Jurisdiction D News from Noridian Administrative Services, LLC.

Happenings

March 2009
Issue No. 19

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

In This Issue…

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CEDI

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

Accreditation

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

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

FYI

Holiday Schedule

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

Holiday	Date
Good Friday	April 10, 2009
Memorial Day	May 25, 2009
Independence Day	July 3, 2009
Labor Day	September 7, 2009
Columbus Day *	October 12, 2009
Veterans Day *	November 11, 2009
Thanksgiving	November 26 and 27, 2009
Christmas Eve **	December 24, 2009
Christmas Day	December 25, 2009
** Partial day closure	

Sources for "Jurisdiction D Happenings" Articles

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

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

Medicare Learning Network Matters Disclaimer Statement

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

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

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

MLN Matters Number: MM6139 Revised
Related Change Request (CR) #: 6139
Related CR Release Date: February 10, 2009
Related CR Transmittal #: R23COM
Effective Date: April 6, 2009
Implementation Date: April 6, 2009 for providers

Note: This article was revised on February 11, 2009, to reflect the revised CR 6139, which CMS re-issued on February 10, 2009. The effective and implementation dates for providers have been changed to April 6, 2009. Also, the CR release date, transmittal number, and the Web address of the CR have been changed. All other information remains the same.

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

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

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

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

Because of issues with the public availability of previous authentication elements, CMS has addressed the current provider authentication process for providers who use the IVR system or call a CSR. To better safeguard providers' information before sharing information on claims status, beneficiary eligibility, and other provider related questions, CR 6139, from which this article is taken, announces that

FYI CONT'D

CMS has added the last 5-digits of the provider's TIN as an additional element in the provider authentication process. Your Medicare contractor's system will verify that the NPI, PTAN, and last 5-digits of the TIN are correct and belong to you before providing the information you request.

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

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

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

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

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

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

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

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

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

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

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

Additional Information
You can find more information about the new provider authentication requirements for Medicare inquiries by going to CR 6139, located at http://www.cms.hhs.gov/Transmittals/downloads/R23COM.pdf on the CMS Web site.

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, 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

Denial Only Letter Requests for Hearing Services

In accordance with the CMS 2008 DME Jurisdiction List, NAS DME will no longer send denial only letters for hearing aids and related services, HCPCS V5008-V5299. Effective immediately, suppliers will need to contact their local Medicare Part B carrier to request these letters. Hearing services denial letter requests received by NAS DME will be answered with a response that these should be sent to the local Medicare Part B carrier.

The 2008 DME Jurisdiction List is available at http://www.cms.hhs.gov/Transmittals/downloads/R1644CP.pdf. For assistance in contacting your Medicare Part B carrier, refer to the contact list located at http://www.cms.hhs.gov/MedicareProviderSupEnroll/downloads/contact_list.pdf.

CSI and BE Medicare System Security Semi-Annual Review

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

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

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

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

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

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

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

DME Contact List

Trent Cable: 701-277-6779

Susan Boer: 701-277-2572

HHS OCR Posts New Web Site for Health Information Privacy

The Department of Health and Human Services, Office for Civil Rights has posted its new Web site. The health information privacy (HIP) pages have been extensively revised to improve organization and ease of use for consumers, covered entities and others seeking reliable advice on the HIPAA Privacy Rule and the Patient Safety Rule.

The Web site contains significant new content including:

- For Consumers pages (with new information on):
  - Medical Records
  - Employers and Health Information in the Workplace
  - Personal Representatives
  - Family Members and Friends
  - Court Orders and Subpoenas
  - Notice of Privacy Practices
- Privacy Rule home page-rulemaking timeline
- Enforcement Rule home page-rulemaking timeline
- Emergency Preparedness home page
- Genetic Information Nondiscrimination Act page
- Special Topics home page
- Before you File a HIP Complaint
- Patient Safety Rule home page
- Patient Safety Statute home page
- Patient Safety Enforcement Activities and Results home page

You can reach the new health information privacy Web pages at http://www.hhs.gov/ocr/privacy/index.html.

EDUCATIONAL

Updated Chapters Added to Supplier Manual

Chapters 11, 12, 13, 15 and 17 of the supplier manual have been updated. Chapter 15, previously titled Resources, has been moved to the Appendix. Chapter 15 now houses Overpayments and Refunds. These chapters can now be viewed in HTML and PDF versions. The PDF version will be updated on a quarterly basis, while the HTML or Web version will continue to be updated real time.

We welcome your feedback on our manual. Please provide comments or suggestions by sending an email to dme@noridian.com, and use Supplier Manual as the subject line.

NAS DME Responses to Survey Comments

NAS DME appreciates and reviews all supplier comments provided on the ForeSee Results Web site satisfaction survey. The following responses give locations of information on our site and other Web sites based on survey comments received in December 2008.

If a patient changes from E1390 to K0738, do I need additional documentation or a new Certificate of Medical Necessity (CMN)?

The Oxygen and Oxygen Equipment Local Coverage Determination (LCD) outlines when a recertification and revised CMN are required. A link to the LCDs and Policy Articles is provided on the LCD page of our Web site. Chapter 4 of the Jurisdiction D supplier manual also provides common scenarios for different types of CMNs.

Why is an update for the 2009 fees posted to your Web site, but not the actual fee schedule?

NAS received and posted MLN Matters 6270 on November 18, 2008, which was prior to CMS releasing the DMEPOS fee schedule.

Where are the noncovered items listed?

The *Medicare National Coverage Determinations (NDC) Manual*, Chapter 1, Part 4, Section 280.1, provides a list of items that are noncovered with the reason for denial. NAS also provides a link to a list of itemized NCDs on the Coverage/MR page of our Web site.

I am trying to find a specific modifier for a specific procedure code.

NAS DME has posted an article titled Modifiers for DME Services twice on November 5, 2007, and June 11, 2007. These articles are found in the What's New section of our Web site. It is helpful to know how the DMEPOS being billed is categorized for payment as this often determines which modifiers can be submitted. The payment categories for DME HCPCS are listed in Chapter 16 of the Jurisdiction D supplier manual.

I can't find the code for some items I was trying to bill.

NAS provides code listings in Chapter 16 of the Jurisdiction D supplier manual. The Pricing, Data Analysis and Coding (PDAC) contractor provides an excellent resource for coding called the DME Coding System (DMECS). Suppliers can search for HCPCS codes, modifiers, fee schedules, and product classification on DMECS. A link to their site, https://www.dmepdac.com, is provided on several pages of our Web site: NAS homepage, Chapter 16 and the Resources section of the supplier manual, and on the Contact tab under Phone Numbers and Addresses.

Where can I find the quantity limits for a HCPCS code?

Quantity limits of HCPCS codes are found in the LCDs, when applicable. The Medically Unlikely Edits (MUEs), which are found on the Claims page of our Web site, under Claims Submission, provides the maximum units of service that a provider would report under most circumstances for a beneficiary on a single date of service.

One supplier suggested NAS have a search by HCPCS code that will tell the user what LCD applies.

On the LCD page of our Web site, NAS provides a table with each HCPCS code addressed in a policy, the title and number of the LCD, and a short description of the policy.

Several comments were about billing repair or replacement items. Modifier coding for these situations changed for 2009. See the articles on New Repair and Replacement Modifiers posted to our Web site, starting on December 31, 2008. Chapter 5 of the Jurisdiction D supplier manual also discusses repair and replacement billing.

NAS DME encourages all suppliers to complete the ForeSee Results survey when it randomly pops up on the screen when navigating our Web site. This survey helps us determine supplier needs as well as the areas of the Web site that are useful.

Recent Web Site Enhancements

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

News/Publications

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

Fees

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

Coverage/MR

- Physician Resources – All documents addressed to physicians that suppliers may use to educate physicians about supplying medical documentation for DME claims are located under this heading.
- Documentation Checklists – All of these will be reviewed and updated. The following have been completed:
  - Ankle-Foot/Knee-Ankle-Foot Orthosis
  - Canes and Crutches
  - Glucose Monitors and Supplies
  - Immunosuppressive Drugs
  - Ostomy Supplies
  - Oxygen and Oxygen Equipment
  - Refractive Lenses
  - Spinal Orthoses
  - Suction Pumps
  - Support Surfaces: Group 1
  - Support Surfaces: Group 2
  - Tracheostomy Care Supplies

- Urological Supplies
- Walkers

These are excellent tools to assist in gathering required documentation.

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

Ask the Contractor Teleconference – March 17, 2009

NAS will conduct the next Ask the Contractor Teleconference on March 17, 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) will be 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 these ACTs, dial 1-800-398-9389. For those suppliers who may need an international number (American Samoa, Guam or the Northern Mariana Islands) dial 1-612-338-1917.

PDAC Web Site

The Pricing, Data Analysis, and Coding (PDAC) Web site is a great tool that performs the following activities:

- Guides manufacturers and suppliers on the proper use of the Healthcare Common Procedure Coding System (HCPCS) through product reviews and decisions
- Provides pricing information for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) services
- Provides a link to the Durable Medical Equipment Coding System (DMECS)

DMECS provides HCPCS coding assistance and national pricing information via searches for HCPCS Level II codes and modifiers, DMEPOS, and CMS National fee schedules. DMECS is designed to assist the public with coding of DMEPOS for submission to the DME MACs. DMECS contains HCPCS codes beginning with the letters A, B, E, J, K, L, Q, and V.

