Approver" and as such cannot personally access applications for which they serve in this role.

Though the UGA may frequently be the appropriate person who should have this role, organizations have discretion in how they designate the Application Approvers so that it is appropriate for their particular organization. For example, the UGA may be designated by the SO or BSO to serve in this role for their user group, or an End User may be approved for this role by the SO or BSO for the user group with which they are associated.

Note: If a user group does not have an Application Approver for an application, the requests will, by default, be routed to the SO and BSO for a decision.

Application Approver - Key Points

- An Application Approver must be a member of the user group(s) for which they serve as an Application Approver (this does not apply if the SO/BSO is the Application Approver).
- Providers have flexibility in assigning the Application Approver role.

FYI CONT'D

- The UGA does not have to be the Application Approver within the user group.
- An End User within a user group may serve in the role of the Application Approver.
- A different person may serve as an Application Approver in a user group for each application.
- The same person can be the Application Approver for multiple applications in a user group.
- The same person can be the Application Approver for multiple user groups (though they must be a member of each group.)
- There can be multiple Application Approvers for the same application within the same user group. In this situation, the first approver who approves or denies the request will serve as the decision authority. All of the application approvers within the user group do not need to act on each request.
- A person can be an Application Approver for one application, and an application user for a different application, just not for the same one.
- If an Application Approver does not exist for an application in a user group, the user group requests for that application will go to the SO and BSO for a decision.
- Organizations with a large number of IACS users are encouraged to have Application Approvers in each user group for each application (can be the same person) so that all of the application requests are not routed to the SO and BSO as the default application approvers.

Note: System security requires a "separation of duties" – which means that those who approve user requests for CMS enterprise application roles will not have access to the applications for which they have an approver role. Therefore those in Application Approver roles will not have access to the application for which they are an approver. Security Officials and Backup Security Officials, by definition, can never access any applications as they serve as the default Application Approvers as noted above.

Instructions for approving application role requests are the same as for approving IACS registration requests. The IACS User Guide for Approvers may be found by selecting General User Guides and Resources in the left column of the page at http://www.cms.hhs.gov/IACS/04_Provider_Community.asp#TopOfPage on the CMS Web site.

Step 3: Enter the application when it becomes available.
You will be notified as CMS enterprise applications become available. After you have been approved in steps 1 and 2, you will be able to access available CMS enterprise applications in accordance with approved application specific roles via the CMS or application Web site.

Additional CMS Partner and Customer Communities will use IACS
IACS protects and allows access to CMS enterprise applications. IACS Communities (e.g., the IACS - Provider/Supplier Community) are comprised of groups of users who provide a similar service to CMS and who need access to similar applications. For example, the next community will be the FI/Carrier/MAC community. It will be comprised of users who work within Medicare Fee for Service contracting organizations (FIs, Carriers and MACs). Since many IACS communities will be added in the future, the IACS community's user instructions are generic to allow use by multiple communities. The rules and concepts across communities are very similar.

When given a choice in IACS to select your community, please select the "Provider/Supplier Community".

Additional Help
CMS has established the External User Services (EUS) Help Desk to support providers and Medicare contractors in their access to IACS. The EUS Help Desk may be reached by e-mail at EUSSupport@cgi.com or by phone on 1-866-484-8049 or TTY/TDD on 1-866-523-4759.

In addition, you can find an informative reference chart outlining the steps for organizations to access CMS enterprise applications at http://www.cms.hhs.gov/MLNProducts/downloads/IACSchart.pdf on the CMS Web site.

Information on the steps needed to register to access Physician Quality Reporting Initiative (PQRI) feedback reports is available in MLN Matters articles SE0830 and SE0831. These articles are available at http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0830.pdf and http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0831.pdf, respectively.

Coming Soon

- CMS enterprise applications to be made available via the Web include others related to the Physician Quality Reporting Initiative (PQRI) and the Provider Statistical and Reimbursement Report (PS&R)
- Instructions for modifying your user profile
- What to do if you forget your user ID or password
- Tools for SOs, BSOs and UGAs to manage user accounts

EDUCATIONAL

Ask the Contractor Teleconference for Small Suppliers – May 20, 2009

NAS will conduct the next DME Ask the Contractor Teleconference to assist **small suppliers** on May 20, 2009. CMS has defined a small supplier as a supplier with ten or fewer full time equivalent employees. During this teleconference, knowledgeable NAS staff representing a variety of functions will be available to answer your questions. If we cannot answer your question during the teleconference, we will research the issue and then call you with the answer.

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

To participate in this ACT for **small suppliers**, dial 1-800-398-9389. For those suppliers who may need an international number (American Samoa, Guam or the Northern Mariana Islands) dial 1-612-338-1917.

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

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

Note: The teleconference will start promptly at 3 p.m. CT and will last up to 90 minutes. NAS encourages participants to place the call 15 minutes prior to the start of the teleconference.

NAS looks forward to your participation in these **small supplier** teleconferences.

Ask the Contractor Q & A - February 18, 2009

Prior to taking questions, NAS provided the following updates:

Recent Web Site Enhancements
NAS DME has recently made several improvements to our Web site to provide additional resources and to reduce the number of pages suppliers need to review to find information.

News/Publications
Upcoming Changes - Watch this area of the Web site for overviews of updates and changes. Currently NAS has posted information on the DMEPOS Competitive Bidding Program, Accreditation, Oxygen and Oxygen Equipment, and ICD-10-CM.

Fees
Fee Schedule Lookup Tool - Enter a HCPCS, year/quarter, and/or state to find the fee schedule amounts for specific codes.

Coverage/MR
Physician Resources - All documents addressed to physicians that suppliers may use to educate physicians about supplying medical documentation for DME claims are located under this heading.

Documentation Checklists - All of these will be reviewed and updated. The date on the last page shows which checklists have recently been updated. The dates with 2006 will be reviewed soon.

These are excellent tools to assist in gathering required documentation.

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

Accreditation
CMS wants to ensure that suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) who bill Medicare for Part B services have ample time to complete the accreditation process and thus receive an accreditation decision by the ***September 30, 2009***, deadline. In order to meet this deadline, CMS is encouraging all enrolled DMEPOS suppliers, except those eligible professionals and other persons exempted by law, to submit a complete accreditation application to an accreditation organization by ***January 31, 2009***.

The following is a list of eligible professionals and other persons that are exempted from the accreditation requirement: physicians, physical and occupational therapists, qualified speech-language pathologists, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, certified nurse-midwives, clinical social workers, clinical psychologists, registered dietitians/nutrition professionals, orthotists, prosthetists, opticians, and audiologists.

Surety Bond
On December 29, 2008, CMS announced regulations requiring certain DMEPOS suppliers of certain DMEPOS to post a surety bond as a condition of new or continued Medicare enrollment. The regulation states that beginning May 4, 2009, suppliers seeking to enroll or changing the ownership of a DMEPOS supplier must submit a $50,000 surety bond for each assigned NPI for which the DMEPOS supplier is seeking to obtain Medicare billing privileges. Existing DMEPOS suppliers must submit to the NSC a $50,000 surety bond for each assigned NPI no later than October 2, 2009.

In addition, a DMEPOS supplier enrolling a new practice location must submit to the NSC a new surety bond or an amendment or rider to the existing bond, showing the new practice location is covered by an additional base surety bond of $50,000.

New Repair and Replacement Modifiers
Effective for claims with dates of service on/after January 1, 2009, the RP modifier is no longer accepted for the use of repair and replacement and will be denied for inappropriate use if submitted. The following modifiers are required:

RA **Replacement** of beneficiary-owned DMEPOS due to the expiration of the equipment's reasonable useful lifetime or to loss, irreparable damage, or when the item has been stolen

RB Replacement parts furnished in order to **repair** beneficiary-owned DMEPOS

The meaning of the replacement modifier has not changed. It needs to be appended only to the first month rental claim, a narrative explaining the reason for the replacement is required on the claim, and a new order or Certificate of Medical Necessity (CMN) is required, if applicable.

Please refer to the following articles for further information:

New Repair and Replacement Modifiers
New Repair and Replacement Modifiers - Clarification
Replacement - RA Modifier Clarification

Signature and Date Stamps for DME Suppliers - CMNs and DIFs
As of February 2, 2009, signature and date stamps are no longer acceptable for use on CMNs and DIFs. Hand written, facsimiles of original written and electronic signatures and

dates will only be accepted by the DME MACs. See MLN Matters 6261 for more information.

Medtrade and National Home Infusion Association Conference
NAS will be attending Spring Medtrade in Las Vegas, NV from March 24-26th. Staff from each of the four DME MACs, NSC, CEDI, and CBIC will be among the many exhibitors available to provide information and address questions. We will be located in booth 932. The DME MACs will also provide a one-hour "Medicare Updates" presentation on March 26th from 9:45 - 10:45 am.

NAS will also be attending the National Home Infusion Association Annual (NHIA) Conference in Baltimore on March 1-3. We will share a booth with the other DME MACs and will have a roundtable session during the evening of March 2nd.

Medicare Contractor Provider Satisfaction Survey
The Medicare Contractor Provider Satisfaction Survey (MCPSS) gives suppliers the opportunity to rate NAS' DME performance regarding the business functions of outreach and education, provider inquiries, claims processing, appeals, and medical review. This survey can be completed in about twenty minutes via a secure website, mail, fax, or over the telephone. Suppliers are encouraged to respond timely to this survey if one was sent to your office.

Common Electronic Data Interchange Updates
Please see the Common Electronic Data Interchange (CEDI) Web site for more information on the implementation of Stage 2 changes to the front-end process. If you bill electronically, you will also want to ensure that you are a member of CEDI's email list so you can receive updates timely.

Q1. If a patient owns a CPAP under Medicare and he/she is a compliant CPAP user but after having another sleep study it is determined the patient needs to switch to a Bi-PAP, which protocol should be used, the replacement protocol or the new PAP LCD with the face-to-face reevaluation and adherence data?
A1. In this situation, the patient is receiving a new piece of equipment, not a replacement. If you are considering giving the beneficiary a Bi-PAP, you need to meet the criteria in the LCD that applies based on the patient's condition. If the patient's condition is OSA, follow the PAP policy. If the patient's condition is something other than OSA, follow the Respiratory Assist Device (RAD) policy.

Q2. MLN Matters 6270 has to do with the new KE modifier effective 1/1/09, based on Round 1 of Competitive Bid. I am getting a lot of claims with dates of service in 2009, for example batteries, that are denying "procedure code is inconsistent with the modifier used".
A2. The following article clarifies which procedure codes can be used with the KE modifier: 2009 DMEPOS Fee Schedule Changes Overview.

Q3. Do pharmacies have to be accredited for Part D Medicare?
A3. DMPOS accreditation only applies to DME Medicare Part B suppliers. If a pharmacy is a DME supplier, bills DME, and only provides drugs and biologicals, they do not need to be accredited. If the pharmacy provides a walker, cane, diabetic strips, etc., they must be accredited. A list of exempt suppliers is located on our DMEPOS Supplier Accreditation page.

Follow-up question: What if in the past the pharmacy provided walkers, etc., but in the future will only provide drugs and biologicals? Do they need to then be accredited?
A. The supplier would need to contact the National Supplier Clearinghouse (NSC) to verify what specialty of DME they are considered. The pharmacy may have to update their information with the NSC to reflect that they are a pharmacy only providing drugs and biologicals and not other types of DME to then be exempt from accreditation.

Q4. We need clarification on the 36-month cap for oxygen equipment. Who maintains ownership after the cap?
A4. The supplier maintains ownership of the oxygen equipment.

Follow-up question: After the 36-month cap, suppliers will only be paid for maintenance and servicing every six months, correct?
A. Yes, in 2009, suppliers can receive payment for maintenance and servicing only for concentrators and home fill units, however CMS is reevaluating whether this will continue in 2010 or not.

Q5. What do we do with a newly relocated patient that has had their oxygen equipment for 35 months? Do we start a new capped rental period because they are coming to a new supplier?
A5. If you decided to take on this newly relocated patient, you would only receive one month rental payment. A new capped rental period does not start. You could also bill for maintenance and servicing after the 36-month rental period for those items for which maintenance and servicing is allowed per the oxygen guidelines.

Q6. Regarding the PAP LCD, we are finding that a few patients need up to an extra month past the allowed three months to acclimate to the treatment in order to meet the adherence criteria. What should we do if the patient needs a little more time to become compliant? For example, a patient is now consistently using the device every night but her 12-week trial period ends today and they need three more days worth of data to be compliant. What should we do?
A6. A period of ninety days ought to, in nearly all circumstances, be sufficient to allow evidence of compliance. For what should be a rare circumstance where a longer period is needed, the supplier may obtain a signed Advance Beneficiary Notice of Noncoverage (ABN) in the third month for a fourth month's claim, stating the coverage criteria was not met because of non-compliance and no evidence of adherence. Submit your claim without the KX modifier. This will enable the beneficiary to be billed when the claim denies or if there are unusual, compelling circumstances that the delay was medically necessary, an appeal can be done.

Follow-up question: Can we hold the claim and not submit it for the third month until the patient becomes compliant and just make our next month start on the next day she is compliant? For example, her cycle date is the 15th and she doesn't become compliant until the 22nd, can we make the next month the 22nd and bill from there?

A. If a patient is not being compliant in the first three months, coverage is not allowed for the third or fourth month. An ABN should be obtained once it is determined the patient is not compliant and a claim submitted without the KX modifier. One cannot just skip the week that the patient is not compliant as the beneficiary was using the PAP at that time.

Q7. Does the oxygen policy become effective January 1, 2006?
A7. January 1, 2006 is when the 36 month capped rental begins.

Q8. Can you explain the CMN and order requirements for replacing oxygen after five years? We have submitted many CMNs that have been rejected when the patient is starting a new capped rental period.
A8. Examples were provided by the supplier. A new CMN is not loaded into our system when there is already another one for the same code on file. The claim will hit several edits for the processing staff to look at. When they come across this situation, the new CMN is then added to our system when appropriate.

Q9. I am having trouble receiving payment from patients that switch from a private insurance to Medicare. I am submitting claims with oxygen CMNs with the patient's eligibility date of Medicare as the initial date and I am not receiving payment. The denial is stating it doesn't meet medical necessity guidelines for Medicare to receive oxygen. There is also no test taken 30 days prior to the initial date of the CMN.
A9. The only exception for not being within 30 days of the initial date on the CMN for the test is when the patient transfers from a Medicare HMO to Medicare Fee-for-Service, otherwise your claims will deny.

Q10. When a patient purchased an oxygen concentrator two years ago through their private insurance, but is now on Medicare, are we able to start billing maintenance and servicing starting July 2009?
A10. There would need to be 36-month rental Medicare payments before maintenance and servicing payments would apply.

Follow-up question: Since the concentrator was bought through their private insurance, we would be able to start the patient with a new 36-month cap rental period for the concentrator when they become eligible for Medicare?
A. That would be correct. The patient would need to be tested and requalify for the new piece of equipment in order to receive a new 36-month rental. Any months paid by private insurance are not taken into account by Medicare.

Q11. If a patient owns a PAP bought under Medicare and it breaks and the loaner is rented for one month during the repair time, is it necessary to get a new prescription to cover the loaner?
A11. No you would not need a new prescription. Bill your claim with code K0462 with a narrative indicating the reason why loaner equipment was required. You will only receive one-month rental payment for loaner equipment.

Q12. How often will Medicare pay for the loaner piece of equipment, K0462?
A12. Medicare will pay for loaner equipment based on medical need as long as the rental of the loaner for one month and repair charges does not exceed the purchase price of a new piece of equipment.

Medicare will pay one month's payment or rental per piece of loaner equipment per repair. If the piece of equipment needs to be fixed now and two years down the road it needs to be fixed again, Medicare will again consider payment for the K0462.

Q13. We have a patient that has been having problems with their purchased CPAP (E0601) so they want to rent an A-PAP (E0601) (auto titrating PAP) for a month. The A-PAP claims get denied. Will coverage ever be considered for an A-PAP versus a patient coming into the sleep lab for a study? The doctor wants the patient to use an A-PAP for one month to determine what pressure the patient needs to be at.
A13. This would not be considered for coverage since the patient is currently using the same type of equipment, an E0601. A new capped rental period cannot start unless the equipment needs to be replaced for loss, irreparable damage, or because the equipment has reached its useful lifetime (is older than five years). The patient will have to cover this cost.

Q14. We have patients that are renting two ventilators. One is used at bedside and the other is attached to their wheelchair, which his covered by Medicare. We are receiving requests to submit documentation to Medical Review for the second ventilator every month. Why do we have to do this if the patient's condition is stable and not changing?
A14. Examples were asked of the supplier and not provided.

Q15. Can an A-PAP be covered for the first month of rental and then the second month and so forth be covered as the CPAP?
A15. Since these pieces of equipment are billed as the same code, E0601, you would receive payment for the first month rental of the A-PAP and 12 months of rental for the CPAP.

Q16. Can a piece of equipment older than five years be replaced?
A16. The beneficiary must agree to the terms of a new piece of equipment, such as having to pay coinsurance. This cannot be done automatically just because the five-year lifetime rule has been met. If the beneficiary agrees to the terms, you must have the following; a new initial CMN (if applicable), a new order, RA (or RP) modifier on the first month claim, along with a narrative explanation that equipment was replaced for being more than five years old.

Q17. Some suppliers replaced oxygen equipment in 2008, since it had reached its reasonable useful lifetime, i.e., was more than five years old. However, since they were not yet informed of the guidelines for replacing equipment at the time the replacement occurred, can they now ask for an RP modifier to be added to the claim and start a new 36-month capped rental period?
A17. Yes, suppliers in this situation should request a written reopening to have the RP modifier added to their claim along with submitting the documentation that shows proof of delivery for the replaced equipment and the original date the equipment was put into service for the beneficiary. In addition, the order and initial CMN will need to be

submitted, along with an explanation of why the equipment was replaced. NAS will then make the appropriate changes to our claims processing system to start a new-capped rental period.

Q18. I understood that with capped rental equipment, except oxygen, there needed to be medical necessity for replacement. Oxygen can be replaced after five years, without any medical need. Is this the case, since we have had that oxygen piece of equipment out there and paid for five years?
A18. That is correct. Oxygen guidelines are slightly different when it comes to replacement than other items of DME due to the new oxygen payment rules.

