Jurisdiction D News from Noridian Administrative Services, LLC.

Happenings

June 2009
Issue No. 21

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

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

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Jurisdiction D DME MAC Supplier Contacts and Resources

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

Web Site: www.noridianmedicare.com

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

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

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

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

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

Holiday Schedule

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

Holiday	Date
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."

Remittance Advice Requirements for Calling the Contact Center

Suppliers need to have their remittance advice (RA) available when calling the NAS DME Contact Center based on CMS requirements regarding requests for information that is available on a supplier's RA. This requirement will be implemented on June 22, 2009. The result of the CMS requirement will affect a supplier in the following three ways:

1. Suppliers that contact the Contact Center with questions that can be found on a RA will be educated by the customer service representative on how to read the RA. This is meant to encourage the use of self-service when reviewing the RA.
2. Suppliers that do not have the RA present at the time of the call will be instructed by the customer service representative to call back once they have the RA present.
3. Billing staff or representatives that make inquiries to the Contact Center on the supplier's behalf will need a copy of the RA. This includes clearinghouses, billing companies, and any other outsourced billing staff. Callers that do not have the RA present at the time of the call will be instructed by the customer service representative to call back once the caller has the RA present.

Customer service representatives will continue to be available for inquiries such as Medicare policies, processes, general questions, and in-depth claim questions.

Suppliers are reminded that RA's can only be mailed to the address NAS has on file. If an address needs to be updated, suppliers need to contact the National Supplier Clearinghouse (NSC) at 1-866-238-9652.

The following CMS education and training resources are available to assist suppliers in reviewing their RAs:

- Understanding the Remittance Advice: http://www.cms.hhs.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf
- CMS Internet Only Manual (IOM) Publication 100-09, Chapter 6, Section 80.3.4, http://www.cms.hhs.gov/manuals/downloads/com109c06.pdf

Summary of Supplier Manual Updates

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

Chapter	Subheading	Supplier Manual Update	Change Date
All	Jurisdiction D Supplier Manual	All chapters included in one PDF	5/13/09
6	Claim Submission	HTML updated and PDF added	5/13/09
1	Introduction	HTML updated and PDF added	4/29/09
5	DMEPOS	HTML updated and PDF added	4/28/09
16	Coding	PDF added	4/28/09
14	Fraud and Abuse	HTML updated and PDF added	4/24/09
7	Crossover Claims	HTML updated and PDF added	4/24/09
15	Overpayments and Refunds	PDF format change	4/22/09
2	Supplier Enrollment	PDF added	4/22/09
4	Certificate of Medical Necessity/DME Information Form	HTML updated and PDF added	4/22/09
8	Electronic Data Interchange	PDF format change	4/22/09
9	DMEPOS Coverage, Benefit Categories, and Medical Policy	HTML updated and PDF added	4/22/09
10	Indian Health Services	PDF format change	4/22/09
11	Medicare Secondary Payer	HTML updated and PDF added	4/22/09
12	Pricing	HTML updated and PDF added	4/22/09
13	Reopenings and Appeals	PDF reformatted	4/22/09
15	Overpayments and Refunds	PDF format change	4/22/09
17	System Outputs	PDF format change	4/22/09
Appendix	Acronyms/Abbreviations, Resources and Contacting NAS and Inquiries	HTML updated and PDF format change	4/22/09

Quarterly Provider Updates

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

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

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

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

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

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

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

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

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

CSI Medicare System Security Quarterly Review

In accordance with CMS, NAS is required to perform a periodic review of system access for all Claims Status Inquiry (CSI) users.

During the month of April and October each provider will be faxed a listing of their active users. It is the responsibility of the facility contact person to respond to the user CSI listing. Failure to respond within the allotted timeframe will result in removal of access for all users.

If there are no changes to the listing, sign and date page one of the forms. If there are changes to be made to the listing, a Medicare Claims Processing System (MCPS) form must be submitted for each change. Examples of when an MCPS form needs to be submitted are:

- Termination
  - A signature is required either by the employee or the supervisor
- Legal name change
- Adding/removing provider NPI

- Change in facility
- Change type of access for example; eligibility to claims and/or claims to eligibility

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

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

DME Contact List

Trent Cable: 701-277-6779

Susan Boer: 701-277-2572

Information on Swine Flu

CMS asks that you share this important information with all of your association members and State and local chapters.

For the most current information about swine flu, visit the Centers for Disease Control and Prevention (CDC) web site at: http://www.cdc.gov/swineflu/. You will find consumer and provider fact sheets, current information, and steps you can take to protect yourself against infection.

At the CDC site you will also be able to download a widgit that you can post to your own web site to help your membership get the most current and accurate information.

Clarification about Medical Privacy of Protected Health Information

MLN Matters Number: SE0726 Revised

Note: This article was revised on May 11, 2009, to reflect updated Web addresses for several products referenced in the article.

Provider Types Affected

Physicians, providers, and suppliers who bill Medicare contractors (carriers, durable medical equipment Medicare Administrative Contractors (DME MACs), fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), and/or Part A/B Medicare Administrative Contractors (A/B MACs) for services provided to Medicare beneficiaries

Provider Action Needed

The purpose of this Special Edition (SE) article, SE0726, is be sure that heath care providers are aware of the helpful guidance and technical assistance materials the U.S. Department of Health and Human Services (HHS) has published to clarify the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), specifically, the educational material below. Remind individuals within your organization of:

- The Privacy Rule's protections for personal health information held by providers and the rights given to patients, who may be assisted by their caregivers and others, and
- That providers are permitted to disclose personal health information needed for patient care and other important purposes.

HHS Privacy Guidance

HHS' educational materials include a letter to healthcare providers with the following examples to clarify the Privacy Rule:

HIPAA does not require patients to sign consent forms before doctors, hospitals, or ambulances can share information for treatment purposes:

Providers can freely share information with other providers where treatment is concerned, without getting a signed patient authorization. Clear guidance on this topic can be found in a number of places:

- Review the answers to frequently asked questions (FAQs) by searching the FAQs on a likely word or phrase such as "treatment." The link to the FAQs may be found at http://www.hhs.gov/hipaafaq/ on the HHS web site.
- Consult the Fact Sheet, "Uses and Disclosures for Treatment, Payment, and Health Care Operations," which is at http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/usesanddisclosuresfortpo.html on the HHS web site.
- Review the "Summary of the HIPAA Privacy Rule" at http://www.hhs.gov/ocr/privacy/hipaa/understanding/summary/index.html on the HHS web site.

HIPAA does not require providers to eliminate all incidental disclosures:

- The Privacy Rule recognizes that it is not practicable to eliminate all risk of incidental disclosures. That is why, in August 2002, HHS adopted specific modifications to that Rule to clarify that incidental disclosures do not violate the Privacy Rule when providers and other covered entities have policies which reasonably safeguard and appropriately limit how protected health information is used and disclosed.
- OCR guidance explains how this applies to customary health care practices, for example, using patient sign-in sheets or nursing station whiteboards, or placing patient charts outside exam rooms. At the HHS/OCR web site, see the FAQs in the "Incidental Uses and Disclosures" subcategory; search the FAQs on terms like "safeguards" or "disclosure"; or review the Fact Sheet on "Incidental Disclosures". The fact sheet is at http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/usesanddisclosuresfortpo.html on the HHS web site.

HIPAA does not cut off all communications between providers and the families and friends of patients:

- Doctors and other providers covered by HIPAA can share needed information with family, friends, or with anyone else a patient identifies as involved in his or her care as long as the patient does not object.

- The Privacy Rule also makes it clear that, unless a patient objects, doctors, hospitals and other providers can disclose information when needed to notify a family member, or anyone responsible for the patient's care, about the patient's location or general condition.
- Even when the patient is incapacitated, a provider can share appropriate information for these purposes if he believes that doing so is in the best interest of the patient.
- Review the provider's guide on communications with a patient's family, etc. at http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/provider_ffg.pdf on the HHS web site.

HIPAA does not stop calls or visits to hospitals by family, friends, clergy or anyone else:

- Unless the patient objects, basic information about the patient can still appear in the hospital directory so that when people call or visit and ask for the patient, they can be given the patient's phone and room number, and general health condition.
- Clergy, who can access religious affiliation if the patient provided it, do not have to ask for patients by name.
- See the FAQs in the "Facility Directories" at http://www.hhs.gov/ocr/privacy/hipaa/faq/administrative/485.html on the HHS web site.

HIPAA does not prevent child abuse reporting:

Doctors may continue to report child abuse or neglect to appropriate government authorities. See the explanation in the FAQs on this topic, which can be found, for instance, by searching on the term "child abuse;" or review the fact sheet on "Public Health" that can be reviewed at http://www.hhs.gov/ocr/privacy/hipaa/understanding/special/publichealth/index.html on the HHS web site.

HIPAA is not anti-electronic:

Doctors can continue to use e-mail, the telephone, or fax machines to communicate with patients, providers, and others using common sense, appropriate safeguards to protect patient privacy just as many were doing before the Privacy Rule went into effect. A helpful discussion on this topic can be found at http://www.hhs.gov/hipaafaq/providers/smaller/482.html on the HHS web site.

Additional Information

The HHS complete listing of all HIPAA medical privacy resources is available at http://www.hhs.gov/ocr/hipaa/ on the HHS web site.

Ask the Contractor Teleconference – June 23, 2009

NAS will conduct the next Ask the Contractor Teleconference on June 23, 2009, at 3 p.m. CT. We will be continuing with our current format of brief opening remarks followed by the question and answer (Q&A) session.

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

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

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

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

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

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

Top Ten Telephone Inquiries

The purpose of this article is to assist suppliers with solutions to the "Top Ten" telephone inquiries our Supplier Contact Center received from January – March 2009, excluding eligibility and claim status. Our web site, https://www.noridianmedicare.com, contains excellent information to assist with supplier inquiries.

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

Suppliers should review the documentation section of each individual medical policy to verify the utilization guidelines and the documentation requirements needed when billing for quantities of supplies greater than those described in the policy. Each claim submitted for quantities of supplies greater than those described in the policy must have documentation supporting the medical necessity of the higher utilization. This supporting information should be reported in Item 19 on the CMS-1500(08-05) or the narrative field of an electronic claim.

The policies can be accessed from the Coverage/MR Section of the NAS DME web site by going to the section titled Local Coverage Determinations.

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

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

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

3. Medical Necessity
Suppliers are encouraged to consult the Local Coverage Determination (LCD) and related Policy Article for medical policy coverage criteria.

If you receive a medical necessity denial on a claim, you have the option to submit a written signed request to appeal the decision. If you make this choice, NAS recommends using the DME Inquiry/Redetermination form. Please submit the request along with all pertinent medical documentation supporting the need for the item to:

Noridian Administrative Services
PO Box 6727
Fargo ND 58108-6727

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

4. Eligibility
These denials most often occur when the beneficiary is no longer eligible for Part B benefits or the beneficiary information reported on the claim is incorrect.

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. Also, the claim must be submitted with the patient's name exactly as it is shown on the Medicare card.

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

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

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

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

For additional information on downloading MREP, contact the CEDI Help Desk.

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

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

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

6. Certification Requirements
Oxygen equipment, pneumatic compression devices, osteogenesis stimulators, transcutaneous electrical nerve stimulators, and seat left mechanisms require Certificates of Medical Necessity (CMNs). External infusion pumps and enteral and parenteral nutrition require DME Information Forms (DIFs). Suppliers should be knowledgeable regarding the medical policies for these items, as this will aid in completing the CMNs and DIFs. The medical policies can be accessed from the Coverage section of our web site.

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

7. Offsets
When calling for additional information on an offset or overpayment letter, please have the Financial Control Number (FCN) available.

TOTALS:	# of CLAIMS	BILLED AMT	ALLOWED AMT	DEDUCT AMT	COINS AMT	TOTAL RC AMT	PROV PD AMT	PROV ADJ AMT	CHECK AMT
	5	321.00	211.47	0.34	39.88	109.53	161.25	25.44	135.81

PROVIDER ADJ DETAILS:	PLB REASON CODE	FCN	HIC	AMOUNT
	50			15.44
	FB	0202199306770	9999999999	10.00

The FCN is available on your remittance advice when the adjustment refers to a claim that appeared on a previous remittance advice. The FCN is also located on the upper right hand portion of an overpayment letter.

