Jurisdiction D News from Noridian Administrative Services, LLC.

Happenings

January 2009
Issue No. 18

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

In This Issue…

FYI

EDUCATIONAL

CEDI

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

ACCREDITATION

CERT

FORMS

BILLING

REIMBURSEMENT

CODING

Coverage 80

DRUGS/BIOLOGICALS

OXYGEN

PAP

Alphabetical Listing...

Jurisdiction D DME MAC Supplier Contacts and Resources

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

Web site: www.noridianmedicare.com

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

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

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

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

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

Holiday Schedule

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

Holiday	Date
Martin Luther King Day*	January 19, 2009
President's Day *	February 16, 2009
Good Friday	April 10, 2009
Memorial Day	May 25, 2009
Independence Day	July 3, 2009
Labor Day	September 7, 2009
Columbus Day *	October 12, 2009
Veterans Day *	November 11, 2009
Thanksgiving	November 26 and 27, 2009
Christmas Eve **	December 24, 2009
Christmas Day	December 25, 2009
** Partial day closure	

Sources for "Jurisdiction D Happenings" Articles

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

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

Medicare Learning Network Matters Disclaimer Statement

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

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

Information on Medicare Contractor Provider Satisfaction Survey

The Medicare Contractor Provider Satisfaction Survey (MCPSS) will give providers/suppliers the opportunity to rate their contractor(s) on seven business functions: provider outreach and education, provider inquiries, claims processing, appeals, medical review, provider enrollment, and provider audit and reimbursement (for Part A providers). Providers may find out more information about this survey by going to the CMS Web site at: http://www.cms.hhs.gov/mcpss.

Medicare Contractor Provider Satisfaction Survey Home Study page is available at http://www.mcpsstudy.org.

Providers Urged to Participate in Annual MCPSS

MLN Matters Number: SE0843

Provider Types Affected

Medicare physicians, providers, and suppliers selected to participate in the Medicare Contractor Provider Satisfaction Survey (MCPSS).

Provider Action Needed

This article alerts providers that the Centers for Medicare & Medicaid Services (CMS) will distribute its annual Medicare Contractor Provider Satisfaction Survey (MCPSS) to a new sample of Medicare providers. CMS is sending the 2009 survey, designed to be completed in about 20 minutes, to approximately 30,000 randomly selected providers, including physicians and other health care practitioners, suppliers and institutional facilities that serve Medicare beneficiaries across the country. CMS will begin to notify providers selected to participate in the survey in December 2008. Providers are urged to submit their responses via a secure Web site, mail, fax, or over the telephone.

Background

The MCPSS offers providers the opportunity to contribute directly to CMS' understanding of Medicare contractor performance, as well as aid future process improvement efforts at the contractor level. All Medicare Administrative Contractors (MACs) will be measured against performance targets on the 2009 MCPSS as part of their contract requirements.

The 2008 survey results revealed that, for the second consecutive year, the top indicator of satisfaction among providers was how Medicare contractors handled provider inquiries. As in the two previous years, claims processing also remained a strong indicator in 2008 of provider satisfaction

across all contractor types. The shift from claims processing as the top predictor in 2006 to provider inquiries as the top predictor of satisfaction in 2008 is an example of the type of trend data the MCPSS will reveal. Contractors are able to factor such insights into how they prioritize their provider-focused efforts.

Feedback captured through MCPSS is important, and CMS urges all Medicare providers who are selected to participate in the MCPSS to complete and return their surveys upon receipt. CMS plans to analyze the 2009 MCPSS data and release a summary report at http://www.cms.hhs.gov/MCPSS on the CMS Web site in July 2009.

Key Points

- Survey questions focus on seven business functions of the provider-contractor relationship: provider inquiries, provider outreach and education, claims processing, appeals, provider enrollment, medical review, and provider audit and reimbursement.
- Respondents are asked to rate their contractors using the 1 to 6 scale on each of the business functions with "1" representing "not at all satisfied" and "6" representing "completely satisfied." Contractors receive an overall composite score as well as a score on each business function.
- Results from previous surveys have enabled CMS to set performance standards for MAC's.
- Performance standards give contractors a benchmark to use to compare themselves to other contractors, as well as an individual standard to improve upon year after year.
- The contractor's MCPSS score is based on the average survey score from all surveyed Medicare providers in the contractor's jurisdiction. To meet the performance standard, the MAC's score for the 2009 MCPSS must fall within a specified range of the 2008 national mean score. The average 2008 MCPSS for all contractors, released last August, was 4.51 on a scale of 1 to 6. This score was comparable to the 2007 average MCPSS score of 4.56. CMS plans to utilize MCPSS results to help structure future contract incentives.

The MCPSS is required by the Medicare Prescription Drug, Improvement and Modernization Act of 2003. Specifically, the law calls for CMS to develop contract performance requirements, including measuring health care provider satisfaction with Medicare contractors. The MCPSS enables CMS to make valid comparisons of provider satisfaction between contractors and, over time, improvements to the Medicare fee-for- service program.

Additional Information

For further information, visit http://www.cms.hhs.gov/MCPSS on the CMS Web site. If you have questions, please contact your Medicare contractor at their toll-free number which may be found at http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip on the CMS Web site.

Beneficiaries Call 1-800-MEDICARE

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

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

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

Another great resource for beneficiaries is the web site, 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

Update to Medicare Deductible, Coinsurance and Premium Rates for 2009

MLN Matters Number: MM6258 Revised
Related Change Request (CR) #: 6258
Related CR Release Date: November 17, 2008
Related CR Transmittal #: R56GI
Effective Date: January 1, 2009
Implementation Date: January 5, 2009

Note: This article was revised on November 18, 2008, to reflect changes made to CR6258, which was re-issued on November 17. The CR transmittal number and release date (see above) were revised and the Web address for accessing CR6258 was changed. All other information remains the same.

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) 6258, which provides the Medicare rates for deductible, coinsurance and premium payment amounts for calendar year (CY) 2009.

2009 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 2009 deductible and coinsurance amounts are in the following table.

Table 1

2009 Part A – Hospital Insurance (HI)			
Deductible	$1,068.00		
Coinsurance	**Hospital**		**Skilled Nursing Facility**
	Days 61-90	**Days 91-150 (Lifetime Reserve Days)**	**Days 21-100**
	$267.00	$534.00	$133.50

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 2009 Part A premiums are listed in table 2, below.

Table 2

Voluntary Enrollees Part A Premium Schedule	
Base Premium (BP)	$443.00 per month
Base Premium with 10% Surcharge	$487.30 per month
Base premium with 45% Reduction	$244.00 per month (for those who have 30-39 quarters of coverage)
Base premium with 45% Reduction and 10% surcharge	$268.40 per month

2009 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 2009, the standard premium for SMI services is $96.40 a month; the deductible is $135.00 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 6258, which is available at http://www.cms.hhs.gov/Transmittals/downloads/R56GI.pdf on the CMS Web site.

Influenza Pandemic Emergency - The Medicare Program Prepares

MLN Matters Number: SE0836 Revised

Note: This article was revised on November 26, 2008, to include Web revised links to recently-reissued CR6174, CR 6146, and CR 6164, all of which were recently revised by CMS. All other information remains the same.

Provider Types Affected

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

Impact on Providers

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

Background

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

Decision to implement would occur if:

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

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

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

Dedicated CMS Web Page Now Available

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

Additional Information

Additional CMS influenza pandemic policy documents include:

- CR 6146, which can be found at http://www.cms.hhs.gov/Transmittals/downloads/R404OTN.pdf on the CMS Web site;
- CR 6164, which can be found at http://www.cms.hhs.gov/Transmittals/downloads/R402OTN.pdf on the CMS Web site; and
- CR 6174, which can be found at http://www.cms.hhs.gov/Transmittals/downloads/R403OTN.pdf on the CMS Web site.

New OCR Guidance on the HIPAA Privacy Rule and the Electronic Exchange of Health Information

The Department of Health and Human Services (HHS) Office for Civil Rights (OCR) has published new HIPAA Privacy Rule guidance as part of the Department's Privacy and Security Toolkit to implement *The Nationwide Privacy and Security Framework for Electronic Exchange of Individually Identifiable Health Information* (Privacy and Security Framework). The Privacy and Security Framework and Toolkit is designed to establish privacy and security principles for health care stakeholders engaged in the electronic exchange of health information and includes tangible tools to facilitate implementation of these principles. The new HIPAA Privacy Rule guidance in the Toolkit discusses how the Privacy Rule supports and can facilitate electronic health information exchange in a networked environment. In addition, the guidance includes documents that address electronic access by an individual to his or her protected health information and how the Privacy Rule may apply to and supports the use of Personal Health Records.

These new HIPAA guidance documents are available on the OCR Privacy Rule Web Site at http://www.hhs.gov/ocr/hipaa/hit/. For more information on the Privacy and Security Framework and to view other documents in the Privacy and Security Toolkit, visit http://www.hhs.gov/healthit/privacy/framework.html.

EDUCATIONAL

DME Fee Schedule Lookup Tool Now Available

Based on supplier feedback, NAS DME now offers a lookup tool for Jurisdiction D fees on our Fees tab. The following categories are available:

- DMEPOS
- Drug, Dispensing, and Pharmacy Supply
- Parenteral and Enteral Nutrition

Note: Oral Anti Cancer Drug fees are not available in the lookup tool. These fees are found on the Fees tab of our Web site.

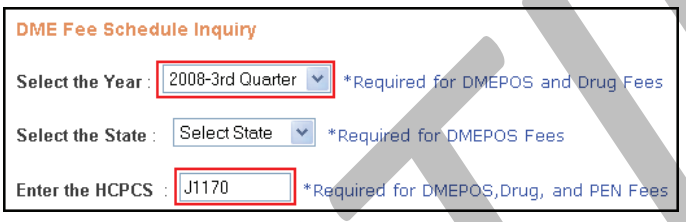
Required Search Criteria

DMEPOS Fees

- Year
- State
- HCPCS

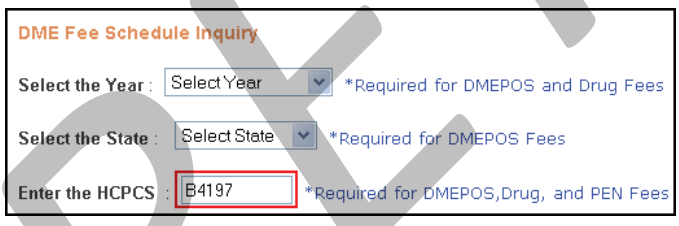
Drug Fees

- Year
- HCPCS

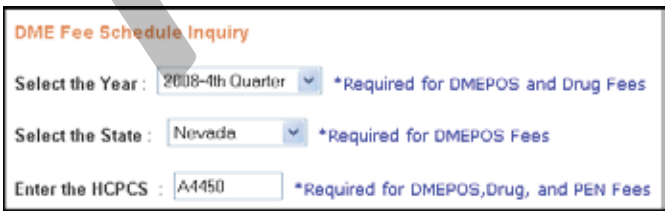


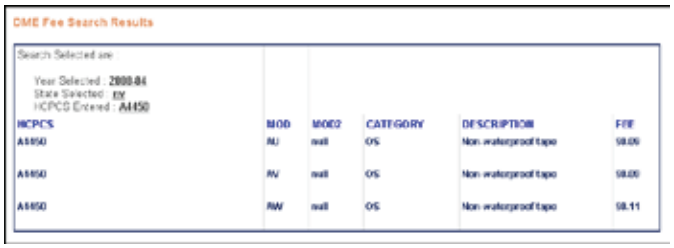
PEN Fees

- HCPCS



If a modifier is attached to the HCPCS code, enter only the HCPCS code in the search. The results display all HCPCS/ modifier combinations published by CMS.





Results Not Displayed

If search criteria is entered but an error message is received:

- Ensure the correct criteria is entered for the type of fee being searched.
- View the Jurisdiction List on the Claims page of our Web site to ensure the HCPCS code is billed to DME.

Updates to Fee Schedules

The Excel, PDF, and CSV formats of the fee schedules will continue to be available and updated on the Fees tab. NAS will add upcoming fees to the lookup tool and Fees tab as they are available.

2009 Ask the Contractor Teleconferences – Quarterly and Small Supplier

NAS is pleased to announce our upcoming schedule of quarterly and small supplier teleconferences for 2009. We will be continuing with our current format of brief opening remarks followed by the question and answer (Q&A) session.

If you have a question on your mind and are not sure who to ask - this teleconference is your opportunity to speak directly to your contractor. Knowledgeable NAS staff representing a variety of functions will be available to answer your questions.

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

Quarterly ACT

The 2009 quarterly ACTs will be held at 3 p.m. CT on:

- March 17, 2009
- June 23, 2009
- September 1, 2009
- December 15, 2009

Small Supplier ACT

CMS has defined a **small supplier** as a supplier with ten or fewer full time equivalent employees.

The 2009 small ACTs will be held at 3 p.m. CT on:

- February 18, 2009
- May 20, 2009
- August 19, 2009
- November 12, 2009

After placing the call for either the quarterly ACT or small supplier ACT, you will be asked to provide the following:

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

NAS looks forward to your participation in these ask the contractor teleconferences.

Ask the Contractor Q & A – December 10, 2008

Prior to taking questions, NAS provided the following updates:

Diagnosis Edits

Suppliers are reminded that many DMEPOS Local Coverage Determinations (LCDs) and corresponding Policy Articles (PAs) specify under what clinical circumstances, or for what diagnosis, DMEPOS items are considered to be reasonable and necessary. NAS has implemented diagnosis requirements from the LCDs and PAs and will continue to do so. This will ensure that DME items are edited for diagnosis as listed in the policy, paid only when appropriate based on the diagnosis and that diagnosis codes are edited to the highest level of specificity.

Criteria for "reasonable and necessary", including the specific diagnosis codes, are defined in the LCDs and corresponding Policy articles, which can be accessed at https://www.noridianmedicare.com/dme/coverage/.

For more information, see the November 18, 2008, Web site article on this topic.

Fee Schedule Look-up Tool

Last week, NAS launched a fee-schedule look up tool which allows suppliers to enter a HCPCS, state and the 2008 quarter timeframe in question and the fees will appear on your screen. Please check out this new tool and provide feedback on this resource.

Web Site Survey

Suppliers are encouraged to take the Web site survey that appears to give us feedback on our recent Web site changes, such as the fee schedule look-up tool. Your feedback is very important so we can continue to offer Web tools and met your needs. You will only be requested to complete this survey once every 30 days but it is important that you provide feedback on our recent Web site changes.

Educational Opportunities

NAS will be offering Web-based workshops on the topics of Glucose Monitors and Testing on December 30, the new ABN form on January 29 and Navigating our DME Web Site on January 13. Registration for the glucose workshop is currently available. The registration for the ABN and Web site workshops will be available soon. See the training section of our Web site to register. Suppliers will also be informed of these events via a Web site posting and email list notice. We encourage you to take advantage of these educational opportunities.

Common Electronic Data Interchange

The Common Electronic Data Interchange staff provided the following updates:

On January 5, 2009 CEDI will be changing their hours of operations. New hours will be from 9:00 a.m. to 7:00 p.m. Telephone options will also change on January 5, 2009. Suppliers will have two options. Option one to hear the hours of operation and an e-mail address to contact CEDI, and option two to speak to a CEDI help desk technician. Option three, password reset, will no longer be available.

CEDI is in the process of changing the current front-end editing process for ANSI X12 837 claims and 276 claim status request transactions.

All new edits have been added to the *CEDI Front-End Reports Manual*. This manual is available on the CEDI Web site at: http://www.ngscedi.com/outreach_materials/outreachindex.htm

The changes to the front-end editing process will occur in two stages:

Stage 1 - Implementation will begin on Friday, January 9, 2009

- On Friday, January 9, 2009 at 3:00 pm ET, the CEDI Gateway will be brought down until Sunday, January 11, 2009 at 6:00 pm ET to implement the additional CEDI edits.

** **During this time, Trading Partners will not be able to connect to CEDI to transmit or receive electronic transactions and/or reports**.

- The additional front-end edits for 837 claims will be added to the current CEDI GenResponse (GENRPT) report.
- 837 claims shown as accepted on the GenResponse Report will be delivered to the DME MACs.
  a. Claims delivered to the DME MACs will continue to edit against the DME MAC Level II edits as they do currently.
  b. Claims accepted on the DME MAC Level II reports will be assigned a Claim Control Number (CCN) that will be attached to the claim as it enters the DME MAC for processing.
  c. CEDI will deliver the DME MAC Level II reports to the Trading Partner.
  d. Claims rejected on the DME MAC Level II report must be corrected and resubmitted to CEDI.
- 837 claims rejected on the GenResponse Report will not be delivered to the DME MACs. These claims must be corrected and resubmitted to CEDI.
- Most, if not all, claims that reject will be returned on the GenResponse Report. It will be extremely important for Trading Partners to monitor the GenResponse Report for rejected claims in order to correct and resubmit the claims to CEDI.

- The additional CEDI front end edits will be implemented for the 276 claim status request transactions.

  e. 276 transactions that reject at CEDI will be reported back on a 277 claim status response.

  f. 276 transactions accepted by CEDI will be delivered to the DME MACs.

  g. 276 transactions delivered to the DME MACs will continue to edit against the DME MAC Level II edits as they do currently.

  h. 276 transactions accepted on the DME MAC Level II reports will be sent to the DME MAC for processing to produce the 277 to report the claim status back to the Trading Partner.

Stage 2 - Implementation will occur on January 30, 2009

- On Friday, January 30, 2009 at 3:00 pm ET, the CEDI Gateway will be brought down until Sunday, February 1, 2009 at 6:00 pm ET for the DME MACs to remove their front end edits for 837 claims and 276 claims status transactions.

** **During this time, Trading Partners will not be able to connect to CEDI to transmit or receive electronic transactions and/or reports.**

- The DME MACs will remove their front end edits and all electronic front-end editing for the X12 837 claims and 276 claim status transactions will be done through CEDI.
- 837 claim front-end rejections will be returned on the CEDI GenResponse (GENRPT) report.
- 276 claims status request front-end rejections will be returned on the 277 claims status response transaction.
- The additional GenResponse edits that were implemented in Stage 1 will replace the DME MAC Level II edits and Trading Partners will no longer receive Level II reports from the DME MACs.
- Claims accepted on the GenResponse Report will be assigned a Claim Control Number (CCN) and these will be indicated on a report that will go back to the Trading Partner from CEDI. This CCN will be attached to the claim as it enters the appropriate DME MAC for processing.
- All electronic front-end editing for the X12 276 claim status request transaction will be done through CEDI and all front-end rejections will be returned on the 277 transaction.

NOTE: The CCN assignment changes scheduled for Stage 2 may occur at a later stage. If this occurs, notification will be sent via the CEDI listserv.

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

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

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

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

Q1. Is the allowance for oxygen contents one unit per tank or per delivery?

A1. Reimbursement for oxygen content is one unit per month. The supplier must provide whatever quantity of oxygen the patient uses. Medicare's reimbursement is the same, regardless of the quantity of oxygen dispensed.

Q2. Once a beneficiary meets the 36-month cap for oxygen and we begin billing for maintenance and servicing, is the policy like the capped rental maintenance and servicing guidelines or do we have to physically perform servicing?

A2. Suppliers must have documentation that shows you went out to the beneficiary's home and what maintenance and service was provided in order to bill for that service. This documentation should be kept in the supplier's files and made available upon request.

Q3. The PAP policy is kind of vague regarding what elements are needed in the patient's chart regarding the initial face-to-face clinical evaluation before the sleep study is performed. Will CMS be providing more details about what exactly they're looking for or can the physician do what they feel is appropriate at that time?

A3. The wording in the PAP policy gives suggested elements that may be included in the patient's medical record, they are not requirements. If one or two of the suggested elements are missing or are not real detailed, that would still suffice. This policy was agreed upon by all four DME MACs, as well as CMS.

Q4. In the LCD, L11493, Respiratory Assist Devices, under initial coverage criteria, section three, subsection C, in relation to central sleep apnea and complex sleep apnea it says "Significant improvement of sleep associated hypoventilation." Does this term have a specific oxygen saturation requirement as we seem to be receiving claim denials for this reason? Some DME suppliers are interpreting the sleep associated hypoventilation to mean that the patient must have an oxygen level below 88% for five minutes, which rarely happens.

A4. The policy only references that a RAD is covered for a patient with central sleep apnea or complex sleep apnea where the patient has one of these diagnoses, CPAP has been ruled out and there is significant improvement of sleep-associated hypoventilation with the RAD device. This section of the policy does not have specific oxygen saturation requirements.

NAS asked for denial examples to be sent via fax but none have been received at this time.

Q5. What can we do if a beneficiary reaches the 36 month cap for oxygen equipment, specifically a concentrator, at the same time they reach the useful lifetime of the equipment (five years) and the beneficiary refuses a new piece of equipment and does not want to start a new rental period? Can the supplier pick up the equipment in this situation even though the patient still requires oxygen?

A5. CMS Response-Joel Kaiser: The supplier can either continue providing the equipment at no charge to the beneficiary, other than maintenance and servicing, or give the beneficiary notice that the equipment will be picked up and they will have to find a new supplier. The supplier's obligation after 36 months of payments have been made is to provide the equipment until the reasonable useful lifetime has been reached.

Follow-up question. Can a supplier transfer title of equipment over to the beneficiary after the 36 months and the useful lifetime has been reached, i.e., convert the rental to a sale for no additional dollars?

CMS Response-Joel Kaiser: The equipment belongs to the supplier therefore they can do what they want as far as transferring title to the beneficiary. You should let the beneficiary know if they would like to obtain new equipment later on, that Medicare will pay for it because the current equipment has reached the reasonable useful lifetime.

Q6. I am a supplier from Alaska and have concerns that are unique to our state. I have attended a recent Open Door forum and heard Joel Kaiser say that the law is the law regarding oxygen payment rules and that we, as suppliers, can provide comments to these changes. If the law is the law, of what use are those comments? Is our only option to challenge this law regarding the new oxygen equipment payment, to go through our legislators?

A6. CMS Response-Joel Kaiser: Staff at CMS and HHS let legislators know what the issues are regarding Medicare changes. We discuss legal requirements and regulatory requirements with general counsel to see if there is anything that can be done to address the various situations. Even though you are pretty sure nothing can be done, given the current statutory requirements, it's worth bring your issues up so people are aware there *is* an issue and at the very least can be *considered* for legislative amendment if the current statute does not allow for flexibility to address your concerns administratively.

Follow up questions. Do you believe specific state issues such as ours, where the cost of living and the cost of contents is five times higher then other states, can be considered individually?

Follow up answer: CMS Response-Joel Kaiser: As far as fee schedule amounts are concerned, those were established a couple of years ago when we created new payment classes for oxygen using the authority that is in the statute. We also increased the payment for portable contents at that time. If there is a reason we should revisit those rates that could be addressed, of course it would have to be addressed through another rule making process. For example, you could say these rules where established in November 9, 2006, in the Federal Register and it is now time to revisit these rates as they may be creating access problems in Alaska or other areas. Oxygen rules in general are fair game for the public to comment.

Q7. My company specializes in upper extremity prosthetics and we would like to know the definition of heavy duty as it applies to L6639 (heavy duty elbow), L6660 (heavy duty control cable), L7621 and L7622 (heavy duty hooks).

A7. The term "heavy duty" refers to the number of locking positions and construction of the elbow unit and the thickness of the control cable for harnessing and operating the terminal device.

The "standard duty" in these codes reflects the average upper extremity amputee who is active in daily activities. The "heavy duty" in these codes reflects the heavy duty user such as a farmer or active outdoors type individual who needs stronger cables and elbow units for heavier duty demands of the prosthesis and cable system. The cable and elbow unit have been made stronger for these type individuals, with the standard cable and elbow units used for less active individuals.

Q8. Does the detailed written order for PAP supplies need to be specific and if so how specific? For example, for the PAP mask, should the detailed written order include the head gear, nasal pillows etc.?

A8. The *Medicare Program Integrity Manual*, Chapter 5, Section 5.2.3, states the following:

> "The written order must be sufficiently detailed, including all options or additional features that will be separately billed."

If the code for the mask includes other components that are not billed separately, an order for mask would be sufficient. On the other hand, if you are replacing a piece that goes on a mask and there is a separate HCPCS code for this, you would bill the components separately and this item would be required on the detailed written order.

Q9. Can oxygen content and accessories be picked up by the beneficiary or shipped to them as opposed to the supplier having to deliver directly to the beneficiary? Can we ask the beneficiary to pick up their contents and ship their supplies, such as cannulas to save costs?

A9. CMS Response-Joel Kaiser: The Supplier Standards require DMEPOS suppliers to deliver equipment to the beneficiary. Accessories, such as cannulas, can be shipped; however oxygen contents cannot be shipped. The supplier must deliver oxygen contents to the beneficiary's home. Suppliers cannot require the beneficiary to come to their location to pick up the tanks.

Q10. If we call a beneficiary seven days prior to the end of expected usage of their enteral formula and find out that they have five days excess over the expected usage, do we need to call back again in seven days to verify they have nearly exhausted the supply on hand?

A10. No, it would not be reasonable to expect you to call back again in seven days since you just verified they have 12 days on hand. If the beneficiary had an excessive quantity on hand (30 plus days), you may want to call back at a later date to verify they have nearly exhausted the supply on hand. Supplies, however, should not be shipped/delivered any sooner than approximately five days prior to the end of usage of the current product on hand, per Medicare guidelines.

Q11. The PAP LCD specifically lists diagnosis code 327.23 as the covered diagnosis. If we also have a diagnosis of 780.53 and/or 780.57, which one should be primary?

A11. You should report the primary diagnosis related to the beneficiary's condition. The required diagnosis, per the LCD, must be included on the claim in order to be covered.

Q12. Once oxygen equipment has capped, what will Medicare be looking for as far as proof of delivery for the contents and do we bill when contents are provided or do we wait until the end of the month?

A12. CMS Response-Joel Kaiser: The supplier should bill for oxygen contents on the typical anniversary date, the day the system/content was first provided to the beneficiary. This is the same way capped items have been billed in the past and the rules have not changed and apply to contents as well.

Q13. After the 36-month cap is reached for oxygen equipment, am I allowed to bill every six months for maintenance and servicing?

A13. CMS Response-Joel Kaiser: No sooner then six months after the end of the 36-month cap, the supplier may bill for routine maintenance and servicing performed for *concentrators* and *trans-fill equipment*. This general maintenance and servicing is intended to check on the equipment to make sure it will continue to function for another six months.

Follow-up question: After the five-year reasonable useful lifetime of the equipment, don't I need to have a valid reason for switching out equipment and beginning a new 36 month cap rental, such as the equipment doesn't work anymore? We can't just go and take someone's concentrator since it's been five years, can we?

Follow-up answer: CMS-Joel Kaiser: The rules for oxygen are unique. Since the supplier is obligated to continue furnishing the equipment for the remainder of the reasonable useful lifetime, and the general policy on reasonable useful lifetime is five years, at the end of the five-year period the reasonable useful lifetime is over. The beneficiary can then elect to obtain new equipment. It is in the beneficiary's best interest to obtain new equipment because after the reasonable useful lifetime of the equipment, the supplier is no longer obligated to continue servicing or supplying content for that equipment. The best way to look at it is the Medicare payment rules for oxygen and oxygen equipment is a five-year service agreement. You deliver the equipment and if they need it for five years, you furnish it for five years. You get paid for 36 months and then at the end of the five years that payment period is over and a new payment period can start for another 36 months of payment. As far as Medicare is concerned the payment rules for oxygen are modality neutral. Liquid or gaseous tanks and accessories are equivalent to a concentrator, so the five-year rule not only applies not only to the concentrator but also to the liquid and gas systems.

Follow-up question: The difficult part for suppliers is that after we have provided the system to a Medicare beneficiary for four years here in Missouri, the beneficiary may move to Phoenix and we are still responsible for the equipment.

Follow-up answer: CMS-Joel Kaiser: In that situation the beneficiary has to be taken care of. We went from a rule where the beneficiary would have owned the equipment after 36 months and could then take it with them, to now a rule where the supplier owns the equipment and the supplier is responsible for continuing to furnish the equipment. That is what Congress legislated.

Q14. Is it required that we split our billing when it spans 2008 into 2009?

A14. No, you do not need to split claims.

Q15. Can we use an ABN when a beneficiary does not want us to bill for an item if they select option 2?

A15. Yes, that is the main reason that option 2 was added to the form.

Follow-up question. Can we use the ABN for non-covered items as well?

A. Yes, the ABN can be used for non-covered items.

Q16. Will oxygen suppliers need a new CMN once the 36 month cap is reached for the supplies and contents that were not on the original CMN, as the payment for those items was all- inclusive in the equipment?

A16. No, you are required to continue to provide supplies, without charge, until the reasonable useful lifetime ends and you do not need an order for maintenance and servicing.

Follow-up question. Will we need a CMN if the beneficiary transferred to us from another supplier after the 36 month capped rental period or are we able to rely on the CMN the other supplier maintains for the maintenance and servicing. Keep in mind that the CMN only includes the portable and concentrator and not accessories, supplies and contents.

Follow-up answer: CMS-Joel Kaiser: The medical necessity will have already been established and a CMN would not be needed for the maintenance and servicing and contents. CMS will follow-up with the medical necessity folks to see if an order would be needed for contents.

Q17. What happens if there is a break-in-service of continuous use after the 36-month cap is reached? For example, if patient is discharged from oxygen at month 38, and then at month 48 the oxygen is re-ordered, does that still fall within the five-year reasonable lifetime of the equipment or would we start a new rental period because of the break-in-service of continuous use?

A17. CMS Response-Joel Kaiser: Medicare pays for no more than 36 months of continuous use of oxygen equipment. Continuous use has been defined and is the same as it has been for capped rental items since 1989. There is no issue of continuous use after the 36 month period because continuous use is only for determining when the 36 month cap is reached. After the 36-month cap, continuous use does not apply because the law requires the supplier to continue providing the equipment for **any** period of medical need for the remainder of the reasonable useful lifetime of the equipment. It does not matter how long the break of need is after the 36 month cap is reached, if it is within the five year reasonable useful lifetime period and there is a need for the oxygen then the supplier must furnish that equipment during those periods of need.

Follow-up question. I heard you say previously that if there were a break-in-service in the first 36 months, a new rental would start. Correct?

Follow-up answer: CMS-Joel Kaiser: Yes, that is correct. And like I said the continuous use policy **during** the 36-month cap period, which is the same policy that has been in effect since 1989, which states if there is a break in need more then 60 days plus any days remaining in the last rental month that was paid, then that is a break in continuous use. So following that break in medical need a new rental period would begin. But **after** the 36-month cap is reached that is where the law requires the supplier to continue providing the equipment for **any** period of medical need until the five-year reasonable useful lifetime period ends and break in service of continuous need no longer applies.

Q18. We are receiving CO176 denials on oxygen claims and we have an ABN, but are unable to get a patient responsibility denial. Can we still bill the patient?

A18. NAS reviewed denials for one patient. This patient had oxygen levels that were too high so they did not qualify for Medicare coverage. The modifier GA was reported on the claim. The claims were processed with the wrong denial code, resulting in the CO176 denials. The claims will be adjusted to deny for medical necessity and patient responsibility since an ABN was obtained.

Q19. Joel Kaiser mentioned that all DME is required to be delivered. Is that a supplier standard or quality standard?

A19. CMS Response Joel Kaiser: This is one of the original 21 Supplier Standards. Supplier Standard 12 states: A supplier is responsible for delivery and must instruct beneficiaries on use of Medicare covered items, and maintain proof of delivery.

Follow-up question. Shouldn't that include delivering items to beneficiaries who walk into our store? The reason I am asking is I'm concerned with Joel's statement that suppliers are required to delivery to the patient's home. Many patients choose to pick items up at our store.

Follow-up answer: CMS-Joel Kaiser: What was meant by that statement is that a supplier cannot **force** a beneficiary to come to their store to pick up items, such as oxygen contents. If the beneficiary wants to walk into a supplier's store and pick up their equipment, they obviously have that right. A supplier cannot say, "I'll furnish the equipment, but you have to come to my store to pick up the contents".

Q20. Does CMS or Noridian have a contingency plan in place for all the small providers that will be going out of business due to the changes in the oxygen payments? What will happen when we have hospitals wanting to give us patients that have already capped? How will we provide services to them with no reimbursement?

Q20. CMS Response-Joel Kaiser: This new law benefits suppliers. The 36-month cap was part of the Deficit Reduction Act (DRA) of 2005. The Medicare Improvements for Patients and Providers ACT (MIPPA) further amends the law before we even got to the point where the first beneficiary would have reached the cap and the supplier was mandated to transfer title of the equipment to the beneficiary. The law was changed in July to repeal that transfer of title requirement.

Follow-up question. I understand the changes from the DRA and the MIPPA. My concern is for beneficiaries with small suppliers that will have to deliver contents in small towns with outlying areas; those suppliers will be put out of business. Six to ten percent of small oxygen suppliers will be put out of business in my estimation. That is why I want to know. What is the contingency plan that CMS has in place to help those beneficiaries when those suppliers go out of business? Who will deliver their supplies and contents?

Follow-up answer: Joel Kaiser, from CMS, invited callers to read the purposed and final rules regarding implementation of the DRA requirements and the interim final rule that was recently published. Fee schedule amounts for oxygen contents have increased from $21.00 to $77.45. Payment classes were adjusted to increase payments. The law required in order to do that it must be done in an annually budge neutral fashion. CMS had to offset that huge payment increase by decreasing the stationary payment. Stationary payment went down a few dollars to allow for the increase from $21.00 to $77.45 for content. Should there be an access problem, CMS can go back to that authority and we could increase oxygen content payment again. But again the law would require we do a budge neutrality offset, so we would have to offset that increase by reducing the stationary oxygen equipment payment. There are ways within the statute that you can address these issues, however we can only do what the statute allows us to do. Joel recommended this supplier take his comments to the IFC as this would not be the appropriate forum to continue with these types of fee payment concerns.

Comments from a caller: I would like to address the Medicare modality neutral interpretation. When a beneficiary goes from 3 to > 4 LPM, Medicare is interpreting this to be the same. Medicare needs to re-look at this because a five liter concentrator costs less then half of what a ten liter concentrator costs. There's a new modifier you have to add. There is another thing that makes it even less modality neutral. Medicare policy states that a revised CMN is required when this situation occurs, so I'm going to ask again that CMS re-look at this interpretation. In addition, Supplier Standard 12, since people have been asking about deliveries, does no specify deliveries must be to the home.

Q21. Does the five-year reasonable useful lifetime follow the actual equipment or does it follow the patient's use? Often when we check on a patient and service the concentrator, we'll exchange it for a different concentrator.

A21. CMS Response-Joel Kaiser: The monthly payment is for oxygen and oxygen equipment. It is modality neutral. It doesn't matter what type of equipment is furnished. The reasonable useful lifetime is based on when the equipment is originally furnished.

Q22. If we provide both a concentrator and portable gaseous system to a beneficiary, for what equipment can we get reimbursed for maintenance and servicing?

A22. CMS Response-Joel Kaiser: Suppliers will be reimbursed for maintenance and servicing for the concentrator, but not the portable gaseous system. If you provide transfilling equipment, maintenance and servicing will also be reimbursed for this equipment, in addition to the concentrator.

Ask the Contractor Q & A - November 12, 2008

Prior to taking questions, NAS provided the following updates:

Accreditation

In order to participate in Medicare Part B, certain DMEPOS suppliers will need to complete the accreditation process and be in compliance with new quality standards. CMS announced on September 3, 2008 that several supplier types are now exempt from all accreditation requirements. Among these supplier types are:

- Physicians
- Orthotists/Prosthetists/Pedorthists
- Opticians/Optometrists
- Audiologists
- Occupational Therapists/Physical Therapists

Suppliers that fall in this subset are reminded that if they provide other DME outside of their specialty, they will be required to be accredited to bill Medicare.

In addition, suppliers that provide drugs and pharmaceuticals ONLY are exempt from the accreditation requirement. If the supplier provides equipment to administer drugs or pharmaceuticals, the supplier must be accredited.

As an exempted supplier, if your enrollment application was returned previously for non-accreditation, you must resubmit your 855S to the National Supplier Clearinghouse (NSC).

CMS also slightly revised the quality standards used for accreditation in late October. These changes are highlighted in yellow on the CMS Web site. Some of the changes relate to employment of ATS certified staff and more in depth guidance for proper fittings for diabetic shoes.

Frequency Edits on LCDs

NAS is required to monitor the utilization patterns of suppliers and determine medical necessity and proper coding practices. Many of the Local Coverage Determinations (LCDs) specify frequencies that define the limit of reasonable and necessary care. Suppliers are reminded to review the LCDs for frequency limitations prior to claims submission. To access LCDs and Policy Articles, see the Local Coverage Determinations page on the NAS DME Web site under Coverage / MR.

NAS has implemented, and will continue to implement, frequency of service limitations edits based on the LCDs. Please see the article posted on October 7, 2008, for a complete listing of the affected LCDs.

MUEs

CMS announced that beginning October 1, 2008, it will publish most of the edits utilized in its Medically Unlikely Edit (MUE) program to improve the accuracy of claims payments.

CMS established the MUE program to reduce payment errors for Medicare Part B claims. Claims processing contractors utilize these edits to assure that providers and suppliers do not report excessive services. These edits check the number of times a service is reported by a provider or supplier for the same patient on the same date of service.

At the start of each calendar quarter, CMS will publish most MUEs active for that quarter. Although the October 1, 2008, publication will contain most MUEs, additional ones will be published on January 1, 2009. CMS is not able to publish all active MUEs because some are primarily designed to detect and deter questionable payments rather than billing errors. Publishing those MUEs would diminish their effectiveness. The MUE edits can be found by clicking this link in the Claim Filing Information section on the Claims page of the NAS DME Web site.

Same and Similar Changes

Effective November 3, 2008, the process of checking same and similar through the contact center telephone line changed. Suppliers must now provide the HCPCS they intend to bill before information on same or similar equipment will be released. This is being changed to be consistent with the functionality of the Interactive Voice Response system.

CEDI

The Common Electronic Data Interchange (CEDI) is currently processing around 12 days receipts on hand. CEDI is finishing up the paperwork from October 24th and moving on to October 27th this afternoon.

A lot of providers are experiencing B108 errors. A list serv was sent out a week ago explaining how to correct those errors, including the proper forms to fill out. When filling out the form, remember to include your NPI number, PTAN number and don't forget to sign the form.

In some cases, the original answers given during the call may have been expanded to provide further detail. These answers were current as of this event. Please check our web site for updates.

Q1. Regarding the new local coverage decisions for treatment of obstructive sleep apnea, after receiving an order with a legitimate sleep study showing the patient has severe obstructive sleep apnea, what happens if we can't get a face-to-face documentation for initiation and treatment, or for the re-evaluation due to the doctor not cooperating?

A1. Patients are not automatically sent to a sleep lab or get a home test sent to them without some type of an evaluation by a physician. Having the evaluation is part of the National Coverage Determination and is a requirement of the PAP policy. Effective November 1st, the re-evaluation is also a requirement of the policy. The medical directors wrote an article regarding the physician responsibilities. This would be helpful to share with the physicians. Also, explain to the physician what this means to their patient and that the PAP device would not be covered by Medicare. After educating the physician and the beneficiary, if the physician still doesn't comply, you can have the beneficiary sign an Advance Beneficiary Notice of Noncoverage (ABN).

Q2. I did the Online Learning Center (OLC) course for Refractive Lenses. I needed to bill for tint, V2744. On the OLC it said to bill it with the modifiers RT/LT/EY, meaning it was patient preference. I did this and received a CO176 denial, which meant the prescription wasn't

correct. I called the DME contractor and was told I had to append the GA modifier because I appended the EY modifier. Is this the case?

A2. The EY modifier means you do not have a physician order for the item. Since the tint was a patient preference item, appending the EY modifier was correct. If you do not get an ABN and inform the patient that the tint is not covered, the denial would be supplier liable. If you get an ABN and append the GA modifier on the claim, then it would be patient liable. The GA and EY modifier have separate meanings. GA means an ABN was obtained while EY means there was not an order for the item.

Follow-up question: If my claim denies CO176, I have an ABN, does this mean I cannot bill the patient because I don't have a PR denial?

A. Since you did not append the GA modifier stating you had the ABN, yes that is correct. You will have to submit an appeal to correct this and ask for the GA modifier to be added to the claim. Make sure to include your ABN. We encourage using the Inquiry/Redetermination form on our Web site when filing your appeal.

There is a separate OLC ABN course available to you as well that would be good to review.

Follow-up question: So I don't actually use the GA modifier until after it denies as a CO?

A. If you get an ABN from the patient before the services are provided, explaining the tint will not be covered, and if they agree they will be financially responsible for that, and you have met all the ABN requirements, then you would put the GA modifier on your original claim along with the RT/LT/EY.

Follow-up question: Would I do that with any product that is not covered and if patient preference? Do I even need to send those to Medicare if I already know they are not covered?

A. If they are denied as non-covered, no, technically you do not need to file the claim to Medicare unless the patient asks you to do so. Many patients need a Medicare denial in order for supplementary Medicare insurance to consider the claim for coverage.

Q3. Regarding the compliance issue for PAP equipment, what information or what modifier is going to be required to show that we have proof on file that the patient has been compliant with their follow-up?

A3. You would append the KX modifier to show the patient has been compliant with their follow-up and that this is documented in your records.

Q4. In the PAP policy, when does the Body Mass Index (BMI) and neck circumference have to be done by the physician or can the respiratory therapist do it upon setup?

A4. This is part of the face-to-face examination done by the physician.

Follow-up question: You can't do the neck circumference upon setup then?

A. No, the evaluation happens before the setup.

Q5. I have heard different deadlines for accreditation. I am already contracted with Medicare. When do I have to be accredited by?

A5. If you are an existing provider and were before 2008, you need to be accredited by September 30, 2009. If you have any questions regarding your accreditation deadline, call the National Supplier Clearinghouse (NSC) at 1-866-238-9652 for clarification.

Q6. I have been told that if we are a hospice, we do not have to be accredited even though we have our own DME company. I wanted to get this clarified because I was told by the state that we did have to be accredited if we're supplying equipment to people other than our hospice patients.

A6. If the hospice owns its own DME, no accreditation is needed. However, if products are offered to non-hospice beneficiaries, this would require accreditation.

Q7. Regarding CPAPs, in the past we had to get evaluations or a letter from the patient after three months stating they were still using the equipment. I am confused between that and the Bi-PAP. Are they different? I know one had just the patient letter and the other the doctor had to have a letter showing they were still using it.