Q19. If a patient has had a CPAP for six years and wants to receive a new one due to new technology, are they able to do that even though their current CPAP is working just fine?
A19. The patient cannot just automatically receive a new CPAP just because it has been in use over five-years. The patient would need a new order from their physician and must meet all of the current criteria within the policy to obtain a replacement CPAP.

Follow-up question: I was under the impression that if a Medicare patient already had a CPAP machine purchased through Medicare, they had to meet the requirements for the sleep study at that time to have continued coverage for any supplies and new equipment. Basically they have been grandfathered in.
A. Yes, per the policy, that is correct.

Q20. On the new order for replacing oxygen equipment, how specific does it have to be? Does it have to say oxygen at two liters, 24-hours or replacement equipment for oxygen patient?
A20. The detailed written order needs to follow all the criteria listed in Chapter 3 of our supplier manual along with it stating the equipment is a replacement.

Q21. If we have a patient on service and they have had oxygen equipment for five years starting in 2004 and they cap out in 2009, is this what you mean by the five-year rule?
A21. The five-year rule starts the day the patient received the equipment.

Q22. The new ostomy LCD article says there is a consolidated code, A4314, insertion tray with drainage bag with indwelling catheter, Foley type, two-way latex with coating. Under this code, if the patient gets a catheter and other supplies on the same date of service, you have to bill A4314. Does the delivery ticket have to state A4314 as the consolidated code or can it list the specific items the patient received?
A22. The delivery ticket does not have a requirement that you use the HCPCS code because beneficiaries do not understand HCPCS codes. You can list the specific items separately on the delivery ticket.

Q23. In the Respiratory Assist Device (RAD) policy, regarding the new bi-pap with central sleep apnea, my understanding is we take a look at the total number of events, including hypopneas. In order for the patient to qualify, they have to have 50% or higher of those events to be of a central nature. Is this correct?
A23. Yes, according to the RAD policy, central apneas/hypopneas greater than 50% of the total apneas/hypopneas is one of the coverage criteria.

Follow-up question: Is this based off the baseline study or CPAP titration?
A. The second criterion for defining central sleep apnea from the LCD is "central apneas/hypopneas greater than 50% of the total apneas/hypopneas". This is a determination made at the time of the initial polysomnography and is a component of the initial polysomnography.

Q24. On replacement oxygen equipment after five years, is the RA modifier necessary along with a new initial CMN?
A24. Yes.

Q25. What modifier do you use to bill for nutritional products, such as Ensure or Fibersource, when they will be administered through a syringe?
A25. Please refer to the Enteral Nutrition or Parenteral Nutrition policy. There is no specific modifier used for this way of administration, however there are other modifiers that apply to providing nutrition services in certain circumstances. The type of administration is question five on the Enteral/Parenteral Nutrition DIF.

Ask the Contractor Q & A – March 17, 2009

Prior to taking questions, NAS provided the following updates. 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 Web site for updates.

Recent Web Site Enhancements

NAS DME has recently made several improvements to our Web site to provide additional resources and to reduce the number of pages suppliers need to review to find information.

News/Publications

- Upcoming Changes - Watch this area of the Web site for overviews of updates and changes. Currently NAS has posted information on the DMEPOS Competitive Bidding Program, Accreditation, Oxygen and Oxygen Equipment, and ICD-10-CM.

Fees

- Fee Schedule Lookup Tool - Enter a HCPCS, year/quarter, and/or state to find the fee schedule amounts for specific codes.

Coverage/MR

- Physician Resources - All documents addressed to physicians that suppliers may use to educate physicians about supplying medical documentation for DME claims are located under this heading.
- Documentation Checklists - All of these will be reviewed and updated. The date on the last page shows which checklists have recently been updated. The dates with 2006 will be reviewed soon.

These are excellent tools to assist in gathering required documentation.

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

Accreditation

CMS wants to ensure that suppliers of durable medical equipment, prosthetics, orthotics, and supplies who bill Medicare for Part B services have ample time to complete the accreditation process and thus receive an accreditation decision by the September 30, 2009, deadline. In order to meet this deadline, CMS encouraged all enrolled DMEPOS suppliers, except those eligible professionals and other persons exempted by law, to submit a complete accreditation application to an accreditation organization by January 31, 2009. If you have missed this deadline, we encourage you to submit your accreditation application as soon as possible.

Surety Bond

On December 29, 2008, CMS announced regulations requiring certain DMEPOS suppliers of certain DMEPOS to post a surety bond as a condition of new or continued Medicare enrollment. The regulation states that beginning May 4, 2009, suppliers seeking to enroll or changing the ownership of a DMEPOS supplier must submit a $50,000 surety bond for each assigned NPI for which the DMEPOS supplier is seeking to obtain Medicare billing privileges. Existing DMEPOS suppliers must submit to the NSC a $50,000 surety bond for each assigned National Provider Identifier (NPI) no later than October 2, 2009.

In addition, a DMEPOS supplier enrolling a new practice location must submit to the NSC a new surety bond or an amendment or rider to the existing bond, showing the new practice location is covered by an additional base surety bond of $50,000.

New Repair and Replacement Modifiers

Effective for claims with dates of service on/after January 1, 2009, the RP modifier is no longer be accepted for the use of repair and replacement and will be denied for inappropriate use if submitted. The following modifiers are required:

RA **Replacement** of beneficiary-owned DMEPOS due to the expiration of the equipment's reasonable useful lifetime or to loss, irreparable damage, or when the item has been stolen

RB Replacement parts furnished in order to **repair** beneficiary-owned DMEPOS

The meaning of the replacement modifier has not changed. It needs to be appended only to the first month rental claim, a narrative explaining the reason for the replacement is required on the claim, and a new order or Certificate of Medical Necessity (CMN) is required, if applicable.

Suppliers should also note that the code for billing repair for labor is changing for dates of service on/after 4/1/09. E1340 will no longer be used and is replaced by:

K0739 Repair or Non-routine Service for Durable Medical Equipment Other than Oxygen Equipment Requiring the Skill of a Technician, Labor Component, Per 15 Minutes

K0740 Repair or Non-routine Service for Oxygen Equipment Requiring the Skill of a Technician, Labor Component, Per 15 Minutes

Tax Identification Number Authentication

Effective April 6, 2009, when you call either the Interactive Voice Recognition (IVR) system, or a Customer Service Representative, CMS will require you to provide three data elements for authentication: NPI; PTAN; and the last 5-digits of your tax identification number (TIN). For more information, see MLN Matters 6139.

Medtrade

NAS will be attending Spring Medtrade in Las Vegas, NV from March 24-26th. Staff from each of the four DME MACs, National Supplier Clearinghouse (NSC), Common Electronic Data Interchange (CEDI), and Competitive Bidding Implementation Contractor (CBIC) will be among the many exhibitors available to provide information and address questions. We will be located in booth 932. The DME MACs will also provide a one-hour "Medicare Updates" presentation on March 26th from 9:45 – 10:45 am.

Face-to-Face and Web-based Workshops

NAS is pleased to announce the Spring 2009 round of face-to-face workshops. Outreach and Education staff will be traveling to 11 locations throughout Jurisdiction D and offer two 3-hour sessions. The morning sessions will be titled Unlock the Mysteries of DME (basics) and the afternoon session will be titled A Breath of Fresh Air (Oxygen and PAP). Please visit the NAS Web site training page for more information and registration, which will only be accepted through the mail.

Also, NAS has a number of Web-based training sessions available on topics such as, Oxygen, Documentation Prior to DME Claims Submission, Glucose Monitor and Testing Supplies, Advance Beneficiary Notice of Noncoverage and Wheelchair Options and Accessories.

CEDI Updates

Starting on Friday, March 20, 2009, at 3 p.m. ET, the CEDI Gateway is going to be down until Sunday March 22, 2009, at 6 p.m. ET, so that they can make some changes to editing and to the functionality of that system. Starting at 3 p.m. on Friday afternoon ET through Sunday night at 6 p.m. ET, you cannot submit claims or dial in to pick up reports as the gateway will be down. It should be up on Monday morning.

For more details on the editing changes that are going to be moving more from the DME MACs to the CEDI front end, see the CEDI Web site and the NAS DME Web site.

Q1. I have a client who is just now getting their NPI and is having some difficulty because she's hitting accreditation issues. She may not be accredited for billing to Medicare for a while, but still wants to do immunizations. When you say accreditation for Medicare Part B services, do you mean flu vaccines also?
A1. The accreditation that we talked about was for DME suppliers. This does not apply to other non-DME Part B services, such as immunizations.

Q2. My question is about accreditation and the comment regarding the eligible professionals that are exempt by the regulations. We've seen that physical therapists (PT) and occupational therapists (OT) are exempt. Is this PTs and OTs in private practice only or are PTs and OTs that work for an outpatient rehab facility required to be accredited?
A2. Accreditation does not apply to any PT/OT who is enrolled as DME supplier. If a PT/OT is working for a outpatient rehab facility and that rehab facility is a DME supplier and they provide other services, then the facility may have to be accredited for DME.

Follow-up question: All our facilities are classified as outpatient freestanding rehab facilities under Medicare with a provider number and the therapists work under that provider number and everything is billed underneath this rehab provider number.
Follow-up answer: If you have further questions, we would suggest that you call the NSC at 866-238-9652. They can look at your supplier number and how they have you categorized as a DME supplier and best advise you about whether you need to be accredited or not.

Q3. My question has to do with a posting on February 25, 2009, in regards to supplies and accessories used with beneficiary-owned equipment. Does this apply to pumps or just capped rental items?
A3. This article applies to all supplies and accessories that are being used with equipment, such as a pump, when Medicare did not pay for that pump and therefore we wouldn't have any record that the patient is using a pump, owns a pump or has rented a pump, but we're getting claims for the supplies and accessories. We need to know the status of that pump.

Q4. My question is on dual therapy. I have a patient who is on Total Parenteral Nutrition (TPN) and also IV therapy. When we submit the claims, only the IV therapy is getting paid and not the TPN. Do I have to submit the DME Information Form (DIF) on each TPN claim?
A4. NAS requested that examples be faxed for research but none were received. A DIF is not required on every TPN claim, only the initial claim or if information on the DIF changes. In this situation, both a DIF for the TPN and the external infusion pump are needed, since both type of therapies are being provided.

Q5. I have a question about use of the KX modifier. We're having a little internal confusion about appropriate use for pneumatic compression devices. The Local Coverage Determination (LCD) for this device doesn't require a KX modifier, but our billing person believes it should be appended to demonstrate the coverage criteria has been met. Another camp says, no, that's just messing up the claim submission, because it is not required. What is your perspective?
A5. Submitting a KX modifier when not required by the policy will not cause a problem with claims processing. In the future, the KX modifier may be required so you would be ahead of the game when this occurs.

Q6. This has to do with the National Supplier Clearinghouse, but in a way it has to do with NAS, since one of our stores cannot bill Medicare until we get a supplier number from the National Supplier Clearinghouse. The problem is the store has been open since last June but a number has not yet been assigned. When we call, we are just told it being worked on. My concern is that if I hit May 4, 2009, then a surety bond will be required. I have asked to speak to a supervisor and have a list of all the people I've talked to and the dates.
A6. Our education team worked with the NSC to get this number assigned. This supplier enrollment application was in process and a supplier number was assigned on March 13, 2009. The supplier was notified of this assigned number.

Q7. We have been in business for 17 years and have many customers that come to us to get new power wheelchairs. We have received numerous denials for these claims. Is it true that if we added verbiage in the HA0 record that we know that the reasonable useful lifetime has been met (equipment is older than five years) that this would prevent denials?
A7. This will help, but an RA modifier for claims in 2009 and RP modifier for claims before 2009 is also required, indicating that the equipment is being replaced. We also need a comment of when the original equipment was provided to the beneficiary so we can determine if five years of usage has elapsed.

Q8. I just received a code E0700 for a product. Could you tell me payment policies for the device? The device is a full truncal-dynamic balance stabilizing orthosis and a lower truncal-dynamic balance stabilizing device. I was told by a call center representative that it is a billable code, but online it looked like it was not a billable code. I need to know whether or not I need to reapply with Pricing Data Analysis and Coding (PDAC) to get a code that would be billable.
A8. This code is for a safety device, which is not covered by Medicare under DME. These devices are not medical in nature. If you feel that PDAC coded these devices incorrectly, you can ask for an appeal of this decision by following the process outlined in the PDAC coding decision letter.

Follow-up question: I feel that these devices are not safety devices. This is a new type of device, like a thoracolumbar orthosis, only it changes people's balance control and they move differently so they move with more control. This device stabilizes the spine and controls movement in the three-dimensional plane so I'm confused as to why this was coded as safety equipment.

Follow-up answer: NAS requested that the decision letter and product information be faxed for additional research, but a fax was never received.

Q9. My question is in regards to Comprehensive Error Rate Testing (CERT) reviews on catheters. For the most part people catheter more than once a day, obviously to empty their bladder. In the requests that we get from CERT, they ask for progress notes for the exact number of times people cath. But if we're within the guidelines and knowing that people need to cath at least more than once a day, I just wanted to get your insight in regards to the documentation needed, to establish reasonableness.
A9. NAS assumes that what CERT is looking for is an order from the physician as to how many times per day the patient should cath. The supplier responded that they have this on the order. Dr. Whitten stated that this order, along with documentation that states that the patient is continuing to

self-cath, ought to be sufficient. If you're getting a denial from CERT on this request, when frequency of catheterization is within the guidelines, NAS would like to hear about this.

Q10. This is a question about the Advance Beneficiary Notice of Noncoverage (ABN) and the use of option number two. We have patients who want to use option number two "I want the item listed above, but do not bill Medicare. You may be asked to be paid now." They are interpreting this as their decision. "I don't want Medicare billed for this, I just want the piece of equipment." But then when you look at the CMS Claims Processing Manual it says, "This option allows the beneficiary to receive the non-covered items and/or services."

When using the term non-covered in this instance, is the manual referring to truly non-covered or is it things that are not covered, because they are not medically necessary, because any item can fall under this. Do you see what I'm saying, because the definition of non-covered are things like wigs, diapers and air conditioners? So can they use option two, just to say, "Yes, we want the product listed above, but we don't want you to bill Medicare. We just want to pay for it right now."
A10. That's how we interpret option two. This option can be used for non-covered or not medically necessary items if the beneficiary chooses to pay for the item themselves and they do not want the claim filed.

Dr. Whitten offered the following: Previously, we had a split between the ABN and the Notice of Exclusion of Medicare Benefits (NEMB) form. CMS tried to put them together, hoping to provide the beneficiary with a single form that would accomplish both purposes. It was not the intent that providers would automatically take things that otherwise would be covered and coerce beneficiaries to sign the ABN and to choose option two.

The second option was designed to allow the beneficiary to have autonomy, if they truly didn't want a claim filed, but it was not designed to try to allow a way around a claim being filed for items that otherwise would be covered items.

The way you are describing it, where clearly you are trying to do the right thing, if it's a medical necessity issue, you're trying to get option one checked, is correct.

Suppliers are also required to explain the three options to the beneficiary, so that they understand the difference between them. If a patient has secondary insurance, they need a Medicare denial before secondary will consider the claim for payment.

Q11. I have a question regarding a power wheelchair that I am getting ready to bill today. Regarding the new R modifiers, the beneficiary has had a power wheelchair for five years already, and we're providing her another chair, so instead of the NUKHBP, I'm going to use the RA. Is this correct?
A11. You would still need to bill the other rental modifiers, but you would also want to include an RA modifier to show that this is a replacement piece of equipment. (RP modifier signified replacement for dates of service before 1/1/09).

Follow-up question: So would I use the NU also or would I replace the NU with the R modifier?

Follow-up answer: You would still have to use your rental modifiers, so you would still use NUKHBP or RRKHBP, but you have to also add an RA or RP modifier.

Follow-up question: But it's a purchase, I'm going to use the NUKHBP and then you would not use the RR or the KH, because those are rental modifiers.
Follow-up answer: KH is still need to show that the beneficiary is purchasing in the first month. BP is required to show that the beneficiary elected to purchase the item.

Q12. I understand that you need to have a surety bond for each NPI that you have. We are a one location company, but we have two NPIs, because Blue Cross Blue Shield in Iowa requires us to have separate NPI numbers, one for our infusion therapy line of service and one for our durable medical equipment line. I am trying to understand the rationale in having two surety bonds for one company, even though we have two service lines. Can you clarify?
A12. The surety bond requirement only applies to Medicare, so it would not pertain to your Blue Cross Blue Shield NPIs. So if you have one NPI for billing to Medicare for DME, you only need one surety bond.

Follow-up question: But if I have another DME NPI number that is listed with Medicare, will I need to have a second bond? I bill with both NPIs to Medicare now; infusion therapy claims go under one NPI number and the DME claims go under a second NPI.
Follow-up answer: The supplier was asked to fax in both NPIs so this situation could be researched. Since Medicare DME requires only one NPI, the second NPI was closed out and only one surety bond will be required. The supplier was notified of the appropriate action to take to close out the NPI that they no longer wish to use for Medicare. This action did not affect the use of two NPIs for Blue Cross Blue Shield of Iowa claims.

Q13. We provide service to the power wheelchairs that we have provided to our customers, along with providing service to customers that have gotten their wheelchair from other suppliers. Beginning April 1, we are required to report the date of purchase on the claim. What should we do when we are unable to obtain that information because the customer got their unit four years ago from an HMO and they have no record of this. How do we as a provider obtain this information? If we can't, we're still going to provide service to them, because they need their power equipment, but what is our leg to stand on if we cannot get that information?
A13. In your narrative, you will want to indicate that the beneficiary owns the chair and it was paid for by another insurance four years ago. Dr. Whitten reminded the callers that Medicare isn't going to cover service or supplies to a chair, unless the chair itself is medically necessary. So if you have no record of where it was obtained and when, there is nothing to substantiate the medical necessity and that's where we could have difficulty in trying to figure out whether the repair is covered. The dates and the record are ways of helping to identify the patient did meet some medical necessity and they didn't just decide they wanted a power wheelchair. You may have to otherwise have a way to establish the patient's medical necessity, if you have no access to the other records. The purpose of dates is to help establish medical necessity.

