Jurisdiction D News from Noridian Administrative Services, LLC.

Happenings

December 2009
Issue No. 25

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

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

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Jurisdiction D DME MAC Supplier Contacts and Resources

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

web site: www.noridianmedicare.com

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

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

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

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

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

FYI

Holiday Schedule

NAS offices will be closed on December 24, 2009, for training and on December 25, 2009, in observance of the Christmas holiday.

Medicare Learning Network Matters Disclaimer Statement

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

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

Sources for "Jurisdiction D Happenings" Articles

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

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

Summary of Supplier Manual Updates

The following table outlines an update to the DME MAC Jurisdiction D Online Supplier Manual.

Chapter	Subheading	Supplier Manual Update	Change Date
Chapter 16	E Codes	Removed CMN/DIF Required for E0776	12/4/09

The summary of updates is found on the Supplier Manual homepage, www.noridianmedicare.com/dme/news/manual/index.html.

Duplicate Remittance Advices Now Available Through IVR System

Beginning Friday, October 30, 2009, suppliers will be able to order duplicate remittance advices through the NAS Jurisdiction D Interactive Voice Response (IVR) system. Below are instructions on how to utilize this new menu option.

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

Touch-tone Option	Vocal Option
7	Duplicate Remittance Advice

When requested, key or speak the following information:

- NPI
- PTAN
- Last five digits of supplier TIN

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

1. **Check Number**

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

Check Number and Date	
Touch-tone Option	**Vocal Option**
1	Check Number

Key or speak the following information when requested:

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

Note: Using the 15 digit EFT Transaction Number will result in an unsuccessful remittance request.

2. **Claim Control Number**

To order a duplicate remittance advice using the claim control number, key or speak the selection as below:

Claim Control Number	
Touch-tone Option	**Vocal Option**
2	Claim Control

Key or speak the following information when requested:

- 14 digit claim control number

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

Successful Request

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

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

Unsuccessful Request

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

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

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

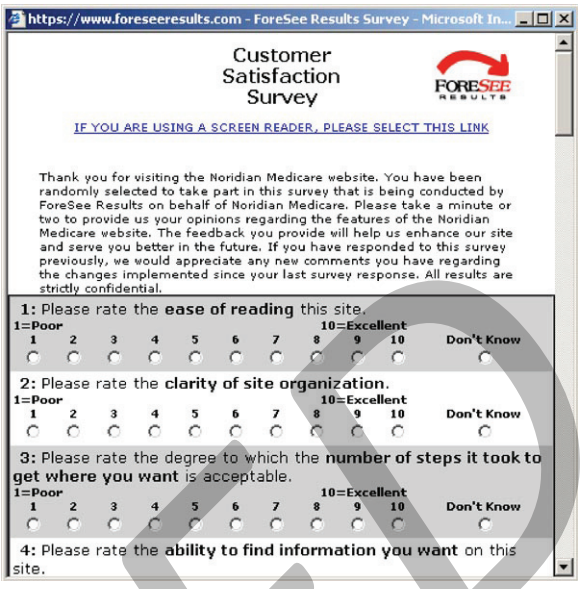
Web Site Survey – Share Your Thoughts Regarding Tools Implemented in 2009

NAS encourages suppliers to complete the randomly distributed ForeSee Results survey that pops up when navigating the Web site. Enhancements to the NAS DME Web site, https://www.noridianmedicare.com/dme, are made based on comments received from this survey. Review the summary of the enhancements made during 2009, visit the Web site, take the survey, and continue sharing what works well and ideas for improvement.

During 2009, several improvements were made to provide additional resources and to reduce the number of pages suppliers need to review to find information.

1. Consolidated the Supplier Manual chapters into a single PDF (09/24/09)
2. Created Claim Filing Timeline tool (08/28/09)
3. Added the Local Coverage Determinations (LCDs) and Policy Articles (08/07/09)
4. Removed old CIGNA DMERC Dialogue bulletins to improve search results (10/01/09)
5. Added "Welcome New Supplier" Web page for top 10 tasks to complete
6. Developed consolidated topic Web pages for surety bond, accreditation, and oxygen
7. Remittance Advice Tutorial created (08/13/09)
8. Published listing of noncovered items (07/30/09)
9. Published Same and/or Similar Reference Chart (05/21/09)
10. Developed a Reason / Remark Resource (03/25/09)

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



NAS evaluates and values all feedback and suggestions received from this survey. We greatly appreciate the time you invested in taking the survey as the feedback will help us improve and enhance our Web site and help us serve you better in the future.

IRS B-Notice

Attention: Suppliers Who Received a Letter from NAS and a Copy of the IRS B-Notice

NAS is required to provide an IRS Form 1099-MISC to each supplier who receives payment of $600 or more in a calendar year. The IRS Form 1099-MISC is an official tax document and as such, the name and Taxpayer Identification Number (TIN) information on the Form1099-MISC that is issued by NAS must exactly match the information on file with the IRS.

On October 30, 2009, NAS sent a notification letter and a copy of the IRS B-Notice, (which provides additional information about withholding) to suppliers who received an IRS Form 1099-MISC for the 2008 calendar year and whose name and/or TIN information on the form did not match their IRS records. This letter contains instructions to assist the supplier in updating their information with NAS.

First, the supplier must complete a new IRS Form W-9 (found at http://www.irs.gov) and mail the completed form with a copy of the notification letter to NAS at this address:

Noridian Administrative Services
Attention: CR 6117
PO Box 6727
Fargo, ND 58108 6707

Then, the supplier must go to the National Supplier Clearinghouse (NSC) Web site at http://www.palmettogba.com/nsc and complete, print, and sign a CMS-855S form. This form must be mailed to:

National Supplier Clearinghouse
Palmetto GBA
P.O. Box 100142
Columbia, SC 29202-3142

Please make sure the information you provide to these entities is complete and correct and reflects **EXACTLY** the information on file with the IRS.

Both documents require original signatures on file, so faxed copies will not be accepted.

If the IRS Form W-9 and CMS-855S are not completed and received within 30 days of the date of the letter, the IRS requires NAS to begin backup income tax withholding at a rate of 28%. This withholding will continue until the updated documents are received.

If you did not receive this letter and a copy of the B-Notice, your information with NAS matches the information on file with the IRS and you do not need to take action.

Medicare DMEPOS Rules to Take Effect in 2010 – Oxygen and Competitive Bidding

CMS has announced that the following final rule is on display at the *Federal Register*:

Medicare Program; Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2010

The rule can be viewed at: http://federalregister.gov/page2.aspx

This final rule includes rules regarding the following Durable Medical Equipment Prosthetics/Orthotics and Supplies (DMEPOS) subjects:

1. Maintenance and servicing of oxygen equipment;
2. The establishment of a notification process for suppliers choosing to become grandfathered suppliers under the DMEPOS Competitive Bidding Program; and
3. Payment for damages resulting from termination of contracts awarded in 2008 under Round 1 of the DMEPOS Competitive Bidding Program

Maintenance and Servicing of Oxygen Equipment

New rules regarding payment and supplier responsibilities for maintenance and servicing of oxygen equipment have been established in accordance with Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 requirements. The new maintenance and servicing rules permit payment every 6 months, beginning 6 months after the end of the 36 month rental payment cap, for maintenance and servicing of oxygen concentrators and transfilling equipment to ensure that the equipment is kept in good working order for the safety of the beneficiary. The new rules are effective for items furnished on or after July 1, 1010. The maintenance and servicing policy established for 2009 as part of an Interim Final Rule (73 FR 69726) will continue for items furnished through June 30, 2010.

Beginning July 1, 2010, a single maintenance and servicing payment of $66 may be made once every 6 months for maintenance and servicing of an oxygen concentrator (stationary or portable) and, if applicable, oxygen transfilling equipment. Separate payment is not made for each piece of equipment serviced. The maintenance and servicing payment does not apply to liquid or gaseous oxygen equipment (stationary or portable). The maintenance and servicing fee covers all maintenance and servicing needed during the 6 month period. The supplier is responsible for performing all necessary maintenance, servicing and repair of the equipment at the time it is needed and must also visit the beneficiary's home during the first month of each 6 month period to inspect the equipment and perform any necessary maintenance and servicing needed at the time of each visit.

CMS will issue program guidance with specific information for claims processing and beneficiary education over the next few months.

Grandfathering Notification Process

A process has been established for suppliers that are not awarded contracts under the DMEPOS Competitive Bidding Program to provide notification of their decisions regarding whether they will continue furnishing rented durable medical equipment (DME) and/or oxygen and oxygen equipment as grandfathered suppliers under the program. This process requires noncontract suppliers to provide written notification of their grandfathering decisions to CMS and all Medicare beneficiaries who reside in a competitive bidding area to whom they are furnishing these items. The process also requires beneficiaries to notify grandfathered suppliers regarding whether they wish to continue receiving their items from a grandfathered supplier.

The regulation also establishes a requirement that there be coordination between contract and noncontract suppliers regarding the removal and delivery of medically necessary items to and from a beneficiary's home. Noncontract and contract suppliers are required to work together to ensure that DMEPOS services are uninterrupted.

A grandfathered item is defined in the regulation to encompass all oxygen and oxygen equipment or all rented DME within a product category other than oxygen and oxygen equipment. Therefore, if a supplier chooses to become a grandfathered supplier for oxygen and oxygen equipment, it must continue to furnish all items of oxygen and oxygen equipment to all beneficiaries who choose to continue receiving the items from the grandfathered supplier. Likewise, if a supplier chooses to become a grandfathered supplier for an item of rented DME in a given product category, it must continue to furnish all rented DME in the product category to all beneficiaries who choose to continue receiving the items from the grandfathered supplier.

Process for Considering Claims for DAMAGES

MIPPA terminated contracts awarded under Round 1 of the Medicare DMEPOS Competitive Bidding Program and stipulated that, to the extent that any damages may be applicable as a result of the termination of contracts, such damages shall be payable from the Federal Supplementary Medical Insurance Trust Fund.

In accordance with the final regulation, claims for damages may only be filed by suppliers that submitted a bid and were awarded a contract in 2008 during Round 1 of the program. Any damages that are claimed must be substantiated and must be the direct result of termination of a contract under Round 1 of the program. The extent of the obligation for payment of damages is limited to damages realized by

the contract supplier. Therefore, entities that entered into subcontracting relationships with a contract supplier for purposes related to the furnishing items and services under the program are not eligible to submit claims for damages.

The Competitive Bidding Implementation Contractor (CBIC) will be the intake point for claims for damages, which will be reviewed by the CBIC and CMS. Claims must comply with all requirements specified in the final regulations. The CBIC will accept claims that are submitted by April 1, 2010. The date of submission is the actual date of receipt of the completed claim by the CBIC. No claims for damages will be accepted if they are received by the CBIC after April 1, 2010. If a claim for damages is not submitted by the deadline, the CBIC will recommend to CMS not to process the claim any further.

Claims for damages must be submitted in writing to the following address (electronic submissions via e-mail or facsimile will not be accepted):

Competitive Bidding Implementation Contractor
2743 Perimeter Pkwy, Ste 200-400
Augusta, Georgia 30909-6499

Every effort will be made to make a determination within 120 days of initial receipt of a claim or the receipt of additional information, whichever is later. However, in the case of more complex cases, or in the event that a large volume of claims is submitted, it may take more than 120 days to process a claim.

Why Was My Written Inquiry, Redetermination or Reopening Request Dismissed?

This article explains why claims previously denied as unprocessable are being dismissed and result in front-end dismissal letters.

Suppliers should not use an Inquiry/Redetermination Form or Reopening Form to submit claims that previously denied as unprocessable (Remittance Advice [RA] message MA130) or were returned with an Education Status letter. These claims cannot be appealed or reopened, but must be corrected and resubmitted.

All paper claims must be submitted according the CMS-1500 (08-05) claim form instructions, located on the NAS Web site at https://www.noridianmedicare.com/dme/claims/cms1500_08-05_instructions.html.

The following are common reasons why dismissal letters are sent to suppliers:

- The original claim submitted did not contain the correct information needed for the claim to process. You must make the appropriate corrections and resubmit a new CMS-1500 claim for processing. For additional details on what information was invalid or missing, refer to the RA for the original claim denial.
- There is no claim in the system for the date of service and procedure code you have listed on your written inquiry, redetermination or reopening request. You must submit a new CMS-1500 claim for these services.

Note: To ensure timely processing of claims, **please do not include any type of correspondence, such as a letter or a written inquiry, redetermination or reopening request form**. Simply submit a claim for these services. It is also not necessary to indicate that the claim is a corrected or resubmitted claim anywhere on the claim form. Doing so may delay or impede the processing of the claim.

For more information, please call the Supplier Contact Center at 1-866-243-7272.

Fax Submission: Top Five Things Suppliers Should Know

This article describes processes suppliers should use when faxing documents to NAS DME. To ensure the faxes you submit are received and processed in a timely manner, follow these five guidelines:

1. Direct your fax to the correct NAS DME department.

Department	Fax Number
Reopenings and Redeterminations	1-888-408-7405
Administrative Simplification Compliance Act (ASCA)	1-888-523-8449
Refunds to Medicare (non-MSP)	1-888-529-3666
Immediate Offsets	1-888-529-3666
Medicare Secondary Payer (MSP) Inquiries and Refunds	1-888-408-7405
DME Recovery Audit Contractor (RAC) Offsets	1-866-640-9459
DME RAC Redeterminations	1-888-408-7405
Advance Determination of Medicare Coverage (ADMC) Requests/ Documentation	1-877-662-8445
Medical Review Medical Documentation	1-866-465-0213
Comprehensive Error Rate Testing (CERT) Medical Documentation	1-877-436-4479

2. Submit a fax cover sheet which includes the total number of pages, NAS DME department name, supplier name, and contact information.
3. Submit all documents in one fax transmission as there is not a system in place to consolidate multiple responses to a single claim, inquiry, appeal etc.
4. Submit a separate fax for each claim, inquiry, or response with all of the supporting documentation attached for that specific claim.
5. Review the clarity of the documents being faxed to ensure the contents will not be distorted if faxed (highlights, shading, previously faxed pages where readability may be further diminished if re-faxed).

Additional NAS Jurisdiction D DME MAC phone, mail, fax, and e-mail contact information is available at https://www.noridianmedicare.com/dme/contact/contact.html.

Reminder: Physician Documentation Responsibility

Suppliers may use the Physician Letter – Medical Records located on the Coverage/MR page of our Web site to remind physicians of their responsibility in determining and documenting medical need for beneficiaries.

This letter reminds physicians that DMEPOS suppliers are their partners in caring for patients and providing information is a legal requirement.

Source: *Medicare Program Integrity Manual*, Chapter 5, Section 5.3.2

Revised DMECS User Guide

The Pricing, Data Analysis and Coding (PDAC) contractor has revised the Durable Medical Equipment Coding System (DMECS) User Guide. This guide provides an introduction of what DMECS is, how to locate the tool and how to use it.

DMECS provides HCPCS codes, modifiers, descriptions, fee schedules, manufacturer information, and more.

View DMECS and the User Guide at https://www.dmepdac.com/dmecs/index.html.

Automatic Mailing/Delivery of DMEPOS Reminder

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

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

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

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

Quarterly Provider Updates

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

Regulations and instructions published in the previous quarter are also included in the Update. The purpose of the Quarterly Provider Update is to:

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

To receive notification when regulations and program instructions are added throughout the quarter, sign up for the Quarterly Provider Update e-mail list at: http://list.nih.gov/cgi-bin/wa?SUBED1=cms-qpu&A=1.

The Quarterly Provider Update can be accessed at http://www.cms.hhs.gov/QuarterlyProviderUpdates/01_Overview.asp. We encourage you to bookmark this Web site and visit it often for this valuable information.

New Medicare Requirements Take Effect for Suppliers of Medical Equipment and Supplies

New Standards Prevent Fraud and Promote Quality Care

CMS issued a final reminder about new requirements for most suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) to meet new quality standards by October 1 and obtain a surety bond by October 2 as required under Federal law. These new supplier enrollment requirements will help to prevent fraud in Medicare and ensure that people with Medicare get high-quality medical items and services from qualified suppliers.