If you have been searching the DME NAS Web site for PDAC related information, you have been searching the wrong Web site. The correct Web site to find this information is https://www.dmepdac.com. We encourage you to bookmark this page or add to your favorites for easiest access in the future.

If you are already on the DME NAS Web site, you can find the link to PDAC one of two ways:

1. Click on the Contact tab and then Phone and Fax Numbers, Emails, & Mailing Addresses. Scroll down to the Other Important Medicare Contact Information section to locate the Coding Assistance box, which contains the link to the PDAC Web site.
2. Click Home in the Navigation bar at the top of your Web browser to go to the main NAS Web page. Next, select the Pricing, Data Analysis, and Coding link in the DME section.

From the DMEPDAC home page, select the DMECS tab from the top of the page and click on Search for Codes and Fees.

In order to find information you are looking for, be sure you are searching the correct Web site.

Searching the Appropriate Place for Part B Versus DME Information

Do you bill to both Medicare Part B and DME? Do you get frustrated because you search for something on the DME Web site and are unable find any information? If this is the case, you may be looking on the incorrect NAS Web site.

The NAS DME Web site provides information regarding durable medical equipment (DME), prosthetics and orthotics (P&O), parenteral and enteral nutrition (PEN), and supplies. The HCPCS codes associated with these items begin only with letters. Search the NAS DME Web site for information regarding canes, refractive lenses, wheelchairs, oxygen and oxygen equipment, oral anticancer drugs, and oral antiemetic drugs, infused drugs and those provided through a nebulizer, among more.

The NAS Part B Web site provides information regarding medically necessary services provided by a physician or other medical professional in an office setting, outpatient hospital and other outpatient services. Most Part B services are services coded using CPT codes, which are all numeric codes, rather than HCPCS codes. Search the NAS Part B Web site for information regarding vaccinations, injections, spirometry, routine foot care, surgery, therapy, implantable devices, and chiropractic services, among others.

The Jurisdiction List, located on the Claims page of the NAS DME site, can assist in determining whether the DME MAC or the Part B contractor, or both process a HCPCS code. Use this list before beginning your search so you can search the correct Medicare Web site for more information.

In order to find information regarding what you are looking for, be sure you are searching the correct Web site.

CMS Guided Pathways Educational Materials Available

Try the new Guided Pathways (DEC2008) Medicare Learning Network (MLN) products! These booklets incorporate existing MLN products and other CMS resources into well-organized sections that can help Medicare Fee-for-Service (FFS) providers find information to understand and navigate the Medicare Program.

The Guided Pathways booklets guide learners to resources that provide a fundamental overview of Medicare knowledge, as well as detailed FFS polices and requirements.

Products that make up the Guided Pathways curricula that apply to DME suppliers are:

1. Guided Pathways Basic Curriculum for all Medicare Fee-for-Service (FFS) Health Care Professionals, Suppliers, and Providers
2. Guided Pathways to Medicare Resources Intermediate Curriculum (Part B) for FFS Health Care Professionals and Suppliers who enroll in Medicare using the 855 B, I or S forms

Select the following link to access additional information about Guided Pathways educational web guide and booklets: http://www.cms.hhs.gov/mlnedwebguide/30_guided_pathways.asp.

Revised January 2009 – Medicare Fraud & Abuse Fact Sheet

The revised Medicare Fraud & Abuse Fact Sheet is now available at http://www.cms.hhs.gov/MLNProducts/downloads/Fraud_and_Abuse.pdf on the Medicare Learning Network (MLN). The Centers for Medicare & Medicaid Services (CMS) works with other government agencies and law enforcement organizations to protect the Medicare program from fraud and abuse. Together with CMS, providers can help identify and prevent fraud and abuse; the first step for providers to protect themselves is to understand the legal definitions and be able to identify fraudulent and abusive practices. This fact sheet provides information on many available resources to help you understand what to do if you suspect or become aware of incidents of potential Medicare fraud or abuse.

Update on the CEDI Front-End Changes – Stage 2

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

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

Stage 2 - Implementation will occur on February 27, 2009*

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

- On Friday, February 27, 2009 at 3:00 p.m. ET, the CEDI Gateway will be brought down until Sunday, March 1, 2009 at 6:00 p.m. ET for the DME MACs to remove their front-end edits for 837 claims and 276 claims status transactions.

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

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

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

and assign the Claim Control Number (CCN) to accepted NCPDP claims.

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

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

Successful Completion of CEDI Implementation of Additional X12 837 and 276 Front End CEDI Edits

National Government Services, Common Electronic Data Interchange (CEDI) implementation of the additional X12 837 and 276 front end CEDI edits was successfully completed ahead of schedule on Saturday, January 10, 2009. At that time, the CEDI Gateway was re-opened to accept and process electronic transactions.

This completes Stage 1 of the implementation of the full X12 837 and 276 front end edits at CEDI. Further communication will be provided on Stage 2 for the DME MACs to remove all front end edit logic and for CEDI to begin assigning the Claim Control Number (CCN) to accepted claims.

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

Stage 1 – Completed January 10, 2009

- On Friday, January 9, 2009, at 3:00 p.m. ET, the CEDI Gateway was brought down.

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

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

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

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

CEDI Front-End Edits Currently Being Modified

The CEDI has identified front-end edits that are not firing correctly on the CEDI GenResponse Report (GENRPT) as of January 9, 2009. This is causing claims to inappropriately reject.

Listed below are the CEDI edits that are not firing correctly. CEDI is working diligently to modify these edit to correct these issues. Software vendors have received a separate notification and are aware of these issues. CEDI will provide updates as the edit issues are resolved.

Note: Edits C003 and C008 were firing inappropriately in some cases, but have been corrected. Claims that generated those rejections from January 9, 2009, through January 18, 2009, can be resubmitted.

Detailed information on the CEDI edits and the GenResponse Reports is available in the *CEDI Front End Reports Manual* on the CEDI Web site (http://www.ngscedi.com/) under Resource Materials.

CEDI Edits Not Firing Correctly				
CEDI Edit Code	**Edit Code Message**	**Loop**	**Segment / Field**	**Description / Logic**
A020	Billing Provider First Name is invalid	2010AA	NM104	The billing provider first name is invalid. The first position cannot be a space. If NM102 = 1 (person), NM104 (first name) may only contain alpha characters (A – Z), period (.), hyphen (-), apostrophe ('), or a space. **Issue: The hyphen is not being accepted.**
A182		2430	SVD03	The procedure code submitted must be on external code source being referenced **Issue: Edit will be turned off**
A353	Billing Provider Contact # contain invalid values	2010AA	PER04 PER06 PER08	The communication number must be all numeric when qualifier is TE, FX or EX. If TE or FX, the communication number must be exactly 10 numeric digits **Issue: Requiring telephone extensions (EX) to be 10 digits in PER06/PER08**
A363	Other Payer Contact # contains invalid values	2330B	PER04 PER06 PER08	The communication number must be exactly ten digits. **Issue: Requiring telephone extensions (EX) to be 10 digits in PER06/PER08**
C003	Billing NPI Not on Crosswalk	2010AA	NM109	The billing provider NPI is not found on the crosswalk. **RESOLVED**. Claims that incorrectly received this CEDI edit from 1/9/09 through 1/18/09 can be resubmitted.
C008	EIN/SSN Not On File w/ NPI	2010AA	REF02	The SSN/EIN submitted for the NPI is not matched on the crosswalk. **RESOLVED**. Claims that incorrectly received this CEDI edit from 1/9/09 through 1/18/09 can be resubmitted.
C044	Subscriber Primary ID Invalid	2010BA	NM109	The subscriber HICN is invalid. Verify the HICN is entered exactly as it appears on the beneficiary's red, white and blue Medicare card. **Issue: Lowercase values not being allowed in HICN**
C103	Oxygen ABG Results Missing	2400	CR510	If question 6a on Oxygen CMN 484.3 is answered with a value between 55 and 60, then at least one of Questions 7 through 9 on Oxygen CMN 484.3 must be answered "Yes". **Issue: "55" and "60" are being rejected inappropriately. Values 56.0 – 59.9 are working correctly.**

CEDI Edits Not Firing Correctly				
CEDI Edit Code	**Edit Code Message**	**Loop**	**Segment / Field**	**Description / Logic**
C157	Line Level Adjustments Not Balanced	2430	CAS	The total line level adjustment amounts indicated for this line plus the primary paid amount does not equal the line charge. TECHNICAL INFORMATION: When 2430.SVD01 = 2330B.NM109 (Primary Payer),then the sum of 2430.SVD02 + 2430.CAS03 + 2430.CAS06 + 2430.CAS09 + 2430.CAS12 + 2430.CAS15 + 2430.CAS18, must = 2400.SV102 This information is used for MSP claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare. **Issue: Error setting inappropriately in some cases when paid/ adjustment amounts are in balance**

The next set of CEDI edits are currently not firing at CEDI, but continue to fire at the DME MACs. CEDI is working to modify these edits so they will set at CEDI and appear on the GenResponse report (GENRPT). Once these edits begin to generate on the CEDI GenResponse report, they will no longer be listed on the DME MAC (RPT) report.