A7. The new guidelines for the PAP say that between the 31st day and the 91st day, beneficiaries must have to have a face-to-face reevaluation by the physician. The LCD has more details.

Follow-up question: Is there a certain form that must be used or can the physician just write a letter saying he did this?

A. No specific form is required. We are looking for medical documentation from the office visit from the physician.

Follow-up question: Do I still need to have a letter in my file showing the doctor did that?

A. No, because you could get a copy of the medical record for that office visit where that was discussed and that would meet the requirements. If the physician wants to write a separate letter, that is fine, but it is not required if you have the medical documentation to support the face-to-face re-evaluation.

Follow-up question: With the new qualifications, we do not need to get anything from the patient, just from the doctor?

A. As part of the face-to-face evaluation, the physician needs to look at their compliance data. Outlined in the policy are how many hours per night they have to use it and what kind of data you can use to support that. You cannot just go off what the patient says. You have to look at the data from their machine.

Follow-up question: When was this changed? Is it the same for the Bi-PAP also?

A. This policy came out about six weeks ago. Parts of it are effective after services on November 1st while other parts were effective retroactive back to March. This is for the PAP only.

Q8. We are a small-hospital based DME supplier. Will inspections by state health departments have the provocation requirements?

A8. No, the accreditation requirements are separate from any other type of hospital or facility accreditation and are specific to providing DME items.

Q9. After the 36-month cap rental on oxygen, who maintains ownership of that equipment?

A9. The supplier will maintain ownership. This rule was changed this summer due to a change in legislation.

Q10. For the capped rental for the 13 versus the 15 months, all our patients have been opting to go for the 13-month rental. We did have one patient request the 15 months. Is this a reduced rate or will it be reimbursed at the same amount for the additional two months?

A10. Beneficiaries no longer have the option to choose 13 or 15 months. As of January 1, 2006, the rules changed. The rule changed in 2006 to state if the beneficiary does not purchase that piece of equipment up front, they will rent it for 13 months and then the equipment becomes the patient's. Previously, they had to make a decision in the 10th month whether or not they wanted to continue to rent or purchase. If they decided to rent, they would have 15 rental months. It has changed from having the option to only have a 13-month rental.

Follow-up question: Do patients have the option to purchase at the time they pick up the equipment?

A. They only have the purchase option at time of pick up for electric wheelchairs.

Q11. In regards to the face-to-face evaluation for the PAP therapy, there are several things involved in the evaluation outlined in the policy. What if the doctor sees the patient prior to the sleep test as required, documents all of it, but is missing one or two things, such as an airway exam or neck circumference? Also, can the doctor's assistant, his nurse practitioner, do any of these things?

A11. Yes, the physician assistant can do some of these services. The elements listed for the exams in the LCD are recommendations. They are not requirements, so if one or two are missing, you would still be fine.

Follow-up question: How do we know which elements are critical and have to be there?

A. The physicians should know to do a thorough enough exam so you should be able to trust their judgment. You can educate them with the document we have prepared specifically for physicians on their role. What should be in the exam is specifically outlined in this document. The document is titled Positive Airway Pressure (PAP) Devices for the Obstructive Sleep Apnea - Revised Policy - Important Information for the Ordering Physician located under the What's New section of our Web site, posted September 17th.

Q12. I have a question about the ownership on the oxygen after it capped out. You are saying it goes back to the supplier now?

A12. The beneficiary never owns the equipment. The supplier owns it the entire time the beneficiary uses it, even after it has capped out at 36 months.

Follow-up question: What are we responsible for?

A. Suppliers can get paid for contents, as well as maintenance and servicing every 6 months after the 36 month cap. With the maintenance and servicing, the supplier is responsible for going into the beneficiary's home and inspecting the equipment. Recently, CMS provided changes in Medicare payments for Oxygen and Oxygen Equipment, which we posted to our Web site, on October 31, 2008. Please read this for further clarification.

Follow-up question: Whenever the patient is done with the equipment, we get it back? Like if the patient dies or they do not need it any longer?

A. Yes, that is correct, the equipment can be picked-up when the medical necessity ends.

Follow-up question: How often can you bill maintenance and servicing?

A. Every six months.

Q13. For the PAP, if we find on a follow-up that a patient is non-compliant, does payment stop at that time or do we have a grace period to reeducate and get them back on track?

A13. If they become compliant several months down the road, you can start billing again. In those months when they did not meet compliance, you would want to get an ABN and those months would be non-covered and patient liable. If you do not get an ABN, those months would be supplier liable.

Q14. Regarding the oxygen capping out, we noticed about half of our patients have had their concentrator for five years or more. Does this mean we are able to start them off on a new capped rental with a new oxygen concentrator in January?

A14. Yes. If they have had that equipment for five years, they can be eligible for a new piece of equipment and would start a new capped rental period of 36 months. However, the beneficiary does not receive a new piece of equipment automatically. There would need to be a reason documented for the replacement.

Follow-up question: As far as documenting the need for a new piece of equipment, do we have to put something in the narrative? Are we going to be given instructions on this?

A. We are waiting for those details from CMS. They have not been clear on what documentation would be needed to replace the equipment.

Q15. We are a new DME company and started in December of last year or January of this year. We have not done any billing yet because we were told we have to be accredited before we are allowed to bill. Is this correct? I think we have an NSC and National Provider Identifier (NPI) number.

A15. First of all, you want to check to see if you do have an NSC number. If you do not, that means you needed to become accredited prior to receiving your number and you would not be able to bill yet. If you do have an NSC number, that means you will be able to bill. If you have any questions regarding your NSC number, call the NSC at 866-238-9652. Also, make sure your NSC and NPI numbers crosswalk on the National Plan and Provider Enumeration System (NPPES).

Follow-up question: What do you mean by crosswalk?

A. You have to link the two numbers, your NSC supplier number or PTAN and the NPI, in the NPPES system, which

is the NPI system. If you are unsure if they are crosswalking, call our Supplier Contact Center at 866-243-7272 and they will be able to assist you. If they do crosswalk, you should be able to start billing.

Q16. I know that aphakia and after-cataract are covered diagnoses for lenses but I had a patient the other day say Medicare has paid for her glasses in the past because she is diabetic. I did not read any verbiage that said Medicare would cover diabetic diagnoses. Is there any truth to this statement?

A16. No, we do not pay for glasses for someone with diabetes per the LCD. The beneficiary could have a Medicare Advantage plan that covers more than Medicare does and the beneficiary may be confusing the two. You could direct her to 1-800-MEDICARE to investigate what kind of options she has also.

Q17. Concerning PAP for OSA, who is responsible for acquiring the downloaded data from the devices to determine adherence?

A17. The beneficiary, supplier or physician can download this information. It is not specified in the LCD who can download the information, but the physician needs to look at the data as part of the face-to-face re-evaluation.

Follow-up question: The first LCD was changed slightly to allow for visual inspection of the usage data but it seems that is inconsistent with acquiring the requirement of four hours a night 70% of the time for 30 consecutive nights. I was thinking we could document the hours when the patient starts and call them 30 or more days after and have them read off the hours, however this would not reflect the day-by-day usage, so how can you use the visual inspection?

A. Visual inspection means you can take the values from the machine and write them down, however the data needs to be the correct type of data. Just documenting pure hours is not a reflection it was used four or more hours per night 70% of the time in a consecutive 30-day period. Clarification from the medical directors on this issue should be coming out within the next few weeks.

Follow-up question: In other words, as it stands today, somebody would have to document the hours every single night?

A. Yes, a log would have to be kept of usage of the CPAP, not just how many hours the machine is on.

Q18. Regarding the PAP policy, what if the patient is ill and cannot wear their CPAP for two to three weeks? Many times they are admitted to the hospital and are told to withhold using their CPAP machine due to pneumonia or bronchitis. Is there any way those patients can be granted some kind of extension on the time frame of 90 days?

A18. No. Data has to be documented for 30 consecutive days, so if they were to wear it four hours per night, 70% or the nights in a consecutive 30-day period, that would meet the criteria. In addition, the DME supplier would suspend billing for the PAP when the patient is in the hospital and would restart billing when the patient is home.

Q19. This has to do with coverage of a PAP for a patient who has central sleep apnea. Before it was covered and now it appears to be no longer covered. This is rare but it does and can happen. What should we do?

A19. The original policy also said the CPAP was for the treatment of obstructive sleep apnea. That part has not changed. The only change made was the added specific ICD-9 diagnosis coding. You can request an LCD reconsideration if you feel strongly from a medical perspective and you have documentation to back up the fact that CPAP does help for a patient with central sleep apnea. Send this in writing to our medical director. More information regarding the LCD Reconsideration Process can be found under the Coverage/MR section of our Web site.

Q20. My question is in regards to the High Frequency Chest Wall Oscillation Devices LCD and the Mechanical In-exsufflation Devices LCD. The High Frequency Chest Wall Oscillation states it will only be covered if the patient does not already have the mechanical in-exsufflation device. However, when you look at the Mechanical In-exsufflation LCD, it does not say anything like that. So it is very possible for a company to provide a mechanical in-exsufflator not knowing the patient already has the other device. What do we do?

A20. NAS is researching this further and will provide an answer in these minutes upon completion of this research.

Follow-up question: Can you also request they add coverage of the accessories after the patient owns the equipment, which is a capped rental item? The accessories do not have a HCPCS code for them.

A. NAS has contracted the supplier for the specific information on the accessories and will be researching how these codes may be billed. We will provide the answer in the minutes upon completion of this research.

Q21. We have an oxygen patient who is at 90% and does not qualify for oxygen. We received an ABN and the patient wants us to bill Medicare. We keep getting a front-end edit saying the oxygen saturation is not available. CEDI does not know how to resolve the problem so we are at a loss.

A21. This is a known limitation with the format used for electronic claim submission. The supplier can submit a paper claim for this situation, as per the Administrative Simplification Compliance Act guidelines, which state the following exception for submission of electronic claims:

- Providers of home oxygen therapy claims for which the CR5 segment is required in the X12 837 version 4010A1 claim but for which the requirement notes in either CR513, CR514 and/or CR515 do not apply, e.g., oxygen saturation is not greater than 88%, arterial PO2 is more than 60 mmHg;

CEDI should be aware of this situation.

Follow-up question: CEDI asked me if this was a case where question number one triggers the need for the last three questions. I was told to fill out the last three questions but the patient does not have a need for this and I do not feel comfortable doing so.

A. You should not have to fill those out. This is a known paper claims exception and has been for a number of years.

In the actual ANSI format, if question number one specifies greater than 88% and a PO2 rate in the 50's, it says the last three questions have to be answered even if you know better. The claim format is causing the problem. Please refer to MLN Matters 4119 for further information.

Q22. How often can you bill for battery replacements for scooter and power wheelchairs?

A22. There is not set criteria for battery replacements. It is based on when they are needed, based on life of the battery, the circumstances under which the batteries are used, etc.

Follow-up question: As long as the equipment is not under warranty and the beneficiary is still in need of the chair, we can bill for that?

A. Yes.

Q23. As far as repairs go, as long as it costs less to do the repair than to get a new one, it is covered, right? Given the fact the need is still there for the piece of equipment.

A23. Yes.

Q24. Regarding billing eyeglasses following cataract surgery, whenever I am billing for patient preference items that are going to have an EY and GA modifier, scratch coat or tint, these have to be on separate claims from the covered items?

A24. Yes. Non-EY items must be submitted on a separate claim from the items for which an order was obtained. The reason why is because on physician ordered items, you have an NPI for that ordering physician. When you have patient preference items, there is no order so you use your DME supplier NPI. You cannot have two NPIs on the same claim. Thus, the reason you have to split your claim.

Follow-up question: On my patient preference items, the NPI is going to be my optical dispensary's NPI?

A. Yes.

Q25. In regards to coverage beyond the initial 91 days for PAP therapy, are we required to contact these patients on a monthly basis to confirm usage until it caps?

A25. Yes, because the rule is if the patient is not using it, you should not be billing it.

Q26. Concerning the 36-month oxygen cap, if a beneficiary has been on oxygen for over five years after the capped rental goes into effect (January 2009); we are able to restart a 36-month capped rental if the beneficiary still has a need for the oxygen and the concentrator broke?

A26. Yes, the beneficiary could start a new 36-month capped rental period in this case.

Follow-up question: Do I need a new CMN or retesting?

A. We are waiting to hear clarification from CMS on this issue.

Q27. For the 36-month capped rental for oxygen, if our beneficiary moves to another state, we are responsible for finding a provider for them. What if this is not possible because we have called numerous providers and cannot find one that will take on the beneficiary? What legal consequences would there be?

A27. This will be a requirement, however, we have not received specifics from CMS regarding the legal ramifications.

Q28. Regarding the family doctor, who does the evaluation, orders the sleep tests and then prescribes the CPAP. After that, he refers the patient to see a sleep specialist in the office to let them do the reevaluation and all the follow up. Is it acceptable for the re-evaluation to be done by a different doctor if they are directly referred?

A28. Yes. The treating physician or specialist can do the re-evaluation.

Q29. If it is just a replacement of a CPAP the patient has been using for five years or longer and it has reached its useful life, we do not have to go through the face-to-face, etc, do we?

A29. The answer depends on if Medicare paid for the CPAP or if another insurance did. If it was paid for by Medicare and you need to replace it, the only thing you need is a new order and proof that the patient is still using the device and it was covered at the time the initial CPAP was dispensed. As far as if another insurance paid for the CPAP, we are waiting for further clarification from CMS.

Q30. If I have a patient with a broken CPAP and they have had it for seven years, can they get a new machine? Do we need proof that we can't fix it?

A30. Yes, if the CPAP is broken, a new capped rental begins. The beneficiary does not automatically receive a new piece of equipment because it is five years old or more. They can have a new piece of equipment only if there is need for it.

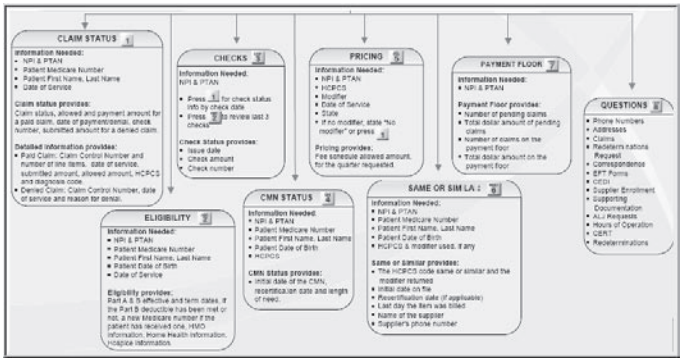
Follow-up question: So after five years, you do not have to show it can be fixed cheaper than getting a new one?

A. Correct.

Top Ten Telephone Inquiries and Solutions

The purpose of this article is to assist suppliers with solutions to the "Top Ten" telephone inquiries that our Supplier Contact Center received from July – September 2008.

Reminder: Suppliers are mandated by CMS to utilize the IVR for most inquiries. Below lists the functions of the IVR:



- IVR Phone Number: 1-877-320-0390
- IVR Hours: 6 a.m. – 6 p.m. Monday-Friday CT
- IVR-At-A-Glance

1. DME Same or Similar Equipment

Since the implementation of the IVR enhancements for same or similar equipment in June, calls to the Contact Center continue to decrease for this inquiry. The average number of inquires in April was 2,000 inquires per day, with the current average of 400 calls per day. The same or similar functionality was added to the IVR to address the higher call volume.

To access same or similar information from the IVR Main Menu, use the voice activation option by saying "same or similar" or press 6 on the phone keypad. The IVR will determine the HCPCS on file that is considered same/similar, initial date of the equipment on file, recertification date, last day equipment was billed, and the name and phone number of the supplier who billed the paid equipment. **The IVR will also provide information on** CMNs that are posted to the Common Working File. To access CMNs on file, say "CMN" or press 4 on the phone keypad.

Suppliers should also have a very thorough intake assessment to assist with determining whether a beneficiary currently has or previously had an identical or similar piece of equipment. A Suggested Intake Form can be accessed on our Web Site under Forms.

2. Entitlement

CMS mandates suppliers check beneficiary eligibility through the IVR. The IVR provides beneficiary eligibility information including when the beneficiary became eligible for Medicare, Part A and B effective and termination dates, a new Medicare number if applicable, HMO information, MSP information, and home health and hospice information based on the date of service entered.

3. Frequency/Dollar Amount Limitation

Utilization guidelines can be found in the Indications and Limitations of Coverage and/or Medical Necessity section **of most medical policies. Q**uantities of supplies greater than the allowable amount must have documentation supporting the medical necessity, as outlined in the Documentation section of the policy. There must be clear documentation in the patient's medical record that corroborates the order and any additional documentation that pertains to the medical necessity of the items and quantities billed. This supporting information should be reported in Item 19 on the CMS-1500 or the narrative field of an electronic claim.

LCDs and Policy Articles can be located on our Web site under Coverage or on the CMS Web site under the Medicare Coverage Database.

4. Duplicate Remittance Advice (RA)

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

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

- Print and export reports about ERAs including denied, adjusted and deductible applied claims.
- Print ERAs in the Standard Paper Remittance (SPR) format.
- For additional information on downloading MREP, contact the CEDI Help Desk. The CEDI Help Desk will provide support for electronic transactions exchanged with CEDI including claims, reports, ERAs and 276/277 transactions.
- E-mail: NGS.CEDIHelpdesk@wellpoint.com
- Phone: 866-311-9184
- CEDI Web site: www.ngscedi.com
- Many electronic claim billing software programs will have a feature that allows for an electronic remittance advice to be received electronically to print and/or post the payment information to each beneficiary's account. Contact your software vendor for the availability of these features.

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

5. CWF Rejects

During the intake process, suppliers should ask beneficiaries very specific questions:

- Does the beneficiary live in a skilled nursing facility?
- Has the beneficiary recently been hospitalized? If so, ask for admission and discharge dates. Refer to Chapter 5 of the Supplier Manual for specifics on consolidated billing.
- Does the beneficiary have home health services? Ask if anyone is coming into the home to aid the beneficiary. A list of items included in a covered home health episode can be found at www.cms.hhs.gov/HomeHealthPPS/03_coding_billing.asp#TopOfPage. These items cannot be billed to the DME MAC during a Part A covered home health episode.
- Verify the beneficiary is not covered under a Medicare Advantage (HMO) Plan. Verify the beneficiary's Medicare name and HICN on the Medicare card. Make a copy of their Medicare card for reference. Always submit claims with the beneficiary's name exactly as it is listed on their Medicare card, i.e., include the middle name or initial of the middle name, Jr or Sr, if listed on the Medicare card.

6. Payment Explanation/Calculation

Most DMEPOS are paid based on a fee schedule established by CMS for each state or territory. The beneficiary's permanent address will determine the amount allowed by Medicare for a particular service. Drugs, however, have the same allowance regardless of where the beneficiary resides. Medicare pays 80% of the allowed amount for DMEPOS and drugs and biologicals. Access the NAS DME Web site for:

- Fee schedules located under Fees.
- Remittance advice codes located under Claims.

7. Claim Not on File

Claims that are incomplete or have invalid information will not be processed or the supplier may receive an education status letter which outlines the errors on the claims. These claims are considered unprocessable. Claims must be corrected and submitted as new claims. If the IVR states no claim is on file, verify the claim form was completed appropriately by checking the following items:

- Item 1A – Verify the HICN is correct. Most HICNs have nine digits and either leading or ending alpha character(s).
- Item 11 – Completed with the word "NONE" if Medicare is primary. If Medicare is secondary, enter the policy or group number.
- Items 17 and 17b – Name of the referring or ordering physician and physician's NPI.
- Item 21 – Diagnosis is coded to the highest specificity.
- Item 33a – NPI of supplier.
- References:
- Refer to the CMS 1500 claim form tutorial located on our Web site under Claims.
- If billing electronically, verify the claim was transmitted and not rejected during front-end processing as listed on an error report.

8. Medical Necessity

There has been an increase in claims denying for medical necessity. Suppliers are reminded that if the KX modifier is referenced in an LCD, and the item being billed meets the coverage criteria, the KX must be appended to the HCPCS code or the item may be denied as not reasonable and necessary. If the beneficiary does not meet coverage criteria, the supplier should have the beneficiary sign an Advance Beneficiary Notice of Noncoverage (ABN) explaining why Medicare will likely deny the item and append the GA modifier to all HCPCS at issue.

The LCDs are housed in the Medicare Coverage Database which can be accessed in the Coverage/MR section on our DME Web site.

9. Certification Requirements

Suppliers should be knowledgeable in the medical policies for items that require a CMN or DIF. Refer to the Web site for:

- Local Coverage Determinations, Documentation Checklists and Policy Decision Trees located under Coverage.
- CMN and DIF Forms located under Forms.
- Chapter 4 of the Supplier Manual which provides additional information regarding CMN and DIF requirements.

Reminders:

- If a claim denies due to a CMN missing, verify through the IVR, under the CMN option, if there is a CMN on file for the billed item.
- If there was a break in service in the item being billed, enter the reason for the break with "**BIS" in Item 19 on the CMS-1500 claim form or the NTE segment, 2400 loop for electronic claims.** A comment of BIS allows claims processing staff to ensure that a new rental period begins and to enter the "new" initial CMN. This will prevent claim denials and the need for requesting a redetermination on denied claims.

10. Eligibility

It is the supplier's responsibility to determine whether the patient is entitled to receive Medicare benefits and to report the Medicare number as shown on the patient's Medicare Health Insurance card. The claim must be submitted with the patient's name exactly as it is shown on the Medicare card. Utilize the IVR to verify Part B entitlement, possible HMO coverage or possible date of death information.

Stay up-to-date with Medicare changes!

- Log onto www.noridianmedicare.com to keep abreast of Medicare changes.
- The latest news regarding policy changes, claim filing issues and other important information is found in the "What's New" section of our Web site.

Subscribe to the NAS DME E-Mail List to receive emails with the latest news and information.

ICD-10-CM/PCS Fact Sheet

The *ICD-10-Clinical Modification/Procedure Coding System Fact Sheet*, which provides general information about the International Classification of Diseases, 10th Edition, Clinical Modification/Procedure Coding System (ICD-10-CM/PCS) including benefits of adopting the new coding system, structural differences between ICD-9CM and ICD-10-CM/PCS, and implementation planning recommendations, is now available in print format from the Centers for Medicare & Medicaid Services **Medicare Learning Network**.

To place your order, visit http://www.cms.hhs.gov/MLNProducts/01_Overview.asp, scroll down to "Related Links Inside CMS" and select "MLN Product Ordering Page."

Transcript Now Available-ICD-10-CM/PCS National Provider Conference Call for Other Part A and Part B Providers

The transcript of the Centers for Medicare & Medicaid Services ICD-10-CM/PCS National Provider Conference Call for Other Part A and Part B Providers that was held on November 12, 2008 is now available at http://www.cms.hhs.gov/ContractorLearningResources/Downloads/November12calltranscript.pdf.

Medicare Physician Guide: A Resource for Residents, Practicing Physicians, and Other Health Care Professionals

The revised *Medicare Physician Guide: A Resource for Residents, Practicing Physicians, and Other Health Care Professionals* (October 2008), which offers general information about the Medicare Program, becoming a Medicare provider or supplier, Medicare reimbursement, Medicare payment policies, evaluation and management services, protecting the Medicare Trust Fund, inquiries, overpayments, and appeals, is now available in print format from the Centers for Medicare & Medicaid Services **Medicare Learning Network**. To place your order, visit http://www.cms.hhs.gov/MLNProducts/01_Overview.asp, scroll down to "Related Links Inside CMS" and select "MLN Product Ordering Page."

CEDI

Updated CEDI FAQ Document Now Available

National Government Services, Common Electronic Data Interchange (CEDI) has updated the Frequently Asked Questions (FAQ) document on the CEDI Web site. All changes made to the FAQ for the November 7 update are highlighted for easy reference.

The FAQ document is located in the "Resource Materials" section and can be accessed using the following link www.ngscedi.com/outreach_materials/outreachindex.htm.

CEDI Enrollment Status and How to Avoid the Most Common Errors Seen on CEDI Enrollment Requests

As of November 6, 2008, National Government Services CEDI is processing enrollment paperwork received on October 21, 2008. Most requests are being processed within eleven (11) days of receipt. CEDI is making every effort to reach our goal to be current in processing enrollment requests under ten (10) days of receipt of the request.

To prevent a delay in the processing of CEDI enrollment requests, electronic trading partners should review the information below on the most common errors seen by CEDI.

The most common errors include:

1. **Signature missing on the Enrollment Request:** After completing any of the on-line CEDI forms, you must click on the "Submit" button, print, sign and fax the form to the number located on the printed form. Do not print the screen before you click on "Submit". IMPORTANT: Forms that are not printed after clicking on "Submit" and/or are not signed and faxed will not be processed.
2. **Invalid PTAN and/or NPI Number:** Be sure to submit the enrollment forms with a valid PTAN and/or NPI Number. A Provider Transaction Access Number (PTAN) is the legacy number suppliers receive from the National Supplier Clearinghouse. Both the PTAN and NPI must be valid and included on all CEDI requests; otherwise the enrollment request will be rejected.
3. **NPI number submitted on the request is not on the NPPES Crosswalk:** The NPI number submitted on the enrollment request must match what is in the National Plan and Provider Enumeration System (NPPES). To view or update information within NPPES, go to https://nppes.cms.hhs.gov/NPPES/Welcome.do
4. **Billing Service or Clearinghouse submits only one Supplier Authorization Form for all of their customers:** All Clearinghouses, Billing Services or Third Party Services must complete a Supplier Authorization form for each of their customers. The authorization form must be signed by the supplier.
5. **Trading Partners not completing the appropriate form:** The following provides a list of the CEDI Enrollment Forms and a description of when to complete each form.

Form	Complete for:
CMS EDI Enrollment Form	Every new DME MAC Electronic Trading Partner (Must also complete the Submitter Action Request Form) Trading Partners to add a new PTAN/NSC or NPI number to an existing Submitter ID
Supplier Submitter Action Request Form	Every new DME MAC Electronic Trading Partner (Must also complete the CMS EDI Enrollment Form) Ordering the Express Plus Software Program (Check box included on the form, under Section II - SOFTWARE VENDOR) Existing Trading Partners to: · Request the addition of a new transaction · Changing a file transfer option · Changing software vendors · Update contact information
Supplier Authorization Form	Suppliers using a Clearinghouse, Billing Service or other Third Party to exchange any transactions with CEDI (This includes claims, ERAs and 276/277 transactions.) Existing Trading Partners changing to a Clearinghouse, Billing Service or Third Party Biller

CEDI enrollment forms that are not completed correctly will be rejected and returned to the trading partner, which causes a delay in processing. A letter will accompany the rejected requests, along with a reason for the rejection. If you are experiencing a B108 front end error message and must resubmit your paperwork, please write "B108" on your fax coversheet.

If you have any questions, please contact the CEDI Enrollment team via e-mail at ngs.cedienrollment@wellpoint.com.

CEDI News: Approved Vendor List and FAQs Have Been Updated

National Government Services, Common Electronic Data Interchange (CEDI), updated the Approved Vendor List and the Frequently Asked Questions (FAQ) document on the CEDI Web site.

The Approved Vendor List provides contact information for all software vendors, billing services, clearinghouses and network service vendors that have completed testing with CEDI. The updated list is available on the Resource Materials page and can be accessed using the following link http://www.ngscedi.com/outreach_materials/outreachindex.htm.

The FAQ document contains answers to questions received most often by CEDI. All changes made to the FAQ for the December 12 update are highlighted for easy reference.

The FAQ document is located in the "Resource Materials" section and can be accessed using the following link http://www.ngscedi.com/outreach_materials/outreachindex.htm.

How to Resolve the 20011, 20004, and B108 Front-End Rejections

Common Electronic Data Interchange (CEDI) Electronic Trading Partners receiving the 20011, 20004 or B108 rejections, should review the information below to determine how to resolve these edits.

20011 Rejection:
These rejections are returned on the Level II reports created by the DME MACs and delivered by CEDI.

To correct the front-end rejection error code of 20011, suppliers can either:

- Submit the online EDI Enrollment Form to CEDI at www.ngscedi.com. CEDI will then setup the supplier with the ability to send electronic transactions in all four DME MACs

OR

- Submit an e-mail to CEDI Enrollment using the following instructions:
  - Send an e-mail to: cedienrollment@wellpoint.com
  - Subject line should read: Edit 20011 Resolution
  - Provide the following within the e-mail:
    - Submitter (Trading Partner) ID
    - Submitter (Trading Partner) Name, Address, City, State, ZIP
    - NSC/PTAN AND NPI numbers that received this error
    - Contact Name
    - Contact Phone Number

All CEDI enrollment forms can be found under the EDI Enrollment section of the CEDI Web site (www.ngscedi.com).

Note: Requests submitted online with CEDI or through e-mail requests are processed in the same timeframe. Do not submit both the online form and an e-mail request. This could delay the processing time of your setup.

20004 Rejection:
These rejections are returned on the Level II reports created by the DME MACs and delivered by CEDI.

To correct the front-end rejection error code of 20004, suppliers can either:

Submit the online Submitter Action Request Form to CEDI at www.ngscedi.com. CEDI will setup the Trading Partner/Submitter ID with the ability to send and receive electronic transactions to all four DME MACs.

OR

- Submit an e-mail to CEDI Enrollment using the following instructions:
  - Send an e-mail to: cedienrollment@wellpoint.com
  - Subject line should read: Edit 20004 Resolution
  - Provide the following within the e-mail:
    - Submitter (Trading Partner) ID
    - Submitter (Trading Partner) Name, Address, City, State, ZIP
    - Contact Name
    - Contact Phone Number

All CEDI enrollment forms can be found under the EDI Enrollment section of the CEDI Web site www.ngscedi.com.

Note: Requests submitted online with CEDI or through e-mail requests are processed in the same timeframe. Do not submit both the online form and an e-mail request. This could delay the processing time of your setup.

B108 Rejection:
These rejections are returned on the GenResponse (GENRPT) reports created and delivered by CEDI.

The CEDI provided a B108 warning message on the CEDI GenResponse (GENRPT) Report when the NPI was not linked to the Trading Partner (Submitter) ID. Prior to October 1, 2008, this was a warning message and the submitted claims did not reject. Accepted claims with the B108 warning message were being forwarded to the appropriate DME MAC.

The CEDI edit B108 changed from a warning to a rejection on October 1, 2008. Claims that do not have an NPI matched to the Trading Partner (Submitter) ID are now being rejected by CEDI and **not** forwarded to the DME MACs.

If the B108 error is received, the supplier must complete and sign the appropriate form on the CEDI Web site www.ngscedi.com and return to CEDI for processing.

- Suppliers using a third party (e.g., a clearinghouse or billing service) must complete the *Supplier Authorization Form*. **Note:** The *Supplier Authorization Form* cannot be signed by a third party. This form MUST be signed by the supplier.
- Suppliers who submit their own claims and do not use a third party biller must complete the CMS *EDI Enrollment Agreement*.

The CEDI Enrollment Team is processing all enrollment requests in the order they are received and will respond once your setup is complete.

CEDI News: Electronic Front-End Reports and Top Rejections Document

National Government Services has important CEDI News to share. Please view the CEDI News item listed on their Web site at www.ngscedi.com and select 'News' from the bulleted list of links.

The new article is entitled:

CEDI Electronic Front-End Reports and Top Rejections for September 2008

Update on CEDI Front-End Editing Process

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

All new edits have been added to the *CEDI Front-End Reports Manual*. This manual is available on the CEDI Web site at http://www.ngscedi.com/outreach_materials/outreachindex.htm.

Please note the following edits are currently in place at CEDI on the GenResponse (GENRPT) report:

NGS0005	C065	C125
NGS0006	C072	C131
NGS0008	C077	C137
B108	C086	C141
C007	C087	C143
C015	C088	C147
C055	C089	C157
C060	C090	

The changes to the front-end editing process will occur in two stages.

Stage 1 - Implementation will begin on Friday, January 9, 2009

- On Friday, January 9, 2009, at 3 p.m. ET, the CEDI Gateway will be brought down until Sunday, January 11, 2009, at 6 p.m. ET to implement the additional CEDI edits.
  ** **During this time, Trading Partners will not be able to connect to CEDI to transmit or receive electronic transactions and/or reports.**
- The additional front-end edits for 837 claims will be added to the current CEDI GenResponse (GENRPT) report.
- 837 claims shown as accepted on the GenResponse Report will be delivered to the DME MACs.
- Claims delivered to the DME MACs will continue to edit against the DME MAC Level II edits as they do currently.
- Claims accepted on the DME MAC Level II reports will be assigned a Claim Control Number (CCN) that will be attached to the claim as it enters the DME MAC for processing.
- CEDI will deliver the DME MAC Level II reports to the Trading Partner.
- Claims rejected on the DME MAC Level II report must be corrected and resubmitted to CEDI.
- 837 claims rejected on the GenResponse Report will not be delivered to the DME MACs. These claims must be corrected and resubmitted to CEDI.
- Most, if not all, claims that reject will be returned on the GenResponse Report. It will be extremely important for Trading Partners to monitor the GenResponse Report for rejected claims in order to correct and resubmit the claims to CEDI.
- The additional CEDI front end edits will be implemented for the 276 claim status request transactions.
- 276 transactions that reject at CEDI will be reported back on a 277 claim status response.
- 276 transactions accepted by CEDI will be delivered to the DME MACs.
- 276 transactions delivered to the DME MACs will continue to edit against the DME MAC Level II edits as they do currently.
- 276 transactions accepted on the DME MAC Level II reports will be sent to the DME MAC for processing to produce the 277 to report the claim status back to the Trading Partner.

Stage 2 - Implementation will occur on January 30, 2009

- On Friday, January 30, 2009, at 3 p.m. ET, the CEDI Gateway will be brought down until Sunday, February 1, 2009, at 6 p.m. ET for the DME MACs to remove their front end edits for 837 claims and 276 claims status transactions.
  ** **During this time, Trading Partners will not be able to connect to CEDI to transmit or receive electronic transactions and/or reports.**
- The DME MACs will remove their front end edits and all electronic front-end editing for the X12 837 claims and 276 claim status transactions will be done through CEDI

CEDI CONT'D

- 837 claim front-end rejections will be returned on the CEDI GenResponse (GENRPT) report.
- 276 claims status request front-end rejections will be returned on the 277 claims status response transaction.
- The additional GenResponse edits that were implemented in Stage 1 will replace the DME MAC Level II edits and Trading Partners will no longer receive Level II reports from the DME MACs.
- Claims accepted on the GenResponse Report will be assigned a Claim Control Number (CCN) and these will be indicated on a report that will go back to the Trading Partner from CEDI. This CCN will be attached to the claim as it enters the appropriate DME MAC for processing.
- All electronic front-end editing for the X12 276 claim status request transaction will be done through CEDI and all front-end rejections will be returned on the 277 transaction.

Note: The CCN assignment changes scheduled for Stage 2 may occur at a later stage. If this occurs, notification will be sent via the CEDI Listserv.

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

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

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

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

CEDI Help Desk Telephone Line Modifications Effective Monday, January 5, 2009

The following changes are being made to better sere the Common Electronic Data Interchange (CEDI) customers. Effective Monday, January 5, 2009, the CEDI Helpdesk will modify the hours of operations. The CEDI Help Desk will be open from 9 a.m. to 7 p.m. ET Monday through Friday.

Additionally, CEDI has determined there is not a need to have a separate option for password resets due to the Average Speed of Answer (ASA) stabilizing at acceptable standards and the volume of password reset calls.

Below are the options callers will hear when they contact the CEDI Help Desk by telephone at 866-311-9184.

Press 1 to hear the hours of operation and e-mail address:

To report issues via e-mail, submit issue to ngs.cedihelpdesk@wellpoint.com.

Hours of Operation are Monday through Friday, 9 a.m. to 7 p.m. ET.

Press 2 to speak to a DME CEDI Help Desk Technician:

Please be prepared to provide your NPI or PTAN number as well as your Trading Partner ID (Sender ID). Your Trading Partner ID begins with an A08, B08, C08 or D08.

CEDI Listserv

To stay informed of all CEDI updates, visit the CEDI Web site at http://www.ngscedi.com and sign up for the CEDI Listserv by selecting the Listserv Registration Link. You will then be prompted to submit your email address and name to subscribe. This listserv is for all entities participating with CEDI whether you are a third-party billing agency or a supplier performing your own EDI transmissions.

CEDI – Duplicate Claim Files

CEDI has discovered duplicate claim files were delivered to the DME MACs on January, 2, 2009. These were claims received after the last files were created for delivery on December 31, 2008, through the holiday on January 1, 2009, and Friday January 2, 2009. This caused a high number of duplicate file rejection on the DME MAC Front End Error Reports with edit 20268 to be returned to our CEDI Trading Partners.

The second file created by CEDI will receive the front end rejection, 20268, for a duplicate file. Please review any errors on the first instance of the file on the DME MAC Front End Error Report for any rejections to be corrected and resubmitted.

CEDI apologizes for any inconvenience this has caused.

ACCREDITATION

CMS Announces Accreditation Clarification

CMS recently released a Technical Direction Letter (TDL) providing clarification to the accreditation requirements for suppliers of Durable Medical Equipment, Prosthetics, Orthotics and Supplies. Suppliers enrolled with the National Supplier Clearinghouse (NSC) prior to March 1, 2008, must submit accreditation documentation to the NSC no later than October 1, 2009. Also detailed in the TDL are additional supplier types that require accreditation. Pedorthists, mastectomy fitters, orthopedic fitters/technicians and athletic trainers shall require accreditation to obtain/maintain Medicare billing privileges. Those suppliers exempt from accreditation are:

Suppliers providing drugs and pharmaceuticals ***ONLY***

Physicians (including Dentists)

- Audiologists
- Optometrists

- Orthotists
- Prosthetists (including Occularists)
- Opticians
- Occupational Therapists
- Physical Therapists

Exempt suppliers are reminded that accreditation exemptions only extend to the normal scope of services for the supplier specialty. Any products or services provided outside the normal range of services will require accreditation to obtain/maintain Medicare billing privileges. Suppliers submitting applications March 1, 2008, and forward must be accredited prior to enrolling with the NSC if not exempt from the accreditation requirement. If an enrolled DMEPOS supplier does not submit a complete accreditation application to the accrediting organizations by January 31, 2009, CMS cannot ensure that the accrediting organizations will be able to accredit them by the October 1, 2009, deadline.

Written Clarification on Medicare for Patients and Providers Act of 2008

Medicare for Patients and Providers Act of 2008 (MIPPA) section 154(b) added a new subparagraph (F) to section 1834(a)(20) of the Social Security Act. This subparagraph states that eligible professionals and other persons are exempt from meeting the ***September 30, 2009***, accreditation deadline that generally applies to other DMEPOS suppliers unless CMS determines that the quality standards are specifically designed to apply to such professionals and persons.

The eligible professionals to whom this exemption applies are set out at sections 1848(k)(3)(B) and 1861(r) of the Act, and include Physicians, Physical Therapists, Occupational Therapists, Qualified Speech-Language Pathologists, Physician Assistants, and Nurse Practitioners.

Additionally, section 154(b) of MIPPA allows the Secretary to specify "other persons" that, like the eligible professionals described above, are exempt from meeting the accreditation requirements unless CMS determines that the quality standards are specifically designed to apply to such other persons. At this time, we are defining "such other persons" as Orthotists, Prosthetists, Opticians, and Audiologists.

CMS will define how the quality standards apply to these eligible professionals and other persons by rulemaking in 2009.

Individuals *not included* in this exemption list, *such as* pedorthotists, mastectomy fitters, orthopaedic fitters/technicians or athletic trainers applying for Medicare enrollment in order to bill for Medicare part B services are not exempt from meeting the September 30, 2009 deadline for DMEPOS accreditation.

Accreditation Guidelines for Pharmacy

The National Supplier Clearinghouse has provided the following information on accreditation.

CMS has deemed that suppliers providing drugs and pharmaceuticals only are not required to be accredited to obtain/maintain Medicare billing privileges. If suppliers bill for DMEPOS outside of pharmaceuticals, including products to administer drugs or pharmaceuticals, accreditation will be required to maintain Medicare billing privileges. Pharmacy suppliers must update their file with the National Supplier Clearinghouse (NSC) by choosing Pharmacy as the supplier type in section 2B and selecting Drugs/Pharmaceuticals only in section 2C of the CMS-855S enrollment form. All other products/services must be removed to assume the accreditation exemption. Suppliers found to be in violation of this rule by billing for other products or services will be subject to appropriate actions up to and including revocation.

CERT

September 2008 CERT Newsletter

The following summary of articles provides information for DME suppliers regarding Comprehensive Error Rate Testing (CERT). To view the complete newsletter, see the CERT Provider Web site at http://www.certcdc.com/certproviderportal/newsletters.aspx.

Save Money and Time by Submitting Medical Records Electronically on CDs

Until recently, approximately 70- 80% of the medical records received by the CERT Documentation Contractor, or CDC, from the provider community were received by fax. We would like to encourage the providers, to submit the requested records electronically on a CD. Beginning November 1, 2008, CDC can receive images in both .tif and .pdf format. By submitting records electronically, providers can save money in copying and postage and reduce the turnaround time of receipt.

Reminder – CERT does not Reimburse Providers for Copying Costs

The CDC and CERT Rreview Contractor (CRC) continue to receive invoices from providers and copying services for the cost of medical record duplication. Please be reminded that the CERT does not reimburse providers/suppliers or copying services for the cost of medical record copying or mailing.

Reminder for DME Suppliers: CERT Review Contractor Requests for Additional Documentation

The CERT Documentation Contractor handles requests for additional documentation from the CERT Review Contractor. CMS Publication 100-8, Chapter 5, with effective/implementation dates of 3/01/08, outlines documentation requirements for DMEPOS items.

Specifically, under Chapter 5, sections 5.7, 5.8, and 5.9, for any DMEPOS item to be covered by Medicare, the patient's medical record must contain sufficient documentation of the patient's medical condition to substantiate the necessity for the type and quantity of items ordered and for the frequency

of use or replacement (if applicable). Under section 5.7, it further states that, "However, neither a physician's order nor a CMN nor a DIF nor a supplier prepared statement nor a physician attestation by itself provides sufficient documentation of medical necessity, even though it is signed by the treating physician or supplier. There must be information in the patient's medical record that supports the medical necessity for the item and substantiates the answers on the CMN (if applicable) or DIF (if applicable) or information on a supplier prepared statement or physician attestation (if applicable)."

Under this same section, it further stipulates, "The documentation in the patient's medical record does not have to be routinely sent to the supplier or to the DME MACs, DME PSCs, or ZPICs. However, the DME MACs, DME PSCs, or ZPICs may request this information in selected cases. If the DME, DME PSCs, or ZPICs do not receive the information when requested or if the information in the patient's medical record does not adequately support the medical necessity for the item, then on assigned claims the supplier is liable for the dollar amount involved unless a properly executed advance beneficiary notice (ABN) of possible denial has been obtained."