While the majority of Medicare beneficiaries will not be impacted by these new rules, people with Medicare should ask their suppliers if they are approved by Medicare to continue to ensure that Medicare will pay their claims. Suppliers must post notice if they are not accredited by Medicare or have the beneficiary sign an Advanced Beneficiary Notice of Noncoverage (ABN) before they are charged for the items or service. Beneficiaries who need to find a new supplier can go to the "Find a Supplier" page at http://www.medicare.gov or call 1-800-MEDICARE.

More information about the accreditation and surety bond requirements for DMEPOS suppliers can be found at http://www.cms.hhs.gov/MedicareProviderSupEnroll.

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

Therapy Cap Values for Calendar Year 2010

MLN Matters® Number: MM6660 Revised
Related Change Request (CR) #: 6660
Related CR Release Date: November 23, 2009
Related CR Transmittal #: R1860CP
Effective Date: January 1, 2010
Implementation Date: January 4, 2010

Note: This article was revised on November 24, 2009, to reflect a revised CR 6660 that the Centers for Medicare & Medicaid Services issued on November 23, 2009. As a result of the revised CR, the article was revised to include Regional Home Health Intermediaries as an additional contractor type involved with this issue. The CR release date, transmittal number, and Web address for accessing CR 6660 were also changed. Also, carriers were added as a contractor type involved as they were inadvertently not included in the original article. All other information remains the same.

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 6660 which describes the policy for outpatient therapy caps for 2010 and announces that therapy caps for 2010 will be $1860. Billing staff should be aware of these revised caps.

Background

The Balanced Budget Act 1997, P.L. 105-33, Section 4541(c) set annual caps for Part B Medicare patients. These limits change annually. The Deficit Reduction Act of 2005 (signed Feb. 8, 2006) directed that a process for exceptions to therapy caps for medically necessary services be implemented. Subsequently, the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) was enacted on July 15, 2008, and Section 141 extended the effective date of the exceptions process to the therapy caps to December 31, 2009. The exceptions process will continue unchanged for the time frame directed by Congress.

For physical therapy and speech language pathology services combined, the limit on incurred expenses is $1860 for calendar year (CY) 2010. For occupational therapy services, the limit is $1860 for CY 2010. The limit is based on incurred

FYI CONT'D

expenses and includes applicable deductible and coinsurance.

CR 6660 revises the *Medicare Claims Processing Manual* (Pub. 100-04, Chapter 5 (Part B Outpatient Rehabilitation and CORF/OPT Services), Sections 10 (Part B Outpatient Rehabilitation and Comprehensive Outpatient Rehabilitation Facility (CORF) Services - General), and Section 20 (HCPCS Coding Requirement) to include the CY 2010 therapy caps, and this revision is included as an attachment to CR 6660.

Additional Information

You can find out more about Medicare therapy services and resources at http://www.cms.hhs.gov/therapyservices/ on the Centers for Medicare and Medicaid Services (CMS) Web site.

The official instruction, CR 6660, issued to your carrier, FI, RHHI, A/B MAC, and DME MAC regarding this change may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R1860CP.pdf on the CMS Web site.

EDUCATIONAL

Ask the Contractor Q & A - November 12, 2009

The following questions and answers are from the November 12, 2009, Ask-the-Contractor Teleconference. In some cases, the original answers given during the call may have been expanded to provide further detail.

Prior to taking questions, NAS provided the following updates:

Duplicate Remittance Advices on IVR

As of Friday, October 30, 2009, suppliers are able to order duplicate remittance advices through the Interactive Voice Response (IVR) System. Instructions on how to utilize this new menu option are on the IVR At-A-Glance guide, as well as the User Guide. These guides can be found by going to the Contact page of our Web site and clicking on the Phone Numbers and Addresses link.

Upcoming Web-based Workshops

The Education team will be conducting many Web-based workshops in November and December including Glucose Monitors and Testing Supplies, Refractive Lenses, Positive Airway Pressure Devices, Respiratory Assist Devices, Oxygen and Oxygen Equipment, Enteral Nutrition and DME Modifiers. Sign up for these workshops by going to the Training/Events page of our Web site.

Change Request 6421

Change Request 6421 states the ordering/referring provider on a DMEPOS claim must be enrolled in the Medicare Provider Enrollment, Chain and Ownership System (PECOS) and is of a specialty that is eligible to order and refer. This verification is being implemented in two phases:

Phase 1 (October 5, 2009 through April 4, 2010): DMEPOS suppliers who report ordering/referring providers who do not meet these requirements will receive an informational message on their remittance. Electronic claims will continue to process.

Phase 2 (April 5, 2010 and thereafter): DMEPOS suppliers claims will be denied if these requirements are not met. Use of an Advance Beneficiary Notice of Noncoverage (ABN) is not appropriate for these situations.

CMS will be creating an internet national file available to suppliers to verify a physician's enrollment in PECOS. Some helpful reminders when checking PECOS include:

- Enter in the ordering provider name in all uppercase letters
- Do not use nicknames such as Bob for Robert
- Do not use punctuation such as the apostrophe in O'Connell

All four DME MACs together shared their concerns with the Common Electronic Data Interchange (CEDI) and have been assured when the National Provider Identifier (NPI) file is moved to PECOS on December 21st, most error messages will go away. CMS is monitoring this situation and NAS will continue to keep the supplier community updated.

For further clarification on this rule, please read Change Request 6421 and the article Delay in Implementing Phase 2 of CRs 6417 and 6421 posted to the What's New section of our Web site.

Medicare DMEPOS Rules to Take Effect in 2010

CMS has announced the following final rule on display at the *Federal Register*: Medicare Program; Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2010. This final rule includes maintenance and servicing of oxygen equipment, the establishment of a notification process for suppliers choosing to become grandfathered suppliers under the DMEPOS Competitive Bidding Program and payment for damages resulting from termination of contracts awarded in 2008 under Round 1 of the DMEPOS Competitive Bidding Program. Read the rules in their entirety by reading the article titled *Medicare DMEPOS Rules to Take Effect in 2010* posted to the What's New section of our Web site.

Q1. I am a physician and am exempt from accreditation. Supplier Standards 22-26 deal with accreditation. If we are audited, how do we prove we do not have to meet these standards?

A1. Accreditation exemptions are located on the NAS DME Web site under Enrollment. Links to CMS articles are also provided and can be used for verifications that physicians are exempt from accreditation.

Q2. According to the article CERT Errors - Oxygen posted to the NAS Web site, it states the Comprehensive Error Rate Testing (CERT) contractor is looking for the following documentation: "for claims subsequent to the recertification date, physician visit notes supporting continued medical monitoring of oxygen use and needs". Was this requirement added to the policy? We have had beneficiaries tell us they would give back their oxygen before going to the doctor again.

A2. This requirement was not added to the policy and all jurisdictions are having the same issue. When CERT is

reviewing claims, they are looking for all documentation to determine the continued medical necessity for oxygen. CERT is allowed to request this information until the DME MACs are told differently. If the beneficiary does not go to the doctor for oxygen issues specifically but for another reason, the continued need for oxygen can be documented in the medical records at that time.

Q3. Can you tell me how to bill an E0652 (pneumatic compressor, segmental home model with calibrated gradient pressure) when the beneficiary did not qualify for the E0651 (pneumatic compressor, segmental home model without calibrated gradient pressure)? Do I need to send in documentation of that medical necessity with a claim or do I just keep it in my files?

A3. Bill the claim the same way as an E0651, add a narrative stating "E0651 failed" and submit the Certificate of Medical Necessity (CMN) CMS 846 Pneumatic Compression Devices form. If the claim denies and a redetermination is requested, send all appropriate documentation for the medical necessity of the item with the request.

Q4. I know the power wheelchair (PWC) needs to be medically necessary for use within a patient's home. If a patient is in assisted living, is getting to the group dining room considered needing it within their home?

A4. There needs to be definite documentation supporting that the PWC is the only way the patient can accomplish eating, which is one of the mobility-related activities of daily living (MRADLs) referenced in the Power Mobility Devices LCD. If there is a way to get the food to the patient without the PWC, and they can accomplish all other MRADLs, this would not satisfy the LCD.

Q5. I am an independent, outpatient, physical therapy provider who makes custom splints for upper extremities. When I am billing L3808, which covers a variety of splints, do I need to include a narrative describing the specifics of that splint?

A5. A narrative is not required for code L3808.

Q6. I am a hospital based durable medical equipment (DME) and have a patient in the nursing home using a continuous positive airway pressure (CPAP) device. Can I bill the CPAP to Medicare? Chapter five of the supplier manual says for Medicare beneficiaries in a non-covered stay in the nursing home, only therapy services are subject to the consolidated billing.

A6. A CPAP is not covered by Medicare when the patient is in a nursing home.

In general, DME is not covered for a patient in a nursing facility (skilled or non-skilled). Coverage consideration in place of service 31 or 32 is limited to the following:

- Prosthetics, orthotics and related supplies
- Urinary incontinence supplies
- Ostomy supplies
- Surgical dressings
- Oral anticancer drugs
- Oral antiemetic drugs
- Therapeutic shoes for diabetics
- Parenteral/enteral nutrition (including E0776BA, the IV pole used to administer parenteral/enteral nutrition)
- ESRD - dialysis supplies only
- Immunosuppressive drugs

If a patient is in a Medicare Part A covered stay, payment is based on a prospective payment system under consolidated billing. The only items that may be covered by the DME MAC in a covered Part A stay include:

- Erythropoietin (EPO) services
- Dialysis supplies
- Customized prosthetic devices

Follow-up question. Can nursing homes make the beneficiary sign an ABN to make them responsible for non-covered items?

A. The nursing home cannot make the beneficiary sign an ABN if they are in a covered Part A stay. A beneficiary in a non-covered Part A stay is outside the scope of DME except for the items listed above.

For a beneficiary in a Part A stay, all DME items the beneficiary needs as ordered by their physician should be provided by the nursing home, with the exception of EPO, customized prosthetic devices and home dialysis equipment and supplies. If the beneficiary requests a DMEPOS item for convenience, for example, the nursing home may have the beneficiary sign a properly executed ABN.

Q7. We are having problems with the remittance advice not being specific enough to understand the reason for denial.

A7. The supplier contact center (866-243-7272) can help you understand the reason for claim denials. We are also in the process of making the reason codes as clear as possible. References for reason codes can be found on the NAS DME Web site under the Claims section.

Q8. In regards to PECOS, I will not receive warning messages if I get electronic remittance notices. How will I know that there is a problem with the ordering physician information?

A8. Warning notices should be seen on the GenResponse Report. If you are not receiving this report, contact your software vendor.

Follow-up question. If I tell a physician to sign up with PECOS because they are not currently, is there a way to find out they have signed up to become compliant?

A. A database is being created to show which ordering/referring physicians are compliant. In the meantime, suppliers should contact the physician to inform them they are not listed in PECOS based on the error messages received on the EDI (electronic data interchange) reports.

Q9. How do I bill if I have a new patient on oxygen starting in October but am not accredited until December and do not start billing until January?

A9. Start billing in January. The patient would have a valid CMN from when they were set up for oxygen in October. November and December would not be paid. You can not bill the patient for those months unless you have written proof that you informed the patient you were not accredited making them responsible for the months not paid.

Q10. We built a custom wrist/hand/finger splint that did not fit the patient correctly. Can we bill for the time to adjust the splint or is it considered a lump sum payment of the original splint reimbursement?

A10. Reimbursement is made in a lump sum payment with no extra payment for adjustment time.

Q11. We had a physician order a palm-based splint billed as an L3808. Later the physician ordered a new splint but wanted it fabricated on the other side of the hand. Is it appropriate to bill L3808 again?

A11. Yes, you can bill the L3808 again. Enter the reason for the new brace on the narrative of the claim. If the claim denies for same or similar equipment, submit a redetermination with medical documentation supporting the need for the new brace. The LT and RT modifiers should also be used on this code to identify which hand the split was applied.

Q12. Is there a Web page to find Healthcare Common Procedure Coding System (HCPCS) codes?

A12. HCPCS can be found in Chapter 16 of the Supplier Manual or in the Durable Medical Equipment Coding System (DMECS) on the Pricing Data Analysis Contractor Web site.

Q13. We have a patient on oxygen that has been in and out of the nursing home. Do we extend the CMN to get 36 actual rental payments or does it go by 36 months from the oxygen CMN initial date?

A13. The CMN would need to be extended to get 36 actual rental payments. Indicate on the narrative that the CMN needs to be extended in order to receive the full 36 rental payments.

Q14. We do a lot of debridement and are not charging for dressings. Do we have to record on the claim agents (gauze to clean the wound, not necessarily left on the wound, saline, etc.) as part of our dressings even though they are not covered?

A14. You do not have to bill non-covered items. If you do bill those items, they would be processed based on policy.

Q15. Every time a patient comes in and has their wound debrided and we put a new dressing on it in an outpatient setting, do we need proof of delivery signed to comply with the supplier standards? The patient might come back a couple times a week to have their wound checked and debrided and then dressings reapplied.

A15. The supplier standard for proof of delivery would not apply in this situation because when changing the dressings in an outpatient setting, this would be billed to Medicare Part B, not DME.

Follow-up question. If I fabricated a splint in the office and the patient wears it home, would I need to have proof of delivery?

A. Yes, because the splint is primarily used in the patient's home.

Q16. We provide wheelchairs to patients in the nursing home and bill place of service 31, skilled nursing facility (SNF). We are trying to get a denial for patient responsibility so that Medicaid can pay. What codes need to be put on the claim to ensure a patient responsibility denial?

A16. If the stay is covered by Medicare Part A, the supplier receives payment from the SNF. If the stay is not covered by Medicare Part A, modifier GY (item or service statutorily excluded or does not meet the definition of any Medicare benefit) can be used because the nursing home or SNF is not considered part of the patient's home.

Follow-up question. Why are we getting informational requests to prove the patient lives in a nursing home?

A. Example requested and not received.

Q17. We have a patient that started oxygen on 6/30/03. We replaced his concentrator on 8/18/08. Can we go back a year (November 2008) in billing? What date do we put on the new CMN to start the new 36 month rental period?

A17. The new oxygen capped rental starts on the date of delivery of the new equipment, provided a CMN and order was obtained before replacing the equipment. The date on the CMN would be the date the new oxygen concentrator was delivered.

REMINDERS

Refunds to Medicare

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

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

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

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

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

CERT

CERT Documentation

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

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

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

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

Mail all requested documentation to:

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

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

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

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

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

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

CEDI

Express Plus Transitioning to PC-ACE Pro32

CEDI has made the decision to offer and support a single free billing software solution to our DME suppliers. After careful consideration, Express Plus submitters will migrate to PCACE Pro32, the software of choice. CEDI feels this is the best solution to meet the needs of the DME Supplier Community.

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

Note: This conversion will not erase or delete any information currently stored in the Express Plus software.

Benefits offered by the PC-ACE Pro32 software include:

- Stores and maintains the code lists including Diagnosis Codes, Procedure Codes, and Modifiers and receives quarterly updates for these code sets;
- Checks the claims for missing or invalid information and provides for easy editing by highlighting the missing or invalid information;
- Claim data entry is numbered according to the 1500 paper claim form;
- Will be updated for version 5010 and be made available to PC-ACE Pro32 users.

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

For more information about the conversion or to setup a time for assistance in making the transition, please send an e-mail to the CEDI Help Desk at ngs.cedihelpdesk@wellpoint.com.

CEDI Supplier/Provider Authorized Signatures

In order to verify CEDI forms are submitted by the supplier, the CEDI Customer Support Unit will validate all signatures on the EDI Enrollment Forms and the Supplier Authorization Form. The person signing these documents must be listed with the National Supplier Clearinghouse (NSC) as an authorized signer on behalf of the supplier as provided on the CMS 855 Enrollment Application Form submitted to the NSC.