Q14. I have a question regarding the ABN and having it filled out by the patient. We supply diabetic shoes and diabetic inserts, but we bill them non-assigned to Medicare. We would like to know if the ABN needs to be offered and filled out by the patient at that time.
A14. Assignment has nothing to do with whether or not you should get an ABN. You need to get an ABN if you feel that service is not going to be medically covered by Medicare or if it is something that is never covered by Medicare, i.e., if a patient does not have diabetes and they want a pair of orthopedic shoes, this is statutorily non-covered, so you could use the ABN form to educate them that Medicare will not pay for this. But use of the ABN is not tied at all to whether you accept assignment or not.

We would encourage you to go to our ABN workshops that may be offered in the future. The ABN PowerPoint used in these workshops can also be located on our Web site on the Training/Events page under Presentations.

Q15. We have many denials where the customer has moved or the address is different from what is on file with the Common Working File and the customer has to have the records updated. What is a realistic timeframe for us to expect the common working file to be updated?
A15. It depends on how timely the beneficiary updated their address with Social Security. We cannot control what Social Security does. In the interim you can file the claim to the correct contractor, based on the beneficiary's address on file currently.

Follow-up question: Most of the time we've spoken with the customer and they've told us that they've already contacted Social Security and we wait about two weeks and then we resubmit our claim and we still get another denial, because it is still not updated.
Follow-up answer: You can call customer service and they can verify the current address on file, so you can prevent those claim denials or as stated before, you can file the claim to the jurisdiction for the beneficiary address that is currently on file. You do not need to wait until the address is changed. You can file it to the appropriate DME MAC.

Q16. My question is regarding sending in redeterminations when we are refunding an overpayment to Medicare. There is a spot to checkmark the box saying that we are wanting Medicare to reprocess this claim, because we want to pay money back. But we seem to keep getting them denied, saying that they've already paid us what they're going to pay us and they're not going to pay us any more. So we're looking for the most effective way to submit these, because it seems like that keeps getting missed.

For example, we might be billing a home patient or a skilled nursing facility patient, and maybe the order changed and we've already billed for the month. We found out about the order change after the fact, so we're reprocessing the claim for fewer calories or less units, and we want to give money back. We submit the redetermination form, with the checkmark that says we want to have it processed as an overpayment, but they get denied. I think they're missing the whole part where we are trying to give money back.

A16: First of all, in this situation, you should be filling out a Refunds to Medicare form, not a redetermination form, with an explanation of how you want the units changed.

Follow-up question: We've done that in the past and we've gotten conflicting information from NAS, stating that we should be only doing this if we're refunding the entire claim.
Follow-up answer: This is an incorrect response. Anytime you want to refund money to Medicare, you would complete the refunds form. The redetermination form only applies with overpayments when we have recouped money and you wish to dispute that. That's when you would use a redetermination form and check the overpayment box.

On the refund form, specific exactly what units you would like changed, indicating the HCPCS involved and the dollar amount that you would like us to recoup.

Follow-up question: Should a check accompany the refund?
Follow-up answer: You may choose to do that or you may choose to simply send in the refund form and not send a check. Many people do that if they are not certain what the exact dollar amount of the refund will be. NAS will send an overpayment request letter that will provide the amount that the system has calculated that is owed. It is your choice whether you want to send a check along with the refund. You also have a third choice, which is to check a box on the refund form that says immediate offset. We will then take payments directly from the next claims payment.

Q17. This is a follow-up to the question about the refunds to Medicare. When we are sending in the request for Medicare to take money back, there is usually a new DIF or a revised DIF that goes with it, showing that there was a change in the order. Will that get processed and put into Medicare's system as part of the refund process?
A17. The recoupment department does not do that ourselves, we're strictly financial, but we will communicate with the claims processing department and they will make the DIF correction.

Q18. I have another question regarding a supplier that does not have a supplier number yet as they are still going through the accreditation process. This is a small supplier in a town that doesn't have any other home infusion companies. She is turning away Medicare patients at this time, however there are some Medicare services that are non-covered, which she could provide, if she could get a denial to have the patient's secondary insurance cover. Is there a way for her to get a Medicare denial on those non-covered services, if she does not have a Medicare supplier number?
A18. We have to that Medicare supplier number and NPI match before we can process the claim.

Follow-up question: Is there any future possibly in getting that done, considering accreditation is going to be required and providers possibly dropping out, only because in talking to her she is in a small town in Alaska, and no other providers do this service. So she is sending all home infusion patients to Anchorage, which is costing hundreds of dollars to ship it back down to Juneau.
Follow-up answer: We consulted and we understand your situation, but the Medicare rules are that you have to have a supplier number before you can do any billing, even for non-covered services. Because of the timing, you do have to be

accredited if you are a new supplier at this time so there is no way to get a denial for her for those services.

Follow-up question: Is there anything in the works to try to get that available for non-providers?
Follow-up answer: No, because of the fraud situation in DME, CMS is requiring that all suppliers be accredited.

Dr.Whitten suggested that the supplier work with the other payers on a short-term basis to see if they would accept claims for coverage without a Medicare denial.

Q19. This is regarding appeals that we may have for a power wheelchair or services that have been provided. Sometimes we submit a redetermination request and we do not receive a decision, whether it be favorable or unfavorable and we call Medicare asking for a duplicate decision and the representatives say that they will mail us one and we still do not receive one for some reason or another. Is it possible to give the representatives the ability to fax or e-mail those decisions, because without that decision we are unable to move on to the next level? We have about 20 of these pending.
A19. At this time appeal decision letters are only generated by mail. If you are not receiving them, have you discussed the mailing address with the CSR? Perhaps there is some sort of error in the mailing address.

Follow-up question: No, we get NAS Medicare mail everyday. I mean it's very frequent and free-flowing. We just have problems receiving the appeal decisions.
Follow-up answer: The reason that we do not fax them is because there is no way for us to verify that the fax number you are providing to us is at your location or that you even work for that company. So to protect the information that is put in that letter, we will only mail them.

Follow-up question: Do you have a way of printing them out and putting them in envelopes, so that they are not going to a mailroom?
Follow-up answer: That is something that we could suggest. But unfortunately at this time there is no way for us to fax them. NAS also suggested that the next time appeal letter decisions are requested that we could follow them through to make sure they get mailed. The supplier was asked to fax examples but none were received.

Q20. I have a question regarding patients enrolled in hospice programs. We are providing a DME service and we don't know that they went into hospice. This particular patient actually went into hospice in September of 2008. Our first denial for showing that she is in hospice is 2/20/09. The January claim was processed and applied to her deductible. The hospice agency indicated that their first payment from Medicare was in October of 2008. I'm wondering why there was such a lag time between getting the record updated and our first denial, because obviously now, retroactively, we're going to have to give all that money back to the September date of her hospice eligibility. Why would January apply to the deductible and not deny as being enrolled in hospice?
A20. NAS believes the hospice has to file a claim to Part A to show the patient has elected hospice. If the hospice delayed and did not file a claim for several months, that would explain the timing of all of this. And as far as applying the deductible, I believe that's just normal Medicare claims processing.

Follow-up question: That's my concern, because this isn't the first time I've noticed that. I have had patients who get new equipment, and it happens to be the same or similar where the denial is applied to the deductible.
Follow-up answer: It's possible that if the patient is responsible, the denial will apply to deductible. NAS received examples and it was determined the claims were paid in error as they related to the hospice diagnosis and the hospice record was on file. The supplier was informed of these errors and the resulting recoupment of erroneous payment. This also explains why money was applied to the deductible.

Q21. Where can I find more information about implementation of the surety bonds?
A21. Not a lot of details have yet been released, other than those published on our Web site. One of our postings on this topic has a link to the actual federal register ruling on this, where you could read more. There was a CMS call today on this topic. Your best resource is going to be the CMS enrollment page, http://www.cms.hhs.gov/medicareprovidersupenroll/, where CMS will be posting new information on this topic.

Q22. We have a patient for which 36 months of oxygen have been paid. The patient's condition changed, as well as the liter flow. Does this mean we could start a new rental or not?
A22. No, once you've received 36 months of payment, if the modality has changed, even if it is due to a change in their condition, you cannot start a new capped rental period.

Follow-up question: So we just keep them on as a maintenance and service?
Follow-up answer: Correct, you're allowed one maintenance service in 2009 for concentrators or transfilling equipment, so it depends on the type of equipment you dispense.

Follow-up question: So we do not need to get a new CMN, because of the liter flow change and condition change.
Follow-up answer: The policy states that if liter flow changes, you do need to get a revised CMN if switching between flow categories: (a) less than 1 LPM, (b) 1-4 LPM, (c) greater than 4 LPM. If the change is from category (a) or (b) to category (c), a repeat blood gas study with the patient on 4 LPM must be performed within 30 days prior to the start of the greater than 4 LPM flow. If liter flow is changing within a category, a new CMN is not required, but a new order would be.

Q23. Our physicians see patients in the local emergency room and occasionally they do not have the braces available through the hospital that the patient needs. The doctors would like to call our orthotists to retrieve the brace they need from our supply, to use on the hospitalized patient. I'm a little uncomfortable with this arrangement. I'm concerned about place of service and the payment piece is murky to me. If they are in the hospital, that is paid through Part A. If they get a DME from a doctor's office, that's Part B. Can you help clarify that for me, about place of service and whether this arrangement would be an acceptable arrangement for Medicare?
A23. The only arrangement that we see as acceptable is that you would have to have a contract with the hospital for you

to provide what the hospitalized patient needs. The hospital would bill through Part A and then they would have to pay you so you would not be filing a claim to DME, because it's all for a hospitalized patient and it's all part of the Part A payment. But the hospital could contract with you to provide the braces that they need for their patients. You are correct to be concerned about any other types of relationships.

Q24. Regarding the denials that we received for either a power wheelchair or for repair services that we've completed, we get C016 denials, which is a miscellaneous code, stating that we're missing or have incomplete information in order for the claim to be reviewed. But when we call the CSR and direct them to the narrative, the information they were looking for is already there, so they reprocess or reopen the claim. Why is this information being missed when the claim is worked?
A24. NAS requested examples so we could research but none were provided.

Q25. Can Medicare beneficiaries go to non-Medicare suppliers, if they so choose. I do understand a good practice would be for that non-Medicare supplier to have them sign an ABN, indicating that there is no supplier number, specifically if it is a covered Medicare item, so they can have the option to go to another supplier that has a number. And then also with this documentation, what do we do with it? We are obviously not going to bill Medicare, because we do not have a Medicare number. Do we keep it for seven years like other Medicare documentation?
A25. In regards to your documentation question, as you know Medicare requires suppliers to keep documentation in their files for seven years. If you are not enrolled with Medicare, we really can't govern the documentation aspect, but I would highly recommend that you do retain it for a considerable amount of time, whether it is seven years or whatever your discretion may be. The reason being that let's say the beneficiary contacts 1-800-Medicare at a later time and is concerned about some aspect of the claim, NAS would contact you and ask to see that documentation. So it would just be a failsafe, so to speak, if you did retain it for at least some amount of time, whether it be seven years or whatever your decide.

Your understanding of how the ABN should be used in this case is also correct. It is a CMS requirement that if you do not have a supplier number that you inform the beneficiary of this and give them an ABN for that reason.

Follow-up question: Only for items that are normally covered, right? You wouldn't have to do it for something that is not covered.
Follow-up answer: Correct.

Q26. On the new repair codes effective for dates of service April 1, 2009 or later, I'm a little bit concerned, because my understanding of the new oxygen rules would be that starting in June, six months after the cap date, there could be a repair service, at least for 2009, the way the rule reads, to be able to be done for oxygen. This, the way it's worded would lead me to believe that is not going to happen.
A26. Maintenance and service is being confused with repair. If you repair any oxygen equipment, it is denied, after the 36 month cap, since the rental payments for equipment includes repairing the equipment. If you are doing maintenance and service on concentrators and home fills, we'll allow one payment in 2009.

Follow-up question: So it would be the old rules of billing maintenance and servicing, put the code of the item we're providing, plus the MS modifier.
Follow-up answer: Yes, but you actually have to do maintenance and service for oxygen equipment.

Q27. I have a question on adding the RA modifier to replacement equipment. Sometimes when we call Medicare, especially the IVR, if it has been over four years say on a CPAP, they do not show that the patient had equipment. Therefore, I wouldn't bill the claim as a replacement.
A27. The IVR logic will only provide you information that could cause your claim to deny. So the IVR wouldn't necessarily be able to help you if you were looking for equipment over five years old. The call center reps also respond the same way. If an item is over five years old and the replacement modifier was not added to the claim, the claim will still suspend for review by our claims staff and will not deny as same and similar.

Q28. If oxygen has been paid for 36 months and the patient goes to another category and qualifies for high flow oxygen at six liters, is there an increase in payment at that point in time?
A28. If going from one oxygen category to another, you do need to submit a revised CMN and you use a different modifier, if it's greater than four liters per minute.

Follow-up question: Correct, but will payment increase, as it does in the 36 months?
Follow-up answer: Well, you won't be getting any payment now.

Follow-up question: But I will if I bill for contents.
Follow-up answer: Correct, you will for contents.

Follow-up question: Will that payment increase?
Follow-up answer: No, it will not. You get paid monthly for the contents for everything that the patient needs for that month, whether they're on a low flow or a higher flow.

Follow-up question: But if it is less than 36 months, I do get an increase in payments,
Follow-up answer: Based on the modifier, correct, for the equipment you receive an increased payment amount, but not for the contents.

Follow-up question: The content is what is costing us.
Follow-up answer: Hopefully you will have some patients that are receiving the lower flow, to compensate for the ones that receive the higher flow.

Q29. There were several comments earlier about the five year useful lifetime rule and I'd like some clarification as whether the provider is expected to determine if the equipment can be repaired or after the five year time, we have the option of whether to replace the equipment.
A29. For equipment, other than oxygen, how we look at, and historically it has been looked at, is you have the right to replace the equipment, but it is not an automatic replacement

of the equipment. It needs to be worn out. If it is something that you could repair and it is a relatively minor cost, that might be a better option for the beneficiary than having them having to pay deductible and coinsurance on a brand new piece of equipment. So it is sort of up to the beneficiary. It's not really an automatic replacement like it is for oxygen after five years of usage.

Follow-up question: Do you have a definition of a minor repair?
Follow-up answer: Well it's going to depend on what kind of chair you have and what the condition of the chair is and if repairs are reasonable and necessary. If you anticipate you're going to have to keep repairing lots of little things and it's going to add up to a lot of money in a short period of time, you might be better off replacing that chair. It would depend on how much it would cost to replace the chair now versus what you anticipate for repairs or what you're looking at for repairs right now. So it is somewhat the beneficiaries choice too, based on their share of the expense.

Q30. My question has to do with the new repair policy with the allowable units of service. The wording on this is that supplier may only bill the allowable units of service listed in the repair table. Is the expectation that we are to bill either the actual or up to the allowed?

A30. If you have less units than what is in that article you can bill less or you can bill up to what is listed. In either case, you are asked to give us a narrative of your actual time spent.

Follow-up question: If other items, other than the those listed the article are repaired, I believe there were seven types of repairs listed for power wheelchairs, we can still charge the actual time for those particular items, correct?
Follow-up answer: Correct and the time should be documented.

Q31. I had a follow-on question in regards to the high flow concentrator usage that is indicated by use of a modifier, because I've had several patients that have been high flow for which I could never determine how I was supposed to get paid. After reviewing the LCD, I am thinking that I will either only get the increased payment for the high flow concentrator or the portable system. Is this correct?
A31. Yes, this is correct. Your rental payment on one of the pieces of equipment is higher, but not on both pieces. There are two separate modifiers for this circumstance: QF for high flow and portable is prescribed and QG for high flow and portable is not prescribed.

Follow-up question: So if I bill an E1390 with a QF, indicating that I was also providing portability, I am only going to get paid for the higher concentrator charge, correct?
Follow-up answer: This is correct.

Q32. I have a follow-up question to the previous question on the high flow oxygen. How does that affect the 36 month cap and getting paid for contents on a high flow patient, if we have been billing for the concentrator at the higher flow rate charge and not the portability and the patient reaches the cap, how am I going to start to get covered for portable contents at that point?

A32: Based on how contents are paid, you have to provide all the contents the patient needs for one month and you only get seventy-seven dollars and some cents, whether they're on high flow or lower flow.

Follow-up question: But say we bill for the concentrator for the 36 months, with the modifier, to get the additional reimbursement for the high flow, but the patient has a portable that we don't bill for, because we cannot get paid for it. When the patient caps at 36 months on the concentrator, we need to start billing for portable contents, but there will be no indication of portable in the system, other than the high liter flow modifier on the concentrator claim?
Follow-up answer: Based on the high liter flow modifier on the concentrator claim, the claims processing system will allow portable contents after the 36 month capped is reached on the concentrator.

Q33. This is in regards to a patient that enrolls in hospice. When a patient enrolls in hospice, are all Part B services covered under hospice at that point? Should we bill all services to the hospice organization?
A33. Yes, this is correct in general. If there are services or items provided that are not related to the patient's terminal condition, you can bill a GW modifier and Medicare will consider these for payment. The diagnosis has to be different than what their hospice diagnosis is in this situation. No additional documentation is needed on the claim as Medicare can determine the diagnosis for the hospice claim.

Top Ten Telephone Inquiries

The purpose of this article is to assist suppliers with solutions to the "Top Ten" telephone inquiries our Supplier Contact Center received from October - December 2008. Our Web site, https://www.noridianmedicare.com, contains excellent information to assist with supplier inquiries.

1. DME Same or Similar Equipment

Same or similar information for the previous five years can be obtained through the IVR. Utilizing the IVR for same or similar questions allows the contact center staff to be available to answer more complex inquiries.

To access the same or similar HCPCS lookup option from the IVR Main Menu, use the voice activation option by saying "same or similar" or press 6 on the phone keypad. The IVR provides the same information regarding previous equipment on file as a customer service representative would provide.

For complete instructions on how to use the IVR, please review the IVR Guide located at https://www.noridianmedicare.com/dme/contact/docs/ivr_guide.pdf.

Be sure to complete a very thorough intake assessment. Suppliers should ask the beneficiary if they currently have or had an identical or similar piece of equipment. A Suggested Intake Form can be accessed on our Web site under the Forms section.