Further information regarding evidence of Medical Necessity is outlined under section 5.9: … "Suppliers must have documentation to support the medical necessity of changes in the equipment, device, or supply utilization requirements.... It also states that "If necessary or appropriate for a medical necessity determination, the DME MAC, DME PSC, or ZPIC must ask the supplier to obtain documentation from the treating physician establishing the severity of the patient's condition and the immediate and long term need for the equipment and therapeutic benefits the patient is expected to realize from its use…."

The CRC has been requesting additional documentation for medical necessity in keeping with this publication. If information supplied by the supplier does not contain the necessary medical necessity information initially, an additional documentation letter will be sent to the supplier from the CDC requested detailed information still supporting the medical necessity of the item or service billed.

CERT Documentation

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

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

The CDC sends written requests for medical records to suppliers that include a checklist of the types of documentation required. The CDC will mail these letters to suppliers individually. Suppliers must submit documentation to the CERT Operations Center via fax, the preferred method, or mail at the number/address specified below. The secure fax number for submitting documentation to the CDC is (240) 568-6222.

Mail all requested documentation to:

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

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

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

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

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

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

Inquiry/Redetermination Request Form Update

The DME Inquiry/Redetermination Request Form on the Forms page of our Web site has been updated to allow for a date field after the requestor's signature. This was added to help suppliers track the date the redetermination was requested.

Reminder: If you have this form saved to your computer, be sure to replace it with this updated version.

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

Tips for Submitting the Refunds to Medicare – DME Form

Below are suggestions for correctly submitting the Refunds to Medicare form to expedite processing of these refunds. This article also explains when a refund is involved that may necessitate use of a different form or when an appeal may be required for an overpayment.

1. Use the most recent version of the Refunds to Medicare - DME form or update supplier-created forms with any new required fields.
2. Complete the interactive form on the Web site, or print it and type or handwrite very clearly in dark ink.
3. Avoid crossing out or overwriting letters or numbers.
4. Supply all information requested. Attach a separate page if more space is needed for multiple claims.
5. To speed processing, include both the PTAN and NPI number on the form.
6. Use the "Immediate offset requested" option to request claim payment(s) be applied to the refund owed to Medicare. **Note**: If the claims payments available are not sufficient to cover the entire refund amount, interest will accrue on the balance remaining after 30 days.
7. Send the completed form to the fax number or post office box listed at the top of the form. Sending forms to the wrong fax number or post office box can result in handling delays while the correspondence is redirected to the correct team.
8. When multiple claims are submitted on a single refund form, it is not unusual for one or more claims to suspend, resulting in a delay in the final processing. To avoid this delay, suppliers with large numbers of claims to adjust may choose to submit 100 claims or fewer per refund request.
9. Use the correct form for the purpose. Use the Refunds to Medicare form for only non-MSP refund requests. There are other forms for other adjustment requests.
   a. When requesting a claim adjustment because of an MSP status change, use the MSP Inquiry & Refunds form located at https://www.noridianmedicare.com/dme/forms/docs/msp_inq_dme.pdf. When requesting an adjustment because another insurer is primary, include a copy of the Explanation of Benefits (EOB) from the primary insurer.

      Note: If claim status on the remit indicates a non-MSP reason (i.e., non-covered, Certificate of Medical Necessity (CMN), modifier change needed, etc), select one of the forms below.

   b. When requesting a correction because of a clerical omission or error, other than MSP-related, use the Medicare DME Reopening form located at https://www.noridianmedicare.com/dme/forms/docs/nas_reopen_dme.pdf or request a Telephone Reopening by calling 888-826-5708. For more information about what constitutes a Reopening, see the article at https://www.noridianmedicare.com/dme/news/docs/2008/09_sep/091808b.html
   c. When requesting an appeal, use one of the following:
      i. For a redetermination (first level appeal), use the Medicare DME Inquiry/Redetermination form located at https://www.noridianmedicare.com/dme/forms/docs/nas_redeterm_dme.pdf
      ii. For a reconsideration (second level appeal), use the CMS 20033 Medicare Reconsideration Request form located at http://www.cms.hhs.gov/cmsforms/downloads/cms20033.pdf.
      iii. For more information on Redeterminations and Reconsiderations, see the PowerPoint presentation located at https://www.noridianmedicare.com/dme/train/presentations/reopenings_appeals.pdf.

Updated Refunds to Medicare Form

As of December 2, 2008, the Refunds to Medicare form located at https://www.noridianmedicare.com/dme/forms/docs/ref_med_dme.pdf has been updated.

For supplier convenience, NAS has added new reason code choices for "Patient in SNF" (Skilled Nursing Facility) and "Patient has Home Health." The "Other" choice has been moved to allow more space for comments.

In addition, there are two new required fields on the form. In the Required Information section, there is a new "Date of Service" field.

Under the Item(s) Returned reason code, a new field, "Return Date," has been added. This field must be completed when the supplier requests a refund due to equipment or products being returned.

The form will continue to be published in an interactive PDF format to allow suppliers to complete the form online, print, and fax to NAS. Please update supplier-created forms with the new required fields.

For helpful hints on how to speed processing of the Refunds to Medicare form, see the article titled "Tips for Submitting the Refunds to Medicare – DME form." posted to What's New on December 3, 2008.

New Repair and Replacement Modifiers

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

RA – Replacement of a DME item, due to loss, irreparable damage or when the item has been stolen

RB – Replacement of a part of DME furnished as part of a repair

Please report the appropriate modifier on claims in 2009. Electronic claims submitted with an RP modifier for dates of service on/after January 1, 2009, will be rejected via an error on the GenResponse report. Paper claims submitted with an RP modifier for dates of service on/after January 1, 2009 will be denied as an unprocessable with the following reason code:

CO-4 The procedure code is inconsistent with the modifier used or a required modifier is missing

Claims will need to be resubmitted with the correct modifier.

2009 DMEPOS Fee Schedule Changes Overview

NAS provides additional clarification on the changes in Medlearn Matters 6270, Fee Schedule Update for 2009 DMEPOS.

E2313 – Power wheelchair accessory, harness for upgrade to expandable controller, including all fasteners, connectors and mounting hardware, each

A temporary instruction was provided in the April 2007 Quarterly Update to use code E2399 (Power wheelchair accessory, not otherwise classified interface, including all related electronics and any type mounting hardware) when submitting claims for the electronics necessary to upgrade from a non-expandable controller to an expandable controller at initial issue. Effective January 1, 2008, claims submitted for the electronics provided at initial issue should be billed with E2313. E2399 should no longer be used for this item and will be denied as supplier liable.

KL Modifier – DMEPOS item delivered via mail

Effective January 1, 2009, the KL is a pricing modifier used with HCPCS codes A4233, A4234, A4235, A4236, A4253, A4256, A4258, and A4259 that are furnished to beneficiaries via mail order.

KE Modifier – Bid under round one of the DMEPOS Competitive Bidding Program for use with non-competitive bid base equipment (Effective January 1, 2009)

The KE modifier is a pricing modifier that suppliers must use to identify when the same accessory HCPCS code can be furnished in multiple competitive and non-competitive bidding product categories. All fee schedules for Power Mobility Devices (PMD) accessory codes with the KE modifier will receive a 5% covered item update for 2009, whereas those billed without the KE modifier will receive a required 9.5% reduction for 2009.

Instructions for the Use of the KE modifier with HCPCS Codes Competitively Bid in 2008

Standard or Complex Rehabilitative Power Mobility Device Accessories

When billing a Column I accessory code for use with a base code in Column II, do not use the KE modifier.

When billing a Column I accessory code for use with a base code in Column III, use the KE modifier.

Column I	Column II (No KE Modifier)	Column III (KE Modifier)
E0950	K0813	K0001
E0951	K0814	K0002
E0952	K0815	K0003
E0955	K0816	K0004
E0956	K0820	K0005
E0957	K0821	K0006
E0960	K0822	K0009
E0973	K0823	K0830
E0978	K0824	K0831
E0981	K0825	K0898
E0982	K0826	E1050
E0990	K0827	E1060
E0995	K0828	E1070
E1016	K0829	E1083
E1020	K0835	E1084
E1028	K0836	E1085
E2208	K0837	E1086
E2209	K0838	E1087
E2210	K0839	E1088
E2361	K0840	E1089
E2363	K0841	E1090
E2365	K0842	E1092
E2366	K0843	E1093
E2367	K0848	E1100
E2368	K0849	E1110
E2369	K0850	E1130
E2370	K0851	E1140
E2371	K0852	E1150
E2381	K0853	E1160
E2382	K0854	E1161
E2383	K0855	E1170
E2384	K0856	E1171
E2385	K0857	E1172
E2386	K0857	E1180
E2387	K0858	E1190
E2388	K0859	E1195
E2389	K0860	E1200
E2390	K0861	E1220
E2391	K0862	E1221

E2392	K0863	E1222
E2394	K0864	E1223
E2395		E1224
E2396		E1225
E2601		E1226
E2602		E1227
E2603		E1228
E2604		E1229
E2605		E1231
E2606		E1232
E2607		E1233
E2608		E1234
E2611		E1235
E2612		E1236
E2613		E1237
E2614		E1238
E2615		E1239
E2616		E1240
E2619		E1250
E2620		E1260
E2621		E1270
K0015		E1280
K0017		E1285
K0018		E1290
K0019		E1295
K0020		
K0037		
K0038		
K0039		
K0040		
K0041		
K0042		
K0043		
K0044		
K0045		
K0046		
K0047		
K0050		
K0051		
K0052		
K0053		
K0098		
K0195		
K0733		
K0734		
K0735		
K0736		
K0737		

Complex Rehabilitative Power Mobility Device Only Accessories

When billing a Column I accessory code used with a base code in Column II, do not use the KE modifier.

When billing a Column I accessory code used with a base code in Column III, use the KE modifier.

* When billing E2373 KC for use with a Column III wheelchair, use the KE modifier in place of the KC pricing modifier.

Column I	Column II (No KE Modifier)	Column III (KE Modifier)
E1002	K0835	K0001
E1003	K0836	K0002
E1004	K0837	K0003
E1005	K0838	K0004
E1006	K0839	K0005
E1007	K0840	K0006
E1008	K0841	K0009
E1010	K0842	K0830
E1029	K0843	K0831
E1030	K0848	K0898
E2310	K0849	E1050
E2311	K0850	E1060
E2321	K0851	E1070
E2322	K0852	E1083
E2323	K0853	E1084
E2324	K0854	E1085
E2325	K0855	E1086
E2326	K0856	E1087
E2327	K0857	E1088
E2328	K0857	E1089
E2329	K0858	E1090
E2330	K0859	E1092
E2351	K0860	E1093
E2373 KC*	K0861	E1100
E2374	K0862	E1110
E2375	K0863	E1130
E2376	K0864	E1140
E2377		E1150
		E1160
		E1161
		E1170
		E1171
		E1172
		E1180
		E1190
		E1195
		E1200
		E1220
		E1221
		E1222
		E1223
		E1224
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		E1228
		E1229
		E1231
		E1232

		E1233
		E1234
		E1235
		E1236
		E1237
		E1238
		E1239
		E1240
		E1250
		E1260
		E1270
		E1280
		E1285
		E1290

IV Pole

When billing an IV pole for use with an enteral code in Column II, do not use the KE modifier. Continue to use the BA modifier.

When billing the IV pole for use with a parenteral code in Column III, use the KE modifier in place of the BA modifier.

Column 1	Column II (No KE, only BA Modifier)	Column III (KE Modifier)
E0776 BA	B4149	B4164
	B4150	B4168
	B4152	B4176
	B4153	B4178
	B4154	B4180
	B4155	B4185
		B4189
		B4193
		B4197
		B4199
		B4216
		B4220
		B4222
		B4224
		B5000
		B5100
		B5200

Canister Used with Negative Pressure Wound Therapy Pumps

When billing A7000 for use with a negative pressure wound therapy pump in Column II, do not use the KE modifier.

When billing A7000 for use with a respiratory or gastric suction pump code in Column III, use the KE modifier.

Column 1	Column II (No KE Modifier)	Column III (KE Modifier)
A7000	E2402	E0600
		E2000

Walker Replacement Handgrips and Tips

When billing replacement handgrips and tips for use with a walker code in Column II, do not use the KE modifier.

When billing replacement handgrips and tips to use with a cane or crutch code in Column III, use the KE modifier.

Column 1	Column II (No KE Modifier)	Column III (KE Modifier)
A4636	E0130	E0100
A4637	E0135	E0105
	E0140	E0110
	E0141	E0111
	E0143	E0112
	E0144	E0114
	E0147	E0116
	E0148	E0117
	E0149	E0118

Diagnosis Edits on LCDs

Many of the DMEPOS Local Coverage Determinations (LCDs) and corresponding Policy Articles (PAs) specify under what clinical circumstances, or for what diagnosis, DMEPOS items are considered to be reasonable and necessary. NAS has implemented diagnosis requirements from the LCDs and PAs and will continue to do so. This will ensure that DME items are edited for diagnosis as listed in the policy, paid only when appropriate based on the diagnosis and that diagnosis codes are edited to the highest level of specificity.

New edits will be implemented for the following LCDs and related PAs in the coming weeks.

LCD Number	Local Coverage Determination Title
L142	Ankle-Foot/Knee-Ankle-Foot Orthosis
L13577	Automatic External Defibrillators
L11569	External Breast Prostheses
L11570	External Infusion Pumps
L196	Glucose Monitors
L27058	Knee Orthoses
L12739	High Frequency Chest Wall Oscillation Devices
L27261	Intravenous Immune Globulin
L12744	Mechanical In-exsufflation Devices
L11488	Nebulizer
L11574	Oral Anticancer Drugs
L11575	Oral Antiemetic Drugs
L11456	Orthopedic Footwear
L11491	Ostomy Supplies
L11490	Osteogenesis Stimulators
L51	Refractive Lenses
L171	Positive Airway Pressure (PAP) Devices for the Treatment of Obstructive Sleep Apnea (formerly CPAP)
L11460	Surgical Dressings
L157	Therapeutic Shoes for Persons with Diabetes
L166	Tracheostomy Care Supplies
L15670	Wheelchair Seating

Suppliers are reminded that LCDs and PAs are administrative and educational tools to assist in submitting correct claims for payment. DME MACs have the responsibility to educate suppliers about proper claim submission and to process claims

in accordance with the LCDs and PAs. Ensuring proper diagnosis editing helps us meet this goal and will help lower the Comprehensive Error Rate Testing (CERT) program error rates.

The CERT program, established by CMS, monitors and reports on the accuracy of Medicare Fee-For-Service (FFS) payments. The CERT program calculates the paid claims error rate for Medicare claims: both contractor-specific and service-specific paid claim error rates. CERT data is used to determine reasons for errors in claim payments or denials and the results are used to implement corrective actions, such as diagnosis editing described above, and educating suppliers about correct claim submission. For additional information about CERT, see https://www.noridianmedicare.com/dme/coverage/psc/cert.html.

For any item to be covered by Medicare, it must 1) be eligible for a defined Medicare benefit category, 2) be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, and 3) meet all other applicable Medicare statutory and regulatory requirements.

For the items addressed in the LCDs and PAs, the criteria for "reasonable and necessary" are defined. Suppliers are reminded to review the LCDs and corresponding PAs for criteria prior to claims submission. To access LCDs and PAs, see https://www.noridianmedicare.com/dme/coverage.

Signature and Date Stamps for DME Supplies - CMNs and DIFs

MLN Matters Number: MM6261
Related Change Request (CR) #: 6261
Related CR Release Date: December 31, 2008
Related CR Transmittal #: R281PI
Effective Date: February 2, 2009
Implementation Date: February 2, 2009

Provider Types Affected

Providers and suppliers submitting claims, CMNs, or DIFs to Medicare contractors (carriers, DME Medicare Administrative Contractors (DME MACs), Fiscal Intermediaries (FIs), Part A/B Medicare Administrative Contractors (A/B MACs), and/or Regional Home Health Intermediaries (RHHIs)) related to durable medical equipment, prosthetic, and orthotic supplies (DMPEOS) provided to Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 6261 and alerts providers that the Centers for Medicare & Medicaid Services (CMS) has issued instructions regarding signature requirements for Certificates of Medical Necessity (CMNs) and DME MAC Information Forms (DIFs). Signature and date stamps are not acceptable for use on CMNs and DIFs. Be sure your billing staffs are aware of this change. Your Medicare contractors will accept only hand written, facsimiles of original written and electronic signatures and dates on medical record documentation for medical review purposes on CMNs and DIFs.

Background

CMNs and DIFs are forms used to determine if the medical necessity and applicable coverage criteria for durable medical equipment, prosthetic, and orthotic supplies (DMPEOS) have been meet. The *Program Integrity Manual* (PIM), Chapter 3, Section 3.4.1.1, which may be reviewed at http://www.cms.hhs.gov/manuals/downloads/pim83c03.pdf on the CMS Web site, states that Medicare requires a legible identifier for services provided/ordered. The method used should be hand written including facsimiles of original written or an electronic signature in accordance with Chapter 3, Section 3.4.1.1 to sign an order or other medical record documentation for medical review purposes. Signature and date stamps are not acceptable for use on CMNs and DIFs.

Additional Information

For complete details regarding this Change Request (CR) please see the official instruction (CR6261) issued to your Medicare A/B MAC, DME/MAC, carrier, FI or RHHI. That instruction may be viewed by going to http://www.cms.hhs.gov/Transmittals/downloads/R281PI.pdf on the CMS Web site.

2008 Jurisdiction List for DMEPOS HCPCS Codes

MLN Matters Number: MM6062 Revised
Related Change Request (CR) #: 6062
Related CR Release Date: December 5, 2008
Related CR Transmittal #: R1644CP
Effective Date: October 27, 2008, except December 12, 2008 for HCPCS code A4559
Implementation Date: October 27, 2008, except December 12, 2008 for HCPCS code A4559

Note: This article was revised on December 8, 2008, to reflect that CR 6062 was revised by the Centers for Medicare & Medicaid Services on December 5, 2008. CR 6062 was revised to reflect a revised 2008 jurisdiction list to clarify that HCPCS code A4559 (coupling gel) may only be billed to the local carrier. The CR release date, transmittal number (above), and Web address for accessing CR 6062 were also revised. All other information remains the same.

Provider Types Affected

Providers and suppliers submitting claims to Medicare Contractors (carriers, DME Medicare Administrative Contractors (DME MACs), and Part A/B Medicare Administrative Contractors (A/B MACs)) for DMEPOS services provided to Medicare beneficiaries.

Impact on Providers

This article is informational and is based on Change Request (CR) 6062 that notifies providers that the spreadsheet containing an updated list of the HCPCS codes for DME MAC and Part B local carrier or A/B MAC jurisdictions is updated annually to reflect codes that have been added or discontinued (deleted) each year. The spreadsheet is helpful to billing staff by showing the appropriate Medicare contractor to be billed for HCPCS appearing on the spreadsheet. The spreadsheet for the 2008 Jurisdiction List is attached to CR6062 at http://www.cms.hhs.gov/Transmittals/downloads/R1644CP.pdf on the CMS Web site.

Additional Information

To see the official instruction (CR6062) issued to your Medicare DME MAC, carrier, or A/B MAC visit http://www.cms.hhs.gov/Transmittals/downloads/R1644CP.pdf on the CMS Web site.

2008 Jurisdiction List

HCPCS	DESCRIPTION	JURISDICTION
A0021 - A0999	Ambulance Services	Local Carrier
A4206 - A4209	Medical, Surgical, and Self-Administered Injection Supplies	Local Carrier if incident to a physician's service (not separately payable). If other DME MAC.
A4210	Needle Free Injection Device	DME MAC
A4211	Medical, Surgical, and Self-Administered Injection Supplies	Local Carrier if incident to a physician's service (not separately payable). If other DME MAC.
A4212	Non Coring Needle or Stylet with or without Catheter	Local Carrier
A4213 - A4215	Medical , Surgical, and Self-Administered Injection Supplies	Local Carrier if incident to a physician's service (not separately payable). If other DME MAC.
A4216 - A4218	Saline	Local Carrier if incident to a physician's service (not separately payable). If other DME MAC.
A4220	Refill Kit for Implantable Pump	Local Carrier
A4221 - A4250	Medical, Surgical, and Self-Administered Injection Supplies	Local Carrier if incident to a physician's service (not separately payable). If other DME MAC.
A4252 - A4259	Diabetic Supplies	DME MAC
A4261	Cervical Cap for Contraceptive Use	Local Carrier
A4262 - A4263	Lacrimal Duct Implants	Local Carrier
A4265	Paraffin	Local Carrier if incident to a physician's service (not separately payable). If other DME MAC.
A4266 - A4269	Contraceptives	Local Carrier
A4270	Endoscope Sheath	Local Carrier
A4280	Accessory for Breast Prosthesis	DME MAC
A4281 - A4286	Accessory for Breast Pump	DME MAC
A4290	Sacral Nerve Stimulation Test Lead	Local Carrier
A4300 - A4301	Implantable Catheter	Local Carrier
A4305 - A4306	Disposable Drug Delivery System	Local Carrier if incident to a physician's service (not separately payable). If other DME MAC.
A4310 - A4358	Incontinence Supplies/ Urinary Supplies	If provided in the physician's office for a temporary condition, the item is incident to the physician's service & billed to the Local Carrier. If provided in the physician's office or other place of service for a permanent condition, the item is a prosthetic device & billed to the DME MAC.
A4359 (deleted 12/31/06)	Incontinence Supplies/ Urinary Supplies	See description above.
A4361 - A4434	Urinary Supplies	If provided in the physician's office for a temporary condition, the item is incident to the physician's service & billed to the Local Carrier. If provided in the physician's office or other place of service for a permanent condition, the item is a prosthetic device & billed to the DME MAC.
A4450 - A4455	Tape;Adhesive Remover	Local Carrier if incident to a physician's service (not separately payable). If other DME MAC.
A4458	Enema Bag	DME MAC
A4461-A4463	Surgical Dressing Holders	Local Carrier if incident to a physician's service (not separately payable). If other DME MAC.
A4465	Non-elastic Binder for Extremity	DME MAC
A4470	Gravlee Jet Washer	Local Carrier
A4480	Vabra Aspirator	Local Carrier
A4481	Tracheostomy Supply	Local Carrier if incident to a physician's service (not separately payable). If other DME MAC.

A4483	Moisture Exchanger	DME MAC
A4490 - A4510	Surgical Stockings	DME MAC
A4520	Diapers	DME MAC
A4550	Surgical Trays	Local Carrier
A4554	Disposable Underpads	DME MAC
A4556 - A4558	Electrodes; Lead Wires; Conductive Paste	Local Carrier if incident to a physician's service (not separately payable). If other DME MAC.
A4559	Coupling Gel	Local Carrier
A4561 - A4562	Pessary	Local Carrier
A4565	Sling	Local Carrier
A4570	Splint	Local Carrier
A4575	Topical Hyperbaric Oxygen Chamber, Disposable	DME MAC
A4580 - A4590	Casting Supplies & Material	Local Carrier
A4595	TENS Supplies	Local Carrier if incident to a physician's service (not separately payable). If other DME MAC.
A4600	Sleeve for Intermittent Limb Compression Device	DME MAC
A4601	Lithium Ion Battery for Non-Prosthetic Use	DME MAC
A4604	Tubing for Positive Airway Pressure Device	DME MAC
A4605	Tracheal Suction Catheter	DME MAC
A4606	Oxygen Probe for Oximeter	DME MAC
A4608	Transtracheal Oxygen Catheter	DME MAC
A4611 - A4613	Oxygen Equipment Batteries and Supplies	DME MAC
A4614	Peak Flow Rate Meter	Local Carrier if incident to a physician's service (not separately payable). If other DME MAC.
A4615 - A4629	Oxygen & Tracheostomy Supplies	Local Carrier if incident to a physician's service (not separately payable). If other DME MAC.
A4630 - A4640	DME Supplies	DME MAC
A4641 - A4642	Imaging Agent; Contrast Material	Local Carrier
A4648	Tissue Marker, Implanted	Local Carrier
A4649	Miscellaneous Surgical Supplies	Local Carrier if incident to a physician's service (not separately payable) or if supply for implanted prosthetic device or implanted DME. If other DME MAC.
A4650	Implantable Radiation Dosimeter	Local Carrier
A4651 - A4932	Supplies for ESRD	DME MAC
A5051 - A5093	Additional Ostomy Supplies	If provided in the physician's office for a temporary condition, the item is incident to the physician's service & billed to the Local Carrier. If provided in the physician's office or other place of service for a permanent condition, the item is a prosthetic device & billed to the DME MAC.
A5102 - A5200	Additional Incontinence and Ostomy Supplies	If provided in the physician's office for a temporary condition, the item is incident to the physician's service & billed to the Local Carrier. If provided in the physician's office or other place of service for a permanent condition, the item is a prosthetic device & billed to the DME MAC.
A5500 - A5513	Therapeutic Shoes	DME MAC
A6000	Non-Contact Wound Warming Cover	DME MAC

A6010-A6024	Surgical Dressing	Local Carrier if incident to a physician's service (not separately payable) or if supply for implanted prosthetic device or implanted DME. If other DME MAC.
A6025	Silicone Gel Sheet	Local Carrier if incident to a physician's service (not separately payable) or if supply for implanted prosthetic device or implanted DME. If other DME MAC.
A6154 - A6411	Surgical Dressing	Local Carrier if incident to a physician's service (not separately payable) or if supply for implanted prosthetic device or implanted DME. If other DME MAC.
A6412	Eye Patch	Local Carrier if incident to a physician's service (not separately payable) or if supply for implanted prosthetic device or implanted DME. If other DME MAC.
A6413	Adhesive Bandage	Local Carrier if incident to a physician's service (not separately payable) or if supply for implanted prosthetic device or implanted DME. If other DME MAC.
A6441 - A6512	Surgical Dressings	Local Carrier if incident to a physician's service (not separately payable) or if supply for implanted prosthetic device or implanted DME. If other DME MAC.
A6513	Compression Burn Mask	DME MAC
A6530 - A6549	Compression Gradient Stockings	DME MAC
A6550	Supplies for Negative Pressure Wound Therapy Electrical Pump	DME MAC
A7000 - A7002	Accessories for Suction Pumps	DME MAC
A7003 - A7039	Accessories for Nebulizers, Aspirators and Ventilators	DME MAC
A7040 - A7041	Chest Drainage Supplies	Local Carrier
A7042 - A7043	Pleural Catheter	Local Carrier
A7044 - A7046	Respiratory Accessories	DME MAC
A7501-A7527	Tracheostomy Supplies	DME MAC
A8000-A8004	Protective Helmets	DME MAC
A9150	Non-Prescription Drugs	Local Carrier
A9152 - A9153	Vitamins	Local Carrier
A9155	Artificial Saliva	Local Carrier
A9180	Lice Infestation Treatment	Local Carrier
A9270	Noncovered Items or Services	DME MAC
A9274 - A9278	Glucose Monitoring	DME MAC
A9279	Monitoring Feature/Device	DME MAC
A9280	Alarm Device	DME MAC
A9281	Reaching/Grabbing Device	DME MAC
A9282	Wig	DME MAC
A9283	Foot Off Loading Device	DME MAC
A9300	Exercise Equipment	DME MAC
A9500 - A9700	Supplies for Radiology Procedures	Local Carrier
A9900	Miscellaneous DME Supply or Accessory	Local Carrier if used with implanted DME. If other, DME MAC.
A9901	Delivery	DME MAC

A9999	Miscellaneous DME Supply or Accessory	Local Carrier if used with implanted DME. If other, DME MAC.
B4034 - B9999	Enteral and Parenteral Therapy	DME MAC
D0120 - D9999	Dental Procedures	Local Carrier
E0100 - E0105	Canes	DME MAC
E0110 - E0118	Crutches	DME MAC
E0130 - E0159	Walkers	DME MAC
E0160 - E0175	Commodes	DME MAC
E0181 - E0199	Decubitus Care Equipment	DME MAC
E0200 - E0239	Heat/Cold Applications	DME MAC
E0240 - E0248	Bath and Toilet Aids	DME MAC
E0249	Pad for Heating Unit	DME MAC
E0250 - E0304	Hospital Beds	DME MAC
E0305 - E0326	Hospital Bed Accessories	DME MAC
E0328 - E0329	Pediatric Hospital Beds	DME MAC
E0350 - E0352	Electronic Bowel Irrigation System	DME MAC
E0370	Heel Pad	DME MAC
E0371 - E0373	Decubitus Care Equipment	DME MAC
E0424 - E0484	Oxygen and Related Respiratory Equipment	DME MAC
E0485 - E0486	Oral Device to Reduce Airway Collapsibility	DME MAC
E0500	IPPB Machine	DME MAC
E0550 - E0585	Compressors/Nebulizers	DME MAC
E0600	Suction Pump	DME MAC
E0601	CPAP Device	DME MAC
E0602 - E0604	Breast Pump	DME MAC
E0605	Vaporizer	DME MAC
E0606	Drainage Board	DME MAC
E0607	Home Blood Glucose Monitor	DME MAC
E0610 - E0615	Pacemaker Monitor	DME MAC
E0616	Implantable Cardiac Event Recorder	Local Carrier
E0617	External Defibrillator	DME MAC
E0618 - E0619	Apnea Monitor	DME MAC
E0620	Skin Piercing Device	DME MAC
E0621 - E0636	Patient Lifts	DME MAC
E0637 - E0642	Standing Devices/Lifts	DME MAC
E0650 - E0676	Pneumatic Compressor and Appliances	DME MAC
E0691 - E0694	Ultraviolet Light Therapy Systems	DME MAC

E0700	Safety Equipment	DME MAC
E0701 (deleted 12/31/06)	Protective Helmet	DME MAC
E0705	Transfer Board	DME MAC
E0710	Restraints	DME MAC
E0720 - E0745	Electrical Nerve Stimulators	DME MAC
E0746	EMG Device	Local Carrier
E0747 - E0748	Osteogenic Stimulators	DME MAC
E0749	Implantable Osteogenic Stimulators	Local Carrier
E0755	Reflex Stimulator	DME MAC
E0760	Ultrasonic Osteogenic Stimulator	DME MAC
E0761	Electromagnetic Treatment Device	DME MAC
E0762	Electrical Joint Stimulation Device	DME MAC
E0764	Functional Neuromuscular Stimulator	DME MAC
E0765	Nerve Stimulator	DME MAC
E0769	Electrical Wound Treatment Device	DME MAC
E0776	IV Pole	DME MAC
E0779 - E0780	External Infusion Pumps	DME MAC
E0781	Ambulatory Infusion Pump	Billable to both the local carrier and the DME MAC. This item may be billed to the DME MAC whenever the infusion is initiated in the physician's office but the patient does not return during the same business day.
E0782 - E0783	Infusion Pumps, Implantable	Local Carrier
E0784	Infusion Pumps, Insulin	DME MAC
E0785 - E0786	Implantable Infusion Pump Catheter	Local Carrier
E0791	Parenteral Infusion Pump	DME MAC
E0830	Ambulatory Traction Device	DME MAC
E0840 - E0900	Traction Equipment	DME MAC
E0910 - E0930	Trapeze/Fracture Frame	DME MAC
E0935 - E0936	Passive Motion Exercise Device	DME MAC
E0940	Trapeze Equipment	DME MAC
E0941	Traction Equipment	DME MAC
E0942 - E0945	Orthopedic Devices	DME MAC
E0946 - E0948	Fracture Frame	DME MAC
E0950 - E1298	Wheelchairs	DME MAC
E1300 - E1310	Whirlpool Equipment	DME MAC
E1340	Repair or Non-routine Service	Local Carrier if repair of implanted DME. If other, DME MAC.
E1353 - E1392	Additional Oxygen Related Equipment	DME MAC
E1399	Miscellaneous DME	Local Carrier if implanted DME. If other, DME REGIONAL Carrier.
E1405 - E1406	Additional Oxygen Equipment	DME MAC

E1500 - E1699	Artificial Kidney Machines and Accessories	DME MAC
E1700 - E1702	TMJ Device and Supplies	DME MAC
E1800 - E1841	Dynamic Flexion Devices	DME MAC
E1902	Communication Board	DME MAC
E2000	Gastric Suction Pump	DME MAC
E2100 - E2101	Blood Glucose Monitors with Special Features	DME MAC
E2120	Pulse Generator for Tympanic Treatment of Inner Ear	DME MAC
E2201 - E2399	Wheelchair Accessories	DME MAC
E2402	Negative Pressure Wound Therapy Pump	DME MAC
E2500 - E2599	Speech Generating Device	DME MAC
E2601 - E2621	Wheelchair Cushions	DME MAC
E8000 - E8002	Gate Trainers	DME MAC
G0008 - G0332	Misc. Professional Services	Local Carrier
G0333	Dispensing Fee	DME MAC
G0337 - G0368	Misc. Professional Services	Local Carrier
G0372	Misc. Professional Services	Local Carrier
G0375 - G0376	Misc. Professional Services	Local Carrier
G0378 - G9140	Misc. Professional Services	Local Carrier
J0120 - J3570	Injection	Local Carrier if incident to a physician's service or used in an implanted infusion pump. If other, DME MAC.
J3590	Unclassified Biologics	Local Carrier
J7030 - J7130	Miscellaneous Drugs and Solutions	Local Carrier if incident to a physician's service or used in an implanted infusion pump. If other, DME MAC.
J7187 - J7195	Antihemophilic Factor	Local Carrier
J7197	Antithrombin III	Local Carrier
J7198	Anti-inhibitor; per I.U.	Local Carrier
J7199	Other Hemophilia Clotting Factors	Local Carrier
J7300 - J7307	Intrauterine Copper Contraceptive	Local Carrier
J7308	Aminolevulinic Acid HCL	Local Carrier
J7310	Ganciclovir, Long-Acting Implant	Local Carrier
J7311	Fluocinolone Acetonide, intravitrea implant	Local Carrier
J7317 (deleted 12/31/06)	Sodium Hyaluronate	Local Carrier
J7319 (deleted 12/31/07)	Hyaluronan	Local Carrier
J7320 (deleted 12/31/06)	Hylan	Local Carrier
J7321 - J7324	Hyaluronan	Local Carrier
J7330	Autologous Cultured Chondrocytes Implant	Local Carrier

J7340 - J7349	Dermal and Epidermal Tissue	Local Carrier
J7350 (deleted 12/31/06)	Dermal and Epidermal Tissue	Local Carrier
J7500 - J7599	Immunosuppressive Drugs	Local Carrier if incident to a physician's service or used in an implanted infusion pump. If other, DME MAC.
J7602 - J7699	Inhalation Solutions	Local Carrier if incident to a physician's service. If other, DME MAC.
J7799	NOC, Other than Inhalation Drugs through DME	Local carrier if incident to a physician's service. If other, DME MAC.
J8498	Anti-emetic Drug	DME MAC
J8499	Prescription Drug, Oral, Non Chemotherapeutic	Local carrier if incident to a physician's service. If other, DME MAC.
J8501 - J8999	Oral Anti-Cancer Drugs	DME MAC
J9000 - J9999	Chemotherapy Drugs	Local Carrier if incident to a physician's service or used in an implanted infusion pump. If other, DME MAC.
K0001 - K0108	Wheelchairs	DME MAC
K0195	Elevating Leg Rests	DME MAC
K0455	Infusion Pump used for Uninterrupted Administration of Epoprostenal	DME MAC
K0462	Loaner Equipment	DME MAC
K0552	External Infusion Pump Supplies	DME MAC
K0553 - K0555 (deleted 12/31/07)	Accessories for CPAP and Ventilators	DME MAC
K0601 - K0605	External Infusion Pump Batteries	DME MAC
K0606 - K0609	Defibrillator Accessories	DME MAC
K0669	Wheelchair Cushion	DME MAC
K0730	Inhalation Drug Delivery System	DME MAC
K0733	Power Wheelchair Accessory	DME MAC
K0734 - K0737	Power Wheelchair Seat Cushions	DME MAC
K0738	Oxygen Equipment	DME MAC
K0800 - K0899	Power Mobility Devices	DME MAC
L0100 (deleted 12/31/06)	Orthotics	DME MAC
L0110 (deleted 12/31/06)	Orthotics	DME MAC
L0112 - L2090	Orthotics	DME MAC
L2106 - L2116	Orthotics	DME MAC
L2126 - L4398	Orthotics	DME MAC
L5000 - L5999	Lower Limb Prosthetics	DME MAC
L6000 - L7499	Upper Limb Prosthetics	DME MAC
L7500 - L7520	Repair of Prosthetic Device	Local Carrier if repair of implanted prosthetic device. If other, DME MAC.
L7600	Prosthetic Donning Sleeve	DME MAC
L7611 - L7622	Prosthetic Terminal Devices	DME MAC

L7900	Vacuum Erection System	DME MAC
L8000 - L8485	Prosthetics	DME MAC
L8499	Unlisted Procedure for Miscellaneous Prosthetic Services	Local Carrier if implanted prosthetic device. If other, DME MAC.
L8500 - L8501	Artificial Larynx; Tracheostomy Speaking Valve	DME MAC
L8505	Artificial Larynx Accessory	DME MAC
L8507 - L8515	Voice Prosthesis	DME MAC
L8600 - L8699	Prosthetic Implants	Local Carrier
L9900	Miscellaneous Orthotic or Prosthetic Component or Accessory	Local Carrier if used with implanted prosthetic device. If other, DME MAC.
M0064 - M0301	Medical Services	Local Carrier
P2028 - P9615	Laboratory Tests	Local Carrier
Q0035	Influenza Vaccine; Cardiokymography	Local Carrier
Q0081	Infusion Therapy	Local Carrier
Q0083 - Q0085	Chemotherapy Administration	Local Carrier
Q0091	Smear Preparation	Local Carrier
Q0092	Portable X-ray Setup	Local Carrier
Q0111 - Q0115	Miscellaneous Lab Services	Local Carrier
Q0144	Azithromycin Dihydrate	Local Carrier if incident to a physician's service. If other, DME MAC.
Q0163 - Q0181	Anti-emetic	DME MAC
Q0480 - Q0505	Ventricular Assist Devices	Local Carrier
Q0510 - Q0514	Drug Dispensing Fees	DME MAC
Q0515	Sermorelin Acetate	Local Carrier
Q1003 - Q1005	New Technology IOL	Local Carrier
Q2004	Irrigation Solution	Local Carrier
Q2009	Fosphenytoin	Local Carrier
Q2017	Teniposide	Local Carrier
Q3001	Radio Elements for Brachytherapy	Local Carrier
Q3014	Telehealth Originating Site Facility Fee	Local Carrier
Q3025 - Q3026	Vaccines	Local Carrier
Q3031	Collagen Skin Test	Local Carrier
Q4001 - Q4051	Splints and Casts	Local Carrier
Q4080	Inhalation Drug	Local Carrier if incident to a physician's service. If other, DME MAC.
Q4081	Epoetin	DME MAC for method II home dialysis. If other, Local Carrier.
Q4082	Drug Subject to Competitive Acquisition Program	Local Carrier
Q4083 - Q4086 (deleted 12/31/07)	Hyaluronan	Local Carrier

Q4087 - Q4092 (deleted 12/31/07)	Injection	Local Carrier if incident to a physician's service or used in an implanted infusion pump. If other DME MAC.
Q4093 - Q4094 (deleted 12/31/07)	Inhalation Solutions	Local Carrier if incident to a physician's service or used in an implanted infusion pump. If other DME MAC.
Q4095 (deleted 12/31/07)	Injection	Local Carrier if incident to a physician's service or used in an implanted infusion pump. If other DME MAC.
Q4096 - Q4098	Injection	Local Carrier if incident to a physician's service or used in an implanted infusion pump.
Q4099	Inhalation Solutions	DME MAC
Q5001 - Q5009	Hospice Services	Local Carrier
Q9945 - Q9950 (deleted 12/31/07)	Imaging Agents	Local Carrier
Q9951 - Q9954	Imaging Agents	Local Carrier
Q9955 - Q9957	Microspheres	Local Carrier
Q9958 - Q9967	Imaging Agents	Local Carrier
R0070 - R0076	Diagnostic Radiology Services	Local Carrier
V2020 - V2025	Frames	DME MAC
V2100 - V2513	Lenses	DME MAC
V2520 - V2523	Hydrophilic Contact Lenses	Local Carrier if incident to a physician's service. If other, DME MAC.
V2530 - V2531	Contact Lenses, Scleral	DME MAC
V2599	Contact Lens, Other Type	Local Carrier if incident to a physician's service. If other, DME MAC.
V2600 - V2615	Low Vision Aids	DME MAC
V2623 - V2629	Prosthetic Eyes	DME MAC
V2630 - V2632	Intraocular Lenses	Local Carrier
V2700 - V2780	Miscellaneous Vision Service	DME MAC
V2781	Progressive Lens	DME MAC
V2782 - V2784	Lenses	DME MAC
V2785	Processing--Corneal Tissue	Local Carrier
V2786	Lense	DME MAC
V2787 - V2788	Intraocular Lenses	Local Carrier
V2790	Amniotic Membrane	Local Carrier
V2797	Vision Supply	DME MAC
V2799	Miscellaneous Vision Service	DME MAC
V5008 - V5299	Hearing Services	Local Carrier
V5336	Repair/Modification of Augmentative Communicative System or Device	DME MAC
V5362 - V5364	Speech Screening	Local Carrier

Changes in Payment for Oxygen Equipment and Additional Instructions Regarding Payment for DMEPOS

MLN Matters Number: MM6297
Related Change Request (CR) #: 6297
Related CR Release Date: December 23, 2009
Related CR Transmittal #: R421OTN
Effective Date: January 1, 2009
Implementation Date: January 6, 2009

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 6297 and alerts providers that the Centers for Medicare & Medicaid Services (CMS) **terminates all Round I supplier contracts awarded under the DMEPOS Competitive Bidding Program**, as a result of Section 154 of the MIPPA which delays the Program. Therefore, in the 10 areas where competitive bidding was initiated, Medicare will resume paying for DMEPOS items, retroactive to June 30, 2008, in accordance with the standard payment rules and fee schedule amounts. This article also provides guidance on the changes in payment for oxygen and oxygen equipment as a result of section 144(b) of the MIPPA of 2008, as well as, additional claims processing and payment instructions for DMEPOS items.