Edits Not Firing at CEDI but Firing at the DME MACs				
CEDI Edit Code	**Edit Code Message**	**Loop**	**Segment / Field**	**Description / Logic**
C054	Invalid NPI Check Digit	2310A	NM109	The referring provider NPI number has an invalid check digit.
C058	Invalid NPI Check Digit	2310B	NM109	The rendering provider NPI number has an invalid check digit.
C064	Invalid NPI Check Digit	2310C	NM109	The purchased service provider NPI number has an invalid check digit.
C069	Invalid NPI Check Digit	2310D	NM109	The service facility location NPI number has an invalid check digit.
C075	Invalid NPI Check Digit	2310E	NM109	The supervising provider NPI number has an invalid check digit.
C111	Invalid Service Count - RR Modifier	2400	DTP03	The number of services entered for this line is invalid. Rentals can only have one unit of service. Questions regarding the correct modifier to submit on a claim should be directed to the DME MAC where the claim would be processed based on the patient's state code in the address provided on the claim.

Edits Not Firing at CEDI but Firing at the DME MACs				
CEDI Edit Code	**Edit Code Message**	**Loop**	**Segment / Field**	**Description / Logic**
C172	Invalid Procedure Code and/or Modifier	2400	SV101-2	The procedure code or modifier is invalid. Verify the HCPCS and modifier combination is valid. Verify the first position does not contain a space. Questions regarding the correct procedure code and/or modifier to submit on a claim should be directed to the DME MAC where the claim would be processed based on the patient's state code in the address provided on the claim. Helpful Tips to verify a Procedure Code/HCPCS and modifier combination: • Check the validity of the procedure code/modifier combination by using the Pricing, Data Analysis and Coding (PDAC) Web site https://www.dmepdac.com/. • Check the Local Coverage Determination (LCD) at the DME MACs for guidelines on procedure codes and modifier usage for that LCD. • Reference the supplier manual at the DME MAC Jurisdiction(s). • Contact the Customer Care department at the appropriate Jurisdiction: Jurisdiction A: 1-866-590-6731 Jurisdiction B: 1-866-590-6727 Jurisdiction C: 1-866-270-4909 Jurisdiction D: 1-866-243-7272
C180	Service Date Greater than Receipt Date	2400	DTP03	The service start/from date is greater than the date this claim was received.

NPI Crosswalk Issue Resolution

If you are having difficulties establishing the crosswalk between your NPI (National Provider Identifier) and PTAN/NSC numbers, the following information needs to be verified with both the NSC (National Supplier Clearinghouse) and the NPPES Web site.

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.

Please visit the NPPES Web site at https://nppes.cms.hhs.gov/NPPES/Welcome.do to verify or enroll the supplier's information. The PTAN/NSC number must be indicated under Issuer as MEDICARE NSC.

**If you need assistance logging in to NPPES, please call 1-800-465-3203.

CEDI CONT'D

CEDI Enrollment would also like to make you aware of the following information:

When submitting the EDI Enrollment Form, please send all pages of the form, not just the signature page. Any EDI Enrollment Form received that has just the signature page will not be processed and will be returned to the supplier.

Top Five Reasons Forms are Returned

1. The NPI is not on the crosswalk.
2. The name provided on the forms does not match the records from the National Supplier Clearinghouse.
3. There is not an EDI Enrollment Form on file for the supplier entered on the Supplier Authorization Form.
4. The Supplier Authorization Form was not submitted for a supplier joining a Clearinghouse or Billing Service.
5. The Submitter Action Request Form was not submitted to enroll for a NEW Submitter ID.

If your forms have been returned due to one of the NPI and/or PTAN/NSC reasons, the following information provides steps in correcting the issues:

- **The supplier's PTAN/NSC number is ____ missing or ____ invalid.** Please contact the National Supplier Clearinghouse at 1-866-238-9652, if you have questions about this number or do not have a Supplier PTAN/NSC number.
- **The supplier's NPI number is ____ missing or ____ invalid or ____ not on the NPI-NSC crosswalk created by NPPES.** Please visit the NPPES Web site https://nppes.cms.hhs.gov/NPPES/Welcome.do to verify or enroll the supplier's information. The PTAN/NSC number must be indicated under Issuer as MEDICARE NSC.

MREP Software Codes Update

The latest Claim Adjustment Reason Codes and Remittance Advice Remark Codes are available in the Codes.ini file for the Medicare Remit Easy Print (MREP) software. You can access this file in the Zipped folder for "Medicare Remit Easy Print - Version 2.5" at http://www.cms.hhs.gov/AccesstoDataApplication/02_MedicareRemitEasyPrint.asp on the CMS Web site.

Important Information Regarding Issue with Displaying Date of Service for Claims on GenResponse Report

National Government Services, Common Electronic Data Interchange (CEDI) has become aware of an issue with displaying the Date of Service for claims on the GenResponse Report. This issue is causing the Date of Service of the last claim within the file to not display on the GenResponse Report.

All accepted and rejected claims are being reported correctly. All accepted claims will be sent to the DME MACs with the Dates of Service. This is only a reporting issue and not an issue with the claims.

CEDI will provide an update when this issue has been resolved.

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

VMS Modifications to Implement CEDI System, Final Implementation

MLN Matters Number: MM6357
Related Change Request (CR) #: 6357
Related CR Release Date: February 6, 2009
Related CR Transmittal #: R435OTN
Effective Date: On or before April 6, 2009
Implementation Date: On or before April 6, 2009

Provider Types Affected
Providers and suppliers who submit claims to Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for services provided to Medicare beneficiaries

Provider Action Needed
This article is based on CR 6357 and is informational in nature. CR 6257 implements significant changes in Medicare's systems necessary to prepare for the implementation of the Common Electronic Data Interchange (CEDI) System, a common EDI front end developed to support the DME MACs.

Background
ViPS Medicare Systems (VMS), the DME MAC shared system maintainer developed and elevated the software changes necessary to remove or disable certain functionality of the electronic data interchange (EDI) front end system; however, the implementation of edits and claims control numbering at the CEDI system has been delayed. This change request prescribes the requirements for ViPs to implement the final changes which will disable all levels of pre-pass editing associated with the Health Insurance Portability & Accountability Act of 1996 HIPAA version of ANSI 837 and 276 transactions, and will discontinue the claim control number (CCN) assignment process for X12 (837 claims only).

The key information for providers and suppliers of DME services are that new editing processes will be put in place for DME claims. These new processes will not change the codes that are transmitted back to you when you submit claims for DME services. These changes only affect how these claims are handled and processed at your DME MAC.

Additional Information
The official instruction, CR 6357, issued to your DME MAC regarding this change may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R435OTN.pdf on the Centers for Medicare & Medicaid Services (CMS) Web site.

DMEPOS Suppliers Must Be Accredited By October 1, 2009 (Unless Exempt) To Retain Enrollment Number

The Medicare Improvements for Patients and Providers Act (MIPPA) of July 2008, section 154(b), added a new subparagraph (F) which states that on or after ***October 1, 2009***, all DMEPOS suppliers must have evidence of accreditation by one of the ten CMS approved accreditation organizations.

MIPPA goes on to say that eligible professionals and other persons are exempt from meeting the ***October 1, 2009***, accreditation deadline unless CMS determines that the quality standards are specifically designed to apply to such professionals and persons. The eligible professionals exempted are defined by statute to include physicians, physical therapists, occupational therapists, qualified speech-language pathologists, physician assistants, and nurse practitioners. Additionally, MIPPA allows the Secretary to specify "other persons" that are exempt from meeting the accreditation deadline. Such other persons are defined as orthotists, prosthetists, opticians, and audiologists. CMS will define how the quality standards apply to these eligible professionals and other persons by rulemaking in 2009.

If you are an individual that is not included in this exemption list, such as a pedorthotist, mastectomy fitter, orthopaedic fitter/ technician or an athletic trainer and you have a Medicare enrollment number in order to bill for DME Medicare part B supplies, you must be accredited by the ***October 1, 2009***, deadline for DMEPOS accreditation.

CMS wants to ensure that the DMEPOS supplier will receive an accreditation decision (provided that they meet the all the accreditation requirements) by ***October 1, 2009***. CMS is encouraging that all enrolled DMEPOS suppliers, except those eligible professionals and other persons exempted, submit a complete accreditation application to one of the accreditation organizations by ***January 31, 2009***.

Accreditation Clarification for Physician Owned Pharmacies

In an effort to further clarify accreditation guidelines, DMEPOS suppliers are reminded that a physician owned pharmacy is not guaranteed an accreditation exemption. Each pharmacy must be accredited to obtain/ maintain Medicare billing privileges unless it only supplies pharmaceuticals (e.g., anti-cancer drugs, anti-emetics, etc.). Pharmacies and physician offices, even when in the same building, are usually separated with individual suite numbers recognized by the postal service. Therefore, they can and should be enrolled separately with the National Supplier Clearinghouse (NSC).

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.