04/02/09
Amount: See OVP Services Report
FCN/DCN [redacted]
Payee [redacted]

We are able to provide the beneficiary name, date of service, dollar amount, and patient account number related to the offset, but not the beneficiary's Medicare identification number.

If you have multiple National Provider Identifier (NPI)/Provider Transaction Access Number (PTAN) combinations, be sure to provide the pair associated with the FCN in question.

8. Coding Errors/Modifiers
This denial is most often seen when a required modifier is missing or the modifier used is inconsistent with the Healthcare Common Procedure Code System (HCPCS) code used.

Please refer to the LCDs and related Policy Articles to verify which modifiers are appropriate to use with the HCPCS code billed and that all applicable modifiers have been appended to the claim.

The Medicare Pricing, Data Analysis and Coding (PDAC) web site can be used to determine if the HCPCS code used is effective for the dates of service billed. Please refer questions regarding the appropriateness of the HCPCS code used to the PDAC.

9. Appeal Status/Explanation/Resolution
NAS will send out an acknowledgement letter within 10 calendar days of receiving a redetermination request. If you have sent in a redetermination request and have not received an acknowledgement letter within 10 calendar days, you may wish to resubmit your request.

Once received, NAS will process redeterminations within 60 calendar days. If a fully favorable determination is made, written notification will not be sent. CMS has determined the supplier's remittance advice and the Medicare Summary Notice (MSN) sent to the beneficiary provide adequate information regarding the claim reversal.

Redetermination decision letters will be sent out on unfavorable or dismissed redetermination requests. Once a redetermination has been completed, another redetermination cannot be filed on the claim. The next step in the appeal process is to file a reconsideration. For more information on the appeals process, please review Chapter 13 of the DME MAC Jurisdiction D Supplier Manual.

10. Duplicate
To minimize duplicate claim denials, please utilize the IVR to check on the status of any outstanding claims. Often times, claims the supplier believes are outstanding have been previously processed and paid. The IVR can provide the remittance advice date, check number, and amount paid on these items.

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

Top Ten Written Inquiries

In an effort to make our written correspondence staff more effective in helping suppliers with their inquiries, the top ten written inquiries for January – March 2009 are listed below along with reminders and resources related to each inquiry.

1. Issues not Identified/Incomplete Information Provided
When sending documentation to NAS, please clearly state the question or request. If information is submitted without a specific question or request, the written correspondence staff will reply with a letter indicating the inquiry was incomplete.

Before sending your request, ensure all pertinent information has been included. NAS receives letters of medically necessity with no Health Insurance Claim Number (HICN), appeal request or Date of Service (DOS). Without this information, we are unable to identify the patient and/or claim in question. Lack of information may cause the inquiry to be returned as unprocessable.

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

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

Please be sure to provide all pertinent information and sign the form before returning it for processing. Failure to do so may result in your request being returned as unprocessable. Return the completed form and documentation to address below or fax it to 1-888-408-7405.

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

If the claim does not require substantiating documentation, but was afforded appeal rights, a reopening may be appropriate. Please review the article "What Can and Can Not Be Done as a Reopening – Clarification" for further information.

If the claim was not afforded appeal rights, corrections must be made and a new claim submitted for processing.

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

3. Misrouted Written Correspondence
Please be sure forms and requests are sent to the correct entity. NAS has been receiving correspondence intended for the National Supplier Clearinghouse (NSC) and the Common Electronic Data Interchange (CEDI). Sending inquiries and information to the incorrect entity may cause a delay in processing. Should we provide more detail about what type of inquiries go to NSC and CEDI?

4. Benefits/Exclusions/Coverage Criteria/Rules
Suppliers are encouraged to reference the Local Coverage Determinations (LCDs) and Policy Articles for specific coverage criteria. The LCDs can be accessed from the Coverage/MR section of our web site. Select "Local Coverage Determinations (LCDs)" followed by Current LCDs or Current Articles.

NAS' web site contains many valuable resources related to benefits, exclusions, coverage criteria, and rules. A brief overview of some of these resources is below:

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

Training/Events: Links to numerous presentations, created by our Education staff, as well as the Online Learning Center, and upcoming workshops.

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

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

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

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

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

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

For additional information on downloading MREP, contact the CEDI Help Desk.

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

EDUCATIONAL CONT'D

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

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

7. Filing/Billing Instructions
Sending a copy of an invoice or returning an education status letter asking for NAS to make payment is not the appropriate procedure to receive timely reimbursement. Please review Chapter 6 of the DME Jurisdiction D Supplier Manual, for valuable information regarding claims submission.

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

If you are exempt from billing electronically, you may bill a paper CMS-1500 (08-05) claim form. Please reference the CMS 1500 (08-05) claim form instructions, available in the Claims section of our web site, for assistance in properly completing the form.

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

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

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

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

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

9. Claim Documentation
Please be aware, requests to manually load CMNs should only be submitted if the CMN is on an old version of the form, or if the supplier is unable to submit it electronically. Otherwise, the CMN must be submitted along with a claim. Requests to load CMNs which do not meet these requirements will be deemed unprocessable and returned.

For information regarding the cost of CMN related denials to suppliers and the Medicare Trust Fund and helpful hints on how to avoid CMN related denials, please review the article, "CMN and DIF Denials Cost Suppliers", located on our web site.

10. Provider Demographic Information Changes
NAS has seen an increase in the number of requests to update supplier addresses, telephone numbers, and participation status.

Please be aware, this information cannot be changed by NAS or any other Durable Medical Equipment Medicare Administrative Contractor (DME MAC). This information must be sent to the National Supplier Clearinghouse (NSC).

The NSC is contracted by CMS to issue Medicare billing privileges to suppliers of Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) and to maintain the supplier file containing the information collected via the CMS 855S enrollment form. The supplier standards require that any changes made to the information submitted in your enrollment form must be reported to the NSC within 30 days.

The NSC may be reached at 1-866-238-9652 9 a.m. - 4 p.m. ET or via the addresses below.

National Supplier Clearinghouse
Palmetto GBA * AG-495
PO Box 100142
Columbia SC 29202-3142

Overnight Mailing Address

National Supplier Clearinghouse
Palmetto GBA * AG-495
2300 Springdale Drive Bldg. 1
Camden SC 29020

CEDI

Top 10 CEDI Edits for April 2009

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

C172 Invalid Procedure Code and/or Modifier

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

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

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

- Check the validity of the procedure code/modifier combination by using the Pricing, Data Analysis and Coding (PDAC) web site https://www.dmepdac.com/.
- Check the Local Coverage Determination (LCD) at the DME MACs for guidelines on procedure codes and modifier usage for that LCD.

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- Reference the supplier manual at the DME MAC Jurisdiction(s).
- Contact the Customer Care department at the appropriate Jurisdiction:
  - Jurisdiction A: 1-866-590-6731
  - Jurisdiction B: 1-866-590-6727
  - Jurisdiction C: 1-866-270-4909
  - Jurisdiction D: 1-866-243-7272

C008 EIN/SSN Not on File with NPI

When C008 fires on its own, it can indicate the Tax ID/ Social Security Number that was submitted does not match what is on file with the NPPES or the National Supplier Clearinghouse (NSC). Verify the information entered on the NPPES web site matches what you are submitting. The NPPES web site can be accessed at https://nppes.cms.hhs.gov/NPPES/StaticForward.do?forward=static.npistart.

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

C003 Billing NPI Not on Crosswalk

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

For Individuals:

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

For Organizations:

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

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

1001 Required Loop Not Found

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

C095 Diagnosis Code Invalid – Pointer 1

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

B108 Billing Provider Not Authorized for Submitter

The NPI submitted is not linked to the Submitter ID under which the claim file was sent to CEDI. If this error is received, the supplier must complete and sign the appropriate form on the CEDI web site (http://www.ngscedi.com/) and return to CEDI for processing.

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

Suppliers who submit their own claims and do not use a third party biller must complete the CMS EDI Enrollment Agreement

C044 Subscriber Primary ID Invalid

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

C143 Ordering Provider ID Qualifier Invalid

This edit will be received if either the Ordering Provider NPI was not sent or the Ordering Provider's UPIN was sent on a charge line. Verify that the Ordering Provider's NPI is being sent on every charge line of the patient's claim.

3001 Duplicate File Found – File Not Processed

This edit is received when a duplicate file has been submitted to CEDI. A duplicate file is determined by the Submitter ID, claim count, service line count, record, count, total charge amount, and the first and last patients listed in the claim file. To prevent this edit when resubmitting a corrected claim, add an additional claim to the file or remove a claim from the file.

C171 Capped Rental – Modifier Missing

The item (whether for purchase or rental) is classified as a Capped Rental Item (or possibly a Pen Pump Item), and the required KH, KI, or KJ modifier (whichever is appropriate) was not submitted.

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

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

New CEDI Articles

National Government Services has important CEDI news to share. Please view the news item(s) listed on our site at http://www.ngscedi.com/news/newsindex.htm.

The new article(s) is/are entitled:

- CEDI Documents Updated
- CEDI Terminology
- CEDI Case Sensitive Edits
- Top CEDI Edits for March 2009
- Updating CEDI Enrollment Forms

Edit C172 Issue on Claims with KE Modifier

An issue existed where edit C172 was being received in error on some service lines containing modifier KE for dates of service on or after January 1, 2009. This issue has been resolved and claims with the KE modifier should no longer receive this edit in error when submitted to CEDI.

This fix only affects claims submitted with the KE modifier for dates of service on or after January 1, 2009. If you feel you received this edit in error for claims previously submitted with the KE modifier, those claims may now be resubmitted to CEDI.

If you continue to receive CEDI edit C172, please contact the appropriate DME MAC to determine if you are submitting the correct HCPCS and/or modifiers.

Contact the CEDI Help Desk concerning any questions at ngs.cedihelpdesk@wellpoint.com or at 866-311-9184.

Issues with Data Reported on DME Remits

Recently there have been two issues reported with data returned on the Electronic Remittance Advice (ERA) files produced by the DME MACs. These issues are described below and CEDI has received notice that both have been resolved.

Crossover Carrier Name Segment (2100.NM101 = TT)

This issue involved some situations where no data was populated in the name field (2100.NM103) of Crossover Carrier Name segment.

Line Item Control Number (2100.REF01 = 6R)

This issue involved situations where the Line Item Control Number as submitted on the claim was truncated.

Please contact the CEDI Help Desk with any questions or concerns at ngs.cedihelpdesk@wellpoint.com or at 866-311-9184.

CEDI Edit Issues

Below is a list of CEDI edits that can be received in error on some claims being submitted to CEDI. The edits are being looked into for resolution to the issues listed. Currently, there is not an estimated time for correction available.

Edit C180 (Service 'To' Date Of Service)

An issue currently exists where edit C180 is being received in error on some service lines although the HCPCS/ modifier(s) submitted should be allowed to contain a future 'To' Date Of Service.

276 Error (HICN Format)

An issue currently exists where an error is being received incorrectly for 276 requests containing a beneficiary HICN where positions 7-9, of the submitted HICN, contain zeroes.

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

CEDI Enrollment Forms

On May 1, 2009, CEDI completed enhancements to its online enrollment forms. Forms will still be accessed from the CEDI web site at http://www.ngscedi.com/.

With these enhancements, all forms must be completed online and submitted electronically. It will still be necessary to sign and date the forms and fax all pages to CEDI to meet CMS and CEDI verification and audit requirements. Requests for CEDI enrollment submitted online that do not have a signed, faxed copy submitted within three (3) business days of receipt of the electronic submission will be rejected and will not be processed.

These enhancements will allow for more accurate submissions by our Trading Partners and suppliers as critical fields on the form, such as NPI number and demographic information, will be required. By submitting the forms online, CEDI will also be able to more accurately track the status of enrollment requests and prevent forms from being returned for missing or invalid information.

CEDI will send an e-mail confirmation stating the application has been received with the subject of the e-mail indicating the form submitted and received by CEDI. As the forms are processed, notifications will be generated to advise the status of the request. The notifications include that the form was "Accepted" (the form has been prescreened and will be processed), "Rejected" (the form will be returned via mail and a brief description of the reason for rejection will be included in the e-mail), and "Completed" (the enrollment request has been completed at CEDI and an e-mail confirmation letter will be sent within 24 hours). At this time, CEDI cannot accept responses to the e-mail status updates; however, questions and comments may be directed to the CEDI Enrollment e-mail address: cedienrollment@wellpoint.com.