EDI Enrollment Forms and/or Supplier Authorization Forms received by CEDI with a signature other than an authorized representative will be rejected and returned to the supplier with a letter indicating that the representative is not authorized to sign the documents. Rejected enrollment forms will need to be completed again and resubmitted on-line at http://www.ngscedi.com. Once the new forms have been submitted on-line, please print the form and have the authorized party for the supplier sign and date the form. Forms will need to be faxed to 315-442-4299.

If you have any questions about who is authorized to sign a document on behalf of a supplier, please contact the National Supplier Clearinghouse at 1-866-238-9652. If you wish to update the authorized party's name, you will need to complete and submit the CMS 855 Enrollment Application Form to the NSC.

If you have any questions about this listserv please contact the CEDI Help Desk at 1-866-311-9184.

Update to MREP

The Medicare Remit Easy Print (MREP) version 2.7 is now available for download from the CMS Web site. This file can be accessed at http://www.cms.hhs.gov/AccesstoDataApplication/02_MedicareRemitEasyPrint.asp**.**

The latest Claim Adjustment Reason Codes and Remittance Advice Remark Codes are available in the Codes.ini file for the MREP software. For instructions on how to import the Codes.ini file, refer to page 66 of the *MREP User Guide*. On page 7, descriptions of other changes in the MREP 2.7 version can be located under the "What's New" section.

The *MREP User Guide* can be located at http://www.cms.hhs.gov/AccesstoDataApplication/Downloads/EasyPrintUserGuide.pdf

For assistance with upgrading MREP, please contact the CEDI Help Desk at ngs.cedihelpdesk@wellpoint.com or at 866-311-9184.

NCPDP Front-End Transition Reminder

As a reminder, the current NCPDP front-end process will be transitioning from the DME MACs to the Common Electronic Data Interchange (CEDI) beginning November 2009 and completing in December 2009. The timeline for this process is as follows:

- NCPDP claims received **through 8 a.m. ET on Sunday November 8, 2009**, will process at CEDI and only the DME MAC reports will be produced and returned for these claims.
- On November 8, 2009, CEDI will utilize the Sunday maintenance window to implement an NCPDP dual front-end process. NCPDP claims received **after 8 a.m. ET on Sunday November 8, 2009**, will be part of this dual front-end process. Once the dual process is in place:

During the dual front-end processing, CEDI will begin producing and returning front-end reports for NCPDP claims and the DME MACs will continue to send back the current NCPDP reports.

The CEDI NCPDP reports will be returned to the trading partner in a real time mode typically within 30 minutes; however, the size of the NCPDP claims file and other files that precede it will determine how long it takes to produce the report. If the CEDI NCPDP front-end report is not received within four hours, contact the CEDI Help Desk at 866-311-9184. The DME MAC NCPDP reports will continue to be available within 24-48 hours after the NCPDP file is submitted.

Although the CEDI NCPDP reports will be returned before the DME MAC NCPCP reports, NCPDP submitters must rely on reports produced by the DME MACs to determine the claim control number (CCN), claims accepted and to identify errors that need correcting.

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.

For claims received after 5 p.m. on Friday December 4, 2009, the DME MACs will discontinue all NCPDP front-end processes and the CEDI front-end process will remain in place. At that time, only CEDI will perform NCPDP front-end editing and produce NCPDP reports for the trading partners. CEDI will also assign the CCN to accepted claims and deliver the accepted claims to the appropriate DME MAC based on the beneficiary state code submitted on the claim.

The following manuals are available to assist with this implementation:

- The ***CEDI NCPDP Front-End Manual*** provides the new CEDI front-end process/reports for the upcoming transition occurring November 2009 through December 2009.
- The ***NCPDP Error Code Manual*** provides the durable medical equipment Medicare contract administrator (DME MAC) front-end process/reports that are currently in place and will continue to be produced through December 4, 2009.

Both manuals can be downloaded at http://www.ngscedi.com/outreach_materials/outreachindex.htm.

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.

Source: Common Electronic Data Interchange (CEDI)

New CEDI NCPDP Front-End Manual Now Available

A new Common Electronic Data Interchange ***(CEDI)*** National Council for Prescription Drug Programs ***(NCPDP) Front-End Manual*** is now available on the CEDI Web site at http://www.ngscedi.com/outreach_materials/outreachindex.htm.

The ***CEDI NCPDP Front-End Manual*** provides the new CEDI front-end process/reports for the upcoming transition occurring November 2009 through December 2009.

The ***NCPDP Error Code Manual*** provides the durable medical equipment Medicare contract administrator (DME MAC) front-end process/reports that are currently in place and will continue to be produced through December 4, 2009.

As a reminder, the current NCPDP front-end process will be transitioning from the DME MACs to CEDI beginning November 2009 and completing in December 2009. The timeline for this process is as follows:

- NCPDP claims received **through 8 a.m. ET on Sunday November 8, 2009**, will process at CEDI and only the DME MAC reports will be produced and returned for these claims.
- On November 8, 2009, CEDI will utilize the Sunday maintenance window to implement an NCPDP dual front-end process. NCPDP claims received **after 8 a.m. ET on Sunday November 8, 2009**, will be part of this dual front-end process. Once the dual process is in place:

CEDI will begin producing front-end reports for NCPDP claims and the DME MACs will continue to send back the current NCPDP reports.

The CEDI NCPDP reports will be returned in a real time mode (typically delivered back to the trading partner within 30 minutes; however, the size of the NCPDP claims file and other files that precede it will determine how long it takes to produce the report. If the CEDI NCPDP front-end report is not received within four hours, contact the CEDI Help Desk at 866-311-9184) and the DME MAC NCPDP reports will continue to be available within 24-48 hours after a file is sent.

Although the CEDI NCPDP reports are returned before the DME MAC NCPCP reports, NCPDP submitters must rely on reports produced by the DME MACs to determine the claim control number (CCN), claims accepted and to identify errors that need correcting.

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.

- For claims received **after 5 p.m. on Friday December 4, 2009**, the DME MACs will discontinue all NCPDP front-end processes and the CEDI front-end process will remain in place. At that time, only CEDI will perform NCPDP front-end editing and produce NCPDP reports for the trading partners. CEDI will also assign the CCN to accepted claims and deliver the accepted claims to the appropriate DME MAC based on the beneficiary state code submitted on the claim.

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.

CEDI Documents Updated

Common Electronic Data Interchange (CEDI) has updated the following documents on the Web site http://www.ngscedi.com to include information about the NCPDP 5.1 Implementation:

CEDI Frequently Asked Questions: This document contains answers to questions frequently asked by suppliers contacting the CEDI Help Desk. It has been updated to include information concerning the NCPDP 5.1 Implementation, the Express Plus software conversion, and Ordering/Referring Provider warning edits.

CEDI NCPDP Error Code Manual: This document contains information concerning edits received on the CEDI Front-End Report when submitting NCPDP claims after November 8, 2009.

Companion Document: The Companion document provides information regarding the following transactions; the 837 claim format, the 835 remittance notice, the 276/277 transactions, and the National Council for Prescription Drug Programs (NCPDP) claim format. This is intended as a reference to be used in addition to the ANSI ASC X12 Implementation Guides and NCPDP reference documents. The Companion Document has been updated to include information about the NCPDP 5.1 Implementation.

The *CEDI Frequently Asked Questions and CEDI NCPDP Error Code Manual* can be accessed at the following link: http://www.ngscedi.com/outreach_materials/outreachindex.htm

The Companion Document is located on the Technical Specifications page at http://www.ngscedi.com/TechnicalSpec/techindex.htm.

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

CEDI Enrollment Forms

Common Electronic Data Interchange (CEDI) Enrollment has been receiving enrollment requests using older versions of the enrollment forms. The new enrollment forms have a Record Identification Number (RID#) located on the bottom right hand side of the form once it has been submitted electronically. This RID# is a tracking number that allows CEDI Enrollment to track enrollment requests for CMS Audit purposes.

All requests must be submitted online at http://www.ngscedi.com and then printed, signed, dated and faxed to CEDI Enrollment at 315-442-4299. The RID# will only be shown on the printed copy of the enrollment form after the submit option is selected. Beginning October 26, 2009, if CEDI Enrollment does not receive the enrollment forms with the RID# at the bottom right hand side, the request(s) will be returned to the submitter.

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

Source: Common Electronic Data Interchange (CEDI)

Top 10 CEDI Edits for October 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 October. The edit, its description and tips to resolve the error are provided below.

For more information regarding the CEDI front-end edits, please review the *CEDI Front End Report Manual* located on the CEDI 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. C202 Ordering Provider Not Authorized

The edit C202 is a warning edit. It will not reject the claims until it becomes a rejection in January 2010. The edit indicates that the ordering provider submitted in the claim is not found on the CMS supplied PECOS file of Providers/Suppliers who are authorized to order DME supplies. Contact the ordering provider identified in the edit to verify their information, including their National Provider Identifier (NPI), and eligibility with the Provider Enrollment, Chain and Ownership System (PECOS).

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

2. C200 Referring Provider Not Authorized

The edit C200 is a warning edit. It will not reject the claims until it becomes a rejection in January 2010. The edit indicates that the referring provider submitted in the claim is not found on the CMS supplied PECOS file of providers/suppliers who are authorized to refer DME supplies. Contact the referring provider identified in the edit to verify their information, including their National Provider Identifier (NPI), and eligibility with the Provider Enrollment, Chain and Ownership System (PECOS).

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

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

3. C201 Referring Provider Not Authorized

The edit C201 is a warning edit. It will not reject the claims until it becomes a rejection in January 2010. The edit indicates that the referring provider submitted in the claim is not found on the CMS supplied PECOS file of providers/suppliers who are authorized to refer DME supplies. Contact the referring provider identified in the edit to verify their information, including their National Provider Identifier (NPI), and eligibility with the Provider Enrollment, Chain and Ownership System (PECOS).

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

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

4. C172 Invalid Procedure Code and/or Modifier

The procedure code, modifier, or procedure code and modifier combination is invalid. To resolve this error, verify the 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:

1. Check the validity of the procedure code/modifier combination by using the Pricing, Data Analysis and Coding (PDAC) Web site https://www.dmepdac.com.
2. Check the local coverage determination (LCD) at the DME MACs for guidelines on procedure codes and modifier usage for that LCD.
3. Reference the supplier manual at the DME MAC Jurisdiction(s).
4. 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

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. C008 EIN/SSN Not on File with NPI

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

Note: This edit can fire with the C003 Billing NPI Not on Crosswalk. If this occurs, the Tax ID (Employer Identification

CEDI CONT'D

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.

7. 1001 Required Loop Not Found

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

8. 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.

9. 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.

10. 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.

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.

Source: Common Electronic Data Interchange (CEDI)

ACCREDITATION

Accreditation Time Frame for Pharmacies is January 1, 2010

Since HR 3663 postponed the accreditation time frame for pharmacies until January 1, 2010, we are reminding **pharmacies who have not been accredited to do so by January 1, 2010**.

We encourage all pharmacies going through the accreditation process to resolve any outstanding issues on your accreditation report so that the Accrediting Organization can make an accreditation determination in advance of the January 1, 2010 deadline. The DMEPOS Accrediting Organization will notify the National Supplier Clearinghouse (NSC) when your organization is accredited.

Pharmacies who do not plan to remain enrolled in the DMEPOS Medicare Program are strongly encouraged to notify their customers as soon as possible. This will give your customers an opportunity to find another DMEPOS supplier.

Pharmacies Only Supplying Non Accredited Products – 855S Information

Enrolled pharmacies that have elected to only supply Non Accredited Products (i.e. step down), as shown in Section 2 of the Medicare enrollment application (i.e. CMS-855S), who have now obtained accreditation should not submit a new CMS - 855S to the NSC. The NSC will automatically change your enrollment status to allow you to supply the products and services for which you are accredited. The NSC will obtain this information directly from your accrediting organization. You can bill for the accredited products and services as of the date of accreditation.

Reminder: Bidding Now Open for Round 1 Rebid of DMEPOS Competitive Bidding Program

CMS is currently accepting bids for the Round 1 Rebid of the Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding Program. **All bids must be submitted in DBidS, the on-line bidding system, by 9 p.m. prevailing Eastern Time on December 21, 2009; all required hardcopy documents that must be included as part of the bid package must be postmarked by 11:59 p.m. on December 21, 2009**.

Here are some important things to remember when submitting your bid:

- You must submit your bid in DBidS using the user ID you received during registration. If you have not already logged into DBidS, we strongly recommend that you do so before December 7, 2009, in order for you to have plenty of time to complete your bid. Please note that you must answer at least 2 and up to 10 authentication questions the first time you log in.
- The Covered Document Review Date (CDRD) for the Round 1 Rebid was November 21, 2009. **If you submitted financial documents by the CDRD, we will notify you of any missing financial documents by January 5, 2010, and you will have 10 business days to submit the missing financial documents.** Bidders that did not submit any hardcopy financial documents by the CDRD will not be notified of any missing documents. If you did not submit any hardcopy financial documents by the CDRD, you are still required to submit all required hardcopy documents specified in the Request for Bids (RFB) instructions by 11:59 p.m. on December 21, 2009.
- The Round 1 Rebid competitive bidding areas (CBAs), product categories, DBidS information, bidder charts, educational materials, and complete RFB instructions can be found on the CBIC Web site, http://www.dmecompetitivebid.com. You should review this information prior to submitting your bid(s).
- If you have any questions about the bidding process, please contact the CBIC Customer Service Center at 1-877-577-5331.

Competitive Bidding Documents

Important Notice for DMEPOS Competitive Bidding

This notice applies to all suppliers bidding in the Round 1 Rebid of the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program.

All bidders must submit certain required hardcopy documents as specified in the Request for Bids (RFB) Instructions. It is critically important that all of your financial documents meet all requirements. If your documents do not meet all requirements, all of your bids will be disqualified, and you will not be eligible for a contract. The way to make sure that your financial documents are acceptable is to read Appendix B of the RFB Instructions and the sample financial statements and then carefully check your documents to make sure that they comply.

If you submitted any financial documents by November 21, 2009, we will notify you of any missing financial documents. The notification will only alert you of missing documents. You will not be notified as to whether your financial documents are accurate, acceptable, or in accordance with the RFB instructions. Even if you have already submitted your financial documents, there is still time for you to review the RFB instructions and send in revised documents before bidding closes on December 21, 2009. You will not be able to submit any revised documents after December 21, 2009. Please be sure to put your bidder number on each page of your financial documents.

Here are some key reminders:

- Your tax extract MUST include all required pages. For example, if you are a corporation, you must include page 1 AND page 2 AND the supporting schedule for "Other Expenses," if the supporting schedule for "Other Expenses" is noted on your tax extract.
- Your financial statements MUST be for the SAME accounting period (fiscal or calendar) as your tax extract. For example, if your tax extract is for calendar year 2008, then your financial statements must be for calendar year 2008.
- Your financial statements MUST be submitted for your most recent operating year (fiscal or calendar) prior to the date of bid submission. For example, if your tax year ended on 6/30/2009, you must submit your tax extract for this accounting period and corresponding financial statements for the SAME accounting period.
- Your financial statements MUST be for 12 full months.
- Your financial statements MUST meet all requirements as shown on the sample financial statements. You cannot substitute other types of financial statements for the required financial statements. For example, do NOT submit a bank reconciliation as a substitute for a statement of cash flow.
- Your credit report MUST be from one of the five accepted credit bureaus: Equifax, Experian, TransUnion, Dun & Bradstreet, or Standard & Poor's. You cannot submit credit reports from Credit.net, Dealertracker.com, MyFICO or any other non-approved credit bureau.

The Round 1 Rebid competitive bidding areas (CBAs), product categories, DBidS information, bidding information charts, educational materials, and complete RFB Instructions can be found on this Web site. If you have any questions about the bidding process, please contact the CBIC Customer Service Center at **1-877-577-5331**.

