Jurisdiction D News from Noridian Administrative Services, LLC.

Happenings

July 2009
Issue No. 22

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

In This Issue…

FYI

Educational

CEDI

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.

Competitive bidding

CERT

ICD-10

MSP

Reimbursement

Billing

Coverage

Drugs/Biologicals

PAP

Oxygen

Wheelchairs/Power Mobility Devices

Alphabetical Listing...

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.adminastar.com
Jurisdiction C: CIGNA Government Services	1-866-270-4909	www.cignagovernmentservices.com

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

FYI

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 - 5:30 p.m. CT.

2009 Holiday Schedule	
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	

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."

Sources for "Jurisdiction D Happenings" Articles

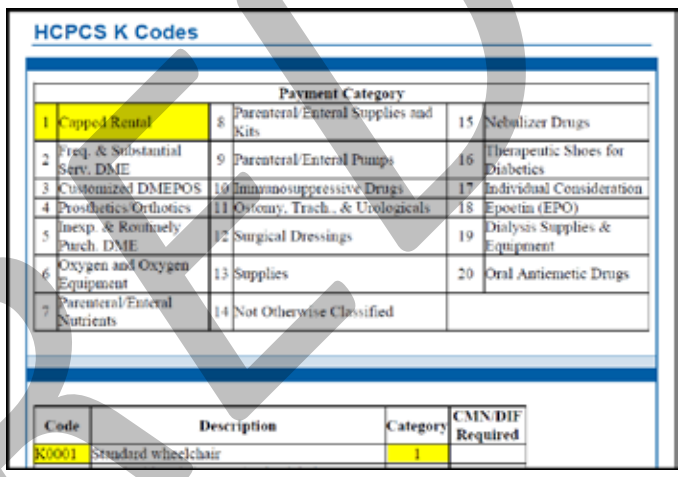
The purpose of "Jurisdiction D Happenings" is to educate NAS' Durable Medical Equipment supplier community. The educational articles can be advice written by NAS staff or directives from CMS. Whenever NAS publishes material from CMS, we will do our best to retain the wording given to us; however, due 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.

Modifier Required When Using the IVR for Same or Similar Inquires

Failure to use the appropriate modifier when checking same or similar on the IVR may result in inaccurate or incomplete same or similar information being returned. To determine what modifier is appropriate when requesting same or similar from the IVR, first determine which payment category is assigned to the equipment being checked.

For assistance in making this determination, please refer to Chapter 16 of the DME MAC Jurisdiction D Supplier Manual. Locate the code in the HCPCS code list and find the number assigned to the code in the Category field. Use the Payment Category key at the top of the page to identify which payment category corresponds to the assigned number.


HCPCS K Codes

Payment Category

1	Capped Rental	8	Parenteral/Enteral Supplies and Kits	15	Nebulizer Drugs
2	Freq. & Substantial Serv. DME	9	Parenteral/Enteral Pumps	16	Therapeutic Shoes for Diabetics
3	Customized DMEPOS	10	Immunosuppressive Drugs	17	Individual Consideration
4	Prosthetics/Orthotics	11	Ostomy, Trach., & Urologicals	18	Epoetin (EPO)
5	Inexp. & Routinely Purch. DME	12	Surgical Dressings	19	Dialysis Supplies & Equipment
6	Oxygen and Oxygen Equipment	13	Supplies	20	Oral Antiemetic Drugs
7	Parenteral/Enteral Nutrients	14	Not Otherwise Classified		

Code	Description	Category	CMN/DIF Required
K0001	Standard wheelchair	1	

Below is a list of the applicable payment categories and the modifier(s) which would be appropriate to use when checking for equipment within that category. Not all payment categories are listed below, as same and similar cannot be verified for all DMEPOS. Diabetic supplies, diabetic shoes, orthotics, prosthetics, lenses and frames are some of the items which are not able to be verified.

Capped Rental Item - RR or NU

Inexpensive and Routinely Purchased DME - RR or NU

Oxygen and Oxygen Equipment - RR

Parentral/Enteral Nutrients - none

Parentral/Enteral Pumps - RR

When checking same or similar it is not appropriate to enter the rental month modifier (KH, KI, and KJ).

HCPCS Quarterly Update

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

DMEPOS Supplier Accreditation and Surety Bond Requirement Deadlines Coming In October

Suppliers May Choose to Voluntarily Terminate Enrollment If They Do Not Plan To Comply

Medicare suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS), unless exempt, must be accredited and obtain a surety bond by October 1, 2009, and October 2, 2009, respectively.

If you have made the decision not to obtain accreditation or a surety bond when required, you may want to voluntarily terminate your enrollment in the Medicare program before the implementation dates above. You can voluntary terminate your enrollment with the Medicare program by completing the sections associated with voluntary termination on page 4 of the Medicare enrollment application (CMS-855S). Once complete, you should sign, date and send the completed application to the National Supplier Clearinghouse (NSC). By voluntarily terminating your Medicare enrollment, you will preserve your right to re-enroll in Medicare once you meet the requirements to participate in the Medicare program.

If you do not comply with the accreditation and surety bond requirements and do not submit a voluntary termination, your Medicare billing privileges will be revoked. A revocation will bar you from re-enrolling in Medicare for at least one year after the date of revocation.

Suppliers who do not plan to stay enrolled in Medicare are strongly encouraged to notify their beneficiaries as soon as possible so the beneficiary can find another supplier.

For additional information regarding DMEPOS accreditation or the provisions associated with a surety bond, go to http://www.cms.hhs.gov/MedicareProviderSupEnroll. Frequently Asked Questions (FAQs) on the surety bond requirement can be found on the NSC's FAQ page at http://www.palmettogba.com/nsc.

Summary of Supplier Manual Updates

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

Chapter	Subheading	Supplier Manual Update	Change Date
3	Supplier Documentation	Source: Changed Chapter 30 to Chapter 20	6/5/09

Crossover Claims Impacted by Common Working File Southeast Host Site Problem

Joint Signature Memorandum 09333

The Centers for Medicare & Medicaid Services (CMS) is alerting all providers, physicians, and suppliers to a problem that occurred during the timeframe of May 26-28, 2009, and would have negatively impacted their patients' crossover claims. On the indicated dates, Medicare contractors that utilize the Common Working File (CWF) Southeast host site for paid claims authorization for their beneficiaries who primarily reside, or until recently resided, in Alabama, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee, the United States Virgin Islands, and Puerto Rico did not receive the customary confirmation from their host site that various claims were selected for crossover. The identified problem, which arose as part of the second CWF contractor transition, would have inhibited the crossing over of claims billed to Part A and Part B Medicare Administrative Contractors, carriers, fiscal intermediaries, and Durable Medical Equipment Medicare Administrative Contractors roughly during the timeframe of May 22-25, 2009, inclusive.

The CMS regrets the negative impact that the aforementioned Southeast CWF host site transition problem has caused and recommends that individual providers, physicians, and suppliers take the following action: Examine your remittance advice or standard paper remittance advice to determine if your patients' claims are identified as having been crossed over to your patients' supplemental insurers. If you determine these claims were not crossed over, you are within your rights to submit claims to your patients' insurers for supplemental payment using methodologies acceptable to those entities.

Questions concerning this broadcast may be directed to your local Medicare contractor's Provider Relations Call Center.

Crossover Claims Impacted by Common Working File Pacific Host Site Problem – Revised

Joint Signature Memorandum 09321 - Revised

The Centers for Medicare & Medicaid Services (CMS) is alerting all providers, physicians, and suppliers to a problem that occurred on May 4, 2009, and would have negatively impacted their patients' crossover claims. On May 4, 2009, Medicare contractors that utilize the Common Working File (CWF) Pacific Host Site for paid claims authorization for their beneficiaries who primarily reside, or until recently resided, in Arizona, California, Hawaii, and Nevada did not receive the customary confirmation from their host site that various claims were selected for crossover. The identified problem inhibiting the crossing over of claims was limited to the CWF Pacific Host's payment authorization process on May 4, 2009, and most likely would have impacted those claims billed to Part A and Part B Medicare Administrative Contractors (A/B MACs), carriers, fiscal intermediaries, and Durable Medical Equipment Medicare Administrative Contractors (DME MACs) around April 30 or May 1, 2009. The CMS volume estimates in terms of impacted claims are as follows: approximately 78,700 Part B physician claims; over 10,000 institutional claims; and an undetermined number of DME MAC claims (claims for durable medical equipment, prosthetics, orthotics, and medical supplies).

Providers, physicians, and suppliers should note that, as aforementioned, not all claims sent to the CWF Pacific Host Site on May 4, 2009, encountered crossover problems. Therefore, CMS' recommendation to individual providers, physicians, and suppliers is as follows: Examine your electronic remittance advice or standard paper remittance advice to determine if your patients' claims are identified as having been crossed over to your patients' supplemental insurers. If you determine these claims were not crossed over, you are within your rights to submit claims to your patients' insurers for supplemental payment using methodologies acceptable to those entities.

DDE, PPTN, and CSI Medicare System Security Semi Annual Review

In accordance with CMS, NAS is required to perform a periodic review of system access for all Direct Data Entry (DDE), Professional Provider Telecommunication Network (PPTN), and Claims Status Inquiry (CSI) users.

During the month of January and July each provider will be faxed a listing of their active users along with the Provider Transaction Access Number (PTAN)/ National Provider Identifier (NPI) numbers each user accesses. It is the responsibility of the facility contact person to respond to the user/PTAN/NPI listing. Failure to respond within the allotted timeframe will result in removal of access for all users.

If there are no changes to the listing, sign and date page one of the form as well as the PTAN/NPI numbers page, as both are required. If there are changes to be made to the listing, a Medicare Claims Processing System (MCPS) form must be submitted for each change, in addition to the PTAN/ NPI listing. Examples of when an MCPS form needs to be submitted are:

- Termination
  - A signature is required either by the employee or the supervisor
- Legal name change
- Adding/removing provider NPI
- Change in facility
- Change type of access for example; eligibility to claims and/or claims to eligibility

All **Third Party Billers** are required to submit a current letter of authorization for each NPI/ PTAN number access is needed for. If a current letter is not received along with the review verification, access will be removed.

The facility contact person is the individual responsible for reviewing, coordinating signatures, and returning the fax to NAS **within 14 calendar days** from the date of the letter. Providers will not receive additional notice of this review. This article, along with the fax, is the only notification that will be given to providers.

If your facility does not receive a fax from NAS in January and July, please contact a member of System Security listed below:

DME Contact List

Trent Cable: 701-277-6779

Pat Schrock: 701-277-2155

Jamie Larson: 701-277-2843

Influenza Pandemic Emergency - The Medicare Program Prepares

MLN Matters Number: SE0836 Revised

Note: This article was revised on May 29, 2009, to include a Web link to CR6284, which was recently issued by CMS. All other information remains the same.

Provider Types Affected
In the event of a pandemic flu, all physicians and providers who submit claims to Medicare Part C or Part D plans or to Medicare contractors (Medicare Administrative Contractors (A/B MACs), fiscal intermediaries (FIs), Durable Medical Equipment Medicare Administrative Contractors (DME MACs), carriers or Regional Home Health Intermediaries (RHHIs)) for services provided to Medicare beneficiaries

Impact on Providers
This article is informational only and is alerting providers that the Centers for Medicare & Medicaid Services (CMS) has begun preparing emergency policies and procedures that may be implemented in the event of a pandemic or national emergency.

Background
As part of its preparedness efforts for influenza pandemic, CMS has begun developing certain emergency policies and procedures that may be implemented for the Medicare program in the event of a pandemic or other emergency.

Decision to implement would occur if:

1. The President declares an emergency or disaster under the National Emergencies Act or the Stafford Act; and
2. The Secretary of the Department of Health and Human Services declares – under 319 of the Public Health Service Act – that a public health emergency exists; and
3. The Secretary elects to waive one or more requirements of Title XVIII of the Social Security Act (Act) pursuant to 1135 of such Act.

In the event of a pandemic or other national emergency, CMS will issue communications to Medicare providers to specify which policies and procedures will be implemented and other relevant information.

This article includes links to policy documents that have been released by CMS. As additional policy becomes available, CMS will revise this article to include links to all available influenza pandemic policy documents.

Dedicated CMS Web Page Now Available
Providers should be aware that all relevant materials will be posted on a CMS dedicated "Pandemic Flu" Web page at http://www.cms.hhs.gov/Emergency/10_PandemicFlu.asp on the CMS web site. That page will contain all important information providers need to know in the event of an influenza pandemic, including the policy documents discussed above.

Additional Information
Additional CMS influenza pandemic policy documents include:

- CR 6146, which can be found at http://www.cms.hhs.gov/Transmittals/downloads/R404OTN.pdf on the CMS web site;
- CR 6164, which can be found at http://www.cms.hhs.gov/Transmittals/downloads/R402OTN.pdf on the CMS web site;
- CR 6174, which can be found at http://www.cms.hhs.gov/Transmittals/downloads/R403OTN.pdf on the CMS web site;
- CR 6209, which is available at http://www.cms.hhs.gov/Transmittals/downloads/R411OTN.pdf on the CMS web site;
- CR 6256, which is available at http://www.cms.hhs.gov/Transmittals/downloads/R428OTN.pdf on the CMS web site;
- CR 6280, which is available at http://www.cms.hhs.gov/Transmittals/downloads/R441OTN.pdf on the CMS web site;
- CR6284, which is at http://www.cms.hhs.gov/Transmittals/downloads/R439OTN.pdf ; and
- CR 6378, which is available at http://www.cms.hhs.gov/Transmittals/downloads/R454OTN.pdf on the CMS web site.

Scam Alert: CMS Has Become Aware of a Scam Targeting Physician Offices

CMS has become aware of a scam where perpetrators are sending faxes to physician offices posing as the Medicare carrier or Medicare Administrative Contractor (MAC). The fax instructs physician staff to respond to a questionnaire to provide an account information update within 48 hours in order to prevent a gap in Medicare payments. The fax may have the CMS logo and/or the contractor logo to enhance the appearance of authenticity.

Medicare FFS providers, including physicians, non-physician practitioners, should be wary of this type of request. If you receive a request for information in the manner described above, please check with your contractor before submitting any information. Medicare providers should only send information to a Medicare contractor using the address found in the download section of the CMS.gov web site found at http://www.cms.hhs.gov/MLNGenInfo/ or http://www.cms.hhs.gov/MedicareProviderSupEnroll.

FDA Consumer Alert: Warning Consumers of a Tainted Skin Sanitizer

Following an announcement by the U. S. Food and Drug Administration (FDA) warning consumers of a tainted skin sanitizer, CMS is advising health care providers and consumers not to use skin products made by Clarcon Biological Chemistry Laboratory. Clarcon is voluntarily recalling some skin sanitizers and skin protectants marketed under several different brand names because of high levels of disease-causing bacteria found in the product during a recent inspection.