All trading partners, suppliers, vendors, billing services and clearinghouses should begin utilizing the enhanced CEDI enrollment process and should discontinue the process of submitting legacy and/or handwritten forms.

Please contact the CEDI Help Desk at 866-311-9184 or the CEDI Enrollment Team at cedienrollment@wellpoint.com with questions or assistance in completing the online forms.

CEDI CONT'D

MREP Updated for Remittance Code Changes

The Medicare Remit Easy Print (MREP) software has been modified to include the remittance advice remark and claim adjustment reason codes updates as outlined in MLN Matters 6336. MREP Version 2.6 is available to download from http://www.cms.hhs.gov/AccesstoDataApplication/02_MedicareRemitEasyPrint.asp.

Since changes are being made to the MREP software, the updated CARC/RARCs file is included with version 2.6 of the MREP software. However, the separate Codes.ini file is provided when version 2.6 of the MREP software is distributed. If you have questions, contact CEDI at 1-866-311-9184.

CMS developed the MREP software to give Medicare providers/suppliers a free tool to read and print an Electronic Remittance Advice (ERA) in a readable format. MREP allows for the printing of paper documentation that can be used to reconcile accounts receivable, as well as create document(s) that can be included with claim submission to secondary/tertiary payers. The output of MREP is similar to the current Standard Paper Remittance (SPR) format.

HIPAA 5010

An Introductory Overview of HIPAA 5010

MLN Matters Number: SE0904

Provider Types Affected

All physicians, providers, and suppliers who bill Medicare Carriers, Fiscal Intermediaries (FIs), Medicare Administrative Contractors (A/B MACs), and Durable Medical Equipment MACs (DME MACs) for services provided to Medicare beneficiaries

What You Need to Know

The implementation of HIPAA 5010 presents substantial changes in the content of the data that you submit with your claims as well as the data available to you in response to your electronic inquiries. **The implementation will require changes to the software, systems, and perhaps procedures that you use for billing Medicare and other payers. So it is extremely important that you are aware of these HIPAA changes and plan for their implementation.**

The Administrative Simplification Act (ASCA) requires the use of electronic claims (except for certain rare exceptions) in order for providers to receive Medicare payment. **Therefore, effective January 1, 2012, you must be ready to submit your claims electronically using the X12 Version 5010 and NCPDP Version D.0 standards. This also is a prerequisite for implementing the new ICD-10 codes.** The Centers for Medicare & Medicaid Services (CMS) will provide additional information to assist you and keep you apprised of progress on Medicare's implementation of HIPAA 5010 through a variety of communication vehicles. **Remember that the HIPAA standards, including the X12 Version 5010 and Version D.0 standards, are national standards and apply to your transactions with all payers, not just with Fee-for-Service (FFS) Medicare. Therefore, you must be prepared to implement these transactions with regard to your non-FFS Medicare business as well. Medicare expects to begin transitioning to the new formats January 1, 2011 and ending the exchange of current formats on January 1, 2012. While the new claim format accommodates the ICD-10 codes, ICD-10 codes will not be accepted as part of the 5010 project. Separate MLN Matters® articles will address the ICD-10 implementation.**

In preparing for the implementation of these new X12 and NCPDP standards, providers should also consider the requirements for implementing the ICD-10 code set as well. You are encouraged to prepare for the implementation of these standards or speak with your billing vendor, software vendor, or clearinghouse to inquire about their readiness plans for these standards.

Background

The Health Insurance Portability and Accountability Act (HIPAA) requires the Secretary of the Department of Health and Human Services (HHS) to adopt standards that covered entities (health plans, health care clearinghouses, and certain health care providers) must use when they electronically conduct certain health care administrative transactions, such as claims, remittance, eligibility, claims status requests and responses, and others. The Transactions and Code Sets final rule published on Aug. 17, 2000, adopted standards for the statutorily identified transactions, some of which were modified in a subsequent final rule published on Feb. 20, 2003.

These current versions of the standards (the Accredited Standards Committee X12 Version 4010/4010A1 for health care transactions, and the NCPDP Version 5.1 for pharmacy transactions) are widely recognized as lacking certain functionality that the health care industry needs. On January 16, 2009, HHS announced a final rule that replaces the current Version 4010/4010A and NCPDP Version 5.1 with Version 5010 and Version D.0, respectively.

Over 99 per cent of Medicare Part A claims and over 95 per cent of Medicare Part B claims transactions are received electronically and it is imperative that providers be ready for these new standards in order to continue submitting claims electronically. The remainder of this article will provide some rationale for the new standards and also provide some guidance to providers on preparing for this implementation.

Version 5010 (Health Care Transactions)

Version 5010 of the HIPAA standards includes improvements in structural, front matter, technical, and data content (such as improved eligibility responses and better search options). It is more specific in requiring the data that is needed, collected, and transmitted in a transaction (such as tightened, clear situational rules, and in misunderstood areas such as corrections and reversals, refund processing, and recoupments). Further, the new claims transaction standard contains significant improvements for the reporting of clinical data, enabling the reporting of ICD–10–CM diagnosis codes and ICD – 10 - PCS procedure codes, and distinguishes between principal diagnosis, admitting diagnosis, external

cause of injury and patient reason for visit codes. These distinctions will improve the understanding of clinical data and enable better monitoring of mortality rates for certain illnesses, outcomes for specific treatment options, and hospital length of stay for certain conditions, as well as the clinical reasons for why the patient sought hospital care.

Finally, Version 5010 also addresses a variety of currently unmet business needs, including an indicator on institutional claims for conditions that were "present on admission," and accommodating the use of the ICD-10 code sets, which are not supported by Version 4010/4010A1.

Version D.0 (Pharmacy Claims)

Version D.0 specifically addresses business needs that have evolved with the implementation of the Medicare prescription drug benefit (Part D) as well as changes within the health care industry. New data elements and rejection codes in Version D.0 will facilitate both coordination of benefits claims processing and Medicare Part D claims processing.

In addition, Version D.0:

- Provides more complete eligibility information for Medicare Part D and other insurance coverage;
- Better identifies patient responsibility, benefits stages, and coverage gaps on secondary claims; and
- Facilitates the billing of multiple ingredients in processing claims for compounded drugs.

The 5010/D.0 rule also adopts a standard for the Medicaid pharmacy subrogation transaction (known as NCPDP Version 3.0), as currently one does not exist for this process by which State Medicaid agencies recoup funds for payments they have made for pharmacy services for Medicaid recipients, when a third party payer has primary financial responsibility. Since many States presently conduct this transaction electronically, and employ a variety of standards with different payers, adoption of a standard for this transaction will increase efficiencies and reduce costs for Medicaid programs.

The compliance date for implementing Version 5010 and Version D.0 is January 1, 2012, to allow time to test the standards internally, to ensure that systems have been appropriately updated, and then to transition to the new formats between trading partners before the compliance date. For the Medicaid pharmacy subrogation standard, the compliance date is also January 1, 2012, except for small health plans, which must be compliant on January 1, 2013.

CMS Progress in Implementing the New Standards

CMS is well into the process of readying its FFS Medicare systems to handle the 5010/D.0 standards. All Medicare systems will be ready to handle the new standards by January 1, 2011. Medicare plans for its systems to handle the current 4010A standard and the new 5010/D.0 standards for incoming claims and inquiries and for outgoing replies and remittances from January 1, 2011, until January 1, 2012. This will allow providers who are ready to begin using the new standards on January 1, 2011, while providing an additional year for all providers to be ready.

In addition, where possible, CMS will be making system enhancements concurrent with the 5010/D.0 changes. These enhancements include capabilities such as:

- Implementing standard acknowledgement and rejection transactions across all jurisdictions (TA1, 999 and 277CA transactions);
- Improving claims receipt, control, and balancing procedures;
- Increasing consistency of claims editing and error handling;
- Returning claims needing correction earlier in the process; and
- Assigning claim numbers closer to the time of receipt.

Additional Information

You can find more information about HIPAA 5010 by going to http://www.cms.hhs.gov/ElectronicBillingEDITrans/18_5010D0.asp on the Electronic Billing & EDI Transactions page on the CMS web site. Medicare has prepared a comparison of the current X12 HIPAA EDI standards (Version 4010/4010A1) with Version 5010 and the NCPDP EDI standards Version 5.1 to D.0, and has made these side-by-side comparisons available at this web site. These comparisons may be of interest to other covered entities and their business associates.

A special edition MLN Matters® article on the ICD-10 code set is available at http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0832.pdf on the CMS web site.

CMS will also use the Open Door Forums and listservs as means of keeping providers informed of its implementation progress and will also use the vehicles to assist providers in getting ready for the new standards. Information on the Open Door Forums is available at http://www.cms.hhs.gov/OpenDoorForums/ on the CMS web site. Information about listservs (email updates) is available at http://www.cms.hhs.gov/AboutWebsite/EmailUpdates/ on that same site.

In addition, a fact sheet on HIPAA 5010 is available at http://www.cms.hhs.gov/apps/media/press/factsheet.asp?Counter=3246&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&srchOpt=0&srchData=&keywordType=All&chkNewsType=6&intPage=&showAll=&pYear=&year=&desc=&cboOrder=date on the CMS web site. Finally, you can read the proposed rule in the Federal Register, Vol. 73, No. 164, Friday, August 22, 2008 at http://edocket.access.gpo.gov/2008/pdf/E8-19296.pdf; and the final rule in the Federal Register, Vol. 74, No. 11, Friday, January 16, 2009, at http://edocket.access.gpo.gov/2009/pdf/E9-740.pdf on the CMS web site.

DMEPOS Supplier Accreditation Requirements

MLN Matters Number: SE0903 Revised

Note: This article was revised on May 20, 2009, to provide important information for suppliers who choose not to become accredited.

Provider Types Affected

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

Provider Action Needed

DMEPOS suppliers enrolled with the National Supplier Clearinghouse (NSC) are required to obtain accreditation by **September 30, 2009**.

In order to obtain or retain your Medicare Part B billing privileges, all DMEPOS suppliers (except for exempted professionals and other persons as specified by the Secretary of the Department of Health and Human Services as noted below in this article) must comply with the Medicare program's supplier standards and quality standards and become accredited. These standards can be found in 42 CFR 424.57 or on page 36 & 37 of the CMS 855S. A DMEPOS supplier's Medicare Part B billing privileges will be revoked on or after October 1, 2009, if the DMEPOS supplier fails to obtain accreditation unless the DMEPOS supplier submits a voluntary termination to the NSC by September 30, 2009.

For those DMEPOS suppliers who choose not to become accredited at this time, they will need to submit an amended CMS-855S application which reflects their voluntary termination. This will prevent the supplier from being revoked and subsequently barred from the Medicare program, as cited in 42 CFR Section 424.535(c). For pharmacies that choose not to become accredited but wish to remain a DMEPOS supplier in order to continue to bill Medicare for drugs and biologicals only, an amended CMS 855S will have to be completed. In addition to updating their application, the supplier must ensure that they have checked the appropriate boxes in Section 2 (C) to reflect which drugs and biologicals they will provide to beneficiaries. Providers and suppliers can find the latest version of CMS 855S at http://www.cms.hhs.gov/cmsforms/downloads/cms855s.pdf on the Centers for Medicare & Medicaid Services (CMS) web site.

Background

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

Covered Items and Services

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

- Durable Medical Equipment (DME);
- Medical supplies;
- Home dialysis supplies and equipment;
- Therapeutic shoes;
- Parenteral and enteral nutrient, equipment and supplies;
- Blood products;
- Transfusion medicine;
- Prosthetic devices, and
- Prosthetics and orthotics.

Non-Covered Items include:

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

DMEPOS Quality Standards

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

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

Accreditation Deadline for DMEPOS Suppliers

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) set a deadline for all DMEPOS suppliers to be accreditated by September 30, 2009.

Who Needs Accreditation?

The September 30, 2009, accreditation deadline applies to all suppliers of durable medical equipment, medical supplies,

home dialysis supplies and equipment, therapeutic shoes, parenteral/enteral nutrition, transfusion medicine and prosthetic devices, prosthetics and orthotics that are enrolled with the NSC. The accreditation deadline also applies to pharmacies, pedorthists, mastectomy fitters, orthopedic fitters/technicians and athletic trainers.

Who is Exempt?