2. Entitlement

CMS mandates suppliers check beneficiary eligibility through the IVR. The IVR provides beneficiary eligibility information including the Medicare Part A and B effective and term dates, Part B deductible, HMO, Home Health and Hospice

information for the date of service entered, and newly assigned Medicare numbers (if applicable).

3. Frequency/Dollar Amount Limitation

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

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

The policies can be accessed from the Coverage/MR section of the NAS DME Web site by going to the subsection titled Local Coverage Determinations and clicking on the link for Current LCDs.

It is also important for suppliers to complete a very thorough intake assessment. Suppliers should ask the beneficiary if they currently have or had an identical or similar piece of equipment. Utilize the IVR to verify the same or similar information provided by the beneficiary.

4. Common Working File Rejects

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

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

5. Payment Explanation/Calculation

When questioning the amount paid on a claim, please consult the fee schedules as well as your remittance advice.

Most DMEPOS are paid based on a fee schedule established by CMS for each state or territory. The beneficiary's permanent address will determine the amount allowed by Medicare for a particular service. Drugs, however, have the same allowance regardless of where the beneficiary resides.

Medicare pays 80% of the allowed amount for DMEPOS, drugs and biologicals. The most current fee schedules are located in the News and Publications section of the NAS DME Web site.

Please refer to the guide Understanding the Remittance Advice found on CMS's Web site at http://www.cms.hhs.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf, for additional information on the claim adjustment reasons codes.

6. Claim Not on File

If you have not received a remittance advice for your claim, check the IVR for claim status. If the IVR is unable to find your claim, verify the claim was properly completed and submit a new claim for processing.

Please be aware, Medicare will not process claims containing incomplete or invalid information. Suppliers may receive notification of the errors through education status letters. These claims are considered unprocessable. Corrections must be made and new claims submitted.

If you bill electronically, verify the claim was transmitted and not rejected during EDI front-end processing as listed on an error report.

7. Medical Necessity

Suppliers are encouraged to consult the Local Coverage Determination (LCD) and policy article for individual medical policy coverage criteria. The LCDs can be accessed from Coverage/MR section of our Web site.

If you receive a medical necessity denial on a claim, you have the option to submit a written signed request to appeal the decision. If you make this choice, NAS recommends using the DME Inquiry/Redetermination interactive form located on our Web site and submitting it along with all pertinent medical documentation supporting the need for the item at issue to:

Noridian Administrative Services
PO Box 6727
Fargo ND 58108-6727

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

8. Duplicate Remittance Advice

To eliminate the need to request duplicate remittance advices from our Contact Center, NAS recommends suppliers download the Medicare Remit Easy Print (MREP) software. MREP is offered free of charge to read and print Health Insurance Portability and Accountability Act (HIPAA) compliant Electronic Remittance Advices (ERAs) for accounts reconciliation and crossover claims submission to secondary/tertiary payers.

The software is updated annually along with three additional updates to implement the Claim Adjust Reason and Remittance Advice Remark Code (CARC and RARC) changes and allows the supplier to:

- Print ERAs in the Standard Paper Remittance (SPR) format;
- Print and export reports about ERAs including denied, adjusted and deductible applied claims.

For additional information on downloading MREP, contact the CEDI Help Desk. The CEDI Help Desk will provide support for electronic transactions exchanged with CEDI including claims, reports, ERAs and 276/277 transactions.

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

Many electronic claim billing software programs have a feature that allows for an electronic remittance advice to be received electronically, printed and/or post the payment information to each beneficiary's account. Contact your software vendor for the availability of these features.

CEDI only keeps a copy of remittance advices for 45 days so ensure that you are pulling remittance advices timely from your electronic mailbox.

9. Certification Requirements

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

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

10. Eligibility

It is the supplier's responsibility to determine whether the patient is entitled to receive Medicare benefits and to report the Medicare number as shown on the patient's Medicare Health Insurance card. The claim must be submitted with the patient's name exactly as it is shown on the Medicare card.

Please utilize the IVR to verify Part B entitlement, possible HMO coverage or date of death information.

Top Ten Written Inquiries

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

1. Medical Review

Before submitting a redetermination, be sure to review the claim to determine if the denial requires substantiating information from the patient's medical record and was afforded appeal rights.

If the claim meets these criteria, you may submit a redetermination request. We suggest using the DME Inquiry/Redetermination interactive form available on our Web site under the Forms section.

Please be sure to provide all the pertinent information and sign the form before sending to us for processing. Failure to do so may result in your request being dismissed. The completed form and documentation may be mailed to the address below or faxed to 1-888-408-7405.

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

If the claim does not require substantiating documentation, but was afforded appeal rights, you can request a reopening. If the claim was not afforded appeal rights, corrections must be made and a new claim submitted for processing.

Note: The remark codes found on your remittance advice will indicate whether the claim has been afforded appeal rights. For help understanding your remittance advice, please reference the remittance advice guide available on the CMS Web site at http://www.cms.hhs.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf in conjunction with the remittance advice remark codes and definitions found on the Washington Publishing Company's Web site at http://www.wpc-edi.com/content/view/507/228.

2. Issues not Identified/Incomplete Information Provided

When sending documentation to NAS, please clearly state the question or request. If information is submitted without a specific question or request, the written correspondence staff will reply with a letter indicating the inquiry was incomplete.

Please ensure you provide all pertinent information so the inquiry can be completed. NAS receives letters stating an item is medically necessary with no Health Insurance Claim Number (HICN), appeal request, Date of Service (DOS), etc., which would allow us to correctly identify the patient or claim in question. Lack of information may cause the inquiry to be returned as unprocessable.

3. Claim Information Change

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

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

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

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

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

4. Additional Development Request Letters

If a supplier receives an Additional Documentation Request (ADR) letter, it is very important the requested information is mailed back to the address on the ADR letter, along with a copy of the letter, within thirty days. If these steps are not followed, the claim could deny as the requested information was not received timely.

If the allotted time has expired and the claim has been denied, the next step for reimbursement is to submit a redetermination request. Please be advised, the documentation requirements for this service may differ from the information requested in the original ADR letter. Refer to the Documentation Guide on our Web site at https://www.noridianmedicare.com/dme/coverage/, to ensure all necessary documentation is included with your redetermination requests.

5. Misrouted Written Correspondence

Please be sure forms and requests are sent to the correct entity. NAS has been receiving correspondence intended for the National Supplier Clearinghouse and the Common Electronic Data Interchange (CEDI). Sending inquiries and information to the incorrect entity may cause a delay in processing.

6. Claim Documentation

Requests to manually load Certificates of Medical Necessity (CMNs) should only be submitted if the CMN is on an old version of the form or if the supplier is unable to submit it electronically. Otherwise, the CMN must be submitted along with a claim. Requests to load CMNs which do not meet these requirements will be deemed as unprocessable and returned.

For information regarding the cost of CMN related denials to suppliers and the Medicare Trust Fund and helpful hints on how to avoid CMN related denials, please review the article, CMN and DIF Denials Cost Suppliers, located on our Web site at https://www.noridianmedicare.com/dme/news/docs/2008/10-oct/cmn_dif_denials_cost_suppliers.html.

7. Other Issues

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

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

8. Duplicate Remittance Advice

To eliminate the need to request duplicate remittance advices from our Contact Center, NAS recommends suppliers download the Medicare Remit Easy Print (MREP) software. MREP is offered free of charge to read and print Health Insurance Portability and Accountability Act (HIPAA) compliant Electronic Remittance Advices (ERAs) for accounts reconciliation and crossover claims submission to secondary/tertiary payers.

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For additional information on downloading MREP, contact the CEDI Help Desk. The CEDI Help Desk will provide support for electronic transactions exchanged with CEDI including claims, reports, ERAs and 276/277 transactions.

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

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Remember that CEDI only keeps a copy of remittance advices for 45 days so ensure that you are pulling remittance advices timely from your electronic mailbox.

9. Benefits/Exclusions/Coverage Criteria/Rules

Suppliers are encouraged to reference the Local Coverage Determinations (LCDs) and Policy Articles for specific coverage criteria. The LCDs can be accessed from the Coverage/MR section of our Web site.

NAS's Web site contains many valuable resources related to benefits, exclusions, coverage criteria, and rules. A brief overview of some of the sections you may find helpful is below:

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

Training/Events: links to numerous presentation done by our Education staff, as well as the Online Learning Center, and upcoming workshops.

News/Publications: links to the DME Jurisdiction D Supplier Manual, Frequently Asked Questions (FAQ) Database, bulletins, and What's New Latest Updates.

10. Filing/Billing Instructions

Sending in a copy of an invoice, or returning an education status letter asking for NAS to make payment, is not the appropriate procedure to receive timely reimbursement. Please review Chapter 6 of the supplier manual, for valuable information regarding claims submission.

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

If you are exempt from billing electronically, you may bill a paper CMS-1500 claim form. Please reference the CMS 1500 claim form instructions, available in the Claims section of our Web site, for assistance in properly completing the form.

CEDI

Express Plus Version 4.4.0 Available for Download

The Express Plus version 4.4.0 upgrade is now available for download from the CEDI Web site http://www.ngscedi.com/ under Software Downloads and Documentation. The link to this page is: http://www.ngscedi.com/downloads/ExpressPlusindex.htm

Note: The Express Plus Upgrade document provides instructions to assist with installing this upgrade. This document is available on the same page as the Express Plus 4.4.0 upgrade and may be accessed using the link provided above.

Some of the changes include:

- Name fields have been updated to allow special characters as defined in the CEDI Error Code Manual.
- Added functionality to be able to search by Supplier and Ordering Provider NPI.
- Taxonomy Codes will no longer cause an error in the CEDI Front-end checks.

If you need assistance with upgrading the Express Plus program, please contact the CEDI Help Desk at ngs.cedihelpdesk@wellpoint.com or at 866-311-9184.

CEDI Enrollment Tips

National Government Services CEDI is currently processing paperwork in 5-7 business days. When completing enrollment forms, here are some general tips to remember:

1. All enrollment forms must be signed and dated by the provider within 30 days of the form being faxed to enrollment.
2. When submitting the EDI Enrollment form, the entire form must be faxed to CEDI. If only the signature page of this form is received, it will be returned.
3. The Supplier information entered on the enrollment form(s) must match the information on file with the National Supplier Clearinghouse (NSC). To verify this information, please contact the NSC at 866-238-9652.
4. The National Provider Identifier (NPI) number and the Provider Transaction Access Number (PTAN)/NSC number must be entered on the NPI crosswalk. This crosswalk uses data from the NSC and the National Plan & Provider Enumerator System (NPPES) to create the crosswalk entry. The PTAN/NSC number must be listed on the NPPES Web site under Other Provider Identifier as "MEDICARE NSC". Also, verify the information registered with NPPES matches what is on file with the NSC. To view/update this information within NPPES, go to https://nppes.cms.hhs.gov/NPPES/Welcome.do.
5. Complete the appropriate form for the enrollment you are requesting. For more information on the CEDI forms and their uses, please refer to the CEDI Web site http://www.ngscedi.com/ and view the EDI Enrollment link. More information can be found in the CEDI Frequently Asked Questions (FAQ) under the Resource Materials link on the CEDI Web site.
6. When completing multiple forms you must include the PTAN, NPI numbers and the Submitter ID on all forms. Forms missing this information will be returned.

If you are have questions when completing the CEDI Enrollment forms, please contact the CEDI Help Desk at ngs.cedihelpdesk@wellpoint.com or 866-311-9184.

Healthcare Provider Taxonomy Codes Update

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

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

Valid HPTCs are those codes approved by the NUCC for current use. Terminated codes are not approved for use after a specific date and newly approved codes are not approved for use prior to the effective date of the code set update in which each new code first appears. Although the NUCC generally posts their updates on the WPC Web page 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 Washington Publishing Company (WPC). To view the April 2009 changes, visit the WPC Web site at http://www.wpc-edi.com/codes/taxonomy, then select the New Code tab for a listing of new HPTCs or the Modifications tab for a listing of modified HPTCs.

The complete list is available in two forms:

- A free Adobe PDF download.

- An electronic representation of the code set that facilitates automatic loading of the codes. (available for purchase)

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

Notifying CEDI for Registering New PTAN/NSC Numbers

If you are a DME Supplier who has received a new Provider Transaction Authentication Number (PTAN)/National Supplier Clearinghouse (NSC) number, you must notify Common Electronic Data Interchange (CEDI) Enrollment of the new PTAN/NSC number and its associated National Provider Identifier (NPI). The new PTAN/NSC number must also be linked to the NPI in the National Plan and Provider Enumeration System (NPPES).

If you do not enroll the new PTAN/NSC number with CEDI and register it with NPPES, claims associated with this new PTAN/NSC number will be rejected.

- Claims submitted without a valid PTAN/NSC match on the NPI crosswalk, will be rejected with CEDI edit C003.
- Claims submitted before March 20, 2009 with an NPI linked to a PTAN/NSC not enrolled with CEDI will reject with DME MAC edit 20011.

After March 20, 2009, claims submitted with an NPI linked to a PTAN/NSC not enrolled with CEDI will be returned on the supplier's Electronic Remittance Advice or Standard Paper Remittance with the Reason/Remark Codes to indicate the "Claim service lacks information which is needed for adjudication" and/or "Electronic interchange agreement not on file for provider/submitter."

To resolve DME MAC edit 20011 or Remittance Reason/ Remark Codes, suppliers must either:

- Complete the EDI Enrollment Form to register all PTAN/ NSC numbers with CEDI.

If you submit claims through a clearinghouse or third party biller, you will need to complete the Supplier Authorization Form as well as the EDI Enrollment Form.

The EDI Enrollment and the Supplier Authorization Forms can be accessed through the CEDI Web site http://www.ngscedi.com under EDI Enrollment.

OR

- If you have an existing EDI Enrollment Form on file with CEDI for your NPI, you may submit an e-mail to cedienrollment@wellpoint.com with the Subject line reading: "Reason/Remark Code Supplier Not Authorized for EDI". Please include the following within your e-mail request:
  - Submitter ID
  - Submitter Name
  - Address
  - Contact Name
  - NPI number
  - The new PTAN/NSC that received the error.

CEDI will add your PTAN/NSC and notify you via e-mail when this has been completed. Once your CEDI enrollment has been completed, you can resubmit your claims.

CEDI: Delay in Delivery of 277 Files for 276 Transactions Sent on Friday, April 3, 2009

CEDI would like to inform Trading Partners who submitted 276 transactions on Friday, April 3, 2009, that there is a delay in CEDI receiving the 277 response files from the DME MACs. This delay only affects the 277 response transactions and does not affect claims, electronic remittance advice, and/ or report files.

More information will follow when it is available.

Please direct questions to the CEDI Help Desk at ngs.cedihelpdesk@wellpoint.com or at 866-311-9184.

CEDI Front-End Implementation Update

National Government Services, Common Electronic Data Interchange (CEDI) is in the process of changing the front-end processes for ANSI X12 837 claims and 276 claim status request transactions. There are some changes being made to what was originally communicated.

Stage 2 - Implementation will occur on March 20, 2009

- On Friday, March 20, 2009, at 3:00 p.m. ET, the CEDI Gateway will be brought down until Sunday, March 22, 2009, at 6:00 p.m. ET for the DME MACs to remove their front-end edits for 837 claims and 276 claims status transactions.
  ** During this time, Trading Partners will not be able to connect to CEDI to transmit or receive electronic transactions and/or reports.
- The DME MACs will remove their front-end edits and all electronic front-end editing for the X12 837 claims and 276 claim status transactions will be done through CEDI.
- All 837 claim front-end rejections will be returned on the CEDI GenResponse (GENRPT) report.
- 276 claims status request front-end rejections will be returned on the 277 claims status response transaction.
- The additional GenResponse edits that were implemented in Stage 1 will replace the DME MAC Level II edits and Trading Partners will no longer receive front-end rejections on the Level II reports from the DME MACs.
- Claims accepted on the GenResponse Report will be assigned a Claim Control Number (CCN) and these will be indicated on the report that will go back to the Trading Partner from CEDI. This CCN will be attached to the claim as it enters the appropriate DME MAC for processing. The CCN will also be provided on the DME MAC front-end report (RPT report).

CEDI CONT'D

- All electronic front-end editing for the X12 276 claim status request transaction will be done through CEDI and all front-end rejections will be returned on the 277 transaction produced by CEDI.

DME MAC Front End-Report: The DME MACs will continue to produce their Front-End Report showing accepted claims received from CEDI. This report is returned through CEDI with the "RPT" prefix. All claims received by the DME MAC from CEDI will be shown on this report as "Accepted" and provide the CCN assigned by CEDI. This is the same CCN shown on the GenResponse (GENRPT) report and will not change once it has been assigned by CEDI.

CMN Rejection Report: The process for DME MACs to edit CMNs submitted on the 837 claims will not change. Any CMN rejections will be returned on the CMN Rejection Report produced by the DME MACs and delivered to the Trading Partners CEDI mailbox in the RPT file.

NCPDP Claims: NCPDP claims are not affected by these changes. CEDI will continue to receive the NCPDP claims from the Trading Partner and forward the claims to the DME MACs. The DME MACs will perform all front-end editing and assign the CCN to accepted NCPDP claims.

Edits to be Resolved with March 20, 2009 Implementation: During the implementation taking place on March 20, 2009, CEDI will make modifications to some of the CEDI Front-end edits. The CEDI edits that will be updated are listed below.

A142	(2310B PRV03)	Corrected edit firing as a warning instead of rejection on Taxonomy code
C083	(2430 DTP)	Corrected edit firing inappropriately when tertiary payer data is present
C103	(2400 CR510)	Updated edit to not set when the value in the CR510 is 59.1-59.9 on oxygen claims
C180	(2400 DTP472)	Corrected instances of edit not firing for future 'TO' date of service
C191	(2440 FRM03)	Updated edit to not allow first position of FRM03 to be a space (was setting if entire field was spaces)
C199	(2400 CRC)	New edit added to reject when CRC01=07/70, is present

The following edits are still being modified at CEDI:

1001 Error not consistently reporting appropriate loop on GENRPT.

A360 Edit not setting on CARC when 2330B/2430 Primary Payer Adjudication date is before 2003.

C172 Edit setting inappropriately due to error 1001 setting (errors reported incorrectly).

For more information in understanding the CEDI Front End Reports, visit the CEDI Web site at http://www.ngscedi.com under Resource Materials.