Medicare Announces Delay of Effective Date for Interim Final Rule with Comment Period for Competitive Acquisition Program for Certain DMEPOS

The Centers for Medicare & Medicaid Services (CMS) has delayed the effective date for the Interim Final Rule with Comment Period (IFC) that implements certain provisions of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) for the Round 1 Rebid of the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Acquisition Program. The effective date was originally February 17, 2009, and is now April 18, 2009.

The original comment period on the Interim Final Rule remains unchanged. The public has until March 17, 2009, to submit comments on the substantive policy issues discussed in the rule.

Visit the CMS Web site at http://www.cms.hhs.gov/CompetitiveAcqforDMEPOS/ to view additional information.

Medicare DMEPOS Competitive Bidding Program Announcements

The Centers for Medicare & Medicaid Services (CMS) has announced that an Interim Final Rule with Comment Period, which implements certain provisions of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) for the Round 1 Rebid of the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Acquisition Program, is on display at the Federal Register.

CMS has also announced the appointment of new members to serve on the Program Advisory and Oversight Committee (PAOC) for the DMEPOS competitive bidding program.

Visit the CMS Web site at http://www.cms.hhs.gov/DMEPOSCompetitiveBid/ to view the list of PAOC members and for the latest information on the DMEPOS competitive bidding program.

To view the Press Release, go to http://www.cms.hhs.gov/apps/media/press_releases.asp.

HHS Issues Final ICD-10 Code Sets and Updated Electronic Transaction Standards Rules

The U.S. Department of Health and Human Services (HHS) recently released two final rules that will facilitate the United States' ongoing transition to an electronic health care environment through adoption of a new generation of diagnosis and procedure codes and updated standards for electronic health care and pharmacy transactions.

The first final rule replaces the ICD-9-CM code sets now used to report health care diagnoses and procedures with greatly expanded ICD-10 code sets, with a compliance date of Oct. 1, 2013. The second final rule adopts an updated X12 standard, Version 5010, for certain electronic health care transactions, an updated version of the National Council for Prescription Drug Programs (NCPDP) standard, Version D.0, for electronic pharmacy-related transactions, and a standard for Medicaid pharmacy subrogation transactions. Version 5010 includes updated standards for claims, remittance advice, eligibility inquiries, referral authorization, and other administrative transactions. Version 5010 also accommodates the use of the ICD-10 code sets, which are not supported by Version 4010/4010A1, the current X12 standard.

"These regulations will move the nation toward a more efficient, quality-focused health care system by helping accelerate the widespread adoption of health information technology," HHS Secretary Mike Leavitt said. "The greatly expanded ICD-10 code sets will fully support quality reporting, pay-for-performance, bio-surveillance, and other critical activities. The updated X12 transaction standards, Version 5010, provide the framework needed to support the ICD-10 codes."

The ICD-10 rule titled "HIPAA Administrative Simplification: Modifications to Medical Data Code Set Standards to Adopt ICD–10–CM and ICD–10–PCS" is available in text format at http://edocket.access.gpo.gov/2009/E9-743.htm and in pdf format at http://edocket.access.gpo.gov/2009/pdf/E9-743.pdf.

The updated X12 transaction standards, version 5010, rule titled "Health Insurance Reform; Modifications to the Health Insurance Portability and Accountability Act (HIPAA) Electronic Transaction Standards" is available in text format at http://edocket.access.gpo.gov/2009/E9-740.htm and in pdf format at http://edocket.access.gpo.gov/2009/pdf/E9-740.pdf.

A fact sheet describing both rules may be viewed on the CMS Web site.

FORMS

Updated Refunds to Medicare Form

As of February 16, 2009, the Refunds to Medicare form located at https://www.noridianmedicare.com/dme/forms/docs/ref_med_dme.pdf has been updated.

To streamline processing of returns and partial claims adjustments, two new required fields have been added under the Items Returned reason code. The fields are titled "HCPCS code" and "Quantity." These fields must be completed when requesting a partial claim adjustment.

Failure to provide this information may lead to delays in processing, a request to resubmit the Refunds to Medicare - DME form with the full information, or, at contractor discretion, the entire claim may be recouped and the supplier requested to re-submit a corrected claim.

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."

APPEALS

What Can and Can Not be Completed as a Reopening – Clarification

Is this effective now? Yes, effective now. Are we loosening up or tightening up? Loosening Suppliers may now request reopenings to change the units for negative pressure wounds, surgical dressings, and wound covers/compression stockings as long as the changes are allowed within the policy. Utilization beyond what the policy states must be sent in as a redetermination with supporting documentation.

Reopenings are separate and distinct from the appeals process. Reopenings are a discretionary action on the part of the contractor to correct a clerical error or omission. A contractor's decision to reopen a claim is not an initial determination and is therefore not appealable.

What Can be Done as a Reopening
The following is a list of clerical errors and omissions that can be completed as a telephone or written reopening. This list is not all-inclusive.

- Diagnosis changes/additions
- Date of service changes (except for the year)
- Procedure code changes
- CMN/DIF Updates (with the exception of parenteral and enteral nutrition, which must be done as a written redetermination and oxygen Break In Service (BIS) which can only be done as a written reopening)
- Certain modifier changes/additions (not all inclusive list):
  - KH - DMEPOS item, initial claim, purchase or first month
  - KI - DMEPOS item, second or third month rental
  - KJ - DMEPOS item, parenteral enteral nutrition (PEN) pump or capped rental, months four to fifteen
  - KX - Specific required documentation on file
  - RR - Rental
- Surgical Dressing (when number of services are within the policy-if the request is to allow over the policy amount, these must go to written redeterminations)
- Wheelchairs/Power Mobility Devices - HCPCS K0004 and lower

Disclaimer: If any of the above changes, upon research, are determined to be too complex, the requestor will be notified that the request needs to be sent in writing, with the appropriate documentation, as a redetermination.

What Can Not be Done as a Reopening
The following issues must be requested and completed as a redetermination rather than a telephone or written reopening.

- Any item billed over the allowance listed in the medical policy-documentation is required to support amount billed
- Parenteral and Enteral CMN/DIF issues
- Oxygen Break in Service (BIS)
- Wheelchairs/Power Mobility Devices - HCPCS K0005 and higher
- Recoupment/Reduction of payment - Complete Refunds to Medicare Form
- Medicare Secondary Payer (MSP)-send inquiry to MSP Department
- Timely Denials
- Late Files
- Requests that require documentation
- ABN Issues
- GA/GY/GZ Modifiers
- Liability Issues
- Repairs to equipment
- Miscellaneous codes

Claims with remittance message MA130 can never be submitted as a reopening. Claims with message MA130 are considered unprocessable. The claim is missing information that is needed for processing the claim or the claim information is invalid. Unprocessable claims do not have reopening or redetermination rights and must be corrected and submitted as a new claim.

Change in Amount in Controversy Requirement for Administrative Law Judge Hearings and Federal District Court Appeals

MLN Matters Number: MM6295
Related Change Request (CR) #: 6295
Related CR Release Date: January 30, 2009
Related CR Transmittal #: R1676CP
Effective Date: May 4, 2009
Implementation Date: May 4, 2009

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

Provider Action Needed
This article is based on Change Request (CR) 6295, which notifies Medicare contractors of the Amount in Controversy (AIC) required to sustain Administrative Law Judge (ALJ) and Federal District Court appeal rights beginning January 1, 2009.

The amount remaining in controversy requirement for ALJ hearing requests made before January 1, 2009, is $120. The amount remaining in controversy requirement for requests made on or after January 1, 2009, is $120.

For Federal District Court review, the amount remaining in controversy goes from $1,180 for requests on or after January 1, 2008, to $1,220 for requests on or after January 1, 2009.

Background
The Medicare claims appeal process was amended by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA). CR 6295 modifies the *Medicare Claims Processing Manual* (Publication 100-4, Chapter 29, Section 330.1 and Section 345.1) to update the AIC required for an ALJ hearing or judicial court review.

Additional Information
The official instruction (CR6295) issued to your Medicare Carrier, A/B MAC, DME MAC, FI, and/or RHHI is available at http://www.cms.hhs.gov/Transmittals/downloads/R1676CP.pdf on the CMS Web site.

CMS Announces Surety Bond Requirements for DMEPOS Suppliers

On December 29, 2008, the Centers for Medicare & Medicaid Services (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 or changing the ownership of a DMEPOS supplier must submit a $50,000 surety bond for each assigned NPI for which the DMEPOS supplier is seeking to obtain Medicare billing privileges. Existing DMEPOS suppliers must submit to the NSC a $50,000 surety bond for each assigned NPI no later than October 2, 2009.

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

The final regulations are effective March 3, 2009. 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 information or to view the regulation in its entirety, visit http://edocket.access.gpo.gov/2009/pdf/E8-30802.pdf.

CMS Announces Regulatory Revisions Pertinent to Suppliers of DMEPOS

Recently, CMS released Change Request 6282 (CR 6282) announcing regulatory revisions pertinent for suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS). CR 6282 reinforced supplier time frames for submitting developmental information to the NSC for application processing as well as stressed the effective dates of certain type of revocations. In addition CR 6282 informed DMEPOS suppliers that the NSC will maintain alert codes received from the DME MACs and the Program Integrity Contractors. Suppliers exempted from accreditation are reminded that products/services that fall outside of the scope of specialty will require accreditation to obtain/maintain Medicare billing privileges.