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

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

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

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

Key Points

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

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

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

A DMEPOS supplier's Medicare Part B billing privileges will be revoked on or after October 1, 2009, if the DMEPOS supplier fails to obtain accreditation or a voluntary termination has not been received by the NSC by September 30, 2009. **If a supplier chooses not to become accredited, they must submit an amended CMS 855S to prevent revocation and subsequent exclusion from the Medicare program.**

Accreditation Frequently Asked Questions (FAQs)

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

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

2. **Who are the approved DMEPOS accrediting organizations?**

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

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

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

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

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

5. **Is information transferred between the accreditor and NSC?**

   Transfer of information between these two entities concerning their findings does occur.

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

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

Reporting Accreditation Status to NSC

It is the supplier's responsibility to report their accreditation information, once accredited, to the National Supplier Clearinghouse (NSC) via section 2F on the CMS-855S form.

If you are an existing supplier that was accredited prior to January 1, 2008, report your accreditation status to the NSC by September 30, 2009, unless you have recently submitted a change to the enrollment information on file or recently submitted re-enrollment information with the NSC and at that time provided your accreditation information in section 2F.

Suppliers must also verify that the products and services, for which they are accredited, match what is on file with the NSC. If there are any changes, complete sections 2B and 2C of the CMS-855S form and submit to the NSC. In addition, suppliers should submit sections 1, 2A1, and 15. Completing section 13 is optional.

We encourage suppliers to contact the NSC with any accreditation questions to avoid disruptions in claims payment on/after October 1, 2009, the accreditation deadline. The NSC can be reached at 1-866-238-9652, Monday - Friday, 9:00 am - 5:00 pm, EST.

For more information regarding the accreditation process, please see the Accreditation page on this web site.

Podiatrists and DMEPOS Accreditation

Podiatrists are exempt from the accreditation requirement. While they were not specifically listed as an exempt provider in MIPPA, they are included under the definition of a physician as defined in section 1861(r) of the Social Security Act.

The Pedorthists are not exempt from the accreditation requirement at this time. A clarification was sent via Listserv message.

Bonds for Suppliers of DMEPOS

National Supplier Clearinghouse

Recently, CMS announced regulations requiring suppliers of certain durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) to post a surety bond as a condition of new or continued Medicare enrollment. The regulation states that beginning May 4, 2009, suppliers seeking to enroll as a new applicant, adding an additional practice location, or changing the ownership of a DMEPOS supplier must submit a $50,000 surety bond to obtain Medicare billing privileges. Existing DMEPOS suppliers must submit to the NSC a $50,000 surety bond for each assigned NPI beginning on October 2, 2009, to maintain Medicare billing privileges.

Suppliers who have certain adverse legal actions imposed against them in the past may be required to post a higher bond amount. The final regulations permit the NSC to require DMEPOS suppliers to obtain a base surety bond of $50,000 and an elevated surety bond of $50,000 for each occurrence of an adverse legal action within ten years preceding enrollment, revalidation, or reenrollment in the Medicare program.

A list of sureties from which a bond can be secured is found at the Department of the Treasury's "Listing of Certified (Surety Bond) Companies" web site at http://www.fms.treas.gov/c570/c570_a-z.html.

Some companies or organizations that supply DMEPOS are exempt from the surety bond requirements. Such exemptions include:

- Certain physician and non-physician practitioners
- Physical therapists
- Occupational therapists
- State-licensed orthotic and prosthetic personnel
- Government-owned suppliers

For more detailed information or to view the MLN Matters article in its entirety, visit http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6392.pdf.

Surety Bonds for Suppliers of DMEPOS

MLN Matters Number: MM6392
Related Change Request (CR) #: 6392
Related CR Release Date: March 27, 2009
Related CR Transmittal #: R287PI
Effective Date: April 6, 2009
Implementation Date: April 6, 2009

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 6392. The Centers for Medicare & Medicaid Services (CMS), via the Medicare Program Integrity Manual, Chapter 10,

SURETY BOND CONT'D

alerts **certain DMEPOS suppliers that they need to obtain a surety bond as a prerequisite for enrolling and maintaining enrollment in the Medicare program**. Be sure you are familiar with and in compliance with Medicare's surety bond requirements as summarized in this article and as detailed in CR 6392.

Background

Effective May 4, 2009, DMEPOS suppliers submitting: (1) an initial enrollment application to enroll in the Medicare program for the first time, (2) an initial application to establish a new practice location, or (3) an enrollment application to change the ownership of an existing supplier, are required to obtain and submit a copy of its required surety bond to the NSC with their CMS-855S enrollment application.

All existing DMEPOS suppliers subject to the bonding requirement must submit a copy of the required surety bond to the NSC no later than October 2, 2009.

Exceptions

All DMEPOS suppliers are subject to the surety bond requirement, except:

- Government-operated DMEPOS suppliers are exempted if the supplier has provided CMS with a comparable surety bond under State law. (All Indian Health Service (IHS) facilities that are not wholly owned and operated by a tribe are exempt.)
- State-licensed orthotic and prosthetic personnel (which, for purposes of the surety bond requirement, does not include pedorthists) in private practice making custom-made orthotics and prosthetics are exempted if -
  - The business is solely-owned and operated by the orthotic and prosthetic personnel, and
  - The business is only billing for orthotic, prosthetics, and supplies.
- Physicians and non-physician practitioners, as defined in section 1842(b)(18) of the Social Security Act, are exempted if the items are furnished only to the physician or non-physician practitioner's own patients as part of his or her physician service. The non-physicians covered under this exception are: physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, certified nurse-midwives, clinical social workers, clinical psychologists, and registered dietitians or nutrition professionals.
- Physical and occupational therapists in private practice are exempted if -
  - The business is solely-owned and operated by the physical or occupational therapist;
  - The items are furnished only to the physical or occupational therapist's own patients as part of his or her professional service; and
  - The business is only billing for orthotics, prosthetics, and supplies.

Amount and Basis of the Surety Bond

The surety bond must be in an amount of no less than $50,000 per National Provider Identifier (NPI). Since DMEPOS suppliers must obtain an NPI by practice location, except for sole proprietorships, an organizational DMEPOS supplier with 10 locations would be required to secure a $500,000 surety bond.

Suppliers will be required to maintain an additional elevated surety bond amount of $50,000 for each final adverse action imposed against it within the 10 years preceding enrollment or reenrollment. This amount is in addition to, and not in lieu of, the base $50,000 amount that must be maintained.

A supplier may obtain a single bond that encompasses multiple locations. For instance, if a supplier has 10 separately-enrolled DMEPOS locations, it may obtain a $500,000 bond that covers all 10 locations. Likewise, if a supplier seeks to enroll a new location, it may submit to the NSC an amendment or rider to the existing bond, rather than a new, separate surety bond.

Bond Terms

Specific terms that the bond must contain include:

- A guarantee that the surety will - within 30 days of receiving written notice from CMS containing sufficient evidence to establish the surety's liability under the bond of unpaid claims, civil monetary penalties (CMPs), or assessments - pay CMS a total of up to the full penal amount of the bond in the following amounts:
  - The amount of any unpaid claim, plus accrued interest, for which the DMEPOS supplier is responsible, and
  - The amount of any unpaid claims, CMPs, or assessments imposed by CMS or the OIG on the DMEPOS supplier, plus accrued interest.
- A statement that the surety is liable for unpaid claims, Civil Monetary Penalties (CMPs), or assessments that occur during the term of the bond;
- A statement that actions under the bond may be brought by CMS or by CMS contractors;
- The surety's name, street address or post office box number, city, state, and zip code; and
- Identification of the DMEPOS supplier as the Principal, CMS as the Obligee, and the surety (and its heirs, executors, administrators, successors and assignees, jointly and severally) as the surety.

A copy of the bond agreement, as well as any certificates of proof, must be submitted.

Sureties

The list of sureties from which a bond can be secured is found at the Department of the Treasury's "Listing of Certified (Surety Bond) Companies" web site at http://www.fms.treas.gov/c570/c570_a-z.html on the Internet. For purposes of the surety bond requirement, these sureties are considered "authorized".

Additional Information

If you have questions, please visit the National Supplier Clearinghouse's "Frequently Asked Questions" page at

SURETY BOND CONT'D

http://www.palmettogba.com/PALMETTO/PALMETTO.NSF/DocsCat/Home. (When you get to this page, click on the FAQ link, followed by the "National Supplier Clearinghouse" link.)

The official instruction (CR6392) issued to your Medicare DME MAC, is available at http://www.cms.hhs.gov/Transmittals/downloads/R287PI.pdf on the CMS web site. Included with CR 6392 is the actual revision to Chapter 10 of the *Medicare Program Integrity Manual*, which has further details on the surety bond requirement.

COMPETITIVE BIDDING

Statement on DMEPOS Competitive Bidding Program

Centers for Medicare & Medicaid Services

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), enacted on July 15, 2008, made limited changes to the competitive bidding program for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS), including a requirement that the Secretary conduct a second competition to select suppliers for Round 1 in 2009. CMS issued an interim final rule with comment period (IFC) on January 16, 2009. The rule incorporates into existing regulations specific statutory requirements contained in MIPPA related to the competitive bidding program.

The Administration delayed the effective date for the IFC to allow CMS officials the opportunity for further review of the issues of law and policy raised by the rule. Based upon its review and on the need to ensure that CMS is able to meet the statutory deadlines contained in MIPPA, the Administration has concluded that the effective date should not be further delayed. The rule will become effective April 18, 2009. However, there will be no immediate effect on the Medicare DMEPOS benefit and Medicare beneficiaries may continue to use their current DMEPOS suppliers at this time.

During the comment period, CMS received many suggestions by a range of stakeholders to make further improvements to the competitive bidding program, such as ensuring that CMS's processes for collecting and evaluating bids are fair and transparent. In the upcoming weeks, CMS will be issuing further guidance on the timeline for and bidding requirements related to the Round 1 re-bid. In finalizing these guidelines, CMS will continue to seek input from all affected stakeholders to ensure program implementation consistent with the legislative requirements.

ICD-10

ICD-10 CM/PCS - Next Generation of Coding

MLN Matters Number: SE0832 Revised

Note: This article was revised on May 14, 2009, to modify a diagnosis code example and a procedure code example on page 3 of this article. All other information remains the same.

Provider Types Affected

This article is informational only for all physicians, providers, and suppliers who submit claims to Medicare contractors (carriers, Medicare Administrative Contractors (A/B MACs), durable medical equipment Medicare Administrative Contractors (DME MACs), fiscal intermediaries (FIs), and regional home health intermediaries (RHHIs)) for services provided to Medicare beneficiaries.

Provider Action Needed

This Special Edition article (SE0832) outlines general information for providers detailing the International Classification of Diseases, 10th Edition (ICD-10) classification system. Compared to the current ICD-9 classification system, ICD-10 offers more detailed information and the ability to expand specificity and clinical information in order to capture advancements in clinical medicine. Providers may want to become familiar with the new coding system.

The system is not yet implemented in Medicare's fee-for-service (FFS) claims processes so no action is needed at this time.

Background

A number of other countries already use ICD-10, including:

- United Kingdom (1995);
- France (1997);
- Australia (1998);
- Germany (2000); and
- Canada (2001).

ICD-10-CM/PCS consists of two parts:

- ICD-10-CM – The diagnosis classification system was developed by the Centers for Disease Control and Prevention for use in all United States of America health care treatment settings. Diagnosis coding under this system uses a different number of digits and some other changes, but the format is very much the same as International Classification of Diseases, 9th Edition, Clinical Modification (ICD-9-CM); and
- ICD-10-PCS – The procedure classification system was developed by CMS for use in the U.S. for inpatient hospital settings ONLY. The new procedure coding system uses 7 alpha or numeric digits while the ICD-9-CM coding system uses 3 or 4 numeric digits.

ICD-10-CM/PCS:

- Incorporates much greater specificity and clinical information, which results in:

- Improved ability to measure health care services;
- Increased sensitivity when refining grouping and reimbursement methodologies;
- Enhanced ability to conduct public health surveillance; and
- Decreased need to include supporting documentation with claims.

- Includes updated medical terminology and classification of diseases.
- Provides codes to allow comparison of mortality and morbidity data.
- Provides better data for:
  - Measuring care furnished to patients;
  - Designing payment systems;
  - Processing claims;
  - Making clinical decisions;
  - Tracking public health;
  - Identifying fraud and abuse; and

Conducting research.