Consumers and providers are being warned to not use any Clarcon products and to throw these products away in household refuse.

FDA analyses of several samples of Clarcon products revealed high levels of various bacteria, including some associated with unsanitary conditions. Some of these bacteria can cause opportunistic infections of the skin and underlying tissues. Such infections may need medical or surgical attention, and may result in permanent damage. Examples of products that should be discarded include:

- Citrushield Lotion
- Dermasentials DermaBarrier
- Dermassentials by Clarcon Antimicrobial Hand Sanitizer
- Iron Fist Barrier Hand Treatment
- Skin Shield Restaurant
- Skin Shield Industrial
- Skin Shield Beauty Salon Lotion
- Total Skin Care Beauty
- Total Skin Care Work

Health care professionals and consumers may report serious adverse events (side effects) or product quality problems with the use of this product to the FDA's MedWatch Adverse Event Reporting program either online, by regular mail, fax or phone.

- Online
- Regular Mail: use postage-paid FDA form 3500 and mail to MedWatch, 5600 Fishers Lane, Rockville, MD 20852-9787
- Fax: 800-FDA-0178
- Phone: 800-FDA-1088

For more information:
http://www.fda.gov/ForConsumers/ConsumerUpdates/ucm164845.htm

FYI CONT'D

Beneficiaries Call 1-800-MEDICARE

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

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

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

Review of DMEPOS

MLN Matters® Number: MM6468
Related Change Request (CR) #: 6468
Related CR Release Date: June 12, 2009
Related CR Transmittal #: R293PI
Effective Date: June 1, 2009
Implementation Date: July 13, 2009

This article was rescinded on July 2, 2009, because related CR 6468 was rescinded on that date.

EDUCATIONAL

Ask the Contractor Teleconference – September 1, 2009

NAS will conduct the next Ask the Contractor Teleconference on September 1, 2009, at 3 p.m. CT. We will be continuing with our current format of brief opening remarks followed by the question and answer (Q&A) session.

If you have a question on your mind and are not sure who to ask - this teleconference is your opportunity to speak directly to your contractor. Knowledgeable NAS staff representing a variety of functions will be available to answer your questions. If we cannot answer your question during the teleconference, we will research the issue and then call you with the answer.

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

To participate in this ACT, 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

NAS looks forward to your participation in this Ask the Contractor Teleconference.

Ask the Contractor Q&A - June 23, 2009

Prior to taking questions, NAS provided the following updates:

Web Site Updates

Supplier Manual
The supplier manual chapters have recently been reviewed and updated. They are now available in HTML format as well as PDF. The HTML version will be updated as needed on a daily basis and the PDF version will be updated quarterly.

Documentation Checklists & Policy Trees
All of the documentation Checklists and Policy Trees found on our Coverage/MR page have been reviewed and updated. We encourage suppliers to use these resources to ensure you are obtaining the appropriate documentation for your specific item.

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 questions regarding the Accreditation process, please contact the National Supplier Clearinghouse (NSC).

Surety Bonds
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 National Provider Identifier (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. For more information on this topic, see the Surety Bond section on our Publications Web page, listed under Upcoming Changes.

ABN and Oxygen ACT
On Thursday, June 25th at 3 p.m. CT, NAS will be conducting an Advance Beneficiary Notice of Noncoverage (ABN) Ask the Contractor Teleconference (ACT) and on June 30th at 1:30 p.m. CT, NAS will conduct an Oxygen specific ACT. A brief update session along with questions and answers will begin the call with the solicitation of supplier questions to follow. The questions and answers from the teleconference will be posted on the ACT Questions and Answers page of our web site.

Remittance Advices
CMS now requires that suppliers have a copy of their remittance advice in front of them prior to contacting the call center. The remittance advice contains valuable information and rationale for claims payment and denials. As of June 22nd, the Customer Service Representatives are unable to assist suppliers with questions that can be answered based on information contained on the remittance advice. Please ensure your office procedures allow your staff access to the remittance advices before they contact our office. Our staff is trained to assist you with reading your remittance advice.

Note: 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.

Q1. We have concerns about a patient with a Positive Airway Pressure (PAP) device not getting an appointment for a reevaluation with their physician until after the 91st day. If this occurs, will the third and fourth month be noncovered?

A1. The patient would have coverage for the first three months which is considered the trial period. They will not have coverage for subsequent months until after they are reevaluated. In addition, the patient must meet the adherence guidelines specified in the PAP Device policy during the trial period for continued coverage.

Follow-up: If the physician reevaluation does not occur until after the 91st day, does the patient need to have a face-to-face examination and a new sleep study?

A: No. When the patient is meeting the adherence guidelines (usage of four hours, 70% of 30 consecutive days) during the trial period, coverage will start from the date of the physician reevaluation.

Q2. Are physicians, optometrists and opticians exempt from the surety bond?

A2. Physicians and optometrists are exempt from the surety bond. Optometrists fall under the physician exemption as they are considered a physician according to Social Security Law Section 1861(r). Please verify with the National Supplier Clearinghouse (NSC) whether opticians are exempt or not. The NSC is the contractor that deals with surety bonds.

Follow-up: If a physician or optometrist needs to reenroll or reactivate their DME number and fill out the CMS-855S application, are they still exempt from the surety bond?
A: Please contact the NSC for surety bond clarifications at 866-238-9652.

Q3. We have not received confirmation from the NSC in regards to our completed surety bond and accreditation. Do I contact the NSC to see if my files have been updated?

A3. Yes, you would need to contact the NSC.

Q4. If a patient with obstructive sleep apnea (OSA) failed qualifications for a PAP and switched to a Respiratory Assist Device (RAD), would they need the beneficiary statement and the physician certification?

A4. The beneficiary statement and physician certification is a requirement under the RAD policy for conditions such as restrictive thoracic disorders, chronic obstructive pulmonary disorder (COPD), and central/complex apnea. For the treatment of OSA you would follow the PAP policy. The PAP policy has specific criteria when switching to a RAD device.

Follow-up: Do you have to get a reevaluation at 31 or 61 days for the RAD for OSA?

A: The beneficiary should receive a reevaluation between the 31st and 91st day after initiating therapy with the RAD device. If the beneficiary switches to a RAD within the first three months of therapy, the trial period remains the same unless the patient started using the RAD with less than 30 days left in the trial period. If less than 30 days remain in the trial period then it is extended to 120 days and that reevaluation must occur prior to the 120th day.

Q5. If I am a Part B participating provider with a DME supplier number which I have not used for a long time so it could be inactive. Can I opt out of DME such that my transactions for supplies are not billed to Medicare by either me or the patient?

A5. You would need to contact the NSC for status on your supplier number.

Follow-up: I provide Part B medical services and part of our business is to sell optical supplies to post-cataract patients. However, I want to be outside the entire DME process and have those transactions be separate and never billed to Medicare. Is this possible?

A: No. Under mandatory claim submission laws, if you provide a covered service to a Medicare beneficiary, you are required to obtain an NSC supplier number and submit claims for those covered items.

Follow-up: If you opt out, you cannot utilize the patient's Medicare benefits or fill the eyeglass prescription if you are not a DME supplier?

A: That is correct.

Q6. If a patient is non-compliant in their third month after the trial, in the fourth month we get an ABN and append the GA modifier to the claim. The patient then becomes compliant. How does that work into the 13 month rental period? If the patient is billed for one month in the middle of the 13, as the claim is denied and is patient responsibility, does that count towards our 13 month rental payments?

A6. Only paid claims are included in the 13 months payment so that month submitted with the GA modifier that denied would not be included in the 13. If you know the beneficiary will be following up with their physician after the 91st day, NAS recommends holding that claim until that physician visit occurs and adherence to therapy is verified and documented and then begin billing the fourth month at that time.

Q7. I have a patient with a PAP that was rented for nine months from Blue Cross Blue Shield (BCBS). They are now Medicare eligible. Medicare would start over with a new capped rental even if nine months payment were received before, correct?

A7. Yes, since BCBS and Medicare are separate entitlements. We would follow Medicare rules and regulations and pay 13 months rental.

Q8. We are a DME company attached to a hospital with a separate supplier number. Even though we are covered under the hospital, do we still have to get the $50,000 surety bond?

A8. Each National Provider Identifier (NPI) must have a separate $50,000 surety bond. For clarifications on surety bonds, contact the NSC.

Q9. Are there any plans to revise the purchase option letter for first month purchase of custom wheelchairs and power wheelchairs as the current one offered by CMS has the previous rent-to-own policy information or maintenance agreement?

A9. The caller was asked to fax the specific letter in question. A fax was not received at the time of the posting of these minutes.

Q10. Is it appropriate to ask you a question about filling out the 855S enrollment form or do I need to contact the NSC?

A10. You would need to contact the NSC.

Q11. If a patient has had a concentrator for over five years but did not receive 36 months of payment between January 2006 and January 2009 due to being in a skilled nursing facility (SNF) for a few months, would the reasonable useful lifetime (RUL) be met even though they did not get paid the full 36 months?

A11. Yes, the RUL would be met and the concentrator could be replaced. The RUL starts counting when the patient receives the piece of equipment while on Medicare regardless of how many months were paid by Medicare.

Q12. Can we use the UPS/FedEx tracking number with a printout of the online record, attach this to the delivery ticket and use this as proof of delivery without having the beneficiary's signature?

A12. Yes, this along with your invoices can be your proof of delivery.

Q13. If we contact the beneficiary prior to shipping to their home and let them know it is coming, would we be covered if UPS leaves the shipment on the porch because the beneficiary was not home at the time of delivery?

A13. NAS follows the Program Integrity Manual Chapter 4 guidelines regarding this type of proof as being proof of delivery, however this could become problematic if the beneficiary stated they did not receive the shipment.

Q14. Our pharmacy ships nebulizer medications within five days prior to the end of the current product usage, which it states we can do within the policy. We have been receiving the CO150 denial stating the payer deems the information submitted does not support this level of service. We have called

the Supplier Contact Center and were told that it is because the date of service is prior to the 30 day usage of the current product. How do we avoid these denials? The dates of service on our denied claims were from December and January.

A14. We have corrected our system to allow a seven day grace period and that happened after your dates of service. You should not receive that denial for future claims.

Q15. If we have stationary oxygen equipment that has capped out at 36 months and is in maintenance and servicing and a portable was delivered to the beneficiary 18 months after having stationary oxygen, I can continue billing portable and contents in the same month?

A15. Yes, once the stationary equipment is capped out with 36 months paid, you can collect payment for both the portable system and contents for the portable system.

Follow-up: Just to clarify, we can bill for portable equipment and contents as long as the stationary is capped out or the patient does not have a stationary piece of equipment?

A: Yes, that is correct.

Q16. I understand that NAS changed their position in regards to the PAP policy and an ABN and that we cannot obtain an ABN until after the third month as other usage would be considered a blanket ABN. Why was this changed?

A16. CMS felt we had been too liberal in allowing an ABN to be obtained prior to dispensing the equipment to inform the patient of the coverage criteria for PAP and this was a blanket ABN. The change, effective July 1, is that the ABN should be obtained once you determine the patient is not able to meet the coverage criteria.

CMS' Dedicated web site for Information & Education on Versions 5010, D.0 and 3.0 Now Available

5010: Taking EDI to the Next Level
CMS has launched its web site for agency-wide information and education on Versions 5010, D.0 and 3.0. As you may already know, Version 5010 is the new version of the X12 standards for HIPAA transactions; version D.0 is the new version of the National Council for Prescription Drug Program (NCPDP) standards for pharmacy and supplier transactions; and version 3.0 is a new NCPDP standard for Medicaid pharmacy subrogation.

On this web site, you can view background information on the new standards, regulatory information, the latest outreach messages from CMS, educational resources, resources specific to D.0 and 3.0, as well as implementation information for the Medicare Fee-For-Service systems. CMS plans to add additional information as it becomes available so bookmark the site today! http://www.cms.hhs.gov/Versions5010andD0

You can also view the presentation, transcript and listen to the audiofile from the June 9th national provider conference call on Versions 5010 and D.0 on the Educational Resources page or at http://www.cms.hhs.gov/Versions5010andD0/Downloads/6-9-2009_National_Provider_Call.pdf on the CMS web site.

Revised Certificate of Medical Necessity Web-Based Training Course

Revised in June 2009— The Certificate of Medical Necessity (CMN) Web-Based Training (WBT), which is made available by CMS Medicare Learning Network (MLN), contains information about the Certificate of Medical Necessity, commonly known as a CMN.

This course will be helpful to physicians, health care professional, and medical administrative staff in the completion, submission and maintenance of the documentation required to verify the CMN. It can be accessed by going to http://www.cms.hhs.gov/MLNGenInfo. Scroll to the "Related Links Inside CMS" section at the bottom of the page, and select Web Based Training (WBT) Modules. You will find the "Certificate of Medical Necessity WBT" from the list provided.

Upon completion of this course you should be able to:

- List the items that require a Certificate of Medical Necessity (CMN)
- Identify the responsibilities of Physicians, Physician Assistants, Nurse Practitioners, or Clinical Nurse Specialists as they relate to the CMN
- Define medical record documentation
- Identify the sections of a CMN
- List CMN common Errors
- Identify CMN completion resources

Successful completion of this course requires completion of all course lessons, pre-test, course evaluation and a score of 70 percent of higher on the post-test.

CMS is authorized by IACET to offer 0.1 continuing education units (CEUs) for this program.

CMS designates this educational Activity for a maximum of 1 AMA PRA Category 1 Credit(s)TM. Physicians should only claim credit commensurate with the extent of their participation in the activity.

Credit for this course expires May 4, 2012.

This course and its post test score of 70% or higher, is approved for 1 CEU by the American Academy of Professional Coders (AAPC). Index # CMS06140728A.

When submitting a CMS completed Web-based training course to AAPC as part of your recertification, please retain a copy of your CMS certificate and a copy of the course description that contains the AAPC index number and number of AAPC CEUs. The AAPC will request copies of these if you are selected for verification of the CEUs listed on your renewal form.

The author has no conflicts of interest to disclose. This course was developed without any commercial support.

Click here to view the biographical information of the course developers. http://www.cms.hhs.gov/MLNEdWebGuide/Downloads/2009_May_Biographical_Data_CMN_WBT.pdf

Medicare Remit Easy Print

The Medicare Remit Easy Print (MREP) version 2.6 will not require an update for the July 2009 quarterly release.