Incorporation of Recent Regulatory Revisions Pertinent to Suppliers of DMEPOS

MLN Matters Number: MM6282
Related Change Request (CR) #: 6282
Related CR Release Date: December 31, 2008
Related CR Transmittal #: R280PI
Effective Date: February 2, 2009
Implementation Date: February 2, 2009

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

Provider Action Needed
This article is informational in nature and based on Change Request (CR) 6282 which incorporates recent regulatory changes and applicable instructions for the National Supplier Clearinghouse – Medicare Administrative Contractor (NSC-MAC) into the *Medicare Program Integrity Manual* (Chapter 10 (Healthcare Provider/Supplier Enrollment)).

Background
The *Medicare Program Integrity Manual* (Chapter 10) specifies the procedures Medicare fee-for-service contractors must use to establish and maintain provider and supplier enrollment in the Medicare program. Change Request (CR) 6282 incorporates National Supplier Clearinghouse – Medicare Administrative Contractor (NSC-MAC) instructions into the *Medicare Program Integrity Manual*, Chapter 10 (Healthcare Provider/Supplier Enrollment), Section 21 (Special Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Instructions).

These NSC-MAC instructions evolved from recent regulatory revisions regarding the following topics:

- The timeframe in which providers and suppliers must furnish developmental information to the NSC-MAC;
- Effective dates of certain types of revocations;
- Alert codes; and
- Accreditation.

A complete description of these NSC-MAC instructions/topics is included as an attachment to CR 6282, and the following provides a summary:

1. The timeframe in which providers and suppliers must furnish developmental information to the contractor

A Medicare contractor (including the NSC-MAC) may reject a provider/supplier's application if the provider/supplier fails to furnish complete information on the enrollment application, including all supporting documentation, within 30 calendar days from the date of the contractor's request for the missing information or documentation.

The 30-day clock starts on the date the pre-screening letter was sent to the provider/supplier. If the contractor makes a follow-up request for information, the 30-day clock does not start anew; rather, it keeps running from the date the pre-screening letter was sent. To illustrate, suppose that the contractor sent out a pre-screening letter on March 1 (thus triggering the 30-day clock) that asked for clarifying information in Sections 4 and 5 of the CMS-855B. (All supporting documentation was provided.) The provider sent in most, but not all of the requested data. Though not required to make an additional contact beyond the pre-screening letter, the contractor telephoned the provider on March 20 to request the remaining missing data. The provider failed to respond. The contractor can reject the application on March 31, which is 30 days after the initial request.

2. Effective dates of certain types of revocations

A revocation is effective 30 days after the Centers for Medicare & Medicaid Services (CMS) or the Medicare contractor (including the NSC-MAC) mails the notice of its determination to the provider or supplier. However, a revocation based on a Federal exclusion or debarment is effective with the date of the exclusion or debarment. In addition, if the revocation was due to the revocation or suspension of the provider/supplier's license or certification to perform Medicare services, said revocation can be made retroactive to the date of the license suspension/revocation.

3. Alert codes

The NSC-MAC will receive and maintain "alert indicators" based on findings from the DME-MACs as well as on information received from Medicare's Program Integrity contractors.

4. Accreditation

The NSC-MAC will follow the accreditation requirements in the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA). Individual medical practitioners, inclusive of group practices of same, will not currently require accreditation for enrollment. The practitioner types are those specifically stated in Sections 1848(K)(3)(B) and 1842(b)(18)(C) of the Social Security Act as Amended. In addition, the practitioner categories of physicians, orthotists, prosthetists, optometrists, opticians, audiologists, occupational therapists, physical therapists and suppliers who provide drugs and pharmaceuticals (only) will not currently require accreditation for enrollment.

Suppliers that fall in this subset who provide other durable medical equipment outside of their specialty are required to be accredited to bill Medicare as a DMEPOS supplier. DMEPOS companies that are owned by any exempted individuals are NOT exempt from accreditation. For example, physicians are exempt from accreditation requirements for supplies they provide to their physician practice patients; however, if a physician owns a DMEPOS company, that company is NOT exempt from accreditation. Similarly, suppliers that provide only drugs and pharmaceuticals are exempt from the accreditation requirement; however, if the supplier provides equipment to administer drugs or pharmaceuticals, the supplier must be accredited.

If a previously exempted supplier enrollment application was returned for non-accreditation, the supplier must resubmit its CMS 855S Medicare enrollment application to the NSC to obtain/maintain Medicare billing privileges.

Additional Information
The official instruction, CR 6282, issued to your DME MAC regarding this change may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R280PI.pdf on the CMS Web site.

New Repair and Replacement Modifiers

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

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

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

Please report the appropriate modifier on claims in 2009.

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

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

Claims will need to be resubmitted with the correct modifier.

Replacement – RA Modifier Clarification

NAS has seen an increase in claims where the RA modifier is used inappropriately. The RA modifier is described as replacement of a DME item, due to loss, irreparable damage, or when the item has been stolen.

The meaning of the replacement modifier has not changed and the following rules still apply:

- The RA modifier should only be used on the first month rental claim for a replacement item.
- A narrative explaining the reason for the replacement, if it happens prior to the useful lifetime of the item being reached, i.e., five years for most DMEPOS, is required on the claim.
- A new order or Certificate of Medical Necessity (CMN), if applicable, is required.

If the RA modifier is reported inappropriately, the claim will be denied as unprocessable with remark code M51: Missing/incomplete/invalid procedure code. These claims will need to be resubmitted.

For further clarification, please refer to the following What's New articles:

- New Repair and Replacement Modifiers - Posted on December 31, 2008
- New Repair and Replacement Modifiers – Clarification - Posted January 13, 2009.

Repair Labor Billing and Payment Policy

Effective for dates of service on or after April 1, 2009, the Durable Medical Equipment Medicare Administrative Contractors (DME MACs) are instituting a billing and payment policy for common repairs based on standardized labor times. This applies to non-rented and out-of-warranty items. This effective date coincides with the effective date of the new code for repairs for non-oxygen equipment – K0739 (REPAIR OR NONROUTINE SERVICE FOR DURABLE MEDICAL EQUIPMENT OTHER THAN OXYGEN REQUIRING THE SKILL OF A TECHNICIAN, LABOR COMPONENT, PER 15 MINUTES). One unit of service = 15 minutes. Code E1340 is no longer valid for repairs for dates of service on or after April 1, 2009.

The following table contains repair units of service allowances for commonly repaired items. Units of service include basic troubleshooting and problem diagnosis. Suppliers are reminded that there is no Medicare payment for travel time or equipment pick-up and/or delivery.

Type of Equipment	Part Being Repaired/Replaced	Allowed Units of Service (UOS)
Power Wheelchair	Batteries (includes cleaning and testing)	2
Power Wheelchair	Joystick (includes programming)	2
Power Wheelchair	Charger	2
Power Wheelchair	Drive wheel motors (single/pair)	2/3
Power or Manual Wheelchair	Wheel/Tire (all types, per wheel)	1
Power or Manual Wheelchair	Armrest or armpad	1
Power Wheelchair	Shroud/cowling	2
Manual Wheelchair	Anti-tipping device	1
Hospital Bed	Pendant	2
Hospital Bed	Headboard/footboard	2
CPAP	Blower Assembly	2
Seat Lift	Hand Control	2
Seat Lift	Scissor mechanism	3
Patient Lift	Hydraulic Pump	2

Suppliers may only bill the allowable units of service listed in the above table for each repair, regardless of the actual repair time. Claims for repairs must include narrative information itemizing each repair and the time taken for each repair. Suppliers are also reminded that Medicare does not pay for repairs to capped rental items during the rental period or items under warranty.

Supplies and Accessories Used with Beneficiary Owned Equipment

Effective for claims submitted on or after April 1, 2009, for supplies and accessories used with beneficiary-owned equipment, all of the following information must be submitted 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 of whether the patient owns the equipment that requires the part or supply.

Medicare requires that supplies and accessories only be provided for equipment that meets the existing coverage criteria for the base item. In addition, should the supply or accessory have additional, separate criteria, these must be met also. 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.

Bill NDC Code for Oral Anticancer Drugs-Reminder

Suppliers are reminded that when billing oral anticancer drugs that only the National Drug Code (NDC) must be reported on the claim, rather than the corresponding HCPCS code or other code identifiers. This applies to the following oral anticancer drugs:

- Busulfan
- Capecitabine
- Cyclophosphamide
- Etoposide
- Melphalan
- Methotrexate
- Temozolomide
- Topotecan*

*The NDC for Topotecan is not yet ready to be processed by the DME claims processing system, therefore this oral drug should be billed as J8999. Include the name of the drug, manufacturer, NDC # and number of tablets or capsules dispensed in Item 19 for paper claims or the NTE segment for electronic claims when billing Topotecan.

The NDC is an 11-digit number, which uniquely identifies a manufacturer's product in terms of the strength of each tablet/capsule, quantity of tablets/capsules in a package, and other packaging details. Suppliers must use the NDC that matches the product dispensed. Most manufacturer packages have 10 digits so a zero should be added to the front for billing to Medicare to meet the 11-digit NCD requirement.

For all NDC numbers, 1 unit of service = 1 tablet or 1 capsule.