Structural Differences Between the Two Coding Systems

1. **Diagnoses Codes**

   ICD-9-CM diagnoses codes are 3 – 5 digits in length with the first digit being alpha (E or V) or numeric and digits 2 – 5 being numeric. For example:

   - 496 – Chronic airway obstruction not elsewhere classified (NEC);
   - 511.9 – Unspecified pleural effusion; and
   - V02.61 – Hepatitis B carrier.

   ICD-10-CM diagnoses are 3 – 7 digits in length with the first digit being alpha, digits 2 and 3 being numeric and digits 4 – 7 are alpha or numeric. The alpha digits are not case sensitive. For example:

   - A78 - Q fever;
   - A69.21 – Meningitis due to Lyme disease; and
   - S52.131a – Displaced fracture of neck of right radius, initial encounter for closed fracture.

2. **Procedure Codes**

   ICD-9-CM procedures are 3 – 4 digits in length and all digits are numeric. For example:

   - 43.5 – Partial gastrectomy with anastomosis to esophagus; and
   - 44.42 – Suture of duodenal ulcer site.

   ICD-10-PCS procedures are 7 digits in length with each of the 7 digits being either alpha or numeric. The alpha digits are not case sensitive. Letters O and I are not used to avoid confusion with the numbers 0 and 1. For example:

   - 0FB03ZX – Excision of Liver, Percutaneous Approach, Diagnostic; and
   - 0DQ10ZZ – Repair upper esophagus, open approach

Note that ICD-10-CM/PCS would not affect physicians, outpatient facilities, and hospital outpatient departments' usage of Current Procedural Terminology (CPT) codes on Medicare FFS claims as CPT use would continue.

Additional Information

The Centers for Medicare & Medicaid Services (CMS) has developed a dedicated Web page for ICD-10 information. That page is at http://www.cms.hhs.gov/ICD10 on the CMS web site.

Details on the ICD-10-PCS Coding System, mappings, and a related training manual may be found at http://www.cms.hhs.gov/ICD10/02_ICD-10-PCS.asp#TopOfPage on the CMS web site.

The ICD-10 Notice of Proposed Rulemaking is available at http://edocket.access.gpo.gov/2008/pdf/E8-19298.pdf on the Internet.

Details on the ICD-10-CM Coding system, mappings, and guidelines may be found at http://www.cdc.gov/nchs/about/otheract/icd9/abticd10.htm on the Internet and also at http://www.cms.hhs.gov/ICD10/03_2008_ICD_10_CM.asp#TopOfPage on the CMS web site.

Many private sector professional organizations and businesses have resources available that may help with ICD-10-CM/PCS implementation planning.

Please note that the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) is published by the United States Government. A CD-ROM, which may be purchased through the Government Printing Office, is the only official Federal government version of the ICD-9-CM. ICD-9-CM is an official Health Insurance Portability and Accountability Act (HIPAA) standard. The dedicated CMS ICD-10 page also has links to these resources in the "Related Links Outside of CMS" at the bottom of the page.

New Medicare Learning Network Publication and FAQs Now Available

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

General Equivalence Mappings Fact Sheet

The *General Equivalence Mappings - ICD-9-CM To and From ICD-10-CM and ICD-10-PCS Fact Sheet* (March 2009), which provides information and resources regarding the General Equivalence Mappings that were developed as a tool to assist with the conversion of International Classification of Diseases, 9th Edition, Clinical Modification (ICD-9-CM) codes to International Classification of Diseases, 10th Edition (ICD-10) and the conversion of ICD-10 codes back to ICD-9-CM, is now available in print format from the Centers for Medicare & Medicaid Services **Medicare Learning Network**. To place your order, visit http://www.cms.hhs.gov/MLNGenInfo/, scroll down to "Related Links Inside CMS" and select "MLN Product Ordering Page."

May 2009 NSC News Now Available

The May 2009 National Supplier Clearinghouse (NSC) supplier newsletter has been published. Included in this issue is accreditation and surety bond information as well as a review of the appeals process and the requirements for completing the revised CMS-855S enrollment application for initial enrollment, reenrollments and changes of information. Suppliers are also provided with tips for successful site inspections. View the May 2009 NSC News here.

Reminders When Submitting Online Enrollment Forms

On May 1, 2009, CEDI completed enhancements to its online enrollment forms. The forms are still accessed from the CEDI web site at http://www.ngscedi.com. Provided below are some tips for completing and submitting the enrollment forms.

1. All forms must be completed and submitted online, then faxed with the authorized signature of the supplier to the CEDI Enrollment department for processing.
2. All signed forms must be received within three days of the online submission of the enrollment form(s).
3. An e-mail confirmation will be sent shortly after submission of the online form(s) stating the form has been received. The SUBMIT key only needs to be selected once. Submitting duplicate requests online may delay the processing of the request. Note: If submitting a Supplier Authorization form, an email will be sent to the submitter's email address, not the supplier's.
4. When the enrollment form(s) have been processed, an e-mail confirmation will be sent as notification.
5. The enrollment process takes 5 to 7 business days once the signed forms are received.

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

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.

APPEALS

Email Available for Redetermination and Reopening Questions

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

Questions and concerns may include but are not limited to:

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

Confidential information cannot be e-mailed. This includes Protected Health Information (PHI), such as patient names, claim information, Health Insurance Claim (HIC) numbers, Social Security numbers, Claim Control numbers (CCNs) or supplier numbers. This type of information cannot be e-mailed because it may be possible for others to view the contents. If you have a question that would contain PHI, please call our Contact Center at 1-866-243-7272.

CMS states that PHI cannot be transmitted via e-mail, therefore, NAS will not respond to any requests that contain PHI. Those requests that do not contain PHI will be answered within two business days.

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

FORMS

Diabetic Supplies Beneficiary Form

It has been brought to NAS' attention that suppliers are having difficulty receiving the appropriate documentation from physicians in regards to glucose monitors and supplies. Diabetic supplies are a group of codes being over-utilized, without the correct documentation to support what is billed. The Medical Review Department has created a tool to guide physicians in documenting information that would assist in meeting the Local Coverage Determination (LCD) (L196) requirements for their patient's diabetic supplies.

Documentation of the correct nature is critical to the payment of diabetic supplies, especially when a claim is for utilization over the recommendation of the LCD. Two forms have been created for suppliers to give to beneficiaries who in turn would give the form to their physician at their next clinical visit. The form given to the patient will depend on whether or not they are using insulin.

The following steps assist the supplier and physician on the use of these forms:

- The supplier should print the patient's name, where indicated, on the appropriate form depending on if the patient is using insulin or not.
- The supplier will then provide the beneficiary with this form.
- The beneficiary can then present this form directly to their healthcare provider at their next visit.
- The beneficiary should request that their healthcare provider document, in the narrative of their medical record, a detailed answer to the questions on the form.
- The supplier can contact the physician's office to obtain a copy of these medical notes to keep on file.

Please remember that this form is only a guide to help the healthcare provider know what is important to document for diabetic patients. It is not a guarantee of payment as the form will only assist in providing the specific reason the physician has ordered a testing frequency that exceeds the utilization guidelines.

It is imperative that the supplier understands that even if the healthcare provider answers each question in detail in the patient's medical record, this may not support medical necessity for the frequency of testing because the higher the frequency of testing, the more detailed the supporting documentation must be to meet medical necessity.

You can find the Insulin Using Patients and Non-Insulin Using Patients forms under Physician Resources on the Coverage/MR page of our web site.

Updated Refunds to Medicare Form

As of April 8, 2009, the Refunds to Medicare form located at https://www.noridianmedicare.com/dme/forms/docs/ref_med_dme.pdf will be updated.

The update is in response to CR 6139, which addresses the provider authentication requirements necessary to complete IVR transactions and calls to the Supplier Contact Center. The same authentication requirements also apply to supplier written correspondence. These requirements have been put into place to better safeguard providers' information.

As of April 8, 2009, NAS will require the supplier's National Provider Identifier (NPI), Provider Transaction Number (PTAN), and at least the last five digits of the Tax Identification Number (TIN) on the Refunds to Medicare form.

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.

A link to instructions for completing this form may be found under the Recoupments and Overpayments section on the Forms page at https://www.noridianmedicare.com/dme/forms.

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."

For more information about CR 6139, please see the MLN Matters article number MM6139 - Revised. This article can be viewed at https://www.noridianmedicare.com/dme/news/docs/2009/02_feb/mm6139.pdf..

FORMS CONT'D

Updated MSP Inquiry & Refunds Form

As of April 8, 2009, the MSP Inquiry & Refunds form located at https://www.noridianmedicare.com/dme/forms/docs/msp_inq_dme.pdf will be updated.

The update is in response to CR 6139, which addresses the provider authentication requirements necessary to complete IVR transactions and calls to the Supplier Contact Center. The same authentication requirements also apply to supplier written correspondence. These requirements have been put into place to better safeguard providers' information.

As of April 8, 2009, NAS will require the supplier's National Provider Identifier (NPI), Provider Transaction Number (PTAN), and at least the last five digits of the Tax Identification Number (TIN) on the MSP Inquiry & Refunds form.

In addition, one minor change in format has been implemented. The NAS mailing and fax information has been moved to the bottom of the page. The rest of the information on the form remains consistent.

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 more information about CR 6139, please see the MLN Matters article number MM6139 - Revised. This article can be viewed at https://www.noridianmedicare.com/dme/news/docs/2009/02_feb/mm6139.pdf.

BILLING

Same or Similar Reference Chart

This Same or Similar Reference Chart was created by NAS for DME Jurisdiction D suppliers as a tool to assist in understanding same or similar denials. More information regarding this topic is available in the "Same or Similar Denials" article published in January 2007. Suppliers should verify the patient has not had a same or similar item within the previous five years by calling the IVR at 1-877-320-0390.

DME suppliers are expected to be familiar with DME coverage policies and any additional pertinent information that may have an impact on medical necessity determinations. In order to be protected under the limitation of liability provision, a supplier must provide a proper Advance Beneficiary Notice of Noncoverage (ABN) for each item that it believes is likely to be denied as not medically necessary.

If a beneficiary has had any piece of equipment from the same DMEPOS item category within the previous five years, a same or similar denial can be expected.

DMEPOS Item	HCPCS
Apnea Monitor	E0618
Bed Side Rails	E0305 E0310
Blood Glucose Monitors	E0607 E2100 E2101
Canes	E0100 E0105
Commodes	E0163 E0164 E0165 E0166 E0168 E0169 E0170 E0171
Compressor/ Nebulizer **NOTE: When used with Intermittent Positive Pressure Breathing (IPPB) treatments or oxygen delivery**	E0565 E0572 E0575 E0585
Crutches	E0110 E0111 E0112 E0113 E0114 E0116 E0117 E0118
Cushions	E0176 E0177 E0178 E0179 E0962 E0963 E0964 E0965 E2601 E2602 E2603 E2604 E2605 E2606 E2607 E2608 E2609 E2610 E2618 K0650 K0651 K0652 K0653 K0654 K0655 K0656 K0657 K0658 K0659 K0734 K0735 K0736 K0737
Enteral Formula	B4149 B4150 B4151 B4158 B4159 B4160 B4161 B4162
Enteral Pumps	B9000 B9002
Heat Lamps	E0200 E0205
Heat Pads	E0210 E0215 E0217 E0220 E0221 E0225 E0236 E0237 E0238 E0239
Hospital Beds	E0250 E0251 E0255 E0256 E0260 E0261 E0265 E0266 E0290 E0291 E0292 E0293 E0294 E0295 E0296 E0297 E0300 E0301 E0302 E0303 E0304 E0328 E0329 E0462 K0549 K0550
Humidifiers **NOTE: When used with Intermittent Positive Pressure Breathing (IPPB) treatments or oxygen delivery**	E0550 E0560