The Claim Adjustment Reason Codes and Remittance Advice Remark Codes are available in the Codes.ini file for the MREP software. The next upgrade to the Codes.ini file will be part of the October 2009 quarterly release.

The current version of the MREP program can be located at: http://www.cms.hhs.gov/AccesstoDataApplication/02_MedicareRemitEasyPrint.asp#TopOfPage

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

Top 10 CEDI Edits for May 2009

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

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

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

1. **C172 Invalid Procedure Code and/or Modifier**
   The procedure code, modifier, or procedure code and modifier combination is invalid. To resolve this error, verify the HCPCS and modifier combination is valid.

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

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

   Check the validity of the procedure code/modifier combination by using the Pricing, Data Analysis and Coding (PDAC) web site https://www.dmepdac.com/.

   Check the local coverage determination (LCD) at the DME MACs for guidelines on procedure codes and modifier usage for that LCD.

   Reference the supplier manual at the DME MAC Jurisdiction(s).

   Contact the Customer Care department at the appropriate Jurisdiction:

   - Jurisdiction A: 1-866-590-6731
   - Jurisdiction B: 1-866-590-6727
   - Jurisdiction C: 1-866-270-4909
   - Jurisdiction D: 1-866-243-7272

2. **C008 EIN/SSN Not on File with NPI**
   When C008 fires on its own, it can indicate the Tax ID (Employer Identification Number/Social Security Number) that was submitted does not match what is on file with the NPPES or the National Supplier Clearinghouse (NSC).

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

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

3. **C003 Billing NPI Not on Crosswalk**
   The edit C003 indicates there is no link between the NPI that was submitted and a PTAN/NSC. Verify the PTAN/NSC has been entered on the NPPES web site as Medicare NSC and/or the supplier's information at NPPES and the NSC has the same information to create a match. The following information needs to be verified:

   For Individuals:

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

   For Organizations:

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

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

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

5. **C095 Diagnosis Code Invalid – Pointer 1**
   The diagnosis code pointed to as the first relevant diagnosis on the claim was not valid for the date of service. This is usually, but not always, the first diagnosis code on the claim. Contact the DME MAC Jurisdiction

where the claim would be processed based on the beneficiary state code for assistance with the diagnosis code entered.

6. **C143 Ordering Provider ID Qualifier Invalid**
   This edit will be received if either the Ordering Provider NPI was not sent or the Ordering Provider's UPIN was sent on a charge line. Verify that the Ordering Provider's NPI is being sent on every charge line of the patient's claim.
7. **B108 Billing Provider Not Authorized for Submitter**
   The NPI submitted is not linked to the Submitter ID under which the claim file was sent to CEDI. If this error is received, the supplier must complete and sign the appropriate form on the CEDI web site (http://www.ngscedi.com/) and return to CEDI for processing.

   Suppliers who use a third party (e.g. a clearinghouse or billing service) must complete the Supplier Authorization Form.

   Suppliers who submit their own claims and do not use a third party biller must complete the CMS EDI Enrollment Agreement.
8. **C044 Subscriber Primary ID Invalid**
   The patient's Medicare ID (HICN) is invalid. Verify the number on the patient's red, white, and blue Medicare card.
9. **C171 Capped Rental – Modifier Missing**
   The item (whether for purchase or rental) is classified as a capped rental item (or possibly a pen pump item), and the required KH, KI, or KJ modifier (whichever is appropriate) was not submitted.
10. **3001 Duplicate File Found – File Not Processed**
    This edit is received when a duplicate file has been submitted to CEDI. A duplicate file is determined by the following:
    - Claim count
    - Service line count
    - Record count
    - Total charge amount
    - First and last patients listed in the claim file.

    To work around this edit, submitters should verify the following information with their vendors:
    - If a single ST to SE envelope is being created per claim

    OR
    - If one ST to SE segment envelope is being created for the entire claim file.

    If the first scenario outlined above is being created, please contact the CEDI Help Desk to ask if the record of the duplicate claims can be deleted. The original claims file itself will not be removed, only the data stored to compare future claim files for a duplicate submission. A resubmission of those claims can then be prepared and submitted.

    If the second scenario outlined above is being created, either add or delete a claim from the claims file. A resubmission of the claims can then be prepared and submitted.

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

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

Edit C180 Resolution

An issue existed where edit C180 was being received in error on some service lines when the 'To' Date Of Service was a future date and the HCPCS/modifier(s) submitted should be allowed to contain a future 'To' Date Of Service. This edit has been corrected and claims that received this edit in error prior to May 31, 2009 may be resubmitted to CEDI. If the error has been received since May 31, 2009, please refer to medical policy regarding the HCPCS being billed.

For more information, please contact the CEDI Help Desk at ngs.cedihelpdesk@wellpoint.com or at 866-311-9184.

Returned CEDI Enrollment Form(s)

All CEDI enrollment form(s) returned for invalid or missing information will need to be re-entered electronically on the CEDI web site at http://www.ngscedi.com/forms/formsindex.htm.

CEDI requires all returned enrollment form(s) be resubmitted electronically before the corrected form is faxed to CEDI Enrollment for processing. Any returned form(s) that are resubmitted without completion of the electronic record will be returned.

The top reasons for enrollment paperwork to be returned are:

- Missing or invalid NPIs, PTANS and/or submitter IDs
- The supplier's authorized signature(s) is missing.
- Any form with a signature that is dated over 30 days.
- The NPI(s), PTAN(s) and/or trading partner ID(s) are missing or invalid.
- The NPI or PTAN/NSC is not registered through NPPES web site and is not on the NPI crosswalk.
- The supplier's name on the form does not match the records at the national supplier clearinghouse.
- There is not an EDI Enrollment Form on file for the supplier's NPI and PTAN/NSC entered on the Supplier Authorization Form.
- The Submitter Action Request Form was not submitted to request a NEW Trading Partner/Submitter ID.

To ensure that paperwork does not get returned, review it carefully before faxing it to the CEDI Enrollment department.

Please contact the CEDI Help Desk at ngs.cedihelpdesk@wellpoint.com or at 866-311-9184 for more information. Questions can also be sent to cedienrollment@wellpoint.com.

Update: CEDI Gateway is Not Processing Files Received

At approximately 2:09 a.m. ET Monday June 22, 2009, National Government Services, Inc. CEDI experienced an issue with processing inbound files and was unable to produce TA1, TRN, 997 or GenResponse Reports.

This issue was resolved at 7:45 a.m. ET Monday June 22, 2009.

All files received during the time of this issue will be processed; however, there will be a delay in creating and returning the CEDI front-end reports. If you submitted files between 2:09 a.m. and 7:45 a.m. ET, **please do not resubmit your files as this will cause delays due to having to process additional unnecessary files.**

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

Jurisdiction B Weekly 835 Remittances

The correct flat file for the Jurisdiction B Weekly 835 remittance notices that were supposed to be delivered on Sunday, July 5, 2009, has now been delivered to CEDI this morning July 7, 2009. The remittances should be available for download.

CEDI apologizes for any inconvenience this may have caused.

For more information, please contact the CEDI Help Desk at ngs.cedihelpdesk@wellpoint.com or at 866-311-9184.

CMS Change Request 6507 - VMS Modifications to Implement CEDI System, Part III, NCPDP 5.1 Implementation

Currently, all durable medical equipment Medicare administrative contractors' (DME MAC) National Council for Prescription Drug Programs (NCPDP) claims are received by CEDI, but are not edited or translated within CEDI. Instead, CEDI passes the NCPDP claims to the DME MACs based on the contractor code in the file and the editing and translation are performed at the DME MACs. The DME MACs also assign the Claim Control Number (CCN) to accepted NCPDP claims.

The current NCPDP front-end process will be transitioning from the DME MACs to CEDI. To prepare for the upcoming changes, CEDI is currently working on their front-end system. CEDI is planning to create an NCPDP front-end report that will closely match the current DME MAC NCPDP report formats. There will be minor changes to the format of the front end reports and the front-end edit numbers will be changing from the current DME MAC numbering scheme of 6#### to the CEDI format of N####. Updates will be made to the NCPDP Error Code Manual to include these changes. Sample reports and the updated manual will be provided to the DME MAC supplier community once available.

In November 2009, CEDI expects to begin performing the new NCPDP function **in parallel with the current process.** During this parallel processing, CEDI will produce front-end reports and continue to forward all NCPDP claims to the DME MACs for their editing, translation, CCN assignment and report production. NCPDP submitters will receive reports from both CEDI and the DME MACs. During this time, NCPDP submitters must rely on reports produced by the DME MACs to identify errors that need correcting and to identify the claims accepted. CEDI will be comparing the reports produced by CEDI and the DME MAC to make any changes to the CEDI NCPDP editing and/or reporting process. CEDI will look for feedback from the NCPDP submitters and software vendors on the new CEDI process.

In December 2009, CEDI expects to move fully into production with the NCPDP process changes. At that time, CEDI will perform NCPDP front-end editing, assign the CCN to accepted claims, create flat files for delivery to the appropriate DME MAC based on the beneficiary state code and return all CEDI produced front-end reports to the Trading Partner. The DME MACs will turn off their front-end edits/reports and CCN assignment at that time.

Questions on the changes to the NCPDP front-end process may be directed to the CEDI Help Desk at ngs.cedihelpdesk@wellpoint.com or 1-866-311-9184.

COMPETITIVE BIDDING

Get Ready For DMEPOS Competitive Bidding

The Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program Round 1 Rebid is coming soon!!

Summer 2009

- CMS announces bidding schedule/schedule of education events
- CMS begins bidder education campaign
- Bidder registration period to obtain user ID and passwords begins

Fall 2009

- Bidding begins

If you are a supplier interested in bidding, prepare now – don't wait!

UPDATE YOUR NSC FILES: DMEPOS supplier standard # 2 requires ALL suppliers to notify the National Supplier Clearinghouse (NSC) of any change to the information provided on the Medicare enrollment application (CMS-

855S) within 30 days of the change. DMEPOS suppliers should use the 3/09 version of the CMS-855S and should review and update:

- The list of products and services found in section 2.D;
- The Authorized Official(s) information in sections 6A and 15; and
- The correspondence address in section 2A2 of the CMS-855S.

This is especially important for suppliers who will be involved in the Medicare DMEPOS Competitive Bidding Program. These suppliers must ensure the information listed on their supplier files is accurate to enable participation in this program. Information and instructions on how to submit a change of information may be found on the NSC web site (http://www.palmettogba.com/nsc) and by following this path: Supplier Enrollment/Change of Information/Change of Information Guide.

GET LICENSED: Suppliers submitting a bid for a product category in a competitive bidding area (CBA) must meet all DMEPOS state licensure requirements and other applicable state licensure requirements, if any, for that product category for every state in that CBA. Prior to submitting a bid for a CBA and product category, the supplier must have a copy of the applicable state licenses on file with the NSC. As part of the bid evaluation, we will verify with the NSC that the supplier has on file a copy of all applicable required state license(s).

GET ACCREDITED: CMS would like to remind DMEPOS suppliers that time is running out to obtain accreditation by the September 30, 2009, deadline or risk having their Medicare Part B billing privileges revoked on October 1, 2009. Accreditation takes an average of six months to complete. DMEPOS suppliers should contact a CMS deemed accreditation organization to obtain information about the accreditation process and the application process. Suppliers must be accredited for a product category in order to submit a bid for that product category. CMS cannot contract with suppliers that are not accredited by a CMS-approved accreditation organization.

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 the CMS web site: http://www.cms.hhs.gov/MedicareProviderSupEnroll/01_Overview.asp.

GET BONDED: CMS would like to remind DMEPOS suppliers that certain suppliers will need to obtain and submit a surety bond by the October 2, 2009, deadline or risk having their Medicare Part B billing privileges revoked. Suppliers subject to the bonding requirement must be bonded in order to bid in the DMEPOS Competitive Bidding Program. A list of sureties from which a bond can be secured is found at the Department of the Treasury's "List of Certified (Surety Bond) Companies;" the web site is located at: http://www.fms.treas.gov/c570/c570_a-z.html.

Visit the CMS web site at http://www.cms.hhs.gov/CompetitiveAcqforDMEPOS/ or the CBIC web site at http://www.dmecompetitivebid.com/palmetto/cbic.nsf/DocsCat/Home for the latest information on the DMEPOS Competitive Bidding Program.

Take Action Now to Prepare for DMEPOS Competitive Bidding Program

MLN Matters® Number: SE0915

Provider Types Affected
Suppliers of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) that wish to participate in the upcoming Round 1 Rebid of the Medicare DMEPOS Competitive Bidding Program.

Provider Action Needed
In order to participate in the 2009 Round 1 Rebid of the DMEPOS Competitive Bidding Program, suppliers will be required to register in the Centers for Medicare & Medicaid Services (CMS) security system known as the Individuals Authorized Access to the CMS Computer Services (IACS). This includes suppliers that bid in the first round of competition in 2007 and are interested in competing in the Round 1 Rebid. CMS urges suppliers' planning to bid in the 2009 bidding cycle to be sure that they have provided the National Supplier Clearinghouse (NSC) an updated CMS-855S (Medicare Enrollment Application), with any changes made concerning their Authorized Official(s) information and correspondence mailing address which have occurred since their last CMS-855S submission. The accuracy of this data is critical for successful bidder registration.

Background
In this year's bid cycle, suppliers who wish to bid will need to first register in IACS once the registration window opens. There will be three user roles available, which are described as follows:

- Authorized Official (AO) – Each supplier's organization will be allowed one AO. The AO role can approve all other users associated with their organization who are requesting access to the bidding system. The AO will be able to input bid data, approve Form A and certify Form B in the bidding system.
- Backup Authorized Official (BAO) - Each supplier organization is encouraged to designate one or more BAOs. This applies when the organization has additional personnel who qualify as an AO. In this role, the BAO can approve the supplier's End User registration for access to the bidding system. Like the AO, the BAO can also input bid data, approve Form A and certify Form B in the bidding system.
- End User - Each supplier organization will be allowed one or more End User(s). The End User can input bid data, but cannot approve Form A or certify Form B.

Save Time and Potential Delay by Verifying CMS-855S Information Prior to Registering to Bid
Only those AOs listed on the CMS-855S as an AO can register in IACS to approve and certify as described above for the AO and BAO user roles. As part of the CMS-855S, a supplier designates one or more AO(s). The AO means an appointed official (for example, chief executive officer, chief financial officer, general partner, chairman of the board, or direct owner) to whom the organization has granted the legal authority to enroll it in the Medicare program, to make changes or updates to the organization's status in the

COMPETITIVE BIDDING CONT'D

Medicare program, and to commit the organization to fully abide by the statutes, regulations and program instructions of the Medicare program.