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

All CEDI Listservs are posted to the "News" section of the CEDI Web site at: http://www.ngscedi.com/news/newsindex.htm.

ACCREDITATION

DMEPOS Supplier Accreditation

MLN Matters Number: SE0903

Provider Types Affected
All providers and suppliers that furnish Medicare Part B durable medical equipment (DME), prosthetic devices, prosthetic or orthotic items, and medical supplies to Medicare beneficiaries

Provider Action Needed
DMEPOS (durable medical equipment, prosthetics, orthotics and supplies) providers and suppliers enrolled in the Medicare Part B program are required to obtain accreditation by **September 30, 2009**.

In order to retain or obtain a Medicare Part B billing number, all DMEPOS providers and suppliers (except for exempted professionals and other persons as specified by the Secretary of the Department of Health and Human Services as noted below in this article) must comply with the Medicare program's supplier standards and quality standards and become accredited. A DMEPOS supplier's Medicare Part B billing privileges will be revoked on October 1, 2009, if the DMEPOS supplier fails to obtain accreditation by September 30, 2009.

DMEPOS providers and suppliers that have not yet d one so should contact an accreditation organization (AO) right away to obtain information about the accreditation process and submit an accreditation application to the AO of their choosing. Suppliers can find a list of the deemed accrediting organizations at http://www.cms.hhs.gov/MedicareProviderSupEnroll/Downloads/DeemedAccreditationOrganizations.pdf on the CMS Web site.

Background
Section 302 of the Medicare Modernization Act of 2003 (MMA) added a new paragraph 1834(a)(20) to the Social Security Act (the Act) that required the Secretary to establish and implement quality standards for suppliers of DMEPOS. All suppliers that furnish such items or services set out at subparagraph 1834(a)(20)(D) as the Secretary determines appropriate must comply with the quality standards in order to receive Medicare Part B payments and to receive or retain a provider or supplier number.

Covered Items and Services
Pursuant to subparagraph 1834(a)(20)(D) of the Act, the covered items and services are defined in Section 1834 (a)(13), Section 1834 (h) (4) and Section 1842 (s) (2) of the Act. The covered items and services include:

- Durable Medical Equipment (DME);

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

Non-Covered Items

- Medical supplies furnished by Home Health Agencies;
- Drugs used with DME (inhalation drugs and drugs infused with a DME pump);
- Implantable items and;
- Other Part B drugs:
- Immunosuppressive drugs
- Anti-emetic drugs.

DMEPOS Quality Standards

The quality standards, published at http://www.cms.hhs.gov/medicareprovidersupenroll on the CMS Web site, are separated into two sections and have three appendices as follows:

- **Section I** includes the business standards that apply to all suppliers and focus on standards for administration, financial management, human resource management, consumer services, performance management, product safety and information management.
- **Section II** contains service standards, including intake, delivery and setup, training and instruction of the beneficiary and/or their caregiver and follow-up service.
- **Appendix A** addresses respiratory equipment, supplies and services.
- **Appendix B** addresses manual wheelchairs and power mobility devices, including complex rehabilitation and assistive technology.
- **Appendix C** addresses custom fabricated and custom fitted orthoses, prosthetic devices, external breast prostheses, therapeutic shoes and inserts and their accessories and supplies, and custom-made somatic, ocular and facial prostheses.

Accreditation Deadline for DMEPOS Suppliers

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) required all DMEPOS suppliers to meet quality standards for Medicare accreditation by September 30, 2009.

Who Needs Accreditation?

The September 30, 2009, accreditation deadline applies to all Medicare Part B enrolled providers and suppliers of durable medical equipment, medical supplies, home dialysis supplies and equipment, therapeutic shoes, parenteral/enteral nutrition, transfusion medicine and prosthetic devices, prosthetics and orthotics. The accreditation deadline also applies to pharmacies, pedorthists, mastectomy fitters, orthopedic fitters/technicians and athletic trainers.

As of March 1, 2008, new DMEPOS providers and suppliers submitting an enrollment application to the National Supplier Clearinghouse (NSC), except those eligible professionals and other persons mentioned below, must be accredited prior to submitting the application. The NSC shall reject the enrollment application unless the DMEPOS supplier demonstrates an approved accreditation.

Who is Exempt?

MIPPA stated that certain eligible professionals and other persons do not have to be accredited by September 30, 2009, unless the Secretary determines that the quality standards are specifically designed to apply to such professionals and persons. In addition, those providers that were accredited prior to the enactment of MIPPA (July 15, 2008) will not have to undergo a re-accreditation process.

The eligible professionals that are exempt from the September 30, 2009, accreditation deadline include the following practitioners:

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

Additionally MIPPA allows the Secretary to specify "other persons" that are exempt from meeting the September 30, 2009, accreditation deadline unless the Secretary determines that the quality standards are specifically designed to apply to such other persons. At this time, these "other persons" are only defined as the following practitioners:

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

Accreditation Process

The accreditation process takes an average of 6-7 months but may take up to 9 months to complete for a Medicare enrolled or new DMEPOS supplier that submits a complete application to an accrediting organization (AO) and has no deficiencies to correct post onsite-survey.

Pre-application Process

- A DMEPOS supplier that wishes to become accredited should contact the AOs and obtain information about each organization's accreditation process.
- The supplier should review the information and choose the organization to which it will apply.

- The AO will assist the supplier to determine what changes will be required to meet the accreditation standards (e.g., modify existing services, practices, developing appropriate policies and procedures, develop an implementation plan, timeline, and training employees).
- The supplier should apply for accreditation after the changes are in place or during implementation.

Application Review and On-site Survey

- The supplier submits a completed application to the AO with all the supporting documentation.
- The AO reviews the application and documentation (verify licensures, organizational chart, etc.).
- The on-site surveys are conducted minimally every 3 years and are unannounced.
- The AO will determine whether to accredit the supplier based on the submitted data and the results of the on-site survey.

Key Points

All Medicare Part B enrolled DMEPOS providers and suppliers are required to obtain accreditation by September 30, 2009.

DMEPOS suppliers who submitted a completed application to an accrediting organization on or before January 31, 2009, will have their accreditation decision (either full accreditation or denied accreditation) on or before the September 30, 2009, deadline.

DMEPOS suppliers submitting applications to an accrediting organization after January 31, 2009, may or may not have their accreditation decision by the September 30, 2009, deadline.

It takes an average of 6-7 months but could take as long as 9 months for a DMEPOS supplier to complete the accreditation process. Accordingly, DMEPOS suppliers should contact an accreditation organization right away to obtain information about the accreditation process and submit an application.

A DMEPOS supplier's Medicare Part B billing privileges will be revoked on October 1, 2009, if the DMEPOS supplier fails to obtain accreditation by September 30, 2009.

Note: The current delay in the DMEPOS Competitive Bidding Program has no impact on the September 30, 2009, accreditation deadline.

Accreditation Frequently Asked Questions (FAQs)

1. Do the accrediting organizations have enough capacity to get everyone who applies at least 9 months before September 30, 2009 accredited by the deadline?

Yes. The AO's have increased surveyor staffing anticipating the additional workload. A DMEPOS supplier should choose an AO based upon their deemed status, policies, procedures and the philosophy of the organization. CMS encourages suppliers to ask the AO's questions, such as, how long it takes to become accredited from application to accreditation decision. The time to become accredited can take up to 9 months for some organizations.

2. Who are the approved DMEPOS accrediting organizations?

In November 2006, CMS approved (deemed) 10 national accreditation organizations that will accredit providers and suppliers of DMEPOS as meeting new quality standards under Medicare Part B. Most of the accreditation organizations are authorized to accredit all major supplier types, and most will be able to accredit both national and local suppliers, as well as mail order companies. A list of the CMS-approved deemed accreditation organizations and information about the types of suppliers each accrediting organization is approved to accredit and how to contact a deemed accrediting organization is posted at http://www.cms.hhs.gov/medicareprovidersupenroll on the CMS Web site.

3. Is accreditation transferable upon merger, acquisition or sale of a supplier?

Accreditation cannot be transferred upon merger, acquisition or sale of a supplier. As specified in 42 CFR 424.57 (c) (3), CMS, the NSC and the accrediting organization must be notified when a new DMEPOS location is opened.

4. If I have just recently received a survey by an accreditor, will I be subject to a site visit by a representative of the National Supplier Clearinghouse (NSC)?

These actions are independent of one another. The accreditor checks quality standards. The NSC site visit concerns enforcing supplier standards. In many cases a new supplier will receive a site survey by the AO and a site visit by the NSC.

5. Is information transferred between the accreditor and NSC?

Transfer of information between these two entities concerning their findings does occur. The NSC needs to know if a supplier is accredited prior to issuing an enrollment number, thus they will need to verify the accreditation status.

6. Will the accreditation survey efforts be coordinated with reenrollment efforts?

Not at the present time. A supplier must meet both the NSC supplier standards and the accreditation requirements on a continuous basis. We are not changing reenrollment dates and timeframes to match survey timeframes.

Additional Information

There is additional information on the accreditation process at http://www.cms.hhs.gov/MedicareProviderSupEnroll/Downloads/DeemedAccrediationOrganizations.pdf on the CMS Web site.

DMEPOS Supplier Accreditation – Get It Now

Deadline is September 30, 2009

CMS wants to remind suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) who bill Medicare under Part B that they must obtain accreditation by September 30, 2009. In order to retain or obtain a Medicare Part B billing number, all DMEPOS suppliers (except for exempted professionals and other persons as specified by the Secretary) must comply with Medicare's supplier and quality standards and become accredited. DMEPOS suppliers should contact an accreditation organization right away to obtain information about the accreditation process and submit an application.

ACCREDITATION CONT'D

DMEPOS suppliers who submitted a completed application to an accrediting organization, on or before January 31, 2009, will have an accreditation decision (either full accreditation or denied accreditation) on or before the September 30, 2009, deadline. DMEPOS suppliers submitting applications to an accrediting organization, on or after February 1, 2009, ***may or may not*** *have their accreditation decision by the September 30, 2009, deadline.*

The accreditation requirement applies to suppliers of durable medical equipment, medical supplies, home dialysis supplies and equipment, therapeutic shoes, parenteral/enteral nutrition, transfusion medicine and prosthetic devices, prosthetics and orthotics. Pharmacies, pedorthists, mastectomy fitters, orthopedic fitters/technicians and athletic trainers must also meet the September 30, 2009, deadline for DMEPOS accreditation. Certain eligible professionals and other persons as specified by the Secretary are exempt from the accreditation requirement.

Further information on the DMEPOS accreditation requirements along with a list of the accreditation organizations and those professionals and other persons exempted from accreditation may be found at http://www.cms.hhs.gov/medicareprovidersupenroll.

CERT

CERT Documentation

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

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

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

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

Mail all requested documentation to:

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

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

Suppliers may call the CDC at (888) 779-7477 or (301) 957-2380 with questions regarding specific documentation to submit.

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

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

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

NPI

Enhancements/Updates to NPPES Effective March 7, 2009

On March 7, 2009, the National Plan and Provider Enumeration System (NPPES) had system maintenance. As such, neither NPPES nor the National Provider Identifier (NPI) Registry was available on March 7, 2009.

The following enhancements were incorporated into NPPES:

- The NPPES application help page text was revised to ensure consistency with the instructions found on the revised National Provider Identifier (NPI) Application/Update Form (CMS-10114 (11/08)).
- NPPES Web users are required to change their passwords after the Enumerator has reset them. When the Enumerator resets a user's password, the user will be redirected to the password reset page in order to change the reset password to a password of his/her choice. NPPES also enforces a minimum password length of eight characters.

The following enhancements were incorporated into the NPI Registry:

- The 'doing business as' (DBA) search feature was restored.
- The NPI Registry is updated daily.
- The NPI Registry displays all results in all capital letters. This change does not affect the way information is displayed in a health care provider's NPPES record.

Electronic File Interchange (EFI)
In addition, the EFI User Manual and Technical Companion Guide have been revised. The changes did not impact the EFI XML Schema.

Additional Information
Health care providers can apply for an NPI online at https://nppes.cms.hhs.gov. Health care providers needing assistance with applying for an NPI or updating their data in NPPES records may contact the NPI Enumerator at 1-800-465-3203 or email the request to the NPI Enumerator at CustomerService@NPIEnumerator.com.

ICD-10

New Medicare Learning Network Publication and FAQs Now Available

*The General Equivalence Mappings – ICD-9-CM To and From ICD-10-CM and ICD-10-PCS Fact Shee*t (March 2009), which provides information and resources regarding the General Equivalence Mappings that were developed as a tool to assist with the conversion of International Classification of Diseases, 9th Edition, Clinical Modification (ICD-9-CM) codes to International Classification of Diseases, 10th Edition (ICD-10) and the conversion of ICD-10 codes back to ICD-9-CM, is now available in downloadable format from the CMS **Medicare Learning Network** at http://www.cms.hhs.gov/MLNProducts/downloads/ICD-10_GEM_factsheet.pdf. The General Equivalence Mappings information discussed in this fact sheet has also been posted in the CMS Frequently Asked Questions database at https://questions.cms.hhs.gov/cgi-bin/cmshhs.cfg/php/enduser/std_alp.php?p_sid=l2s5Zouj. If you are unable to access any of the hyperlinks in this message, please copy and paste the URL into your Internet browser.

Update on CEDI Front-End Changes – Stage 2 – March 20, 2009

National Government Services, Common Electronic Data Interchange (CEDI) is in the process of changing the front-end processes for ANSI X12 837 claims and 276 claim status request transactions.

Stage 1 was completed on January 10, 2009, at which time CEDI began performing all front-end edits for ANSI X12 837 claims and 276 claims status request transactions. All new edits have been added to the *CEDI Front-End Reports Manual*. This manual is available on the CEDI Web site at http://www.ngscedi.com/outreach_materials/outreachindex.htm.

Stage 2 - Implementation will occur on March 20, 2009*

* **Note:** The implementation date for Stage 2 was changed from previous communications.

- On Friday, March 20, 2009, at 3:00 p.m. ET, the CEDI Gateway will be brought down until Sunday, March 22, 2009, at 6:00 p.m. ET for the DME MACs to remove their front-end edits for 837 claims and 276 claims status transactions.
  ** During this time, Trading Partners will not be able to connect to CEDI to transmit or receive electronic transactions and/or reports.
- The DME MACs will remove their front-end edits and all electronic front-end editing for the X12 837 claims and 276 claim status transactions will be done through CEDI.
- All 837 claim front-end rejections will be returned on the CEDI GenResponse (GENRPT) report.
- 276 claims status request front-end rejections will be returned on the 277 claims status response transaction.
- The additional GenResponse edits that were implemented in Stage 1 will replace the DME MAC Level II edits and Trading Partners will no longer receive Level II Claims accepted on the GenResponse Report will be assigned a Claim Control Number (CCN) and these will be indicated on the report that will go back to the Trading Partner from CEDI. This CCN will be attached to the claim as it enters the appropriate DME MAC for processing.
- All electronic front-end editing for the X12 276 claim status request transaction will be done through CEDI and all front-end rejections will be returned on the 277 transaction.

CMN Rejection Report: The process for DME MACs to edit CMNs submitted on the 837 claims will not change. Any CMN rejections will be returned on the CMN Rejection Report produced by the DME MACs and delivered to the Trading Partners CEDI mailbox in the RPT file.

NCPDP Claims: NCPDP claims are not affected by these changes. CEDI will continue to receive the NCPDP claims from the Trading Partner and forward the claims to the DME MACs. The DME MACs will perform all front-end editing and assign the Claim Control Number (CCN) to accepted NCPDP claims.

Please contact the CEDI Help Desk at 1-866-311-9184 or by e-mail at ngs.cedihelpdesk@wellpoint.com if you have questions about the upcoming changes or the CEDI front-end edits.

All CEDI Listservs are posted to the "News" section of the CEDI Web site at: http://www.ngscedi.com/news/newsindex.htm.

APPEALS

Email Available for Redetermination and Reopening Questions

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

Questions and concerns may include but are not limited to:

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

Confidential information cannot be e-mailed. This includes Protected Health Information (PHI), such as patient names, claim information, Health Insurance Claim (HIC) numbers, Social Security numbers, Claim Control numbers (CCNs) or supplier numbers. This type of information cannot be e-mailed because it may be possible for others to view the

APPEALS CONT'D

contents. If you have a question that would contain PHI, please call our Contact Center at 1-866-243-7272.

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

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

ENROLLMENT

CMS Publishes FAQs for DMEPOS Surety Bond Requirements

On December 29, 2008, CMS announced regulations requiring suppliers of certain DMEPOS to post a surety bond as a condition of new or continued Medicare enrollment. Recently, CMS published a list of Frequently Asked Questions (FAQ) to provide more information about the surety bond requirement. View the list of FAQs.

CMS Announces Use of Revised CMS-855S Enrollment Application for DMEPOS Suppliers

Recently, CMS announced the use of the revised CMS-855S enrollment application to be used by DMEPOS suppliers for initial enrollment, reactivations, reenrollments, and to report changes of information. The application revision includes new sections for reporting surety bond information and accreditation exempt drugs and pharmaceuticals. Other changes to the application include the posting of the business' hours of operation and the addition of Supplier Standard 26. In accordance with CMS instruction, the NSC shall no longer accept initial submissions of the 855-S form received after June 1, 2009. View the (03/09) CMS-855S here.

BILLING

New Repair Codes Effective April 1, 2009

To distinguish between the repair or non-routine service of beneficiary-owned DME and oxygen equipment, two new "K" codes are **effective for claims with dates of service on or after April 1, 2009**. E1340 will no longer be a valid code for labor for repair for dates of service on/after April 1, 2009.

K0739 Repair or Non-routine Service for Durable Medical Equipment Other than Oxygen Equipment Requiring the Skill of a Technician, Labor Component, Per 15 Minutes

K0740 Repair or Non-routine Service for Oxygen Equipment Requiring the Skill of a Technician, Labor Component, Per 15 Minutes

The new non-covered code K0740 should be to indicate the labor associated with the repair of stationary or portable oxygen equipment.

Source: MLN Matters 6296

Reason Remark Resource

The Reason Remark Resource has been created to assist the supplier community with better understanding why claims are being denied and how to prevent those denials on future claims submissions.