A list of valid NDC numbers for covered oral anticancer drugs can be found on the Pricing Data Analysis and Coding (PDAC) contractor's Web site, https://www.dmepdac.com/, in the OACD (oral anticancer drug) section. Suppliers should contact the PDAC contractor for guidance on the correct coding of these items.

NDCs may be billed only when the drug is used as an oral anticancer drug. If cyclophosphamide or methotrexate is prescribed as an oral immunosuppressive drug following an organ transplant, code J8530 or J8610 respectively must be used. (Refer to the Immunosuppressive Drugs policy for additional information.) If cyclophosphamide or methotrexate is prescribed as an oral immunosuppressive drug for other conditions, e.g., lupus, rheumatoid arthritis, etc., a claim should not be submitted to Medicare (unless requested by the beneficiary) because there is no statutory benefit for oral immunosuppressive drugs in these conditions.

Oral anticancer drugs which are not covered under the oral anticancer drug benefit, i.e., those that are not specifically listed above, must be billed using code A9270 (noncovered item or service) if the supplier chooses to submit a claim.

If billing oral anticancer drugs, using the NCPDP format, refer to the NCPDP Companion Document available on the CMS Web site.

Sources: Oral Anticancer Drug LCD (L11574) and Oral Anticancer Policy Article (A25372)

Claim Status Category Code and Claim Status Code Update

MLN Matters Number: MM6325
Related Change Request (CR) #: 6325
Related CR Release Date: January 16, 2009
Related CR Transmittal #: R1670CP
Effective Date: April 1, 2009
Implementation Date: April 6, 2009

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

Provider Action Needed
Change Request (CR) 6325, from which this article is taken, reminds providers of the periodic updates to the Claim Status Codes and Claim Status Category Codes that Medicare contractors use with the Health Care Claim Status Request (ASC X12N 276), and the Health Care Claim Response (ASC X12N 277).

BILLING CONT'D

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

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

CR 6325 updates the changes in the Claim Status Codes and Claim Status Category Codes from the September, 2008 committee meeting. These updates were posted at http://www.wpc-edi.com/content/view/180/223/ on November 1, 2008. Medicare contractors must have completed the entry of all applicable code text changes and new codes, and terminated the use of deactivated codes by April 6, 2009. On and after this date, these code changes are to be used in editing of all X12 276 transactions processed and must be reflected in the X12 277 transactions issued.

Additional Information
The official instruction (CR6325) issued to your Medicare MAC, carrier, DME MAC, FI, and/or RHHI is available at http://www.cms.hhs.gov/Transmittals/downloads/R1670CP.pdf on the CMS Web site.

New CWF MSP Type for WCMSAs to Stop Conditional Payments

MLN Matters Number: MM5371
Related Change Request (CR) #: 5371
Related CR Release Date: January 9, 2009
Related CR Transmittal #: R1665CP
Effective Date: July 1, 2009
Implementation Date: July 6, 2009

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

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

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

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

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

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

Additional Information
You can find the official instruction, CR 5371, issued to your Medicare contractor at http://www.cms.hhs.gov/Transmittals/downloads/R1665CP.pdf on the CMS Web site.

OXYGEN

Oxygen and Oxygen Equipment Changes – New Web Page

NAS DME has added a Web page dedicated to the many changes currently affecting oxygen and oxygen equipment.

This new page is on the News/Publications tab, under Upcoming Changes. It contains information on what happens during and after the 36-month rental period, beneficiary issues, replacement of equipment, changes of equipment during the reasonable useful lifetime period, continuous use, and proof of delivery. This page also contains a list of resources available to suppliers on these topics.

As new information is provided from CMS, updates will be made to the Oxygen and Oxygen Equipment Changes page.

Medicare Billing Requirements and Policies for Replacement of Oxygen Equipment and Oxygen Contents

This joint signature memorandum/technical direction letter (JSM/TDL) provides instructions for processing claims for oxygen and oxygen equipment following the enactment of MIPPA.

MIPPA was enacted on July 15, 2008. Section 144(b) of MIPPA repeals the requirement that the supplier transfer title to oxygen equipment to the beneficiary after the 36 month rental period. Section 144(b) also establishes new payment rules and supplier responsibilities following the 36 month payment cap. The Centers for Medicare & Medicaid Services (CMS) implemented Section 144(b) through an Interim Final Rule with Comment published on November 19, 2008. Section 144(b) and the regulations became effective on January 1, 2009.

New Healthcare Common Procedure Coding System (HCPCS) Modifiers
Effective January 1, 2009, the following two new modifiers were added to the HCPCS:

RA – Replacement of a DME item;

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

HCPCS modifiers RA and RB replace modifier RP (descriptor below), which was discontinued effective December 31 2008, but remains in effect for claims with dates of service prior to January 1, 2009.

RP – Replacement and Repair - RP may be used to indicate replacement of DME, orthotic and prosthetic devices which have been in use for sometime. The claim shows the code for the part, followed by the 'RP' modifier and the charge for the part.

Additional instructions regarding implementation of HCPCS modifiers RA and RB will be provided in future program instructions.

Replacement of Oxygen Equipment
If 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 patient may elect to obtain a new piece of equipment. Irreparable damage refers to a specific incident of damage to equipment such as equipment falling down a flight of stairs as opposed to equipment that is worn out over time. In these situations, a new 36-month rental period and new reasonable useful lifetime is started on the date that the new, replacement item is furnished. 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 HCPCS modifier depending on the date that the equipment is furnished.

Suppliers must include on the claim for the first month of use a narrative explanation of the reason why the equipment was replaced and supporting documentation must be maintained in the supplier's files. For example, if equipment is stolen, the supplier should keep a copy of the police report in its files. For lost or irreparably damaged equipment, the supplier should maintain any documentation that supports the narrative account of the incident. For reasonable useful lifetime replacements, the narrative explanation should include the date that the beneficiary received the equipment being replaced.

Contractors shall process claims for replacement oxygen equipment in these situations that are submitted by suppliers using the HCPCS Code for the oxygen equipment and HCPCS modifier RA on claims with dates of service on or after January 1, 2009. Contractors shall process claims for replacement oxygen equipment in these situations that are submitted by suppliers using the HCPCS Code for the oxygen equipment and HCPCS modifier RP on claims with dates of service prior to January 1, 2009.

When submitting claims electronically for replacement of oxygen equipment, suppliers may use, for the narrative explanation, loop 2400 (line note), segment NTE02 (NTE01=ADD) of the ASC X12, version 4010A1 professional electronic claim format. In addition, contractors shall instruct suppliers billing using the Form CMS-1500 paper claim that they may report this information in Item 19 of the claim form. When submitting claims electronically for replacement of oxygen equipment, home health agencies may use, for the narrative explanation, loop 2300, segment NTE (billing note) of the ASC X12, version 4010A1 institutional electronic claim format. In addition, contractors shall instruct home health agencies billing using the UB-04 paper claim that they may report this information in Form Locator 80 (Remarks).

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. New testing, however, is not required unless it is necessary, in order to meet existing medical review guidelines for oxygen and oxygen equipment. Contractors should continue to follow the existing guidelines for requiring recertification CMNs for all situations in which oxygen equipment is being replaced. The most recent qualifying value and testing date should be entered on the CMN. (See Section 100.2.3 of Chapter 20 of the *Claims Processing Manual* (Pub. 100-04)).

Contractors shall bypass the ViPS Medicare System (VMS) Edits, if necessary, to allow these claims to pay if the narrative adequately describes the need for replacement due to an incident of loss, theft, or irreparable damage. As is the case for all DME items, suppliers must maintain proof-of-delivery documentation in their files for replacement oxygen equipment. (See Section 5.8 of Chapter 5 of the *Program Integrity Manual* (Pub. 100-08)). In addition, for equipment that is being replaced because it has been in continuous use by the beneficiary for the reasonable useful lifetime and the beneficiary has elected to obtain new equipment, the supplier must also have proof-of-delivery documentation in their files for the item being replaced that documents that the oxygen equipment has been in use for at least 5 years.

Change in Oxygen Equipment During the Reasonable Useful Lifetime Period

The reasonable useful lifetime for stationary or portable oxygen equipment begins when the oxygen equipment is first delivered to the beneficiary and continues until the point at which the stationary or portable oxygen equipment has been used by the beneficiary on a continuous basis for 5 years. Computation of the reasonable useful lifetime is not based on the age of the equipment. If there is a change in oxygen equipment modalities (e.g., from a concentrator to a stationary liquid oxygen system) prior to the end of the reasonable useful lifetime period, this does not result in the start of a new reasonable useful lifetime period or a new 36 month payment period. In addition, if oxygen equipment that is not functioning properly has to be replaced prior to the end of the reasonable useful lifetime period, this does not result in the start of a new reasonable useful lifetime period or a new 36 month payment period. Finally, if the beneficiary switches to a new supplier and new equipment prior to the end of the reasonable useful lifetime period, this does not result in the start of a new reasonable useful lifetime period or a new 36 month payment period. A beneficiary may elect to obtain new oxygen equipment at the end of the 5 year reasonable useful lifetime period in these situations.