Take Action Now
Be sure the most recent CMS-855S submission is current and accurate. In particular, this concerns:

- The AO's personal identifying information, including the AO's legal name, date of birth, and Social Security number (SSN) as on file with the Social Security Administration (SSA). Make sure the AO's legal name, date of birth and SSN in sections 6 and 15 of the CMS-855S reflects that which is on file with SSA. Reviewing a Social Security card or most recent Social Security Statement is a fast and easy way to verify information on file with SSA. If the information on file at SSA is not correct, then you should immediately contact SSA and have the correction made.
- The supplier's correspondence mailing address as reflected in section 2A2 of the CMS-855S.

If any of these data elements have changed since your last submission of the CMS-855S to the NSC or if the AO's personal identifying information on the CMS-855S does not exactly reflect that which is on file with the SSA, then you should PROMPTLY complete a change of information on the CMS-855S. Remember, any change of name reported to SSA should also be reported to the NSC on the CMS-855S.

CMS urges suppliers to do it now. The NSC processing time to complete a change of information on the CMS-855S is approximately 45 days, and all submissions are processed in the order in which they are received.

Overview of IACS Registration Process
For an AO, the verification of his/her legal name, date of birth, and SSN must be validated against SSA's records and AO data maintained by the NSC. The NSC received this AO data when the supplier completed its most recent CMS-855S. The AO's legal name, date of birth, and SSN are listed in sections 6 and 15 of the CMS-855S. If the AO legal name, date of birth and SSN data input into IACS during registration does not match SSA's records and NSC AO data, the registration will be rejected.

Following successful registration, as an added measure of security, the AO's User ID and password are then mailed in two separate correspondences to the mailing address listed in section 2A2 of the CMS-855S.

The BAO goes through the same verification process described above for the AO and the AO for the organization must approve a BAO's request for access before a User ID and password will be e-mailed to the BAO. The BAO must be listed on the CMS-855S as an AO, sections 6 and 15. It is critical that the BAO's legal name, date of birth and SSN data input into IACS during registration matches SSA's records and NSC AO data, otherwise the BAO registration will be rejected.

End Users do not need to be listed on the CMS-855S as an AO. However, their legal name, date of birth and SSN will be verified against SSA's records, and the AO or BAO for the organization will need to approve an End User's request for access to the bidding system.

Do I need a BAO role?
The establishment of a BAO is encouraged, if the organization has someone that can occupy the BAO role, to avoid any disruption in the bidding process. The AO's role is instrumental to bidding, as the AO's role must be active to avoid all other users of the organization from losing access to the bidding system. If the AO leaves the organization, the BAO role can be changed to an AO role by the Competitive Bidding Implementation Contractor (CBIC) Help Desk.

Additional Information
This article provides you with an overview of the registration process. More detailed instructions will be published in future MLN Matters® articles, listserv messages, and other announcements.

For more information on the DMEPOS competitive bidding program, visit http://www.cms.hhs.gov/CompetitiveAcqforDMEPOS/ on the CMS web site.

Proposed DMEPOS Regulatory Updates

CMS has announced limited proposed regulatory provisions for the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program. These proposals include a proposed administrative process for contract suppliers whose contracts were terminated by the Medicare Improvements for Patients and Providers Act of 2008 to submit claims for any applicable damages and proposed grandfathering provision updates. These proposed provisions are found in Section O of the Physician Fee Schedule and Other Revisions to Part B regulation (CMS-1413-P), which is now on display at the Office of the Federal Register.

Visit the Competitive Bidding Implementation Contractor's (CBIC) web site or the CMS web site at http://www.cms.hhs.gov/center/dme.asp to view the rule and obtain additional information.

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.

CERT CONT'D

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.

ICD-10

Second in Series: General Equivalence Mappings – ICD-9 to and from ICD-10-CM and ICD-10-PCS Fact Sheet

The *Second in Series: General Equivalence Mappings – ICD-9-CM to and from ICD-10-CM and ICD-10-PCS Fact Sheet* (May 2009), which provides basic information about the General Equivalence Mappings (GEM) including possible users of the GEMs, why the GEMs are needed, and how the GEMs files are formatted as well as Reimbursement Mappings information, is now available in downloadable format from the Centers for Medicare & Medicaid Services **Medicare Learning Network** at http://www.cms.hhs.gov/MLNProducts/downloads/ICD-10Mappingfctsht.pdf.

ICD-10- CM/ PCS Educational Products from MLN

- The publication titled *ICD-10-CM/PCS Myths & Facts* (June 2009), which presents correct information in response to some myths regarding the ICD-10-Clinical Modification/Procedure Coding System, is now available in downloadable format from the Centers for Medicare & Medicaid Services **Medicare Learning Network** at http://www.cms.hhs.gov/MLNProducts/downloads/ICD-10-CM_PCS_Myths&Facts.pdf.
- *The Second in Series: General Equivalence Mappings – ICD-9-CM to and from ICD-10-CM and ICD-10-PCS Fact Sheet* (May 2009), which provides basic information about the General Equivalence Mappings (GEM) including possible users of the GEMs, why the GEMs are needed, and how the GEMs files are formatted as well as Reimbursement Mappings information, is now available in print format from the Centers for Medicare & Medicaid Services **Medicare Learning Network**. To place your order, visit http://www.cms.hhs.gov/MLNGenInfo/, scroll down to "Related Links Inside CMS" and select "MLN Product Ordering Page."

ICD-10-CM/PCS Implementation and GEMs Conference Call Transcripts

The written and audio transcripts of the ICD-10-CM/PCS Implementation and General Equivalence Mappings (Crosswalks) National Provider Conference Call, which was conducted by the Centers for Medicare & Medicaid Services on May 19, 2009, are now available in the Downloads Section at http://www.cms.hhs.gov/ICD10/06a_2009_CMS_Sponsored_Calls.asp.

MSP

Medicare Secondary Payer

A secondary payer is an insurance plan that covers medical expenses only after a primary insurer has made payment on a claim. For example, if a claim for $100 is filed with a primary insurer under a policy with a 20% co-payment, that insurer would pay $80, while a secondary insurer may take care of the $20 co-payment.

As part of Medicare's Coordination of Benefits, Medicare can be considered a secondary payer (MSP) if a beneficiary has other insurance coverage. In all cases, federal law regarding secondary payers takes precedence over state laws and private contracts.

If a beneficiary is covered under any of the following insurance plans, Medicare would be considered a secondary payer:

- **Group Health Insurance (employer has 20 or more employees)** - This insurance is provided by an employer to a policyholder who is actively working. Laws affecting this type of insurance include TEFRA, DEFRA, OBRA, COBRA and ESRD.

MSP CONT'D

- **Automobile or Liability Insurance** - This insurance is applicable in cases where an accident has occurred, whether it is a car accident, a fall or medical malpractice.
- **Worker's Compensation** - Worker's Compensation covers injuries on the job. The employer's Workmen's Compensation carrier is responsible for the claim first.
- **United Mine Workers** - This is a Medicare plan qualified beneficiaries can elect.
- **Federal Black Lung Program** - This program covers Black Lung claims. Medicare cannot pay claims submitted with a Black Lung Diagnosis code unless a copy of the Explanation of Benefits from the Black Lung Program is submitted showing that no payment was made.
- **Veterans Administration** - Services rendered at a Veterans Administration facility are not covered under Medicare. If services are rendered at a non-VA facility, Medicare may consider payment for the covered part of the services that the VA didn't pay.
- **End Stage Renal Disease (ESRD)** - For beneficiaries covered through an employer sponsored health plan through their own or a family member's current or former employment, Medicare is secondary for 30 months for those beneficiaries entitled to Medicare based solely on ESRD from March 1, 1996.

The following insurance plans are considered a secondary payer to Medicare:

- **Supplemental insurance (also known as Medigap)** - This is an insurance policy purchased to pay benefits after Medicare has paid the claim as the primary insurer.
- **Group Health Insurance (employer has less than 20 employees)** - This insurance is provided by an employer to a policyholder who is actively working. Laws affecting this type of insurance include TEFRA, DEFRA, OBRA, COBRA and ESRD.

The following insurance plans are selected by the beneficiary in place of original fee-for-service Medicare:

- **Medicare Advantage** (some of these are referred to as Health Maintenance Organizations or HMOs) - These plans provide care under contract to Medicare. There are several types of Medicare Advantage plans and are available in many parts of the country. Payment cannot be made under fee-for-service Medicare for beneficiaries enrolled in a Medicare Advantage plan.

MSP Denials

Suppliers are responsible to know insurance status of beneficiaries prior to submitting claims to Medicare. If a claim is submitted for a beneficiary who has a primary insurance record on file, but no primary insurance Explanation of Benefits (EOB) information is included, the claim will be denied for MSP. After receiving a denial for MSP, the supplier should contact the beneficiary to confirm that there is current primary insurance, and submit the claim to the primary insurer. Once the primary insurer has reviewed the claim, the supplier may submit an MSP Inquiry & Refunds form to Medicare, with a copy of the primary insurer's EOB. Medicare will then review the claim for possible secondary payment.

If the supplier discovers that the beneficiary's primary insurance coverage has been terminated, either the beneficiary or the supplier may contact the Coordination of Benefits Contractor (COBC) to update the primary insurance information. Once the update is complete, the supplier may submit an MSP Inquiry & Refunds form to Medicare, noting in the comment section that the COBC record has been updated to remove the primary insurance record for the date of service in question. Contact information for the COBC is located at http://www.cms.hhs.gov/cobgeneralinformation/03_contactingthecobcontractor.asp.

Suppliers are encouraged to ask beneficiaries about insurance coverage and to be aware of changes in coverage that may occur over time. The Medicare Secondary Payer Questionnaire located at https://www.noridianmedicare.com/dme/claims/docs/msp_questionnaire.pdf provides a framework for suppliers to gather MSP information.

If the beneficiary is not available to answer question about their MSP status, the NAS Interactive Voice Recognition System (IVR) provides information about beneficiary MSP status. The Coordination of Benefits Contractor (COBC) also provides verification of Medicare's primary/secondary status for beneficiaries.

Please note that neither the IVR nor the COBC will provide specific insurer information - only whether Medicare is primary or secondary. If Medicare is the secondary payer, the supplier must contact the beneficiary for details about their primary insurer.

It is to the supplier's advantage to maintain current insurance information on beneficiaries. Suppliers who properly bill a primary insurer prior to submitting claims to Medicare speed payments from the primary insurer and reduce the likelihood of claims being denied for MSP.

For more information about Medicare Secondary Payer, please see the following article: https://www.noridianmedicare.com/dme/claims/docs/msp_fact_sheet.pdf

REIMBURSEMENT

July Quarterly Update for 2009 for DMEPOS

MLN Matters® Number: MM6511
Related Change Request (CR) #: 6511
Related CR Release Date: June 5, 2009
Related CR Transmittal #: R1754CP
Effective Date: January 1, 2009 for implementation of fee schedule amounts for codes in effect then; April 1, 2009 for code K0739; July 1, 2009 for all other changes
Implementation Date: July 6, 2009

Provider Types Affected

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

REIMBURSEMENT CONT'D

Provider Action Needed
This article is based on Change Request (CR) 6511 and alerts providers that the Centers for Medicare & Medicaid Services (CMS) has issued instructions for implementing and/or updating the DMEPOS fee schedule payment amounts on a semiannual basis (January and July), with quarterly updates as necessary (April and October).

Background
The DMEPOS fee schedules are updated on a quarterly basis in order to implement fee schedule amounts for new codes and to revise any fee schedule amounts for existing codes that were calculated in error. The quarterly update process for the DMEPOS fee schedule is located in section 60, Chapter 23 of the Medicare Claims Processing Manual and is located at http://www.cms.hhs.gov/manuals/downloads/clm104c23.pdf on the CMS web site. Other information on the fee schedule, including access to the DMEPOS fee schedules is at http://www.cms.hhs.gov/DMEPOSFeeSched/01_overview.asp on the CMS web site.

Key Points of CR 6511
The following table identifies the 2009 fees for the Healthcare Common Procedure Codes System (HCPCS) codes K0739/E1340. The * denotes revised for the 2009 fee schedule.

State	K0739/E1340	State	K0739/E1340
AK*	25.27	MT	13.41
AL*	13.41	NC	13.41
AR*	13.41	ND*	16.72
AZ*	16.59	NE	13.41
CA*	20.58	NH*	14.40
CO*	13.41	NJ*	18.10
CT*	22.40	NM*	13.41
DC*	13.41	NV*	21.37
DE*	24.71	NY*	24.71
FL*	13.41	OH*	13.41
GA*	13.41	OK	13.41
HI*	16.59	OR	13.41
IA*	13.41	PA*	14.40
ID*	13.41	PR	13.41
IL	13.41	RI*	15.99
IN	13.41	SC	13.41
KS	13.41	SD*	14.99
KY	13.41	TN	13.41
LA	13.41	TX	13.41
MA*	22.40	UT*	13.45
MD	13.41	VA	13.41
ME*	22.40	VI	13.41
MI	13.41	VT*	14.40
MN	13.41	WA*	21.37
MO	13.41	WI	13.41
MS	13.41	WV	13.41
		WY*	18.70

- The 2009 allowed payment amounts for codes E1340/K0739 are revised as part of this quarterly update to reflect updates that were brought to CMS' attention. The allowed payment amounts (listed above) for codes E1340/K0739 are effective as follows:
  - For claims with dates of service from January 1, 2009, through March 31, 2009 submitted using HCPCS code E1340 (Repair or Non-routine Service for DME Requiring the Skill of a Technician, Labor Component, Per 15 Minutes); and
  - For claims with dates of service from April 1, 2009, through December 31, 2009 submitted using code K0739 (Repair or Non-routine Service for DME Other Than Oxygen Equipment Requiring the Skill of a Technician, Labor Component, Per 15 Minutes).
- Medicare contractors will adjust previously processed claims for HCPCS code E1340/K0739 with dates of service on or after January 1, 2009 through June 30, 2009, if they are resubmitted as adjustments.
- HCPCS codes A6545, E0656, E0657 and L0113 were added to the HCPCS file effective January 1, 2009. The fee schedule amounts for these HCPCS codes are established as part of this update and are effective for claims with dates of service on or after January 1, 2009. These items were paid on a local fee schedule basis prior to implementation of the fee schedule amounts established in accordance with this update. **Claims for the above codes with dates of service on or after January 1, 2009 that have already been processed will not be adjusted** to reflect the newly established fees if they are resubmitted for adjustment.
- As part of this update CMS is adding the AW modifier to the fee schedule file for HCPCS code A6545 Gradient Compression Wrap, Non-Elastic, Below Knee, 30-50 MM HG, Each. Code A6545 is covered when it is used in the treatment of an open venous stasis ulcer. Currently, code A6545 is noncovered for the following conditions:
  - Venous insufficiency without stasis ulcers, prevention of stasis ulcers, prevention of the reoccurrence of stasis ulcers that have healed, and treatment of lymphedema in the absence of ulcers. In these situations, since an ulcer is not present, the gradient compression wraps do not meet the definition of a surgical dressing. **Suppliers are advised that when the non-elastic gradient compression wrap code A6545 is used in the treatment of an open venous stasis ulcer, it must be billed with the AW modifier.** Claims for code A6545 that do not meet the covered indications should be billed without the AW modifier and as such, will be denied as non-covered.
- As part of this update, the fee schedule amounts for HCPCS code K0606 (Automatic External Defibrillator, with Integrated Electrocardiogram Analysis, Garment

Type) billed without the KF modifier are being removed from the DMEPOS fee schedule file.