The Reason Remark Resource provides the following information:

- Reason Code - The ANSI reason code noted on a supplier Remittance Advice (RA).
- Remark Code - The ANSI remark code noted on a supplier RA.
- Reason for Denial - A general reason the claim may have denied with the noted reason and remark codes.
- Things To Look For - A guide to assist suppliers with where to look within the supplier or patient files to better understand the claim denial.
- What To Do Next - Direction to assist suppliers with knowing their options to try and obtain payment for this claim after the original claim denied.
- How To Prevent This Denial For Future Billings - This section will provide tips and resources for suppliers to prevent the same denial from occurring in the future.

The denials selected for the Resource were based on analysis completed on claim denials for the time period of October-December 2008. Future claim denial analysis will be conducted and additional remark and reason codes will be added to the resource.

Please reference the Reason Remark Resource posted on the Claims page of our Web site.

Interim Action to Process Claims for L5670 Until SNF Consolidated Billing Files Can Be Updated with October 2009 Quarterly Release

This message is to bring your attention to a Skilled Nursing Facility (SNF) Consolidated Billing claim processing issue associated with HCPCS code L5670. Code L5670 was inadvertently left off the SNF Consolidated Billing Coding Files for 2009. L5670 should be separately payable outside of the SNF consolidated billing bundled payment. This problem will be corrected with the October 5, 2009, quarterly system update. Until then, please contact us at 1-866-243-7272 to have claims you have submitted with dates of service January 1, 2009, or later containing L5670 re-opened and re-processed. We apologize for any inconvenience you experience related to this problem.

Modifier CR for Catastrophe Related Claims - Floods

In light of recent flooding in North Dakota, suppliers are reminded that the modifier CR signifies that a claim is due to a catastrophe or is related to a disaster. Reporting this modifier will indicate emergency healthcare needs and facilitate Medicare claims processing for victims of a disaster.

CMS established the CR modifier (Catastrophe/Disaster Related), effective August of 2005 (MLN Matters 4106).

Medicare will cover replacement of DMEPOS items due to a natural disaster as outlined in Chapter 5 of the Jurisdiction D Supplier Manual:

> "Replacement refers to the provision of an identical or nearly identical item. Equipment which the beneficiary owns or is a capped rental item may be replaced in cases of loss or irreparable damage. Irreparable damage refers to a specific accident or to a natural disaster (e.g., fire, flood, etc.)."

New capped rental periods will start for beneficiaries who need to replace equipment due to the flood. Repairs of equipment will also be covered, per the usual guidelines, also outlined in Chapter 5 of the Jurisdiction D Supplier Manual.

CMS released the following regarding the flood situation in North Dakota.

North Dakota Floods - State of Emergency Notice

As a consequence of severe storms and flooding in the State of North Dakota, the President has declared a major disaster, and the Acting Secretary of the U.S. Department of Health and Human Services has declared that a public health emergency exists and has existed since March 13, 2009, in the State of North Dakota. For more information, go to http://www.cms.hhs.gov/Emergency/12_StormFlood.asp.

This CMS Web site includes "downloads" that outline Medicare FFS policy during this emergency.

New CWF MSP Type for WCMSAs to Stop Conditional Payments

MLN Matters Number: MM5371 Revised
Related Change Request (CR) #: 5371
Related CR Release Date: March 20, 2009
Related CR Transmittal #s: R1703CP, 65MSP
Effective Date: July 1, 2009
Implementation Date: July 6, 2009

Note: This article was revised on March 20, 2009, to reflect a revised transmittal related to CR 5371. The CR was changed to clarify some of the requirements. The CR release date, transmittal numbers (see above), and the Web address for accessing that transmittal were changed. All other information remains the same.

Provider Types Affected
Physician, providers and suppliers who bill Medicare contractors (carriers, including Durable Medical Equipment Medicare Administrative Contractors (DME MACs), fiscal intermediaries (FIs), including regional home health intermediaries (RHHIs), and Part A/B Medicare administrative contractors (A/B MACs)) for services related to workers' compensation liability claims

What You Need to Know
In order to prevent Medicare's paying primarily for future medical expenses that should be covered by workers' compensation Medicare set-aside arrangements Workers' Compensation Medicare Set-aside Arrangements (WCMSA), CR 5371, from which this article is taken, provides your Medicare contractors with instructions on the creation of a new Medicare Secondary Payer (MSP) code in Medicare's claims processing systems. With the creation of the new MSP code, the Centers for Medicare & Medicaid Services (CMS) will have the capability to discontinue conditional payments for diagnosis codes related to such settlements.

Background
A Workers' Compensation Medicare Set-aside Arrangement (WCMSA) is an allocation of funds from a workers' compensation (WC) related settlement, judgment or award that is used to pay for an individual's future medical and/or future prescription drug treatment expenses related to a workers' compensation injury, illness or disease that would otherwise be reimbursable by Medicare. The CMS has a review process for proposed WCMSA amounts and updates its Common Working File (CWF) system in connection with its determination regarding the proposed WCMSA amount. For additional information regarding WCMSAs, visit http://www.cms.hhs.gov/WorkersCompAgencyServices on the CMS Web site.

The CMS has determined that establishing a new MSP code in its systems, which identifies situations where CMS has reviewed a proposed WCMSA amount, will assist Medicare contractors in denying payment for items or services that should be paid out of an individual's WCMSA funds. The creation of a new MSP code specifically associated with the WCMSA situation will permit Medicare to generate an automated denial of diagnosis codes associated with the open WCMSA occurrence.

When denying a claim because of these edits, your Medicare contractor will notify the beneficiary using Medicare Summary Notice (MSN) message 29.33 - *Your claim has been denied by Medicare because you may have funds set aside from your settlement to pay for your future medical expenses and prescription drug treatment related to your injury(ies).*

In addition, Medicare will use Reason Code 201, Group Code PR, and Remark Code MA01, on outbound claims and/or remittance advice transactions when Medicare denies claims based on the WCMSA presence. Also, on 271 inquiry reply transactions, Medicare will reflect the WCMSA on the 271 response with "EB" followed by the qualifier WC.

Additional Information
You can find the official instruction (CR 5371) issued to your Medicare contractor in two transmittals: http://www.cms.hhs.gov/Transmittals/downloads/R1703CP.pdf, and

http://www.cms.hhs.gov/Transmittals/downloads/R65MSP.pdf on the CMS Web site.

Remittance Advice Remark Code and Claim Adjustment Reason Code Update

MLN Matters Number: MM6336
Related Change Request (CR) #: 6336
Related CR Release Date: January 30, 2009
Related CR Transmittal #: R1674CP
Effective Date: April 1, 2009
Implementation Date: April 6, 2009

Provider Types Affected
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 provided to Medicare beneficiaries.

Provider Action Needed
CR 6336, from which this article is taken, announces the latest update of Remittance Advice Remark Codes (RARCs) and Claim Adjustment Reason Codes (CARCs), effective April 1, 2009 for Medicare. Be sure billing staff are aware of these changes.

Background
Two code sets—the Group and the reason and remark code sets—must be used to report payment adjustments in remittance advice transactions. For Medicare, remark codes must also be used when appropriate to report additional explanation for any adjustment or to provide general policy information. 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. 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 a national Code Maintenance committee that meets when X12 meets for their trimester meetings (occurring in January/February, June, and September/October) to make decisions about additions, modifications, and retirement of existing reason codes.

Both code lists are updated at the same time and posted at http://www.wpc-edi.com/Codes on the Internet. The lists at the end of the Additional Information section of this article summarize the latest changes to these lists, as announced in CR 6336.

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

Additional Information
To see the official instruction (CR6336) issued to your Medicare Contractor refer to http://www.cms.hhs.gov/Transmittals/downloads/R1674CP.pdf on the CMS Web site. For additional information about Remittance Advice, please refer to Understanding the Remittance Advice (RA): A Guide for Medicare Providers, Physicians, Suppliers, and Billers at http://www.cms.hhs.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf on the CMS Web site. If you use the Medicare Remit Easy Print software from your Medicare Contractor, you may need to download the updated version when it is available on April 6, 2009.

New Codes - CARC:

Code	Current Narrative	Effective Date
226	Information requested from the Billing/Rendering Provider was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason code.)	9/21/2008
227	Information requested from the patient/insured/responsible party was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	9/21/2008
228	Denied for failure of this provider, another provider or the subscriber to supply requested information to a previous payer for their adjudication	9/21/2008

Modified Codes – CARC:

Code	Current Modified Narrative	Effective Date
148	Information requested from the Billing/Rendering Provider was not provided or was insufficient/ incomplete. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason code.)	7/1/2009

Deactivated Codes - CARC

Code	Current Narrative	Effective Date
17	Requested information was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	7/1/2009
B18	This procedure code and modifier were invalid on the date of service.	3/1/2009

New Codes - RARC:

Code	Current Narrative	Medicare Initiated?
N505	Alert: This response includes only services that could be estimated in real time. No estimate will be provided for the services that could not be estimated in real time.	NO
N506	Alert: This is an estimate of the member's liability based on the information available at the time the estimate was processed. Actual coverage and member liability amounts will be determined when the claim is processed. This is not a pre-authorization or a guarantee of payment.	NO
N507	Plan distance requirements have not been met.	NO
N508	Alert: This real time claim adjudication response represents the member responsibility to the provider for services reported. The member will receive an Explanation of Benefits electronically or in the mail. Contact the insurer if there are any questions.	NO
N509	Alert: A current inquiry shows the member's Consumer Spending Account contains sufficient funds to cover the member liability for this claim/service. Actual payment from the Consumer Spending Account will depend on the availability of funds and determination of eligible services at the time of payment processing.	NO
N510	Alert: A current inquiry shows the member's Consumer Spending Account does not contain sufficient funds to cover the member's liability for this claim/service. Actual payment from the Consumer Spending Account will depend on the availability of funds and determination of eligible services at the time of payment processing.	NO
N511	Alert: Information on the availability of Consumer Spending Account funds to cover the member liability on this claim/service is not available at this time.	NO
N512	Alert: This is the initial remit of a non-NCPDP claim originally submitted real-time without change to the adjudication.	NO
N513	Alert: This is the initial remit of a non-NCPDP claim originally submitted real-time with a change to the adjudication.	NO
N514	Consult plan benefit documents/guidelines for information about restrictions for this service.	YES
N515	Alert: Submit this claim to the patient's other insurer for potential payment of supplemental benefits. We did not forward the claim information.	YES

Modified or Deactivated Codes - RARC

There are no modified or deactivated RARC codes in CR 6336.

Instructions for Utilizing 837 Professional Claim Adjustment Segments for Medicare Secondary Payer Part B Claims

MLN Matters Number: MM6211 Revised
Related Change Request (CR) #: 6211
Related CR Release Date: December 12, 2008
Related CR Transmittal #: R62MSP
Effective Date: April 1, 2009
Implementation Date: April 6, 2009

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

Note: This article was rescinded on March 27, 2009, when the related CR 6211 was rescinded. CR 6211 was replaced by CR 6427, which may be found at http://www.cms.hhs.gov/transmittals/downloads/R67MSP.pdf on the CMS Web site. The related MLN Matters article may be found at http://www.cms.hhs.gov/MLNMattersArticles/downloads/mm6427.pdf on the CMS Web site.

Instructions for Utilizing 837 Professional Claim Adjustment Segments for MSP Part B Claims

This CR rescinds and fully replaces CR6211

MLN Matters Number: MM6427
Related Change Request (CR) #: 6427
Related CR Release Date: March 27, 2009
Related CR Transmittal #: R67MSP
Effective Date: July 1, 2009
Implementation Date: July 6, 2009

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

Provider Action Needed
This article is based on Change Request (CR) 6427 which informs Medicare contractors about the changes necessary to derive Medicare Secondary Payer (MSP) payment calculations from incoming 837 4010-A1 claims transactions.

CR 6427 is limited to providers billing Part B contractors (carriers and MACs) and DME MACs.

Include your CAS segment related group codes, claim adjustment reason codes and associated adjustment amounts on your MSP 837 claims you send to your Medicare contractor. Medicare contractors need these adjustments to properly process your MSP claims and for Medicare to make a correct payment. This includes all adjustments made by the primary payer, which explains why the claim's billed amount was not fully paid.

Background
The Health Insurance Portability and Accountability Act (HIPAA) requires that Medicare, and all other health insurance payers in the United States, comply with the Electronic Data Interchange (EDI) standards for health care as established by the Secretary of Health and Human Services. The X12N 837 implementation guides have been established as the standards of compliance for claim transactions, and the implementation guides for each transaction are available at http://www.wpc-edi.com on the Internet.

This article is to remind you to include CAS segment related group codes, claim adjustment reason codes and associated adjustment amounts on your MSP 837 claims you send to your Medicare contractor. Medicare contractors need these adjustments to properly process your MSP claims and for Medicare to make a correct payment. This includes all adjustments made by the primary payer, which, for example, explains why the claim's billed amount was not fully paid.

The instructions detailed by CR 6427 are necessary to ensure:

- Medicare complies with HIPAA transaction and code set requirements,
- Physician and suppliers code for the CAS segments claims to reflect any adjustments made by primary payers; and
- MSP claims are properly calculated by Medicare contractors (and their associated shared systems) using payment information derived from the incoming 837 professional claim.

Adjustments made by the payer are reported in the CAS on the 835 electronic remittance advice (ERA) or on hardcopy remittance advices. Providers must take the CAS segment adjustments (as found on the 835 ERA) and report these adjustments on the 837 (unchanged) when sending the claim to Medicare for secondary payment.

Note: If you are obligated to accept, or voluntarily accept, an amount as payment in full from the primary payer, you must use the group code Contractual Obligation (CO) to identify your contractual adjustment amount, also known as the Obligated to accept as payment in full adjustment (OTAF). Details of the MSP provisions may be found in the CMS Internet Only Manuals 100-05 and in the federal regulations at 42 CFR 411.32 and 411.33. Physician and suppliers should no longer identify the OTAF in the CN1 segment of the 837.

Additional Information
The official instruction (CR6427) issued to your Medicare contractor is available at http://www.cms.hhs.gov/transmittals/downloads/R67MSP.pdf on the CMS Web site.

Over-utilization Edits

NAS is required to monitor the utilization patterns of claims and perform medical review to determine medical necessity and proper coding practices. This includes suspending claims based on edits for units. If data analysis of claims indicates unusual variances in billing practices, claims may be subject to medical review for validation of data analysis findings. Such reviews require the supplier to provide additional documentation to show medical necessity for the number of units provided as described in the Local Coverage Determinations (LCDs) listed below.

Supplies having utilization guidelines include, but are not limited to:

- Glucose Monitors Supplies – LCD L196
- Home Dialysis Supplies and Equipment – LCD L11487
- Nebulizer Supplies – LCD L11488
- Positive Airway Pressure (PAP) Device Supplies – LCD L171
- Surgical Dressings – LCD L11460
- Urological Supplies – LCD L11581

Suppliers must not dispense a quantity of supplies exceeding a beneficiary's expected utilization. Suppliers should stay attuned to atypical utilization patterns on behalf of their clients and verify with the ordering physicians that the atypical utilization is, in fact, warranted.

If refills of quantities of supplies that exceed the utilization guidelines are dispensed, there must be documentation in the physician's or supplier's records that corroborates the need for the quantity of supplies provided.

Supplies billed beyond the utilization guidelines are denied with reason code 150, Payer deems the information submitted does not support this level of service and remark code N115, which indicates this decision is based on an LCD. Denied claims must be appealed with documentation as outlined in the applicable LCD in order to be paid for additional supplies.

For more information on utilization guidelines for supplies and equipment, please refer to the LCDs. These can be accessed at https://www.noridianmedicare.com/dme/coverage/lcd.html.

Diabetic Supplies Documentation

Documentation of the correct nature is critical to the payment of diabetic supplies, especially when a claim is for utilization of these supplies over the recommendation of the Local Coverage Determination (LCD).

The Comprehensive Error Rate Testing (CERT) contractor has supplied a list of HCPCS codes that are receiving high error rates in Jurisdiction D. Diabetic supplies appear on this list as a group of codes being over-utilized without the correct documentation to support what is being billed. Therefore, NAS would like to provide education as to the type of documentation the medical review staff and the CERT contractor look for when reviewing a diabetic claim where the utilization of supplies is over the recommendation of the LCD.

The following is a detailed list of documentation which will assist in paying claims accurately and timely the first time. Please keep in mind that LCD 196, the glucose monitors medical policy, indicates that **suppliers should stay attuned to atypical utilization patterns on behalf of their clients and verify with the ordering physician that the atypical utilization is, in fact, warranted.**

- Physician's order that indicates the patient's name, how often they are to test per day, physician signature and date of the order.
- Proof that the patient needed and requested more supplies within seven days of a new shipment being sent.
- Proof that the supplies were delivered to the patient or picked up by the patient no earlier than five days before their current supply runs out.
- Physician clinical office note that supports the following:
  - The patient was seen at least once in a six-month period of time for the evaluation of their diabetes prior to the ordering of more supplies.
  - The patient's compliance to testing and care of their diabetes.
  - The increased testing frequency is necessary to assist the physician in the patient's treatment. This may be supported by:
    - Lab results showing increased Hemoglobin A1c with records indicating how this is being addressed with increased testing;
    - Hyperglycemic or hypoglycemic episodes resulting in medication changes and any other treatment alterations that could affect the patient's diabetes.
- Patient's testing log should be appropriate for the date-of-service billed (i.e., billing date is June 1; the log should either come from March, April or May unless the supplier is billing monthly, then the log should come from the previous month). Also, the logs must support that the patient is testing at the frequency ordered otherwise this may cause a lesser number of units to be paid.
- If the ordered testing frequency is greater than the LCD guidelines and the record does not clearly indicate the necessity for this testing frequency, an Advance Beneficiary Notice of Noncoverage (ABN) should be obtained from the patient. The quantity in excess of the guidelines, justified by the records, should be submitted as a separate

line item with the GA modifier which indicates the ABN is on file.

Medical review staff would like to stress that the medical documentation submitted for review must meet the coverage criteria of the LCD and sent in a timely manner. Lack of correct documentation continues to be a major reason that supplier claims are being held up, denied or recouped. When the correct documentation is provided timely, claims can be paid expediently and accurately.