Background

Oxygen and oxygen equipment are paid on a fee schedule basis in accordance with section 1834(a)(5) of the Social Security Act. The Deficit Reduction Act of 2005 (DRA) limited monthly payments for oxygen and oxygen equipment to 36 months of continuous use, after which the equipment title transferred to the beneficiary. As part of the DRA rulemaking effort, CMS established beneficiary safeguards to ensure that suppliers would continue to maintain and service beneficiary-owned oxygen equipment after the 36-month cap. The safeguards included payment for periodic (every six months) general maintenance and servicing of beneficiary-owned oxygen equipment, payment for pickup of beneficiary-owned oxygen tanks that are no longer needed, and rules for furnishing or replacing oxygen equipment during the 36 month payment period.

MIPPA was enacted on July 15, 2008. Section 144(b) of the MIPPA repeals the transfer of ownership provision established by the DRA for oxygen equipment and establishes new payment rules and supplier responsibilities after the 36-month payment cap. This one-time update provides guidance on the changes in payment for oxygen and oxygen equipment resulting from Section 144(b) of the MIPPA. CR6297 also contains additional claims processing and payment instructions for DMEPOS. Specific instructions related to the implementation of these changes will be issued in a separate CR (CR6296). Once CR 6296 is released, a related MLN Matters article will be available at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6296.pdf on the CMS Web site.

Key Points in CR6297

Payment Policies for Oxygen and Oxygen Equipment and Capped Rental Following the Enactment of the MIPPA of 2008

- Section 154 of the MIPPA delays the Durable Medical Equipment ,Prosthetic, Orthotics & Supplies (DMEPOS) Competitive Bidding Program and terminates all Round I supplier contracts. Therefore, in the 10 areas where competitive bidding was initiated, Medicare will resume paying for DMEPOS items, retroactive to June 30, 2008, in accordance with the standard payment rules and fee schedule amounts.
- Medicare will pay no more than 13 continuous rental months for capped rental items and 36 continuous monthly payment amounts for oxygen and oxygen equipment.
- The competitive bidding policy that would have provided an additional 13 months of rental payments in situations where beneficiaries transitioned from non-contract suppliers to contract suppliers in the middle of the 13 month rental period for capped rental items is no longer valid. Therefore, for capped rental items, the supplier who received payment for the 13th continuous rental month must transfer title of the equipment to the beneficiary.
- The competitive bidding policy that would have provided a minimum of 10 monthly payments to contract suppliers in situations where beneficiaries transitioned from non-contract suppliers to contract suppliers in the middle of the 36 month rental period for oxygen and oxygen equipment is no longer valid. Therefore, for oxygen and oxygen equipment, the supplier who receives payment for the 36th continuous rental month must continue to furnish the oxygen and oxygen equipment until the reasonable useful lifetime of the oxygen equipment expires.
- Beneficiaries residing in the 10 competitive bidding areas for Round I may obtain oxygen and oxygen equipment and capped rental items and supplies from any Medicare-enrolled supplier and are not required to return to the supplier they were using before July 1, 2008.

New HCPCS Modifiers for Repair and Replacement

- The following two modifiers are being added to the HCPCS on January 1, 2009, and are effective for claims with dates of service on or after January 1, 2009:

  RA - Replacement of a DME item

  RB - Replacement of a part of DME furnished as part of a repair

- The existing RP modifier will be deleted from the HCPCS, effective 12/31/08.
- Suppliers should use the new RA modifier on DMEPOS claims to denote instances where an item is furnished as a replacement for the same item which has been lost, stolen or irreparably damaged. In contrast, the new RB

modifier should be used on a DMEPOS claim to indicate replacement parts of a DMEPOS item (base equipment/device) furnished as part of the service of repairing the DMEPOS item (base equipment/device).

- Medicare contractors will accept modifier "RA" rather than "RP" for replacement of beneficiary-owned DMEPOS due to loss, irreparable damage, or when the item has been stolen.
- Medicare contractors will accept modifier "RB" rather than "RP" for replacement parts furnished in order to repair beneficiary-owned DMEPOS.

Additional Instructions for Implementation of MIPPA 144(b) – Oxygen Equipment

- Section 144(b) of the MIPPA eliminates the requirement for suppliers to transfer title to oxygen equipment to the beneficiary following the 36th continuous month during which payment is made for the equipment. The requirement for suppliers to transfer title to the beneficiary for capped rental equipment following the 13th continuous month during which payment is made for the equipment remains in effect. As noted above, section 144(b) of MIPPA repealed the Deficit Reduction Act (DRA) transfer of title provision for oxygen equipment and allows suppliers to retain ownership of the oxygen equipment following the 36-month rental cap.
- The supplier who furnished the stationary and/or portable oxygen equipment during the 36-month rental period is required to continue furnishing the stationary and/or portable equipment following the 36-month rental period for any period of medical need for the remainder of the equipment's reasonable useful lifetime.
- The supplier who receives payment for furnishing the equipment during the 36th month of continuous use is responsible for furnishing the oxygen equipment at any time after the 36 month rental period and before the expiration of the reasonable useful lifetime of the oxygen equipment if the beneficiary has a medical need for oxygen and oxygen equipment furnished under Medicare Part B. This requirement includes situations where there is a temporary break in need or break in use of the equipment of any duration after the 36-month rental cap. In such situations, the supplier remains responsible for furnishing the oxygen equipment after the break in need for the remainder of the reasonable useful lifetime during which the medical need for oxygen and oxygen equipment continues.
- Following the 36-month cap, the supplier is responsible for furnishing all of the same necessary services associated with furnishing oxygen equipment that were furnished during the 36-month rental period. For example, as required by the Medicare quality standards for respiratory equipment, supplies, and services established in accordance with 1834(a)(20) of the Social Security Act, the supplier shall provide services 24 hours a day, 7 days a week as needed by the beneficiary. Suppliers may not bill beneficiaries separately for these services.
- Medicare oxygen equipment rental payments continue to be limited to 36 months and under no circumstances will a new rental period start following the completion of the 36-month rental period unless the equipment is replaced because it is lost, stolen, irreparably damaged, or is replaced after the reasonable useful lifetime expires.
- As indicated in Section 30.6 of Chapter 20 of the *Medicare Claims Processing Manual* (Pub. 100-04), the monthly payment amount for oxygen and oxygen equipment covers equipment, contents, supplies and accessories. Section 144(b) of MIPPA caps the all inclusive oxygen and oxygen equipment monthly payments at 36 months and does not provide for payment of replacement oxygen supplies and accessories following the 36-month cap. The supplier who received payment for furnishing the oxygen and oxygen equipment during the 36-month rental period is responsible for continuing to furnish any accessories and supplies necessary for the effective use of the equipment for any period of medical need following the 36-month rental cap for the remainder of the reasonable useful lifetime of the equipment. Therefore, separate payment shall not be made for replacement of supplies and accessories for use with oxygen equipment that are furnished on or after January 1, 2009. This applies to any supply or accessory billed under a miscellaneous HCPCS code, any codes added to the HCPCS in the future, or under the following current HCPCS codes:

HCPCS Code	Descriptor
A4608	Transtracheal oxygen catheter, each
A4615	Cannula, nasal
A4616	Tubing (oxygen), per foot
A4617	Mouth piece
A4619	Face tent
A4620	Variable concentration mask
A7525	Tracheostomy mask, each
E0555	Humidifier, durable, glass or autoclavable plastic bottle type, for use with regulator or flowmeter
E0560	Humidifier, durable for supplemental humidification during IPPB treatment or oxygen delivery
E0580	Nebulizer, durable, glass or autoclavable plastic, bottle type, for use with regulator or flowmeter
E1353	Regulator
E1354	Wheeled cart for portable cylinder or concentrator (Added to HCPCS effective January 1, 2009)
E1355	Stand/Rack
E1356	Battery pack/cartridge for portable concentrator (Added to HCPCS effective January 1, 2009)
E1357	Battery charger for portable concentrator (Added to HCPCS effective January 1, 2009)
E1358	DC Power adapter for portable concentrator (Added to HCPCS effective January 1, 2009)

- Instructions regarding claims for oxygen accessory or supply codes will be provided in a separate transmittal/change request (CR 6296) that will be issued as part of the April 2009 release.

Additional Instructions for Implementation of MIPPA 144(b) – Oxygen Contents

- Section 144(b) of MIPPA also mandates that Medicare payment for oxygen contents used with liquid or gaseous oxygen equipment (stationary or portable) continue after the 36-month rental cap. The supplier who furnished the liquid or gaseous oxygen equipment during the 36-month rental period is responsible for furnishing the oxygen contents used with the supplier-owned oxygen equipment for any period of medical need following the 36-month rental cap for the remainder of the reasonable useful lifetime of the equipment.
- Monthly payment for oxygen contents for beneficiary-owned liquid or gaseous oxygen equipment (stationary or portable) shall continue to be made in accordance with existing program instructions in Section 30.6.3 of Chapter 20 of the *Medicare Claims Processing Manual*, which is available at http://www.cms.hhs.gov/manuals/IOM/list.asp on the CMS Web site. Suppliers should continue to use HCPCS codes E0441 through E0444 in order to bill and receive payment for furnishing oxygen contents.
- Separate payment shall not be made under any circumstances for the pick up and disposal of liquid or gaseous oxygen equipment (i.e., tanks).
- Instructions regarding claims for oxygen contents will be provided in a separate transmittal/change request (CR 6296) that will be issued as part of the April 2009 release.

Additional Instructions for Implementation of MIPPA 144(b) – Maintenance and Servicing of Oxygen Equipment

- Section 144(b) of MIPPA mandates payment for reasonable and necessary maintenance and servicing of oxygen equipment furnished after the 36-month rental cap. The 36-month cap applies to stationary and portable oxygen equipment furnished on or after January 1, 2006; therefore, the 36-month cap may end as early as January 1, 2009, for beneficiaries using oxygen equipment on a continuous basis since January 1, 2006. CMS has determined that under no circumstances would it be reasonable and necessary to pay for any maintenance and servicing or repair of supplier-owned oxygen equipment, with the exception of an in-home visit by suppliers to inspect oxygen concentrators and transfilling equipment and provide general maintenance and servicing 6 months after the 36-month rental cap.
- Additional claims processing and payment instructions regarding these maintenance and servicing visits will be furnished in a separate CR.
- In the case of all oxygen equipment furnished after the 36-month rental cap, the supplier is responsible for performing any repairs or maintenance and servicing of the equipment that is necessary to ensure that the equipment is in good working order for the remainder of the reasonable useful lifetime of the equipment. This includes parts that must be replaced in order for the supplier-owned equipment to continue to function appropriately.
- Payment shall not be made for any repairs or maintenance and servicing, other than the maintenance and servicing payments described above. In no case shall payment be made for any replacement part furnished as part of any repair or maintenance and servicing of oxygen equipment.
- Payment shall not be made for loaner equipment furnished during periods when these repairs or maintenance and servicing services are performed.

Payment for Capped Rental Equipment Following the Enactment of MIPPA

- As noted above, MIPPA of 2008 did not eliminate or amend the provisions of the DRA of 2005 that apply to capped rental DME. All previously issued Medicare instructions relating to these provisions remain in effect, including the requirement for suppliers to transfer title of the equipment on the first day after the 13th continuous month of use during which payment is made for the equipment.

MIPPA Remittance Advice (RA) Messages

- Although Section 144(b) of the MIPAA takes effect on January 1, 2009, the new Remittance Advice (RA) and Medicare Summary Notice (MSN) messages associated with this provision are not yet available. Therefore, in the interim, for claims with dates of service of January 1, 2009, and later, the following non-specific RA message will be used when paying the 36th month oxygen equipment claim:

  Reason Code 223: Adjustment code for mandated federal, state or local law/legislation that is not already covered by another code and is mandated before a new code can be created.

- Additional instructions related to the implementation of this provision of the MIPPA will be provided in the near future.

Revisions to the Labor Payment Rates Associated with Repairing DMEPOS Items

- As part of this update, CMS is revising the labor payment rates for HCPCS code(s) E1340, L4205, and L7520. The current rates were established based on historic supplier charges; however, annual inflation adjustments were not applied consistently from state to state. In addition, the rates differ dramatically among the states in the continental United States (e.g., from $9.51 to $23.53 in the case of E1340). To reduce this span and correct the disparity in payments for codes E1340, L4205, and L7520, CMS is revising the fees to apply inflation updates in years where it determined that these updates were not provided. Secondly, state payment amounts below the median state payment amount are being increased to the median state payment amount for each code. These changes are effective for claims with dates of service on or after January 1, 2009.
- Attachment A (see Additional Information section of this article) contains the revised 2009 payment amounts for HCPCS codes E1340, L4205, and L7520. The payment

rates include all costs (other than replacement of parts) associated with repairing DMEPOS items.

- Suppliers should only bill in 15 minutes for the time spent repairing the item and cannot bill for the time spent traveling to the beneficiary's home.
- The rates established for codes E1340, L4205, and L7520 are based on 25 percent (¼) of the previous hourly repair rates for codes E1350, L4200, and L7500, respectively. The supplier's travel costs are assumed to have been taken into account by suppliers in setting the prices they charged for these services under these codes. As such, these costs have already been accounted for in the calculation of the rates for codes E1340, L4205, and L7520. Therefore, separate payment shall not be made for travel costs associated with repairing DMEPOS items. In addition, suppliers may not bill beneficiaries directly for travel charges.
- DME MACs, RHHIs and Medicare Carriers and/or MACs will use the 2009 allowed payment amounts for code E1340 in Attachment A (see Additional Information section of this article) to pay claims for the labor associated with reasonable and necessary repairs of beneficiary-owned DME with dates of service from January 1, 2009, through December 31, 2009.
- DME MACs, FIs, Medicare Carriers and/or MACs will use the 2009 allowed payment amounts for codes L4205 and L7520 in Attachment A to pay claims for the labor associated with reasonable and necessary repairs of beneficiary-owned orthotics, prosthetics, and prosthetic devices with dates of service from January 1, 2009, through December 31, 2009.

Medicare Coverage of Elastic Support Garments

- CMS has received questions regarding coverage of elastic support garments such as leg, arm, back, or neck braces (orthotics). The definition of a brace in Section 130 of Chapter 15 of the *Medicare Benefit Policy Manual* specifies that:

> A brace includes rigid and semi-rigid devices which are used for the purpose of supporting a weak or deformed body member or restricting or eliminating motion in a diseased or injured part of the body. Elastic stockings, garter belts, and similar devices do not come within the scope of the definition of a brace.

Elastic garments or devices in general do not meet the definition of a brace because they are not rigid or semi-rigid devices. This includes devices that include stays that do not provide sufficient pressure to restrict or eliminate motion in the body part. While elastic devices may provide compression or warmth to a leg, arm, back, or neck, if they do not restrict or eliminate motion in a diseased or injured part of the body, then they may not be covered as braces. When a Medicare contractor identifies an elastic device that does not meet the Medicare definition of a brace, they shall not cover claims submitted for these devices and they shall not classify such devices under a HCPCS code that describes items that do meet the Medicare definition of a brace.

Additional Information

For complete details regarding this Change Request (CR) please see the official instruction, CR6297, issued to your Medicare FI, RHHI, DME/MAC, or A/B MAC. That instruction may be viewed by going to http://www.cms.hhs.gov/Transmittals/downloads/R421OTN.pdf on the CMS Web site.

For more information on CR5461, you may go to http://www.cms.hhs.gov/Transmittals/downloads/R1177CP.pdf on the CMS Web site. The related MLN Matters article may be found at http://www.cms.hhs.gov/MLNMattersArticles/downloads/mm5461.pdf on the CMS Web site.

Attachment A

2009 Repair and Service Fees, 15 minute unit

STATE	E1340	L4205	L7520	STATE	E1340	L4205	L7520
AK	23.59	28.79	33.88	NC	13.41	19.99	27.14
AL	24.71	19.99	27.14	ND	13.41	28.73	33.88
AR	24.71	19.99	27.14	NE	13.41	19.97	37.84
AZ	22.40	19.97	33.39	NH	13.41	19.97	27.14
CA	22.40	32.83	38.26	NJ	15.99	19.97	27.14
CO	22.40	19.99	27.14	NM	14.00	19.99	27.14
CT	19.95	20.45	27.14	NV	14.40	19.97	36.99
DC	19.95	19.97	27.14	NY	14.40	19.99	27.14
DE	19.22	19.97	27.14	OH	14.40	19.97	27.14
FL	17.46	19.99	27.14	OK	13.41	19.99	27.14
GA	18.10	19.99	27.14	OR	13.41	19.97	39.03
HI	15.61	28.79	33.88	PA	13.41	20.56	27.14
IA	15.49	19.97	32.49	PR	13.41	19.99	27.14
ID	15.49	19.97	27.14	RI	13.41	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	13.41	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	13.41	19.97	42.27
MA	15.32	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	13.41	19.97	27.14	VT	13.41	19.97	27.14
MI	13.41	19.97	27.14	WA	13.41	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	13.41	26.65	37.84
MT	13.41	19.97	33.88				

Surgical Dressings Billing Instruction for HCPCS Code A6545

Recent revisions to the Local Coverage Determination (LCD) for Surgical Dressings and the related Policy Article were published with an effective date of January 1, 2009. The Policy Article revision neglected to include billing instructions for HCPCS Code A6545.

A6545 GRADIENT COMPRESSION WRAP, NON-ELASTIC, BELOW KNEE 30-50 MM HG, EACH

Similar to codes A6531 and A6532 (compression stockings), which are addressed in the Policy Article Coding Guidelines section, HCPCS modifiers A1-A9 are not to be used with A6545.

When a gradient compression wrap, A6545, is used for an open venous stasis ulcer, the code must be billed with the AW modifier. If there is no open ulcer, the AW modifier must not be used. Claims for code A6545 without an AW modifier will be denied as statutorily noncovered.

The right (RT) and left (LT) modifiers must also be used with this code. When the same code for bilateral items (left and right) is billed on the same date of service, bill both items on the same claim line using LTRT modifiers and 2 units of service.

These guidelines will be included in a future revision of the Surgical Dressings medical policy.

The only products that may be billed with code A6545 (non-elastic compression wrap) are those which have received a written Coding Verification Review from the Pricing, Data Analysis, and Coding (PDAC) contractor and that are posted in the Product Classification List on the PDAC web site.

Suppliers should refer to the Surgical Dressings LCD and related Policy Article for additional guidance on the coverage, coding and documentation requirements.

Date Span Over Calendar Years

When billing claims for items/services that span between 2008 and 2009, date spans may be submitted. For example, claims with a date span of December 15, 2008, to January 15, 2009, will be accepted into the claims processing system.

The Advance Beneficiary Notice of Noncoverage and Correct Use of Modifiers GA and GY – Revised

Both Medicare beneficiaries and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers have certain rights and protections related to financial liability under the Fee-for-Service (FFS) Medicare program. These financial liability and appeal rights and protections are communicated to beneficiaries through Advance Beneficiary Notices of Noncoverage (ABN) given by suppliers.

An ABN is a written notice the supplier gives to a Medicare beneficiary before providing items and or services that are expected to be denied by Medicare based on one of the following statutory exclusions:

1. The item or service may be denied as "not reasonable and necessary" pursuant to Section 1862(a)(1) of the Social Security Act
2. The item or service may be denied due to an unsolicited telephone contact pursuant to Section 1834(a)(17)(B)
3. The supplier number requirements not being met pursuant to Section 1834(j)(1)
4. Denial of a request for Advance Determination of Medicare Coverage (ADMC) pursuant to Section 1834(a)(15)

When an item or service is provided to a Medicare beneficiary and is expected to be denied based on one of the four exclusions listed above, it is the responsibility of the supplier to notify the beneficiary in writing through the use of the ABN before the item or service is delivered or purchased. If the supplier issues a properly executed ABN with Option 1 selected by the beneficiary, the DMEPOS supplier must submit the claim to Medicare using the GA modifier on each Healthcare Common Procedural Coding System (HCPCS) code that is expected to be denied. The GA modifier indicates that the supplier has a waiver of liability statement on file.

Statutorily Excluded Items

The GY modifier indicates that an item or service is statutorily excluded or does not meet the definition of any Medicare benefit. Some local coverage determinations (LCD) require the use of the GY modifier when the item or service may be excluded from coverage. In this situation, suppliers are instructed to code the claim with the appropriate HCPCS code indicated in the LCD and append the GY modifier. Some examples of statutory exclusions where the GY modifier is required per policy would include:

- An infusion drug not administered using a durable infusion pump
- A wheelchair that is for use for mobility outside the home

To determine if an exclusion of Medicare benefits exist, suppliers must review the applicable LCD and policy article for the item or service being provided.

Suppliers are reminded that modifiers GA and GY should never be coded together on the same line for the same HCPCS code. It is important to distinguish situations in which an item is denied because it is **statutorily excluded or does not meet the definition of any Medicare benefit** from those situations in which at item is denied because it is not reasonable and necessary. Some examples of ***statutorily excluded items*** or situations include, but are not limited to:

- Eyeglasses or contact lenses—except those provided following cataract removal or other cause of aphakia;
- Durable Medical Equipment and related accessories and supplies provided to patients in nursing facilities;
- Personal comfort items; and
- Orthopedic shoes or shoe inserts -other than those covered under the therapeutic shoes for diabetics benefit or those that are attached to a covered leg brace.

A description of the **statutory benefit** items that are processed by the DME Medicare Administrative Contractors (MACs) can be found in the *Jurisdiction D DME MAC*

Supplier Manual, Chapter 9. Some examples of **items** or situations which **do not meet the definition of a Medicare benefit** include, but are not limited to:

- Parenteral or enteral nutrients that are used to treat a temporary (rather than permanent) condition;
- Enteral nutrients that are administered orally;
- Infusion drugs that are not administered through a durable infusion pump;
- Surgical dressings that are used to cleanse a wound, clean intact skin, or provide protection to intact skin;
- Irrigation supplies that are used to irrigate the skin or wounds;
- Immunosuppressive drugs when they are used for conditions other than following organ transplants;
- Most oral drugs;
- Oral anticancer drugs when there is no injectable or infusion form of the drug;
- Nondurable items (that are not covered under any other benefit category);
  - e.g., compression stockings and sleeves;
- Durable items that are not primarily designed to serve a medical purpose;
  - e.g., exercise equipment.

To access the LCDs and policy articles, please see https://www.noridianmedicare.com/dme/coverage/.

Voluntary Notification

Under the new instruction for the revised ABN, the Centers for Medicare & Medicaid Services (CMS) advise that this form may be used to voluntarily notify Medicare beneficiaries of an expected noncovered denial of Medicare payment due to the statutory exclusion of an item or service, or the item or service not meeting the definition of any Medicare benefit.

Section 1848(g)(4) of the Social Security Act states that items that are categorically excluded from Medicare benefits (i.e. hearing aids, personal comfort items, etc.) are not required to be submitted to the Medicare program by the supplier. However, if the beneficiary requests the supplier to submit the claim to Medicare, the claim should be coded with the designated HCPCS, however, neither modifiers GA nor GY are required. The supplier and the Medicare beneficiary will receive a patient responsibility denial for the noncovered services.

For additional instruction regarding the proper execution of an ABN, suppliers are encouraged to review the CMS Internet-Only Manual *Medicare Claims Processing Manual*, Chapter 30, "Financial Liability Protections," Sections 50 and 60 at: http://www.cms.hhs.gov/manuals.

Fee Schedule Update for 2009 for DMEPOS

MLN Matters Number: MM6270 Revised
Related Change Request (CR) #: 6270
Related CR Release Date: November 7, 2008
Related CR Transmittal #: R1630CP
Effective Date: January 1, 2009
Implementation Date: January 5, 2009

Note: This article was revised on December 3, 2008 to clarify language in the second paragraph of page 5. The revised language more completely explains the rationale for the revised 2009 monthly national payment rate for stationary oxygen equipment. All other information remains the same.

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 6270 and alerts providers that the Centers for Medicare & Medicaid Services (CMS) has issued instructions for implementing and/or updating the DMEPOS fee schedule payment amounts on a semiannual basis (January and July), with quarterly updates as necessary (April and October).

Background

The update process for the DMEPOS fee schedule is contained in section 60, Chapter 23 of the *Medicare Claims Processing Manual*, which is located at http://www.cms.hhs.gov/manuals/downloads/clm104c23.pdf on the CMS Web site. Other information on the fee schedule, including access to the DMEPOS fee schedules is at http://www.cms.hhs.gov/DMEPOSFeeSched/01_overview.asp on the CMS Web site. The key points of CR6270 are as follows:

The following codes are being deleted from the Healthcare Common Procedure Coding System (HCPCS) effective January 1, 2009, and are therefore being removed from the DMEPOS fee schedule files:

L5993	L5994	L5995	L7611	L7612	L7613
L7614	L7621	L7622			

For gap-filling purposes, the 2008 deflation factors by payment category are:

0.500 for Oxygen	0.504 for Capped Rental	0.505 for Prosthetics and Orthotics	0.641 for Surgical Dressings	0.697 for Parental and Enteral Nutrition

- The fee schedule amounts for HCPCS code **K0672** (Addition to Lower Extremity Orthosis, Removable Soft Interface, All Components, Replacement Only, Each) are added to the fee schedule file on January 1, 2009, and are effective for claims submitted with dates of service on or after January 1, 2009.

- HCPCS code E2295 (Manual wheelchair accessory, for pediatric size wheelchair, dynamic seating frame, allows coordinated movement of multiple positioning features) is added to the HCPCS file on January 1, 2009. Due to low claims volumes expected, your Medicare contractor will establish local fee schedule amounts to pay claims for E2295.
- Fee schedule amounts for L3905, L3806, and L3808 were revised in the July 2008 Quarterly Update. However, CMS has determined that the gap-filled fees originally established for these three codes were correct and the fee amounts will revert back to what was in place prior to the July update. Claims already processed for dates of service on or after July 1, 2008, through December 31, 2008, will not be adjusted.

2009 Fee Schedule Updates following the Enactment of the Medicare Improvements for Patients and Providers Act (MIPPA)

- MIPPA of 2008 mandates a fee schedule covered item update of -9.5% for 2009 for items included in round 1 of the DMEPOS Competitive Bidding Program. The reduction applies to items furnished on or after January 1, 2009, in any geographical area.
- Items selected for competitive bidding in 2008 will receive a -9.5% update for 2009 with the exception of HCPCS codes E1392, K0738, E0441, E0442, E0443 and E0444. These six oxygen generating portable equipment (OGPE) and oxygen contents codes will receive a 0% update for 2009 as the fees for these items are not adjusted by the covered item update specified in 1834(a)(14), and are not reduced by the -9.5%, even though they are competitive bid items.
- Non-competitive bid items will receive a 5.0% covered item update for 2009.

New KE Modifier and the KL Modifier

A new HCPCS modifier was added to the HCPCS on January 1, 2009, and is effective for claims with dates of service on or after January 1, 2009. The new modifier is KE (Bid Under Round One of the DMEPOS Competitive Bidding Program for use with Non-Competitive Bid Base Equipment). To accommodate the fee schedule updates required per the MIPPA, CMS is adding the KE modifier to the fee schedule for all power mobility device (PMD) accessory items selected for competitive bidding in 2008 as part of this update. The KE modifier is a pricing modifier that suppliers must use to identify when the same accessory HCPCS code can be furnished in multiple competitive and non-competitive bidding product categories. For example, HCPCS code E0981 *Wheelchair Accessory, Seat Upholstery, Replacement Only, Each* can be used with both competitively bid standard and complex rehabilitative power wheelchairs (K0813 thru K0829 and K0835 thru K0864), as well as with non-competitively bid manual wheelchairs (K0001 thru K0009) or a miscellaneous power wheelchair (K0898).

All fee schedules for PMD accessory codes with the KE modifier will receive a 5% covered item update for 2009, whereas the fee schedules for the PMD accessory codes without the KE modifier will receive the MIPPA-required 9.5% reduction for 2009. Suppliers need to know that if a competitively bid PMD accessory code is used with a competitively bid standard PMD base code (K0813 thru K0829) or complex rehabilitative PMD base code (K0835 thru K0864), claims for the PMD accessory code should be submitted without the KE modifier. If such claims are submitted with the KE modifier, they will be rejected with message M78 (Missing/incomplete/invalid HCPCS modifier) and 125 (Submission/billing error (s)).

Suppliers should bill the accessory code with the KE modifier when the accessory is used in conjunction with a non-competitively bid manual wheelchair (K0001 through K0009) or a miscellaneous PMD (K0898). In the case of the complex rehabilitative only PMD accessory code E2373 KC, suppliers should bill for the replacement only of E2373 without the KE modifier, but with the KC modifier when the accessory is used with a competitively bid complex rehabilitative PMD base code (K0835 thru K0864). When the replacement only code E2373 is used with a non-competitively bid manual or miscellaneous wheelchair, suppliers should bill code E2373 without the KC modifier, but with the KE modifier.

For the aforementioned reasons, CMS is also adding the KE modifier to the fee schedule for the following competitively bid HCPCS codes: A4636, A4637, A7000, and E0776. If codes A4636 and A4637 are used in conjunction with a competitively bid walker code (E0130, E0135, E0140, E0141, E0143, E0144, E0147, E0148, and E0149), claims for the replacement handgrip (A4636) or tip (A4637) should be submitted without the KE modifier. Suppliers should bill codes A4636 and A4637 with the KE modifier when the codes are used with non-competitively bid cane or crutch codes. Likewise, suppliers should bill the disposable canister code A7000 without the KE modifier when this code is used in conjunction with the competitively bid negative pressure wound therapy pump code E2402. When code A7000 is used with a non-competitively bid respiratory or gastric suction pump, suppliers should bill code A7000 with the KE modifier. Similarly when an IV pole (E0776) is used in conjunction with competitively bid enteral nutrient codes (B4149, B4150, and B4152 thru B4155), suppliers should bill code E0776 with the BA modifier, but without the KE modifier. When code E0776 is used with non-competitively bid parenteral nutrient codes, suppliers should bill code E0776 without the BA modifier, but with the KE modifier.

Further instruction on the use of the KE modifier with codes competitively bid in 2008 is available in Attachment B of CR 6270, which is available at http://www.cms.hhs.gov/Transmittals/downloads/R1630CP.pdf on the CMS Web site.

Note: Suppliers should not use the KE modifier on any claims for payment for items that were included under Round 1 such as an accessory for a standard power wheelchair.

With CR 6270, CMS is also adding the KL modifier to the fee schedule for the following diabetic supply HCPCS codes: A4233, A4234, A4235, A4236, A4253, A4256, A4258, and A4259. As indicated in CR 5641 (July Quarterly Update for 2007 DMEPOS Fee Schedule, discussed in MLN Matters article MM5641 at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5641.pdf), suppliers began using the KL modifier as an informational modifier

to identify diabetic supplies (HCPCS codes A4233-A4236, A4253, A4256, A4258 and A4259) furnished via mail order on or after July 1, 2007. Effective January 1, 2009, the KL modifier has been changed from an informational modifier to a pricing modifier in the HCPCS file. Suppliers must use the KL modifier on all claims for the aforementioned diabetic supply codes that are furnished via mail order to beneficiaries. The KL modifier is not used with diabetic supply codes that are not delivered to the beneficiary's residence and are obtained from local supplier storefronts.

Note: Inappropriate use of a competitive bidding modifier on a competitive bidding claim is in violation of the law and may lead to claims denial and/or other corrective actions. The use of a competitive bidding modifier does not supersede existing Medicare modifier use requirements for a particular code, but rather should be used in addition, as required.

Competitive Bidding Items from 2008 Impacted by 2009 Pricing

The following product lists of the HCPCS codes that were selected for competitive bidding in 2008 are subject to the -9.5% covered item update for 2009. The detailed descriptions of the listed HCPCS codes (for product categories 1-10) are not repeated in this article, but are available in Attachment A of CR 6270, which is available at http://www.cms.hhs.gov/Transmittals/downloads/R1630CP.pdf on the CMS Web site.

Product Category 1—Oxygen, Supplies and Equipment (for the detailed product description of each HCPCS code see Attachment A)

E1390	E1391	E0424	E0439	E0431
E0434	A4608	A4615	A4616	A4617
A4620	E0560	E0580	E1353	E1355

As part of this update, CMS is implementing the 2009 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, 2009. CMS is revising the fee schedule file to include the new national 2009 monthly payment rate of $175.79 for stationary oxygen equipment. This revised 2009 monthly payment rate of $175.79 is reduced by 11.8% from the 2008 monthly payment rate. This reduction includes the 9.5% covered item reduction ascribed to items selected for competitive bidding in 2008 as required by section 154(a)(2)(A) of MIPPA and the 2.53% budget neutrality reduction as required by section 1834(a)(9)(D)(ii) of the Social Security Act and discussed in a final rule published in the Federal Register on November 9, 2006. The previously announced payment amount for 2009 of $193.21 did not include the 9.5% reduction and assumed a higher shift to oxygen generating portable equipment (OGPE).

As a result of the above adjustments, CMS is also revising the fee schedule amounts for HCPCS codes E1405 and E1406 as part of this update. 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.

Product Category 2—Standard Power Wheelchairs, Scooters, and Related Accessories (for the detailed product description of each HCPCS code see Attachment A)

E0950	E0951	E0952	E0955	E0956	E0957	E0960	E0973
E0978	E0981	E0982	E0990	E0995	E1016	E1020	E1028
E2208	E2209	E2210	E2361	E2363	E2365	E2366	E2367
E2368	E2369	E2370	E2371	E2381	E2382	E2383	E2384
E2385	E2386	E2387	E2388	E2389	E2390	E2391	E2392
E2394	E2395	E2396	E2601	E2602	E2603	E2604	E2605
E2606	E2607	E2608	E2611	E2612	E2613	E2614	E2615
E2616	E2619	E2620	E2621	K0015	K0017	K0018	K0019
K0020	K0037	K0038	K0039	K0040	K0041	K0042	K0043
K0044	K0045	K0046	K0047	K0050	K0051	K0052	K0053
K0098	K0195	K0733	K0734	K0735	K0736	K0737	K0800
K0801	K0802	K0806	K0807	K0808	K0813	K0814	K0815
K0816	K0820	K0821	K0822	K0823	K0824	K0825	K0826
K0827	K0828	K0829					

Product Category 3—Complex Rehabilitative Power Wheelchairs and Related Accessories (for the detailed product description of each HCPCS code see Attachment A)

E0950	E0951	E0952	E0955	E0956	E0957	E0960	E0973
E0978	E0981	E0982	E0990	E0995	E1002	E1003	E1004
E1005	E1006	E1007	E1008	E1010	E1016	E1020	E1028
E1029	E1030	E2208	E2209	E2210	E2310	E2311	E2321
E2322	E2323	E2324	E2325	E2326	E2327	E2328	E2329
E2330	E2351	E2361	E2363	E2365	E2366	E2367	E2368
E2369	E2370	E2371	E2373 KC	E2374	E2375	E2376	E2377
E2381	E2382	E2383	E2384	E2385	E2386	E2387	E2388
E2389	E2390	E2391	E2392	E2394	E2395	E2396	E2601
E2602	E2603	E2604	E2605	E2606	E2607	E2608	E2611
E2612	E2613	E2614	E2615	E2616	E2619	E2620	E2621
K0015	K0017	K0018	K0019	K0020	K0037	K0038	K0039
K0040	K0041	K0042	K0043	K0044	K0045	K0046	K0047
K0050	K0051	K0052	K0053	K0098	K0195	K0733	K0734
K0735	K0736	K0737	K0835	K0836	K0837	K0838	K0839
K0840	K0841	K0842	K0843	K0848	K0849	K0850	
K0851	K0852	K0853	K0854	K0855	K0856	K0857	K0858
K0859	K0860	K0861	K0862	K0863	K0864		

Product Category 4—Mail-Order Diabetic Supplies (for the detailed product description of each HCPCS code see Attachment A)

A4233 KL	A4234 KL	A4235 KL	A4236 KL
A4253 KL	A4256 KL	A4258 KL	A4259 KL

Product Category 5—Enteral Nutrients, Equipment, and Supplies (for the detailed product description of each HCPCS code see Attachment A)

B4034	B4035	B4036	B4081	B4082	B4083	B4087	B4088
B4149	B4150	B4152	B4153	B4154	B4155	B9000	B9002
E0776							

Product Category 6—Continuous Positive Airway Pressure Devices, Respiratory Assist Devices, and Related Supplies and Accessories (for the detailed product description of each HCPCS code see Attachment A)

A4604	A7030	A7031	A7032	A7033	A7034	A7035	A7036
A7037	A7038	A7039	A7044	A7045	A7046	E0470	E0471
E0472	E0561	E0562	E0601				

Product Category 7—Hospital Beds and Related Supplies (for the detailed product description of each HCPCS code see Attachment A)

E0250	E0251	E0255	E0256	E0260	E0261	E0265	E0266
E0271	E0272	E0280	E0290	E0291	E0292	E0293	E0294
E0295	E0296	E0297	E0300	E0301	E0302	E0303	E0304
E0305	E0310	E0316	E0910	E0911	E0912	E0940	

Product Category 8—Negative Pressure Wound Therapy Pumps and Related Supplies and Accessories (for the detailed product description of each HCPCS code see Attachment A)

A6550	A7000	E2402

Product Category 9—Walkers and Related Supplies (for the detailed product description of each HCPCS code see Attachment A)

A4636	A4637	E0130	E0135	E0140	E0141	E0143	E0144	E0147
E0148	E0149	E0154	E0155	E0156	E0157	E0158	E0159	

Product Category 10—Support Surfaces (for the detailed product description of each HCPCS code see Attachment A)

E0193	E0277	E0371	E0372	E0373

Billing Instructions for Power Wheelchair Harness (HCPCS code E2313)

The April Quarterly Update for the 2007 DMEPOS Fee Schedule included instructions for suppliers to submit claims for the electronics necessary to **upgrade from a non-expandable controller to an expandable controller at initial issue using HCPCS code E2399. This instruction was intended as a temporary measure** until a new code could be added to describe the electronics/cables/junction boxes used when upgrading from a non-expandable controller at initial issue.

- HCPCS code E2313 (Power Wheelchair Accessory, Harness For Upgrade to Expandable Controller, Including all Fasteners, Connectors and Mounting Hardware, Each) was added to the HCPCS effective January 1, 2008, for use in paying claims for the electronics furnished when upgrading from a non-expandable controller at initial issue.
- Suppliers may submit claims for the electronics provided at initial issue using HCPCS code E2313 for dates of service on or after January 1, 2008, and must no longer use code E2399 for submission of such items.
- Claims submitted for the electronics necessary to upgrade from a non-expandable controller to an expandable controller using HCPCS code E2399 are invalid and will be denied as contractor/supplier responsibility. When such claims are denied, CMS will use message codes of M20 (Missing/incomplete/invalid HCPCS), 189 (Not otherwise classified or unlisted procedure code (CPT/HCPCS) was billed when there is a specific procedure code for this procedure/service.), N211 (Alert: You may not appeal this decision.), and MA13 (You may be subject to penalties if you bill the patient for amount not reported with the PR (patient responsibility) group code.). These denials are made as CO-Contractual Obligation denials.

Additional Information

For complete details regarding this Change Request (CR) please see the official instruction (CR6270) issued to your Medicare A/B MAC, DME/MAC, carrier, FI or RHHI. That instruction may be viewed by going to http://www.cms.hhs.gov/Transmittals/downloads/R1630CP.pdf on the CMS Web site.

Annual Update of HCPCS Codes Used for Home Health Consolidated Billing Enforcement

MLN Matters Number: MM6262
Related Change Request (CR) #: 6262
Related CR Release Date: November 7, 2008
Related CR Transmittal #: R1633CP
Effective Date: January 1, 2009
Implementation Date: January 5, 2009

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 Administrative Contractors (A/B MACs), and/or Regional Home Health Intermediaries (RHHIs)) for services provided to Medicare beneficiaries during an episode of home health care.

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of Healthcare Common Procedure Codes System (HCPCS) codes subject to the consolidated billing provision of the Home Health Prospective Payment System (HH PPS).

This article is based on Change Request (CR) 6262 which provides the annual HH consolidated billing update effective January 1, 2009.

Background

The Social Security Act (Section 1842(b)(6); see http://www.ssa.gov/OP_Home/ssact/title18/1842.htm on the Internet) requires that payment for home health services provided under a home health plan of care is made to the home health agency (HHA). This requirement is found in Medicare regulations at 42 CFR 409.100 (see http://edocket.access.gpo.gov/cfr_2005/octqtr/42cfr409.100.htm on the Internet and in the Medicare Claims Processing Manual (Chapter 10, Section 20.1), available at http://www.cms.hhs.gov/manuals/IOM/list.asp on the CMS Web site.

The home health 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 (i.e., 'K' codes) throughout the calendar year.

The following HCPCS code is added to the home health consolidated billing supply code list, and it is a new code that does not replace any prior HCPCS code on the list:

Added HCPCS Code	Descriptor
A6545	Gradient compression wrap, non-elastic, below knee, 30-50 mmHg, each.

The following HCPCS code is deleted from the home health consolidated billing supply code list, and this code is being removed because it is non-covered by Medicare statute.

Deleted HCPCS Code	Descriptor
A6413	Adhesive Bandage, First-Aid Type, any size, each

Additional Information

The official instruction, CR 6262, issued to your carrier, FI, A/B MAC, RHHI, and DME MAC regarding this change may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R1633CP.pdf on the CMS Web site.

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

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

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 6211 which informs Medicare contractors about the changes necessary to derive Medicare Secondary Payer (MSP) payment calculations from incoming 837 4010-A1 claims transactions.

CR 6211 is limited to providers billing Part B contractors (carriers and MACs) and DME/MACs.

Background

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

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

The instructions detailed by CR 6211 are necessary to ensure:

- Medicare complies with HIPAA transaction and code set requirements, and
- MSP claims are properly calculated by Medicare contractors (and their associated shared systems) using payment information derived from the incoming 837 professional claim.

Adjustments made by the payer are reported in the CAS segments on the 835 electronic remittance advice (ERA) or on hardcopy remittance advices.

Providers must take the CAS segment adjustments (as found on the 835 ERA) and report these adjustments on the 837 (unchanged) when sending the claim to Medicare for secondary payment. **NOTE: If you are obligated to accept, or voluntarily accept, an amount as payment in full from the primary payer, you must use the group code Contractual Obligation (CO) to identify your contractual adjustment amount, also known as the Obligated to accept as payment in full adjustment (OTAF). Details of the MSP provisions may be found in the Medicare Secondary Payer Manual, which is available at http://www.cms.hhs.gov/manuals/IOM/list.asp on the CMS Web site and in the federal regulations at 42 CFR 411.32 and 411.33.**

Additional Information

The official instruction, CR 6211, issued to your carrier, A/B MAC, and DME/MAC regarding this change may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R62MSP.pdf on the CMS Web site.