- A one-time notification regarding the changes in payment for oxygen and oxygen equipment as a result of the MIPPA of 2008 and additional instructions regarding payment for DMEPOS was issued on December 23, 2008, (Transmittal 421, Change Request (CR) 6297). A related MLN Matters® article may be reviewed at http://www.cms.hhs.gov/mlnmattersarticles/downloads/MM6297.pdf on the CMS web site). CR 6297 included 2009 labor payment rates for HCPCS codes E1340, L4205 and L7520.
- In 2009, code K0739 was established in the HCPCS file to replace code E1340 for Medicare claims for the repair of beneficiary-owned DME with dates of service on or after April 1, 2009 (see Transmittal 443, CR 6296 issued on February 13, 2009 which may be reviewed at http://www.cms.hhs.gov/transmittals/downloads/R443OTN.pdf on the CMS web site). The 2009 allowed payment amounts for code E1340 mapped directly to code K0739.

BILLING

Billing Instruction - KX, GA/GZ and GY - New Uses

Many policies use the KX modifier to indicate compliance with specified coverage criteria. The following LCDs have revised instructions on modifier use. Refer to each policy for detailed guidance.

- Automatic External Defibrillators
- Cervical Traction Devices
- Commodes
- Epoetin
- Home Dialysis Supplies and Equipment
- Positive Airway Pressure Devices
- Respiratory Assist Devices
- Therapeutic Shoes for Persons with Diabetes

The revised information is contained in the Documentation Section and outlines the use of additional modifiers to indicate that an item is statutorily noncovered or not medically necessary and whether or not a waiver of liability statement (i.e., Advance Beneficiary Notice or ABN) is on file for an expected medical necessity denial.

Proper use of the KX modifier expedites claim processing. An absent modifier causes a claim denial. However, increasing numbers of claims are submitted without the modifier resulting in a growing appeals volume. If the patient meets the criteria for use of the KX modifier but the supplier forgets to include it on the claim line, currently the supplier may request a reopening of the claim. This procedure requires manual intervention by the DME MAC and is responsible for a substantial workload for the contractor.

Effective with these LCD revisions, the contractors will use the presence of a KX, GA, GZ, or GY modifier to indicate whether the coverage criteria are or are not met. The DME MACs are implementing system edits that will **reject** a claim line if the supplier does not include one of these modifiers as specified in each of these LCDs. If a claim line is rejected, the supplier may resubmit the claim line with the appropriate modifier. Requesting a reopening to correct a claim that is missing one of these modifiers will no longer be an available option.

Since the KX modifier has a differing definition depending on the LCD requirements, suppliers should review the revised LCDs carefully to understand the proper use of the modifiers KX, GA, GZ, or GY for each policy.

Over the coming months, other LCDs that include use of the KX modifier will be updated to incorporate instructions for the use of the GA, GZ, or GY modifiers.

Billing for Sales Tax

Reminder: Medicare does not reimburse separately for sales tax. The *Medicare Claims Processing Manual*, Chapter 23, Section 80.3.1, states the following:

> Sales taxes where appropriate were included in the calculation of reasonable charges computed. They were also accounted for in the calculation of the base fee schedules for DME and orthotic/prosthetic devices. The Consumer Price Index used to update fee schedules also accounts for sales tax. Therefore, contractors do not make any additional payment for sales taxes and do not make adjustments in fees to reflect local changes in tax rates.

Claims submitted with HCPCS Code E1399 with a narrative of sales tax will be denied contractual obligation (CO-97).

Supplies and Accessories Used With Beneficiary Owned Equipment

This article is in regards to supplies and accessories used with beneficiary owned equipment that was not paid for by Medicare Fee For Service (FFS) - i.e., only equipment that was paid by other insurance or by the beneficiary. The following elements need to be submitted with the initial claim in Item 19 on the CMS-1500 claim form or in the NTE segment for electronic claims:

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

Claims for supplies and accessories must include all three pieces of information listed above. Claims lacking any one of the above elements will be denied for missing information.

Medicare requires that supplies and accessories only be provided for equipment that meets the existing coverage criteria for the base item. In addition, if the supply or accessory has additional, separate criteria, these must also be met. In the event of a request for documentation, suppliers should provide information justifying the medical necessity for the base item and the supplies and/or accessories. Refer to

the applicable Local Coverage Determination(s) and related Policy Article(s) located on the Coverage/MR tab of our web site for information on the relevant coverage, documentation, and coding requirements.

Claim Not Covered By This Payer/Contractor - Understanding CO-109

Recent analysis shows a high percentage of claim denials with claim adjustment reason code 109, claim not covered by this payer/contractor. This guide will assist you in understanding the different situations causing this denial and provides recommended steps you can take to reduce these types of denials on future claims.

Situation	Prevention
The carrier received a reject code from the Common Working File (CWF) indicating that the services are subject to consolidated billing and must be submitted to the skilled nursing facility (SNF) for payment.	Be aware when your patients is admitted as an inpatient (i.e., hospital, skilled nursing facility) because the facility may be responsible for the DMEPOS the patient is receiving while in their care. If the patient is within a SNF stay, check the appropriate annual carrier update found at http://www.cms.hhs.gov/SNFConsolidatedBilling/01_Overview.asp#TopOfPage to verify the contractor to which the services should be billed.
A claim is sent to a carrier who does not process services for the beneficiary's state.	Verify the beneficiary's state to determine the appropriate DMEMAC.
The service billed is billable to Part B.	Verify if the service is billable to the DMEMAC or carrier using the most current jurisdiction list found at http://www.cms.hhs.gov/center/dme.asp.
The patient is enrolled in a Health Maintenance Organization (HMO).	Verify the beneficiary's eligibility for the Date of Service (DOS) by calling the Interactive Voice Response (IVR) unit. **1-877-320-0390**
The carrier received a reject code from CWF indicating the patient was enrolling in a Home Health or Hospice program.	Be aware of the patients' Home Health or Hospice enrollment. If the patient is enrolled in Home Health or Hospice, the product or service may be covered by a different contractor. Verify the patients' enrollment in a Home Health or Hospice program.

Discontinuance of UPIN Registry

MLN Matters® Number: MM5584 Revised
Related Change Request (CR) #: 5584
Related CR Release Date: September 14, 2007
Related CR Transmittal #: R222PI
Effective Date: May 29, 2007
Implementation Date: June 29, 2007

Note: This article was revised on June 1, 2009, to remove the Web link to the Unique Physician Identifier Number (UPIN) registry, which is no longer maintained, and also to remove another link to the NPI contingency plan that no longer works as the information is no longer available on the Internet.

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

Provider Action Needed
This article is based on Change Request (CR) 5584, which announces that the Centers for Medicare & Medicaid Services (CMS) will discontinue assigning Unique Physician Identification Numbers (UPINs) on June 29, 2007.

The National Provider Identifier (NPI) is a requirement of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and the NPI will replace the use of UPINs and other existing legacy identifiers. (However, CMS recently announced a contingency plan that allows for use of legacy numbers for some period of time beyond May 23, 2007. Under the Medicare FFS contingency plan, UPINs and surrogate UPINs may still be used to identify ordering and referring providers and suppliers until further notice.)

If you do not have an NPI, you should obtain one as soon as possible. Applying for an NPI is fast, easy and free by going to the National Plan and Provider Enumeration System (NPPES) web site at https://nppes.cms.hhs.gov/ on the CMS web site. See the Background and Additional Information Sections of this article for further details.

Background
The Centers for Medicare & Medicaid Services (CMS) was required by law to establish an identifier that could be used in Medicare claims to uniquely identify providers/suppliers who order services for Medicare patients or who refer Medicare patients to physicians and certain other suppliers. The UPIN was established to meet this requirement. CMS assigns UPINs to those physicians and eligible suppliers who are permitted by Medicare to order or refer in the Medicare program. Medicare claims for services that were ordered or for services that resulted from referrals must include UPINs to identify the providers/suppliers who ordered the services or made the referral.

On January 23, 2004, the Secretary of Health and Human Services published a Final Rule in which the Secretary adopted a standard unique health identifier to identify health care providers in transactions for which the Secretary has adopted standards (known as HIPAA standard transactions). This identifier is the National Provider Identifier (NPI). The NPI will replace all legacy provider identifiers that are used in HIPAA standard transactions, including the UPIN, to identify health care providers. All HIPAA covered entities (health plans, health care clearinghouses, and those health care providers who transmit any data electronically in connection with a HIPAA standard transaction) are required by that regulation to begin using NPIs in these transactions no later than May 23, 2007 (small health plans have until May 23, 2008). Medicare is also requiring the use of NPIs in paper claims no later than May 23, 2007, but see the note in the following box regarding the May 23, 2007 implementation by Medicare.

The CMS discontinued assigning UPINs on June 29, 2007. In addition, CMS published the NPPES Data Dissemination Notice (CMS-6060-N) in the Federal Register on May 30, 2007. This Notice describes the policy by which information, to include NPIs, may be disseminated by CMS from the National Plan and Provider Enumeration System (NPPES).

Additional Information
For additional information regarding NPI requirements and use, please see MLN Matters articles, MM4023 (http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4023.pdf) titled, "Requirements for Use and Editing of National Provider Identifier (NPI) Numbers Received in Electronic Data Interchange Transactions, via Direct Data Entry Screens or Paper Claim Forms", and MM4293 (http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4293.pdf) titled, "Revised CMS-1500 Claim Form", which describes the revision of claim form CMS-1500 (12-90) to accommodate the reporting of the National Provider Identifier (NPI) and renamed CMS-1500 (08-05).

The official instruction, CR5584, issued to your carrier, intermediary, RHHI, A/B MAC and DME MAC regarding this change may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R222PI.pdf on the CMS web site.

CARC, RARC, and MREP Update

MLN Matters® Number: MM6453
Related Change Request (CR) #: 6453
Related CR Release Date: May 15, 2009
Related CR Transmittal #: R1734
Effective Date: July 1, 2009
Implementation Date: July 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.

Provider Action Needed
CR 6453, from which this article is taken, announces the latest update of Remittance Advice Remark Codes (RARCs) and Claim Adjustment Reason Codes (CARCs), effective July 1, 2009. Be sure billing staff are aware of these changes.

Background
The reason and remark code sets are used to report payment adjustments in remittance advice transactions. The reason codes are also used in some coordination-of-benefits (COB) transactions. The RARC list is maintained by the Centers for Medicare & Medicaid Services (CMS), and used by all payers; and additions, deactivations, and modifications to it may be initiated by any health care organization. The RARC list is updated 3 times a year – in early March, July, and November although the Committee meets every month.

The CARC list is maintained by 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. The CARC list is also updated 3 times a year – in early March, July, and November along with the RARC list.

Both code lists are 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 6453.

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
As a reminder, CR 6336 noted that CARC 17 is being replaced with 2 new CARCs:

- 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.)
- 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.)

To see the official instruction (CR6453) issued to your Medicare Carrier, RHHI, DME/MAC, FI and/or MAC refer to http://www.cms.hhs.gov/Transmittals/downloads/R1734CP.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.

New Codes - CARC:

Code	Current Narrative	Effective Date per WPC Posting
229	Partial charge amount not considered by Medicare due to the initial claim Type of Bill being 12X. Note: This code can only be used in the 837 transaction to convey Coordination of Benefits information when the secondary payer's cost avoidance policy allows providers to bypass claim submission to a prior payer. Use Group Code PR.	1/25/2009
230	No available or correlating CPT/HCPCS code to describe this service, Note: Used only by Property and Casualty	1/25/2009

Modified Codes – CARC:

Code	Current Narrative	Effective Date per WPC Posting
187	Health Savings account payments. This change to be effective 10/1/2009: Consumer Spending Account payments (includes but is not limited to Flexible Spending Account, Health Savings Account, Health Reimbursement Account, etc.)	1/25/2009

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
156	Flexible spending account payments. Note: Use code 187.	10/1/2009

New Codes - RARC:

Code	Current Narrative	Medicare Initiated
N516	Records indicate a mismatch between the submitted NPI and EIN.	NO
N517	Resubmit a new claim with the requested information	YES
N518	No separate payment for accessories when furnished for use with oxygen equipment.	YES

Modified Codes – RARC:

Code	Current Narrative	Medicare Initiated
M6	Alert: You must furnish and service this item for any period of medical need for the remainder of the reasonable useful lifetime of the equipment. Start: 01/01/1997 Last Modified: 03/01/2009 Notes: (Modified 4/1/07. 3/1/2009)	YES
N109	This claim/service was chosen for complex review and was denied after reviewing the medical records. Start: 02/28/2002 Last Modified: 03/01/2009 Notes: (Modified 3/1/2009)	YES
N387	Alert: Submit this claim to the patient's other insurer for potential payment of supplemental benefits. We did not forward the claim information. Start: 04/01/2007 Last Modified: 03/01/2009 Notes: (Modified 3/1/2009)	YES

Deactivated Codes – RARC

Code	Current Narrative	Medicare Initiated
N515	Alert: Submit this claim to the patient's other insurer for potential payment of supplemental benefits. We did not forward the claim information. (use N387 instead) Start: 11/01/2008 Stop: 10/01/2009	YES

October Quarterly Update to 2009 Annual Update of HCPCS Codes Used for SNF Consolidated Billing Enforcement

MLN Matters® Number: MM6503
Related Change Request (CR) #: 6503
Related CR Release Date: June 5, 2009
Related CR Transmittal #: R1750CP
Effective Date: January 1, 2009
Implementation Date: October 5, 2009

Provider Types Affected
Suppliers submitting claims to DME Medicare Administrative Contractors (DME MACs)) for services provided to Medicare beneficiaries.

Provider Action Needed
This article is based on Change Request (CR) 6503 which provides the October quarterly update to the 2009 Healthcare Common Procedure Coding System (HCPCS) codes for Skilled Nursing Facility (SNF) consolidated billing (CB). Be sure your billing staff know of the one change related to HCPCS L5670 as noted below.

