Jurisdiction D News from Noridian Administrative Services, LLC.

Happenings

November 2009
Issue No. 24

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

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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	888-408-7405
ADMC Requests/Documentation	877-662-8445
Medical Review Medical Documentation	866-465-0213
CERT Medical Documentation	877-436-4479

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

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

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

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

Holiday Schedule

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

2009 Holiday Schedule	
Thanksgiving	November 26 and 27, 2009
Christmas Eve **	December 24, 2009
Christmas Day	December 25, 2009
** Partial day closure	

Medicare Learning Network Matters Disclaimer Statement

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

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

Sources for "Jurisdiction D Happenings" Articles

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

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

Summary of Supplier Manual Updates

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

Chapter	Subheading	Supplier Manual Update	Change Date
13	Table	Changed "original claim decision" under Reconsideration and "redetermination request" under ALJ to "redetermination decision" and "reconsideration decision"	10/27/09
All	Jurisdiction D Supplier Manual	All chapters included in one PDF for September 2009	9/24/09
2	Supplier Standards	Removed Note	9/24/09
2	Surety Bond	Section added	9/24/09
3	Repairs and Replacement Charts	Split tables	9/24/09
3	Written Order Prior to Delivery	Updated items listed	9/24/09
3	ABN	Removed "-G" from ABN form name	9/24/09
4	Supporting Medical Documentation	Removed this sentence	9/24/09
4	CMN Common Scenarios	Changed 7 and 8 to "recertification" and "The recertification date should be the date of the physician visit" and removed 10 and 11	9/24/09
5	Repair HCPCS Codes	Removed E1340	9/24/09
5	Replacement Modifiers	Removed RP	9/24/09

6	Definition of an Upgrade	Change ABN link and CMS Web Site link	9/24/09
8	CEDI GenResponse Report	Added "These warnings provide notification to suppliers and vendors that it will soon become an error"	9/24/09
8	Electronic Report Package	Changed to "Within minutes"	9/24/09
8	Beneficiary Eligibility	Removed	9/24/09
8	Additional Options	Added Claim Status in Batch Mode (276/277)	9/24/09
8	Billing Software	Added PC-Ace Pro 32 and changed CEDI Helpdesk times	9/24/09
11	MSP Overpayment Refunds	Changed to "EOB from the third party"	9/24/09
11	Medicare Secondary Claim Filing Tips	Changed third bullet wording	9/24/09
13	Reopenings	Added "initial" to sentence	9/24/09
13	Redeterminations	Added definition of MA130 and "but are not limited to"	9/24/09

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

ADMC for Customized DME Acknowledgement Method Change

Starting October 12, 2009, NAS will no longer mail acknowledgement letters confirming the receipt of Advance Determination of Medicare Coverage (ADMC) requests. Suppliers will be able to call into the supplier contact center 3-5 business day after faxing or 5-7 business days after mailing an ADMC request, to confirm that NAS received the request.

This method change will allow our Medical Review Personnel a more focused approached in processing the requests and will dramatically increase our effectiveness in completing these within the 30 calendar day period.

Please call our Supplier Contact Center with any additional questions regarding the ADMC process or ADMC decisions at (866) 243-7272 or (866) 879-2704 (TTY/TTD).

CMS Issues Clarification on Surety Bond and Accreditation Exemptions for Optometrists

Optometrists who own their own optical shop and furnish only cataract glasses and cataract lenses are currently exempt from the requirements concerning bonding and accreditation. This applies even if there is an optician at the optical shop.

Source: National Supplier Clearinghouse

Enhancements/Updates to NPPES Effective On/After September 13, 2009

The following security enhancements will be incorporated into NPPES:

- **NPPES Web users will be required to select five secret questions and answers**. Upon implementation of this enhancement and upon successful login, NPPES Web users will be prompted to select five secret questions and provide answers to those questions. These five secret questions and answers will be saved and used for verification in order to allow NPPES Web users to reset their own passwords.
- **NPPES Web users will be prevented from changing their passwords more than once within 24 hours from the last password update**. Upon implementation of this enhancement, NPPES Web users will be required to wait 24 hours before attempting to change their passwords once they have already successfully reset their passwords.