Claim Status Category Code and Claim Status Code Update

MLN Matters Number: MM6328
Related Change Request (CR) #: 6328
Related CR Release Date: December 31, 2008
Related CR Transmittal #: R1656CP
Effective Date: January 1, 2009
Implementation Date: January 5, 2009

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 6328, from which this article is taken, reminds providers of the periodic updates to the Claim Status Codes and Claim Status Category Codes that Medicare contractors use with the Health Care Claim Status Request (ASC X12N 276), and the Health Care Claim Response (ASC X12N 277).

Background

The Claim Category and Claim Status Codes explain the status of submitted claims. The Health Insurance Portability and Accountability Act (HIPAA) requires all health care benefit payers to use only national Code Maintenance Committee-approved codes in the X12 276/277 Health Care Claim Status Request and Response transactions.

The national Code Maintenance Committee meets at the beginning of each X12 trimester meeting (February, June, and October) to decide about additions, modifications, and retirement of existing codes. Included in the code lists are specific details, including the date when a code was added, changed, or deleted.

CR 6328 updates the changes in the Claim Status Codes and Claim Status Category Codes from the June, 2008 committee meeting. These updates were posted at http://www.wpc-edi.com/content/view/180/223/ on June 30, 2008. Medicare contractors must have completed the entry of all applicable code text changes and new codes, and terminated the use of deactivated codes by January 5, 2009. On and after this date, these code changes are to be used in editing of all X12 276 transactions processed and must be reflected in the X12 277 transactions issued.

Additional Information

The official instruction (CR6328) issued to your Medicare MAC, carrier, DME MAC, FI, and/or RHHI is available at http://www.cms.hhs.gov/Transmittals/downloads/R1656CP.pdf on the CMS Web site.

Remittance Advice Remark Code and Claim Adjustment Reason Code Update

MLN Matters Number: MM6229
Related Change Request (CR) #: 6229
Related CR Release Date: November 14, 2008
Effective Date: January 1, 2009
Related CR Transmittal #: R1634CP
Implementation Date: January 5, 2009

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 Administrative Contractors (A/B MACs), and/or Regional Home Health Intermediaries (RHHIs)) for services provided to Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 6229 which updates Remittance Advice Remark Codes (RARCs) and Claim Adjustment Reason Codes (CARCs). If you use the Medicare Remit Easy Print software, note that Medicare will update that software as a result of implementing CR6229. Be sure billing staff are aware of these updates.

Background

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 instructs health plans to be able to conduct standard electronic transactions adopted under HIPAA using valid standard codes. Medicare policy states that Claim Adjustment Reason Codes (CARCs) are required in the remittance advice and coordination of benefits transactions. Medicare policy further states that appropriate Remittance Advice Remark Codes (RARCs) that provide either supplemental explanation for a monetary adjustment or policy information are required in the remittance advice transaction.

X12N 835 Health Care Remittance Advice Remark Codes

The Centers for Medicare & Medicaid Services (CMS) is the national maintainer of the remittance advice remark code list. This code list is used by reference in the ASC X12 N transaction 835 (Health Care Claim Payment/Advice) version 004010A1 Implementation Guide (IG). Under HIPAA, all payers, including Medicare, are required to use reason and remark codes approved by X12 recognized code set maintainers instead of proprietary codes to explain any adjustment in the claim payment. CMS, as the X12 recognized maintainer of RARCs, receives requests from Medicare and non-Medicare payers for new codes and modification/deactivation of existing codes. Additions, deletions, and modifications to the code list resulting from non-Medicare requests may or may not impact Medicare.

Note: The complete list of remark codes is available at http://www.wpc-edi.com/codes on the Internet.

Medicare contractors will use the latest approved and valid codes in the 835, corresponding Standard Paper Remittance (SPR) advice and coordination of benefits transactions.

CMS has developed a new Web site to help navigate the RARC database more easily. A tool is provided to help search if you are looking for a specific category of codes. At this site you can find some other information that is also available from the WPC Web site. The Web site address is http://www.cmsremarkcodes.info/on the Internet.

Note I: This Web site is not replacing the WPC Web site as the official site where the most current RARC list resides. If there is any discrepancy, always use the list posted at the WPC Web site.

Note II: Some remark codes may only provide general information that may not necessarily supplement the specific explanation provided through a reason code and in some cases another/other remark code(s) for a monetary adjustment. Codes that are "Informational" will have "Alert" in the text to identify them as informational rather than explanatory codes. These "Informational" codes may be used without any CARC explaining a specific adjustment.

BILLING CONT'D

An example of an informational code:

N369 Alert: Although this claim has been processed, it is deficient according to state legislation/regulation.

The above information is sent per state regulation, but does not explain any adjustment.

These informational codes are used only if specific information about adjudication (like appeal rights) needs to be communicated but not as default codes when a RARC is required with a CARC -16, 17, 96, 125, and A1.

Remittance Advice Remark Code Changes

New Codes:

Code	Current Narrative	Medicare Initiated
N434	Missing/Incomplete/Invalid Present on Admission indicator. Start: 7/1/2008	
N435	Exceeds number/frequency approved /allowed within time period without support documentation. Start: 7/1/2008	
N436	The injury claim has not been accepted and a mandatory medical reimbursement has been made. Start: 7/1/2008	
N437	Alert: If the injury claim is accepted, these charges will be reconsidered. Start: 7/1/2008	
N438	This jurisdiction only accepts paper claims. Start: 7/1/2008	
N439	Missing anesthesia physical status report/indicators. Start: 7/1/2008	
N440	Incomplete/invalid anesthesia physical status report/indicators. Start: 7/1/2008	
N441	This missed appointment is not covered. Start: 7/1/2008	
N442	Payment based on an alternate fee schedule. Start: 7/1/2008	
N443	Missing/incomplete/invalid total time or begin/end time. Start: 7/1/2008	
N444	Alert: This facility has not filed the Election for High Cost Outlier form with the Division of Workers' Compensation. Start: 7/1/2008	
N445	Missing document for actual cost or paid amount. Start: 7/1/2008	
N446	Incomplete/invalid document for actual cost or paid amount. Start: 7/1/2008	
N447	Payment is based on a generic equivalent as required documentation was not provided. Start: 7/1/2008	
N448	This drug/service/supply is not included in the fee schedule or contracted/legislated fee arrangement. Start: 7/1/2008	
N449	Payment based on a comparable drug/ service/supply. Start: 7/1/2008	
N450	Covered only when performed by the primary treating physician or the designee. Start: 7/1/2008	
N451	Missing Admission Summary Report. Start: 7/1/2008	
N452	Incomplete/invalid Admission Summary Report. Start: 7/1/2008	
N453	Missing Consultation Report. Start: 7/1/2008	
N454	Incomplete/invalid Consultation Report. Start: 7/1/2008	
N455	Missing Physician Order. Start: 7/1/2008	
N456	Incomplete/invalid Physician Order. Start: 7/1/2008	
N457	Missing Diagnostic Report. Start: 7/1/2008	
N458	Incomplete/invalid Diagnostic Report. Start: 7/1/2008	
N459	Missing Discharge Summary. Start: 7/1/2008	
N460	Incomplete/invalid Discharge Summary. Start: 7/1/2008	
N461	Missing Nursing Notes. Start: 7/1/2008	
N462	Incomplete/invalid Nursing Notes. Start: 7/1/2008	
N463	Missing support data for claim. Start: 7/1/2008	
N464	Incomplete/invalid support data for claim. Start: 7/1/2008	
N465	Missing Physical Therapy Notes/ Report. Start: 7/1/2008	
N466	Incomplete/invalid Physical Therapy Notes/Report. Start: 7/1/2008	
N467	Missing Report of Tests and Analysis Report. Start: 7/1/2008	
N468	Incomplete/invalid Report of Tests and Analysis Report. Start: 7/1/2008	

N469	Alert: Claim/Service(s) subject to appeal process, see section 935 of Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). Start: 7/1/2008	YES
N470	This payment will complete the mandatory medical reimbursement limit. Start: 7/1/2008	
N471	Missing/incomplete/invalid HIPPS Rate Code. Start: 7/1/2008	
N472	Payment for this service has been issued to another provider. Start: 7/1/2008	
N473	Missing certification. Start: 7/1/2008	
N474	Incomplete/invalid certification Start: 7/1/2008	
N475	Missing completed referral form. Start: 7/1/2008	
N476	Incomplete/invalid completed referral form Start: 7/1/2008	
N477	Missing Dental Models. Start: 7/1/2008	
N478	Incomplete/invalid Dental Models Start: 7/1/2008	
N479	Missing Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer). Start: 7/1/2008	
N480	Incomplete/invalid Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer). Start: 7/1/2008	
N481	Missing Models. Start: 7/1/2008	
N482	Incomplete/invalid Models Start: 7/1/2008	
N483	Missing Periodontal Charts. Start: 7/1/2008	
N484	Incomplete/invalid Periodontal Charts Start: 7/1/2008	
N485	Missing Physical Therapy Certification. Start: 7/1/2008	
N486	Incomplete/invalid Physical Therapy Certification. Start: 7/1/2008	
N487	Missing Prosthetics or Orthotics Certification. Start: 7/1/2008	
N488	Incomplete/invalid Prosthetics or Orthotics Certification Start: 7/1/2008	
N489	Missing referral form. Start: 7/1/2008	
N490	Incomplete/invalid referral form Start: 7/1/2008	
N491	Missing/Incomplete/Invalid Exclusionary Rider Condition. Start: 7/1/2008	
N492	Alert: A network provider may bill the member for this service if the member requested the service and agreed in writing, prior to receiving the service, to be financially responsible for the billed charge. Start: 7/1/2008	
N493	Missing Doctor First Report of Injury. Start: 7/1/2008	
N494	Incomplete/invalid Doctor First Report of Injury. Start: 7/1/2008	
N495	Missing Supplemental Medical Report. Start: 7/1/2008	
N496	Incomplete/invalid Supplemental Medical Report. Start: 7/1/2008	
N497	Missing Medical Permanent Impairment or Disability Report. Start: 7/1/2008	
N498	Incomplete/invalid Medical Permanent Impairment or Disability Report. Start: 7/1/2008	
N499	Missing Medical Legal Report. Start: 7/1/2008	
N500	Incomplete/invalid Medical Legal Report. Start: 7/1/2008	
N501	Missing Vocational Report. Start: 7/1/2008	
N502	Incomplete/invalid Vocational Report. Start: 7/1/2008	
N503	Missing Work Status Report. Start: 7/1/2008	
N504	Incomplete/invalid Work Status Report. Start: 7/1/2008	

Modified Codes

Code	Current Modified Narrative	Last Modified
M29	Missing operative note/report.	7/1/08
N10	Payment based on the findings of a review organization/ professional consult/ manual adjudication/ medical or dental advisor.	7/1/08
N26	Missing itemized bill/statement.	7/1/08

N40	Missing radiology film(s)/image(s).	7/1/08
N130	Alert: Consult plan benefit documents/guidelines for information about restrictions for this service.	7/1/08
N209	Missing/incomplete/invalid taxpayer identification number (TIN).	7/1/08
N232	Incomplete/invalid itemized bill/ statement.	7/1/08
N233	Incomplete/invalid operative note/ report.	7/1/08
N242	Incomplete/invalid radiology film(s)/image(s).	7/1/08
N350	Missing/incomplete/invalid description of service for a Not Otherwise Classified (NOC) code or for an Unlisted/By Report procedure.	7/1/08
N367	Alert: The claim information has been forwarded to a Consumer Spending Account processor for review; for example, flexible spending account or health savings account.	7/1/08
N390	This service/report cannot be billed separately	7/1/08
N393	Missing progress notes/report	7/1/08
N394	Incomplete/invalid progress notes/ report.	7/1/08

Deactivated Codes

There are no newly deactivated codes with CR 6229. Lists of all deactivated and scheduled to be deactivated RARCs are available at the WPC Web site at http://www.wpc-edi.com/codes on the Internet.

X12 N 835 Health Care Claim Adjustment Reason Codes

A national code maintenance committee maintains the health care Claim Adjustment Reason Codes (CARCs). The Committee meets at the beginning of each X12 trimester meeting (January/February, June and September/October) and makes decisions about additions, modifications, and retirement of existing reason codes. The updated list is posted 3 times a year around early November, March, and July.

The list is available at http://www.wpc-edi.com/codes on the Internet.

New Codes:

Code	Current Narrative	Implementation Date
222	Exceeds the contracted maximum number of hours/ days/units by this provider for this period. This is not patient specific. Start Date: 6/1/2008	1/5/2009
223	Adjustment code for mandated federal, state or local law/ regulation that is not already covered by another code and is mandated before a new code can be created. Start Date: 6/1/2008	1/5/2009
224	Patient identification compromised by identity theft. Identity verification required for processing this and future claims. Start Date: 6/1/2008	1/5/2009
225	Penalty or Interest Payment by Payer (Only used for plan to plan encounter reporting within the 837) Start Date: 6/1/2008	1/5/2009

Note: Codes 223 and 224 are Medicare initiated

Modified Code(s):

Code	Modified Narrative	Implementation Date
60	Charges for outpatient services with this proximity to inpatient services are not covered. This change to be effective 1/1/2009: Charges for outpatient services are not covered when performed within a period of time prior to or after inpatient services.	1/5/2009

Deactivated Code(s):

Code	Current Narrative	Implementation Date
D22	Reimbursement was adjusted for the reasons to be provided in separate correspondence. (Note: To be used for Workers' Compensation only) - Temporary code to be added for timeframe only until 01/01/2009. Another code to be established and/or for 06/2008 meeting for a revised code to replace or strategy to use another existing code. Start: 01/27/2008 | Stop: 01/01/2009	1/1/2009

Note: The Code Committee also reactivated CARC 207

Additional Information

The official instruction, CR6229, issued to your carrier, FI, A/B MAC, RHHI, and DME MAC regarding this change may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R1634CP.pdf on the CMS Web site.

HCPCS Codes Selected for Competitive Bidding in 2008 Receiving 9.5% Reduction in 2009

The items listed are those that were included in Round 1 of the DMEPOS Competitive Bidding Program. A 9.5% reduction applies to these items furnished on/after January 1, 2009, in any geographical area. (E1392, K0738, E0441, E0442, E0443, and E0444 are exceptions and are not reduced by -9.5%)

PRODUCT CATEGORY 1 **Oxygen Supplies and Equipment**	
E1390	OXYGEN CONCENTRATOR, SINGLE DELIVERY PORT, CAPABLE OF DELIVERING 85 PERCENT OR GREATER OXYGEN CONCENTRATION AT THE PRESCRIBED FLOW RATE
E1391	OXYGEN CONCENTRATOR, DUAL DELIVERY PORT, CAPABLE OF DELIVERING 85 PERCENT OR GREATER OXYGEN CONCENTRATION AT THE PRESCRIBED FLOW RATE, EACH
E0424	STATIONARY COMPRESSED GASEOUS OXYGEN SYSTEM, RENTAL; INCLUDES CONTAINER, CONTENTS, REGULATOR, FLOWMETER, HUMIDIFIER, NEBULIZER, CANNULA OR MASK, AND TUBING
E0439	STATIONARY LIQUID OXYGEN SYSTEM, RENTAL; INCLUDES CONTAINER, CONTENTS, REGULATOR, FLOWMETER, HUMIDIFIER, NEBULIZER, CANNULA OR MASK, & TUBING
E0431	PORTABLE GASEOUS OXYGEN SYSTEM, RENTAL; INCLUDES PORTABLE CONTAINER, REGULATOR, FLOWMETER, HUMIDIFIER, CANNULA OR MASK, AND TUBING
E0434	PORTABLE LIQUID OXYGEN SYSTEM, RENTAL; INCLUDES PORTABLE CONTAINER, SUPPLY RESERVOIR, HUMIDIFIER, FLOWMETER, REFILL ADAPTOR, CONTENTS GAUGE, CANNULA OR MASK, AND TUBING
A4608	TRANSTRACHEAL OXYGEN CATHETER, EACH
A4615	CANNULA, NASAL
A4616	TUBING (OXYGEN), PER FOOT
A4617	MOUTH PIECE
A4620	VARIABLE CONCENTRATION MASK
E0560	HUMIDIFIER, DURABLE FOR SUPPLEMENTAL HUMIDIFICATION DURING IPPB TREATMENT OR OXYGEN DELIVERY
E0580	NEBULIZER, DURABLE, GLASS OR AUTOCLAVABLE PLASTIC, BOTTLE TYPE, FOR USE WITH REGULATOR OR FLOWMETER
E1353	REGULATOR
E1355	STAND/RACK

PRODUCT CATEGORY 2 **Standard Power Wheelchairs, Scooters, and Related Accessories**	
E0950	WHEELCHAIR ACCESSORY, TRAY, EACH
E0951	HEEL LOOP/HOLDER, ANY TYPE, WITH OR WITHOUT ANKLE STRAP, EACH
E0952	TOE LOOP/HOLDER, ANY TYPE, EACH
E0955	WHEELCHAIR ACCESSORY, HEADREST, CUSHIONED, ANY TYPE, INCLUDING FIXED MOUNTING HARDWARE, EACH
E0956	WHEELCHAIR ACCESSORY, LATERAL TRUNK OR HIP SUPPORT, ANY TYPE, INCLUDING FIXED MOUNTING HARDWARE, EACH
E0957	WHEELCHAIR ACCESSORY, MEDIAL THIGH SUPPORT, ANY TYPE, INCLUDING FIXED MOUNTING HARDWARE, EACH
E0960	WHEELCHAIR ACCESSORY, SHOULDER HARNESS/STRAPS OR CHEST STRAP, INCLUDING ANY TYPE MOUNTING HARDWARE
E0973	WHEELCHAIR ACCESSORY, ADJUSTABLE HEIGHT, DETACHABLE ARMREST, COMPLETE ASSEMBLY, EACH
E0978	WHEELCHAIR ACCESSORY, POSITIONING BELT/SAFETY BELT/PELVIC STRAP, EACH
E0981	WHEELCHAIR ACCESSORY, SEAT UPHOLSTERY, REPLACEMENT ONLY, EACH

E0982	WHEELCHAIR ACCESSORY, BACK UPHOLSTERY, REPLACEMENT ONLY, EACH
E0990	WHEELCHAIR ACCESSORY, ELEVATING LEG REST, COMPLETE ASSEMBLY, EACH
E0995	WHEELCHAIR ACCESSORY, CALF REST/PAD, EACH
E1016	SHOCK ABSORBER FOR POWER WHEELCHAIR, EACH
E1020	RESIDUAL LIMB SUPPORT SYSTEM FOR WHEELCHAIR
E1028	WHEELCHAIR ACCESSORY, MANUAL SWINGAWAY, RETRACTABLE OR REMOVABLE MOUNTING HARDWARE FOR JOYSTICK, OTHER CONTROL INTERFACE OR POSITIONING ACCESSORY
E2208	WHEELCHAIR ACCESSORY, CYLINDER TANK CARRIER, EACH
E2209	ACCESSORY, ARM TROUGH, WITH OR WITHOUT HAND SUPPORT, EACH
E2210	WHEELCHAIR ACCESSORY, BEARINGS, ANY TYPE, REPLACEMENT ONLY, EACH
E2361	POWER WHEELCHAIR ACCESSORY, 22NF SEALED LEAD ACID BATTERY, EACH, (E.G. GEL CELL, ABSORBED GLASSMAT)
E2363	POWER WHEELCHAIR ACCESSORY, GROUP 24 SEALED LEAD ACID BATTERY, EACH (E.G. GEL CELL, ABSORBED GLASSMAT)
E2365	POWER WHEELCHAIR ACCESSORY, U-1 SEALED LEAD ACID BATTERY, EACH (E.G. GEL CELL, ABSORBED GLASSMAT)
E2366	POWER WHEELCHAIR ACCESSORY, BATTERY CHARGER, SINGLE MODE, FOR USE WITH ONLY ONE BATTERY TYPE, SEALED OR NON-SEALED, EACH
E2367	POWER WHEELCHAIR ACCESSORY, BATTERY CHARGER, DUAL MODE, FOR USE WITH EITHER BATTERY TYPE, SEALED OR NON-SEALED, EACH
E2368	POWER WHEELCHAIR COMPONENT, MOTOR, REPLACEMENT ONLY
E2369	POWER WHEELCHAIR COMPONENT, GEAR BOX, REPLACEMENT ONLY
E2370	POWER WHEELCHAIR COMPONENT, MOTOR AND GEAR BOX COMBINATION, REPLACEMENT ONLY
E2371	POWER WHEELCHAIR ACCESSORY, GROUP 27 SEALED LEAD ACID BATTERY, (E.G. GEL CELL, ABSORBED GLASSMAT), EACH
E2381	POWER WHEELCHAIR ACCESSORY, PNEUMATIC DRIVE WHEEL TIRE, ANY SIZE, REPLACEMENT ONLY, EACH
E2382	POWER WHEELCHAIR ACCESSORY, TUBE FOR PNEUMATIC DRIVE WHEEL TIRE, ANY SIZE, REPLACEMENT ONLY, EACH
E2383	POWER WHEELCHAIR ACCESSORY, INSERT FOR PNEUMATIC DRIVE WHEEL TIRE (REMOVABLE), ANY TYPE, ANY SIZE, REPLACEMENT ONLY, EACH
E2384	POWER WHEELCHAIR ACCESSORY, PNEUMATIC CASTER TIRE, ANY SIZE, REPLACEMENT ONLY, EACH
E2385	POWER WHEELCHAIR ACCESSORY, TUBE FOR PNEUMATIC CASTER TIRE, ANY SIZE, REPLACEMENT ONLY, EACH
E2386	POWER WHEELCHAIR ACCESSORY, FOAM FILLED DRIVE WHEEL TIRE, ANY SIZE, REPLACEMENT ONLY, EACH
E2387	POWER WHEELCHAIR ACCESSORY, FOAM FILLED CASTER TIRE, ANY SIZE, REPLACEMENT ONLY, EACH
E2388	POWER WHEELCHAIR ACCESSORY, FOAM DRIVE WHEEL TIRE, ANY SIZE, REPLACEMENT ONLY, EACH
E2389	POWER WHEELCHAIR ACCESSORY, FOAM CASTER TIRE, ANY SIZE, REPLACEMENT ONLY, EACH
E2390	POWER WHEELCHAIR ACCESSORY, SOLID (RUBBER/PLASTIC) DRIVE WHEEL TIRE, ANY SIZE, REPLACEMENT ONLY, EACH
E2391	POWER WHEELCHAIR ACCESSORY, SOLID (RUBBER/PLASTIC) CASTER TIRE (REMOVABLE), ANY SIZE, REPLACEMENT ONLY, EACH
E2392	POWER WHEELCHAIR ACCESSORY, SOLID (RUBBER/PLASTIC) CASTER TIRE WITH INTEGRATED WHEEL, ANY SIZE, REPLACEMENT ONLY, EACH
E2394	POWER WHEELCHAIR ACCESSORY, DRIVE WHEEL EXCLUDES TIRE, ANY SIZE, REPLACEMENT ONLY, EACH
E2395	POWER WHEELCHAIR ACCESSORY, CASTER WHEEL EXCLUDES TIRE, ANY SIZE, REPLACEMENT ONLY, EACH
E2396	POWER WHEELCHAIR ACCESSORY, CASTER FORK, ANY SIZE, REPLACEMENT ONLY, EACH
E2601	GENERAL USE WHEELCHAIR SEAT CUSHION, WIDTH LESS THAN 22 INCHES, ANY DEPTH

E2602	GENERAL USE WHEELCHAIR SEAT CUSHION, WIDTH 22 INCHES OR GREATER, ANY DEPTH
E2603	SKIN PROTECTION WHEELCHAIR SEAT CUSHION, WIDTH LESS THAN 22 INCHES, ANY DEPTH
E2604	SKIN PROTECTION WHEELCHAIR SEAT CUSHION, WIDTH 22 INCHES OR GREATER, ANY DEPTH
E2605	POSITIONING WHEELCHAIR SEAT CUSHION, WIDTH LESS THAN 22 INCHES, ANY DEPTH
E2606	POSITIONING WHEELCHAIR SEAT CUSHION, WIDTH 22 INCHES OR GREATER, ANY DEPTH
E2607	SKIN PROTECTION AND POSITIONING WHEELCHAIR SEAT CUSHION, WIDTH LESS THAN 22 INCHES, ANY DEPTH
E2608	SKIN PROTECTION AND POSITIONING WHEELCHAIR SEAT CUSHION, WIDTH 22 INCHES OR GREATER, ANY DEPTH
E2611	GENERAL USE WHEELCHAIR BACK CUSHION, WIDTH LESS THAN 22 INCHES, ANY HEIGHT, INCLUDING ANY TYPE MOUNTING HARDWARE
E2612	GENERAL USE WHEELCHAIR BACK CUSHION, WIDTH 22 INCHES OR GREATER, ANY HEIGHT, INCLUDING ANY TYPE MOUNTING HARDWARE
E2613	POSITIONING WHEELCHAIR BACK CUSHION, POSTERIOR, WIDTH LESS THAN 22 INCHES, ANY HEIGHT, INCLUDING ANY TYPE MOUNTING HARDWARE
E2614	POSITIONING WHEELCHAIR BACK CUSHION, POSTERIOR, WIDTH 22 INCHES OR GREATER, ANY HEIGHT, INCLUDING ANY TYPE MOUNTING HARDWARE
E2615	POSITIONING WHEELCHAIR BACK CUSHION, POSTERIOR-LATERAL, WIDTH LESS THAN 22 INCHES, ANY HEIGHT, INCLUDING ANY TYPE MOUNTING HARDWARE
E2616	POSITIONING WHEELCHAIR BACK CUSHION, POSTERIOR-LATERAL, WIDTH 22 INCHES OR GREATER, ANY HEIGHT, INCLUDING ANY TYPE MOUNTING HARDWARE
E2619	REPLACEMENT COVER FOR WHEELCHAIR SEAT CUSHION OR BACK CUSHION, EACH
E2620	REPLACEMENT COVER FOR WHEELCHAIR SEAT CUSHION OR BACK CUSHION, EACH
E2621	POSITIONING WHEELCHAIR BACK CUSHION, PLANAR BACK WITH LATERAL SUPPORTS, WIDTH 22 INCHES OR GREATER, ANY HEIGHT, INCLUDING ANY TYPE MOUNTING HARDWARE
K0015	DETACHABLE, NON-ADJUSTABLE HEIGHT ARMREST, EACH
K0017	DETACHABLE, ADJUSTABLE HEIGHT ARMREST, BASE, EACH
K0018	DETACHABLE, ADJUSTABLE HEIGHT ARMREST, UPPER PORTION, EACH
K0019	ARM PAD, EACH
K0020	FIXED, ADJUSTABLE HEIGHT ARMREST, PAIR
K0037	HIGH MOUNT FLIP-UP FOOTREST, EACH
K0038	LEG STRAP, EACH
K0039	LEG STRAP, H STYLE, EACH
K0040	ADJUSTABLE ANGLE FOOTPLATE, EACH
K0041	LARGE SIZE FOOTPLATE, EACH
K0042	STANDARD SIZE FOOTPLATE, EACH
K0043	FOOTREST, LOWER EXTENSION TUBE, EACH
K0044	FOOTREST, UPPER HANGER BRACKET, EACH
K0045	FOOTREST, COMPLETE ASSEMBLY
K0046	ELEVATING LEGREST, LOWER EXTENSION TUBE, EACH
K0047	ELEVATING LEGREST, UPPER HANGER BRACKET, EACH
K0050	RATCHET ASSEMBLY
K0051	CAM RELEASE ASSEMBLY, FOOTREST OR LEGREST, EACH
K0052	SWINGAWAY, DETACHABLE FOOTRESTS, EACH
K0053	ELEVATING FOOTRESTS, ARTICULATING (TELESCOPING), EACH
K0098	DRIVE BELT FOR POWER WHEELCHAIR

K0195	ELEVATING LEG RESTS, PAIR (FOR USE WITH CAPPED RENTAL WHEELCHAIR BASE)
K0733	POWER WHEELCHAIR ACCESSORY, 12 TO 24 AMP HOUR SEALED LEAD ACID BATTERY, EACH (E.G., GEL CELL, ABSORBED GLASSMAT)
K0734	SKIN PROTECTION WHEELCHAIR SEAT CUSHION, ADJUSTABLE, WIDTH LESS THAN 22 INCHES, ANY DEPTH
K0735	SKIN PROTECTION WHEELCHAIR SEAT CUSHION, ADJUSTABLE, WIDTH 22 INCHES OR GREATER, ANY DEPTH
K0736	SKIN PROTECTION AND POSITIONING WHEELCHAIR SEAT CUSHION, ADJUSTABLE, WIDTH LESS THAN 22 INCHES, ANY DEPTH
K0737	SKIN PROTECTION AND POSITIONING WHEELCHAIR SEAT CUSHION, ADJUSTABLE, WIDTH 22 INCHES OR GREATER, ANY DEPTH
K0800	POWER OPERATED VEHICLE, GROUP 1 STANDARD
K0801	POWER OPERATED VEHICLE, GROUP 1 HEAVY DUTY
K0802	POWER OPERATED VEHICLE, GROUP 1 VERY HEAVY DUTY
K0806	POWER OPERATED VEHICLE, GROUP 2 STANDARD
K0807	POWER OPERATED VEHICLE, GROUP 2 HEAVY DUTY
K0808	POWER OPERATED VEHICLE, GROUP 2 VERY HEAVY DUTY
K0813	POWER WHEELCHAIR, GROUP 1 STANDARD, PORTABLE, SLING/SOLID SEAT AND BACK
K0814	POWER WHEELCHAIR, GROUP 1 STANDARD, PORTABLE, CAPTAINS CHAIR
K0815	POWER WHEELCHAIR, GROUP 1 STANDARD, SLING/SOLID SEAT AND BACK
K0816	POWER WHEELCHAIR, GROUP 1 STANDARD, CAPTAINS CHAIR
K0820	POWER WHEELCHAIR, GROUP 2 STANDARD, PORTABLE, SLING/SOLID SEAT/BACK
K0821	POWER WHEELCHAIR, GROUP 2 STANDARD, PORTABLE, CAPTAINS CHAIR
K0822	POWER WHEELCHAIR, GROUP 2 STANDARD, SLING/SOLID SEAT/BACK
K0823	POWER WHEELCHAIR, GROUP 2 STANDARD, CAPTAINS CHAIR
K0824	POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, SLING/SOLID SEAT/BACK
K0825	POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, CAPTAINS CHAIR
K0826	POWER WHEELCHAIR, GROUP 2 VERY HEAVY DUTY, SLING/SOLID SEAT/BACK
K0827	POWER WHEELCHAIR, GROUP 2 VERY HEAVY DUTY, CAPTAINS CHAIR
K0828	POWER WHEELCHAIR, GROUP 2 EXTRA HEAVY DUTY, SLING/SOLID SEAT/BACK
K0829	POWER WHEELCHAIR, GROUP 2 EXTRA HEAVY DUTY, CAPTAINS CHAIR

PRODUCT CATEGORY 3 **Complex Rehabilitative Power Wheelchairs and Related Accessories**	
E0950	WHEELCHAIR ACCESSORY, TRAY, EACH
E0951	HEEL LOOP/HOLDER, ANY TYPE, WITH OR WITHOUT ANKLE STRAP, EACH
E0952	TOE LOOP/HOLDER, ANY TYPE, EACH
E0955	WHEELCHAIR ACCESSORY, HEADREST, CUSHIONED, ANY TYPE, INCLUDING FIXED MOUNTING HARDWARE, EACH
E0956	WHEELCHAIR ACCESSORY, LATERAL TRUNK OR HIP SUPPORT, ANY TYPE, INCLUDING FIXED MOUNTING HARDWARE, EACH
E0957	WHEELCHAIR ACCESSORY, MEDIAL THIGH SUPPORT, ANY TYPE, INCLUDING FIXED MOUNTING HARDWARE, EACH
E0960	WHEELCHAIR ACCESSORY, SHOULDER HARNESS/STRAPS OR CHEST STRAP, INCLUDING ANY TYPE MOUNTING HARDWARE
E0973	WHEELCHAIR ACCESSORY, ADJUSTABLE HEIGHT, DETACHABLE ARMREST, COMPLETE ASSEMBLY, EACH
E0978	WHEELCHAIR ACCESSORY, POSITIONING BELT/SAFETY BELT/PELVIC STRAP, EACH
E0981	WHEELCHAIR ACCESSORY, SEAT UPHOLSTERY, REPLACEMENT ONLY, EACH
E0982	WHEELCHAIR ACCESSORY, BACK UPHOLSTERY, REPLACEMENT ONLY, EACH
E0990	WHEELCHAIR ACCESSORY, ELEVATING LEG REST, COMPLETE ASSEMBLY, EACH

E0995	WHEELCHAIR ACCESSORY, CALF REST/PAD, EACH
E1002	WHEELCHAIR ACCESSORY, POWER SEATING SYSTEM, TILT ONLY
E1003	WHEELCHAIR ACCESSORY, POWER SEATING SYSTEM, RECLINE ONLY, WITHOUT SHEAR REDUCTION
E1004	WHEELCHAIR ACCESSORY, POWER SEATING SYSTEM, RECLINE ONLY, WITH MECHANICAL SHEAR REDUCTION
E1005	WHEELCHAIR ACCESSORY, POWER SEATNG SYSTEM, RECLINE ONLY, WITH POWER SHEAR REDUCTION
E1006	WHEELCHAIR ACCESSORY, POWER SEATING SYSTEM, COMBINATION TILT AND RECLINE, WITHOUT SHEAR REDUCTION
E1007	WHEELCHAIR ACCESSORY, POWER SEATING SYSTEM, COMBINATION TILT AND RECLINE, WITH MECHANICAL SHEAR REDUCTION
E1008	WHEELCHAIR ACCESSORY, POWER SEATING SYSTEM, COMBINATION TILT AND RECLINE, WITH POWER SHEAR REDUCTION
E1010	WHEELCHAIR ACCESSORY, ADDITION TO POWER SEATING SYSTEM, POWER LEG ELEVATION SYSTEM, INCLUDING LEG REST, PAIR
E1016	SHOCK ABSORBER FOR POWER WHEELCHAIR, EACH
E1020	RESIDUAL LIMB SUPPORT SYSTEM FOR WHEELCHAIR
E1028	WHEELCHAIR ACCESSORY, MANUAL SWINGAWAY, RETRACTABLE OR REMOVABLE MOUNTING HARDWARE FOR JOYSTICK, OTHER CONTROL INTERFACE OR POSITIONING ACCESSORY
E1029	WHEELCHAIR ACCESSORY, VENTILATOR TRAY, FIXED
E1030	WHEELCHAIR ACCESSORY, VENTILATOR TRAY, GIMBALED
E2208	WHEELCHAIR ACCESSORY, CYLINDER TANK CARRIER, EACH
E2209	ACCESSORY, ARM TROUGH, WITH OR WITHOUT HAND SUPPORT, EACH
E2210	WHEELCHAIR ACCESSORY, BEARINGS, ANY TYPE, REPLACEMENT ONLY, EACH
E2310	POWER WHEELCHAIR ACCESSORY, ELECTRONIC CONNECTION BETWEEN WHEELCHAIR CONTROLLER AND ONE POWER SEATING SYSTEM MOTOR, INCLUDING ALL RELATED ELECTRONICS, INDICATOR FEATURE, MECHANICAL FUNCTION SELECTION SWITCH, AND FIXED MOUNTING HARDWARE
E2311	POWER WHEELCHAIR ACCESSORY, ELECTRONIC CONNECTION BETWEEN WHEELCHAIR CONTROLLER AND TWO OR MORE POWER SEATING SYSTEM MOTORS, INCLUDING ALL RELATED ELECTRONICS, INDICATOR FEATURE, MECHANICAL FUNCTION SELECTION SWITCH, AND FIXED MOUNTING HARDWARE
E2321	POWER WHEELCHAIR ACCESSORY, HAND CONTROL INTERFACE, REMOTE JOYSTICK, NONPROPORTIONAL, INCLUDING ALL RELATED ELECTRONICS, MECHANICAL STOP SWITCH, AND FIXED MOUNTING HARDWARE
E2322	POWER WHEELCHAIR ACCESSORY, HAND CONTROL INTERFACE, MULTIPLE MECHANICAL SWITCHES, NONPROPORTIONAL, INCLUDING ALL RELATED ELECTRONICS, MECHANICAL STOP SWITCH, AND FIXED MOUNTING HARDWARE
E2323	POWER WHEELCHAIR ACCESSORY, SPECIALTY JOYSTICK HANDLE FOR HAND CONTROL INTERFACE, PREFABRICATED
E2324	POWER WHEELCHAIR ACCESSORY, CHIN CUP FOR CHIN CONTROL INTERFACE
E2325	POWER WHEELCHAIR ACCESSORY, SIP AND PUFF INTERFACE, NONPROPORTIONAL, INCLUDING ALL RELATED ELECTRONICS, MECHANICAL STOP SWITCH, AND MANUAL SWINGAWAY MOUNTING HARDWARE
E2326	POWER WHEELCHAIR ACCESSORY, BREATH TUBE KIT FOR SIP AND PUFF INTERFACE
E2327	POWER WHEELCHAIR ACCESSORY, HEAD CONTROL INTERFACE, MECHANICAL, PROPORTIONAL, INCLUDING ALL RELATED ELECTRONICS, MECHANICAL DIRECTION CHANGE SWITCH, AND FIXED MOUNTING HARDWARE
E2328	POWER WHEELCHAIR ACCESSORY, HEAD CONTROL OR EXTREMITY CONTROL INTERFACE, ELECTRONIC, PROPORTIONAL, INCLUDING ALL RELATED ELECTRONICS AND FIXED MOUNTING HARDWARE
E2329	POWER WHEELCHAIR ACCESSORY, HEAD CONTROL INTERFACE, CONTACT SWITCH MECHANISM, NONPROPORTIONAL, INCLUDING ALL RELATED ELECTRONICS, MECHANICAL STOP SWITCH, MECHANICAL DIRECTION CHANGE SWITCH, HEAD ARRAY, AND FIXED MOUNTING HARDWARE

E2330	POWER WHEELCHAIR ACCESSORY, HEAD CONTROL INTERFACE, PROXIMITY SWITCH MECHANISM, NONPROPORTIONAL, INCLUDING ALL RELATED ELECTRONICS, MECHANICAL STOP SWITCH, MECHANICAL DIRECTION CHANGE SWITCH, HEAD ARRAY, AND FIXED MOUNTING HARDWARE
E2351	POWER WHEELCHAIR ACCESSORY, ELECTRONIC INTERFACE TO OPERATE SPEECH GENERATING DEVICE USING POWER WHEELCHAIR CONTROL INTERFACE
E2361	POWER WHEELCHAIR ACCESSORY, 22NF SEALED LEAD ACID BATTERY, EACH, (E.G. GEL CELL, ABSORBED GLASSMAT)
E2363	POWER WHEELCHAIR ACCESSORY, GROUP 24 SEALED LEAD ACID BATTERY, EACH (E.G. GEL CELL, ABSORBED GLASSMAT)
E2365	POWER WHEELCHAIR ACCESSORY, U-1 SEALED LEAD ACID BATTERY, EACH (E.G. GEL CELL, ABSORBED GLASSMAT)
E2366	POWER WHEELCHAIR ACCESSORY, BATTERY CHARGER, SINGLE MODE, FOR USE WITH ONLY ONE BATTERY TYPE, SEALED OR NON-SEALED, EACH
E2367	POWER WHEELCHAIR ACCESSORY, BATTERY CHARGER, DUAL MODE, FOR USE WITH EITHER BATTERY TYPE, SEALED OR NON-SEALED, EACH
E2368	POWER WHEELCHAIR COMPONENT, MOTOR, REPLACEMENT ONLY
E2369	POWER WHEELCHAIR COMPONENT, GEAR BOX, REPLACEMENT ONLY
E2370	POWER WHEELCHAIR COMPONENT, MOTOR AND GEAR BOX COMBINATION, REPLACEMENT ONLY
E2371	POWER WHEELCHAIR ACCESSORY, GROUP 27 SEALED LEAD ACID BATTERY, (E.G. GEL CELL, ABSORBED GLASSMAT), EACH
E2373 KC	POWER WHEELCHAIR ACCESSORY, HAND OR CHIN CONTROL INTERFACE, COMPACT REMOTE JOYSTICK, PROPORTIONAL, INCLUDING FIXED MOUNTING HARDWARE
E2374	POWER WHEELCHAIR ACCESSORY, HAND OR CHIN CONTROL INTERFACE, STANDARD REMOTE JOYSTICK (NOT INCLUDING CONTROLLER), PROPORTIONAL, INCLUDING ALL RELATED ELECTRONICS AND FIXED MOUNTING HARDWARE, REPLACEMENT ONLY
E2375	POWER WHEELCHAIR ACCESSORY, NON-EXPANDABLE CONTROLLER, INCLUDING ALL RELATED ELECTRONICS AND MOUNTING HARDWARE, REPLACEMENT ONLY
E2376	POWER WHEELCHAIR ACCESSORY, EXPANDABLE CONTROLLER, INCLUDING ALL RELATED ELECTRONICS AND MOUNTING HARDWARE, REPLACEMENT ONLY
E2377	POWER WHEELCHAIR ACCESSORY, EXPANDABLE CONTROLLER, INCLUDING ALL RELATED ELECTRONICS AND MOUNTING HARDWARE, UPGRADE PROVIDED AT INITIAL ISSUE
E2381	POWER WHEELCHAIR ACCESSORY, PNEUMATIC DRIVE WHEEL TIRE, ANY SIZE, REPLACEMENT ONLY, EACH
E2382	POWER WHEELCHAIR ACCESSORY, TUBE FOR PNEUMATIC DRIVE WHEEL TIRE, ANY SIZE, REPLACEMENT ONLY, EACH
E2383	POWER WHEELCHAIR ACCESSORY, INSERT FOR PNEUMATIC DRIVE WHEEL TIRE (REMOVABLE), ANY TYPE, ANY SIZE, REPLACEMENT ONLY, EACH
E2384	POWER WHEELCHAIR ACCESSORY, PNEUMATIC CASTER TIRE, ANY SIZE, REPLACEMENT ONLY, EACH
E2385	POWER WHEELCHAIR ACCESSORY, TUBE FOR PNEUMATIC CASTER TIRE, ANY SIZE, REPLACEMENT ONLY, EACH
E2386	POWER WHEELCHAIR ACCESSORY, FOAM FILLED DRIVE WHEEL TIRE, ANY SIZE, REPLACEMENT ONLY, EACH
E2387	POWER WHEELCHAIR ACCESSORY, FOAM FILLED CASTER TIRE, ANY SIZE, REPLACEMENT ONLY, EACH
E2388	POWER WHEELCHAIR ACCESSORY, FOAM DRIVE WHEEL TIRE, ANY SIZE, REPLACEMENT ONLY, EACH
E2389	POWER WHEELCHAIR ACCESSORY, FOAM CASTER TIRE, ANY SIZE, REPLACEMENT ONLY, EACH
E2390	POWER WHEELCHAIR ACCESSORY, SOLID (RUBBER/PLASTIC) DRIVE WHEEL TIRE, ANY SIZE, REPLACEMENT ONLY, EACH
E2391	POWER WHEELCHAIR ACCESSORY, SOLID (RUBBER/PLASTIC) CASTER TIRE (REMOVABLE), ANY SIZE, REPLACEMENT ONLY, EACH
E2392	POWER WHEELCHAIR ACCESSORY, SOLID (RUBBER/PLASTIC) CASTER TIRE WITH INTEGRATED WHEEL, ANY SIZE, REPLACEMENT ONLY, EACH
E2394	POWER WHEELCHAIR ACCESSORY, DRIVE WHEEL EXCLUDES TIRE, ANY SIZE, REPLACEMENT ONLY, EACH