Source: Competitive Bidding Implementation Contractor (CBIC)

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

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

Provider Types Affected

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

What You Need To Know

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

Key Points of CR6677

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

Background

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

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

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

Additional Information

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

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

DMEPOS Competitive Bidding Program Round One Rebid Implementation - Phase 8B: Oxygen Modality

MLN Matters® Number: MM6692
Related Change Request (CR) #: 6692
Related CR Release Date: November 6, 2009
Related CR Transmittal #: R593 OTN
Effective Date: April 1, 2010
Implementation Date: April 5, 2010

Provider Types Affected

Suppliers submitting claims to Medicare Regional Home Health Intermediaries (RHHIs) or Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for stationary or portable oxygen equipment provided to Medicare beneficiaries need to be aware of this article.

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) issued CR 6692 to announce changes in the way grandfathered oxygen competitive bid claims are processed following a change in stationary or portable equipment modality under Round One of the DMEPOS Competitive Bidding Program. RHHIs and DME MACs are required to apply a single 36-month cap for stationary oxygen equipment and a separate single 36-month cap for portable oxygen equipment regardless of how many different HCPCS codes are billed for a beneficiary during the rental period. See the Background and Key Points sections below and make certain your billing staff is aware of these changes.

Background

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

Section 1847(a)(4) of the Act requires that in the case of covered DME items for which payment is made on a rental basis under section 1834(a) of the Act, and in the case of oxygen for which payment is made under section 1834(a)(5) of the Act, the Secretary establish a grandfathering process by which rental agreements for those covered items and supply arrangements with oxygen suppliers entered into before the start of a competitive bidding program may be continued. This grandfathering provision provides the beneficiary the choice of receiving a grandfathered item from a grandfathered supplier or a contract supplier. Unless the beneficiary elects to change suppliers, the rental agreements and supply arrangements for grandfathered items last for the duration of a beneficiary's medical need or for the items reasonable useful lifetime. In the case of oxygen and oxygen equipment, a change in stationary or portable oxygen equipment modality during the 36-month period does not start a new 36 month rental period and does not, in and of itself, terminate a supplier's role as a grandfathered supplier of oxygen and oxygen equipment.

Key Points of CR 6692

- For stationary oxygen systems codes **E0424, E0439, E1390, E1391, E1405, and E1406**, any change in modalities at any point during the 36-month rental payment period (i.e., from one HCPCS code for a stationary oxygen system to another) does not affect the status of a grandfathered supplier and its ability to continue billing and receiving payment for furnishing stationary oxygen and oxygen equipment to a beneficiary residing in a competitive bidding area (CBA) for whom it had furnished such stationary oxygen and oxygen equipment prior to the start of the competitive bidding program.
- For portable oxygen equipment codes **E0431, E0434, E1392, and K0738**, any change in modalities at any point during the 36-month rental payment period (i.e., from one HCPCS code for portable oxygen equipment to another) does not affect the status of a grandfathered supplier and its ability to continue billing and receiving payment for furnishing portable oxygen and oxygen equipment to a beneficiary residing in a CBA for whom it had furnished such portable oxygen and oxygen equipment prior to the start of the competitive bidding program.
- Previously CMS instructed that non-contract suppliers of stationary and portable oxygen equipment **may continue to provide their equipment to their existing beneficiaries, if the beneficiary agrees to the arrangement**. CMS also instructed that, if a non-contract supplier does not want to continue to provide oxygen equipment to its existing beneficiaries at the bid amount, the beneficiary must obtain the item from a contract supplier. If a beneficiary no longer rents a grandfathered item from his or her previous supplier (because the previous supplier elected not to become a grandfathered supplier or the beneficiary elected to change suppliers), a maximum of 45 rental payments may be made for portable oxygen equipment and up to 45 payments may be made for stationary oxygen equipment.
- In situations where a beneficiary in a CBA is receiving oxygen services via portable and/or stationary oxygen equipment prior to competitive bidding and the beneficiary's oxygen equipment and suppliers are not grandfathered (because the previous supplier chose not to be grandfathered or the beneficiary chose not to stay with that supplier), Medicare will allow for a minimum of 10 monthly rental payments to be paid to the contract supplier for any modality of portable and/or stationary oxygen equipment. In such cases, the beneficiary is liable for the co-payments for any additional payments made to the contract supplier.

Additional Information

The official instruction, CR6692, issued to your Medicare RHHI or DME MAC regarding this change may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R593OTN.pdf on the CMS Web site.

For an overview of the DMEPOS competitive bidding program you may go to http://www.dmecompetitivebid.com on the Internet.

Round One Rebid of DMEPOS Competitive Bidding Program - Phase 8C of Implementation: Repairs and Replacements

MLN Matters® Number: MM6678
Related Change Request (CR) #: 6678
Related CR Release Date: November 6, 2009
Related CR Transmittal #: R592OTN
Effective Date: April 1, 2010
Implementation Date: April 5, 2010

Provider Types Affected

This article is for Medicare Durable Medical Equipment Prosthetic, Orthotics & Supplies (DMEPOS) suppliers who submit claims for Medicare payment to DME Medicare Administrative Contractors (DME MACs).

Provider Action Needed

This article is based on Change Request (CR) 6678 which provides instructions for contractors to allow any supplier with a valid Medicare billing number to furnish and bill for services (labor and parts) associated with the repair of DME or enteral nutrition equipment owned by beneficiaries in a competitive bidding area (CBA). It also requires a supplier that replaces an item that is subject to the DMEPOS Competitive Bidding Program to be a contract supplier. Please make sure your billing staff know about the modifier changes related to repair and replacement of DME and DME parts. Those modifier changes are discussed in this article.

Background

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

CR6678 provides instructions to the DME MACs for processing claims submitted with the new repair and replacement modifiers under the DMEPOS Competitive Bidding Program Round One Rebid. Specifically, the existing modifier for repairs and replacement of DME items, RP, was deleted from the Health Care Common Procedure Code Set (HCPCS), effective December 31, 2008. To distinguish between the repair and the replacement of an item, the following two modifiers were added to the HCPCS on January 1, 2009:

- RA – Replacement of a DME item; and
- RB – Replacement of a part of DME furnished as part of a repair

The new RA modifier will be used in the DMEPOS Competitive Bidding Program to identify claims for the replacement of an entire competitive bid item. The RB modifier will be used to denote the replacement of a part for repair purposes.

CR 6678 provides instructions to allow any supplier with a valid Medicare billing number to furnish and bill for services (labor and parts) associated with the repair of DME or enteral nutrition equipment owned by beneficiaries in a CBA. In these situations, Medicare payment for labor will be made based on the standard payment rules. Medicare payment for replacement parts associated with repairing competitively bid DME or enteral nutrition equipment, that are submitted with the RB modifier, will be based on the single payment amount for the part if the part and equipment being repaired are included in the same competitive bidding product category in the CBA. Otherwise, Medicare payment for replacement parts associated with repairing equipment owned by the beneficiary will be made based on the standard payment rules.

CR 6678 also requires a supplier that replaces an entire item, submitted with the RA modifier that is subject to the DMEPOS Competitive Bidding Program, to be a contract supplier. For these items, Medicare payment will be based on the single payment amount for the item in the beneficiary's CBA.

Additional Information

All providers may find more detailed information about the competitive bidding program at http://www.cms.hhs.gov/DMEPOSCompetitiveBid/ on the CMS Web site.

PECOS

Delay in Implementing Phase 2 of CRs 6417 and 6421

The Centers for Medicare & Medicaid Services (CMS) will delay, until April 5, 2010, the implementation of Phase 2 of Change Request (CR) 6417 (Expansion of the Current Scope of Editing for Ordering/Referring Providers for Claims Processed by Medicare Carriers and Part B Medicare Administrative Contractors (MACs)) and CR 6421 (Expansion of the Current Scope of Editing for Ordering/Referring Providers for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Supplier Claims Processed by Durable Medical Equipment Medicare Administrative Contractors (DME MACs)). CRs 6417 and 6421 are applicable to Part B claims only.

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

Although enrolled in Medicare, many physicians and non-physician practitioners who are eligible to order items or services or refer Medicare beneficiaries to other Medicare providers or suppliers for services do not have current enrollment records in Medicare. A current enrollment record is one that is in the Medicare Provider Enrollment, Chain and Ownership System (PECOS) and also contains the physician/non-physician practitioner's National Provider Identifier (NPI). Under Phase 2 of the above referenced CRs, a physician or non-physician

practitioner who orders or refers and who does not have a current enrollment record that contains the NPI will cause the claim submitted by the Part B provider/supplier who furnished the ordered or referred item or service to be rejected.

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

For physicians and non-physician practitioners who order or refer:

- If you are not enrolled in the Medicare program, or if you enrolled more than 6 years ago and have not submitted any updates or changes to your enrollment information in more than 6 years, you do not have an enrollment record in PECOS. In order to continue to order or refer items or services for Medicare beneficiaries, you will have to submit an initial enrollment application. You may do so either by (1) using Internet-based PECOS (which transmits your enrollment application to the Medicare carrier or A/B MAC via the Internet - be sure to mail the signed and dated Certification Statement to the carrier or A/B MAC immediately after submitting the application), or (2) filling out the appropriate paper Medicare provider enrollment application(s) (CMS-855I and CMS-855R, if appropriate) and mailing the application, along with any required additional supplemental documentation, to the local Medicare carrier or A/B MAC, who will enter your information into PECOS and process your enrollment application. Information on how to enroll in Medicare is found on the Medicare provider/supplier enrollment Web site at http://www.cms.hhs.gov/MedicareProviderSupEnroll.
- If you are already enrolled in Medicare, make sure you have a current enrollment record. You can find out if you have an enrollment record in PECOS by calling your designated carrier or A/B MAC or by going on-line, using Internet-based PECOS, to view your enrollment record. We will be posting information to the Medicare provider/supplier enrollment Web site that will guide you through this process. Information about Internet-based PECOS and a link to Internet-based PECOS can be found on the Medicare provider/supplier enrollment Web site. Before using Internet-based PECOS, we recommend that you read the information that is posted there and that is available in the downloadable documents section.
- If you are a dentist or a physician with a specialty such as a pediatrics who is eligible to order or refer items or services for Medicare beneficiaries but have not enrolled in Medicare because the services you provide are not covered by Medicare or you treat few Medicare beneficiaries, you need to enroll in Medicare in order to continue to order or refer items or services for Medicare beneficiaries.
- If you are a physician who is employed by the Department of Veterans Affairs, the Public Health Service, or the Department of Defense Tricare program but have not enrolled in Medicare because you would not be paid by Medicare for your services, you need to enroll in Medicare in order to continue to order or refer items or services for Medicare beneficiaries.
- If you are a resident who has a medical license but have not enrolled in Medicare because you would not be paid by Medicare for your services, you do not need to enroll in Medicare in order to continue to order or refer items or services for Medicare beneficiaries. The teaching physician - not the resident - should be identified in claims as the ordering/referring provider when a resident orders or refers items or services for Medicare beneficiaries.

CMS actions to mitigate the number of informational messages

Since many Part B providers and suppliers are receiving a high volume of informational messages in their Remittances, CMS is taking the following actions to reduce the number of informational messages being generated:

1. Prior to the implementation of Phase 2, CMS will systematically add the NPIs to the PECOS enrollment records of all physicians and non-physician practitioners whose enrollment records are in PECOS but do not contain their NPIs. Because the NPI is one of the matching criteria used in implementing the two new edits on the Ordering/Referring Provider, it is essential that the NPI be in the PECOS enrollment record. Because the data file used to implement the two edits contains only the eligible physicians and non-physician practitioners who are in PECOS with NPIs in their enrollment records, this action will add many more physicians and non-physician practitioners to that data file.
2. Prior to the implementation of Phase 2, CMS will make publicly available on the Internet the names and NPIs of the Medicare physicians and non-physician practitioners who are eligible to order or refer in the Medicare program. The name displayed will be that of the physician or non-physician practitioner as it appears in his or her PECOS enrollment record. This will allow Part B providers and suppliers who furnish and bill for items or services based on orders or referrals to determine if the Ordering/Referring Provider being identified in their claims will pass the two new edits prior to submitting the claims to Medicare.
3. Prior to the implementation of Phase 2, CMS will issue instructions to carriers and A/B MACs that will assist them in processing enrollment applications from physicians who are employed by the Department of Veterans Affairs, the Public Health Service, and the Department of Defense Tricare program. The instructions will also state that the teaching physician should be reported as the Ordering/Referring Physician in situations where a resident orders or refers items or services for Medicare beneficiaries. The instructions will also note that dentists and pediatricians, who sometimes order or refer items or services for Medicare beneficiaries, may be enrolling in Medicare in order to continue to order and refer.
4. CMS will be preparing a Special Edition Medicare Learning Network (MLN) Matters Article on the implementation of these two new edits. This MLN Matters Article will expand upon the information currently available in MLN Matters Articles MM 6417 and MM 6421.

Message for Providers/Suppliers Concerning CR 6421

To: DMEPOS suppliers and their billing agents clearinghouses
Physicians/non-physician practitioners and their group practice offices

Subject: Change Request 6421—Editing the Ordering/Referring Provider in DMEPOS Claims

This message is directed at Medicare suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS), their billing agents and clearinghouses, and the physicians and non-physician practitioners who order items of DMEPOS for their Medicare patients. We refer to those physicians and non-physician practitioners as "ordering/referring providers."

Background

To implement Section 1833(q) of the Social Security Act that requires all physicians and non-physician practitioners that meet the definitions at section 1861(r) and 1842(b)(18)(C) be uniquely identified for all claims for services that are ordered or referred and to address concerns raised by Congress, the public, and Government agencies for paying claims for DMEPOS that were ordered by physicians or non-physician practitioners who were not permitted by the Medicare program to do so.

As a first step in addressing these concerns, CMS is verifying that the ordering/referring provider on a DMEPOS claim (1) has a current enrollment record in Medicare (i.e., the ordering/referring provider enrolled or updated his/her enrollment record within the past 5 years and the NPI is in the record) and (2) is of a specialty that is eligible to order and refer.

This verification is being implemented in two phases:

- In Phase 1 (October 5, 2009 through January 3, 2010), DMEPOS suppliers who report ordering/referring providers who do not pass both edits will receive an informational message on their remittance. (Paper billers will not receive an informational message.) The claims will be paid.
- In Phase 2 (January 4, 2010 and thereafter), DMEPOS suppliers who report ordering/referring providers who do not pass both edits will have their claims rejected.

The following physicians and non-physician practitioners may order/refer in the Medicare program:

- Physicians (doctors of medicine or osteopathy—all specialties, and doctors of dental medicine, dental surgery, podiatric medicine, optometry, and chiropractic medicine)
- Physician assistants,
- Certified Clinical Nurse Specialists,
- Nurse Practitioners,
- Clinical Psychologists,
- Certified Nurse Midwives, and
- Clinical Social Workers.

How the new edits are being implemented

CMS has furnished the DME claims processing system with a national file that was generated from the CMS' national provider enrollment repository, Provider Enrollment, Chain and Ownership System (PECOS). We refer to this file as the PECOS List. PECOS maintains Medicare enrollment information for all providers and suppliers (including physicians and the non-physician practitioners shown above), except DMEPOS suppliers; however, it is important to note that PECOS only maintains enrollment information for physicians and non-physician practitioners if they have enrolled or updated their enrollment information since November 2003.

Medicare transmits updates to the PECOS List daily to the claims processing system. The PECOS List contains only the physicians and non-physician practitioners who are enrolled in the above specialties and who have current enrollment records (i.e., they have enrollment records in PECOS that contain their NPIs). CEDI (the front-end claims processing system for electronic DMEPOS claims) compares the NPI and the first letter of the first name and the first four letters of the last name of the ordering/referring provider as reported on the claim to that same information in the PECOS List. If a match is found, no informational message is sent to the DMEPOS supplier in the Remittance. If a match is not found, an informational message is sent to the DMEPOS supplier in the Remittance. Beginning January 5, 2010, and thereafter, if a match is not found, the claim will be rejected.