Refer to the Glucose Monitors Local Coverage Determination for additional information at https://www.noridianmedicare.com/dme/coverage/lcd.html.

Physician Documentation Requirements - Blood Glucose Strips and Lancets

Durable Medical Equipment suppliers should not dispense a quantity of blood glucose monitoring supplies that exceeds the beneficiary's expected utilization without documentation to support the need for additional supplies. This is the cause for one of the highest Comprehensive Error Rate Testing (CERT) program errors.

Prescribing physicians should be aware of the following:

1. **Insulin** treated patients meeting coverage criteria can have up to 100 strips and up to100 lancets **every** month.
2. **Non-insulin** treated patients meeting coverage criteria can have up to 100 strips and up to 100 lancets every **three** months.

If the supplies exceed these utilization guidelines, **there must be documentation in the physician's records** that supports the patient is actually testing at a frequency that corroborates the quantity of supplies that have been ordered and dispensed. The treating physician that has ordered a frequency of testing that exceeds the utilization guidelines **must** document in the patient's medical record the **specific reason** for the additional materials for that particular patient.

Documentation examples may include:

A specific narrative statement that adequately documents the frequency at which the patient is actually testing

a. A copy of the beneficiary's test log
b. Lab results
c. Medication changes
d. Symptom management

If the patient is regularly using quantities of supplies that exceed the utilization guidelines, new documentation must be present at least every six months. **If documentation is not available to support the dispensing of excessive utilization of blood glucose monitoring supplies, suppliers are not allowed to bill for these supplies, as they will not be covered by Medicare.**

The prescribing physician must provide accurate and complete written orders to the suppliers to support the medical necessity of the blood glucose strips and lancets. An order for each item must be signed and dated by the physician who is treating the patient with diabetes. The written order for diabetic testing supplies must include all of the following elements:

1. Beneficiary name
2. Treating physician's signature
3. Date of the treating physician's signature
4. Exact item(s) to be dispensed, such as lancets, strips, etc.
5. Start date of the order - only required if the start date is different than the signature date
6. Specific frequency of testing

Note: An order that only states "as needed" or "use as directed" is not an acceptable written order as it does not provide the medical necessity for the supplies. This will result in a denial for claims selected for review.

Please refer to the Local Coverage Determination (LCD) L196 Glucose Monitors for further information. The policy may
be accessed on the NAS Web site, https://www.noridianmedicare.com/dme/coverage/lcd.html.

Nebulizers - Documentation Guidance

The Nebulizers Local Coverage Determination (LCD) stipulates that for coverage of long-acting beta agonist (LABA) formulations the following criterion must be met:

It is medically necessary to administer formoterol (J7606) or arformoterol (J7605) for the management of chronic obstructive pulmonary disease (ICD-9 diagnosis codes 491.0-492.8, 496) and the patient has a documented history of routine use of at least four doses per day of an FDA-approved albuterol or metaproterenol inhalation solution or at least three doses per day of an FDA-approved levalbuterol inhalation solution.

Suppliers have inquired about how to document the "history of routine use" and the time required to be on a short acting beta agonist (SABA) before converting to formoterol or arformoterol. The supplier's records should reflect that the beneficiary has used SABA therapy at the frequencies listed in the coverage criteria for a period of three (3) months.

Suppliers should refer to the Nebulizer LCD for further information about coverage, coding and documentation requirements.

LCD and Policy Article Revisions - Summary for March 2009

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

Ankle-Foot/Knee-Ankle-Foot Orthosis LCD	Revision Effective Date: 04/01/2009 INDICATIONS AND LIMITATIONS OF COVERAGE: • Deleted: L1901 from code range of AFO-KAFO used with ambulation HCPCS CODES AND MODIFIERS: • Revised: Code L4360 descriptor • Deleted: Code L2860
Policy Article	Revision Effective Date: 04/01/2009 NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES: • Added: Noncoverage language for elastic support garments CODING GUIDELINES: • Deleted: Code L1901 from the prefabricated orthoses list and from the from ankle-foot orthosis worn by ambulatory patients. • Added: Code L2770 is invalid. • Revised: Removed Column I/Column II table in lieu of statement about billing replacement codes at time of initial issue. • Revised: SADMERC to PDAC
Knee Orthoses LCD	Effective Date: 04/01/09 INDICATIONS AND LIMITATIONS OF COVERAGE: • Added: ICD-9 diagnosis codes 844.0 – 844.2 and 996.40 – 996.49 to range of codes for L1830, L1832, L1834, L1843, L1844, L1845 and L1846 in response to request for reconsideration. • Deleted: Codes L1800, L1815, L1825 from prefabricated knee orthoses • Deleted: Codes L1800, L1815, L1825 from Base code & Addition Codes - Eligible for Separate Payment • Deleted: Codes L1800, L1815, L1825 from Base code & Addition Codes - Not Medically Necessary HCPCS CODES AND MODIFIERS: • Revised: KX modifier ICD-9 CODES THAT SUPPORT MEDICAL NECESSITY: • Added: ICD-9 diagnosis codes 844.0 – 844.2 and 996.40 – 996.49 to range of codes for L1830, L1832, L1834, L1843, L1844, L1845 and L1846 DOCUMENTATION: • Added: Clarified that use of KX modifier is applicable to both the base and addition codes. • Revised: Changed DMERC to DME MAC
Policy Article	Revision Effective Date: 04/01/2009 NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES: Deleted: Codes L1800, L1815, L1825 from the reasonable useful lifetime chart Added: Noncoverage language for elastic support garments CODING GUIDELINES: Deleted: Codes L1800, L1815, L1825 from Base code & Addition Codes - Not Separately Payable Deleted: Code L2860 Revised: SADMERC to PDAC
Spinal Orthoses: TLSO and LSO LCD	Revision Effective Date: 04/01/2009 HCPCS CODES AND MODIFIERS: Added: CG, GY DOCUMENTATION REQUIREMENTS: Added: Use of CG and GY modifiers with elastic spinal orthoses

Policy Article	Revision Effective Date: 04/01/2009 NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES: Added: Statement concerning noncoverage of elastic spinal orthoses CODING GUIDELINES: Changed: SADMERC to PDAC
Wheelchair Options and Accessories LCD	Revision Effective Date: 01/01/2009 INDICATIONS AND LIMITATIONS OF COVERAGE: Changed: Terminology from Assistive Technology Supplier/ Practitioner to Assistive Technology Professional HCPCS CODES AND MODIFIERS: Added: E2230, E2295 (to Miscellaneous Accessories section), RB modifier Revised: KX modifier Deleted: RP modifier
Policy Article	Revision Effective Date: 01/01/2009 NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES: Added: Noncoverage statement for E2230 CODING GUIDELINES: Replaced: RP with RB modifier and revised instructions Revised: Billing instructions for bilateral items Changed: References from SADMERC to PDAC Changed: Statement concerning E0968, E1228 to indicate that they are invalid for claim submission Added: E2373 to instructions for KC modifier
Note: The information contained in this article is only a summary of revisions to LCDs and Policy Articles. For complete information on any topic, you must review the LCD and/or article.	

Additional LCD and Policy Article Revisions Summary for March 26, 2009

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

Ankle-Foot/Knee-Ankle-Foot Orthosis
LCD
Revision Effective Date: 06/01/2009
HCPCS CODES AND MODIFIERS:
Added: KX modifier
Deleted: L2770
DOCUMENTATION:
Added: Instructions for use of KX modifier with both the base and addition code(s)

Policy Article
Revision Effective Date: 06/01/2009
CODING GUIDELINES:
Deleted: Code L2035 from the custom-fabricated orthoses list
Deleted: Codes K0628 and K0629 from the list used in diabetic foot problems management
Added: Codes A5512 and A5513 to the list used in diabetic foot problems management
Added: Code L4392 to list of codes rejected as incorrect coding when billed with initial issue of a base orthosis.

Wheelchair Options and Accessories
Policy Article
Revision Effective Date: 01/01/2009 (March Revision)
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Corrected: Noncoverage statement for E2230
CODING GUIDELINES:
Deleted: Codes E0977, E0997-E0999, E2320, and K0099 from list of invalid codes. These codes have been discontinued.

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

April 2009 Quarterly ASP Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files

MLN Matters Number: MM6380
Related Change Request (CR) #: 6380
Related CR Release Date: February 20, 2009
Related CR Transmittal #: R1685CP
Effective Date: April 1, 2009
Implementation Date: April 6, 2009

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

Provider Action Needed
This article is based on Change Request (CR) 6380 which informs Medicare contractors that on or after December 16, 2008, the January 2009 Average Sales Price (ASP) file will be available for download along with revisions to prior ASP payment files, if CMS determines that revisions to these prior files are necessary. In addition, on or after March 16, 2009, the April 2009 ASP NOC files will be available for retrieval from the Centers for Medicare & Medicaid Services (CMS) ASP Web page along with revisions to prior ASP NOC files, if CMS determines that revisions to these prior files are necessary.

Background
The Medicare Modernization Act of 2003 (Section 303(c); see http://www.cms.hhs.gov/MMAUpdate/downloads/PL108-173summary.pdf on the CMS Web site) revised the payment methodology for Part B covered drugs and biologicals that are not paid on a cost or prospective payment basis. The vast majority of drugs and biologicals not paid on a cost or prospective payment basis are paid based on the average sales price (ASP) methodology. Pricing for compounded drugs is performed by your local Medicare contractor.

CMS has been working further to ensure that accurate and separate payment is made for single source drugs and biologicals as required by the Social Security Act (Section 1847A; see http://www.ssa.gov/OP_Home/ssact/title18/1847.htm on the internet). As part of this effort, CMS has also reviewed how the terms "single source drug," "multiple source drug," and "biological product" have been operationalized in the context of payment under section 1847A.

For the purposes of identifying "single source drugs" and "biological products" subject to payment under section 1847A, generally CMS (and its contractors) will utilize a multi-step process. Specifically, CMS considers:

- The Food and Drug Administration (FDA) approval,
- Therapeutic equivalents as determined by the FDA, and
- The date of first sale in the United States.

The payment limit for the following will be based on the pricing information for products marketed or sold under the applicable FDA approval:

- A biological product (as evidenced by a new FDA Biologic License Application or other relevant FDA approval) first sold in the United States after October 1, 2003, or
- A single source drug (that is, not a drug for which there are two or more drug products that are rated as therapeutically equivalent in the most recent FDA Orange Book) first sold in the United States after October 1, 2003.

As appropriate, a unique Healthcare Common Procedure Coding System (HCPCS) code will be assigned to facilitate separate payment. Separate payment may be operationalized through use of "not otherwise classified, (NOC)" HCPCS codes.

ASP Methodology
The ASP methodology is based on quarterly data submitted to CMS by manufacturers. CMS supplies Medicare contractors with the ASP drug pricing files for Medicare Part B drugs on a quarterly basis. Note that payment allowance limits under the Outpatient Prospective Payment System (OPPS) are incorporated into the Integrated Outpatient Code Editor (I/OCE) through separate instructions.

In general, beginning January 1, 2005, the payment allowance limits for Medicare Part B drugs and biologicals that are not paid on a cost or prospective payment basis are 106 percent of the ASP. Further, beginning January 1, 2006, payment allowance limits are paid based on 106 percent of the ASP for:

- End Stage Renal Disease (ESRD) drugs (when separately billed by freestanding and hospital-based ESRD facilities), and
- Specified covered outpatient drugs and drugs and biologicals with pass-through status under the OPPS.

Beginning January 1, 2008, under the OPPS, payment allowance limits for specified covered outpatient drugs are paid at ASP+5%. Beginning January 1, 2009, under the OPPS, payment allowance limits for specified covered outpatient drugs are paid at ASP+4%. Drugs and biologicals with pass-through status under the OPPS continue to have a payment allowance limit of 106% of the ASP. CMS will update these payment allowance limits quarterly.

Exceptions to this general rule as summarized below.

- The payment allowance limits for blood and blood products (other than blood clotting factors) that are not paid on a prospective payment basis, are determined in the same manner the payment allowance limits were determined on October 1, 2003. Specifically, the payment allowance limits for blood and blood products are 95 percent of the average wholesale price (AWP) as reflected in the published compendia. The payment allowance limits will be updated on a quarterly basis. Blood and blood products furnished in the hospital outpatient department are paid under OPPS at the amount specified for the Ambulatory Payment Classification (APC) to which the product is assigned.
- Payment allowance limits for infusion drugs furnished through a covered item of durable medical equipment on

or after January 1, 2005, will continue to be 95 percent of the AWP reflected in the published compendia as of October 1, 2003, unless the drug is compounded or the drug is furnished incident to a professional service. The payment allowance limits were not updated in 2008. The payment allowance limits for infusion drugs furnished through a covered item of durable medical equipment that were not listed in the published compendia as of October 1, 2003, (i.e., new drugs) are 95 percent of the first published AWP unless the drug is compounded or the drug is furnished incident to a professional service.

- Payment allowance limits for influenza, Pneumococcal and Hepatitis B vaccines are 95 percent of the AWP as reflected in the published compendia except where the vaccine is furnished in a hospital outpatient department. Where the vaccine is administered in the hospital outpatient department, the vaccine is paid at reasonable cost.
- The payment allowance limits for drugs and biologicals that are not included in the ASP Medicare Part B Drug Pricing File or Not Otherwise Classified (NOC) Pricing File, other than new drugs and biologicals that are produced or distributed under a new drug application (or other application) approved by the Food and Drug Administration, are based on the published wholesale acquisition cost (WAC) or invoice pricing, except under OPPS where the payment allowance limit is 95 percent of the published AWP. In determining the payment limit based on WAC, the contractors follow the methodology specified in the Medicare Claims Processing Manual, Chapter 17, Drugs and Biologicals, for calculating the AWP but substitute WAC for AWP. The payment limit is 100 percent of the lesser of the lowest-priced brand or median generic WAC. For 2006, the blood clotting furnishing factor of $0.146 per I.U. is added to the payment amount for the blood clotting factor when the blood clotting factor is not included on the ASP file. For 2007, the blood clotting furnishing factor of $0.152 per I.U. is added to the payment amount for the blood clotting factor when the blood clotting factor is not included on the ASP file. For 2008, the blood clotting furnishing factor of $0.158 per I.U. is added to the payment amount for the blood clotting factor when the blood clotting factor is not included on the ASP file. For 2009, the blood clotting furnishing factor of $0.164 per I.U. is added to the payment amount for the blood clotting factor when the blood clotting factor is not included on the ASP file.

Note: At the contractors' discretion, contractors may contact CMS to obtain payment limits for drugs and biologicals not included in the quarterly ASP or NOC files or otherwise made available by CMS on the CMS Web site. If the payment limit is available from CMS, contractors will substitute CMS-provided payment limits for pricing based on WAC or invoice pricing. CMS will provide the payment limits either directly to the requesting contractor or via posting an MS Excel file on the CMS Web site.

- The payment allowance limits for new drugs and biologicals that are produced or distributed under a new drug application (or other new application) approved by the Food and Drug Administration and that are not included in the ASP Medicare Part B Drug Pricing File or Not Otherwise Classified (NOC) Pricing File are based on 106 percent of the WAC, or invoice pricing if the WAC is not published, except under OPPS where the payment allowance limit is 95 percent of the published AWP. This policy applies only to new drugs and biologicals that were first sold on or after January 1, 2005. Your Medicare contractor, at their discretion, may contact CMS to obtain payment limits for new drugs and biologicals not included in the quarterly ASP or NOC files or otherwise made available by CMS on the CMS Web site. If the payment limit is available from CMS, contractors will substitute CMS-provided payment limits for pricing based on WAC or invoice pricing.
- The payment allowance limits for radiopharmaceuticals are not subject to the ASP payment methodology. Medicare contractors will determine payment limits for radiopharmaceuticals based on the methodology in place as of November 2003 in the case of radiopharmaceuticals furnished in other than the hospital outpatient department. Radiopharmaceuticals furnished in the hospital outpatient department are paid charges reduced to cost by the hospital's overall cost to charge ratio.

Quarterly Payment Files

On or after March 16, 2009, the April 2009 ASP NOC files will be available for retrieval from the CMS ASP Web page along with revisions to prior ASP NOC files, if CMS determines that revisions to these prior files are necessary. The payment files will be applied to claims processed or reprocessed on or after the effective date of CR 6380 (April 1, 2009) for the dates of service noted in the table that follows.

Please be aware that your Medicare contractor will not search and adjust claims that have already been processed unless you bring them to their attention.

Payment Allowance Limit Revision Date	Applicable Dates of Service
April 2009 ASP and ASP NOC files	April 1, 2009, through June 30, 2009
January 2009 ASP and NOC Files	January 1, 2009, through March 31, 2009
October 2008 ASP and NOC Files	October 1, 2008, through December 31, 2008
July 2008 ASP and NOC files	July 1, 2008, through September 30, 2008
April 2008 ASP and ASP NOC files	April 1, 2008, through June 30, 2008

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

Drugs Furnished During Filling or Refilling an Implantable Pump or Reservoir

Physicians (or a practitioner described in the Social Security Act (Section 1842(b) (18) (C); see http://www.ssa.gov/

OP_Home/ssact/title18/1842.htm on the Internet) may be paid for filling or refilling an implantable pump or reservoir when it is medically necessary for the physician (or other practitioner) to perform the service. Contractors must find the use of the implantable pump or reservoir medically reasonable and necessary in order to allow payment for the professional service to fill or refill the implantable pump or reservoir and to allow payment for drugs furnished incident to the professional service.

If a physician (or other practitioner) is prescribing medication for a patient with an implantable pump, a nurse may refill the pump if the medication administered is accepted as a safe and effective treatment of the patient's illness or injury; there is a medical reason that the medication cannot be taken orally; and the skills of the nurse are needed to infuse the medication safely and effectively. Payment for drugs furnished incident to the filling or refilling of an implantable pump or reservoir is determined under the ASP methodology, as described above, except that pricing for compounded drugs is done by your local Medicare contractor.

Additional Information
The official instruction, CR 6380, issued to your carrier, FI, A/B MAC, RHHI, and DME MAC regarding this change may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R1685CP.pdf on the CMS Web site.

OXYGEN

Oxygen Content Billing

This article provides guidelines for appropriately billing oxygen contents.