BILLING CONT'D

DMEPOS Item	HCPCS
Humidifiers **NOTE: When used with a positive airway pressure (PAP) device**	E0561 E0562 K0268 K0531
Infusion Pumps	E0779 E0780 E0781 E0784 E0791 K0284
Manual Wheelchairs **NOTE: When checking for manual wheelchairs, NAS will provide both manual and power wheelchair equipment on file. When checking for power wheelchair equipment, NAS will provide power wheelchair equipment only.**	E1031 E1037 E1038 E1039 E1161 E1229 E1231 E1232 E1233 E1234 E1235 E1236 E1237 E1238 E1239 K0001 K0002 K0003 K0004 K0005 K0006 K0007 K0009
Nebulizers and Compressors	E0570 E0571 E0574 E0580
Oxygen Contents (Portable)	E0443 E0444
Oxygen Contents (Stationary)	E0441 E0442
Patient Lifts	E0625 E0630 E0635 E0639 E0640
Parenteral Nutrition	B4164 B4180
Parenteral Nutrition	B4168 B4172 B4176 B4178 B4189 B4199 B5000 B5100 B5200
Parenteral Nutrition	B4184 B4186
Parenteral Pumps	B9004 B9006
Percussors	E0480 E0481 E0482
Pneumatic Appliances-Arm	A4600 E0655 E0665 E0668 E0672
Pneumatic Appliances-Leg	A4600 E0660 E0666 E0667 E0669 E0671 E0673
Pneumatic Compressors	E0650 E0651 E0652
Portable Oxygen Equipment	E0430 E0431 E0434 E0435 E1392 K0671 K0738
Power Wheelchairs	E1035 E1230 K0010 K0011 K0012 K0014 K0800 K0801 K0802 K0806 K0807 K0808 K0812 K0813 K0814 K0815 K0816 K0820 K0821 K0822 K0823 K0824 K0825 K0826 K0827 K0828 K0829 K0830 K0831 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 K0868 K0869 K0870 K0871 K0877 K0878 K0879 K0880 K0884 K0885 K0886 K0890 K0891 K0898 K0899
Respiratory Assist Devices	E0450 E0454 E0460 E0461 E0470 E0471 E0472 E0601 K0532 K0533 K0534
Seat Lift Mechanisms	E0627 E0628 E0629
Sitz Baths	E0160 E0161 E0162
Stationary Oxygen Equipment	E0424 E0425 E0439 E0440 E1353 E1390 E1391 E1405 E1406
Stimulators	E0747 E0760
Speech Generating Devices	E2500 E2502 E2504 E2506 E2508 E2510 E2511 K0541 K0542 K0543 K0544 K0545 K0615 K0616 K0617
Support Surfaces	E0180 E0181 E0182 E0184 E0185 E0186 E0187 E0188 E0189 E0193 E0194 E0196 E0197 E0198 E0199 E0277 E0371 E0372 E0373

DMEPOS Item	HCPCS
Traction Frames	E0840 E0850 E0855 E0856 E0860 E0870 E0880 E0890 E0900 E0920 E0930 E0941 E0946 E0947 E0948 K0627 E0849
Trapeze Bars	E0910 E0911 E0912 E0940
Transcutaneous Electrical Nerve Stimulators (TENS)	E0720 E0730
Walkers	E0130 E0135 E0140 E0141 E0143 E0144 E0147 E0148 E0149
Wheelchair Back Cushions	E2611 E2612 E2613 E2614 E2615 E2616 E2617 E2620 E2621
Wound Therapy	E0231 E2402 K0538

Supplies and Accessories Used with Beneficiary Owned Equipment

The DME MACs recently published an article addressing documentation requirements for supplies and accessories used with beneficiary owned equipment. This article only addressed equipment that was not paid for by Medicare FFS – i.e., only equipment that was paid by other insurance or by the beneficiary. For supplies and accessories used with that equipment, all of the following information must be submitted with the initial claim in Item 19 on the CMS-1500 claim form or in the NTE segment for electronic claims:

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

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

Medicare requires that supplies and accessories only be provided for equipment that meets the existing coverage criteria for the base item. In addition, if the supply or accessory has additional, separate criteria, these must also be met. In the event of a documentation request from the contractor or a redetermination request, suppliers should provide information justifying the medical necessity for the base item and the supplies and/or accessories. Refer to the applicable Local Coverage Determination(s) and related Policy Article(s) for information on the relevant coverage, documentation and coding requirements.

Beneficiary Request for Refill of Supplies, Accessories, and Drugs

The *Medicare Claims Processing Manual*, Chapter 20, Section 200 states:

> Suppliers/manufacturers may not automatically deliver DMEPOS to beneficiaries unless the beneficiary, physician, or designated representative has requested additional supplies/equipment. The reason is to assure that the beneficiary actually needs the DMEPOS. A beneficiary or their caregiver must specifically request refills of repetitive services and/or supplies before a supplier dispenses them. A supplier may not initiate a refill of an order. **The supplier must not automatically dispense a quantity of supplies on a predetermined regular basis.**

Furthermore, the *Medicare Program Integrity Manual*, Chapter 4, Section 4.26.1 states:

> For DMEPOS products that are supplied as refills to the original order, suppliers must contact the beneficiary prior to dispensing the refill. Contact with the beneficiary or designee regarding refills should take place no sooner than approximately 7 days prior to the delivery/shipping date. For subsequent deliveries of refills, the supplier should deliver the DMEPOS product no sooner than approximately 5 days prior to the end of usage for the current product.

Beneficiaries cannot "authorize" in advance the routine dispensing of DMEPOS items. Also, because of the time frames specified, the request for subsequent delivery cannot be made at the time of or soon after the current delivery of items. For example, when a beneficiary receives a supply of glucose test strips, it would not acceptable for the beneficiary to tell the supplier at that time to deliver a new supply of test strips in 1-3 months.

Suppliers should document the request for a refill. This could be documented in a number of ways, including but not limited to, a postcard signed and dated by the beneficiary, written record of phone conversation between the supplier and beneficiary/caregiver, etc. The documentation must be available on request.

Jurisdiction D Resources

NAS Contacts

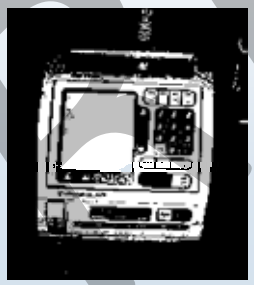
Supplier Contact Center
1-866-243-7272
8 a.m.—5:30 p.m. CT

Interactive Voice Response System (IVR)
1-877-320-0390
6 a.m.—6 p.m. CT

Telephone Reopenings
1-888-826-5708
8 a.m.—4 p.m. CT

References
Infusion Therapy – Billing for Denial posted 9/2007 in News & Publications at noridianmedicare.com/dme

NORIDIAN Administrative Services LLC



4/13/2009

Billing Infusion/Nutrition Services Important Reminders

Drug Administered via an External Infusion Pump

- If the drug does not meet coverage criteria, an ABN should be executed for the drug, supplies and pump. Append the GA modifier to all applicable codes.

Drug or supply <u>not</u> administered through an external infusion pump

- An infusion drug not administered through an external infusion pump will be denied as non-covered (no benefit category).
- Append the GY modifier to the code and add a narrative to the claim such as "not administered through a pump".
- You may execute an ABN, but is not mandatory.

IVIG

- Under the IVIG benefit, only the drug is covered. Supplies and/or pump are not covered.
- Under the Durable Infusion Pump benefit, only subcutaneous immune globulin is covered if coverage criteria are met, along with the pump and supplies.

Supplies

- Submit appropriate supply codes for the infusion pump and enteral/parenteral nutrition.

DME Information Form (DIF)

- Submit DIF with initial claim. Submit revised DIF with applicable claim.
- Submit DIF with redetermination forms.
- Calories over 2000 or less than 750/day requires a medical explanation as to why the patient requires the higher or lower calories.

GY Modifier

- If the drug or supplies are not covered under any Medicare benefit, append the GY modifier to the code(s). Include a narrative to the claim such as "not administered through a pump".

Mandatory Claims Submission and its Enforcement

MLN Matters Number: SE0908

Provider Types Affected

Physicians and suppliers submitting claims to Medicare contractors (carriers and/or Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) is issuing this special edition article to remind physicians and suppliers of the Medicare requirements for mandatory electronic claims submission and its enforcement.

The Social Security Act (Section 1848(g)(4)) requires that claims be submitted for all Medicare patients for services rendered on or after September 1, 1990. This requirement applies to all physicians and suppliers who provide covered services to Medicare beneficiaries, and the requirement to submit Medicare claims does not mean physicians or suppliers must accept assignment.

Background

The Social Security Act (Section 1848(g)(4)) requires that claims be submitted for all Medicare patients for services rendered on or after September 1, 1990. This requirement applies to all physicians and suppliers who provide covered services to Medicare beneficiaries, and the requirement to submit Medicare claims does not mean physicians or suppliers must accept assignment. Compliance to mandatory claim filing requirements is monitored by CMS, and violations of the requirement may be subject to a civil monetary penalty of up to $2,000 for each violation, a 10 percent reduction of a physician's/supplier's payment once the physician/supplier is eventually brought back into compliance, and/or Medicare program exclusion. Medicare beneficiaries may not be charged for preparing or filing a Medicare claim.

For the official requirements, see the following:

- Social Security Act (Section 1848(g)(4)(A); "Physician Submission of Claims") at http://www.ssa.gov/OP_Home/ssact/title18/1848.htm on the Internet.
- Requirement to file claims - The Medicare Claims Processing Manual, Chapter 1, Section 70.8.8: http://www.cms.hhs.gov/manuals/downloads/clm104c01.pdf on the CMS web site.

Exceptions to Mandatory Filing

Physicians and suppliers are not required to file claims on behalf of Medicare beneficiaries for:

- Used Durable Medical Equipment (DME) purchased from a private source;
- Medicare Secondary Payer (MSP) claims when you do not possess all the information necessary to file a claim;
- Foreign claims (except in certain limited situations);
- Services furnished by opt out physicians or practitioners (except in emergency or urgent care situations when the opt out physician or practitioner has not previously entered into a private contract with the beneficiary);
- Services that are furnished for free; or
- Services paid under the indirect payment procedure.

For further details, see the *Medicare Claims Processing Manual* (Chapter 1, Section 70.8.8.8) at http://www.cms.hhs.gov/manuals/downloads/clm104c01.pdf on the CMS web site.

Note: You are not required to file a claim for a service that is categorically excluded from coverage (e.g., cosmetic surgery, personal comfort services, etc; see 42 CFR 411.15 for details). However, many Medicare supplemental insurance policies pay for services that Medicare does not allow, and they may require a Medicare denial notice.

Beneficiary Submitted Claims

The current Medicare manual requirement instructs Medicare contractors (carriers and MACs) to provide education to the providers and suppliers explaining the statutory requirement, including possible penalties for repeatedly refusing to submit claims for services provided. Medicare contractors are instructed to process beneficiary submitted claims for services that:

- Are not covered by Medicare (e.g., for hearing aids, cosmetic surgery, personal comfort services, etc.; see 42 CFR 411.15 for details at http://edocket.access.gpo.gov/cfr_2004/octqtr/pdf/42cfr411.15.pdf on the internet) in accordance with its normal processing procedures, and
- Are covered by Medicare when the beneficiary has submitted a complete claim (Patient's Request for Medical Payment Form CMS-1490S; see http://www.cms.hhs.gov/CMSForms/CMSForms/ or http://www.cms.hhs.gov/cmsforms/downloads/cms1490s-english.pdf on the CMS web site) and all supporting documentation associated with the claim, including an itemized bill with the following information:
  - Date of service,
  - Place of service,
  - Description of illness or injury,
  - Description of each surgical or medical service or supply furnished,
  - Charge for each service,
  - The doctor's or supplier's name, address, and
  - The provider or supplier's National Provider Identifier (NPI).

If an incomplete claim (or a claim containing invalid information) is submitted, the contractor will return the claim as incomplete with an appropriate letter. In addition, contractors will manually return (to the beneficiary) beneficiary submitted claims when the beneficiary used Form CMS-1500 with instructions how to complete and return the appropriate beneficiary claims Form CMS-1490S for processing.

When manually returning a beneficiary submitted claim (Form CMS-1490S) for a Medicare-covered service (because the claim is not complete or contains invalid information), the contractor will maintain a record of the beneficiary submitted claim for purposes of the timely filing rules in the event that the beneficiary re-submits the claim.

When returning a beneficiary submitted claim, the contractor will inform the beneficiary by letter that:

- The provider or supplier is required by law to submit a claim on behalf of the beneficiary (for services that would otherwise be payable); and
- In order to submit the claim, the provider must enroll in the Medicare program.