Background
The Social Security Act (Section 1888; see http://www.ssa.gov/OP_Home/ssact/title18/1888.htm on the Internet) codifies Skilled Nursing Facility (SNF) Prospective Payment System (PPS) and Consolidated Billing (CB), and the Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of Healthcare Common Procedure Coding System (HCPCS) codes that are subject to the CB provision of the SNF PPS. The new coding identified in each update describes the same services that are subject to SNF PPS payment by law.

Services appearing on these lists of HCPCS will not be paid by Medicare to any providers other than a SNF when included in SNF CB. Services excluded from SNF PPS and CB may be paid to providers, other than SNFs, for beneficiaries, even when in a SNF stay. In order to assure proper payment in all settings, Medicare systems must edit for services provided to SNF beneficiaries both included and excluded from SNF CB.

For October 1, 2009, the only change is that HCPCS code L5670 (Addition to lower extremity, below knee, molded supracondylar suspension ("PTS" or similar)) will be added to the File 1 Coding List for SNF CB for dates of service on or after January 1, 2009. Your Medicare DME MAC will re-open and re-process the claims you bring to their attention, that contain HCPCS L5670 with dates of service on or after January 1, 2009, and that have been previously denied prior to the implementation CR 6503.

Additional Information
The official instruction, CR 6503, issued to your DME MAC regarding this change may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R1750CP.pdf on the CMS web site.

Claim Status Category Code and Claim Status Code Update

MLN Matters® Number: MM6525
Related Change Request (CR) #: 6525
Related CR Release Date: June 12, 2009
Related CR Transmittal #: R1756CP
Effective Date: July 1, 2009
Implementation Date: July 6, 2009

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

Provider Action Needed
This article, based on CR6525, explains that the Claim Status Codes and Claim Status Category Codes for use by Medicare contractors with the Health Claim Status Request and Response ASC X12N 276/277 were updated during the January 2009 meeting of the national Code Maintenance Committee and code changes approved at that meeting were posted at http://www.wpc-edi.com/content/view/180/223/ on the Internet on March 1, 2009. All providers should ensure that their billing staffs are aware of the updated codes.

Background
The Health Insurance Portability and Accountability Act (HIPAA) requires all health care benefit payers to use only Claim Status Category Codes and Claim Status Codes approved by the national Code Maintenance Committee in the X12 276/277 Health Care Claim Status Request and Response format adopted as the standard for national use (004010X093A1). These codes explain the status of submitted claim(s). Proprietary codes may not be used in the X12 276/277 to report claim status. All code changes approved during the January 2009 committee meeting were posted at http://www.wpc-edi.com/content/view/180/223/ on March 1, 2009. Medicare will implement those changes on July 6, 2009 as a result of CR6525.

Additional Information
The official instruction issued to your Medicare contractor regarding this change may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R1756CP.pdf on the CMS web site.

Medicare Contractor Annual Update of ICD-9-CM

MLN Matters® Number: MM6520
Related Change Request (CR) #: 6520
Related CR Release Date: July 10, 2009
Related CR Transmittal #: R1770CP
Effective Date: October 1, 2009
Implementation Date: October 5, 2009

Provider Types Affected
Physicians, suppliers, and providers billing Medicare contractors (carriers, Part A/B Medicare Administrative Contractors (MACs), Durable Medical Equipment Medicare Administrative Contractors, and fiscal intermediaries (FIs) including regional home health intermediaries).

Provider Action Needed
This article is based on Change Request (CR) 6520 and reminds the Medicare contractors and providers that the annual ICD-9-CM update will be effective for dates of service on and after October 1, 2009 (for institutional providers, effective for discharges on or after October 1, 2009). You can see the new, revised, and discontinued ICD-9-CM diagnosis codes on the Centers for Medicare & Medicaid Services (CMS) web site at http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/07_summarytables.asp#TopOfPage, or at the National Center for Health Statistics (NCHS) web site at http://www.cdc.gov/nchs/icd9.htm in June of each year.

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

CMS issued CR 6520 as a reminder that the annual ICD-9-CM coding update will be effective for dates of service on or after October 1, 2009 (for institutional providers, effective for discharges on or after October 1, 2009).

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

Additional Information
The official instruction (CR6520) issued to your Medicare MAC and/or FI/carrier is available at http://www.cms.hhs.gov/Transmittals/downloads/R1770CP.pdf on the CMS web site.

Expiration of Medicare Processing of Certain IHS Part B Claims

MLN Matters® Number: SE0912

Provider Types Affected
Indian Health Service (IHS), tribe and tribal organizations (non-hospital or non-hospital based) facilities submitting claims to Medicare contractors (carrier or DME Medicare Administrative Contractors (DME MACs)).

Provider Action Needed
This special edition article is being issued by the Centers for Medicare & Medicaid Services (CMS) to notify affected Indian Health Service (IHS) physicians, IHS providers, and IHS suppliers that beginning January 1, 2010, IHS facilities can no longer bill Medicare for 'other' Part B services, including Durable Medical Equipment (DME), prosthetics, orthotics, therapeutic shoes, clinical laboratory services, surgical dressing, splints and casts, drugs (those processed by the DME/MACs and those processed by the A/B MACs and the Part B carrier) and ambulance services. As a result of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003, coverage of these 'other' Part B items and services started January 1, 2005 for a five-year period which ends January 1, 2010. This article alerts affected providers that the five-year period expires as of January 1, 2010.

Background
The Social Security Act (Section 1880; see http://www.ssa.gov/OP_Home/ssact/title18/1880.htm on the Internet) provides for payment to Indian Health Service (IHS) facilities for services paid under the physician fee schedule.

Additionally, the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA, Section 630) expanded the scope of items and services for which payment could be made to IHS facilities to include all 'other' Part B covered items and services for a 5 year period beginning January 1, 2005 and ending January 1, 2010. See Change Request (CR) 3288 at http://www.cms.hhs.gov/transmittals/downloads/R241CP.PDF on the Centers for Medicare & Medicaid Services (CMS) web site. An MLN Matters® article related to that transmittal is available at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3288.pdf on the CMS web site.

This special edition article is being provided by CMS to notify affected IHS physicians, IHS providers, and IHS suppliers that beginning January 1, 2010, IHS facilities can no longer bill Medicare for the following Part B services:

- Durable medical equipment (DME);
- Prosthetics and orthotics;
- Surgical dressings, Splints and Casts;
- Therapeutic shoes;
- Drugs (those processed by the DME/MACs and those processed by the A/B MACs and the Part B carrier);
- Clinical laboratory services; and
- Ambulance services.

PAP and RAD Devices LCDs Revised

The Positive Airway Pressure (PAP) Devices and the Respiratory Assist Devices (RAD) local coverage determinations (LCD) have been revised effective for dates of service on or after September 1, 2009. The revised information is in the Documentation Section and outlines the use of additional modifiers to indicate that an item is not medically necessary and whether or not a waiver of liability statement (i.e., Advance Beneficiary Notice or ABN) is on file.

Over the coming months, LCDs that include use of the KX modifier will be updated to incorporate instructions for the use of the GA, GZ or GY modifiers. If the patient meets the criteria for use of the KX modifier but the supplier forgets to include it on the claim line, currently the supplier may request a reopening of the claim. This procedure requires manual intervention by the DME MAC and is responsible for a substantial workload for the contractor. Therefore, the DME MACs are implementing system edits that will reject a claim line if the supplier does not indicate that the beneficiary either meets or does not meet the requirements that are specified in each medical policy. The contractors will use the presence of a GA, GZ, or GY modifier as an indication that coverage criteria are not met. If a claim line is rejected, the supplier may resubmit the claim line with the appropriate modifier. Requesting a reopening will no longer be an option.

Since the KX modifier has a different definition depending on the LCD in question, suppliers should read the revised LCDs carefully to understand the proper use of the additional modifiers GA, GZ or GY. Further instructions and details will be published with each LCD revision.

Therapeutic Shoes - Withdrawal of Policy Article

A revision of the Therapeutic Shoes for Persons with Diabetes Policy Article was recently released. The effective date was listed as August 1, 2009. That version of the Policy Article is being withdrawn. The current version of the Policy Article which has an effective date of October 1, 2008, remains in effect until a new revised Policy Article is published.

LCD and Policy Article Revisions Summary for June 2009

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

Oxygen and Oxygen Equipment
LCD
Revision Effective Date: 01/01/2009 (June Revision)

INDICATIONS AND LIMITATIONS OF COVERAGE:
Clarified: Conditions for blood gas studies
Clarified: Testing requirements when exercise test results are used to qualify
Revised: Certification section to address new payment policy
Moved: Information on payment of greater than 4 LPM oxygen to the Policy Article, Non-Medical Necessity Coverage and Payment Rules section

HCPCS CODES AND MODIFIERS:
Added: RA modifier

DOCUMENTATION REQUIREMENTS:
Moved: CMN instructions to Indications and Limitations of Coverage section
Added: Instructions for replacement equipment

Policy Article
Revision Effective Date: 01/01/2009

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Updated: Entire section to account for new oxygen payment policy

CODING GUIDELINES:
Revised: Billing instructions for oxygen contents
Changed: SADMERC reference to PDAC

BILLING INFORMATION:
Created: New section for billing instructions
Added: Instructions on billing for oxygen contents
Moved: Statement about not separately payable items to this section

Therapeutic Shoes for Persons with Diabetes
LCD
Revision Effective Date: 08/01/2009

CMS NATIONAL COVERAGE POLICY:
Added: Benefit Policy Manual reference

HCPCS CODES AND MODIFIERS:
Added: GY modifier

DOCUMENTATION REQUIREMENTS:
Revised: Instructions for certification statement to indicate that it must be completed by the certifying physician
Revised: Instructions concerning KX modifier to refer to the Policy Article
Clarified: Information documenting that KX modifier requirements have been met must be in the records of the certifying physician
Added: Instructions for use of GY modifier

Policy Article
Revision Effective Date: 08/01/2009

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Clarified: Documentation of qualifying conditions must be in the medical records of the certifying physician (This requirement has always been included in the national policy. The 08/01/09 effective date does not apply.)

CODING GUIDELINES:
Clarified: Definitions of A5512 and A5513
Revised: Billing instructions for the RT and LT modifiers
Added: Statement that custom fabricated inserts do not require PDAC Coding Verification Review

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

LCD and Policy Article Revisions Summary for June 25, 2009

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

Automatic External Defibrillators
LCD
Revision Effective Date: 09/01/2009

HCPCS MODIFIERS:
Added: GA and GZ modifiers
Revised: KX Modifier

ICD-9 CODES THAT SUPPORT MEDICAL NECESSITY:
Typographical Error: Corrected 996.04 - 996.61 to 996.04, 996.61

DOCUMENTATION REQUIREMENTS:
Added: Instructions for use of GA and GZ modifiers

Policy Article
Revision Effective Date: 09/01/2009

CODING GUIDELINES:
Changed: SADMERC to PDAC

Canes and Crutches
Policy Article
Revision Effective Date: 07/01/2009

CODING GUIDELINES:
Changed: SADMERC to PDAC

Cervical Traction Devices
LCD
Revision Effective Date: 09/01/2009

INDICATIONS AND LIMITATIONS OF COVERAGE:
Removed: E0856 from range of covered codes

HCPCS CODES AND MODIFIERS:
Added: GA and GZ modifiers
Revised: KX modifier

DOCUMENTATION REQUIREMENTS:
Added: Instructions for the use of GA and GZ modifiers

Policy Article
Revision Effective Date: 09/01/2009

CODING GUIDELINES:
Changed: SADMERC to PDAC

Cold Therapy
Policy Article
Revision Effective Date: 07/01/2009

CODING GUIDELINES:
Changed: SADMERC to PDAC

Commodes
LCD
Revision Effective Date: 09/01/2009

INDICATIONS AND LIMITATIONS OF COVERAGE AND/OR MEDICAL NECESSITY:
Removed: Reference to DMERC

HCPCS CODES AND MODIFIERS:
Added: GA and GZ modifiers
Revised: KX modifier

DOCUMENTATION REQUIREMENTS:
Added: Instructions for the use of GA, GY and GZ modifiers.

Policy Article
Revision Effective Date: 09/01/2009

CODING GUIDELINES:
Changed: SADMERC to PDAC

Enteral Nutrition
Policy Article
Revision Effective Date: 07/01/2009

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: Instructions for delivery of supplies.
Changed: DMERC to DME MAC

CODING GUIDELINES:
Clarified: Definition for supply kit codes B4034-B4036.
Changed: SADMERC to PDAC

Epoetin
LCD
Revision Effective Date: 09/01/2009

CMS NATIONAL COVERAGE POLICY:
Added: CMS Pub. 100-2, Medicare Benefit Policy Manual, Chapter 15, Section 50.5.2

HCPCS CODES AND MODIFIERS:
Added: GY modifier
Revised: KX modifier

DOCUMENTATION REQUIREMENTS:
Added: Instructions for use of GY modifier

Policy Article
Revision Effective Date: 09/01/2009

CODING GUIDELINES:
Changed: SADMERC to PDAC

Eye Prostheses
Policy Article
Revision Effective Date: 07/01/2009

CODING GUIDELINES:
Revised: RT/LT instructions.
Changed: SADMERC to PDAC

Facial Prostheses
Policy Article
Revision Effective Date: 07/01/2009

CODING GUIDELINES:
Revised: RT/LT modifier instructions
Changed: SADMERC to PDAC

Home Dialysis Supplies and Equipment
LCD
Revision Effective Date: 09/01/2009

HCPCS CODES AND MODIFIERS:
Added: GY modifier
Revised: KX modifier

DOCUMENTATION REQUIREMENTS:
Added: Instructions for use of GY modifier.

Policy Article
Revision Effective Date: 09/01/2009

CODING GUIDELINES:
Changed: SADMERC to PDAC

Positive Airway Pressure (PAP) Devices for Obstructive Sleep Apnea
LCD
Revision Effective Date: 09/01/2009

HCPCS CODES AND MODIFIERS
Added: GA and GZ modifiers
Revised: KX Modifier

DOCUMENTATION:
Added: Information about the required use of GA, GZ or KX on claim lines for PAP devices and/or accessories.