Clarification of Policy Regarding Continuous Use of Oxygen and Oxygen Equipment

The instructions pertaining to payments for capped rental items during a period of continuous use now apply to the monthly payment amounts for oxygen and oxygen equipment and the portable oxygen equipment add-on payments. (See Section 30.5.4 of Chapter 20 of the *Claims Processing Manual* (Pub. 100-04)).

A period of continuous use allows for temporary interruptions in the use of the equipment. For breaks in need (beneficiary no longer needs or uses the equipment) of less than 60 days plus the days remaining in the last paid rental month, the period of continuous use does not start over and so the count of continuous months picks up where it left off before the break. For example, if the last paid rental month is month #31 and there is a 50 day break in need, the next paid rental month would be month #32.

If, however, there is a break in need more than 60 days plus the days remaining in the last paid rental month, and the need for the equipment resumes at a later date, a new period of continuous use, a new 36-month payment period, and a new reasonable useful lifetime period would begin provided that:

1. The supplier submits new medical necessity documentation and a narrative explaining why there was a break in need for the equipment; and
2. The contractor determines that there was a break in need of greater than 60 days plus the days remaining in the last paid rental month followed by a resumption in medical necessity for the oxygen equipment.

If medical necessity for the equipment continues during a break in billing/Part B payment (e.g., the beneficiary is hospitalized for 70 days but continues to use oxygen equipment during the hospital stay), which is not a break in need, then a new period of continuous use does not begin.

As is currently done for other capped rental DME, contractors shall require new medical necessity documentation (i.e., a new CMN and retesting) for oxygen and oxygen equipment and portable oxygen equipment whenever there is an interruption in medical need that is greater than 60 days plus the days remaining in the last paid month.

The supplier must submit a narrative explanation describing the reason for the interruption which shows that medical necessity in the prior episode ended. When submitting claims electronically for replacement of oxygen equipment, suppliers may use, for the narrative explanation, loop 2400 (line note), segment NTE02 (NTE01=ADD) of the ASC X12, version 4010A1 professional electronic format. In addition, contractors should instruct suppliers billing using the Form CMS-1500 paper claim that they may report this information in Item 19 of the claim form. When submitting claims electronically for replacement of oxygen equipment, home health agencies may use, for the narrative explanation, loop 2300, segment NTE (billing note) of the ASC X12, version 4010A1 institutional electronic claim format. In addition, contractors should instruct home health agencies billing using the UB-04 paper claim that they may report this information in Form Locator 80 (Remarks). Suppliers and home health agencies are not to use modifier RA on these claims.

If the supplier does not submit this documentation, a new 36-month payment period does not begin.

Processing Oxygen Equipment Claims Containing the RA or RP Modifier

The coding changes needed to implement the new policies established in this JSM/TDL for use of the RA and RP modifiers when submitting claims for replacement of oxygen equipment will not be made until a future release of the shared system. Therefore, until receiving further notice, contractors shall manually process claims for HCPCS Codes E0424, E0431, E0434, E0439, E1390, E1391, E1392, or K0738 that are submitted with either modifier RP (Date of Service (DOS) prior to January 1, 2009) or RA (DOS on or after January 1, 2009). Additional instructions will be issued in the near future to clarify what further actions are needed to process oxygen equipment replacement claims.

Payment for Oxygen Contents (General Policy)

Section 144(b) of MIPPA mandates that Medicare payment for oxygen contents used with liquid or gaseous oxygen equipment (stationary or portable) continue after the 36-month rental cap. The supplier who furnished the liquid or gaseous oxygen equipment during the 36-month rental period is responsible for furnishing the oxygen contents used with the supplier-owned oxygen equipment for any period of medical need following the 36-month rental cap for the remainder of the reasonable useful lifetime of the equipment. In addition, monthly payment for oxygen contents for beneficiary-owned liquid or gaseous oxygen equipment (stationary or portable) shall continue to be made in accordance with existing program instructions in Section 30.6.3 of Chapter 20 of the *Medicare Claims Processing Manual* (Pub.100-04). Suppliers shall continue to use HCPCS Codes E0441 through E0444 in order to bill and receive payment for furnishing oxygen contents. (See Transmittal 421, Pub. 100-20, Change Request (CR) 6297, issued on December 23, 2008).

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

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

* Please note that the descriptors for HCPCS Codes E0441 through E0444 reflect older policies and regulations and need to be revised to reflect current policies and regulations.

If the beneficiary began using portable gaseous or liquid oxygen equipment (E0431 or E0434) more than one month after they began using stationary oxygen equipment, monthly payments for portable gaseous or liquid oxygen contents (E0443 or E0444) may begin following the stationary oxygen equipment payment cap AND prior to the end of the portable equipment payment cap (Code E0431 or E0434). As long as the beneficiary is using covered gaseous or liquid portable oxygen equipment, payments for portable oxygen contents may begin following the stationary oxygen equipment payment cap. This will result in a period during which monthly payments for E0431 and E0443, in the case of a beneficiary using portable gaseous oxygen equipment, or E0434 and E0444, in the case of a beneficiary using portable liquid oxygen equipment, overlap. In these situations, after the 36-month portable oxygen equipment payment cap for E0431 or E0434 is reached, monthly payments for portable oxygen contents (E0443 or E0444) would continue.

If the beneficiary began using portable gaseous or liquid oxygen equipment (E0431 or E0434) following the 36-month stationary oxygen equipment payment period, payments may be made for both the portable equipment (E0431 or E0434) and portable contents (E0443 or E0444). Contractors shall by-pass the VMS Edits, if necessary, to allow claims for portable oxygen contents to pay in these situations.

In all cases, separate payment for oxygen contents (stationary or portable) would end in the event that a beneficiary receives new stationary oxygen equipment and a new 36-month stationary oxygen equipment payment period begins (i.e., in situations where stationary oxygen equipment is replaced because the equipment has been in continuous use by the patient for the equipment's reasonable useful lifetime or is lost, stolen, or irreparably damaged). Again, the monthly payment for stationary oxygen equipment includes payment for both stationary and portable oxygen contents. Therefore, under no circumstances should a supplier receive both the monthly stationary oxygen equipment payment and payment for either stationary or portable oxygen contents.

Contractors shall continue to follow the instructions provided in Business Requirements 5268.1-5268.1.2 for applying the 36-month payment cap for stationary oxygen equipment claims. (See Transmittal 1097, Pub. 100-04, CR 5268, issued on November 1, 2006.)

Proof-of-Delivery Requirements for Oxygen Contents
Following the stationary oxygen equipment payment cap, suppliers should bill for oxygen contents (stationary and/or portable in accordance with the chart above) on the anniversary date of the oxygen equipment billing.

For example, if the 36th month of continuous use of the stationary oxygen equipment begins on March 11th and ends on April 10th, the supplier should begin billing for monthly oxygen contents that the beneficiary will use after the cap on April 11th.

For subsequent months, the supplier does not need to deliver the oxygen contents every month in order to continue billing for the contents on a monthly basis. A maximum of 3 months of oxygen contents can be delivered at one time. In these situations, the delivery date of the oxygen contents does not have to be the DOS (anniversary date) on the claim. However, in order to bill for contents for a specific month, the supplier must have previously delivered quantities of oxygen that are sufficient to last for one month following the date of service on the claim. Suppliers should have proof-of-delivery for each actual delivery of oxygen - but as discussed above this may be less often than monthly.

For example, if the supplier delivers 30 oxygen tanks on April 11th and the beneficiary only uses 15 tanks from April 11th through May 10th and 15 tanks from May 11th through June 10th, the supplier can bill for contents on April 11th and again on May 11th for contents delivered on April 11th that were used for two months.

A Change Request and a MLN Matters will be forthcoming that will incorporate the information contained in this message.

Oxygen – Certificates of Medical Necessity – Replacement Equipment

On January 1, 2009, CMS implemented statutory provisions defining a new payment policy for home oxygen. Payment for oxygen equipment is now made for a 36-month rental period. The supplier retains title to the equipment at the end of this rental period but is required to continue to provide the oxygen equipment and contents (when applicable) for the duration of the 5-year reasonable useful lifetime (RUL) of the oxygen equipment. Multiple recent publications have addressed the details of the new payment policy. This article addresses the use of the Oxygen Certificate of Medical Necessity (CMN) in processing oxygen claims.

There are four general situations in which a new 36-month rental period is begun. In all of these situations a new Initial CMN is required:

1. Initial use of home oxygen.
2. Resumption of use of home oxygen when there has been a break in the medical necessity of oxygen (break-in-need) during the 36-month rental period, for at least 60 days plus the days remaining in the last paid rental month. (**Note A**: A break-in-billing/Part B payment [e.g., due to a hospital or nursing facility stay or enrollment in a Medicare HMO] does not begin a new 36-month rental period if use of oxygen continues during that time.) (**Note B**: During the time from the end of the 36-month rental period to the end of the RUL for the equipment, a new 36-month rental period does not start for either a break-in-need or a break in billing/Part B payment.)
3. Replacement because the RUL of prior equipment has been reached.
4. Replacement because of irreparable damage, theft, or loss of equipment. (**Note C**: Irreparable damage refers to a specific accident or to a natural disaster [e.g., fire, flood]. Irreparable damage does not refer to wear and tear over time.)