If a beneficiary receives services from a provider or supplier that refuses to submit a claim on the beneficiary's behalf (for services that would otherwise be payable by Medicare), the beneficiary should:

- Notify the contractor in writing that the provider or supplier refused to submit a claim to Medicare; and
- Submit a complete Form CMS-1490S with all supporting documentation.

Upon receipt of both the beneficiary's complaint that the provider/supplier refused to submit the claim, and the beneficiary's claim Form CMS-1490S (and all supporting documentation), the contractor will process and pay the beneficiary's claim if it is for a service that would be payable by Medicare were it not for the provider's or supplier's refusal to submit the claim and/or enroll in Medicare.

Important Information Regarding the CMS National Claims Crossover Process

MLN Matters Number: SE0909

Provider Types Affected

All Medicare physicians, providers, and suppliers

Provider Action Needed

Physicians, providers, and suppliers should note that this special edition article is to request that they allow sufficient time for the Medicare crossover process before attempting to balance bill their patients' supplemental insurers and payers for amounts remaining after Medicare's payment determination on their submitted claims.

Background

The Centers for Medicare & Medicaid Services (CMS) consolidated the "automatic" or eligibility file-based crossover process under the Coordination of Benefits Contractor (COBC) as of September 2006. Under the "automatic" crossover process, other supplemental insurers, including Medicaid agencies, sign a standard national Coordination of Benefits Agreement (COBA) with the CMS contractor, the COBC. They then submit enrollment information via a standard eligibility file feed through a secure connection with the COBC. Within this eligibility feed, the supplemental insurers identify their covered members or policy/ certificate holders for Medicare claim matching purposes. The COBC, in turn, transmits this information to the CMS Common Working File (CWF). After the CMS CWF system tags individual claims for crossover to a designated insurer, it then prompts the Medicare contractor to send the adjudicated claims to the COBC for crossover purposes once the claims have met their payment floor requirements, as prescribed by CMS.

The CMS consolidated the Medigap claim-based crossover process under the COBC in October 2007. Under this process, the COBC assigns to a Medigap plan a 5-digit Medigap claim-based COBA ID (range 55000 through 59999) to ensure that if participating Part B physicians or suppliers enter that value on incoming paper CMS-1500 claim forms or 837 professional claims, the Medicare contractor will be able to transfer the claims to the COBC for crossover to that specific Medigap plan.

Important: Virtually all Medigap insurers participate in the automatic or eligibility file-based crossover process. Approximately ten or eleven Medigap plans avail themselves of the less commonly used Medigap claim-based crossover process, which cannot be used in association with Part A 837 institutional claims (including inpatient, outpatient, home health, and hospice related types of bills) or with claims for which the physician or supplier is non-participating with Medicare. These insurers, some of whom also participate in part in the automatic crossover process, may be referenced at http://www.cms.hhs.gov/COBAgreement/Downloads/Medigap%20Claim-based%20COBA%20IDs%20for%20Billing%20Purpose.pdf on the CMS web site.

Situations Where Balance Billing of Supplemental Insurers Is Justified

Situation 1: Claim Data Errors Encountered

Approximately 98 percent of all claims that Medicare indicates crossed-over, as annotated on its generated 835 electronic remittance advice (ERA) and standard paper remittance advice (SPR), actually were successfully transmitted to supplemental insurers. For the remaining two (2) percent of cases, the physician, provider, or supplier's claims fail Health Insurance Portability and Accountability Act (HIPAA) compliance within the COBC's code validation routine. In addition, due to Medicare's shared claims processing systems problems, Medicare contractors occasionally transmit structurally unusable claims to the COBC. Such claims are rejected back to the Medicare contractor within 24 hours of receipt. Finally, the COBC may, in some instances, successfully transmit claims to various supplemental insurers only to have them rejected due to issues such as national provider identifier (NPI) mismatch (dispute error code 200), claims selection criteria problems (dispute error code 600), and less frequently HIPAA compliance matters (dispute error code 700).

When the COBC rejects claims back to the Medicare contractors, they issue special correspondence letters (sent to your Medicare on-file "correspondence" address) to your organization within five (5) business days from COBC's rejection action. The special letters indicate the affected claims, including Health Insurance Claim Number (HICN) and associated internal control number (ICN)/document

control number (DCN), along with an error code and error description specifying why the COBC could not cross-over the affected claims. This same procedure occurs when insurers reject claims, typically several days later through a dispute process with the COBC, with the exception that standard verbiage is carried on the special letter indicating that the affected claim(s) was/were rejected by the supplemental insurer and an associated dispute error code appears (e.g., 200, 600, 700). When providers receive such notifications, they should then attempt to bill the supplemental insurer or benefit program, given that Medicare was unable to cross-over the affected claim(s) successfully.

Situation 2: Patient's Insurer Not Part of Crossover Process

If you can clearly determine that your patient's insurer cannot or will not voluntarily participate in the CMS national crossover process, you are, of course, within your rights to balance bill your patient's supplemental insurer.

A Special Note Regarding Claim Repair Processes

When a Medicare contractor's volume of HIPAA compliance rejections equals or exceeds four (4) percent of all claims that the affected Medicare contractor transmitted to the COBC for a given day, or if entire envelopes of claims fail structural editing at the COBC, that Medicare contractor is instructed by CMS to go into "claim repair mode." That is, the Medicare contractor is to do the following:

- Determine how long it will take, working through its shared claims processing system maintainer, to effectuate a correction of the errored claims; and
- Subject to concurrence from CMS, initiate a claim repair for all claims with a given error condition. Typically, most repairs are accomplished within 10 to 15 business days from the date when the COBC rejected the claims.

Important: At CMS direction, most Medicare contractors, including Medicare Administrative Contractors (MACs), will alert you to such situations in the interests of ensuring that you do not balance bill your affected patients' supplemental insurers or benefit programs. In the majority of instances, Medicare contractors will issue the special correspondence letters, which have been held within the system, if they have determined through consultation with CMS that a claims repair cannot be accomplished. You may also receive additional information about the abandonment of a claims repair process via the affected Medicare contractors' provider web site.

Requested Physician, Provider, and Supplier Action

Recently, CMS has received a growing number of complaints from supplemental insurers about their receipt of paper SPRs or printed 835 ERAs that physician, provider, and supplier billing vendors are generating well in advance of their receipt of the CMS "official" Medicare crossover claims. Consequently, these supplemental insurers are in receipt of duplicate claim pairings - one generated on paper by the provider and another, the "official" crossover claim, generated from the COBC.

Since payment from supplemental insurers should, as a rule, occur only after the Medicare payment has been issued, CMS requests that you do not bill your patients' supplemental insurers for a minimum of 15 work days after receiving the Medicare payment.

This should allow sufficient time for any potential CMS-approved Medicare claims recovery situations should they need to occur and for the supplemental insurer to take actions necessary to issue payment determination following its receipt of a Medicare crossover claim. Additionally, CMS requests that physicians, providers, and suppliers take the following actions before balance billing their patients' supplemental insurers:

- Check the following CMS web site for verification that your patient's supplemental insurer is participating in the automatic crossover process nationally with the CMS COBC: http://www.cms.hhs.gov/COBAgreement/Downloads/Contacts.pdf on the CMS web site.
  Note: As verified by the spreadsheet's header, this document is a listing of all participants in the Medicare automatic crossover process. It is not just a listing of beneficiary and provider contact information for each insurer indicated.
- Prior to submitting a claim to a supplemental payer/insurer, you should utilize available self-service tools to research the status of your supplemental payment (e.g., the supplemental insurer's web site, or claims automated "hot line," as applicable).

In addition, as a reminder, only the "official" Medicare remittance advice or HIPAA 835 ERA should be used for supplemental billing purposes. CMS requests that copies of screen prints from any system that is used to access Medicare claim status not be submitted to a supplemental payer/insurer for billing purposes even if:

- You are billing the supplemental payer/insurer after the 15 work days from the Medicare-issued payment have expired; and
- You have used the available self-service tools to confirm the status of your supplemental payment.

Additional Information

You may also want to review MLN Matters article MM5601 (Transitioning the Mandatory Medigap ("Claim-Based") Crossover Process to the Coordination of Benefits Contractor (COBC)) at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5601.pdf on the CMS web site.

BILLING CONT'D

Modification CWF Copybook to Transmit "WC" Qualifier Alpha Codes to Various Systems - Supplement to CR 5371

MLN Matters Number: MM6438
Related Change Request (CR) #: 6438
Related CR Release Date: May 1, 2009
Related CR Transmittal #: R487OTN
Effective Date: October 1, 2009
Implementation Date: October 5, 2009

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 6438 and is informational only for providers. In order to prevent Medicare's paying primarily for future medical expenses that should be covered by workers' compensation Medicare set-aside arrangements (WCMSA), a prior instruction from Medicare, CR 5371, provided your Medicare contractors with instructions on the creation of a new Medicare Secondary Payer (MSP) code in Medicare's claims processing systems. With the creation of the new MSP code, the Centers for Medicare & Medicaid Services (CMS) has the capability to discontinue conditional payments for diagnosis codes related to WCMSA settlements.

Background

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

Change Request (CR) 5371 added the qualifier of "WC" to distinguish a WCMSA Medicare Secondary Payer (MSP) Auxiliary Record from a WC MSP record. An MLN Matters® article related to CR 5371 is available at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5371.pdf on the CMS web site.

Even though the "WC" qualifier was added by CR 5371, no adjustment was made to allow for the transfer of the WC modifier's alpha codes from the Common Working File (CWF) system to other important Medicare systems and CR 6438 will implement that transfer.

Additional Information

The official instruction, CR 6438, 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/R487OTN.pdf on the CMS web site.

COVERAGE

Compression Stockings/Wraps

Gradient compression stockings/wraps (A6531, A6532, A6545) are eligible for coverage under the Surgical Dressings benefit when they are used as part of a multi-layer compression system for the treatment of venous stasis ulcers.

For the compression stocking codes, A6531 and A6532, one unit of service is generally for one stocking. However, if a manufacturer has a product consisting of two components which are designed to be worn simultaneously on the same leg, the two components must be billed as one claim line with one unit of service, e.g., a product which consists of an unzippered liner and a zippered stocking.

When gradient compression stockings (A6531 and A6532) are used for an open venous stasis ulcer, they must be billed with the AW modifier. The right (RT) and left (LT) modifiers must also be used for gradient compression stockings. 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. Modifiers A1-A9 are not used with codes A6531 and A6532.

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

Coverage of a non-elastic gradient compression wrap (A6545) is limited to one per 6 months per leg. Quantities exceeding this amount will be denied as not medically necessary.

Codes A6531, A6532, and A6545 are noncovered for the following conditions:

- Venous insufficiency without stasis ulcers
- Prevention of stasis ulcers
- Prevention of the reoccurrence of stasis ulcers that have healed
- Treatment of lymphedema in the absence of ulcers

In these situations, since there is no ulcer, the stockings/wraps do not meet the definition of a surgical dressing. Gradient compression stockings described by codes A6530, A6533-A6544, A6549 and surgical stockings described by codes A4490-A4510 are noncovered for all indications because they do not meet the definition of a surgical dressing.

Source: Local Coverage Determination and Policy Article for Surgical Dressings

Training Medicare Patients on Use of Home Glucose Monitors and Related Billing Information

MLN Matters Number: SE0905

Provider Types Affected

Physicians, providers, suppliers, and other healthcare professionals who furnish or provide referrals for and/or file 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 Medicare-covered diabetes self management training (DSMT) benefits.

Provider Action Needed

This Special Edition article is being provided to help clarify the physician's role in prescribing and/or providing blood glucose self-testing equipment and supplies and diabetes self-management training (DSMT) covered for Medicare Beneficiaries with diabetes. The article reminds providers and suppliers about who may bill for DSMT and gives an overview of this benefit.

Background

Diabetes is the sixth leading cause of death in the United States, and approximately 23.6 million Americans have diabetes with an estimated 20.9 percent of the senior population age 60 and older being affected. This special edition article presents an overview of diabetes supplies and self-management training covered by Medicare.

Diabetes Self-Management Training (DSMT)

The Balanced Budget Act of 1997 (Section 4105) permits Medicare coverage of diabetes DSMT services when these services are furnished by a certified provider who meets certain quality standards. The DSMT program is intended to educate beneficiaries in the successful self-management of diabetes. The program includes instructions in self-monitoring of blood glucose; education about diet and exercise; an insulin treatment plan developed specifically for the patient who is insulin-dependent; and motivation for patients to use the skills for self-management.