Respiratory Assist Devices (RAD)
LCD
Revision Effective Date: 09/01/2009

HCPCS CODES AND MODIFIERS:
Added: GA and GZ modifiers
Revised: KX modifier

DOCUMENTATION REQUIREMENTS:
Added: Instructions for the use of GA and GZ modifiers

Policy Article
Revision Effective Date: 09/01/2009

CODING GUIDELINES:
Changed: SADMERC to PDAC

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

HCPCS Coding Decision and Preliminary Medicare Payment Decision for Negative Pressure Wound Therapy Devices

CMS' preliminary Healthcare Common Procedure Coding System (HCPCS) coding decision and preliminary Medicare Payment decision for negative pressure wound therapy (NPWT) devices is now published in the July 9, 2009, NPWT Public Meeting Agenda. This public meeting affords stakeholders an opportunity to provide input concerning the preliminary decision.

The Medicare Improvements for Patients and Providers Act of 2008 required the Secretary to evaluate existing HCPCS codes for NPWT devices to ensure accurate reporting and billing for the items and services under such codes; use an existing process for the consideration of coding changes; and consider all relevant studies and information furnished through the process.

CMS partnered with Agency of Healthcare Research and Quality (AHRQ) to commission a review of NPWT devices to ensure all relevant studies and information on NPWT were captured. ECRI Institute solicited information from stakeholders and searched literature in conducting this review. A draft report of their findings was published for comment in April 2009. After analysis of comments received, ECRI concluded that the available evidence does not support significant therapeutic distinction of a NPWT system or component of a system. The report informed CMS' HCPCS workgroup's decision. The final report will be publicly available no later than June 10, 2009, on AHRQ's homepage for the Technology Assessment Program at http://www.ahrq.gov/clinic/techix.htm.

LCD Reconsideration Process

The Local Coverage Determination (LCD) Reconsideration Process is a mechanism by which interested parties can request a revision to an LCD. The LCD Reconsideration Process is available only for final LCDs. The whole LCD or any provision of the LCD may be reconsidered.

NAS shall consider all LCD reconsideration requests from:

- Beneficiaries residing in a contractor's jurisdiction;
- Suppliers doing business in a contractor's jurisdiction; and
- Any interested party doing business in a contractor's jurisdiction.

NAS will only accept reconsideration requests for LCDs published in final form.

- Requests shall not be accepted for other documents including:
- National Coverage Determinations (NCDs);
- Coverage provisions in interpretive manuals;
- Draft LCDs;
- Template LCDs, unless or until they are adopted by the contractor;
- Retired LCDs;
- Individual claim determinations;
- Bulletins, articles, training materials; and
- Any instance in which no LCD exists, i.e., requests for development of an LCD.

If modification of the LCD would conflict with an NCD, the request would not be valid. For more information about the NCD processes and requesting changes to an NCD, reference http://www.cms.hhs.gov/DeterminationProcess/.

The following steps MUST be followed to submit LCD reconsideration requests.

Requests may be submitted in writing to the following address:

Noridian Administrative Services
DME LCD Reconsiderations
Box 6747
Fargo, ND 58108-6747

Requests may also be **faxed** to **1-866-465-0213**. Please address your fax cover sheet to the DME LCD Reconsideration Administrator.

Requests can also be emailed to dmeregdlcdreconsider@noridian.com

Requests shall be submitted in writing,and shall identify the language that the requestor wants added or deleted from an LCD. Requests shall include a justification supported by new evidence that may materially affect the LCDs content or basis. Copies of published evidence shall be included.

The level of evidence required for LCD reconsideration is the same as that required for new/revised LCD development. See the Program Integrity Manual, Chapter 13, Section 13.7.1, http://www.cms.hhs.gov/manuals/downloads/pim83c13.pdf, for more information.

Any request for LCD reconsideration that, in the judgment of the contractor, does not meet these criteria is invalid.

NAS has the discretion to consolidate valid requests if similar requests are received.

Within 30 days of the day the request is received, NAS shall determine whether the request is valid or invalid. If the request is invalid, NAS shall respond, in writing, to the requestor explaining why the request was invalid. If the request is valid, the contractor should follow the requirements outlined below.

- Within 90 days of the day the valid request was received, the contractor shall make a final LCD reconsideration decision and notify the requestor of the decision with its rationale. Decision options include retiring the policy, no revision, revision to a more restrictive policy or revision to a less restrictive policy.
- If the decision is to retire the LCD or to make no revision to the LCD, then within 90 days of receipt, NAS will inform the requestor of that decision with its rationale. If the decision is to revise the LCD, the normal process for LCD development will be followed.

DRUGS/BIOLOGICALS

New Drug/Biological HCPCS Codes for July 2009 Update

MLN Matters® Number: MM6477
Related Change Request (CR) #: 6477
Related CR Release Date: June 5, 2009
Related CR Transmittal #: R1752CP
Effective Date: July 1, 2009, except as noted in article
Implementation Date: July 6, 2009

Provider Types Affected
Physicians, hospitals, suppliers, and other providers who submit bills to Medicare carriers, fiscal intermediaries (FIs), Medicare Administrative Contractors (MACs), and Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for drugs and biologicals provided to
Medicare beneficiaries.

Provider Action Needed
This article explains updates, effective for dates of service on or after July 1, 2009 (unless otherwise specified), to HCPCS codes for certain drugs and biologicals. Ensure that your staffs are aware of these changes.

Background
The HCPCS code set is updated on a quarterly basis. This article describes updates for specific drug/biological HCPCS codes. Effective for claims with dates of service on or after July 1, 2009, the following HCPCS codes will be payable for Medicare:

HCPCS Code	Short Description	Long Description	TOS Code	MPFSDB* Status Indicator
Q2023	Xyntha, inj	INJECTION, FACTOR VIII (ANTIHEMOPHILIC FACTOR, RECOMBINANT) (XYNTHA), PER I.U.	1	E
Q4115	Alloskin skin sub	SKIN SUBSTITUTE, ALLOSKIN, PER SQUARE CENTIMETER	1	E
Q4116	Alloderm skin sub	SKIN SUBSTITUTE, ALLODERM, PER SQUARE CENTIMETER	1	E

* MPFSDB – Medicare Physician Fee Schedule Data Base

The Medicare Coverage Indicator for the following codes was incorrectly listed on the January 2009, HCPCS code set file. With the July 2009 quarterly update to the HCPCS code set, we are correcting the file to show a Medicare Coverage Indicator of the letter

"D". The letter "D" indicates that "special coverage instructions apply" and the applicable special coverage instructions are provided in the local coverage determinations (LCD) regarding inhalation drugs. These updates are based on change request (CR) 5981 and are effective for claims with dates of service on or after April 1, 2008. Note that Medicare contractors will not search for and adjust claims processed before this change is implemented. However, they will adjust such claims that you bring to their attention.

HCPCS Code	Short Description	Medicare Coverage Indicator
J7611	Albuterol non-comp con	D
J7612	Levalbuterol non-comp con	D
J7613	Albuterol non-comp unit	D
J7614	Levalbuterol non-comp unit	D

PAP

PAP Supplier FAQ Revised

Question 16 of the *Positive Airway Pressure (PAP) Devices - Supplier Frequently Asked Questions* published December 2008 has been revised. After discussions with the Centers for Medicare & Medicaid Services (CMS), the Durable Medical Equipment Medicare Administrative Contractors (DME MACs) have revised previously published information related to the Advance Beneficiary Notice (ABN). The new response to question 16 shall read:

16. Question: Would it be considered use of a blanket Advance Beneficiary Notice (ABN) to have all new PAP patients sign an ABN at the beginning of therapy stating that if they do not get a face-to-face evaluation or refuse to get the follow-up re-examination by their treating physician between the 31st and 91st day that Medicare will deny the claim?

Answer: *Yes, it would be considered a "blanket" ABN if the notice was presented at the beginning of therapy. The supplier may however, after day 60 following the dispensing of the PAP device, present an ABN to the beneficiary if the supplier has knowledge that the beneficiary has not yet met the policy criteria for continued coverage. This ABN should advise the beneficiary that if, by the 90th day of therapy, they do not meet the policy criteria for continue coverage (e.g., adherent to therapy and obtain a follow-up face to face evaluation), Medicare may deny their subsequent claim(s) and that the beneficiary will be liable for payment.*

This new guidance regarding a blanket ABN is effective for claims with initial dates of service on or after July 1, 2009. Advance beneficiary notices executed under the prior instructions contained in the December 2008 FAQ will still be considered valid until the July 1, 2009, effective date of this new instruction.

OXYGEN

Payment for Maintenance and Servicing of Certain Oxygen Equipment

CR 6509 RESCINDS AND FULLY REPLACES CR 6404.

MLN Matters® Number: MM6509
Related Change Request (CR) #: 6509
Related CR Release Date: May 22, 2009
Related CR Transmittal #: R497OTN
Effective Date: July 1, 2009
Implementation Date: July 6, 2009

Provider Types Affected
Suppliers submitting claims to Medicare contractors (Regional Home Health Intermediaries (RHHIs), Medicare Administrative Contractors (MACs) and/or Durable Medical Equipment Medicare Administrative Contractors (DME MACs)) for oxygen services provided to Medicare beneficiaries.

Provider Action Needed
This article is based on replacement change request (CR) 6509 which provides additional instructions regarding maintenance and servicing of oxygen concentrators and transfilling equipment resulting from implementation of section 144(b) of the MIPPA. Earlier instructions pertaining to the MIPPA changes for oxygen equipment were issued as part of CRs 6297 (Transmittal 421) and 6296 (Transmittal 443) and the MLN Matters® articles for these CRs are available at http://www.cms.hhs.gov/MLNMattersArticles/downloads/mm6297.pdf and http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6296.pdf, respectively, on the Centers for Medicare & Medicaid (CMS) web site.

Background
Section 144(b) of MIPPA repeals the transfer of ownership provision established by the Deficit Reduction Act (DRA) of 2005 for oxygen equipment and establishes new payment rules and supplier responsibilities after the 36 month payment cap. Section 144(b) of MIPPA mandates payment for reasonable and necessary maintenance and servicing of oxygen equipment furnished after the 36-month rental cap. The 36-month cap applies to stationary and portable oxygen equipment furnished on or after January 1, 2006; therefore, the 36-month cap may end as early as January 1, 2009, for beneficiaries using oxygen equipment on a continuous basis since January 1, 2006.

CMS has determined that, for services furnished during calendar year 2009, it is reasonable and necessary to make payment for periodic, in-home visits by suppliers to inspect certain oxygen equipment and provide general maintenance and servicing after the 36-month rental cap. These payments only apply to equipment falling under Healthcare Common Procedure Coding System (HCPCS) codes E1390, E1391, E1392, and K0738, and only when the supplier physically makes an in-home visit to inspect the equipment and provide any necessary maintenance and servicing. Payment may be made no more often than every 6 months, beginning 6 months after the 36-month rental cap (as early as July 1, 2009, in some cases), and the allowed payment amount for each visit is equal

to the 2009 fee for code K0739, multiplied by 2, for the State in which the in-home visit takes place.

In the case of all oxygen equipment furnished after the 36-month rental cap, the supplier is responsible for performing any repairs or maintenance and servicing of the equipment that is necessary to ensure that the equipment is in good working order for the remainder of the reasonable useful lifetime for the equipment. This includes parts that must be replaced in order for the supplier-owned equipment to continue to function appropriately. Payment shall not be made for any repairs or maintenance and servicing, other than the maintenance and servicing payments described above, of oxygen equipment. Suppliers may not charge beneficiaries for any repairs, parts or servicing of equipment that they are required to furnish for the remainder of the equipment's reasonable useful lifetime.

Key Points

- Medicare contractors will pay claims with dates of service from July 1, 2009 thru December 31, 2009, for maintenance and servicing for oxygen concentrators no more often than every 6 months beginning 6 months after the end of the 36th month of continuous use when billed with one of the following HCPCS codes and modifiers:
  - E1390MS;
  - E1391MS; or
  - E1392MS.
- In addition to payment for maintenance and servicing for stationary oxygen concentrators (HCPCS codes E1390 or E1391) Medicare contractors will pay claims with dates of service from July 1, 2009 thru December 31, 2009, for maintenance and servicing for portable oxygen transfilling equipment (HCPCS code K0738) no more often than every 6 months beginning 6 months after the end of the 36th month of continuous use. HCPCS code K0738 must be billed with the HCPCS modifier "MS" to obtain such payment.
- Medicare contractors will not pay for maintenance and servicing of both a portable oxygen concentrator (E1392MS) and portable oxygen transfilling equipment (K0738MS).
- If maintenance and servicing is billed for a column I code in the following table, additional payment for the maintenance and servicing of any of the column II codes should not be made as in the following example:

Column I	Column II
E1390 MS	E1391 MS, E1392 MS
E1391 MS	E1390 MS, E1392 MS
E1392 MS	E1390 MS, E1391 MS, K0738 MS
K0738 MS	E1392 MS

- For the oxygen equipment codes E1390, E1391, E1392, and K0738, billed with the modifier "MS", Medicare contractors will make maintenance and servicing payments for covered services equal to the lesser of the supplier's actual charge or 2 units of K0739 every 6 months.
- Medicare contractors will deny claims for maintenance and servicing of oxygen equipment when billed with the HCPCS codes E0424, E0439, E0431, E0434, E1405 or E1406 and the "MS" modifier.
- Program instructions will be issued in the future regarding the continuation of the maintenance and servicing payments for dates of service on or after January 1, 2010.

Additional Information

The official instruction, CR6509, issued to your Medicare DME MAC, MAC and/or RHHI regarding this change may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R497OTN.pdf on the CMS web site.

Payment for Maintenance and Servicing of Certain Oxygen Equipment – Rescinded

MLN Matters Number: MM6404 Rescinded
Related Change Request (CR) #: 6404
Related CR Release Date: March 20, 2009
Related CR Transmittal #: R461OTN
Effective Date: July 1, 2009
Implementation Date: July 6, 2009

Note: This article was rescinded on May 27, 2009, and replaced by article number MM6509, which is at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6509.pdf on the Centers for Medicare & Medicaid Services web site. The article was rescinded because CR 6404 was rescinded and replaced by CR 6509.

WHEELCHAIRS/POWER MOBILITY DEVICES

K0823 - Notification of Prepayment Review

NAS Jurisdiction D DME MAC Medical Review will be initiating a widespread prepayment probe review of claims for HCPCS K0823; power wheelchair, group 2 standard, captain's chair capacity up to and including 300 pounds. Widespread reviews are used to determine the extent of potential problem areas across multiple suppliers. This review is being initiated based on the results of CERT (Comprehensive Error Rate Testing) analysis and analysis of adjudication claim development denials.

In order to evaluate compliance with Medicare coverage and coding rules, all suppliers billing Jurisdiction D for HCPCS code K0823 are subject to this review. Suppliers of the selected claims will receive an Additional Documentation Request (ADR) letter asking for specific information to determine if the item billed complies with the existing reasonable and necessary criteria. Failure to supply the requested information within **30 days** of the date on the letter will result in the claim being denied as not medically necessary. The ADR letter will provide instruction for submitting documentation.