E2395	POWER WHEELCHAIR ACCESSORY, CASTER WHEEL EXCLUDES TIRE, ANY SIZE, REPLACEMENT ONLY, EACH
E2396	POWER WHEELCHAIR ACCESSORY, CASTER FORK, ANY SIZE, REPLACEMENT ONLY, EACH
E2601	GENERAL USE WHEELCHAIR SEAT CUSHION, WIDTH LESS THAN 22 INCHES, ANY DEPTH
E2602	GENERAL USE WHEELCHAIR SEAT CUSHION, WIDTH 22 INCHES OR GREATER, ANY DEPTH
E2603	SKIN PROTECTION WHEELCHAIR SEAT CUSHION, WIDTH LESS THAN 22 INCHES, ANY DEPTH
E2604	SKIN PROTECTION WHEELCHAIR SEAT CUSHION, WIDTH 22 INCHES OR GREATER, ANY DEPTH
E2605	POSITIONING WHEELCHAIR SEAT CUSHION, WIDTH LESS THAN 22 INCHES, ANY DEPTH
E2606	POSITIONING WHEELCHAIR SEAT CUSHION, WIDTH 22 INCHES OR GREATER, ANY DEPTH
E2607	SKIN PROTECTION AND POSITIONING WHEELCHAIR SEAT CUSHION, WIDTH LESS THAN 22 INCHES, ANY DEPTH
E2608	SKIN PROTECTION AND POSITIONING WHEELCHAIR SEAT CUSHION, WIDTH 22 INCHES OR GREATER, ANY DEPTH
E2611	GENERAL USE WHEELCHAIR BACK CUSHION, WIDTH LESS THAN 22 INCHES, ANY HEIGHT, INCLUDING ANY TYPE MOUNTING HARDWARE
E2612	GENERAL USE WHEELCHAIR BACK CUSHION, WIDTH 22 INCHES OR GREATER, ANY HEIGHT, INCLUDING ANY TYPE MOUNTING HARDWARE
E2613	POSITIONING WHEELCHAIR BACK CUSHION, POSTERIOR, WIDTH LESS THAN 22 INCHES, ANY HEIGHT, INCLUDING ANY TYPE MOUNTING HARDWARE
E2614	POSITIONING WHEELCHAIR BACK CUSHION, POSTERIOR, WIDTH 22 INCHES OR GREATER, ANY HEIGHT, INCLUDING ANY TYPE MOUNTING HARDWARE
E2615	POSITIONING WHEELCHAIR BACK CUSHION, POSTERIOR-LATERAL, WIDTH LESS THAN 22 INCHES, ANY HEIGHT, INCLUDING ANY TYPE MOUNTING HARDWARE
E2616	POSITIONING WHEELCHAIR BACK CUSHION, POSTERIOR-LATERAL, WIDTH 22 INCHES OR GREATER, ANY HEIGHT, INCLUDING ANY TYPE MOUNTING HARDWARE
E2619	REPLACEMENT COVER FOR WHEELCHAIR SEAT CUSHION OR BACK CUSHION, EACH
E2620	POSITIONING WHEELCHAIR BACK CUSHION, PLANAR BACK WITH LATERAL SUPPORTS, WIDTH LESS THAN 22 INCHES, ANY HEIGHT, INCLUDING ANY TYPE MOUNTING HARDWARE
E2621	POSITIONING WHEELCHAIR BACK CUSHION, PLANAR BACK WITH LATERAL SUPPORTS, WIDTH 22 INCHES OR GREATER, ANY HEIGHT, INCLUDING ANY TYPE MOUNTING HARDWARE
K0015	DETACHABLE, NON-ADJUSTABLE HEIGHT ARMREST, EACH
K0017	DETACHABLE, ADJUSTABLE HEIGHT ARMREST, BASE, EACH
K0018	DETACHABLE, ADJUSTABLE HEIGHT ARMREST, UPPER PORTION, EACH
K0019	ARM PAD, EACH
K0020	FIXED, ADJUSTABLE HEIGHT ARMREST, PAIR
K0037	HIGH MOUNT FLIP-UP FOOTREST, EACH
K0038	LEG STRAP, EACH
K0039	LEG STRAP, H STYLE, EACH
K0040	ADJUSTABLE ANGLE FOOTPLATE, EACH
K0041	LARGE SIZE FOOTPLATE, EACH
K0042	STANDARD SIZE FOOTPLATE, EACH
K0043	FOOTREST, LOWER EXTENSION TUBE, EACH
K0044	FOOTREST, UPPER HANGER BRACKET, EACH
K0045	FOOTREST, COMPLETE ASSEMBLY
K0046	ELEVATING LEGREST, LOWER EXTENSION TUBE, EACH
K0047	ELEVATING LEGREST, UPPER HANGER BRACKET, EACH
K0050	RATCHET ASSEMBLY
K0051	CAM RELEASE ASSEMBLY, FOOTREST OR LEGREST, EACH
K0052	SWINGAWAY, DETACHABLE FOOTRESTS, EACH

K0053	ELEVATING FOOTRESTS, ARTICULATING (TELESCOPING), EACH
K0098	DRIVE BELT FOR POWER WHEELCHAIR
K0195	ELEVATING LEG RESTS, PAIR (FOR USE WITH CAPPED RENTAL WHEELCHAIR BASE)
K0733	POWER WHEELCHAIR ACCESSORY, 12 TO 24 AMP HOUR SEALED LEAD ACID BATTERY, EACH (E.G., GEL CELL, ABSORBED GLASSMAT)
K0734	SKIN PROTECTION WHEELCHAIR SEAT CUSHION, ADJUSTABLE, WIDTH LESS THAN 22 INCHES, ANY DEPTH
K0735	SKIN PROTECTION WHEELCHAIR SEAT CUSHION, ADJUSTABLE, WIDTH 22 INCHES OR GREATER, ANY DEPTH
K0736	SKIN PROTECTION AND POSITIONING WHEELCHAIR SEAT CUSHION, ADJUSTABLE, WIDTH LESS THAN 22 INCHES, ANY DEPTH
K0737	SKIN PROTECTION AND POSITIONING WHEELCHAIR SEAT CUSHION, ADJUSTABLE, WIDTH 22 INCHES OR GREATER, ANY DEPTH
K0835	POWER WHEELCHAIR, GROUP 2 STANDARD, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
K0836	POWER WHEELCHAIR, GROUP 2 STANDARD, SINGLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
K0837	POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS
K0838	POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, SINGLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS
K0839	POWER WHEELCHAIR, GROUP 2 VERY HEAVY DUTY, SINGLE POWER OPTION SLING/SOLID SEAT/ BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS
K0840	POWER WHEELCHAIR, GROUP 2 EXTRA HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/ BACK, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE
K0841	POWER WHEELCHAIR, GROUP 2 STANDARD, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
K0842	POWER WHEELCHAIR, GROUP 2 STANDARD, MULTIPLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
K0843	POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS
K0848	POWER WHEELCHAIR, GROUP 3 STANDARD, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
K0849	POWER WHEELCHAIR, GROUP 3 STANDARD, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
K0850	POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS
K0851	POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS
K0852	POWER WHEELCHAIR, GROUP 3 VERY HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS
K0853	POWER WHEELCHAIR, GROUP 3 VERY HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS
K0854	POWER WHEELCHAIR, GROUP 3 EXTRA HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE
K0855	POWER WHEELCHAIR, GROUP 3 EXTRA HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE
K0856	POWER WHEELCHAIR, GROUP 3 STANDARD, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
K0857	POWER WHEELCHAIR, GROUP 3 STANDARD, SINGLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
K0858	POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT 301 TO 450 POUNDS

K0859	POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, SINGLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS
K0860	POWER WHEELCHAIR, GROUP 3 VERY HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/ BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS
K0861	POWER WHEELCHAIR, GROUP 3 STANDARD, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
K0862	POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS
K0863	POWER WHEELCHAIR, GROUP 3 VERY HEAVY DUTY, MULTIPLE POWER OPTION, SLING/SOLID SEAT/ BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS
K0864	POWER WHEELCHAIR, GROUP 3 EXTRA HEAVY DUTY, MULTIPLE POWER OPTION, SLING/SOLID SEAT/ BACK, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE
PRODUCT CATEGORY 4 **Mail-Order Diabetic Supplies**	
A4233 KL	REPLACEMENT BATTERY, ALKALINE (OTHER THAN J CELL), FOR USE WITH MEDICALLY NECESSARY HOME BLOOD GLUCOSE MONITOR OWNED BY PATIENT, EACH
A4234 KL	REPLACEMENT BATTERY, ALKALINE, J CELL, FOR USE WITH MEDICALLY NECESSARY HOME BLOOD GLUCOSE MONITOR OWNED BY PATIENT, EACH
A4235 KL	REPLACEMENT BATTERY, LITHIUM, FOR USE WITH MEDICALLY NECESSARY HOME BLOOD GLUCOSE MONITOR OWNED BY PATIENT, EACH
A4236 KL	REPLACEMENT BATTERY, SILVER OXIDE, FOR USE WITH MEDICALLY NECESSARY HOME BLOOD GLUCOSE MONITOR OWNED BY PATIENT, EACH
A4253 KL	BLOOD GLUCOSE TEST OR REAGENT STRIPS FOR HOME BLOOD GLUCOSE MONITOR, PER 50 STRIPS
A4256 KL	NORMAL, LOW AND HIGH CALIBRATOR SOLUTION / CHIPS
A4258 KL	SPRING-POWERED DEVICE FOR LANCET, EACH
A4259 KL	LANCETS, PER BOX OF 100
PRODUCT CATEGORY 5 **Enteral Nutrients, Equipment, and Supplies**	
B4034	ENTERAL FEEDING SUPPLY KIT; SYRINGE FED, PER DAY
B4035	ENTERAL FEEDING SUPPLY KIT; PUMP FED, PER DAY
B4036	ENTERAL FEEDING SUPPLY KIT; GRAVITY FED, PER DAY
B4081	NASOGASTRIC TUBING WITH STYLET
B4082	NASOGASTRIC TUBING WITHOUT STYLET
B4083	STOMACH TUBE - LEVINE TYPE
B4087	GASTROSTOMY / JEJUNOSTOMY TUBE, ANY MATERIAL, ANY TYPE, (STANDARD), EACH
B4088	GASTROSTOMY / JEJUNOSTOMY TUBE, ANY MATERIAL, ANY TYPE, (LOW PROFILE), EACH
B4149	ENTERAL FORMULA, MANUFACTURED BLENDERIZED NATURAL FOODS WITH INTACT NUTRIENTS, INCLUDES PROTEINS, FATS, CARBOHYDRATES, VITAMINS AND MINERALS, MAY INCLUDE FIBER, ADMINISTERED THROUGH AN ENTERAL FEEDING TUBE, 100 CALORIES = 1 UNIT
B4150	ENTERAL FORMULA, NUTRITIONALLY COMPLETE WITH INTACT NUTRIENTS, INCLUDES PROTEINS, FATS, CARBOHYDRATES, VITAMINS AND MINERALS, MAY INCLUDE FIBER, ADMINISTERED THROUGH AN ENTERAL FEEDING TUBE, 100 CALORIES = 1 UNIT
B4152	ENTERAL FORMULA, NUTRITIONALLY COMPLETE, CALORICALLY DENSE (EQUAL TO OR GREATER THAN 1.5 KCAL/ML) WITH INTACT NUTRIENTS, INCLUDES PROTEINS, FATS, CARBOHYDRATES, VITAMINS AND MINERALS, MAY INCLUDE FIBER, ADMINISTERED THROUGH AN ENTERAL FEEDING TUBE, 100 CALORIES = 1 UNIT
B4153	ENTERAL FORMULA, NUTRITIONALLY COMPLETE, HYDROLYZED PROTEINS (AMINO ACIDS AND PEPTIDE CHAIN), INCLUDES FATS, CARBOHYDRATES, VITAMINS AND MINERALS, MAY INCLUDE FIBER, ADMINISTERED THROUGH AN ENTERAL FEEDING TUBE, 100 CALORIES = 1 UNIT

B4154	ENTERAL FORMULA, NUTRITIONALLY COMPLETE, FOR SPECIAL METABOLIC NEEDS, EXCLUDES INHERITED DISEASE OF METABOLISM, INCLUDES ALTERED COMPOSITION OF PROTEINS, FATS, CARBOHYDRATES, VITAMINS AND/OR MINERALS, MAY INCLUDE FIBER, ADMINISTERED THROUGH AN ENTERAL FEEDING TUBE, 100 CALORIES = 1 UNIT
B4155	ENTERAL FORMULA, NUTRITIONALLY INCOMPLETE/MODULAR NUTRIENTS, INCLUDES SPECIFIC NUTRIENTS, CARBOHYDRATES (E.G. GLUCOSE POLYMERS), PROTEINS/AMINO ACIDS (E.G. GLUTAMINE, ARGININE), FAT (E.G. MEDIUM CHAIN TRIGLYCERIDES) OR COMBINATON, ADMINISTERED THROUGH AN ENTERAL FEEDING TUBE, 100 CALORIES = 1 UNIT NOTE: (SEE J7060, J7070, J7042 FOR SOLUTION CODES FOR OTHER THAN PARENTERAL NUTRITION THERAPY USE)
B9000	ENTERAL NUTRITION INFUSION PUMP - WITHOUT ALARM
B9002	ENTERAL NUTRITION INFUSION PUMP - WITH ALARM
E0776	IV POLE

PRODUCT CATEGORY 6 **Continuous Positive Airway Pressure Devices, Respiratory Assist Devices, and Related Supplies and Accessories**	
A4604	TUBING WITH INTEGRATED HEATING ELEMENT FOR USE WITH POSITIVE AIRWAY PRESSURE DEVICE
A7030	FULL FACE MASK USED WITH POSITIVE AIRWAY PRESSURE DEVICE, EACH
A7031	FACE MASK INTERFACE, REPLACEMENT FOR FULL FACE MASK, EACH
A7032	CUSHION FOR USE ON NASAL MASK INTERFACE, REPLACEMENT ONLY, EACH
A7033	PILLOW FOR USE ON NASAL CANNULA TYPE INTERFACE, REPLACEMENT ONLY, PAIR
A7034	NASAL INTERFACE (MASK OR CANNULA TYPE) USED WITH POSITIVE AIRWAY PRESSURE DEVICE, WITH OR WITHOUT HEAD STRAP
A7035	HEADGEAR USED WITH POSITIVE AIRWAY PRESSURE DEVICE
A7036	CHINSTRAP USED WITH POSITIVE AIRWAY PRESSURE DEVICE
A7037	TUBING USED WITH POSITIVE AIRWAY PRESSURE DEVICE
A7038	FILTER, DISPOSABLE, USED WITH POSITIVE AIRWAY PRESSURE DEVICE
A7039	FILTER, NON DISPOSABLE, USED WITH POSITIVE AIRWAY PRESSURE DEVICE
A7044	ORAL INTERFACE USED WITH POSITIVE AIRWAY PRESSURE DEVICE, EACH
A7045	EXHALATION PORT WITH OR WITHOUT SWIVEL USED WITH ACCESSORIES FOR POSITIVE AIRWAY DEVICES, REPLACEMENT ONLY
A7046	WATER CHAMBER FOR HUMIDIFIER, USED WITH POSITIVE AIRWAY PRESSURE DEVICE, REPLACEMENT, EACH
E0470	RESPIRATORY ASSIST DEVICE, BI-LEVEL PRESSURE CAPABILITY, WITHOUT BACKUP RATE FEATURE, USED WITH NONINVASIVE INTERFACE, E.G., NASAL OR FACIAL MASK (INTERMITTENT ASSIST DEVICE WITH CONTINUOUS POSITIVE AIRWAY PRESSURE DEVICE)
E0471	RESPIRATORY ASSIST DEVICE, BI-LEVEL PRESSURE CAPABILITY, WITH BACK-UP RATE FEATURE, USED WITH NONINVASIVE INTERFACE, E.G., NASAL OR FACIAL MASK (INTERMITTENT ASSIST DEVICE WITH CONTINUOUS POSITIVE AIRWAY PRESSURE DEVICE)
E0472	RESPIRATORY ASSIST DEVICE, BI-LEVEL PRESSURE CAPABILITY, WITH BACKUP RATE FEATURE, USED WITH INVASIVE INTERFACE, E.G., TRACHEOSTOMY TUBE (INTERMITTENT ASSIST DEVICE WITH CONTINUOUS POSITIVE AIRWAY PRESSURE DEVICE)
E0561	HUMIDIFIER, NON-HEATED, USED WITH POSITIVE AIRWAY PRESSURE DEVICE

E0562	HUMIDIFIER, HEATED, USED WITH POSITIVE AIRWAY PRESSURE DEVICE
E0601	CONTINUOUS AIRWAY PRESSURE (CPAP) DEVICE
PRODUCT CATEGORY 7 Hospital Beds and Related Supplies	
E0250	HOSPITAL BED, FIXED HEIGHT, WITH ANY TYPE SIDE RAILS, WITH MATTRESS
E0251	HOSPITAL BED, FIXED HEIGHT, WITH ANY TYPE SIDE RAILS, WITHOUT MATTRESS
E0255	HOSPITAL BED, VARIABLE HEIGHT, HI-LO, WITH ANY TYPE SIDE RAILS, WITH MATTRESS
E0256	HOSPITAL BED, VARIABLE HEIGHT, HI-LO, WITH ANY TYPE SIDE RAILS, WITHOUT MATTRESS
E0260	HOSPITAL BED, SEMI-ELECTRIC (HEAD AND FOOT ADJUSTMENT), WITH ANY TYPE SIDE RAILS, WITH MATTRESS
E0261	HOSPITAL BED, SEMI-ELECTRIC (HEAD AND FOOT ADJUSTMENT), WITH ANY TYPE SIDE RAILS, WITHOUT MATTRESS
E0265	HOSPITAL BED, TOTAL ELECTRIC (HEAD, FOOT AND HEIGHT ADJUSTMENTS), WITH ANY TYPE SIDE RAILS, WITH MATTRESS
E0266	HOSPITAL BED, TOTAL ELECTRIC (HEAD, FOOT AND HEIGHT ADJUSTMENTS), WITH ANY TYPE SIDE RAILS, WITHOUT MATTRESS
E0271	MATTRESS, INNERSPRING
E0272	MATTRESS, FOAM RUBBER
E0280	BED CRADLE, ANY TYPE
E0290	HOSPITAL BED, FIXED HEIGHT, WITHOUT SIDE RAILS, WITH MATTRESS
E0291	HOSPITAL BED, FIXED HEIGHT, WITHOUT SIDE RAILS, WITHOUT MATTRESS
E0292	HOSPITAL BED, VARIABLE HEIGHT, HI-LO, WITHOUT SIDE RAILS, WITH MATTRESS
E0293	HOSPITAL BED, VARIABLE HEIGHT, HI-LO, WITHOUT SIDE RAILS, WITHOUT MATTRESS
E0294	HOSPITAL BED, SEMI-ELECTRIC (HEAD AND FOOT ADJUSTMENT), WITHOUT SIDE RAILS, WITH MATTRESS
E0295	HOSPITAL BED, SEMI-ELECTRIC (HEAD AND FOOT ADJUSTMENT), WITHOUT SIDE RAILS, WITHOUT MATTRESS
E0296	HOSPITAL BED, TOTAL ELECTRIC (HEAD, FOOT AND HEIGHT ADJUSTMENTS). WITHOUT SIDE RAILS, WITH MATTRESS
E0297	HOSPITAL BED, TOTAL ELECTRIC (HEAD, FOOT AND HEIGHT ADJUSTMENTS), WITHOUT SIDE RAILS, WITHOUT MATTRESS
E0300	PEDIATRIC CRIB, HOSPITAL GRADE, FULLY ENCLOSED
E0301	HOSPITAL BED, HEAVY DUTY, EXTRA WIDE, WITH WEIGHT CAPACITY GREATER THAN 350 POUNDS, BUT LESS THAN OR EQUAL TO 600 POUNDS, WITH ANY TYPE SIDE RAILS, WITHOUT MATTRESS
E0302	HOSPITAL BED, EXTRA HEAVY DUTY, EXTRA WIDE, WITH WEIGHT CAPACITY GREATER THAN 600 POUNDS, WITH ANY TYPE SIDE RAILS, WITHOUT MATTRESS
E0303	HOSPITAL BED, HEAVY DUTY, EXTRA WIDE, WITH WEIGHT CAPACITY GREATER THAN 350 POUNDS, BUT LESS THAN OR EQUAL TO 600 POUNDS, WITH ANY TYPE SIDE RAILS, WITH MATTRESS
E0304	HOSPITAL BED, EXTRA HEAVY DUTY, EXTRA WIDE, WITH WEIGHT CAPACITY GREATER THAN 600 POUNDS, WITH ANY TYPE SIDE RAILS, WITH MATTRESS
E0305	BED SIDE RAILS, HALF LENGTH
E0310	BED SIDE RAILS, FULL LENGTH
E0316	SAFETY ENCLOSURE FRAME/CANOPY FOR USE WITH HOSPITAL BED, ANY TYPE
E0910	TRAPEZE BARS, A/K/A PATIENT HELPER, ATTACHED TO BED, WITH GRAB BAR
E0911	TRAPEZE BAR, HEAVY DUTY, FOR PATIENT WEIGHT CAPACITY GREATER THAN 250 POUNDS, ATTACHED TO BED, WITH GRAB BAR

E0912	TRAPEZE BAR, HEAVY DUTY, FOR PATIENT WEIGHT CAPACITY GREATER THAN 250 POUNDS, FREE STANDING, COMPLETE WITH GRAB BAR
E0940	TRAPEZE BAR, FREE STANDING, COMPLETE WITH GRAB BAR

PRODUCT CATEGORY 8 **Negative Pressure Wound Therapy Pumps and Related Supplies and Accessories**	
A6550	WOUND CARE SET, FOR NEGATIVE PRESSURE WOUND THERAPY ELECTRICAL PUMP, INCLUDES ALL SUPPLIES AND ACCESSORIES
A7000	CANISTER, DISPOSABLE, USED WITH SUCTION PUMP, EACH
E2402	NEGATIVE PRESSURE WOUND THERAPY ELECTRICAL PUMP, STATIONARY OR PORTABLE

PRODUCT CATEGORY 9 **Walkers and Related Accessories**	
A4636	REPLACEMENT, HANDGRIP, CANE, CRUTCH, OR WALKER, EACH
A4637	REPLACEMENT, TIP, CANE, CRUTCH, WALKER, EACH.
E0130	WALKER, RIGID (PICKUP), ADJUSTABLE OR FIXED HEIGHT
E0135	WALKER, FOLDING (PICKUP), ADJUSTABLE OR FIXED HEIGHT
E0140	WALKER, WITH TRUNK SUPPORT, ADJUSTABLE OR FIXED HEIGHT, ANY TYPE
E0141	WALKER, RIGID, WHEELED, ADJUSTABLE OR FIXED HEIGHT
E0143	WALKER, FOLDING, WHEELED, ADJUSTABLE OR FIXED HEIGHT
E0144	WALKER, ENCLOSED, FOUR SIDED FRAMED, RIGID OR FOLDING, WHEELED WITH POSTERIOR SEAT
E0147	WALKER, HEAVY DUTY, MULTIPLE BRAKING SYSTEM, VARIABLE WHEEL RESISTANCE
E0148	WALKER, HEAVY DUTY, WITHOUT WHEELS, RIGID OR FOLDING, ANY TYPE, EACH
E0149	WALKER, HEAVY DUTY, WHEELED, RIGID OR FOLDING, ANY TYPE
E0154	PLATFORM ATTACHMENT, WALKER, EACH
E0155	WHEEL ATTACHMENT, RIGID PICK-UP WALKER, PER PAIR
E0156	SEAT ATTACHMENT, WALKER
E0157	CRUTCH ATTACHMENT, WALKER, EACH
E0158	LEG EXTENSIONS FOR WALKER, PER SET OF FOUR (4)
E0159	BRAKE ATTACHMENT FOR WHEELED WALKER, REPLACEMENT, EACH

PRODUCT CATEGORY 10 **Support Surfaces**	
E0193	POWERED AIR FLOTATION BED (LOW AIR LOSS THERAPY)
E0277	POWERED PRESSURE-REDUCING AIR MATTRESS

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

MLN Matters Number: MM6288
Related Change Request (CR) #: 6288
Related CR Release Date: December 19, 2008
Related CR Transmittal #: R1650CP
Effective Date: January 1, 2009
Implementation Date: January 5, 2009

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.

What You Need to Know

CR 6288, from which this article is taken, instructs Medicare contractors to download and implement the January 2009 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 2008, July 2008, April 2008, and January 2008 files. They will use the January 2009 ASP and 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 5, 2009, with dates of service January 1, 2009, through March 31, 2009.

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 average sales price (ASP) methodology, and pricing for compounded drugs has been performed by the local contractor.

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

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

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

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

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

ASP Methodology

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

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

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

Exceptions are summarized as follows:

- The payment allowance limits for blood and blood products (other than blood clotting factors) that are not paid on a prospective payment basis are determined in the same manner that the payment allowance limits were determined on October 1, 2003. Specifically, the payment allowance limits for blood and blood products are 95 percent of the average wholesale price (AWP) as reflected in the published compendia. The payment allowance limits are updated on a quarterly basis. Blood and blood products furnished in the hospital outpatient department are paid under OPPS at the amount specified for the Ambulatory Payment Classification (APC) to which the product is assigned.
- Payment allowance limits for infusion drugs furnished through a covered item of durable medical equipment on or after January 1, 2005, will continue to be 95 percent of the AWP reflected in the published compendia as of October 1, 2003, unless the drug is compounded or the drug is furnished incident to a professional service. **The payment allowance limits were not updated in 2008**. The payment allowance limits for infusion drugs furnished through a covered item of durable medical equipment that were not listed in the published compendia as of October 1, 2003, (i.e., new drugs) are 95 percent of the first published AWP unless the drug is compounded or the drug is furnished incident to a professional service.
- The payment allowance limits for influenza, Pneumococcal and Hepatitis B vaccines are 95 percent of the AWP as reflected in the published compendia except when the vaccine is furnished in a hospital outpatient department. When furnished in a hospital outpatient department, the vaccine is paid at reasonable cost.

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

Note: At their discretion, Medicare contractors may contact CMS to obtain payment limits for drugs and biologicals that are not included in the quarterly ASP or NOC files, or otherwise made available on the CMS Web site. If the payment limit is available from CMS, contractors will substitute CMS-provided payment limits for pricing based on WAC or invoice pricing.

- The payment allowance limits for new drugs and biologicals that are produced or distributed under a new drug application (or other new application) approved by the FDA and that are not included in the ASP Medicare Part B Drug Pricing File or NOC Pricing File are based on 106 percent of the WAC, or invoice pricing if the WAC is not published, except under OPPS where the payment allowance limit is 95 percent of the published AWP. This policy applies only to new drugs and biologicals that were first sold on or after January 1, 2005.
- The payment allowance limits for radiopharmaceuticals are not subject to the ASP payment methodology. In the case of radiopharmaceuticals furnished in other than the hospital outpatient department, Medicare contractors determine payment limits for radiopharmaceuticals based on the methodology in place as of November 2003. Radiopharmaceuticals furnished in the hospital outpatient department are paid charges reduced to cost by the hospital's overall cost to charge ratio.

Quarterly Payment Files

On or after December 16, 2008, the January 2009 ASP file will be available for download along with revisions to prior ASP payment files, if CMS determines that revisions to these prior files are necessary. On or after December 16, 2008, the January 2009 ASP NOC files will be available for retrieval from the CMS ASP Web page along with revisions to prior ASP NOC files, if CMS determines that revisions to these prior files are necessary. The payment files will be applied to claims processed or reprocessed on or after the effective date of CR6288 for the dates of service noted in the following table:

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

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

Drugs Furnished During Filling or Refilling an Implantable Pump or Reservoir

Physicians (or a practitioner described in Section 1842(b)(18)(C) of the Social Security Act) may be paid for filling or refilling an implantable pump or reservoir when it is medically necessary for the physician (or other practitioner) to perform the service. Medicare contractors must find the use of the implantable pump or reservoir medically reasonable and necessary in order to allow payment for the professional service to fill or refill the implantable pump or reservoir and to allow payment for drugs furnished incident to the professional service.

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

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

Additional Information

You can find the official instruction, CR6288, issued to your carrier, FI, RHHI, MAC, or DME MAC by visiting http://www.cms.hhs.gov/Transmittals/downloads/R1650CP.pdf on the CMS Web site.

HCPCS Code Update – 2009

The following list identifies changes to level II Healthcare Common Procedure Coding System (HCPCS) codes for 2009.

Added Codes/ Modifiers: New codes and modifiers are effective for dates of service on or after January 1, 2009.

Discontinued Codes/Modifiers: Codes or modifiers that are discontinued will continue to be valid for claims with dates of service on or before December 31, 2008, regardless of the date of claim submission. If there is a direct crosswalk for a discontinued code or modifier, it is listed in the table. The crosswalked codes are also "added" codes effective for dates of service on or after January 1, 2009.

There is no grace period that would allow submission of the discontinued code for dates of service in 2009.

Narrative Changes: A description change for an existing code or modifier is effective for dates of service on or after January 1, 2009.

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

Ankle-Foot and Knee-Ankle-Foot Orthoses

Narrative Changes		
Code	**Old Narrative**	**New Narrative**
L4360	WALKING BOOT, PNEUMATIC, WITH OR WITHOUT JOINTS, WITH OR WITHOUT INTERFACE MATERIAL, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	WALKING BOOT, PNEUMATIC AND/OR VACUUM, WITH OR WITHOUT JOINTS, WITH OR WITHOUT INTERFACE MATERIAL, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT

Discontinued Code		
Code	**Narrative**	**Crosswalk to Code**
L2860	ADDITION TO LOWER EXTREMITY JOINT, KNEE OR ANKLE, CONCENTRIC ADJUSTABLE TORSION STYLE MECHANISM, EACH	NONE

Intravenous Immune globulin

Added Code	
Code	**Narrative**
J1459	INJECTION, IMMUNE GLOBULIN (PRIVIGEN), INTRAVENOUS, NON-LYOPHILIZED (E.G. LIQUID), 500 MG

Narrative Changes		
Code	**Old Narrative**	**New Narrative**
J1572	INJECTION, IMMUNE GLOBULIN, (FLEBOGAMMA), INTRAVENOUS, NON-LYOPHILIZED (E.G. LIQUID), 500 MG	INJECTION, IMMUNE GLOBULIN, (FLEBOGAMMA/ FLEBOGAMMA DIF), INTRAVENOUS, NON-LYOPHILIZED (E.G. LIQUID), 500 MG

Discontinued Code		
Code	**Narrative**	**Crosswalk to Code**
Q4097	INJECTION, IMMUNE GLOBULIN (PRIVIGEN), INTRAVENOUS, NON-LYOPHILIZED (E.G. LIQUID), 500 MG	J1459

Lower Limb Prostheses

Discontinued Codes		
Code	**Narrative**	**Crosswalk to Code**
L5993	ADDITION TO LOWER EXTREMITY PROSTHESIS, HEAVY DUTY FEATURE, FOOT ONLY, (FOR PATIENT WEIGHT GREATER THAN 300 LBS)	NONE
L5994	ADDITION TO LOWER EXTREMITY PROSTHESIS, HEAVY DUTY FEATURE, KNEE ONLY, (FOR PATIENT WEIGHT GREATER THAN 300 LBS)	NONE
L5995	ADDITION TO LOWER EXTREMITY PROSTHESIS, HEAVY DUTY FEATURE, OTHER THAN FOOT OR KNEE, (FOR PATIENT WEIGHT GREATER THAN 300 LBS)	NONE

Miscellaneous

Added Codes	
Code	**Narrative**
A9284	SPIROMETER, NON-ELECTRONIC, INCLUDES ALL ACCESSORIES *(Not covered; no benefit category)*
E0487	SPIROMETER, ELECTRONIC, INCLUDES ALL ACCESSORIES *(Not covered; no benefit category)*
E0770	FUNCTIONAL ELECTRICAL STIMULATOR, TRANSCUTANEOUS STIMULATION OF NERVE AND/OR MUSCLE GROUPS, ANY TYPE, COMPLETE SYSTEM, NOT OTHERWISE SPECIFIED
L0113	CRANIAL CERVICAL ORTHOSIS, TORTICOLLIS TYPE, WITH OR WITHOUT JOINT, WITH OR WITHOUT SOFT INTERFACE MATERIAL, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT
L6711	TERMINAL DEVICE, HOOK, MECHANICAL, VOLUNTARY OPENING, ANY MATERIAL, ANY SIZE, LINED OR UNLINED, PEDIATRIC
L6712	TERMINAL DEVICE, HOOK, MECHANICAL, VOLUNTARY CLOSING, ANY MATERIAL, ANY SIZE, LINED OR UNLINED, PEDIATRIC
L6713	TERMINAL DEVICE, HAND, MECHANICAL, VOLUNTARY OPENING, ANY MATERIAL, ANY SIZE, PEDIATRIC
L6714	TERMINAL DEVICE, HAND, MECHANICAL, VOLUNTARY CLOSING, ANY MATERIAL, ANY SIZE, PEDIATRIC
L6721	TERMINAL DEVICE, HOOK OR HAND, HEAVY DUTY, MECHANICAL, VOLUNTARY OPENING, ANY MATERIAL, ANY SIZE, LINED OR UNLINED
L6722	TERMINAL DEVICE, HOOK OR HAND, HEAVY DUTY, MECHANICAL, VOLUNTARY CLOSING, ANY MATERIAL, ANY SIZE, LINED OR UNLINED

Discontinued Codes		
Code	**Narrative**	**Crosswalk to Code**
L3890	ADDITION TO UPPER EXTREMITY JOINT, WRIST OR ELBOW, CONCENTRIC ADJUSTABLE TORSION STYLE MECHANISM, EACH	NONE
L7611	TERMINAL DEVICE, HOOK, MECHANICAL, VOLUNTARY OPENING, ANY MATERIAL, ANY SIZE, LINED OR UNLINED, PEDIATRIC	L6711
L7612	TERMINAL DEVICE, HOOK, MECHANICAL, VOLUNTARY CLOSING, ANY MATERIAL, ANY SIZE, LINED OR UNLINED, PEDIATRIC	L6712
L7613	TERMINAL DEVICE, HAND, MECHANICAL, VOLUNTARY OPENING, ANY MATERIAL, ANY SIZE, PEDIATRIC	L6713
L7614	TERMINAL DEVICE, HAND, MECHANICAL, VOLUNTARY CLOSING, ANY MATERIAL, ANY SIZE, PEDIATRIC	L6714
L7621	TERMINAL DEVICE, HOOK OR HAND, HEAVY DUTY, MECHANICAL, VOLUNTARY OPENING, ANY MATERIAL, ANY SIZE, LINED OR UNLINED	L6721
L7622	TERMINAL DEVICE, HOOK OR HAND, HEAVY DUTY, MECHANICAL, VOLUNTARY CLOSING, ANY MATERIAL, ANY SIZE, LINED OR UNLINED	L6722

Narrative Changes		
Code	**Old Narrative**	**New Narrative**
E0764	FUNCTIONAL NEUROMUSCULAR STIMULATOR, TRANSCUTANEOUS STIMULATION OF MUSCLES OF AMBULATION WITH COMPUTER CONTROL, USED FOR WALKING BY SPINAL CORD INJURED, ENTIRE SYSTEM, AFTER COMPLETION OF TRAINING PROGRAM	FUNCTIONAL NEUROMUSCULAR STIMULATOR, TRANSCUTANEOUS STIMULATION OF SEQUENTIAL MUSCLE GROUPS OF AMBULATION WITH COMPUTER CONTROL, USED FOR WALKING BY SPINAL CORD INJURED, ENTIRE SYSTEM, AFTER COMPLETION OF TRAINING PROGRAM

Nebulizers

Added Code	
Code	**Narrative**
J7606	FORMOTEROL FUMARATE, INHALATION SOLUTION, FDA APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, UNIT DOSE FORM, 20 MICROGRAMS

Discontinued Code		
Code	**Narrative**	**Crosswalk to Code**
Q4099	FORMOTEROL FUMARATE, INHALATION SOLUTION, FDA APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, UNIT DOSE FORM, 20 MICROGRAMS	J7606

Oxygen and Oxygen Equipment

Added Codes	
Code	**Narrative**
E1354	OXYGEN ACCESSORY, WHEELED CART FOR PORTABLE CYLINDER OR PORTABLE CONCENTRATOR, ANY TYPE, REPLACEMENT ONLY, EACH
E1356	OXYGEN ACCESSORY, BATTERY PACK/CARTRIDGE FOR PORTABLE CONCENTRATOR, ANY TYPE, REPLACEMENT ONLY, EACH
E1357	OXYGEN ACCESSORY, BATTERY CHARGER FOR PORTABLE CONCENTRATOR, ANY TYPE, REPLACEMENT ONLY, EACH
E1358	OXYGEN ACCESSORY, DC POWER ADAPTER FOR PORTABLE CONCENTRATOR, ANY TYPE, REPLACEMENT ONLY, EACH

Pneumatic Compression Devices

Added Codes	
Code	**Narrative**
E0656	SEGMENTAL PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, TRUNK
E0657	SEGMENTAL PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, CHEST

Power Mobility Devices

Narrative Changes		
Code	**Old Narrative**	**New Narrative**
K0899	POWER MOBILITY DEVICE, NOT CODED BY SADMERC OR DOES NOT MEET CRITERIA	POWER MOBILITY DEVICE, NOT CODED BY DME PDAC OR DOES NOT MEET CRITERIA

Surgical Dressings

Added Code	
Code	**Narrative**
A6545	GRADIENT COMPRESSION WRAP, NON-ELASTIC, BELOW KNEE, 30-50 MM HG, EACH

Narrative Changes		
Code	Old Narrative	New Narrative
A6010	COLLAGEN BASED WOUND FILLER, DRY FORM, PER GRAM OF COLLAGEN	COLLAGEN BASED WOUND FILLER, DRY FORM, STERILE, PER GRAM OF COLLAGEN
A6011	COLLAGEN BASED WOUND FILLER, GEL/PASTE, PER GRAM OF COLLAGEN	COLLAGEN BASED WOUND FILLER, GEL/PASTE, STERILE, PER GRAM OF COLLAGEN
A6021	COLLAGEN DRESSING, PAD SIZE 16 SQ. IN. OR LESS, EACH	COLLAGEN DRESSING, STERILE, PAD SIZE 16 SQ. IN. OR LESS, EACH

A6022	COLLAGEN DRESSING, PAD SIZE MORE THAN 16 SQ. IN. BUT LESS THAN OR EQUAL TO 48 SQ. IN., EACH	COLLAGEN DRESSING, STERILE, PAD SIZE MORE THAN 16 SQ. IN. BUT LESS THAN OR EQUAL TO 48 SQ. IN., EACH
A6023	COLLAGEN DRESSING, PAD SIZE MORE THAN 48 SQ. IN., EACH	COLLAGEN DRESSING, STERILE, PAD SIZE MORE THAN 48 SQ. IN., EACH
A6024	COLLAGEN DRESSING WOUND FILLER, PER 6 INCHES	COLLAGEN DRESSING WOUND FILLER, STERILE, PER 6 INCHES
A6196	ALGINATE OR OTHER FIBER GELLING DRESSING, WOUND COVER, PAD SIZE 16 SQ. IN. OR LESS, EACH DRESSING	ALGINATE OR OTHER FIBER GELLING DRESSING, WOUND COVER, STERILE, PAD SIZE 16 SQ. IN. OR LESS, EACH DRESSING
A6197	ALGINATE OR OTHER FIBER GELLING DRESSING, WOUND COVER, PAD SIZE MORE THAN 16 SQ. IN. BUT LESS THAN OR EQUAL TO 48 SQ. IN., EACH DRESSING	ALGINATE OR OTHER FIBER GELLING DRESSING, WOUND COVER, STERILE, PAD SIZE MORE THAN 16 SQ. IN. BUT LESS THAN OR EQUAL TO 48 SQ. IN., EACH DRESSING
A6198	ALGINATE OR OTHER FIBER GELLING DRESSING, WOUND COVER, PAD SIZE MORE THAN 48 SQ. IN., EACH DRESSING	ALGINATE OR OTHER FIBER GELLING DRESSING, WOUND COVER, STERILE, PAD SIZE MORE THAN 48 SQ. IN., EACH DRESSING
A6199	ALGINATE OR OTHER FIBER GELLING DRESSING, WOUND FILLER, PER 6 INCHES	ALGINATE OR OTHER FIBER GELLING DRESSING, WOUND FILLER, STERILE, PER 6 INCHES
A6203	COMPOSITE DRESSING, PAD SIZE 16 SQ. IN. OR LESS, WITH ANY SIZE ADHESIVE BORDER, EACH DRESSING	COMPOSITE DRESSING, STERILE, PAD SIZE 16 SQ. IN. OR LESS, WITH ANY SIZE ADHESIVE BORDER, EACH DRESSING
A6204	COMPOSITE DRESSING, PAD SIZE MORE THAN 16 SQ. IN. BUT LESS THAN OR EQUAL TO 48 SQ. IN., WITH ANY SIZE ADHESIVE BORDER, EACH DRESSING	COMPOSITE DRESSING, STERILE, PAD SIZE MORE THAN 16 SQ. IN. BUT LESS THAN OR EQUAL TO 48 SQ. IN., WITH ANY SIZE ADHESIVE BORDER, EACH DRESSING
A6205	COMPOSITE DRESSING, PAD SIZE MORE THAN 48 SQ. IN., WITH ANY SIZE ADHESIVE BORDER, EACH DRESSING	COMPOSITE DRESSING, STERILE, PAD SIZE MORE THAN 48 SQ. IN., WITH ANY SIZE ADHESIVE BORDER, EACH DRESSING
A6206	CONTACT LAYER, 16 SQ. IN. OR LESS, EACH DRESSING	CONTACT LAYER, STERILE, 16 SQ. IN. OR LESS, EACH DRESSING
A6207	CONTACT LAYER, MORE THAN 16 SQ. IN. BUT LESS THAN OR EQUAL TO 48 SQ. IN., EACH DRESSING	CONTACT LAYER, STERILE, MORE THAN 16 SQ. IN. BUT LESS THAN OR EQUAL TO 48 SQ. IN., EACH DRESSING
A6208	CONTACT LAYER, MORE THAN 48 SQ. IN., EACH DRESSING	CONTACT LAYER, STERILE, MORE THAN 48 SQ. IN., EACH DRESSING
A6209	FOAM DRESSING, WOUND COVER, PAD SIZE 16 SQ. IN. OR LESS, WITHOUT ADHESIVE BORDER, EACH DRESSING	FOAM DRESSING, WOUND COVER, STERILE, PAD SIZE 16 SQ. IN. OR LESS, WITHOUT ADHESIVE BORDER, EACH DRESSING
A6210	FOAM DRESSING, WOUND COVER, PAD SIZE MORE THAN 16 SQ. IN. BUT LESS THAN OR EQUAL TO 48 SQ. IN., WITHOUT ADHESIVE BORDER, EACH DRESSING	FOAM DRESSING, WOUND COVER, STERILE, PAD SIZE MORE THAN 16 SQ. IN. BUT LESS THAN OR EQUAL TO 48 SQ. IN., WITHOUT ADHESIVE BORDER, EACH DRESSING