CMS actions to mitigate the number of information messages

Since many DMEPOS suppliers are receiving informational messages in their Remittances, CMS is taking the following actions to reduce the number of informational messages:

1. Prior to the implementation of Phase 2, CMS will systematically add the NPIs to the PECOS enrollment records of all physicians and non-physician practitioners whose PECOS records do not contain their NPIs. Because the NPI is one of the matching criteria used in implementing the edits, it is essential that the NPI be in the PECOS enrollment record. Because the PECOS List contains only physicians and non-physician practitioners who are in PECOS with NPIs in their enrollment records, this action will result in the addition of many more physicians and non-physician practitioners to the PECOS List.
2. Prior to the implementation of Phase 2, CMS will make publicly available on the Internet a national file of Medicare physicians and non-physician practitioners who are eligible to order/refer. The file will contain the NPI and the Legal Name (from the Medicare PECOS enrollment record). This will allow DMEPOS suppliers to determine if the ordering/referring provider has a current Medicare enrollment record and is eligible to order or refer.
3. Prior to the implementation of Phase 2, CMS will issue instructions that will assist Medicare contractors in enrolling licensed residents, Department of Veterans Affairs physicians, and Public Health Service physicians. These physicians continue to order DMEPOS but have not enrolled in Medicare because they are not eligible

for payments from Medicare. The instructions will also state that the teaching physician should be reported as the ordering/referring physician in situations where a resident orders DMEPOS but is not licensed by the State and thus cannot enroll in Medicare. Note that dentists and pediatricians, who may sometimes order DMEPOS for Medicare beneficiaries but who have not enrolled in Medicare because they see so few Medicare patients or most of their services are not covered by Medicare, are considered "physicians" in terms of eligibility to order/refer, have been and continue to be eligible to enroll in the Medicare program.

4. An MLN Matters Article (MM6421) about CR 6421 is available on the CMS Web site. To supplement that Article, CMS will be preparing a Special Edition Medicare Learning Network (MLN) Matters Article about CR 6421.

5. CMS's Medicare contractors have also initiated a revalidation effort (via CR 6574, Transmittal 557) which is designed to update the Medicare enrollment record for 2,500 physicians and non-physician practitioners (50 practitioners per State). We expect that this revalidation effort will be complete or nearing completion by the time that Phase 2 is implemented.

Points to remember

- For DMEPOS suppliers
  - Upon implementation of Phase 2, only accept and fill orders from eligible Medicare providers. The CMS national file mentioned in item 2 above will greatly assist you.
  - If you submit electronic claims, ensure that the ordering/referring provider name is reported in all uppercase letters. This information is included in the CEDI Companion Document and some of the DME MACs have made this information available separately from the Companion Document.
  - Do not report a nickname in the ordering/referring provider name. For example, a reported first name of "BOB" will result in a non-match to the first name of "ROBERT" (editing includes the comparison of the first initial of the first name), causing the claim to fail the two new edits.
  - Do not use commas, periods, or apostrophes within the ordering/referring provider's name. For example, "O'CONNELL" should be reported as "OCONNELL".
  - Ensure that names are reported correctly. For example, do not include credentials in a name field in the name segment for the ordering/referring provider (e.g., do not report a first name as "DR JOHN.")
  - Use of the Advance Beneficiary Notice of Noncoverage (ABN) is not appropriate on a rejected claim. An ABN is appropriate only when a provider/supplier expects Medicare to *deny coverage* for an item or service under the Limitation on Liability provisions of Section 1879 of the Social Security Act.
  - Many ordering/referring providers are getting their enrollment information into PECOS or are updating their enrollment information. It may take some time for a Medicare enrollment contractor to process these enrollment applications. Once an application has been approved, the ordering/referring provider will have an enrollment record in PECOS that contains the NPI. After the implementation of Phase 2, a DMEPOS claim may identify an ordering/referring provider who now has a current enrollment record (i.e., in PECOS with the NPI in the record) but the date of service that precedes the date the ordering/referring provider's information was effective in PECOS. Such a claim would pass the two new edits—Medicare is not comparing the date of service on the claim to the date the ordering/referring provider was effective in PECOS. The claim would not be rejected.
- For ordering/referring providers
  - If you are not enrolled in the Medicare program, or if you enrolled more than 5 years ago and have not submitted any updates or changes to your enrollment information in 5 years, you do not have an enrollment record in PECOS. In order to continue to order DMEPOS for Medicare beneficiaries, you will have to enroll in the Medicare program or "revalidate" your Medicare enrollment information. You may do so by (1) using Internet-based PECOS (which transmits your enrollment application to the Medicare carrier or A/B MAC via the Internet—be sure to mail the signed and dated Certification Statement to the carrier or A/B MAC immediately after submitting the application), or (2) by filling out the appropriate paper Medicare provider enrollment application(s) and mailing it, along with any required additional paper information, to the local Medicare carrier or A/B MAC, who will enter your information into PECOS and process your enrollment application. Information about enrolling in Medicare is found on the CMS Web site at http://www.cms.hhs.gov/MedicareProviderSupEnroll.
  - Make sure you have a current enrollment record in Medicare. You can do this by calling your designated enrollment contractor or you can go on-line, using Internet-based PECOS, to view your enrollment record. While doing so, if you have a PECOS record, ensure that your NPI is in it. If it is not, update your enrollment record. You can find information about Internet-based PECOS and a link to Internet-based PECOS at http://www.cms.hhs.gov/MedicareProviderSupEnroll. We recommend that all providers and suppliers read the information and downloadable documents about Internet-based PECOS that are available on the CMS provider/supplier enrollment Web page: http://www.cms.hhs.gov/MedicareProviderSupEnroll.
  - If you are a dentist or other specialty who is eligible to order/refer but have not enrolled in Medicare because the services you provide are not covered by Medicare, you need to enroll in Medicare order to continue to order or refer in the Medicare program.
  - If you are a physician who is employed by the Department of Veterans Affairs or the Public Health

Service but have not enrolled in Medicare because you would not be paid by Medicare for your services, you need to enroll in Medicare in order to continue to order or refer in the Medicare program.

- If you are a resident who has a medical license but have not enrolled in Medicare because you would not be paid by Medicare for your services, you need to enroll in Medicare in order to continue to order or refer in the Medicare program. Residents who do not have medical licenses are not eligible to enroll in the Medicare program. Should they order or refer, the teaching physician is to be reported in a claim as the ordering/referring provider.

Update to CEDI Front End Editing for Ordering/Referring Providers

Common Electronic Data Interchange (CEDI) errors C200, C201 and C202 are warning errors/edits that are firing as a Warning on the CEDI GENRPT until January 1, 2010. These errors/edits are in place due to CMS CR6421 and related MLN article MM6421 that was implemented with the October 2009 Release.

Should a supplier receive one of these errors/edits on a claim, CEDI recommends they contact the ordering/referring provider submitted on the claim and have them verify their eligibility with the Provider Enrollment, Chain and Ownership System (PECOS). The issue is not with the supplier (billing provider); it is with the ordering/referring provider.

Ordering/referring providers may use the following Web site to obtain information in relation to PECOS and to enroll and/or access the PECOS system to ensure they are listed and authorized to order/refer services for Medicare:

http://www.cms.hhs.gov/MedicareProviderSupEnroll/04_InternetbasedPECOS.asp

If you have questions, please contact your Medicare DME MAC at its toll-free number, which may be found at http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip on the CMS Web site.

Ordering/Referring Provider Case Sensitive Edits

CEDI has front end edits in place to validate the data submitted conforms to HIPAA and Medicare requirements. As part of these edits, the Common Electronic Data Interchange (CEDI) utilizes external code sources to validate the data on inbound transactions. The Provider Enrollment, Chain and Ownership System (PECOS) file used to verify eligibility for ordering/referring providers is one of the external data code sources utilized by CEDI.

The information from PECOS is provided to CEDI using only upper case characters. The alpha character data on the claim for the ordering/referring provider must be in upper case in order to validate the name against the PECOS file. CEDI will reject inbound transactions submitted with lower case characters where the external code source used to perform the edits is only provided in upper case. If a lower case character is submitted in the ordering/referring provider field, the claim will be rejected.

CEDI strongly encourages submitting all alpha characters in upper case to avoid this type of issue.

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

FORMS

CSI: Updated MCPS Security Request Form

The Medicare Claims Processing System (MCPS) Part A DDE, Part B PPTN, & DME CSI User Request Form and instructions used to request Claims Status Inquiry (CSI) access have been updated. Effective November 2, 2009, only version 1.3 (dated 10/15/2009) of the form will be accepted and all prior versions will be returned. The form is located within the Forms section of the NAS Web site, https://www.noridianmedicare.com/dme/forms/docs/dde_csi_user_id_form.pdf.

Be sure to complete ALL fields and sections on the request form or the form cannot be processed and will be returned.

When requesting removal of access for a user who is no longer available to sign the form, a supervisor or an authorized official of the facility MUST sign the form. Forms without signatures or dates cannot be processed and will be returned.

Effective Date: November 2, 2009

APPEALS

DME Telephone Reopenings Modified Hours

Effective December 9, 2009, the DME Telephone Reopening lines will be closed daily from 11:45 a.m. to 12:30 p.m.CT. This change ensures maximum staffing levels during the remaining business hours of 8 a.m. – 4 p.m. CT, Monday - Friday.

RiverTrust Solutions, Inc. Address Change

In an effort to streamline the mail receipts, effective immediately RiverTrust Solutions, Inc. has a new mailing address for regular mail as well as overnight and priority deliveries. All mail that has been sent to the old address will be forwarded, but only for a short time. If the package and/or envelope states "Return Service Requested", the mail will be returned to the supplier along with the new mailing address. Please note the following address in any future mailings to RiverTrust Solutions, Inc.

RiverTrust Solutions, Inc.
1 Cameron Hill Circle Ste 0011
Chattanooga TN 37402-0011

Usual Maximum Amount of Supplies

Many of the DME MAC local coverage determinations (LCDs) have supplies or accessories with usual maximum quantities and frequency limits. Suppliers are not required to provide these amounts nor are beneficiaries required to accept supplies or accessories at this frequency or in quantities that exceed the amount they typically use. Reordering of supplies and accessories is based upon actual beneficiary usage. Suppliers must not dispense a quantity of supplies exceeding a beneficiary's expected utilization. Suppliers should stay attuned to atypical utilization patterns on behalf of their clients and verify with the ordering physicians that the atypical utilization is, in fact, warranted.

A beneficiary or their caregiver must specifically request refills of supplies before they are dispensed. The supplier must not automatically dispense a quantity of supplies on a predetermined basis, even if the beneficiary has "authorized" this in advance. As referenced in the *Program Integrity Manual* (Internet-Only Manual, CMS Pub. 100-08, Chapter 4.26.1) "Contact with the beneficiary or designee regarding refills should take place no sooner than approximately 7 days prior to the delivery/shipping date. For subsequent deliveries of refills, the supplier should deliver the DMEPOS product no sooner than approximately 5 days prior to the end of usage for the current product."

Update to Medicare Deductible, Coinsurance, and Premium Rates for 2010

MLN Matters Number: MM6690
Related Change Request (CR) #: 6690
Related CR Release Date: November 13, 2009
Related CR Transmittal #: R61GI
Effective Date: January 1, 2010
Implementation Date: January 4, 2010

Provider Types Affected

Physicians, providers, and suppliers who bill Medicare contractors (fiscal intermediaries (FI), regional home health intermediaries (RHHI), Medicare Administrative Contractors (A/B MAC), Durable Medical Equipment Medicare Administrative Contractors (DME MAC) and carriers) for services provided to Medicare beneficiaries.

Impact on Providers

This article is based on Change Request (CR) 6690, which provides the Medicare rates for deductible, coinsurance, and premium payment amounts for calendar year (CY) 2010.

2010 Part A - Hospital Insurance (HI)

A beneficiary is responsible for an inpatient hospital deductible amount, which is deducted from the amount that the Medicare program pays the hospital for inpatient hospital services it furnishes in an illness episode. When a beneficiary receives such services for more than 60 days during an illness encounter, he or she is responsible for a coinsurance amount that is equal to one-fourth of the inpatient hospital deductible per-day for the 61st-90th day spent in the hospital.

Please note that an individual has 60 lifetime reserve days of coverage, which they may elect to use after the 90th day in a spell of illness. The coinsurance amount for these days is equal to one-half of the inpatient hospital deductible.

In addition, a beneficiary is responsible for a coinsurance amount equal to one-eighth of the inpatient hospital deductible per day for the 21st through the 100th day of Skilled Nursing Facility (SNF) services furnished during an illness episode. The 2010 deductible and coinsurance amounts are in the following table.

Table 1

2010 Part A – Hospital Insurance (HI)			
Deductible	**$1,100.00**		
Coinsurance	**Hospital**		**Skilled Nursing Facility**
	Days 61-90	**Days 91-150 (Lifetime Reserve Days)**	**Days 21-100**
	$275.00	$550.00	$137.50

Most individuals age 65 and older (and many disabled individuals under age 65) are insured for Health Insurance (HI) benefits without a premium payment. In addition, the Social Security Act provides that certain aged and disabled persons who are not insured may voluntarily enroll, but are subject to the payment of a monthly Part A premium.

Since 1994, voluntary enrollees may qualify for a reduced Part A premium if they have 30-39 quarters of covered employment. When voluntary enrollment takes place more than 12 months after a person's initial enrollment period, a 2-year 10% penalty is assessed for every year they had the opportunity to (but failed to) enroll in Part A. The 2010 Part A premiums are listed in table 2, below.

Table 2

Voluntary Enrollees Part A Premium Schedule for 2010	
Base Premium (BP)	$461.00 per month
Base Premium with 10% Surcharge	$507.10 per month
Base premium with 45% Reduction	$254.00 per month (for those who have 30-39 quarters of coverage)
Base premium with 45% Reduction and 10% surcharge	$279.40 per month

2010 Part B - Supplementary Medical Insurance (SMI)

Under Part B, the Supplementary Medical Insurance (SMI) program, all enrollees are subject to a monthly premium. In addition, most SMI services are subject to an annual deductible and coinsurance (percent of costs that the enrollee must pay), which are set by statute. Further, when Part B enrollment takes place more than 12 months after a person's initial enrollment period, there is a permanent 10% increase in the premium for each year the beneficiary had the opportunity to (but failed to) enroll.

For 2010, the standard premium for SMI services is $110.50 a month; the deductible is $155.00 a year; and the coinsurance is 20%. The Part B premium is influenced

by the beneficiary's income and can be substantially higher based on income. The higher premium amounts and relative income levels for those amounts are contained in CR 6690, which is available at http://www.cms.hhs.gov/Transmittals/downloads/R61GI.pdf on the CMS Web site.

Additional Information

If you have questions, please contact your Medicare FI, A/B MAC, DME MAC, carriers or RHHI at their toll-free number which may be found at http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip on the CMS Web site.

Home Health Consolidated Billing HCPCS Codes Update

MLN Matters® Number: MM6662
Related Change Request (CR) #: 6662
Related CR Release Date: October 9, 2009
Related CR Transmittal #: R1827CP
Effective Date: January 1, 2010
Implementation Date: January 4, 2010

Provider Types Affected

Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, DME Medicare administrative contractors (DME MACs), fiscal intermediaries (FIs), Part A/B Medicare administrativezth consolidated billing supply code list. Code A4456 is a new code that replaces code A4365 which is deleted below.

Added HCPCS Code	Descriptor
A4360	Disposable external urethral clamp or compression device with pad and/or pouch
A4456	Ostomy adhesive remover wipe

The following HCPCS code is deleted from the home health consolidated billing supply code list.