For situations 1 and 2, the requirements for an Initial, Recertification, and Revised CMNs that are stated in the current Oxygen and Oxygen Equipment local coverage determination (LCD) apply. However, for situations 3 and 4, there are some differences in the requirements related to the Initial and Recertification CMNs. There are no differences with respect to Revised CMNs.

Î. Initial CMN (for replacement equipment)

- Initial Date should be the date that the replacement equipment is initially needed. This is generally understood to be the date of delivery of the oxygen equipment.
- Blood gas study. Repeat testing is not required. Enter the most recent qualifying value and test date. This test does not have to be within 30 days prior to the Initial Date. It could be the test result reported on the most recent prior CMN. (Suppliers are reminded that in an audit they may be asked to provide a copy of the actual test report to verify that coverage criteria have been met.)
- Physician visit. There is no requirement for a physician visit that is specifically related to the completion of the CMN.

II. Recertification CMN (for replacement equipment)

- Recertification Date should be 12 months following the Initial Date when the value on the Initial CMN (for the replacement equipment) meets Group I criteria or 3 months following the Initial Date when the qualifying blood gas value on the Initial CMN meets the Group II criteria. (Note: The Initial Date [for the replacement equipment] should be entered on the Recertification CMN.)
- Blood gas study. Same instructions as for the Initial CMN for the replacement equipment.
- Physician visit. Same instructions as for the Initial CMN for the replacement equipment.

Suppliers are reminded that a written order is required when replacing equipment. The CMN may act as a substitute for a written order if it meets the requirements for a detailed written order.

Claims for the initial rental month (and only the initial rental month) must have the RA modifier (Replacement of DME item) added to the HCPCS code for the equipment when there is replacement due to reasonable useful lifetime or replacement due to damage, theft, or loss. The RA modifier is not used when billing for a new initial following a 60+ day break in need.

These changes will be incorporated in a future revision of the Oxygen LCD. For additional information on the use of CMNs refer to the Supplier Manual and the Oxygen and Oxygen Equipment LCD.

Payment for Repair, Maintenance and Servicing of Oxygen Equipment

MLN Matters Number: MM6296
Related Change Request (CR) #: 6296
Related CR Release Date: February 13, 2009
Related CR Transmittal #: R443OTN
Effective Date: April 1, 2009
Implementation Date: April 6, 2009

Provider Types Affected
Providers and suppliers submitting claims to Medicare DME Medicare Administrative Contractors (DME MACs), and/or Regional Home Health Intermediaries (RHHIs)) for repair, maintenance and servicing of oxygen equipment provided to Medicare beneficiaries

Provider Action Needed
This article is based on Change Request (CR) 6296 and alerts providers that the Centers for Medicare & Medicaid Services (CMS) is providing instructions regarding repair, maintenance, and servicing of oxygen equipment resulting from implementation of Section 144(b) of the MIPPA. The 36-month cap noted in MIPPA applies to stationary and portable oxygen equipment furnished on or after January 1, 2006. **Therefore, the 36-month cap may end as early as January 1, 2009, for beneficiaries using oxygen equipment on a continuous basis since January 1, 2006.**

OXYGEN CONT'D

CMS has determined that, for services furnished during calendar year 2009, it is reasonable and necessary to make payment for periodic, in-home visits by suppliers to inspect certain oxygen equipment and provide general maintenance and servicing after the 36-month rental cap. These payments only apply to equipment falling under HCPCS codes E1390, E1391, E1392, and K0738, and only when the supplier physically makes an in-home visit to inspect the equipment and provide any necessary maintenance and servicing. Payment may be made every 6 months, beginning 6 months after the 36-month rental cap (as early as July 1, 2009, in some cases), and the allowed payment amount for each visit is equal to the 2009 fee for code E1340 (K0739 for dates of service on or after April 1, 2009) multiplied by 2, for the state in which the in-home visit takes place.

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

CMS will issue further instructions in the future regarding continuation of these payments for dates of service on or after January 1, 2010.

Background
Section 144(b) of MIPPA repeals the transfer of ownership provision established by the Deficit Reduction Act (DRA) of 2005 for oxygen equipment and establishes new payment rules and supplier responsibilities after the 36-month payment cap. Initial instructions related to implementation of these changes were issued as part of the January 2009 Durable Medical Equipment Prosthetics Orthotics & Supplies (DMEPOS) Fee Schedule Update, CR 6297. The MLN Matters article related to CR6297 may be viewed at http://www.cms.hhs.gov/MLNMattersArticles/downloads/mm6297.pdf on the CMS Web site.

Key Points in CR6296
- To distinguish between the repair or nonroutine service of beneficiary-owned DME and oxygen equipment, two new "K" codes are effective for claims with dates of service on or after April 1, 2009. Those "K" codes are:
  - **K0739** – Repair or Nonroutine Service for Durable Medical Equipment Other than Oxygen Equipment Requiring the Skill of a Technician, Labor Component, Per 15 Minutes
  - **K0740** – Repair or Nonroutine Service for Oxygen Equipment Requiring the Skill of a Technician, Labor Component, Per 15 Minutes
- The new non-covered code K0740 should be used by suppliers to indicate the labor associated with the repair of stationary or portable oxygen equipment.
- The existing E1340 HCPCS code is invalid for Medicare claims, effective April 1, 2009. The revised 2009 labor payment rates, provided in CR 6297, map directly to the new K0739 code and will be used to pay claims for code K0739 with dates of service on or after April 1, 2009.
- **Note that the two new codes are not yet final and should not be used until effective on April 1, 2009.**
- DME MACs and RHHIs:
  - Deny claims with dates of service on or after April 1, 2009 for HCPCS code K0740.
  - Will deny claims with dates of service on or after January 1, 2009, for claims received on or after April 6, 2009, for replacement parts billed using a HCPCS code and the "RB" modifier when the part is replaced in conjunction with the repair of oxygen equipment identified by HCPCS codes E0424, E0431, E0434, E0439, E1390, E1391, E1392, E1405, E1406, or K0738.

Additional Information
For complete details regarding this Change Request (CR) please see the official instruction (CR 6296) issued to your Medicare DME MAC, or RHHI. That instruction may be viewed by going to http://www.cms.hhs.gov/Transmittals/downloads/R443OTN.pdf on the CMS Web site.

COVERAGE

Physician Letter – Therapeutic Shoes

The following letter may be used to assist in obtaining documentation from physicians on therapeutic shoes for diabetics.

NORIDIAN®
Administrative Services LLC

900 42nd Street South
Fargo, ND 58103

Medicare

January 2009

Therapeutic Shoes for Diabetics – Physician Documentation Requirements

Dear Physician,

Medicare covers therapeutic shoes and inserts for persons with diabetes. This statutory benefit is limited to one pair of shoes and up to three pairs of inserts or shoe modifications per calendar year. However, in order to qualify, the Medicare statute mandates specific coverage and documentation requirements that must be met.

The need for therapeutic shoes must be certified by a physician who is an M.D. or D.O. and who has the primary responsibility for treating the patient's systemic diabetes. This physician must:

1. Documentation in the patient's medical record that the patient has diabetes; and
2. Certify that the patient is being treated under a comprehensive plan of care for diabetes, and that the patient needs diabetic shoes; and
3. Document in the patient's medical record the presence of one or more of the following conditions:
   a. Previous amputation of the other foot, or part of either foot, or
   b. History of previous foot ulceration of either foot, or
   c. History of pre-ulcerative calluses of either foot, or
   d. Peripheral neuropathy and evidence of callus formation of either foot, or
   e. Foot deformity of either foot, or
   f. Poor circulation (i.e., small or large vessel arterial insufficiency) in either foot.

A new certification statement, signed and dated by the treating physician, must be provided on a yearly basis in order to obtain a new pair of shoes or inserts.

It is important to note that even though you may complete and sign a form attesting that all of the coverage requirements have been met, there also must be documentation in your records to indicate that you are managing the patient's diabetes and that one of the conditions listed in 3a – 3f is present. If requested by the supplier, you must provide copies of those records.

As with all items covered by Medicare, there must be a detailed written order for the items that are provided. The specifics of what is being provided may be entered by the supplier, but the physician must sign and date the order. Signature or date stamps are not acceptable. A new order is required yearly.

Although the requirements listed in 1-3 above must be documented by the M.D. or D.O. who has the primary responsibility for treating the patient's diabetes, the order could be provided by that physician or by a podiatrist, physician assistant, nurse practitioner, or clinical nurse specialist.

Physicians can access the complete Local Coverage Determination and Policy Article titled Therapeutic Shoes for Persons with Diabetes from the Noridian Administrative Services (NAS) web site at www.noridianmedicare.com/dme/. It may also be viewed in the national Medicare Coverage Database at www.cms.hhs.gov/mcd/search.asp.

Physicians are reminded that in order for these items to be reimbursed for your patients, the DME supplier will need to collect the medical documentation described above. Providing this documentation is in compliance with the HIPPA Privacy Rule. Also note that you may not charge the supplier or the beneficiary to provide this information. Please cooperate with the supplier so that they can provide the therapeutic shoes and inserts that are needed by your patient.

Sincerely,

Richard W. Whitten, MD, FACP
Medical Director, DME MAC, Jurisdiction D

CMS
CENTERS for MEDICARE & MEDICAID SERVICES