Contents can only be billed monthly, starting with the day after the anniversary date for the oxygen equipment.
NAS is seeing claims billed on a weekly basis for contents, which results in the first submitted claim being paid, but subsequent claims are denied as duplicate. For example, services were billed on 1/5/09, 1/31/09 and 2/5/09. Only the 1/5/09 and 2/5/09 claims will be paid.

Following the stationary oxygen equipment payment cap, suppliers should bill for oxygen contents on the anniversary date of the oxygen equipment billing. Example: If the 36th month of continuous use of the stationary oxygen equipment begins on March 11th and ends on April 10th, the supplier should begin billing for monthly oxygen contents that the beneficiary will use after the cap on April 11th.

For subsequent months, the supplier does not need to deliver the oxygen contents every month in order to continue billing for the contents on a monthly basis. A maximum of three months of oxygen contents can be delivered at one time. In these situations, the delivery date of the oxygen contents does not have to be the DOS (anniversary date) on the claim. However, in order to bill for contents for a specific month, the supplier must have previously delivered quantities of oxygen that are sufficient to last for one month following the date of service on the claim. Suppliers should have proof-of-delivery for each actual delivery of oxygen, but this may be less often than monthly.

Example: Supplier delivers 30 oxygen tanks on April 11th and the beneficiary uses 15 tanks from April 11th through May 10th and 15 tanks from May 11th through June 10th. Supplier bills for contents on April 11th and again on May 11th for contents delivered on April 11th that was used for two months.

The units of service for contents codes, E0441-E0444, should always be one.
This represents providing oxygen contents for one month. Suppliers are responsible to provide all the oxygen contents that the patient needs in one month, so if multiple deliveries are needed to provide the oxygen the patient needs, the supplier must deliver multiple times in a month, but can still only bill monthly. As referenced above, the date for billing contents should be the day after the anniversary date for the oxygen equipment.

Content Codes
Payment for both oxygen contents used with stationary oxygen equipment and oxygen contents used with portable oxygen equipment is included in the 36 monthly payments for oxygen and oxygen equipment (stationary oxygen equipment payment) made for codes E0424, E0439, E1390 or E1391. Beginning with dates of service on or after the end date of service for the month representing the 36th payment for Code E0424, E0439, E1390 or E1391, the supplier may bill on a monthly basis for furnishing oxygen contents (stationary and/or portable), but only in accordance with the following chart:

Equipment Furnished in Month 36	Monthly Contents Payment after Stationary Cap
Oxygen Concentrator (E1390, E1391 or E1392)	None
Portable Gaseous Transfilling Equipment (K0738)	None
Portable Liquid Transfilling Equipment (E1399)	None
Stationary Gaseous Oxygen System (E0424)	Stationary Gaseous Contents (E0441)
Stationary Liquid Oxygen System (E0439)	Stationary Liquid Contents (E0442)
Portable Gaseous Oxygen System (E0431)	Portable Gaseous Contents (E0443)
Portable Liquid Oxygen System (E0434)	Portable Liquid Contents (E0444)

Contents are payable once stationary equipment has reached 36 month cap
If the beneficiary began using portable gaseous or liquid oxygen equipment (E0431 or E0434) more than one month after they began using stationary oxygen equipment, monthly payments for portable gaseous or liquid oxygen contents (E0443 or E0444) may begin following the stationary oxygen equipment payment cap AND prior to the end of the portable equipment payment cap (Code E0431 or E0434). As long as the beneficiary is using covered gaseous or liquid portable oxygen equipment, payments for portable oxygen contents may begin following the stationary oxygen

equipment payment cap. This will result in a period during which monthly payments for E0431 and E0443, in the case of a beneficiary using portable gaseous oxygen equipment, or E0434 and E0444, in the case of a beneficiary using portable liquid oxygen equipment, overlap. In these situations, after the 36-month portable oxygen equipment payment cap for E0431 or E0434 is reached, monthly payments for portable oxygen contents (E0443 or E0444) would continue.

If the beneficiary began using portable gaseous or liquid oxygen equipment (E0431 or E0434) following the 36-month stationary oxygen equipment payment period, payments may be made for both the portable equipment (E0431 or E0434) and portable contents (E0443 or E0444).

Contents are not payable if stationary equipment rental is paid
Separate payment for oxygen contents (stationary or portable) ends when a beneficiary receives new stationary oxygen equipment and a new 36-month stationary oxygen equipment payment period begins (i.e., in situations where stationary oxygen equipment is replaced because the equipment has been in continuous use by the patient for the equipment's reasonable useful lifetime or is lost, stolen, or irreparably damaged). The monthly payment for stationary oxygen equipment includes payment for both stationary and portable oxygen contents. Therefore, under no circumstances should a supplier receive both the monthly stationary oxygen equipment payment and payment for either stationary or portable oxygen contents.

Contents code billed must match the portable or stationary equipment the patient has on file
If the content code billed does not correspond to the type of oxygen equipment submitted on the CMN, the claim will be denied with the following messages:

CO-96: Non-covered charges

M124: Missing indication of whether the patients owns the equipment that requires the part or supply

Oxygen Equipment Denials After 36-Month Capped Rental

Effective immediately, when billing for oxygen equipment for a break in billing, resulting in a date of service after 36 months from the initial date on the CMN, a narrative stating "extend CMN" should be submitted on the claim, along with an explanation of why there was a break in billing. This narrative should be submitted in Item 19 on the CMS 1500 claim form or in the NTE segment, 2400 loop for electronic claims.

If a claim for oxygen equipment is billed with a date of service beyond the original 36-month rental period, based on 36 consecutive months from the initial date on the CMN, and not all 36 months have been paid, you may receive a CO-176 denial. The wording for CO-176 is:

"Payment adjusted because the service was not prescribed by a physician, not prescribed prior to delivery, the prescription is incomplete, or the prescription is not current."

Example:

1. A beneficiary's initial CMN for E1390 has an initial date of 1/10/06
2. Beneficiary goes into hospital for a month during the 36-month period on the CMN
3. CMN ending date on file is 01/10/09, but only 35 months have been paid
4. To have the last payment processed, a comment requesting an extension of the rental period is required

If claims are denied with a CO-176 message, suppliers should submit a written reopening with an explanation for the break in billing, along with the request to extend the CMN.

For information regarding breaks in service when medical necessity ends and restarts, see the article titled "Break in Service and Extending CMNs" posted to our Web site on April 10, 2008 and the article titled "Addendum to Break in Service and Extending CMNs" posted to our Web site on June 19, 2008.

Oxygen Questions and Answers

Below are questions NAS has received from suppliers regarding the 36-month oxygen cap.

Q1: What information, besides the initial date of the previous rental, is Medicare requiring for replacement equipment?
A1. Suppliers must include on the claim for the first month of use a narrative explanation of the reason why the equipment was replaced and supporting documentation must be maintained in the supplier's files:

- If equipment is stolen, the supplier should keep a copy of the police report in its files;
- For lost or irreparably damaged equipment, the supplier should maintain any documentation that supports the narrative account of the incident;
- For reasonable useful lifetime replacements, the narrative explanation should include the date that the beneficiary received the equipment being replaced. The supplier must also have proof-of-delivery documentation in their files for the item being replaced that documents that the oxygen equipment has been in use for at least five years. If this documentation cannot be obtained, i.e., beneficiary cannot recall this date, does not have proof of delivery from five years ago, the supplier providing the replacement equipment did not provide the original equipment, NAS will use the initial date on the oxygen Certificate of Medical Necessity (CMN) as the initial date of use and will determine if the equipment has been in use from five years from this date. The Supplier Contact Center can provide this date, in this situation, when needed.

The RA modifier (for dates of services on/after 1/1/09) or RP modifier (for dates of service prior to 1/1/09) must also be submitted on the claim, to show replacement of the equipment.

Q2: What type of narrative is required when there is a break in billing to extend the CMN?
A2. Please reference the article titled "Oxygen Equipment Denials after 36-Month Capped Rental" posted to our Web site on 3/4/09 for details.

Q3. Do the 36-month oxygen cap rules apply to HMO Medicare patients?
A3. We cannot address this question. This question should be asked of the HMO plan. We will not count months of oxygen payments as part of the 36-month cap for Medicare fee-for-service purposes as there is no claim coordination between HMO and Medicare fee-for-service.

Q4. Does time for a beneficiary on an HMO plan count for the 36 months of capped rental and the five year useful lifetime? If a beneficiary switched to FFS after three years in an HMO, would the three years count toward the five year useful lifetime?
A4. No, time on the HMO would not count for Medicare fee-for-service purposes for the 36 months nor the five year useful lifetime, as there is no coordination between time spent in an HMO and Medicare fee-for-service.

Q5. What was CMS' rationale for requiring a new CMN when replacing equipment but not a new test date? Why should this be required when oxygen has already been recertified in the past?
A5. The replacement guidelines for any DME equipment state that a new order is required, along with a CMN, if applicable. For oxygen equipment, a CMN is required to show that medical necessity exists for the oxygen equipment being replaced. Completion of a CMN establishes documentation that substantiates replacing the equipment.

Q6. If the beneficiary moves after the 36-month rental period, the supplier is required to continue furnishing oxygen and oxygen equipment and must make arrangements for the beneficiary to continue receiving oxygen services at the new place of residence. Can the supplier who received the 36-month payment subcontract with another supplier but continue to bill for contents being that they are the responsible supplier or do they just find a supplier willing to take over for contents, MS and supplies and then the old supplier is out of the picture? It seems if the latter was correct, the new supplier wouldn't have any true obligation and the beneficiary could potentially be left high and dry by the new supplier.
A6. The supplier who received payment for the 36th month is responsible to ensure that the beneficiary is receiving the necessary oxygen services until the reasonable useful lifetime is reached. If the first supplier turned responsibility over to a second supplier and the second supplier is not providing what the beneficiary needs, the first supplier is responsible to rectify this situation or find another new supplier that can meet the beneficiary's needs.

Q7. Some suppliers replaced oxygen equipment in 2008 since it had reached its reasonable useful lifetime, i.e., was more than five years old. However, since they were not yet informed of the guidelines for replacing equipment at the time they replacement occurred, can they now ask for an RP modifier to be added to the claim and start a new 36-month capped rental period?
A7. Yes, suppliers in this situation should request a written reopening to have the RP modifier added to their claim, along with submitting the documentation that shows proof of delivery for the replaced equipment and the original date the equipment was put into service for the beneficiary. In addition, the order and initial CMN will need to be submitted, along with an explanation of why the equipment was replaced. NAS will then make the appropriate changes to our claims processing system to start a new capped rental period.

Q8. After the reasonable useful lifetime is reached, i.e., five years, is the supplier required to continue to service the beneficiary?
A8. The supplier has three options in this situation:

1. Inform the beneficiary that they will discontinue service and arrange for picking up their equipment. The beneficiary will then need to find a new supplier and likely start a new 36-month capped rental period.
2. Inform the beneficiary that they must receive replacement equipment and start a new 36-month rental period if they want to continue receiving services from the current supplier. The beneficiary should also be informed that switching to a new supplier will likely require new equipment and a start of a new 36-month capped rental period.
3. Continue servicing the beneficiary without replacing equipment and only bill contents and maintenance and servicing.

If the beneficiary feels that the equipment is working fine and does not need to be replaced, the supplier is under no obligation to continue furnishing equipment beyond the useful lifetime period.

Q9. Do we need to show intent if we will accept assignment or not if we accepted for the concentrator and do not want to accept for contents?
A9. CMS has said little on this subject, other than stating that suppliers must disclose their intentions for accepting assignment of claims during the 36- month rental period, as referenced in MLN Matters SE0840. We believe this means that suppliers can decide to change to non-assigned for contents after the 36-month rental period is over without disclosing their intent to the beneficiary. CMS will be providing more guidance on this subject.

Q10. If a patient enters a nursing home for six months, does that "stop the clock" on the five year useful lifetime?
A10. The clock does not stop in this situation, as it would be too difficult to keep track of these situations for the supplier and our claims processing system. When determining reasonable useful lifetime for other DME equipment, we do not stop the clock for breaks in service. We calculate the five years from the initial date of use of the equipment.

Q11. When a patient needs to change concentrators, due to a prescribed increase in liter flow by a physician, can a new capped rental period start for the concentrator?
A11: The oxygen guidelines do not allow for a new capped rental period for this situation. The provisions state that the only time a new rental period can start is when equipment is lost, stolen, irreparably damaged or after reasonable useful lifetime expires. Suppliers must provide the oxygen equipment that the patient requires, but they cannot start a new capped rental period in this situation.

K0823 Claim Development

NAS is closely monitoring HCPCS code K0823, Power wheelchair, group 2 standard, captain's chair, patient weight capacity up to and including 300 pounds, due to a high volume of claim errors found by the Comprehensive Error Rate Testing (CERT) contractor.

If you receive a request from NAS for additional documentation on this code, please submit the information requested within 30 days to avoid a claim denial for failure to respond with the requested information.

The six items that will be requested are:

- Valid written order, obtained prior to delivery
- Detailed product description
- Face-to-face examination
- Home assessment
- Proof of delivery
- Beneficiary authorization

For documentation guidelines for K0823, see the Local Coverage Determination (LCD) for Power Mobility Devices (L23598) located at: http://www.noridianmedicare.com/dme/coverage.

FAQ - Complex Rehab Repair Issues

Q1. Clarify the terms "repair" and "replacement" as used in the September 2003 bulletin on repair/replacement issues. Does the 5-year useful lifetime rule apply to replacement parts used to repair DME (e.g., tires and batteries)?
A1. Repair means to fix or mend. During the course of a repair, parts or components of a base item may be replaced. The replacement of parts or components that make up a base item is considered a repair. When the base item is completely replaced with a new base item that is considered a "replacement". The default 5-year reasonable useful lifetime applies to replacement of the base item, not to parts and accessories.

Q2. How often can tires, batteries, etc. be replaced? If the claim denies for frequency limitations, does the supplier get a PR (patient responsibility) denial or a CO (contractual obligation) denial?
A2. No routine or prophylactic replacement is appropriate. Wear items such as batteries and tires are eligible for replacement as a repair to a wheelchair only when they become non-functional. Because the frequency of necessary replacement can vary so much depending on how an individual beneficiary uses his/her wheelchair, it is difficult to set a "usual" replacement frequency. Suppliers are reminded that they should maintain records documenting the need for the repair. Repairs are covered under Medicare only when made to medically necessary equipment. Thus, denials associated with repairs are considered "medical necessity" denials, which get a CO message – unless an ABN has been obtained.

Q3. For repairs to equipment not purchased by Medicare, what are the requirements?
A3. CMS policy is clear. IOM 100-2, Chapter 15, Section 110.2 states:

> "[P]ayment may be made for repair, maintenance, and replacement of medically required DME, including equipment which had been in use before the user enrolled in Part B of the program."

Key to implementing this provision is in understanding the criterion that the equipment is "medically required DME". The criterion means that all of the applicable benefit category and reasonable and necessary requirements for the base item must be met before the item is eligible to have repairs reimbursed. These requirements are generally found in the relevant LCD.

Q4. When repairs are made to equipment by a supplier who did not sell the equipment to the client, it is often difficult to get the correct date of purchase and HCPCS code. Although the repair supplier can verify through the IVR if Medicare paid a claim, that supplier does not know if the original supplier had the proper documentation and was paid properly. Is there a way the repair supplier can be protected?
A4. No. The requirement that repairs are covered for medically necessary equipment applies regardless of who is performing the repair.

Q5. When replacing a drive wheel for a power mobility device, because there is no HCPCS code for a complete power wheel, should this be billed using individual codes for the wheel, tire, and appropriate tube or insert, or should code K0108 be used for the entire assembly?
A5. In the situation described, it would be appropriate to use the codes for the individual components.

Q6. HCPCS code K0462 (temporary replacement for patient-owned equipment being repaired, any type) is used when a supplier provides a complete wheelchair to a beneficiary on a temporary basis if his/her wheelchair requires major repair (i.e., taking more than one day). Rehab power wheelchairs include sophisticated seating systems and advanced electronics that are highly individualized for the patient. Providing a similar loaner wheelchair is not possible. If a supplier is able to substitute a temporary replacement component while the patient's item is being repaired, can K0462 be used in that situation?
A6. Use of HCPCS code K0462 for temporary replacement is applicable when an appropriate complete item is provided or when swapping out individual components while leaving the beneficiary's base equipment in place as described in the scenario above. Suppliers are reminded that detailed records describing the nature of the repair and the justification for the temporary replacement of the item should be maintained.

Q7. With the new modifiers RA and RB, is it correct to say that the RA modifier would only be used when replacing a full piece of equipment, e.g., a full wheelchair that is over 5 years old or is being replaced due to a condition change?
A7. The RA modifier is used for replacement of the complete item due to reasonable useful lifetime or to accidental damage, theft, or loss. If a new item were provided due to a change in condition, it would be a different item, billed with a different HCPCS code, not a "replacement" of the original item. The RA modifier would not be used in this situation.

Q8. If a beneficiary refuses to bring their equipment to the supplier location, can they be charged a fee for this service?
A8. No, Medicare's payment for repairs, i.e., parts and labor, is all-inclusive. There is no separate payment for travel time,

service charges, fuel surcharges, etc. On an assigned claim, suppliers may not charge a beneficiary for these costs. On a nonassigned claim, the beneficiary will be responsible for the difference between the submitted charges for the repairs and the amount Medicare pays.

Q9a. The reasonable useful lifetime for durable medical equipment is 5 years. If an item that is less than 5 years old needs to be repaired because of "wear and tear" (rather than a specific incident) and a thorough evaluation reveals that the cost to repair the equipment exceeds the cost to replace the equipment would Medicare consider payment for a replacement piece of equipment?
A9a. No, according to Medicare statute, during an item's reasonable useful lifetime, payment can only be made for repairs up to the cost of replacement.

Q9b. If the equipment has been repaired on several different occasions, is in need of repair again, and no single repair has exceeded the cost to replace the equipment but the cumulative repair costs will exceed the replacement cost, would Medicare consider payment for a replacement piece of equipment?
A9b. No, according to Medicare statute, during an item's reasonable useful lifetime, payment can only be made for repairs up to the cost of replacement.

Q9c. What percentage of repair to replacement cost would Medicare consider acceptable to deem the purchase of a replacement item more cost effective?
A9c. There is no provision for replacement due to "wear and tear" prior to the end of the item's useful lifetime.