Deleted HCPCS Code	Descriptor
A4365	Ostomy adhesive remover wipe

Background

The CMS periodically updates the lists of Healthcare Common Procedure Coding System (HCPCS) codes that are subject to the consolidated billing provision of the HH PPS. With the exception of therapies performed by physicians, supplies incidental to physician services and supplies used in institutional settings, services appearing on this list that are submitted on claims to Medicare contractors will not be paid separately on dates when a beneficiary for whom such a service is being billed is in a home health episode (i.e., under a home health plan of care administered by a home health agency). Medicare will only directly reimburse the primary home health agencies that have opened such episodes during the episode periods. Therapies performed by physicians, supplies incidental to physician services and supplies used in institutional settings are not subject to HH consolidated billing.

The HH consolidated billing code lists are updated annually, to reflect the annual changes to the HCPCS code set itself. Additional updates may occur as frequently as quarterly in order to reflect the creation of temporary HCPCS codes (e.g., 'K' codes) throughout the calendar year. The new coding identified in each update describes the same services that were used to determine the applicable HH PPS payment rates. No additional services will be added by these updates; that is, new updates are required by changes to the coding system, not because the services subject to HH consolidated billing are being redefined.

Additional Information

The official instruction (CR6662) issued to your Medicare carrier/FI/RHHI/MAC is available at http://www.cms.hhs.gov/Transmittals/downloads/R1827CP.pdf on the CMS Web site.

Claim Status Category Code and Claim Status Code Update

MLN Matters® Number: MM6723
Related Change Request (CR) #: 6723
Related CR Release Date: November 13, 2009
Related CR Transmittal #: R1852CP
Effective Date: January 1, 2010
Implementation Date: January 4, 2010

Provider Types Affected

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

Provider Action Needed

This article, based on CR6723, explains that the Claim Status Codes and Claim Status Category Codes for use by Medicare contractors with the Health Claim Status Request and Response ASC X12N 276/277 were updated during the September 2009 meeting of the national Code Maintenance Committee and code changes approved at that meeting were posted at http://www.wpc-edi.com/content/view/180/223/ on the Internet on November 1, 2009. All providers should ensure that their billing staffs are aware of the updated codes.

Background

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

BILLING CONT'D

Additional Information

The official instruction issued to your Medicare contractor regarding this change may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R1852CP.pdf on the CMS Web site.

Implementation of Version 5010 for Transaction 835 - Health Care Claim Payment/Advice

MLN Matters® Number: MM6589 Revised
Related Change Request (CR) #: 6589
Related CR Release Date: October 16, 2009
Related CR Transmittal #: R577OTN
Effective Date: January 1, 2010
Implementation Date: January 4, 2010 – July 5, 2010
(Date varies based on different Medicare systems)

Note: This article was revised on October 20, 2009, to reflect revisions made to CR 6589 on October 16, 2009. The CR release date, transmittal number, implementation date, and the Web address for accessing CR 6589 were changed. All other information remains the same.

Provider Types Affected

Physicians, providers and suppliers who bill Medicare Contractors (carriers, Fiscal Intermediaries (FIs), Medicare Administrative Contractors (A/B MAC), and Durable Medical Equipment Medicare Administrative Contractors (DME MAC) for services provided to Medicare beneficiaries.

What You Need to Know

CR 6589, from which this article is taken, instructs Medicare Contractors to implement Health Insurance Portability and Accountability Act of 1996 (HIPAA) Transaction 835 version 5010.

Make sure that your billing staffs are aware that the new HIPAA transaction 835 version 5010 is being implemented, and Medicare can begin to generate the 835 version 5010 for testing with trading partners and/or for transitioning early adopters of the new standard as of January 1, 2011. Additional information about this implementation is provided in the Background section, below.

Background

The Secretary of the Department of Health and Human Services (HHS) has adopted ASC X12 version 5010 and National Council of Prescription Drug Programs (NCPDP) version D.0 as the next Health Insurance Portability and Accountability Act (HIPAA) standard for HIPAA covered transactions; and the Centers for Medicare & Medicaid Services (CMS) published the final rule that addressed this adoption on January 16, 2009. Currently, CMS is in the process of implementing this next version of the HIPAA Transaction 835 standard (835v5010).

CR 6589, from which this article is taken, instructs the Medicare Contractors to implement transaction 835 v5010 and to update the Standard Paper Remittance Advice (SPR). CR 6589 provides business requirements for the Medicare Contractors so they can be ready to generate transaction 835 in version 5010 for testing with trading partners and in production for early adopters effective January 1, 2011.

Compliance Details

Please note that there are two levels of compliance:

1. Level I Compliance, which means that: "A covered entity can demonstrably create and receive compliant transactions, resulting from the compliance of all design/build activities and internal testing;"
2. Level II Compliance, which means that: "A covered entity has completed end-to-end testing with each of its trading partners, and is able to operate in production mode with the new versions of the standards."

You should also be aware that the effective date of the 835v5010 regulation is March 17, 2009; and that CMS must achieve level I compliance by December 31, 2010, Level II compliance by December 31, 2011, and all covered entities must be fully compliant on January 1, 2012. In essence, this means that on January 1, 2011, Medicare will make 835 version 5010 available for external testing with trading partners and also in production for willing trading partners who have finished testing successfully. In addition, in order to facilitate testing (subject to trading partner agreement); there will be a transition period (from the March 17, 2009, effective date until the January 1, 2012, compliance date) in which HHS will permit the use of both the existing standards (4010A1 and 5.1) and the new standards (5010 and D.0).

After January 1, 2012, however, covered entities, including Medicare, cannot use the 835v4010A1 and the current Standard Paper Remittance (SPR), regardless of the date of receipt or date of service reported on the electronic or paper claim.

Additional Information

You can find the official instruction, CR6589, issued to your Medicare Contractor by visiting http://www.cms.hhs.gov/Transmittals/downloads/R577OTN.pdf on the CMS Web site.

CODING

Insulin Pump Qualification: Beta Cell Autoantibody - Coding Reminder

The Centers for Medicare & Medical Services (CMS) national coverage determination for infusion pumps (Internet-only Manual, Pub. 100-03, Chapter 1, Part 4, Section 280.14) and the External Infusion Pump local coverage determination (LCD) contain coverage criteria for continuous subcutaneous insulin infusions using an external insulin pump. Criterion B requires a positive beta cell autoantibody test. Recently the DME MACs have received questions about which tests are acceptable to meet the beta cell autoantibody coverage requirement.

There are a number of antibody tests available that are related to pancreatic cells and insulin. The following tests were recently reviewed to evaluate whether they would be acceptable in meeting the policy requirement:

CODING CONT'D

- Insulin Autoantibodies (IAA)
- Islet Cell Cytoplasmic Autoantibodies
- Glutamic Acid Decarboxylase Auto Antibodies (GADA)
- GAD65 Autoantibodies
- ICA512 Autoantibodies
- Insulinoma-Associated-2 Autoantibodies (IA-2A)

After review, it has been determined that only Islet Cell Cytoplasmic Autoantibodies (ICA) would be acceptable to meet the beta cell autoantibody test requirement described in the External Infusion Pump LCD. The other listed tests would not be acceptable alternatives to justify reimbursement of an external insulin pump by Medicare.

Refer to the External Infusion Pumps LCD for additional information about coverage, coding and documentation of external insulin pumps and continuous subcutaneous insulin infusions.

Tracheostomy Care Kit – Coding Guidelines

Codes A4625 (Tracheostomy care kit for new tracheostomy) and A4629 (Tracheostomy care kit for established tracheostomy) describe supplies that are used to maintain a tracheostomy tube including the tracheostomy site. The items listed below are essential items that **must** be included in a tracheostomy care kit but may not be all-inclusive of items that meet the patient's needs. Quantities of items in excess of those listed and/or additional items (e.g. other types of surgical dressings) are included in the kit codes and may not be billed separately. Items included in these codes are not limited to pre-packaged "kits" bundled by manufacturers or distributors.

A tracheostomy care kit for a new tracheostomy (A4625) contains, at a minimum, the following:

Item	Number included
plastic tray	1
basin	1
sterile gloves	1 pair
tube brush	1
pipe cleaners	3
pre-cut tracheostomy dressing	1
gauze	1 roll
4x4 sponges	4
cotton tip applicators	2
twill tape	30 inches

A tracheostomy care kit for an established tracheostomy (A4629) contains, at a minimum the following:

Item	Number included
tube brush	1
pipe cleaners	2
cotton tip applicators	2
twill tape	30 inches
4x4 sponges	2

HCPCS Code Q2024 for Small Dose Bevacizumab (Avastin®)

Effective immediately, the Centers for Medicare & Medicaid Services (CMS) no longer recognizes Healthcare Common Procedure Coding System (HCPCS) Code Q2024 Bevacizumab (Avastin®) for payment of nonoutpatient hospital claims. Practitioners shall return to their previous reporting practice for small intraocular doses of Bevacizumab (Avastin®) furnished prior to October 1, 2009. HCPCS Code Q2024 will be deleted as of January 1, 2010, and, therefore, it will be removed from the Average Sales Price (ASP) pricing file effective with the January 2010 Release.

REIMBURSEMENT

CY 2010 Fee Schedule Update for DMEPOS

MLN Matters® Number: MM6720
Related Change Request (CR) #: 6720
Related CR Release Date: November 13, 2009
Related CR Transmittal #: R1853CP
Effective Date: January 1, 2010
Implementation Date: January 4, 2010

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 items or services paid under the DMEPOS fee schedule need to be aware of this article.

Provider Action Needed

This article, based on CR 6720, advises you of the Calendar Year (CY) 2010 annual update for the Medicare DMEPOS fee schedule. The instructions include information on the data files, update factors, and other information related to the update of the DMEPOS fee schedule.

Key points about these changes are summarized in the Background section below. Please note that the fee schedule for Code E2227 (Manual Wheelchair Accessory, Gear Reduction Drive Wheel, Each) is being revised, effective January 1, 2010, to remove pricing information for one product that was used in calculatingpayment for E2227. That product was erroneously classified as a gear reduction drive wheel when the code was established. Providers should be aware that your Medicare contractor will not adjust previously processed claims for the code E2227 with dates of service on or after January 1, 2009 through December 31, 2009, if they are submitted for adjustments. These changes are effective for DMEPOS provided on or after January 1, 2010. Be sure your billing staffs are aware of these changes.

Background

CR 6720 provides instructions regarding the 2010 annual update for the DMEPOS fee schedule. Payment on a fee schedule basis is required for durable medical equipment (DME), prosthetic devices, orthotics, prosthetics, and surgical

dressings by sections 1834(a), (h), and (i) of the Social Security Act (the Act). Also, payment on a fee schedule basis is a regulatory requirement at 42 Code of Federal Regulations (CFR) section 414.102 for parenteral and enteral nutrition (PEN).

Key Points of CR 6720

The DMEPOS fee schedule file will be available on or after November 17, 2009, for State Medicaid Agencies, managed care organizations, and other interested parties at http://www.cms.hhs.gov/DMEPOSFeeSched/ on the CMS Web site.

2010 Fees for HCPCS labor payment codes K0739, L4205, L7520 are effective January 1, 2010, and those rates are as follows:

State	K0739	L4205	L7520	State	K0739	L4205	L7520
AK	25.27	28.79	33.88	NC	13.41	19.99	27.14
AL	13.41	19.99	27.14	ND	16.72	28.73	33.88
AR	13.41	19.99	27.14	NE	13.41	19.97	37.84
AZ	16.59	19.97	33.39	NH	14.40	19.97	27.14
CA	20.58	32.83	38.26	NJ	18.10	19.97	27.14
CO	13.41	19.99	27.14	NM	13.41	19.99	27.14
CT	22.40	20.45	27.14	NV	21.37	19.97	36.99
DC	13.41	19.97	27.14	NY	24.71	19.99	27.14
DE	24.71	19.97	27.14	OH	13.41	19.97	27.14
FL	13.41	19.99	27.14	OK	13.41	19.99	27.14
GA	13.41	19.99	27.14	OR	13.41	19.97	39.03
HI	16.59	28.79	33.88	PA	14.40	20.56	27.14
IA	13.41	19.97	32.49	PR	13.41	19.99	27.14
ID	13.41	19.97	27.14	RI	15.99	20.58	27.14
IL	13.41	19.97	27.14	SC	13.41	19.99	27.14
IN	13.41	19.97	27.14	SD	14.99	19.97	36.28
KS	13.41	19.97	33.88	TN	13.41	19.99	27.14
KY	13.41	25.60	34.71	TX	13.41	19.99	27.14
LA	13.41	19.99	27.14	UT	13.45	19.97	42.27
MA	22.40	19.97	27.14	VA	13.41	19.97	27.14
MD	13.41	19.97	27.14	VI	13.41	19.99	27.14
ME	22.40	19.97	27.14	VT	14.40	19.97	27.14
MI	13.41	19.97	27.14	WA	21.37	29.30	34.80
MN	13.41	19.97	27.14	WI	13.41	19.97	27.14
MO	13.41	19.97	27.14	WV	13.41	19.97	27.14
MS	13.41	19.99	27.14	WY	18.70	26.65	37.84
MT	13.41	19397	33.88				

The following new codes are effective as of January 1, 2010:

- A4264, A4466, L2861, L3891, L8692, K0739, and K0740, all of which have no assigned payment category;
- A4336, A4360, and A4456, which are in the ostomy, traheostomy, and urological supplies payment category;
- E0433 in the oxygen and oxygen equipment category;
- E0136 in the capped rental category; and
- L5973, L8031, L8032, L8627, L8628, L8629, and Q0506, all of which are in the prosthetics and orthotics category.

The fee schedule amounts for the above new codes will be established as part of the July 2010 DMEPOS Fee Schedule Update, when applicable. The DME MACs will establish local fee schedule amounts to pay claims for the new codes from January 1, 2010 through June 30, 2010**. The new codes are not to be used for billing purposes until they are effective on January 1, 2010.**

The following codes are being deleted from the HCPCS effective January 1, 2010, and are therefore being removed from the DMEPOS fee schedule files:

A4365	L1825	L3701
E2223	L1901	L3909
E2393	L2770	L3911
L0210	L3651	L6639
L1800	L3652	
L1815	L3700	

For gap-filling purposes, the 2009 deflation factors by payment category are listed as follows:

Factor	Category
0.508	Oxygen
0.511	Capped Rental
0.512	Prosthetics and Orthotics
0.650	Surgical Dressings
0.707	Parenteral and Enteral Nutrition

Code E2227 *Manual Wheelchair Accessory, Gear Reduction Drive Wheel, Each* was added to the HCPCS effective January 1, 2008. The fee schedule for code E2227 was calculated using pricing information for two products; however, the fee schedule is being revised effective January 1, 2010, to remove pricing information for one product that was erroneously classified as a gear reduction drive wheel when the code was established. Contractors will not adjust previously processed claims for the code E2227 with dates of service on or after January 1, 2009 through December 31, 2009, if they are submitted for adjustments.

CY 2010 Fee Schedule Update Factor

Under the Act, the DMEPOS fee schedule amounts are being updated for 2010 by the percentage increase in the consumer price index for all urban consumers (United States city average) or CPI-U for the 12-month period ending with June of 2009. Since the percentage change in the CPI-U for the 12-month period ending with June of 2009 is negative (-1.41 percent), the percentage increase in the CPI-U used to update the DMEPOS fee schedule amounts for 2010 is 0 percent.

2010 Update to the Labor Payment Rates

Since the percentage increase in the Consumer Price Index (CPI) for the 12 month period ending with June of the previous year is negative for 2010, a 0% change is applied to the labor payment amounts for 2010 for codes K0739, L4205, and L7520.

2010 National Monthly Payment Amounts for Stationary Oxygen Equipment

CMS will also implement the 2010 national monthly payment rates for stationary oxygen equipment (HCPCS codes E0424, E0439, E1390 and E1391), effective for claims with dates of service on or after January 1, 2010.

The fee schedule file is being revised to include the new national 2010 monthly payment rate of $173.17 for stationary oxygen equipment. The payment rates are being adjusted for the new oxygen generating portable equipment (OGPE) class. The revised 2010 monthly payment rate of $173.17 includes the 0% update due to the -1.41% CPI-U change. The budget neutrality adjustment for 2010 caused the 2010 rate to decrease from $175.79 to $173.17.