A6211	FOAM DRESSING, WOUND COVER, PAD SIZE MORE THAN 48 SQ. IN., WITHOUT ADHESIVE BORDER, EACH DRESSING	FOAM DRESSING, WOUND COVER, STERILE, PAD SIZE MORE THAN 48 SQ. IN., WITHOUT ADHESIVE BORDER, EACH DRESSING
A6212	FOAM DRESSING, WOUND COVER, PAD SIZE 16 SQ. IN. OR LESS, WITH ANY SIZE ADHESIVE BORDER, EACH DRESSING	FOAM DRESSING, WOUND COVER, STERILE, PAD SIZE 16 SQ. IN. OR LESS, WITH ANY SIZE ADHESIVE BORDER, EACH DRESSING
A6213	FOAM DRESSING, WOUND COVER, PAD SIZE MORE THAN 16 SQ. IN. BUT LESS THAN OR EQUAL TO 48 SQ. IN., WITH ANY SIZE ADHESIVE BORDER, EACH DRESSING	FOAM DRESSING, WOUND COVER, STERILE, PAD SIZE MORE THAN 16 SQ. IN. BUT LESS THAN OR EQUAL TO 48 SQ. IN., WITH ANY SIZE ADHESIVE BORDER, EACH DRESSING
A6214	FOAM DRESSING, WOUND COVER, PAD SIZE MORE THAN 48 SQ. IN., WITH ANY SIZE ADHESIVE BORDER, EACH DRESSING	FOAM DRESSING, WOUND COVER, STERILE, PAD SIZE MORE THAN 48 SQ. IN., WITH ANY SIZE ADHESIVE BORDER, EACH DRESSING
A6215	FOAM DRESSING, WOUND FILLER, PER GRAM	FOAM DRESSING, WOUND FILLER, STERILE, PER GRAM
A6219	GAUZE, NON-IMPREGNATED, PAD SIZE 16 SQ. IN. OR LESS, WITH ANY SIZE ADHESIVE BORDER, EACH DRESSING	GAUZE, NON-IMPREGNATED, STERILE, PAD SIZE 16 SQ. IN. OR LESS, WITH ANY SIZE ADHESIVE BORDER, EACH DRESSING
A6220	GAUZE, NON-IMPREGNATED, PAD SIZE MORE THAN 16 SQ. IN. BUT LESS THAN OR EQUAL TO 48 SQ. IN., WITH ANY SIZE ADHESIVE BORDER, EACH DRESSING	GAUZE, NON-IMPREGNATED, STERILE, PAD SIZE MORE THAN 16 SQ. IN. BUT LESS THAN OR EQUAL TO 48 SQ. IN., WITH ANY SIZE ADHESIVE BORDER, EACH DRESSING
A6221	GAUZE, NON-IMPREGNATED, PAD SIZE MORE THAN 48 SQ. IN., WITH ANY SIZE ADHESIVE BORDER, EACH DRESSING	GAUZE, NON-IMPREGNATED, STERILE, PAD SIZE MORE THAN 48 SQ. IN., WITH ANY SIZE ADHESIVE BORDER, EACH DRESSING
A6222	GAUZE, IMPREGNATED WITH OTHER THAN WATER, NORMAL SALINE, OR HYDROGEL, PAD SIZE 16 SQ. IN. OR LESS, WITHOUT ADHESIVE BORDER, EACH DRESSING	GAUZE, IMPREGNATED WITH OTHER THAN WATER, NORMAL SALINE, OR HYDROGEL, STERILE, PAD SIZE 16 SQ. IN. OR LESS, WITHOUT ADHESIVE BORDER, EACH DRESSING
A6223	GAUZE, IMPREGNATED WITH OTHER THAN WATER, NORMAL SALINE, OR HYDROGEL, PAD SIZE MORE THAN 16 SQ. IN., BUT LESS THAN OR EQUAL TO 48 SQ. IN., WITHOUT ADHESIVE BORDER, EACH DRESSING	GAUZE, IMPREGNATED WITH OTHER THAN WATER, NORMAL SALINE, OR HYDROGEL, STERILE, PAD SIZE MORE THAN 16 SQ. IN., BUT LESS THAN OR EQUAL TO 48 SQ. IN., WITHOUT ADHESIVE BORDER, EACH DRESSING
A6224	GAUZE, IMPREGNATED WITH OTHER THAN WATER, NORMAL SALINE, OR HYDROGEL, PAD SIZE MORE THAN 48 SQ. IN., WITHOUT ADHESIVE BORDER, EACH DRESSING	GAUZE, IMPREGNATED WITH OTHER THAN WATER, NORMAL SALINE, OR HYDROGEL, STERILE, PAD SIZE MORE THAN 48 SQ. IN., WITHOUT ADHESIVE BORDER, EACH DRESSING
A6228	GAUZE, IMPREGNATED, WATER OR NORMAL SALINE, PAD SIZE 16 SQ. IN. OR LESS, WITHOUT ADHESIVE BORDER, EACH DRESSING	GAUZE, IMPREGNATED, WATER OR NORMAL SALINE, STERILE, PAD SIZE 16 SQ. IN. OR LESS, WITHOUT ADHESIVE BORDER, EACH DRESSING

A6229	GAUZE, IMPREGNATED, WATER OR NORMAL SALINE, PAD SIZE MORE THAN 16 SQ. IN. BUT LESS THAN OR EQUAL TO 48 SQ. IN., WITHOUT ADHESIVE BORDER, EACH DRESSING	GAUZE, IMPREGNATED, WATER OR NORMAL SALINE, STERILE, PAD SIZE MORE THAN 16 SQ. IN. BUT LESS THAN OR EQUAL TO 48 SQ. IN., WITHOUT ADHESIVE BORDER, EACH DRESSING
A6230	GAUZE, IMPREGNATED, WATER OR NORMAL SALINE, PAD SIZE MORE THAN 48 SQ. IN., WITHOUT ADHESIVE BORDER, EACH DRESSING	GAUZE, IMPREGNATED, WATER OR NORMAL SALINE, STERILE, PAD SIZE MORE THAN 48 SQ. IN., WITHOUT ADHESIVE BORDER, EACH DRESSING
A6231	GAUZE, IMPREGNATED, HYDROGEL, FOR DIRECT WOUND CONTACT, PAD SIZE 16 SQ. IN. OR LESS, EACH DRESSING	GAUZE, IMPREGNATED, HYDROGEL, FOR DIRECT WOUND CONTACT, STERILE, PAD SIZE 16 SQ. IN. OR LESS, EACH DRESSING
A6232	GAUZE, IMPREGNATED, HYDROGEL, FOR DIRECT WOUND CONTACT, PAD SIZE GREATER THAN 16 SQ. IN., BUT LESS THAN OR EQUAL TO 48 SQ. IN., EACH DRESSING	GAUZE, IMPREGNATED, HYDROGEL, FOR DIRECT WOUND CONTACT, STERILE, PAD SIZE GREATER THAN 16 SQ. IN., BUT LESS THAN OR EQUAL TO 48 SQ. IN., EACH DRESSING
A6233	GAUZE, IMPREGNATED, HYDROGEL, FOR DIRECT WOUND CONTACT, PAD SIZE MORE THAN 48 SQ. IN., EACH DRESSING	GAUZE, IMPREGNATED, HYDROGEL, FOR DIRECT WOUND CONTACT, STERILE, PAD SIZE MORE THAN 48 SQ. IN., EACH DRESSING
A6234	HYDROCOLLOID DRESSING, WOUND COVER, PAD SIZE 16 SQ. IN. OR LESS, WITHOUT ADHESIVE BORDER, EACH DRESSING	HYDROCOLLOID DRESSING, WOUND COVER, STERILE, PAD SIZE 16 SQ. IN. OR LESS, WITHOUT ADHESIVE BORDER, EACH DRESSING
A6235	HYDROCOLLOID DRESSING, WOUND COVER, PAD SIZE MORE THAN 16 SQ. IN. BUT LESS THAN OR EQUAL TO 48 SQ. IN., WITHOUT ADHESIVE BORDER, EACH DRESSING	HYDROCOLLOID DRESSING, WOUND COVER, STERILE, PAD SIZE MORE THAN 16 SQ. IN. BUT LESS THAN OR EQUAL TO 48 SQ. IN., WITHOUT ADHESIVE BORDER, EACH DRESSING
A6236	HYDROCOLLOID DRESSING, WOUND COVER, PAD SIZE MORE THAN 48 SQ. IN., WITHOUT ADHESIVE BORDER, EACH DRESSING	HYDROCOLLOID DRESSING, WOUND COVER, STERILE, PAD SIZE MORE THAN 48 SQ. IN., WITHOUT ADHESIVE BORDER, EACH DRESSING
A6237	HYDROCOLLOID DRESSING, WOUND COVER, PAD SIZE 16 SQ. IN. OR LESS, WITH ANY SIZE ADHESIVE BORDER, EACH DRESSING	HYDROCOLLOID DRESSING, WOUND COVER, STERILE, PAD SIZE 16 SQ. IN. OR LESS, WITH ANY SIZE ADHESIVE BORDER, EACH DRESSING
A6238	HYDROCOLLOID DRESSING, WOUND COVER, PAD SIZE MORE THAN 16 SQ. IN. BUT LESS THAN OR EQUAL TO 48 SQ. IN., WITH ANY SIZE ADHESIVE BORDER, EACH DRESSING	HYDROCOLLOID DRESSING, WOUND COVER, STERILE, PAD SIZE MORE THAN 16 SQ. IN. BUT LESS THAN OR EQUAL TO 48 SQ. IN., WITH ANY SIZE ADHESIVE BORDER, EACH DRESSING
A6239	HYDROCOLLOID DRESSING, WOUND COVER, PAD SIZE MORE THAN 48 SQ. IN., WITH ANY SIZE ADHESIVE BORDER, EACH DRESSING	HYDROCOLLOID DRESSING, WOUND COVER, STERILE, PAD SIZE MORE THAN 48 SQ. IN., WITH ANY SIZE ADHESIVE BORDER, EACH DRESSING
A6240	HYDROCOLLOID DRESSING, WOUND FILLER, PASTE, PER FLUID OUNCE	HYDROCOLLOID DRESSING, WOUND FILLER, PASTE, STERILE, PER OUNCE
A6241	HYDROCOLLOID DRESSING, WOUND FILLER, DRY FORM, PER GRAM	HYDROCOLLOID DRESSING, WOUND FILLER, DRY FORM, STERILE, PER GRAM

A6242	HYDROGEL DRESSING, WOUND COVER, PAD SIZE 16 SQ. IN. OR LESS, WITHOUT ADHESIVE BORDER, EACH DRESSING	HYDROGEL DRESSING, WOUND COVER, STERILE, PAD SIZE 16 SQ. IN. OR LESS, WITHOUT ADHESIVE BORDER, EACH DRESSING
A6243	HYDROGEL DRESSING, WOUND COVER, PAD SIZE MORE THAN 16 SQ. IN. BUT LESS THAN OR EQUAL TO 48 SQ. IN., WITHOUT ADHESIVE BORDER, EACH DRESSING	HYDROGEL DRESSING, WOUND COVER, STERILE, PAD SIZE MORE THAN 16 SQ. IN. BUT LESS THAN OR EQUAL TO 48 SQ. IN., WITHOUT ADHESIVE BORDER, EACH DRESSING
A6244	HYDROGEL DRESSING, WOUND COVER, PAD SIZE MORE THAN 48 SQ. IN., WITHOUT ADHESIVE BORDER, EACH DRESSING	HYDROGEL DRESSING, WOUND COVER, STERILE, PAD SIZE MORE THAN 48 SQ. IN., WITHOUT ADHESIVE BORDER, EACH DRESSING
A6245	HYDROGEL DRESSING, WOUND COVER, PAD SIZE 16 SQ. IN. OR LESS, WITH ANY SIZE ADHESIVE BORDER, EACH DRESSING	HYDROGEL DRESSING, WOUND COVER, STERILE, PAD SIZE 16 SQ. IN. OR LESS, WITH ANY SIZE ADHESIVE BORDER, EACH DRESSING
A6246	HYDROGEL DRESSING, WOUND COVER, PAD SIZE MORE THAN 16 SQ. IN. BUT LESS THAN OR EQUAL TO 48 SQ. IN., WITH ANY SIZE ADHESIVE BORDER, EACH DRESSING	HYDROGEL DRESSING, WOUND COVER, STERILE, PAD SIZE MORE THAN 16 SQ. IN. BUT LESS THAN OR EQUAL TO 48 SQ. IN., WITH ANY SIZE ADHESIVE BORDER, EACH DRESSING
A6247	HYDROGEL DRESSING, WOUND COVER, PAD SIZE MORE THAN 48 SQ. IN., WITH ANY SIZE ADHESIVE BORDER, EACH DRESSING	HYDROGEL DRESSING, WOUND COVER, STERILE, PAD SIZE MORE THAN 48 SQ. IN., WITH ANY SIZE ADHESIVE BORDER, EACH DRESSING
A6248	HYDROGEL DRESSING, WOUND FILLER, GEL, PER FLUID OUNCE	HYDROGEL DRESSING, WOUND FILLER, GEL, STERILE, PER FLUID OUNCE
A6251	SPECIALTY ABSORPTIVE DRESSING, WOUND COVER, PAD SIZE 16 SQ. IN. OR LESS, WITHOUT ADHESIVE BORDER, EACH DRESSING	SPECIALTY ABSORPTIVE DRESSING, WOUND COVER, STERILE, PAD SIZE 16 SQ. IN. OR LESS, WITHOUT ADHESIVE BORDER, EACH DRESSING
A6252	SPECIALTY ABSORPTIVE DRESSING, WOUND COVER, PAD SIZE MORE THAN 16 SQ. IN. BUT LESS THAN OR EQUAL TO 48 SQ. IN., WITHOUT ADHESIVE BORDER, EACH DRESSING	SPECIALTY ABSORPTIVE DRESSING, WOUND COVER, STERILE, PAD SIZE MORE THAN 16 SQ. IN. BUT LESS THAN OR EQUAL TO 48 SQ. IN., WITHOUT ADHESIVE BORDER, EACH DRESSING
A6253	SPECIALTY ABSORPTIVE DRESSING, WOUND COVER, PAD SIZE MORE THAN 48 SQ. IN., WITHOUT ADHESIVE BORDER, EACH DRESSING	SPECIALTY ABSORPTIVE DRESSING, WOUND COVER, STERILE, PAD SIZE MORE THAN 48 SQ. IN., WITHOUT ADHESIVE BORDER, EACH DRESSING
A6254	SPECIALTY ABSORPTIVE DRESSING, WOUND COVER, PAD SIZE 16 SQ. IN. OR LESS, WITH ANY SIZE ADHESIVE BORDER, EACH DRESSING	SPECIALTY ABSORPTIVE DRESSING, WOUND COVER, STERILE, PAD SIZE 16 SQ. IN. OR LESS, WITH ANY SIZE ADHESIVE BORDER, EACH DRESSING
A6255	SPECIALTY ABSORPTIVE DRESSING, WOUND COVER, PAD SIZE MORE THAN 16 SQ. IN. BUT LESS THAN OR EQUAL TO 48 SQ. IN., WITH ANY SIZE ADHESIVE BORDER, EACH DRESSING	SPECIALTY ABSORPTIVE DRESSING, WOUND COVER, STERILE, PAD SIZE MORE THAN 16 SQ. IN. BUT LESS THAN OR EQUAL TO 48 SQ. IN., WITH ANY SIZE ADHESIVE BORDER, EACH DRESSING
A6256	SPECIALTY ABSORPTIVE DRESSING, WOUND COVER, PAD SIZE MORE THAN 48 SQ. IN., WITH ANY SIZE ADHESIVE BORDER, EACH DRESSING	SPECIALTY ABSORPTIVE DRESSING, WOUND COVER, STERILE, PAD SIZE MORE THAN 48 SQ. IN., WITH ANY SIZE ADHESIVE BORDER, EACH DRESSING
A6257	TRANSPARENT FILM, 16 SQ. IN. OR LESS, EACH DRESSING	TRANSPARENT FILM, STERILE, 16 SQ. IN. OR LESS, EACH DRESSING

A6258	TRANSPARENT FILM, MORE THAN 16 SQ. IN. BUT LESS THAN OR EQUAL TO 48 SQ. IN., EACH DRESSING	TRANSPARENT FILM, STERILE, MORE THAN 16 SQ. IN. BUT LESS THAN OR EQUAL TO 48 SQ. IN., EACH DRESSING
A6259	TRANSPARENT FILM, MORE THAN 48 SQ. IN., EACH DRESSING	TRANSPARENT FILM, STERILE, MORE THAN 48 SQ. IN., EACH DRESSING
A6260	WOUND CLEANSERS, ANY TYPE, ANY SIZE	WOUND CLEANSERS, STERILE, ANY TYPE, ANY SIZE
A6261	WOUND FILLER, GEL/PASTE, PER FLUID OUNCE, NOT ELSEWHERE CLASSIFIED	WOUND FILLER, GEL/PASTE, PER FLUID OUNCE, NOT OTHERWISE SPECIFIED
A6262	WOUND FILLER, DRY FORM, PER GRAM, NOT ELSEWHERE CLASSIFIED	WOUND FILLER, DRY FORM, PER GRAM, NOT OTHERWISE SPECIFIED
A6266	GAUZE, IMPREGNATED, OTHER THAN WATER, NORMAL SALINE, OR ZINC PASTE, ANY WIDTH, PER LINEAR YARD	GAUZE, IMPREGNATED, OTHER THAN WATER, NORMAL SALINE, OR ZINC PASTE, STERILE, ANY WIDTH, PER LINEAR YARD
A6407	PACKING STRIPS, NON-IMPREGNATED, UP TO 2 INCHES IN WIDTH, PER LINEAR YARD	PACKING STRIPS, NON-IMPREGNATED, STERILE, UP TO 2 INCHES IN WIDTH, PER LINEAR YARD

Wheelchair Options/Accessories

Added Codes	
Code	**Narrative**
E2230	MANUAL WHEELCHAIR ACCESSORY, MANUAL STANDING SYSTEM
E2295	MANUAL WHEELCHAIR ACCESSORY, FOR PEDIATRIC SIZE WHEELCHAIR, DYNAMIC SEATING FRAME, ALLOWS COORDINATED MOVEMENT OF MULTIPLE POSITIONING FEATURES

Wheelchair Seating

Added Code	
Code	**Narrative**
E2231	MANUAL WHEELCHAIR ACCESSORY, SOLID SEAT SUPPORT BASE (REPLACES SLING SEAT), INCLUDES ANY TYPE MOUNTING HARDWARE

Narrative Changes		
Code	**Old Narrative**	**New Narrative**
K0669	WHEELCHAIR ACCESSORY, WHEELCHAIR SEAT OR BACK CUSHION, DOES NOT MEET SPECIFIC CODE CRITERIA OR NO WRITTEN CODING VERIFICATION FROM SADMERC	WHEELCHAIR ACCESSORY, WHEELCHAIR SEAT OR BACK CUSHION, DOES NOT MEET SPECIFIC CODE CRITERIA OR NO WRITTEN CODING VERIFICATION FROM DME PDAC

Modifiers

Added Modifiers	
Modifier	**Narrative**
KE	BID UNDER ROUND ONE OF THE DMEPOS COMPETITIVE BIDDING PROGRAM FOR USE WITH NON-COMPETITIVE BID BASE EQUIPMENT
RA	REPLACEMENT OF A DME ITEM
RB	REPLACEMENT OF A PART OF DME FURNISHED AS PART OF A REPAIR

Discontinued Modifier	
Modifier	**Narrative**
RP	REPLACEMENT AND REPAIR - RP MAY BE USED TO INDICATE REPLACEMENT OF DME, ORTHOTIC AND PROSTHETIC DEVICES WHICH HAVE BEEN IN USE FOR SOMETIME. THE CLAIM SHOWS THE CODE FOR THE PART, FOLLOWED BY THE 'RP' MODIFIER AND THE CHARGE FOR THE PART.

Ankle-Foot Orthoses – Arizona - Type – Correct Coding

Arizona AFO is a company that manufactures a line of custom fabricated ankle-foot orthoses. Other companies manufacture similar products. The Pricing, Data Analysis, and Coding (PDAC) contractor has recently reviewed the Arizona AFO line of products and determined the appropriate HCPCS codes to be used when billing for these and similar items.

For the Arizona Short, Arizona Tall, Arizona Extended, Arizona Unweighting, and similar custom fabricated braces, only the following codes should be used:

L1940 Ankle foot orthosis, plastic or other material, custom fabricated

L2330 Addition to lower extremity, lacer molded to patient model, for custom fabricated orthosis only

L2820 Addition to lower extremity orthosis, soft interface for molded plastic below knee section

L2330 is used whether the closure is a lacer closure or a velcro closure. L2820 is used only if a soft interface, either leather or other material, is provided.

The following codes must not be used for these braces:

L1960 Ankle foot orthosis, posterior solid ankle, plastic, custom fabricated

L2275 Addition to lower extremity, varus/valgus correction, plastic modification, padded/lined

L2280 Addition to lower extremity, molded inner boot

For the Arizona Partial Foot model or similar orthosis, use codes L1940, L2330, L2820, and L5000 (Partial foot, shoe insert with longitudinal arch, toe filler).

Questions concerning the coding of other orthoses should be referred to the Pricing, Data Analysis, and Coding (PDAC) contractor.

Suppliers who have incorrectly coded these orthoses should submit a voluntary refund to the DME MAC.

Budesonide (J7626) – Coding and Coverage

A recent review of claims for the inhalation medication budesonide identified problems with the coding and coverage of this drug.

Coding Issues

The descriptor for HCPCS code J7626 reads:

J7626 – Budesonide, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose form, up to 0.5mg

Budesonide is supplied by the manufacturer as Pulmicort Respules® in 0.25, 0.5 and 1.0 mg unit dose vials. The HCPCS code descriptor indicates one unit of service (UOS) = up to 0.5 mg. Therefore, for the 0.25 mg or 0.5 mg unit dose forms, one UOS is billed for each vial dispensed. For the 1.0 mg unit dose form, one vial = two UOS.

When billing code J7626, suppliers should use the following examples:

Example 1: Dispensing 0.5 mg vials
Order is for budesonide 0.5 mg vials, administer 0.5 mg BID
0.5 mg x 2x/day = 1 mg/day x 31 days = 31 mg/month
1 vial x 2x/day = 2 vials/day x 31 days = 62 UOS/ month
Claim filed for 62 UOS of code J7626

Example 2: Dispensing 0.25 mg vials
Order is for budesonide 0.25 mg vials, administer 0.25 mg BID
0.25 mg x 2x/day = 0.5 mg/day x 31 days = 15.5 mg/month
1 vial x 2x/day = 2 vials/day x 31 days = 62 UOS/ month
Claim filed for 62 UOS of code J7626

Example 3: Dispensing 0.25 mg vials
Order is for budesonide 0.25 mg vials, administer 0.25 mg TID
0.25 mg x 3x/day = 0.75 mg/day x 31 days = 23.25 mg
1 vial x 3x/day = 3 vials/day x 31 days = 93 UOS/ month
Claim filed for 93 UOS of code J7626

Coverage Issues

Budesonide is commonly provided as Pulmicort Respules® (AstraZeneca) which has an FDA indication for the maintenance and treatment of asthma and as a prophylactic therapy in children 12 months to 8 years old. Use for chronic obstructive pulmonary disease (COPD) is considered "off-label" use and therefore subject to the Centers for Medicare & Medicaid Services (CMS) policy on unlabeled use of medications found in the *Benefits Policy Manual*, Internet Only Manual Pub. 100-02, Chapter 15, Section 50.4.2.

There is nothing in the medical literature supporting the use of budesonide at a frequency greater than twice per day (regardless of whether 0.5 mg or 0.25 mg dose is used) or a cumulative dose greater than 1 mg/day. Therefore, according to the local coverage determination (LCD) for Nebulizers, the maximum allowed amount is 62 units of service per month. Billing for quantities greater than 62 UOS per month will be denied as not medically necessary.

In example #3, even though the total mg administered (23.25 mg/mo) is within the policy guidelines (31 mg/mo), the 93 units of service exceeds the guidelines. If 0.75 per day is ordered, there is no medical necessity for three times per day administration. Administration of one 0.5 mg dose and one 0.25 dose per day would be appropriate. The excess units of service will be denied as not medically necessary.

Suppliers should refer to the Nebulizers LCD for additional guidance on the coverage, coding and documentation requirements.

Exercise Equipment – Correct Coding

Exercise equipment is not considered to be Durable Medical Equipment. According to CMS Internet Only Manual 100-2, Ch. 15, Section 110.1,

> "[p]hysical fitness equipment (such as an exercycle), first-aid or precautionary-type equipment (such as preset portable oxygen units), self-help devices (such as safety grab bars), and training equipment (such as Braille training texts) are considered nonmedical in nature." (http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf)

The correct HCPCS Code for exercise items is A9300, Exercise Equipment. Other codes should not be used.

Refer to the Pricing, Data Analysis and Coding (PDAC) contractor for information about the correct coding of a specific product.

A product list is maintained in the DMECS database and may be accessed from the PDAC web site (https://www.

dmepdac.com/dmecsapp/do/search). The list is updated periodically. Products not listed under A9300 may still be considered exercise equipment, so this is only a partial listing.

PRODUCT	MANUFACTURER	HCPCS CODE
ARTHO-AQUATIC FITNESS SYSTEM	ARTHO-AQUATIC FITNESS SYSTEMS, INC.	A9300
BACK PAC PRO	SAND THERAPEUTIC, INC.	A9300
BANTEX DELUXE PEDAL EXERCISER	AMERICAN BANTEX CORP	A9300
BIO-CUSHION	THOMAS A. TANGLOS	A9300
CAMOPED	OPED, INC.	A9300
CHAMPIOT ARMPOWER	FEREZ INDUSTRIES, INC.	A9300
CREWS-ING CHAIR	CREWS-ING CHAIR CO.	A9300
DYNA-CHAIR	ANTHROS MEDICAL.	A9300
E-Z STEPPER	MIRACLE PRODUCTS, INC.	A9300
EXERCYCLE EXERCISER	EXERCYCLE CORPORATION	A9300
EXODUS I	GENESIS CHAIRS, INC.	A9300
EXODUS II	GENESIS CHAIRS, INC.	A9300
FACIAL-FLEX ADULT	FACIAL-FLEX CORPORATION	A9300
FACIAL-FLEX PEDIATRIC	FACIAL-FLEX CORPORATION	A9300
FIT-BACK SPINE CARE SYSTEM	FIT-BACK (NU-BACK, LLC)	A9300
FLEXICISER	FLEXICISER INTERNATIONAL	A9300
FLEXXZOR	MEDICAL DEVICES, INC.	A9300
GENUBENDER	INNOVATIVE INTUITION, INC.	A9300
KNEE/ANKLE MOBILIER	HAYES KAM SYSTEMS	A9300
MACBLOCKER	UNIQUE REHAB SOLUTIONS, INC.	A9300
MASTERCARE BACK-A-TRACTION	SWEDISH BACKCARE SYSTEM, INC.	A9300
MAXM DORSI FLEXION HARNESS	MEDREP, INC.	A9300
MAXM KNEE EXTENSION HARNESS	MEDREP, INC.	A9300
MAXM PRONE FLEXION HARNESS	MEDREP, INC.	A9300
MAXM SEATED FLEXION HARNESS	MEDREP, INC.	A9300
MOTORIZED BICYCLE EXERCISE TRAINER	OZMARK SYSTEMS MANUFACTURING, LLC	A9300
PETTIBON LINKED EXERCISE TRAINER	THE PETTIBON SYSTEM	A9300
PHLEBO PUMP	PREVENT PRODUCTS	A9300
SOLOCISER	A-BAR TECHNOLOGY INC.	A9300
SOLOHAND	BEARFOOT FOOT CRADLE	A9300
SPI-RISE	S.D.R., INC.	A9300
THERA PEDAL ARM AND LEG CYCLE	THERAPEUTIC DESIGNS, INC.	A9300
UE RANGER	REHAB INNOVATIONS, INC.	A9300
WHEELCHAIR BIKE PLUS+	CHIEFS MANUFACTURING COMPANY	A9300

Claims submitted with A9300 will be denied with messages "These services are not covered" to the supplier and "The equipment is not covered because its primary use is not a medical purpose" to the beneficiary.

Functional Electrical Stimulators – New Code

A new HCPCS code been established for electrical stimulators effective for claims with dates of service on or after January 1, 2009.

E0770 Functional electrical stimulator, transcutaneous stimulation of nerve and/or muscle groups, any type, complete system, not otherwise specified

A functional electrical stimulator provides a current, which results in the movement of a body part to accomplish a specific task – e.g., walking, grasping, etc. Products in this category can have a variety of electrical parameters such as current, voltage ranges, and waveforms.

The only products that may be billed with code E0770 are those, which are listed in the DMECS Product Classification List on the Pricing, Data Analysis, and Coding Contractor (PDAC) web site. Currently, the only products that are coded E0770 are the WalkAide device manufactured by Innovative Neurotronics and the NESS L300 device manufactured by Bioness.

Questions concerning the coding of other products should be directed to the PDAC, Noridian Administrative Services Contact Center at 877.735.1326.

The CMS IOM Pub. 100-03 National Coverage Determination (NCD) Manual, section 160.12, addresses coverage criteria for functional electrical stimulators. Coverage is limited to those devices, which enhance the ability to walk and are used by spinal cord injury patients (ICD-9 diagnosis codes 806.00-806.9, 907.2, 952.00-952.9) with all of the following characteristics:

1. Persons with intact lower motor neuron units (L1 and below)(both muscle and peripheral nerve); and
2. Persons with muscle and joint stability for weight bearing in their upper and lower extremities who can demonstrate balance and control to maintain an upright support posture independently; and
3. Persons who demonstrate brisk muscle contraction to neuromuscular electrical stimulation and have sensory perception of electrical stimulation sufficient for muscle contraction; and
4. Persons who possess high motivation, commitment, and cognitive ability to use such devices for walking; and
5. Persons who can transfer independently and can demonstrate independent standing tolerance for at least 3 minutes; and
6. Person who can demonstrate hand and finger function to manipulate controls; and
7. Persons who are at least 6 months post spinal cord injury and restorative surgery; and
8. Persons without hip and knee degenerative disease and no history of long bone fracture secondary to osteoporosis; and
9. Persons who have demonstrated a willingness to use the device long term; and
10. Persons who have completed a one-on-one training program with a physical therapist, which consists of at least 32 physical therapy sessions with the device over a period of 3 months. The training program must be conducted in an inpatient hospital, outpatient hospital, or outpatient rehabilitation facility.

If a patient meets all of these requirements, a KX modifier must be added to code E0770. If any requirement is not met, the KX modifier may not be added.

Claims without a covered diagnosis code and/or without a KX modifier will be denied as not medically necessary.

LCD and Policy Article Revisions Summary for December 2008

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

External Infusion Pumps	
LCD Revision Effective Date: 01/01/2009	INDICATIONS AND LIMITATIONS OF COVERAGE: • Added ICD-9 codes 249.00-249.91 to range for insulin pumps (effective 10/01/2008) • Changed the physician assessment interval for insulin pumps from every 3 months to every 6 months • Removed word "Subcutaneous" from paragraph describing use of epoprostenol/treprostinil • Revised denial for pumps other than E0779 for administration of subcutaneous immune globulin to allow payment at least costly alternative HCPCS CODES AND MODIFIERS: • Narrative changes for codes J9000, J9040, J9100, J9110, J9190, J9200, and J9360 ICD-9 CODES THAT SUPPORT MEDICAL NECESSITY: • Added ICD-9 codes 249.00-249.91 to range for insulin pumps (effective 10/01/2008)
Policy Article Revision Effective Date: 01/01/2009	CODING GUIDELINES: • Replaced SADMERC reference with PDAC
Glucose Monitors	
LCD Revision Effective Date: 10/01/2008	INDICATIONS AND LIMITATIONS OF COVERAGE: • Added: Delivery timeframe for shipping of refills ICD-9 CODES THAT SUPPORT MEDICAL NECESSITY: • Added: 249.00 – 249.91 ICD-9 diagnosis codes
Policy Article Revision Effective Date: 10/01/2008	CODING GUIDELINES: • Deleted: Moved ICD-9 code range to LCD • Revised: Changed SADMERC to PDAC
Intravenous Immune Globulin	
LCD Revision Effective Date: 01/01/2009	HCPCS CODES AND MODIFIERS: • Added J1459 • Changed code descriptor for J1572 • Deleted Q4097
Policy Article Revision Effective Date: 01/01/2009	CODING GUIDELINES: • Replaced SADMERC reference with PDAC
Lower Limb Prostheses	
LCD Revision Effective Date: 01/01/2009	HCPCS CODES AND MODIFIERS: • Deleted: L5993 – L5995
Nebulizers	
LCD Revision Effective Date: 01/01/2009	INDICATIONS AND LIMITATIONS OF COVERAGE: • Deleted: Least costly alternative statement for albuterol/ipratropium combination (J7620) scheduled to become effective November 1, 2008 • Revised: Statement about denial of coverage when more than one beta-adrenergic agent is provided • Added: Maximum amount for albuterol/ipratropium combination • Added: Delivery timeframe for shipping of refills HCPCS CODES AND MODIFIERS: • Added: Code J7606 (formoterol fumarate) • Deleted: Code Q4099 (formoterol fumarate)

Policy Article Revision Effective Date: 01/01/2009	CODING GUIDELINES: • Deleted: References to trademarked name DuoNeb • Revised: Changed SADMERC to PDAC
Ostomy Supplies	
LCD Revision Effective Date: 01/01/2009	INDICATIONS AND LIMITATIONS OF COVERAGE: • Revised: Usual maximum quantity for A5083
Policy Article Revision Effective Date: 01/01/2009	CODING GUIDELINES: • Changed: References from SADMERC to PDAC ICD-9 CODES: • Added: 569.60
Oxygen and Oxygen Equipment	
LCD Revision Effective Date: 01/01/2009	INDICATIONS AND LIMITATIONS OF COVERAGE: • Corrected: Requirements for supplier involvement with home oximetry studies. An incorrect statement was added with the 01/01/2007 revision. • Removed: Statement addressing respiratory therapist services to be consistent with other jurisdictions. Statement remains in the policy article. HCPCS CODES AND MODIFIERS: • Added HCPCS Codes E1354, E1356, E1357, and E1358
Pneumatic Compression Devices	
LCD Revision Effective Date: 01/01/2009	INDICATIONS AND LIMITATIONS OF COVERAGE: • Added: Statement regarding appliances for the chest and trunk. HCPCS CODES AND MODIFIERS: • Added: E0656 and E0657
Policy Article Revision Effective Date: 01/01/2009	CODING GUIDELINES: • Changed: References from SADMERC to PDAC • References from DMERC to DME MAC
Power Mobility Devices	
LCD Revision Effective Date: 01/01/2009	INDICATIONS AND LIMITATIONS OF COVERAGE: • Changed: Terminology from Assistive Technology Supplier/Practitioner to Assistive Technology Professional • Changed: References from SADMERC to PDAC HCPCS CODES AND MODIFIERS: • Revised: K0899 • DOCUMENTATION REQUIREMENTS: • Revised: Guidance concerning the content of the face-to-face examination
Policy Article Revision Effective Date: 01/01/2009	CODING GUIDELINES: • Changed: References from SADMERC to PDAC
Pressure Reducing Support Surfaces - Group 2	
LCD Revision Effective Date: 01/01/2009	APPENDICES: • Revised: Definitions of pressure ulcer stages SOURCES OF INFORMATION AND BASIS FOR DECISION: • Added: Reference to NPUAP guidelines for pressure ulcer staging
Policy Article Revision Effective Date: 01/01/2009	CODING GUIDELINES: • Revised: Changed SADMERC to PDAC

Pressure Reducing Support Surfaces - Group 3	
LCD Revision Effective Date: 01/01/2009	INDICATIONS AND LIMITATIONS OF COVERAGE: • Added: ICD-9 codes 707.23 and 707.24 ICD-9 CODES: • Added: 707.23 & 707.24 – Pressure ulcers, stages III and IV DOCUMENTATION REQUIREMENTS: • Corrected the monthly physician certification requirement to maintain consistency with other jurisdictions. The statement was not revised in the 1/1/07 revision. • Revised KX modifier instruction to maintain consistency with other jurisdictions APPENDICES: • Revised: Definitions of pressure ulcer stages SOURCES OF INFORMATION AND BASIS FOR DECISION: • Added: Reference to NPUAP guidelines for pressure ulcer staging
Policy Article Revision Effective Date: 01/01/2009	CODING GUIDELINES: • Revised: Changed SADMERC to PDAC
Surgical Dressings	
LCD Revision Effective Date: 01/01/2009	INDICATIONS AND LIMITATIONS OF COVERAGE: • Added: Frequency of replacement for compression wrap (A6545) HCPCS CODES AND MODIFIERS: • Added: A4490-A4510, A6545 • Revised: A6010-A6024, A6196-A6199, A6203-A6215, A6219-A6248, A6251-A6266, A6407 APPENDICES: • Revised: Definitions of pressure ulcer stages SOURCES OF INFORMATION AND BASIS FOR DECISION: • Added: Reference to NPUAP guidelines for pressure ulcer staging
Policy Article Revision Effective Date: 01/01/2009	NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES: • Clarified: Allowance for HCPCS codes which use the term "kit" • Added: Coverage statements for compression wraps (A6545) • Added: Noncoverage statement for surgical stockings (A4490-A4510) CODING GUIDELINES: • Added: Requirement for PDAC Coding Verification Review for non-elastic compression wraps (A6545) • Revised: Changed SADMERC to PDAC
Therapeutic Shoes for Persons with Diabetes	
Policy Article Revision Effective Date: 10/01/2008	NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES: • Added: Additional diagnosis codes for diabetes CODING GUIDELINES: • Replaced: References to SADMERC with PDAC ICD-9 CODES THAT ARE COVERED: • Added: 249.00-249.91
Wheelchair Seating	
LCD Revision Effective Date: 01/01/2009	INDICATIONS AND LIMITATIONS OF COVERAGE: • Replaced: Reference to SADMERC with PDAC HCPCS CODES AND MODIFIERS: • Added: E2231 • Revised: K0669

Policy Article Revision Effective Date: 01/01/2009	CODING GUIDELINES: Revised: Guidelines for solid seat support base for manual wheelchair Replaced: References to SADMERC with PDAC

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

LCD and Policy Article Revisions - Summary for December 18, 2008

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

Patient Lifts	
LCD Revision Effective Date: 01/01/2009	INDICATIONS AND LIMITATIONS OF COVERAGE: • Removed: Least costly alternative statement for E0635 • Revised: Coverage criteria for E0636 • Added: Coverage criteria for E0639 and E0640 HCPCS CODES AND MODIFIERS: • Added: KX modifier DOCUMENTATION REQUIREMENTS: • Added: KX modifier requirement for E0636
Policy Article Revision Effective Date: 01/01/2009	NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES: • Deleted: Noncoverage statement for E0639, E0640 • Added: Noncoverage statement about home modifications. • Revised: E0625 noncoverage statement. CODING GUIDELINES: • Added: Definition for E0636, E0639, and E0640. • Revised: Definition of E1035 • Added: Requirement for PDAC coding verification review for E0636, E0639, E0640, and E1035 • Reformatted bundling table • Added E0639 and E0640 to table. • Changed: SADMERC to PDAC
Positive Airway Pressure Devices for the Treatment of Obstructive Sleep Apnea	
LCD Revision Effective Date: 01/01/2009 except where noted otherwise in the LCD.	INDICATIONS AND LIMITATIONS OF COVERAGE: • Revised: Criteria for Type IV home sleep test device • Added: Coverage requirements for beneficiaries enrolling in Medicare and needed replacement PAP device and/or accessories. DOCUMENTATION: • Added: Requirements for beneficiaries enrolling in Medicare and needed replacement PAP device and/or accessories. APPENDICES: • Added: List of approved Type IV devices that do not report AHI/RDI based on direct measurement of airflow or thoracoabdominal movement. • Covered Type IV device list to include Watch-PAT devices

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

LCD Reconsideration Process

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

NAS shall consider all LCD reconsideration requests from:

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

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

Requests shall not be accepted for other documents including:

- National Coverage Determinations (NCDs);
- Coverage provisions in interpretive manuals;
- Draft LCDs;
- Template LCDs, unless or until they are adopted by the contractor;
- Retired LCDs;
- Individual claim determinations;
- Bulletins, articles, training materials; and
- Any instance in which no LCD exists, i.e., requests for development of an LCD.

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

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

Requests may be submitted in writing to the following address:

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

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

Requests can also be emailed to dmeregdlcdreconsider@noridian.com.