Diabetes self-management training services may be covered by Medicare only if the treating physician or treating qualified non-physician practitioner who is managing the beneficiary's diabetic condition certifies that such services are needed. The referring physician or qualified non-physician practitioner must maintain the plan of care in the beneficiary's medical record and documentation substantiating the need for training on an individual basis when group training is typically covered, if so ordered. The order must also include a statement signed by the physician that the service is needed as well as the following:

- The number of initial or follow-up hours ordered (the physician can order less than 10 hours of training);
- The topics to be covered in training (initial training hours can be used for the full initial training program or specific areas such as nutrition or insulin training); and
- A determination that the beneficiary should receive individual or group training.

The provider of the service must maintain documentation in a file that includes the original order from the physician and any special conditions noted by the physician. When the training under the order is changed, the training order/referral must be signed by the physician or qualified non-physician practitioner treating the beneficiary and maintained in the beneficiary's file in the DSMT's program records.

Initial Training

The initial year for DSMT is the 12 month period following the initial date, and Medicare will cover initial training that meets the following conditions:

- DSMT is furnished to a beneficiary who has not previously received initial or follow-up training under Healthcare Common Procedure Coding System (HCPCS) code G0108 or G0109;
- DSMT is furnished within a continuous 12-month period;
- DSMT does not exceed a total of 10 hours (the 10 hours of training can be done in any combination of 1/2 hour increments);
- With the exception of 1 hour of individual training, the DSMT training is usually furnished in a group setting with the group consisting of individuals who need not all be Medicare beneficiaries; and
- The one hour of individual training may be used for any part of the training including insulin training.

Follow-Up Training

Medicare covers follow-up training under the following conditions:

- No more than two hours individual or group training is provided per beneficiary per year;
- Group training consists of 2 to 20 individuals who need not all be Medicare beneficiaries;
- Follow-up training for subsequent years is based on a 12 month calendar after completion of the full 10 hours of initial training;
- Follow-up training is furnished in increments of no less than one-half hour; and
- The physician (or qualified non-physician practitioner) treating the beneficiary must document in the beneficiary's medical record that the beneficiary is a diabetic.

Note: All entities billing for DSMT under the fee-for-service payment system or other payment systems must meet all national coverage requirements.

Certified Providers of DSMT

A designated certified provider bills for DSMT provided by an accredited DSMT program. Certified providers must submit a copy of their accreditation certificate to their Medicare contractor. The statute states that a "certified provider" is a physician or other individual or entity designated by the Secretary that, in addition to providing outpatient self-management training services, provides other items and services for which payment may be made under

BILLING CONT'D

title XVIII, and meets certain quality standards. CMS has designated all providers and suppliers that bill Medicare for other individual services such as hospital outpatient departments, renal dialysis facilities, physicians and durable medical equipment suppliers as certified. All suppliers/providers who may bill for other Medicare services or items and who represent a DSMT program that is accredited as meeting quality standards can bill and receive payment for the entire DSMT program. Registered dietitians are eligible to bill on behalf of an entire DSMT program on or after January 1, 2002, as long as the provider has obtained a Medicare provider number. A dietitian may not be the sole provider of the DSMT service.

Coding and Payment of DSMT Services

The following Healthcare Common Procedure Coding System (HCPCS) codes should be used for DSMT:

- G0108 - Diabetes outpatient self-management training services, individual, per 30 minutes; and
- G0109 - Diabetes outpatient self-management training services, group session (2 or more), per 30 minutes.

Additional Information

See the *Medicare Benefits Policy Manual* (Chapter 15, Section 300) at http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf for complete details on Medicare's policy for DSMT.

See the *Medicare Claims Processing Manual* (Chapter 18, Section 120.1 (Coding and Payment of DSMT Services)) at http://www.cms.hhs.gov/manuals/downloads/clm104c18.pdf for detailed billing instructions for DSMT.

DRUGS/BIOLOGICALS

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

MLN Matters® Number: MM6471
Related Change Request (CR) #: 6471
Related CR Release Date: May 15, 2009
Related CR Transmittal #: R1737
Effective Date: July 1, 2009
Implementation Date: July 6, 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

This article is based on Change Request (CR) 6471 and instructs Medicare contractors to download and implement the July 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 April 2009, January 2009, October 2008 and July 2008, files. They will use the July 2009 ASP and not otherwise classified (NOC) drug pricing files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after July 6, 2009 with dates of service July 1, 2009, through September 30, 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 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), 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 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. There are exceptions to this general rule and they are stated in the *Medicare Claims Processing Manual*, Chapter 17, Section 20.1.3 and may be reviewed at http://www.cms.hhs.gov/manuals/downloads/clm104c17.pdf on the CMS web site.

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.

Use of Quarterly Payment Files

The following table shows how the quarterly payment files will be applied:

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

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

Additional Information

The official instruction (CR6471) issued to your Medicare carrier, FI, RHHI, MAC, or DME MAC is available at http://www.cms.hhs.gov/Transmittals/downloads/R1737CP.pdf on the CMS web site.

Oxygen Claims - Instructions on Resubmitting Subsequent Rental Months if Initial Month Paid with RA or RP Modifier

This article provides instructions for suppliers to resubmit oxygen rental claims for subsequent months if they have received payment for the initial replacement month (the claim with the RA or RP modifier). Some suppliers experienced non-covered denials with the N370 message, billing exceeds the rental months covered/approved by the payer. This occurred because the claim with the RA or RP modifier had not yet been worked by our claims staff and the new CMN for the replacement equipment was not yet loaded into the claims processing system.

Claims that should be resubmitted for this reason are claims with dates of service January 17-March 31, 2009. Our claims staff is currently working April and May claims. For this reason, only resubmit subsequent month's denials for these dates of service when you see the initial "replacement" claim has been paid. NAS has also adjusted the claims for January 1-16, 2009 dates of service and these should not be resubmitted.

Suppliers may have been previously instructed that these subsequent rental claims would be 'mass adjusted' by NAS and no further action would be needed. Our plan was to do these mass adjustments but after further review we have determined that the most expeditious way to handle these claim denials is to ask suppliers to resubmit.

Note: There is no need to reference the prior denials or indicate on the claim that this is a resubmission. Copies of the prior denial are also not needed and these claims should not be directed to Redeterminations or Reopenings.

Reminders about Replacement Oxygen Claims

- Only the initial oxygen claim requires a modifier RP, prior to January 1, 2009, or modifier RA, effective January 1, 2009, and after, when replacing oxygen equipment.
- Subsequent oxygen rental claims, those billed after the initial month of replacement, should not include the RP or RA modifier.

Resources regarding Oxygen Equipment Rentals:

- New Rental Periods for Oxygen Equipment - Billing Reminders
- Medicare Billing Requirements and Policies for Replacement of Oxygen Equipment and Oxygen Contents

Please call the DME Contact Center at (866) 243-7272 with any questions regarding this notice.

New Rental Periods for Oxygen Equipment - Billing Reminders

NAS is seeing claims billed incorrectly when starting a new rental period for oxygen equipment. Claims for the replacement of oxygen equipment for the **first** month of use only are billed using the HCPCS code for the new equipment and either the RA or RP modifier depending on the date that the equipment is furnished. The RA modifier is used when replacing equipment on/after January 1, 2009, whereas the RP modifier is used for equipment replaced before January 1, 2009.

A new Certificate of Medical Necessity (CMN) is required in situations where oxygen equipment is replaced because the equipment has been in continuous use by the patient for the equipment's reasonable useful lifetime or is lost, stolen, or irreparably damaged. The initial date on the CMN and date of service for the claim line with the RA or RP modifier must be the same. This date should be the date of delivery of the oxygen equipment.

Effective immediately, if these dates do not match, you may receive the following message:

> CO-176: Payment adjusted because this service was not prescribed by a physician, not prescribed prior to delivery, the prescription is incomplete, or the prescription is not current.

If claims are denied with a CO-176 message, suppliers should submit a written reopening with the correct CMN and claim date of service.

Inappropriate use of the RA (or RP) modifier would be submitting this modifier on all rental months after the first month of use. Claims submitted with the RA (or RP) modifier after the initial date will be denied with the following messages:

> CO-16: Claim/service lacks information which is needed for adjudication.
>
> M51: Missing/incomplete/invalid procedure code(s).

If claims are denied with the above messages, suppliers should resubmit the claim, as the claim has been denied as unprocessable. The only option is to submit a corrected claim.

Travel Oxygen

A new payment policy for oxygen became effective on January 1, 2009. This article addresses issues related to short term travel (e.g., days or weeks) or to temporary relocation (e.g., snowbird) outside of the supplier's service area.

In this article, the term "oxygen" includes the equipment, contents (if applicable), and all related items and services including, but not limited to accessories, maintenance, and repairs.

In this article, the following terms are used:

- Home supplier refers to the supplier of the oxygen prior to travel or relocation.
- Temporary supplier (non-billing) refers to another supplier with whom the home supplier has made arrangements for provision of oxygen but who will not be billing Medicare for the oxygen. The home supplier will bill for the oxygen.
- Temporary supplier (billing) refers to a supplier in the travel/temporary location who will be billing Medicare for the oxygen instead of the home supplier

36 month rental period

- In all cases, an oxygen supplier must provide or arrange for oxygen to be provided to the beneficiary for the entirety of each month for which it receives payment.
- Medicare will pay only one supplier to provide oxygen during any one rental month.
- Requirements for the home supplier:
  - If the beneficiary travels or relocates outside the supplier's service area, then for the remainder of the rental month for which it billed, the home supplier is required to provide the oxygen itself or arrange for a temporary supplier (non-billing) to provide the oxygen.
  - For subsequent rental months that the beneficiary is outside the service area, the home supplier is encouraged to either provide or arrange for the oxygen itself or assist the beneficiary in finding a temporary supplier (billing) in the new location.
  - If the home supplier provides oxygen to the patient for use out-of-area or arranges for a temporary supplier (non-billing) to provide the oxygen, the home supplier bills for whatever system the patient is using on the anniversary date/billing date. The supplier may provide the patient with different oxygen equipment (e.g., portable concentrator) for travel, if there is an order from the physician.
  - The home supplier may not bill for or be reimbursed by Medicare if it is not providing oxygen or has not arranged for a temporary supplier (non-billing) to provide the oxygen on the anniversary billing date.
- If a temporary supplier (billing) provides equipment:
  - If it is during a month in which the home supplier has not billed Medicare, claims from the temporary supplier (billing) would be paid, if all coverage criteria and payment rules are met.
  - If it is during a month in which the home supplier has billed Medicare and it is not provided under an arrangement with the home supplier, then the claim from the temporary supplier (billing) will be denied as not medically necessary, if it bills Medicare.
  - If the beneficiary returns home before the end of a rental month for which the temporary supplier (billing) has billed, it must provide oxygen itself for the entirety of that month or make arrangements with the home supplier to provide the oxygen.
  - The temporary supplier (billing) must provide a copy of a valid CMN, an order (if the order information was not included on the CMN), a report of the qualifying blood gas study, and documentation of any required physician visit, if requested.

OXYGEN CONT'D

Months 37-60

- The supplier providing oxygen to the patient during the 36th month is required to provide oxygen to the patient either directly or under arrangements with a temporary supplier (non-billing) for beneficiary use out-of-area.
- The home supplier could provide the patient with different oxygen equipment (e.g., portable concentrator) for travel, if there is an order from the physician.
  - The supplier would not submit a claim for that equipment (because it is required to continue to provide equipment after the 36 month cap).
- If the beneficiary had a gaseous or liquid system during the 36th month and the supplier was providing contents to the patient during months 37-60, it may only bill and will only be reimbursed for contents if the patient was using contents at some time during the billed month. It may not bill for contents if, for example, the beneficiary was using a portable concentrator during the entire month.

Miscellaneous

- Oxygen services furnished by an airline are noncovered. Payment for oxygen furnished by an airline is the responsibility of the beneficiary and not the responsibility of the supplier.
- This article only addresses travel and relocation in the United States and its territories. Medicare does not cover items or services provided outside the United States and the supplier is not required to provide or arrange for oxygen outside the United States.

WHEELCHAIRS/POWER MOBILITY DEVICES

K0823 Claim Development

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

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

The six items that will be requested are:

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

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