When updating the oxygen equipment fees, corresponding updates are made to the fee schedule amounts for HCPCS code E1405 and E1406 for oxygen and water vapor enriching systems. Since 1989, the fees for codes E1405 and E1406 have been established based on a combination of the Medicare payment amounts for stationary oxygen equipment and nebulizer codes E0585 and E0570, respectively.

Additional Information

The official instruction, CR 6720, issued to your Medicare contractor regarding this change, may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R1853CP.pdf on the CMS Web site. CR 6720 includes the revisions that will be made to the *Medicare Claims Processing Manual*, Chapter 23 - Fee Schedule Administration and Coding Requirements.

More information on Durable Medical Equipment Prosthetics, Orthotics, and Supplies is available at http://www.cms.hhs.gov/center/dme.asp on the CMS Web site.

Revised October 2009 ASP File Now Available

CMS has posted the revised October 2009 Average Sales Price (ASP) and Not Otherwise Classified (NOC) pricing files, which are available for download at: http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/01a1_2009aspfiles.asp.

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

MLN Matters® Number: MM6708
Related Change Request (CR) #: 6708
Related CR Release Date: November 13, 2009
Related CR Transmittal #: R1854CP
Effective Date: January 1, 2010
Implementation Date: January 4, 2010

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 6708, which instructs Medicare contractors to download and implement the January 2010 Average Sales Price (ASP) drug pricing file for Medicare Part B drugs; and if released by the Centers for Medicare & Medicaid Services (CMS), also the revised October 2009, July 2009, April 2009, and January 2009 files. Medicare will use the January 2010 ASP and not otherwise classified (NOC) drug pricing files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after January 4, 2010, with dates of service January 1, 2010, through March 31, 2010.

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

Background

Section 303(c) of the Medicare Modernization Act of 2003 revised the payment methodology for Part B covered drugs and biologicals that are not paid on a cost or prospective payment basis. Beginning January 1, 2005, the vast majority of drugs and biologicals not paid on a cost or prospective payment basis are paid based on the ASP methodology, and pricing for compounded drugs has been performed by the local contractor.

The ASP methodology is based on quarterly data submitted to CMS by manufacturers. Note that payment allowance limits under the Outpatient Prospective Payment System (OPPS) are incorporated into the Outpatient Code Editor (OCE) under a separate CR.

The following table shows how the quarterly payment files will be applied (for those files that are released):

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

Additional Information

The official instruction (CR6708) issued to your Medicare MAC, carrier, and/or FI may be found at http://www.cms.hhs.gov/Transmittals/downloads/R1854CP.pdf on the CMS Web site.

Reasonable Charge Update for 2010 for Splints, Casts, Dialysis Supplies, Dialysis Equipment, and Certain Intraocular Lenses

MLN Matters® Number: MM6691
Related Change Request (CR) #: 6691
Related CR Release Date: October 23, 2009
Related CR Transmittal #: R1834CP
Effective Date: January 1, 2010
Implementation Date: January 4, 2010

Provider Types Affected

Physicians, providers, and suppliers, billing Medicare contractors (Carriers, Fiscal Intermediaries, (FIs), Part A/B Medicare Administrative Contractors (A/B MACs), and Durable Medical Equipment Medicare Administrative Contractors (DME MACs)) for splints, casts, dialysis supplies, dialysis equipment, and certain intraocular lenses, should be aware of this article.

Provider Action Needed

The payment on a reasonable charge basis is required for splints, casts, dialysis supplies, dialysis equipment, and intraocular lenses by regulations contained in 42 CFR 405.501.

REIMBURSEMENT CONT'D

CR6691, from which this article is taken, instructs your carriers, FIs, MACs, and DME MACs how to calculate reasonable charges for the payment of claims for splints, casts, dialysis supplies, dialysis equipment, and intraocular lenses furnished in calendar year 2010. Make sure your billing staff are aware of these changes.

Background

CR6691 provides instructions regarding the calculation of reasonable charges for payment of claims for splints, casts, dialysis supplies, dialysis equipment, and intraocular lenses furnished in calendar year 2010.

The inflation indexed charge (IIC) is calculated using the lowest of the reasonable charge screens from the previous year updated by an inflation adjustment factor or the percentage change in the consumer price index for all urban consumers (CPI-U)(United States city average) for the 12-month period ending with June of 2009.

Since the percentage change in the CPI-U for the 12-month period ending with June of 2009 is negative (-1.41 percent), the IIC update factor for 2010 is 0 percent. The 2010 payment limits for splints and casts will be based on the 2009 limits that were announced in CR 6221 last year. Those limits are repeated in Attachment A at the end of this article. In addition, please note that: 1) Payment for intraocular lenses is only made on a reasonable charge basis for lenses implanted in a physician's office; and 2) The Q-codes should be used for splints and casts when supplies are indicated for cast and splint purposes. This payment is in addition to the payment made under the Medicare physician fee schedule for the procedure for applying the splint or cast. An attachment to CR6691 lists the 2010 Payment Limits for Splints and Casts.

CR6691 instructs your carrier or MAC to: 1) Compute 2010 customary and prevailing charges for the V2630, V2631, and V2632 (Intraocular Lenses Implanted in a Physician's Office) using actual charge data from July 1, 2008, through June 30, 2009; and 2) Compute 2010 IIC amounts for these codes that were not paid using gap-filled payment amounts in 2009.

For codes identified in the following four tables, CR6691 instructs DME MACs to compute 2010 customary and prevailing charges using actual charge data from July 1, 2008 through June 30, 2009; and to compute 2010 IIC amounts for these codes that were not paid using gap-filled amounts in 2009.

Table 1

Dialysis Supplies Billed With AX Modifier							
A4215	A4216	A4217	A4244	A4245	A4246	A4247	A4248
A4450	A4452	A4651	A4652	A4657	A4660	A4663	A4670
A4927	A4928	A4930	A4931	A6216	A6250	A6260	A6402

Table 2

Dialysis Supplies Billed Without AX Modifier								
A4653	A4671	A4672	A4673	A4674	A4680	A4690	A4706	A4707
A4708	A4709	A4714	A4719	A4720	A4721	A4722	A4723	A4724
A4725	A4726	A4728	A4730	A4736	A4737	A4740	A4750	A4755
A4760	A4765	A4766	A4770	A4771	A4772	A4773	A4774	A4802
A4860	A4870	A4890	A4911	A4918	A4929	E1634		

Table 3

Dialysis Equipment Billed With AX Modifier			
E0210NU	E1632	E1637	E1639

Table 4

Dialysis Equipment Billed Without AX Modifier					
E1500	E1510	E1520	E1530	E1540	E1550
E1560	E1570	E1575	E1580	E1590	E1592
E1594	E1600	E1610	E1615	E1620	E1625
E1630	E1635	E1636			

Additional Information

Detailed instructions for calculating:

- **Reasonable charges** are located in the Medicare Claims Processing Manual, Chapter 23 (Fee Schedule Administration and Coding Requirements), Section 80 (Reasonable Charges as Basis for Carrier/DMERC Payments);
- Manual, Chapter 23 (Fee Schedule Administration and Coding Requirements), Sections 80.2 (Updating Customary and Prevailing Charges) and 80.4 (Prevailing Charge); and
- The **IIC** are located in Medicare Claims Processing Manual, Chapter 23 (Fee Schedule Administration and Coding Requirements), Sections 80.6 (Inflation Indexed Charge (IIC) for Nonphysician Services).

The *Medicare Claims Processing Manual* is available at http://www.cms.hhs.gov/manuals/IOM/list.asp on the Centers for Medicare & Medicaid Services (CMS) Web site.

For complete details regarding this Change Request (CR) please see the official instruction (CR 6691) issued to your Medicare FI, Carrier, MAC, or DME MAC. That instruction may be viewed by going to http://www.cms.hhs.gov/Transmittals/downloads/R1834CP.pdf on the CMS Web site.

Attachment A

Code	Payment Limit	Code	Payment Limit
A4565	$7.75	Q4025	$34.07
Q4001	$44.11	Q4026	$106.37
Q4002	$166.75	Q4027	$17.04
Q4003	$31.69	Q4028	$53.19
Q4004	$109.71	Q4029	$26.05
Q4005	$11.68	Q4030	$68.58
Q4006	$26.33	Q4031	$13.03
Q4007	$5.86	Q4032	$34.28
Q4008	$13.17	Q4033	$24.30
Q4009	$7.80	Q4034	$60.44
Q4010	$17.56	Q4035	$12.15
Q4011	$3.90	Q4036	$30.23
Q4012	$8.78	Q4037	$14.83
Q4013	$14.20	Q4038	$37.14
Q4014	$23.95	Q4039	$7.43
Q4015	$7.10	Q4040	$18.56
Q4016	$11.97	Q4041	$18.02
Q4017	$8.21	Q4042	$30.77
Q4018	$13.09	Q4043	$9.02
Q4019	$4.11	Q4044	$15.39
Q4020	$6.55	Q4045	$10.46
Q4021	$6.07	Q4046	$16.83
Q4022	$10.96	Q4047	$5.22
Q4023	$3.06	Q4048	$8.42
Q4024	$5.48	Q4049	$1.91

Male External Catheter – A4326 – Coding and Utilization Guidelines

Article Retired

The article, "Male External Catheter – A4326 – Coding and Utilization Guidelines," published on October 7, 2009 has been retired effective October 9, 2009.

Vacuum Erection Devices (L7900) - Documentation Requirements

Noridian Administrative Services (NAS) Medical Review has recently received a number of questions regarding documentation of medical necessity for vacuum erection devices (L7900). Coverage for L7900 is provided under the Prosthetic benefit which stipulates that the device must be used to replace all or part of an internal body organ. In addition to the statutory requirements, the general documentation requirements as described in Chapter 3 of the DME MAC Jurisdiction D Supplier Manual apply. For any Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) item to be covered:

> The patient's medical record must contain sufficient documentation of the patient's medical condition to substantiate the necessity for the type and quantity of items ordered and for the frequency of use or replacement (if applicable). The information should include the patient's diagnosis and other pertinent information including, but not limited to, duration of the patient's condition, clinical course (worsening or improving), prognosis, nature and extent of functional limitations, other therapeutic interventions and results, past experience with related items, etc. Neither a physician's order, nor a supplier-prepared statement, nor a physician attestation by itself provides sufficient documentation of medical necessity, even though it is signed by the treating physician or supplier. There must be information in the patient's medical record that supports the medical necessity for the item or information on a supplier-prepared statement or physician attestation (if applicable).

Often claims for these devices do not have diagnostic information that relates to organic impotence. For patients receiving a vacuum erection device, the physician evaluation would generally include a history and physical examination focused on defining the cause of the erectile dysfunction/ impotence and treatment of any co-morbid conditions that may impact sexual function. This is important to assure that specifically treatable conditions are identified before ordering a vacuum erection device. Documentation of this evaluation, conducted prior to the date of service on the claim, must be available to the DME MAC upon request. For claims that meet these documentation requirements, in addition to the ICD-9 diagnosis code for organic impotence (607.84), NAS recommends that providers also include a secondary diagnosis to identify the cause of the impotence.

Enteral Nutrition Supply Kits - Coverage Reminder

Suppliers are reminded that supply kits used for the administration of enteral nutrition must match with the route of administration. The Enteral Nutrition LCD "Indications and Limitations of Coverage and/or Medical Necessity" sections states:

> "**The feeding supply kit (B4034-B4036) must correspond to the method of administration** indicated in question 5 of the DME Information Form (DIF). If it does not correspond, payment for the billed code will be based on the allowance for the code relating to the method of administration specified on the DIF or the billed code, whichever is less. If a pump supply kit (B4035) is ordered and the medical necessity of the pump is not documented, payment will be based on the allowance for the least costly medically appropriate alternative, B4036.
>
> **The codes for feeding supply kits (B4034-B4036) are specific to the route of administration**. Claims for more than one type of kit code delivered on the same date or provided on an ongoing basis will be denied as not medically necessary." (Emphasis added.)

When billing for these codes, suppliers are reminded that the fees for these codes are all-inclusive. It is inappropriate to unbundle and bill separately for these items. The "Coding Guidelines" section of the Enteral Nutrition – Policy Article states:

> "**The codes for enteral feeding supplies (B4034-B4036) include all supplies, other than the feeding tube itself, required for the administration of enteral nutrients to the patient for one day. Codes B4034-B4036 describe a daily supply fee rather than a specifically defined "kit."** Some items are changed daily; others may be used for multiple days. Items included in these codes are not limited to pre-packaged "kits" bundled by manufacturers or distributors. These supplies include, but are not limited to, feeding bag/container, flushing solution bag/container, administration set tubing, extension tubing, feeding/ flushing syringes, gastrostomy tube holder, dressings (any type) used for gastrostomy tube site, tape (to secure tube or dressings), Y connector, adapter, gastric pressure relief valve, declogging device, etc. These items must not be separately billed using the miscellaneous code (B9998) or using specific codes for dressings or tape. The use of individual items may differ from patient to patient and from day to day. Only one unit of service may be billed for any one day. Units of service in excess of one per day will be rejected as incorrect coding." (Emphasis added.)

There are usually not routine changes in the method of administration. It would therefore be unusual to see claims for differing supply codes. In the event of a modification in the route of administration, there should be information in the medical record to justify the change. In any event, only one supply code per day is allowed.

Refer to the Enteral Nutrition LCD and Policy Article for additional information on the coverage and billing of supplies.

Continuation of Maintenance and Servicing Payments in CY 2010 for Certain Oxygen Equipment

MLN Matters® Number: MM6716
Related Change Request (CR) #: 6716
Related CR Release Date: November 2, 2009
Related CR Transmittal #: R589OTN
Effective Date: January 1, 2010
Implementation Date: January 4, 2010

Provider Types Affected

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

Provider Action Needed

This article is based on change request (CR) 6716, which provides instructions on continuing the payment policy for general maintenance and servicing of certain oxygen equipment after the 36-month rental cap, as established in calendar year (CY) 2009, for dates of service through June 30, 2010. See the *Key Points* section of this article for specific payment instructions.

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 rental cap. Section 144(b)(1) of the MIPPA, provides for payment for reasonable and necessary maintenance and servicing of oxygen equipment furnished after the 36-month rental cap if the Secretary of the Department of Health and Human Services determines that such payments are reasonable and necessary. Initial instructions relating to the maintenance and servicing payments for oxygen concentrators and transfilling equipment for CY 2009 were issued in Transmittal 497, CR 6509, dated May 22, 2009. The MLN Matters® article for this CR is available at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6509.pdf on the Centers for Medicare & Medicaid Services (CMS) Web site. CR6716 provides instructions on the continuation of these maintenance and servicing payments in CY 2010 for dates of service through June 30, 2010.

As indicated in Transmittal 497 (CR 6509), CMS 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). In CY 2009, 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. Suppliers should use the HCPCS code for the equipment E1390, E1391, E1392 and/or K0738 along with the MS modifier in order to bill and receive payment for these maintenance and servicing visits.

For example, if the supplier visits a beneficiary's home in Pennsylvania to perform the general maintenance and servicing on a portable concentrator, the supplier would enter E1392 MS on the claim and the allowed payment amount would be equal to the lesser of the supplier's actual charge or two units of the allowed payment amount for K0739 in Pennsylvania. If the supplier visits the beneficiary's home to provide the periodic maintenance and servicing for a stationary concentrator (E1390 or E1391) and a transfilling unit (K0738), payment can be made for maintenance and servicing of both units (E1390MS or E1391MS, and K0738MS). If the supplier visits the beneficiary's home to provide the periodic maintenance and servicing for a portable concentrator (E1392), payment can only be made for maintenance and servicing of the one unit/HCPCS code (E1392MS).

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

Column 1	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 CY 2010, CMS has determined that it is reasonable and necessary to continue the existing payments and payment methodology, as described above and in Transmittal 497 (CR 6509), for maintenance and servicing of certain oxygen equipment for dates of service through June 30, 2010. For dates of service from January 1, 2010, through June 30, 2010, the allowed payment amount for each visit is equal to 2 units of the 2010 fee for code K0739, for the State in which the in-home visit takes place.