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

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

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

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

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

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

DRUGS/BIOLOGICALS

Compendia as Authoritative Sources for Use in Determination of "Medically Accepted Indication" of Drugs and Biologicals Used Off-Label in Anti-Cancer Chemotherapeutic Regimen

MLN Matters Number: MM6191
Related Change Request (CR) #: 6191
Related CR Release Date: October 24, 2008
Related CR Transmittal #: R96BP
Effective Date: June 5, June 10, and July 2, 2008 (see below)
Implementation Date: November 25, 2008

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 6191 which updates the list of compendia recognized as authoritative sources of information for the determination of drugs and biologicals used off-label in anti-cancer chemotherapeutic regimens.

The Centers for Medicare & Medicaid Services (CMS) is recognizing the following as authoritative compendia and listing them in the *Medicare Benefit Policy Manual* (Chapter 15, Section 50.4.5) for use in the determination of a "medically-accepted indication" of drugs and biologicals used off-label in an anti-cancer chemotherapeutic regimen:

- American Hospital Formulary Service-Drug Information (AHFS-DI), (existing)
- National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium, (effective June 5, 2008)
- Thomson Micromedex DrugDex, (effective June 10, 2008) and
- Clinical Pharmacology (effective July 2, 2008).

Background

In the past, the following three compendia were recognized as authoritative sources for use in the determination of a "medically-accepted indication" of drugs and biologicals used off-label in an anti-cancer chemotherapeutic regimen (unless the Secretary of the Department of Health and Human Services determined that the use was not medically appropriate or the use was identified as not indicated in one or more such compendia):

1. American Medical Association Drug Evaluations (AMA-DE),
2. United States Pharmacopoeia-Drug Information (USP-DI) or its successor publication, and
3. American Hospital Formulary Service-Drug Information (AHFS-DI).

Because the AMA-DE and the USP-DI are no longer published (due to changes in the pharmaceutical reference industry), the AHFS-DI became the only remaining statutorily-named compendia available for the CMS to use as a reference. Consequently, CMS received requests from the stakeholder community for a process to revise the list of recognized authoritative compendia.

In the Medicare Physician Fee Schedule final rule for calendar year 2008, CMS established:

- A process for revising the list of compendia. (Section 1861(t)(2) of the Social Security Act; [http://www.ssa.gov/OP_Home/ssact/title18/1861.htm], and
- A definition for "compendium." (72 FR 66222 [http://edocket.access.gpo.gov/2007/07-5506.htm], 72 FR 66303-66306 [http://www.cms.hhs.gov/CoverageGenInfo/Downloads/compendiapreamble.pdf], and 72 FR 66404 [http://www.cms.hhs.gov/CoverageGenInfo/Downloads/compendiareg.pdf].

A compendium is defined "as a comprehensive listing of FDA-approved drugs and biologicals or a comprehensive listing of a specific subset of drugs and biologicals in a specialty compendium, for example, a compendium of anti-cancer treatment." (42 CFR 414.930(a) [http://edocket.access.gpo.gov/2007/pdf/07-3274.pdf].

In addition, a compendium:

1. Includes a summary of the pharmacologic characteristics of each drug or biological and may include information on dosage, as well as recommended or endorsed uses in specific diseases; and,
2. Is indexed by drug or biological. (42 CFR 414.930(a) [http://edocket.access.gpo.gov/2007/pdf/07-3274.pdf], 72 FR 66222 [http://edocket.access.gpo.gov/2007/07-5506.htm], and 72 FR 66404 [http://www.cms.hhs.gov/CoverageGenInfo/Downloads/compendiareg.pdf].

During a public meeting on March 30, 2006, the Medicare Evidence Development and Coverage Advisory Committee (MedCAC) generated a list of desirable characteristics to use when reviewing a compendium. Subsequently, the MedCAC advised CMS of their findings and recommendations regarding the desirable characteristics of compendia for use in the determination of medically-accepted indications of drugs and biologicals in anti-cancer therapy.

After CMS conducted a review of specific compendia and compared their characteristics with the MedCAC list of desirable characteristics, CMS determined the following are recognized as authoritative compendia and is listing them in the *Medicare Benefit Policy Manual* (Chapter 15, Section 50.4.5) for use in the determination of a "medically-accepted indication" of drugs and biologicals used off-label in an anti-cancer chemotherapeutic regimen:

- American Hospital Formulary Service - Drug Information (AHFS-DI),
- National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium,
- Thomson Micromedex DrugDex, and
- Clinical Pharmacology.

The above listed compendia employ various rating and recommendation systems that may not be readily cross-walked from compendium to compendium. In general, a use is identified by a compendium as **medically accepted** if the:

- Indication is a Category 1 or 2A in NCCN, or Class I, Class IIa, or Class IIb in DrugDex; or,
- Narrative text in AHFS-DI or Clinical Pharmacology is supportive.

A use is **not medically accepted** by a compendium if the:

- Indication is a Category 3 in NCCN or a Class III in DrugDex; or,
- Narrative text in AHFS or Clinical Pharmacology is "not supportive."

The complete absence of narrative text on a use is considered neither supportive nor non-supportive.

Medicare contractors may also identify off-label uses that are supported by clinical research under the conditions identified in Section 50.4.5 of the *Medicare Benefits Policy Manual*, as amended by CR6191. Peer-reviewed medical literature may appear in scientific, medical, and pharmaceutical publications in which original manuscripts are published, only after having been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.

In-house publications of entities whose business relates to the manufacture, sale, or distribution of pharmaceutical products are excluded from consideration. Abstracts (including meeting abstracts) are excluded from consideration.

In determining whether an off-label use is supported, Medicare contractors will evaluate the evidence in published, peer-reviewed medical literature listed in the revised Section

50.4.5.C, which is attached to CR6191. When evaluating this literature, Medicare contractors will consider (among other things) the following:

- Whether the clinical characteristics of the beneficiary and the cancer are adequately represented in the published evidence.
- Whether the administered chemotherapy regimen is adequately represented in the published evidence.
- Whether the reported study outcomes represent clinically meaningful outcomes experienced by patients.
- Whether the study is appropriate to address the clinical question.

Additional Information

The official instruction, CR 6191, issued to your carrier, FI, A/B MAC, and DME MAC regarding this change may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R96BP.pdf on the CMS Web site. The revised sections of the *Medicare Benefit Policy Manual* are attached to CR 6191.

OXYGEN

Changes in Medicare Payment for Oxygen and Oxygen Equipment

MLN Matters Number: SE0840

Provider Types Affected

Providers and suppliers submitting claims to Durable Medical Equipment Medicare Administrative Contractors (DME MACs) and/or Regional Home Health Intermediaries (RHHIs)) for oxygen and oxygen equipment provided to Medicare beneficiaries.

Provider Action Needed

This article alerts suppliers and providers that the Centers for Medicare & Medicaid Services (CMS) is implementing new oxygen payment rules and supplier responsibilities as a result of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) in the Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2009 as displayed in the Federal Register on October 30, 2008. These changes are effective for services provided on or after January 1, 2009. Be sure billing staff are aware of these changes.

Background

CMS is making these changes to comply with the new MIPPA requirements for oxygen and oxygen equipment while safeguarding beneficiaries who rely on life sustaining oxygen services. This Special Edition article supplements the information provided in MLN Matters 6296 and 6297 (or MM6296 and MM6297) which, when issued, outline instructions regarding repair, maintenance and servicing of oxygen equipment, and other changes resulting from implementation of section 144(b) of MIPPA. Once issued, MM6296 may be reviewed at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6296.pdf on the CMS Web site. Once issued, MM6297 may be reviewed at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6297.pdf on the CMS Web site.

Key Points

Payment and Billing Issues

- Oxygen and oxygen equipment are paid on a fee schedule basis. The beneficiary pays coinsurance and deductibles.
- The oxygen rental payment covers the equipment, contents, maintenance, and supplies and accessories such as tubing or a mouthpiece, and other services necessary for furnishing oxygen and oxygen equipment.
- The Deficit Reduction Act of 2005 (DRA) limited monthly payments for oxygen and oxygen equipment to 36 months of continuous use after which the equipment title transferred to the beneficiary. Section 144(b) of the **MIPPA repeals the transfer of ownership provision and permits suppliers to retain ownership of the oxygen equipment following the 36-month rental cap**.
- Section 414.226(g)(1) of CMS regulations requires the supplier who furnished the oxygen equipment in the first month to continue furnishing the oxygen equipment for the entire 36 month period with certain exceptions such as when the beneficiary relocates outside the service area, when the beneficiary elects to obtain oxygen equipment from another supplier, or in certain cases granted by the carrier/DME MAC or CMS such as emergency situations.
- Section 414.226(g)(2) of the regulations prevent suppliers from switching oxygen equipment modalities during the 36 month period (e.g., from liquid oxygen to a concentrator). There are special exceptions to this rule in the event the physician orders different equipment based on medical necessity or where the beneficiary chooses newer technology and signs an Advance Beneficiary Notice (ABN) acknowledging potential financial liability for the newer technology.
- Section 414.226(g)(1) also requires the supplier to disclose its intentions for accepting assignment of claims during the 36 month rental period.
- **Be aware that after the 36 month cap the following requirements apply:**
  - The supplier is required to continue furnishing the equipment, supplies and accessories for any period of medical need for the remainder of the reasonable useful lifetime of the equipment. This requirement includes use of equipment following temporary breaks of in-home oxygen services (e.g., due to a hospital or other facility stay) of any duration after the 36-month rental cap.
  - The supplier who furnished the liquid or gaseous oxygen equipment during the 36-month rental period is responsible for furnishing the oxygen contents used with the supplier-owned oxygen equipment for any period of medical need following the 36-month rental cap for the remainder of the reasonable useful lifetime of the equipment. Medicare will pay for oxygen contents for any gaseous or liquid oxygen equipment. Suppliers should continue to use HCPCS codes **E0441 through E0444** in order to bill and receive payment for furnishing oxygen contents. Medicare can

pay for a general maintenance-and-servicing visit for concentrators or transfilling equipment in 2009, which must take place 6 months after the end of the 36-month rental period.

- Other than this general maintenance and servicing payment, payment is not allowable for any repair or maintenance and servicing of supplier-owned oxygen equipment, including any replacement part furnished as part of any repair or maintenance and servicing of oxygen equipment.
- The supplier is responsible for furnishing all of the same items **and services** after the 36-month rental period as they furnished during the 36-month rental period. With the exception of oxygen contents and the general maintenance and servicing visit in 2009, the supplier must furnish these items and services without charging Medicare or the beneficiary.
- Payment is not allowable for supplier pickup or disposal of oxygen tanks or cylinders that are no longer needed.

Beneficiary Relocation Issues

- If the beneficiary relocates before the end of the 36-month rental period, he/she should work with his or her supplier to make arrangements to continue receiving oxygen and oxygen equipment from a new supplier at his or her new place of residence.
- If the beneficiary relocates after the 36-month rental period, the supplier is required to continue furnishing oxygen and oxygen equipment, and therefore, must make arrangements for the beneficiary to continue receiving oxygen services at his or her new place of residence.

Take Note: Suppliers that are found to be out of compliance with existing regulations and these new requirements are subject to significant administrative remedies, including removal of billing privileges.

Beneficiary Issues of Importance to Providers

- Beneficiaries are entitled to change suppliers at any time during their period of medical need. **A word of caution, finding new suppliers after the 36 month cap may be difficult because the new supplier would receive no monthly payments except for maybe the maintenance and servicing visit**.
- If beneficiaries choose to purchase their own oxygen equipment instead of renting, they need to understand that **Medicare does not pay a lump-sum purchase for oxygen equipment**. Medicare pays on a rental basis up to a 36-month rental period.

Additional Information

Questions and answers regarding changes in payment for oxygen and oxygen equipment are posted at http://questions.medicare.gov/cgi-bin/medicare.cfg/php/enduser/std_alp.php?p_sid=AUyrW7ij&p_lva=&p_li=&p_accessibility=0&p_redirect=&p_page=1&p_cv=1.33&p_pv=&p_prods=&p_cats=33&p_hidden_prods=&cat_lvl1=33 on the Internet.

Important Information on Medicare Payment and Supplier Requirements for Oxygen and Oxygen Equipment

CMS has released an *MLN Matters* article that emphasizes important information on Medicare payment and supplier requirements for oxygen and oxygen equipment. To assure proper implementation of these policies, the *MLN Matters* article focuses on significant supplier requirements for furnishing oxygen and oxygen equipment to our beneficiaries. The article (# SE0840 entitled, **Changes in Medicare Payment for Oxygen and Oxygen Equipment)** is available on the CMS Web site at http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0840.pdf.

CMS has also released questions and answers to address beneficiary concerns regarding the changes in payment and supplier requirements for oxygen and oxygen equipment. To view these questions and answers visit questions.medicare.gov on the Internet.

Oxygen Policy Reminders

Please note the following reminders when billing for oxygen and oxygen equipment to Jurisdiction D:

- The blood gas study reported on the Initial CMN must be the most recent study obtained prior to the Initial Date and this study must be obtained within 30 days prior to that Initial Date. There is an exception for patients who were on a Medicare HMO (Medicare Advantage Plan) and transferred to fee-for-service Medicare. For those patients, the blood gas study does not have to be obtained 30 days prior to the Initial Date, but must be the most recent test obtained while in the HMO.
- A break in service refers to a break in monthly billing. A change in medical condition means that the patient's condition changed to the point they no longer require the oxygen. A patient may have a break in service yet have no change in medical condition and still require the oxygen. An example of this would be if the patient were admitted into a SNF, hospital or Medicare HMO. For patients who have a break in service of at least 60 days due to a change in their medical condition and then subsequently require oxygen, a **new Initial CMN** will be required. The "new" initial CMN will reject if submitted electronically, however, the claim will suspend for missing a CMN. If there is a comment of BIS and the reason why in the narrative section of the claim, NAS claims staff will add the "new" initial CMN information into the claims processing system. If the break in service is 60 days or greater with no change in their medical condition or if the break in service is 60 days or less regardless of the change in medical condition, a new Initial CMN is **not** required.

Refer to the Documentation section of the Local Coverage Determination for Oxygen and Oxygen Equipment for additional information on when to submit an Initial, Recertified or Revised CMN at www.noridianmedicare.com/dme/coverage/lcd.html.

Positive Airway Pressure Devices - Supplier Frequently Asked Questions - December 2008

Based on questions received from the clinical and supplier community, the following Frequently Asked Questions will address issues in the Positive Airway Pressure (PAP) Devices local coverage determination (LCD).

Ordering/Treating Physician Issues

1. Question: The LCD uses the term "treating physician" in various places. What is the definition of a treating physician?

Answer: Medicare statute defines treating physician as one "…who furnishes a consultation or treats the beneficiary for a specific medical problem and who uses the [diagnostic x-ray tests, diagnostic laboratory tests and other diagnostic tests] results in the management of the beneficiary's specific medical problem." In a scenario where the beneficiary visits their primary care provider (PCP) who then refers the beneficiary to a sleep specialist for a polysomnogram and subsequent treatment with PAP and follow-up, both the PCP and the sleep specialist would be considered a "treating physician" within the context of Medicare regulations. Both physicians are engaged in diagnosing and treating the beneficiary for sleep disordered breathing. This scenario is quite common in medical practice where the primary medical care for the patient is rendered by the PCP and subspecialty physician consultation is engaged for specific diagnostic and/or therapeutic treatment outside the scope of the PCP's area of medical expertise.

2. Question: Are nurse practitioners, clinical nurse specialists and physician assistants allowed to conduct the initial clinical evaluation and/or follow-up evaluation since the LCD states this must be done by the treating physician?

Answer: Yes. Medicare regulations provide for the use of nurse practitioners, clinical nurse specialists and physician assistants in the care of Medicare beneficiaries. The Social Security Act Section 1861(s) addresses the provision of Medical and Other Services as follows:

Physician Assistants: (K)(i) services which would be physicians' services if furnished by a physician and which are performed by a physician assistant under the supervision of a physician and which the physician assistant is legally authorized to perform by the State in which the services are performed, and such services and supplies furnished as incident to such services as would be covered if furnished incident to a physician's professional service, but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services.

Nurse Practitioners and Clinical Nurse Specialists: (K)(ii) services which would be physicians' services if furnished by a physician and which are performed by a nurse practitioner or clinical nurse specialist working in collaboration with a physician which the nurse practitioner or clinical nurse specialist is legally authorized to perform by the State in which the services are performed, and such services and supplies furnished as an incident to such services as would be covered if furnished incident to a physician's professional service, but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services.

3. Question: Can a registered nurse (RN) conduct the follow-up evaluation?

Answer: No, the treating physician must be directly involved in the follow-up evaluation.

4. Question: The policy states that the data that the physician evaluates must be for a period of 30 consecutive days. The policy is silent on a time frame in which the physician must see the patient in relationship to the data.

Answer: The physician may see the patient and conduct the follow-up evaluation between the 31st and 91st day. Continued coverage of a PAP device requires that a determination be made by the treating physician that the patient is benefiting from the use of the selected device as evidenced by a face-to-face clinical follow-up evaluation and adherence to therapy. While the documentation of adherence may occur following the treating physician's follow-up evaluation, the adherence report must be provided to the treating physician for inclusion in the patient's medical record in order to fulfill the requirement to assess therapy benefit. Consider the following example:

11/01/08	Patient set up with a PAP device
12/05/08	Face-to-face re-evaluation indicates subjective improvement, but objective data is not available
1/30/09	Supplier obtains data demonstrating adherent use; faxes to MD for review
2/01/09	Add KX modifier to fourth month's claim

5. Question: Does the treating physician who does the initial face-to-face examination have to write the order for the PAP therapy or can it be ordered by the interpreting physician from the sleep lab?

Answer: The treating physician that does the initial face-to-face exam does not have to be the same physician that orders the PAP.

6. Question: Is there a time limit from initial face-to-face evaluation to the sleep study?

Answer: No time limit is specified in the policy; however, one would anticipate that these two events occur reasonably close together in time, typically within 3 months.

Adherence Monitoring

7. Question: Help us understand the term "visual inspection" as it relates to adherence monitoring. What does this mean and how can it be documented?

Answer: The LCD was revised to include allowance for visual inspection based on comments that not all suppliers use devices that allow downloading of adherence information. Visual inspection means determining adherence by looking at information on the PAP device's display screen and documenting the values in a written report. As noted in

a prior FAQ, the supplier may contact the beneficiary via telephone and ask them to read values from their device (i.e., phone-in compliance) or the supplier or physician may read the values during a home/office visit. The values must document that the patient is using the device for 4 or more hours per night for 70% of the nights in a consecutive 30-day period.

8. Question: Can we report hours used, for example with information from a device with an hour meter, and meet the requirement for documenting adherence? For example, "Spoke to patient and she states that as of 12/01/08, there are a total of 650 hours on her continuous positive airway pressure (CPAP) machine. She states that she uses the CPAP every night and it is very beneficial. On 11/01/08, the beginning reading was 500 hours. This calculates to 5 hours per night for 30 days."

Answer: No. Devices that simply report "device on" time or "blower on" time will not provide enough information to determine that the PAP device was used ≥ 4 hours per night on 70% of nights during a consecutive 30 day period anytime during the first 3 months of initial usage.

9. Question: Several manufacturers have devices that report "sessions" of use. Are these types of devices acceptable to meet the LCD requirement for adherence?

Answer: Possibly, depending on the definition of "session" which can vary based on the manufacturer or the session definition if a user-defined option. For example, consider a device that measures a "session" as use greater than X hours and also reports number of days used. Assuming that a session was set up to measure use ≥ 4 hours, one could use the number of session in conjunction with total days of use over a 30-day period and determine whether or not the patient met the adherence requirement.

10. Question: We use devices from a manufacturer that reports adherence information on a rolling 30-day basis. Information is displayed in a window on the device; however, adherence may vary depending on which 30-day period is examined. How can we use this device and still meet the adherence requirement?

Answer: Devices that report information on a rolling 30-day interval can be problematic if using visual inspection as the reporting method. One solution is to engage the beneficiary in their care and emphasize the importance of monitoring their therapy, including the potential loss of Medicare reimbursement for their PAP device due to failure to meet the adherence requirements. In the scenario with this specific piece of equipment, the supplier should instruct the beneficiary to monitor their device after the initial 30 days of use and report back to the supplier the point at which they meet the adherence metric.

Note that most devices that allow one to potentially determine adherence through visual inspection are designed to report adherence information in much greater detail via download. Suppliers are strongly encouraged to discuss the capabilities of devices being considered for purchase with each manufacturer to determine the capacity for reporting adherence as defined in the LCD.

11. Question: Must suppliers continue to document adherence as defined in the LCD after the initial 3-month period?

Answer: No. Following the initial 3-month trial and documentation of use ≥4 hrs. per night on 70% of nights in a 30 consecutive day period, suppliers should document continued use of the device. This may be accomplished via documentation of attestation by the beneficiary.

Reimbursement Issues

12. Question: A patient received a CPAP device paid for by fee for service (FFS) Medicare in 1998 and now needs to replace their device. Do they have to get a face-to-face evaluation, a new sleep study and meet the other requirements in the new LCD?

Answer: No. To receive a replacement CPAP device, they must have met the FFS Medicare coverage requirements that were in effect at the time their CPAP was dispensed, continue to use the device and have a new order from their treating physician. Continued use of the device may be documented by the supplier upon attestation of the beneficiary. Additional information may be found in the *Repairs/Replacement Chart* located in Chapter 3 of the Supplier Manual.

13. Question: A patient was diagnosed with obstructive sleep apnea and received a PAP device paid for by private insurance. The patient is now enrolled in FFS Medicare and needs a replacement PAP device and/or accessories. What is required for coverage?

Answer: For beneficiaries who received a PAP device prior to enrollment in FFS Medicare and are now seeking Medicare coverage of either a replacement PAP device and/or accessories, both of the following coverage requirements must be met:

1. Sleep test – There must be documentation that the beneficiary had a sleep test, prior to FFS Medicare, that meets the FFS Medicare AHI/RDI coverage criteria in effect at the time that the beneficiary seeks a replacement PAP device and/or accessories; and,

2. Clinical Evaluation – Following enrollment in FFS Medicare, the beneficiary must have a face-to-face evaluation by their treating physician who documents in the beneficiary's medical record that:

   a. The beneficiary has a diagnosis of obstructive sleep apnea; and,

   b. The beneficiary continues to use the PAP device.

If either criteria 1 or 2 above are not met, the claim will be denied as not medically necessary. The supplier may hold claims, pending confirmation that the above requirements are met, and then submit claims with the KX modifier beginning with the date of the beneficiary's enrollment in FFS Medicare.

14. Question: DME company ABC conducts home sleep tests and then refers patients to DME company XYZ for PAP therapy after the physician makes the diagnosis of obstructive sleep apnea. Since the two companies are not related and DME company XYZ did not conduct the home sleep test, is DME company XYZ allowed to dispense the PAP device based on this test?

Answer: No, a DME supplier is not a qualified provider of laboratory services; therefore, this is not a valid test for Medicare purposes. According to the PAP LCD, "No aspect of an HST [home sleep test], including but not limited to delivery and/or pickup of the device, may be performed by a DME supplier. This prohibition does not extend to the results of studies conducted by hospitals certified to do such tests."

15. Question: If a patient is put on a respiratory assist device (RAD) device with less than 30 day left in the initial 91-day period, the LCD indicates that the patient will be given to 120 days after the initiation of PAP therapy to document adherence. If the patient had a face-to-face exam in the 31 to 91 day period while on a CPAP device, must they have another face-to-face exam after they are on RAD? Certainly if they did not have a face-to-face exam in the 31 to 90 days we understand that one would need to be done before the 120th day.

Answer: Yes, the patient would need to have a follow-up evaluation before the 120th day to determine benefit from the RAD device. This answer is based on the assumption that the reason the patient changed from a CPAP to RAD is the failure to show clinical benefit with the CPAP device. According to the NCD, continued coverage requires demonstration of therapy benefit within the first 90 days. The LCD recognizes that some patients may require a change in therapy to a RAD device and this transition may happen late in the first 90-day period such that an extension to 120 days is necessary.

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

Answer: No, an ABN provided prior to the dispensing of the device that advises the beneficiary of a specific reason(s) why Medicare may deny coverage would not be considered a "blanket" ABN. Alternatively, an ABN may also be obtained in the month prior to a subsequent rental month when the supplier learns that the beneficiary will no longer meet Medicare coverage requirements.

17. Question: What can a supplier do if the patient does not get in to see the treating physician within the 31st-91st day?

Answer: If the patient received the re-evaluation at a later date and it was documented that the patient was benefiting from the use of the PAP device, the supplier may begin submitting claims with the KX modifier from the date of that re-evaluation. Claims for services in the interim between the 91st day and the date of the re-evaluation must be submitted without the KX.

18. Question: What can be done in a situation where an order is received for PAP therapy but the patient never had a face-to-face evaluation? Can the face-to-face evaluation be done after the sleep test or after initiation of PAP therapy and will that meet our documentation requirements?

Answer: The NCD and LCD require that prior to initiating PAP therapy, the patient has a clinical evaluation and sleep test. There is a sound clinical rationale for this specific sequence of events; therefore, a face-to-face evaluation performed after the sleep test or after the initiation of PAP therapy would not meet the coverage requirements and a KX modifier must not be added to the claim. Suppliers may obtain an ABN to inform the beneficiary that the PAP device will not be covered since the coverage requirements were not met.

Positive Airway Pressure Devices - Physician Frequently Asked Questions December 2008

December 18, 2008

Based on questions received from the clinical community, the following Frequently Asked Questions will address issues in the Positive Airway Pressure (PAP) Devices local coverage determination (LCD). The complete medical policy may be viewed on the Durable Medical Equipment Medicare Administrative Contractors (DME MACs) individual web sites or in the CMS Medicare Coverage Database. Note that the formal title of the policy is Positive Airway Pressure (PAP) Devices for the Treatment of Obstructive Sleep Apnea. The web address of the Medicare Coverage Database is: http://www.cms.hhs.gov/mcd/search.asp. Additional information may also be found in the "Dear Physician" letter published in December 2008 on the DME MAC web sites.

Physicians are reminded that in order for these items to be reimbursed for your patients, the DME supplier will need to collect medical documentation including copies of your initial evaluation, the report of the sleep study, your re-evaluation during the PAP trial, and the data report from the PAP device indicating patient compliance during the trial. Please cooperate with them so that they can provide the device that you have ordered for your patient.

Ordering/Treating Physician Issues

1. Question: Explain the physician visits required for patients who are being evaluated for sleep disordered breathing.

Answer: Two face-to-face evaluations are required for a patient to be considered for Medicare coverage for PAP therapy. There must be a face-to-face visit with the treating physician prior to ordering of any sleep test. This should generally include documentation in the patient's medical record the following elements:

a. Sleep history and symptoms

b. Epworth Sleepiness Scale (a standardized patient questionnaire which helps to assess the likelihood of sleep apnea) or other validated sleep inventory

c. Pertinent physical examination – e.g., body mass index, neck circumference, upper airway exam, and cardiopulmonary exam

Medicare coverage is conditional for the first 3 months. Continued coverage beyond the first 3 months is contingent upon demonstration of benefit from the use of a PAP device. Therefore, following the sleep test the patient must see the

treating physician again, sometime between the 31st and 91st day, to document improvement of the patient's symptoms. In addition, the physician must review data from the PAP device which documents use at least 4 hours per night on 70% of nights for a 30 consecutive day period during the trial.

2. Question: The LCD uses the term "treating physician" in various places. What is the definition of a treating physician?

Answer: Medicare statute defines treating physician as one "…who furnishes a consultation or treats the beneficiary for a specific medical problem and who uses the [diagnostic x-ray tests, diagnostic laboratory tests and other diagnostic tests] results in the management of the beneficiary's specific medical problem." In a scenario where the beneficiary visits their primary care provider (PCP) who then refers the beneficiary to a sleep specialist for a polysomnogram and subsequent treatment with PAP and follow-up, both the PCP and the sleep specialist would be considered a "treating physician" within the context of Medicare regulations. Both physicians are engaged in diagnosing and treating the beneficiary for sleep disordered breathing. This scenario is quite common in medical practice where the primary medical care for the patient is rendered by the PCP and subspecialty physician consultation is engaged for specific diagnostic and/or therapeutic treatment outside the scope of the PCP's area of medical expertise.

3. Question: Are nurse practitioners, clinical nurse specialists and physician assistants allowed to conduct the initial clinical evaluation and/or follow-up evaluation since the LCD states this must be done by the treating physician?

Answer: Yes. Medicare regulations provide for the use of nurse practitioners, clinical nurse specialists and physician assistants in the care of Medicare beneficiaries. The Social Security Act §1861(s) addresses the provision of Medical and Other Services as follows:

Physician Assistants: (K)(i) services which would be physicians' services if furnished by a physician and which are performed by a physician assistant under the supervision of a physician and which the physician assistant is legally authorized to perform by the State in which the services are performed, and such services and supplies furnished as incident to such services as would be covered if furnished incident to a physician's professional service, but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services.

Nurse Practitioners and Clinical Nurse Specialists: (K)(ii) services which would be physicians' services if furnished by a physician and which are performed by a nurse practitioner or clinical nurse specialist working in collaboration with a physician which the nurse practitioner or clinical nurse specialist is legally authorized to perform by the State in which the services are performed, and such services and supplies furnished as an incident to such services as would be covered if furnished incident to a physician's professional service, but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services.

4. Question: Can a registered nurse (RN) conduct the follow-up evaluation?

Answer: No, the treating physician (defined and discussed above) must be directly involved in the follow-up evaluation.

5. Question: The policy states that the data that the physician evaluates must be for a period of 30 consecutive days. The policy is silent on a time frame in which the physician must see the patient in relationship to the data.

Answer: The physician may see the patient and conduct the follow-up evaluation between the 31st and 91st day. Continued coverage of a PAP device requires that a determination be made by the treating physician that the patient is benefiting from the use of the selected device as evidenced by a face-to-face clinical follow-up evaluation and adherence to therapy. While the documentation of adherence may occur following the treating physician's follow-up evaluation, the adherence report must be provided to the treating physician for inclusion in the patient's medical record in order to fulfill the requirement to assess therapy benefit.

6. Question: Does the treating physician who does the initial face-to-face examination have to write the order for the PAP therapy or can it be ordered by the interpreting physician from the sleep lab?

Answer: The treating physician that does the initial face to face exam does not have to be the same physician that orders the CPAP.

7. Question: Is there a time limit from initial face-to-face evaluation to the sleep study?

Answer: No time limit is specified in the policy; however, one would anticipate that these two events occur reasonably close together in time, typically within 3 months.

8. Question: Can the face-to-face evaluation be done after the sleep test or after initiation of PAP therapy and will that meet the LCD documentation requirements?

Answer: The NCD and LCD require that prior to initiating PAP therapy, the patient has a clinical evaluation and sleep test. There is a sound clinical rationale for this specific sequence of events; therefore, a face-to-face evaluation performed after the sleep test or after the initiation of PAP therapy would not meet the coverage requirements.

9. Question: If a patient is put on a respiratory assist device (RAD) device with less than 30 days left in the initial 91 day period, the LCD indicates that the patient will be given to 120 days after the initiation of PAP therapy to document adherence. If the patient had a face to face exam in the 31 to 91 day period while on a CPAP device, must they have another face to face exam after they are on RAD? Certainly if they did not have a face to face exam in the 31 to 90 days we understand that one would need to be done before the 120th day.

Answer: Yes, the patient would need to have a follow-up evaluation before the 120th day to determine benefit from the RAD device. This answer is based on the assumption that the reason the patient changed from a CPAP to RAD is the failure to show clinical benefit with the CPAP device. According to the NCD, continued coverage requires demonstration of therapy benefit within the first 90 days. The

PAP CONT'D

LCD recognizes that some patients may require a change in therapy to a RAD device and this transition may happen late in the first 90 day period such that an extension to 120 days is necessary.

10. Question: What happens if the patient does not get in to see the treating physician within the 31st-91st day?

Answer: If the patient does not get in to see the treating physician for the re-evaluation between the 31st and 91st day of PAP treatment, coverage of the PAP device will end after 3 months. If the physician performs the re-evaluation at a later date, coverage would resume on the date of the re-evaluation. The patient may be responsible for payment of the device and accessories during the intervening time period between the end of the third month and whenever the re-evaluation takes place.

Question: What is required for patients who may have received their PAP device from a private insurer and are now enrolled in fee for service (FFS) Medicare? What is needed for those patients to get a new device and/or supplies?

Answer: For beneficiaries who received a PAP device prior to enrollment in FFS Medicare and are now seeking Medicare coverage of either a replacement PAP device and/or accessories, both of the following coverage requirements must be met:

1. Sleep test – There must be documentation that the beneficiary had a sleep test, prior to FFS Medicare enrollment, that meets the FFS Medicare AHI/RDI coverage criteria in effect at the time that the beneficiary seeks a replacement PAP device and/or accessories; and,
2. Clinical Evaluation – Following enrollment in FFS Medicare, the beneficiary must have a face-to-face evaluation by their treating physician who documents in the beneficiary's medical record that:
   a. The beneficiary has a diagnosis of obstructive sleep apnea; and,
   b. The beneficiary continues to use the PAP device.

If either criteria 1 or 2 above are not met, the claim will be denied as not medically necessary.

Sleep Test

12. Question: The LCD notes that Type IV devices that do not directly measure airflow or thoracoabdominal movement to calculate an AHI/RDI will be considered for coverage after evaluation of the medical literature. Are there any Type IV devices that meet the requirements for coverage? If so, where can we find this list?

Answer: The DME MAC medical directors have received information regarding Watch-PAT. After review of the scientific literature, these devices have been added to the local coverage determination (LCD) as a covered Type IV device, effective for tests conducted with dates of service on or after January 1, 2009. The LCD also now includes in the Appendices a list of Type IV devices approved for coverage that indirectly measure AHI/RDI. This coverage expansion will be reflected in an upcoming policy revision.

13. Question: Who is allowed to interpret home sleep tests?

Answer: If a home sleep study is performed after November 1, 2008, it must be interpreted by a physician who holds either:

a. Current certification in Sleep Medicine by the American Board of Sleep Medicine (ABSM); or

b. Current subspecialty certification in Sleep Medicine by a member board of the American Board of Medical Specialties (ABMS); or

c. Completed residency or fellowship training by a program approved by an ABMS member board and has completed all the requirements for subspecialty certification in sleep medicine except the examination itself and only until the time of reporting of the first examination for which the physician is eligible; or

d. Active staff membership of a sleep center or laboratory accredited by the American Academy of Sleep Medicine or the Joint Commission.

Physicians interpreting facility-based polysomnograms will be required to meet this requirement for coverage of PAP devices provided after January 1, 2010.

14. Question: What if my local Part A or Part B contractor has an LCD for polysomnography that is different from the DME MAC LCD. Which one applies?

Answer: Additional coverage and payment rules for sleep tests may be found in the LCD for the applicable Medicare Part A or Part B contractor. There may be differences between those LCDs and the DME MAC LCD. For the purposes of coverage of PAP therapy, the DME MAC coverage criteria take precedence.

Adherence Monitoring

15. Question: Help us understand the term "visual inspection" as it relates to adherence monitoring. What does this mean and how can it be documented?

Answer: The LCD was revised to include allowance for visual inspection, in addition to direct download of information from the PAP device. Visual inspection means determining adherence by looking at information on the PAP device's display screen and documenting the values in a written report. The medical equipment supplier is allowed to contact the beneficiary via telephone or during an in-person visit and ask them to read values from their device. Alternatively, the physician may read the values during a home/office visit and document the adherence information in the patient's medical record. The values must document that the patient is using the device for 4 or more hours per night for 70% of the nights in a consecutive 30-day period.

16. Question: Can the report be based on hours used, for example with information from a device with an hour meter, and meet the requirement for documenting adherence? For example, "Spoke to patient and she states that as of 12/01/08, there are a total of 650 hours on her CPAP machine. She states that she uses the CPAP every night and it is very beneficial. On 11/01/08, the beginning reading was 500 hours. This calculates to 5 hours per night for 30 days."

Answer: No. Devices that simply report device "on" time or "blower on" time will not provide enough information to determine that the PAP device was used ≥ 4 hours per night on 70% of nights during a consecutive thirty (30) day period anytime during the first three (3) months of initial usage.

17. Question: Several manufacturers have devices that report "sessions" of use. Are these types of devices acceptable to meet the LCD requirement for adherence?

Answer: Possibly, depending on the definition of "session" which can vary based on the manufacturer or the session definition if a user-defined option. For example, consider a device that measures a "session" as use greater than X hours and also reports number of days used. Assuming that a session was set up to measure use ≥ 4 hours, one could use the number of session in conjunction with total days of use over a 30 day period and determine whether or not the patient met the adherence requirement.

18. Question: Some devices report adherence information on a rolling 30 day basis. Information is displayed in a window on the device; however, adherence may vary depending on which 30 day period is examined. Can this device and still meet the adherence requirement?

Answer: Devices that report information on a rolling 30 day interval can be problematic if using visual inspection as the reporting method. One solution is to engage the beneficiary in their care and emphasize the importance of monitoring their therapy, including the potential loss of Medicare reimbursement for their PAP device due to failure to meet the adherence requirements. In the scenario with this specific piece of equipment, the supplier or physician should instruct the beneficiary to monitor their device after the initial 30 days of use and report back to the supplier the point at which they meet the adherence metric.

19. Question: Must adherence as defined in the LCD continue to be documented after the initial 3 month period?

Answer: No. Following the initial 3 month trial and documentation of use ≥4 hrs. per night on 70% of nights in a 30 consecutive day period, the medical equipment supplier can document continued use of the device. This may be accomplished via documentation of attestation by the beneficiary.

Important Information for the Ordering Physician

This letter may be shared with physicians to address issues of importance with PAP devices.

Letter is continued on next page.

Medicare

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December 18, 2008

Subject: Positive Airway Pressure (PAP) Devices – Important Information for the Ordering Physician

Dear Physician:

On March 13, 2008, CMS released a revised National Coverage Determination (NCD) for Continuous Positive Airway Pressure (CPAP) devices. In September 2008, the Durable Medical Equipment Medicare Administrative Contractors (DME MACs) published a revised Local Coverage Determination (LCDs) and a "Dear Physician" letter which reviewed the pertinent coverage criteria for these devices, including bi-level positive airway pressure devices (respiratory assist devices, RADs) when they are use to treat obstructive sleep apnea (OSA).

The DME MAC medical directors have updated the PAP LCD; consequently, we are republishing this important information for ordering physicians. In addition, there are Frequently Asked Questions (FAQs) specifically addressing issues of importance to ordering physicians on the DME MAC web sites.

The major requirements for coverage of a PAP device for OSA that pertain to the ordering physician are:

1. There must be a face-to-face visit with the physician prior to ordering the sleep test. This should generally include the following elements:

   b. Sleep history and symptoms which may be caused by OSA

   c. Epworth Sleepiness Scale (a standardized patient questionnaire which helps to assess the likelihood of sleep apnea) or other validated sleep inventory

   d. Pertinent physical examination – e.g., body mass index, neck circumference, upper airway exam, and cardiopulmonary exam

2. The patient must have a facility based polysomnogram or a Type II, III, or IV home sleep study. Type IV home sleep studies are acceptable when performed by devices that either directly or indirectly allow calculation of an apnea-hypopnea index (AHI) or respiratory disturbance index (RDI). Devices that allow direct calculation of AHI/RDI by measuring airflow or thoracoabdominal movement are acceptable.

The only currently acceptable Type IV device that indirectly allows calculation of an AHI/RDI are the Watch-PAT devices (Itamar Medical), effective for tests conducted on or after January 1, 2009. Acceptable indirect measurement products are listed in the LCD.

3. If a home sleep study is performed, it must be interpreted by a physician who holds either:

   a. Current certification in Sleep Medicine by the American Board of Sleep Medicine (ABSM); or

   b. Current subspecialty certification in Sleep Medicine by a member board of the American Board of

   c. Medical Specialties (ABMS); or

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d. Completed residency or fellowship training by a program approved by an ABMS member board and has completed all the requirements for subspecialty certification in sleep medicine except the examination itself and only until the time of reporting of the first examination for which the physician is eligible; or

e. Active staff membership of a sleep center or laboratory accredited by the American Academy of Sleep Medicine or the Joint Commission.

Note: Physicians interpreting polysomnograms will be required to meet this requirement for coverage of PAP devices provided after January 1, 2010.

4. The sleep study results are:

a. AHI or RDI is greater than or equal to 15 events per hour, with a minimum of 30 events; or

b. AHI or RDI is 5-14 events per hour (minimum of 10 events) with documentation of excessive daytime sleepiness, impaired cognition, mood disorders, insomnia, hypertension, ischemic heart disease, or history of stroke.

(Note: For purposes of this policy, the RDI includes only apneas and hypopneas.)

5. To continue coverage for the positive airway pressure (PAP) device (CPAP or RAD) beyond an initial 3 month trial period, there must be:

a. A face-to-face visit with the physician during the second or third month of the trial that documents an improvement of the beneficiary's symptoms; and

b. A data report from the PAP device which documents use the PAP device for at least 4 hours per night on 70% of nights for a 30 consecutive day period during the trial.

6. For beneficiaries who received a PAP device prior to FFS Medicare enrollment and are now enrolled in Medicare and are seeking a new PAP device and/or accessories, both of the following coverage requirements must be met:

1. Sleep test – There must be documentation that the beneficiary had a sleep test, prior to FFS Medicare enrollment, that meets the FFS Medicare AHI/RDI coverage criteria in effect at the time that the beneficiary seeks a replacement PAP device and/or accessories; and,

2. Clinical Evaluation – Following enrollment in FFS Medicare, the beneficiary must have a face-to-face evaluation by their treating physician who documents in the beneficiary's medical record that:

a. The beneficiary has a diagnosis of obstructive sleep apnea; and,

b. The beneficiary continues to use the PAP device.

Additional coverage and payment rules for sleep tests may be found in the local coverage determinations (LCDs) for the applicable Medicare Part A or Part B contractor. There may be differences between those LCDs and the DME MAC LCD. For the purposes of coverage of PAP therapy, the DME MAC coverage criteria take precedence.

The complete medical policy may be viewed on the DME MACs' individual web sites or in the CMS Medicare Coverage Database. The Epworth Sleepiness Scale may be found in the Appendices section of the LCD. Note that the formal title of the policy is Positive Airway Pressure ((PAP) Devices for the Treatment of Obstructive Sleep Apnea. The web address of the Medicare Coverage Database is: http://www.cms.hhs.gov/mcd/search.asp

Physicians are reminded that in order for these items to be reimbursed for your patients, the DME supplier will need to collect medical documentation including copies of your initial evaluation, the report of the sleep study, your re-evaluation during the PAP trial, and the data report from the PAP device indicating patient compliance during the trial. Please cooperate with them so that they can provide the device that you have ordered for your patient.

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