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in Power Mobility Devices Local Coverage Determination (LCD) (L23598) and Policy Article (A41127). Suppliers can review the Power Mobility Devices LCD checklist on the NAS web site at https://www.noridianmedicare.com/dme/coverage/docs/checklists/group_1_pwc_and_group_2_pwc_no_power_options.pdf.

Information about probe/error validation reviews may be found in CMS Publication 100-8, Program Integrity Manual (PIM), Chapter 3.

Documentation Requirements for K0823 Power Wheelchair Claims

Recently NAS began monitoring HCPCS code K0823 (Power wheelchair, group 2 standard, captain's chair) due to a high volume of claim errors found by the Comprehensive Error Rate Testing (CERT) contractor. NAS has found the documentation received for these developed K0823 claims is insufficient to support medical necessity as noted in Power Mobility Devices Local Coverage Determination (LCD).

The documentation guidelines for K0823 can be found in the Power Mobility Devices LCD (L23598) located at: https://www.noridianmedicare.com/dme/coverage.

As a result of K0823 claim monitoring, NAS found the documentation submitted is insufficient to support even the basic coverage criteria for a power mobility device, namely:

- Mobility-related activities of daily living (MRADLs) limitations are not provided in detail. Documentation should identify the beneficiary's specific limitations and clearly indicate what they can and cannot complete in terms of MRADLs. MRADLs are such things as bathing, grooming, eating, transferring, and walking.
- The beneficiary's mobility cannot be sufficiently and safely resolved by the use of an appropriately fitted cane or walker. Documentation should identify specifically why the cane or walker is insufficient.
- The beneficiary does not have sufficient upper extremity function to self-propel an optimally-configured manual wheelchair in the home in order to perform his/her MRADLs during a typical day.
- A walker or manual wheelchair has been tried and the results of this trial are documented.
- Why is this beneficiary unable to use a scooter?

In addition to addressing the MRADLs in detail, the medical documentation should include the following:

- Strength levels and degrees of range of motion (ROM) of the beneficiary's upper and lower extremities
- Coordination
- Transferring abilities: self, assist of how many, or use of assistive devices
- Endurance level
- Pain rating and how performance of MRADLs impacts this pain rating

Supplier Generated Reports of Face-to-Face Mobility Examination:

NAS is seeing the use of supplier generated forms. Forms produced by the supplier for the face-to-face mobility exam do not record a complete medical examination and thus do not provide enough detailed information to adequately describe the medical necessity for the power mobility device in the beneficiary's home and are insufficient to meet the statutory requirements. The Power Mobility Devices LCD states:

"Many suppliers have created forms which have not been approved by CMS which they send to physicians and ask them to complete. Even if the physician completes this type of form and puts it in his/her chart, this supplier-generated form is not a substitute for the comprehensive medical record as noted above. Suppliers are encouraged to help educate physicians on the type of information that is needed to document a beneficiary's mobility needs."

- These forms are vague in the areas addressed with no detailed objective documentation to support the items marked. Check marks in boxes are insufficient to support the statutory requirements.
- NAS has noted that these forms can be in contradiction with the physician's or other Licensed Certified Medical Professional (LCMP) documentation. The forms have also been noted to conflict within itself from page to page.

The documentation submitted should provide a clear concise picture of the beneficiary's status.

- Is the beneficiary able to ambulate?
- What type of assistance is needed including the assistive device used?
- How many caregivers are required to provide assistance?
- What distance can the beneficiary ambulate?
- If no, why is the beneficiary unable to ambulate?
- How long will ambulation be a problem?
- Is this a short term non-weight bearing issue?
- Is the assistive device currently being used safe for the beneficiary?
- If no, why is the beneficiary not safe?
- How does the beneficiary transfer in and out of bed and to and from toilet?
- What equipment or physical assistance is needed for transfers from bed to chair and chair to toilet?
- Can the beneficiary perform pressure relief or weight shifting?
- What is the beneficiary's sitting and standing balance?
- What is the objective functional assessment of the beneficiary's strength and range of motion?
- Statements of moderate weakness are vague and subjective and insufficient to meet statutory requirements.

- Does the beneficiary have abnormal sensation or difficulties with coordination?
- Does the beneficiary have abnormal tone or a deformity of the arms, legs, or trunk, including spasticity?
- What interventions have been tried, and what were the results?

Sequence of Events for Power Mobility Devices:

1. The beneficiary goes to his/her physician to discuss the need for a power wheelchair.
2. The beneficiary is seen by the physician for a face-to-face mobility examination.
   - The physician shall document the examination in a detailed narrative note in the beneficiary's chart in the format used for other entries.
   - The note must clearly indicate that a major reason for the visit was a mobility examination.
   - The physician may also write an additional order for a wheelchair evaluation to be performed by PT/OT personnel who have experience and training in mobility evaluations to perform part of the face-to-face examination.
     - This could be the specialty evaluation as required in LCD L23598 for group 2 single and multiple power wheelchairs, all group 3 and 4 power wheelchairs, and the push-rim activated power assist device.
     - The physician then reviews the written report of the LCMP examination, signs and dates that report, and states concurrence or any disagreement with that examination.
     - The physician must send a copy of the note from his/her initial visit to evaluate the patient plus the annotated, signed, and dated copy of the LCMP examination to the supplier. The 45-day period begins when the physician signs and dates the LCMP examination.
3. The physician writes a seven element order for a power wheelchair which includes the following items:
   - Beneficiary's name
   - Description of the item that is ordered, general or specific
   - Date of the face-to-face mobility examination
   - Pertinent diagnoses or conditions that relate to the need for the power mobility device
   - Length of need
   - Physician's signature
   - Date of signature
4. This seven element order written by the physician is submitted to the supplier.
   - The written **order is completed** after the in-person visit and medical evaluation.
   - The supplier should date stamp or have an equivalent way to document the date this order is received.
   - The supplier must receive this order within 45 from the days after completion of the face-to-face exam and prior to delivery of the power mobility device.
5. The supplier determines the appropriate wheelchair and accessories for the beneficiary based on the mobility needs of the patient. A detailed product description is then created.
   - This form includes the HCPCS codes, billed amount, and Medicare fee schedule amount for the wheelchair and all options and accessories.
   - This form is submitted to the physician for his/her signature and date.
   - Date stamp or equivalent documenting date the supplier received detailed product description back from physician
6. The supplier completes a home evaluation to determine:
   - The power mobility device can access all rooms of the home.
   - The beneficiary is able to use the wheelchair to assist with MRADLS in the home.
   - The home evaluation must be dated and completed prior to delivery.
7. Additional documentation should be sent as requested in the claim development letter or as the physician or supplier deem necessary to assist in determining medical necessity and coverage criteria were met.

Sources:
Power Mobility Devices LCD (L23598)
Power Mobility Devices Policy Article (A41127)

Manual Wheelchair Documentation Requirements

NAS has noted that some suppliers have recreated the Certificates of Medical Necessity (CMNs) or checklists with the assumption that these will support the medical necessity portion of the documentation required for manual wheelchairs. CMNs were eliminated for wheelchairs provided on/after May 5, 2005.

Many suppliers have created forms that they send to physicians and ask them to complete. Even if the physician completes this type of form and includes it in the patient's chart, this supplier-generated form is not a substitute for the comprehensive medical record. Suppliers are encouraged to help educate physicians on the type of information that is needed to document a patient's mobility needs.

Many suppliers have inquired as to what type of documentation they should be obtaining in lieu of the CMN or created forms. Here are a few **suggestions and reminders.**

- Suppliers must obtain a dispensing order (except when the patient presents with a detailed written order right away) prior to dispensing the manual wheelchair and

a detailed written order from the physician is required before submitting the claim. Please see article "Reminder Regarding Physician Orders for Manual Wheelchairs" posted to our web site on November 4, 2008. The Manual Wheelchair Bases Local Coverage Determination (LCD) (L11454) states: "For an item to be covered by Medicare, a written signed and dated order must be received by the supplier **before** a claim is submitted. If the supplier bills for an item addressed in this policy without first receiving the completed order, the item will be denied as not medically necessary."

- Suppliers could create an internal form that would document the receipt of the dispensing order. This form could include items such as:
  - Date order was taken or received
  - How the order was received - by phone, fax, mail, or hand delivered
  - Name of the person who received the order
  - Name of the person who sent or requested the order
  - Patient's name and Medicare number- check supplier manual for correct wording
  - Items requested
  - Diagnosis code(s)
  - Start date of order
  - Full name and National Provider Identifier (NPI) of the physician ordering the item
- An order that is completed and provided by the physician and sent to the supplier must contain all of the following elements:
  - Beneficiary's name
  - Description of the item ordered.
  - Pertinent diagnoses/conditions that relate to the need for the wheelchair
  - Length of need
  - Physician's signature
  - Date of physician signature

The dispensing order needs to be followed up with a detailed order signed by the physician and dated.

Suppliers should not prepare a written order for the physician to sign until they have a preliminary dispensing order on file first. This is the hand written official order from the physician. This must be kept on file and provided when documentation is requested.

- It is the physician's responsibility to determine the length of need for items ordered. Many times the medical need for a wheelchair is short term due to surgery or a temporary condition. Documentation must support length of need.
- Obtain medical documentation that supports the need of a wheelchair. Examples of documentation include: the discharge summary dictated by the physician, Physical Therapist (PT)/ Occupational Therapist (OT) notes, office visit that relates to the patient's mobility limitations or office visit notes from a rehabilitation or occupational medicine physician.
- Obtain the most current documentation, for example; for a beneficiary recently discharged rehabilitation hospital – obtain the discharge summary and the PT/OT notes. Work with the discharge planner or the case manager at the hospital to obtain the correct documentation. Documentation submitted should be relatively close to the date of service to be an accurate reflection of the patient's mobility status. If the patient is receiving home health or home PT - obtain the home health nurses notes and/or the PT notes.
- Review the documentation received to determine if the wheelchair is necessary. Look for mobility limitations, ambulation, and a clear explanation of why the client needs a wheelchair.
  - Can the patient ambulate? If yes with what assistive device? If no, why not?
  - How far can they ambulate?
  - How long will ambulation be a problem? Is this a short term non-weight bearing issue?
  - Is the assistive device currently being used safe? If not, why not?
  - How does the patient transfer in and out of bed, in and out of a chair?
  - Is there any equipment required for transfers?
  - What is the patient's ability to perform pressure relief/ weight shift? If the patient is unable to perform a functional weight shift, documentation should indicate why.
  - Patient's sitting and standing balance.
  - Objective functional assessment that includes impairment of strength, range of motion, sensation, or coordination of arms and legs.
  - Presence of abnormal tone or deformities of arms, legs, or trunk, including any spasticity.
  - Patient's neck, trunk, and pelvic posture and flexibility.
  - Interventions that have been tried in the past and results.
  - Patient's past use of a walker, manual wheelchair, POV, or power wheelchair and results.
- Written Orders and Documentation Requirements from the Supplier Manual, Chapter 3 states as follows:

"Before submitting a claim to the DME MAC, *the supplier must have on file a dispensing order, the written order*, the Certificate of Medical Necessity (CMN) (if applicable), the DME MAC Information Form (DIF) (if applicable), *information from the treating physician concerning the patient's diagnosis* (if an ICD-9-CM code is required on the claim), and any information required for the use of specific modifiers or attestation statements as defined in certain DME policies. *The supplier should also obtain as much documentation from the patient's medical record as they determine they need to assure themselves that coverage criterion for an item has been met. If the information in the patient's medical record does not adequately support the medical necessity for the item, the supplier is liable for*

the dollar amount involved unless a properly executed advance beneficiary notice (ABN) of possible denial has been obtained."

Sources:

Manual Wheelchair Bases, Local Coverage Determination (L11454)
Manual Wheelchair Bases Policy Article (A25378)
Supplier Manual, Chapter 3

Group 3 Power Wheelchair Requirements

NAS would like to remind suppliers of the requirements and coverage criteria for Group 3 Power Wheelchairs, HCPCS codes K0848- K0864.

Power wheelchairs require a:

1. Written order from the physician.
2. Face-to-face mobility examination. Physicians shall document the examination in a detailed narrative in the charts in the format that they use for other entries. The note must clearly indicate that a major reason for the visit was a mobility examination.
3. Home assessment
4. Detailed product description

According to the Power Mobility Devices LCD (L23598) all Group 3 Power Wheelchairs require the following:

- The patient's mobility limitation is due to a neurological condition, myopathy or congenital skeletal deformity; (a **myopathy** is a **neuromuscular disease** in which the muscle fibers do not function, resulting in muscular weakness.) - **and**
- The patient has had a specialty evaluation that was performed by a licensed/certified medical professional, such as a PT or OT, or physician who has specific training and experience in rehabilitation wheelchair evaluations that documents the medical necessity for the wheelchair and its special features. The PT, OT or physician may have no financial relationship with the supplier.- **and**
- The wheelchair is provided by a supplier that employs a RESNA-certified Assistive Technology Professional (ATP) who specializes in wheelchairs and who has direct, in-person involvement in the wheelchair selection for the patient.

Group 3 Power Wheelchairs with Single Power Option (K0856-K0860) or with Multiple Power Options (K0861-K0864) are covered if:

- The patient's mobility limitation is due to a neurological condition, myopathy or congenital skeletal deformity; and also one of the following:
  - The patient requires a drive control interface other than a hand or chin-operated standard proportional joystick (examples include but are not limited to head control, sip and puff, switch control);-**or**
  - The patient meets coverage criteria for a power tilt or a power recline seating system (see Wheelchair Options and Accessories policy for coverage criteria) and the system is being used on the wheelchair;-**or**
  - The patient uses a ventilator which is mounted on the wheelchair.

Group 3 power wheelchairs are reserved for the severely impaired patient afflicted with diseases such as: Amyotrophic Lateral Sclerosis (ALS), spinal cord injuries resulting in quadriplegia, stroke (CVA) with hemiplegia, late stage Parkinson's, late stage Multiple Sclerosis (MS), cerebral palsy or Muscular Dystrophy.

A Group 3 Power Wheelchair would not be appropriate for a beneficiary who has diabetes with peripheral neuropathy. Peripheral neuropathy affects the nerves. It is not a primary neurological condition but rather a symptom of another disease. The Power Mobility Device LCD specifically states that the patient must have a neurological condition; therefore, the patient with peripheral neuropathy does not meet coverage criteria for a group 3 power wheelchair.

Sources:
Power Mobility Devices Local Coverage Determination (L23598)
Power Mobility Devices Policy Article (A41127)