Key Points of CR 6716

- Medicare contractors will pay claims with dates of service from July 1, 2009 thru June 30, 2010, 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, through June 30, 2010, 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 when billed with the HCPCS modifier MS.

- Medicare contractors will not pay for maintenance and servicing of both a portable oxygen concentrator (E1392MS) and portable oxygen transfilling equipment (K0738MS).
- 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.

Additional Information

The official instruction, CR6716, issued to your RHHI, MAC, DME MAC regarding this change may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R589OTN.pdf on the CMS Web site.

HCPCS E1390 and E0431 - Notification of Prepayment Review

NAS Jurisdiction D DME MAC Medical Review will be initiating a widespread prepayment probe review of claims for HCPCS E1390 (oxygen concentrator, single delivery port, capable of delivering 85 percent or greater oxygen concentration at the prescribed flow rate) and E0431 (portable gaseous oxygen system, rental; includes regulator, flowmeter, humidifier, cannula or mask and tubing). Widespread reviews are used to determine the extent of potential problem areas across multiple suppliers. This review is being initiated based on the results of Comprehensive Error Rate Testing (CERT) analysis.

In order to evaluate compliance with Medicare coverage and coding rules, all suppliers billing Jurisdiction D for HCPCS code E1390 and E0431 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 Oxygen and Oxygen Equipment Local Coverage Determination (LCD) L11457 and Policy Article A33677. Suppliers can review the Oxygen and Oxygen Equipment documentation checklist on the NAS Web site at https://www.noridianmedicare.com/dme/coverage/docs/checklists/oxygen_and_oxygen_equipment.pdf

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

CERT Errors - Oxygen

The Comprehensive Error Rate Testing (CERT) contractor has been identifying a significant number of errors on claims for oxygen equipment. Most of the errors are due to insufficient documentation to support the medical necessity for the billed items. Based on reports received by the DME MACs, the documentation that the CERT contractor is looking for includes:

- Most recent CMN prior to the date of service (DOS) on the claim
- Report of the qualifying oximetry or arterial blood gas test listed on the CMN
- Physician visit note within 30 days prior to the initial certification date documenting the diagnosis for which the oxygen is prescribed
- Physician visit note within 90 days prior to the recertification date (if applicable)
- For claims subsequent to the recertification date, physician visit note supporting continued medical monitoring of oxygen use and needs

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

Medicare Policy Regarding Replacement of Oxygen Equipment Lost as a Result of Supplier Bankruptcy

CMS has issued instructions to contractors regarding processing of claims for replacement oxygen equipment in situations in which the equipment is considered lost because a supplier files for Chapter 7 or 11 bankruptcy and is unable to continue furnishing oxygen and oxygen equipment.

The regulation at 42 CFR Section 414.210(f) provides that a patient may elect to obtain a new piece of equipment if the equipment has been in continuous use by the patient for the equipment's reasonable useful lifetime or has been lost, stolen or irreparably damaged.

Oxygen equipment is considered lost if the supplier of the equipment has declared bankruptcy:

1. By filing a petition under Chapter 7 in a United States Bankruptcy Court; or
2. By filing a petition for Chapter 11 bankruptcy in a United States Bankruptcy Court and the oxygen equipment was sold or scheduled to be sold.

Billing for Replacement Oxygen Equipment

Claims for replacement oxygen equipment due to Chapter 7 and 11 bankruptcy will be processed similar to other situations

where oxygen equipment is deemed lost. A new 36-month rental period and new reasonable useful lifetime begins on the date that the replacement equipment is furnished by the new oxygen supplier. Similar to other situations where equipment is lost and new replacement oxygen equipment is provided, repeat blood gas testing is not required, but the new supplier must provide a new, initial Oxygen Certificate of Medical Necessity (CMN) with the first claim. The most recent qualifying value and test date should be entered on the CMN. The initial date provided on the CMN should be the date of delivery for the replacement oxygen equipment.

On the claim for the first month of use, the new oxygen supplier must include the HCPCS code for the new oxygen equipment, the RA HCPCS modifier and a narrative describing why the equipment was replaced along with the specific type of bankruptcy (i.e., Chapter 7 or 11). When submitting claims electronically, suppliers may use loop 2400 (line note), segment NTE02 (NTE01+ADD) of the ASC X12, version 4010A1 electronic claim format. Suppliers billing using the Form CMS-1500 paper claim may report the narrative information in Item 19 of the claim form. In addition, contractors shall instruct home health agencies billing using the UB-04 paper claim that they may report this information in Form Locator 80 (Remarks).

To document that the equipment was lost due to supplier bankruptcy, the new oxygen supplier must submit supporting documentation to the contractor for review.

For a Chapter 7 bankruptcy, the supplier must submit:

- Court records documenting that the previous supplier filed a petition for a Chapter 7 bankruptcy in a United States Bankruptcy Court,

For a Chapter 11 bankruptcy, the supplier must submit:

- Court records documenting that the previous supplier filed a petition for a Chapter 11 bankruptcy in a United States Bankruptcy Court; and
- Documents filed in the bankruptcy case confirming that the equipment was sold or is scheduled to be sold. These documents should include:

1. The Court order authorizing and/or approving the sale; or
2. Evidence that the sale is scheduled to occur or has occurred, e.g., a bill of sale, or an asset purchase agreement signed by the seller and the buyer; or
3. A Court order authorizing abandonment of the equipment.

Upon receipt of a claim for replacement of oxygen equipment lost due to bankruptcy, the contractor will request the supporting court documents from the supplier in order to evaluate whether the equipment can be considered lost. A new 36 month rental period and a new reasonable useful lifetime will not begin unless this documentation is made available to the contractor and, in the case of a Chapter 11 bankruptcy, the contractor is able to verify that the oxygen equipment that was being furnished to the beneficiary was one of the assets that was liquidated.

A Change Request (CR) and a MLN Matters Article will be forthcoming that will incorporate the information contained in this listserv message.

Power Mobility Devices – 7-Element Order

Medicare national and local policy specify that following completion of the face-to-face examination, the physician or treating practitioner must complete a written order containing seven specified elements. Suppliers have the option of providing physicians with a form that lists the seven elements, but which requires the physician to provide all of the requested information. One example of such a form is:

Beneficiary name: _____

Item ordered: _____

Date of face-to-face examination: _____

Diagnosis/condition relating to need for item: _____

_____

_____

Length of need: _____

Physician signature: _____

Signature date: _____

It is not permissible for the supplier to "lead" the physician as to the type of equipment that is ordered. Some examples, not all-inclusive, of unacceptable 7-element orders are:

- A form with "power mobility device" already entered in Item Ordered field.
- A form with check-off boxes for various types of mobility assistive equipment.

A 7-element order with these or similar elements will be considered invalid and the claim for the power mobility device will be denied.

Refer to the Power Mobility Devices Local Coverage Determination and Policy Article for additional information on coverage and documentation.

Power Mobility Devices – Detailed Product Description – Clarification

In a revision of the Power Mobility Devices Local Coverage Determination that became effective on 10/1/09, the requirements for the detailed product description were revised. The LCD states:

> For the wheelchair base and each option/accessory, the supplier must enter all of the following:
> - HCPCS code
> - Narrative description of the HCPCS code
> - Manufacturer name and model name/number
> - Supplier's charge
> - Medicare fee schedule allowance

The second element, the narrative description, does not have to be the full narrative of the HCPCS code. However, it must

be sufficiently detailed to describe the features of the item that distinguish it from items billed with similar codes.

The requirement will be revised to state: Narrative description of the item. This change will be incorporated in a future revision of the Power Mobility Devices LCD. Because this is a liberalization of the requirement, it will have an effective date of 10/1/09.

Refer to the Power Mobility Devices LCD and Policy Article for additional information on coverage, coding, and documentation.

FAQ – Power Mobility Devices – Supplier ATP Involvement (Revised December 2009)

This is a revision of an article originally published in 2008. In addition to revising several questions and responses, the article incorporates the distinction between an ATP conducting the specialty evaluation and the supplier's ATP. The supplier's ATP will be denoted as sATP where applicable.

Q1. What is an ATP?

A. An Assistive Technology Professional (ATP) is a designation of certification by the Rehabilitation Engineering and Assistive Technology Society of North America (RESNA). Prior to January 1, 2009, RESNA maintained two certifications – Assistive Technology Supplier (ATS) and Assistive Technology Practitioner (ATP). Those certifications were combined into one – Assistive Technology Professional (ATP) – with a single certification examination after January 1, 2009. An ATP is a service provider who analyzes the needs of individuals with disabilities, assists in the selection of appropriate equipment and trains the consumer on how to properly use the specific equipment.

Q2. Why does Medicare require "in-person" involvement in the selection of a rehab wheelchair?

A. As one can see from the description of the ATP in Question 1, the sATP with experience and training in proper assistive technology selection is in an ideal situation to translate the functional information from the licensed certified healthcare professional (LCMP) specialty examination into a specific equipment selection for the beneficiary. An sATP must be involved with the selection of a Group 2 single or multiple power option power wheelchair, all Group 3, 4, and 5 power wheelchairs, and a push-rim power assist device for a manual wheelchair.

Q3. Clarify "employ" as it relates to an ATP within this policy.

A. The sATP must be employed by a supplier in a full-time, part-time, or contracted capacity as is acceptable by state law. The sATP, if part-time or contracted, must be under the direct control of the supplier.

Q4. If a supplier has a part time or contracted ATP on staff, what type of special documentation would be needed in an audit to prove the credential?

A. A supplier must show that the employee was working under the supplier's control and guidance. The supplier should also be able to provide evidence of the sATP certification upon request.

Q5. Would a supplier be asked to provide employment records in an MR audit?

A. Yes, employment records, contracting agreements or credential records could be requested. These types of records do not need to be routinely submitted with a claim but must be available upon request.

Q6. What does it mean for the sATP to have direct, in-person involvement in the wheelchair selection process?

A. It means to physically see and interact with the patient and to document that involvement. It is important that the record show how the sATP was involved.

Q7. Can the sATP sign off on the licensed/certified medical professional (LCMP) evaluation, detailed product description, or some other attestation to demonstrate compliance with the requirement?

A. The medical policy does not mandate how suppliers document compliance with the ATP requirement. There must be evidence in the supplier's file of direct in-person interaction with the patient by the sATP in the wheelchair selection process. The supplier, LCMP or treating physician must document how the sATP is involved with the patient. The documentation must be complete and detailed enough so a third party would be able to understand the nature of the sATP involvement and to show that the standard was met. Just "signing off" on a form completed by another individual would not adequately document direct, in-person involvement. For example, if the sATP participates in the specialty evaluation conducted in a multi-specialty clinic, the sATP could request that the person conducting and documenting the specialty evaluation include their name and credentials in the final report - "Ms. Jones was evaluated today for a power mobility device. Taking part in the evaluation was Dr. Smith, Ann Jones, PT, and Bill Doe, ATP from XYZ Mobility." As an alternative, the sATP can create a note documenting their involvement in the specialty evaluation process and that the recommendations reflect their input.

Q8. If the sATP is not present at the specialty evaluation with the therapist or physiatrist, but does assess the patient "in person" following the evaluation by the LCMP, such as during the home evaluation, does this fulfill the requirement for "involvement with the selection process"?

A. If the sATP has direct contact with the patient and has been involved in the wheelchair selection process, the requirement is met, providing that the sATP interaction is clearly documented within the patient's file. If the sATP has not had direct in-person involvement in the wheelchair selection process, the requirement is not met and the KX modifier must NOT be added to the code.

Q9. How should the sATP document their involvement if their evaluation takes place at the office or the beneficiary's home?

A. A critical component in the provision of a PMD is ensuring that the wheelchair and accessories selected are appropriate for the beneficiary and meet their unique,

individual needs. This often includes taking trunk and limb measurements, seating and positioning needs, and other observations about the beneficiary and their ability to use a PMD. This interaction should be documented by the sATP conducting the evaluation and signed and dated by the sATP, including their credentials.

Q10. Must the sATP be present for the delivery, fitting, and/or patient training for the wheelchair provided?

A. The policy states that the credentialed sATP must have direct, in-person involvement with the equipment selection process. The policy does not require that the sATP be present for delivery, fitting, and/or patient training for the wheelchair.

Q11. Can the sATP evaluation be conducted at the time of the PMD delivery to the beneficiary?

A. No. The purpose of the sATP evaluation is determining the proper seating, accessories and other components of the PMD prior to ordering and delivery; therefore, conducting this evaluation at the time of delivery of the device to the beneficiary's residence is not consistent with the intent of this requirement.

Q12. A company employs an ATP, as well as a number of non-credentialed staff who have direct, in-person involvement with the selection process. Is it permissible for the sATP to review the staff's recommendations and sign concurrence to meet the requirement?

A. The sATP must have direct in-person involvement with the wheelchair selection process. An sATP cannot simply "review" and "sign off" on non-credentialed staff work in order to meet the requirement.

Q13. Can the sATP select a product prior to the face-to-face (F2F) examination by the physician and/or prior to the specialty evaluation by the LCMP?

A. Since the role of the sATP is to assure that the equipment selected is appropriate to address the medical needs identified during the F2F examination and specialty evaluation process, it would be inappropriate to begin product selection prior to completion of the F2F examination or specialty evaluation. Any in-person sATP/beneficiary interactions prior to the F2F examination or specialty evaluation would not be considered sufficient to meet the LCD requirement.

Q14. An ATP candidate has taken the RESNA exam but at the time of the in-person evaluation has not yet received the credential. In the event of an audit, will the pending receipt of the sATP credential, retroactively dated to the day the test was taken, be considered compliant?

A. The LCD requires that there must have been an evaluation by a properly credentialed, supplier-employed ATP. The sATP must have been certified as of the date he/she performed the in-person evaluation of the patient. The sATP is not a credentialed ATP until receipt of the credential from RESNA. The RESNA document will specify the effective date of the credential.

Q15. If an ATP employed by a supplier who has had direct in-person involvement in the wheelchair selection process for a patient leaves a company before the wheelchair is delivered, will the claim be considered compliant?

A. Leaving the company employment would not invalidate what that person did while working as a RESNA-certified ATP. The patient's record must illustrate the previously employed sATP had in-person involvement with the wheelchair selection process.

Q16. Can an sATP perform any part of the F2F examination process required for all PMDs or the specialty evaluation required for rehab wheelchairs?

A. No.

Q17. If the sATP participated in the evaluation by means of a live video feed, would that be acceptable?

A. Yes. Involvement of the sATP in the evaluation of the patient via a live video feed is acceptable for beneficiaries who reside in remote locations as long as the evaluation is conducted in accordance with the Telehealth requirements outlined in the Centers for Medicare and Medicaid Services (CMS) *Benefit Policy Manual* (Internet-Only Manual 100-2), Chapter 15, Section 270.

Medical Review Probe Findings on K0823

The NAS Jurisdiction D Medical Review department conducted a Service Specific prepayment probe review for HCPCS K0823, power wheelchair, group 2 standard, captain's chair, weight capacity up to and including 300 pounds. This was a selection of multiple supplier submitted claims based on a specific service that were reviewed for medical necessity.

A total of 117 claims were captured for review and developed for additional documentation. Of these, 114 claims were fully denied (97.37% claim error rate). Below are the top reasons for claim denial.

ACTION	Percent of Claims in Review Sample
Denied as not medically necessary	79.5%
No documentation received	15.4%

The top issues causing these denials are:

- Not responding to request for documentation letter in the required 30 days
- No valid written order
- No or insufficient medical records submitted to justify the need for the wheelchair
- Required documentation not submitted in full or was not complete

It is the supplier's responsibility to understand the Medicare coverage requirements for power mobility devices and related accessories as outlined in the Power Mobility Devices LCD (L23598) and Policy Article for Mobility Devices (A41127) located on the Coverage/MR page on our Web site.