Electronic File Interchange (EFI)

In addition, the EFI User Manual and Technical Companion Guide have been revised. The upcoming changes will not impact the EFI XML Schema.

FYI CONT'D

Additional Information

Health care providers can apply for an NPI online at https://nppes.cms.hhs.gov. Health care providers needing assistance with applying for an NPI or updating their data in NPPES records may contact the NPI Enumerator at 1-800-465-3203 or email the request to the NPI Enumerator at CustomerService@NPIEnumerator.com.

Not sure if you have already obtained an NPI or cannot remember your NPI, you can visit the NPI Registry at https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do to search for the information. The NPI Registry enables you to search for a provider's NPPES information, which includes the NPI. All information displayed in the NPI Registry is done so in accordance with the NPPES Data Dissemination Notice. Information in the NPI Registry is updated daily. You may run simple queries to retrieve this read-only data. For example, users may search for a provider by the NPI or Legal Name/Legal Business Name. There is no charge to use the NPI Registry.

Visit CMS' dedicated NPI Web page at http://www.cms.hhs.gov/NationalProvIdentStand for additional NPI education and information.

Beneficiaries Call 1-800-MEDICARE

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

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

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

Another great resource for beneficiaries is the Web site, http://www.medicare.gov/, where they can:

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

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

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

Revised ICD-10-CM/PCS: An Introduction Fact Sheet

The revised publication titled **ICD-10-CM/PCS: An Introduction Fact Sheet** (August 2009), which provides general information about the International Classification of Diseases, 10th Edition, Clinical Modification/Procedure Coding System (ICD-10-CM/PCS) including benefits of adopting the new coding system, structural differences between ICD-9-CM and ICD-10-CM/PCS, and implementation planning recommendations, is now available in print format from the Centers for Medicare & Medicaid Services **Medicare Learning Network**. To place your order, visit http://www.cms.hhs.gov/MLNGenInfo/, scroll down to "Related Links Inside CMS" and select "MLN Product Ordering Page." If you are unable to access the hyperlink in this message, please copy and paste the url into your Internet browser.

Influenza Pandemic Emergency – The Medicare Program Prepares

MLN Matters Number: SE0836 Rescinded

Note: The Centers for Medicare & Medicaid Services rescinded this article on September 11, 2009.

Ask the Contractor Teleconference for Small Suppliers

NAS is pleased to announce our upcoming schedule of **small supplier** teleconferences for 2007. CMS has defined a small supplier as a supplier with ten or fewer full time equivalent employees. 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 the teleconference the questions and answers (Q&A) from the teleconference will be posted to our web site. You can view the Q&A from the NAS home page by choosing Durable Medical Equipment > Training > Schedule of Events > Ask the Contractor Questions & Answers.

To participate in this ACT for **small suppliers**, dial 1-800-700-8174. For those suppliers who may need an international number (American Samoa, Guam or the Northern Mariana Islands) dial 1-651-291-0278.

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

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

Note: The teleconference will start promptly at 3:00 pm CT and will last up to 90 minutes. NAS encourages participants to place the call 15 minutes prior to the start of the teleconference.

Additional teleconferences for **small suppliers** will be held at 3:00 pm CT on:

- April 18, 2007
- June 20, 2007
- August 22, 2007
- October 24, 2007
- December 19, 2007

NAS looks forward to your participation in these **small supplier** teleconferences.

Small Supplier Ask the Contractor Teleconference Q & A – August 19, 2009

Prior to taking questions, NAS provided the following updates:

LCDs on NAS Web Site

Current, Draft, Future and Retired LCDs and Policy Articles are now easily accessible on the Coverage/MR tab of our DME Web site under Local Coverage Determinations. NAS provides the PDF version along with the effective date of each. Bookmark this page for quick and easy access. If the ForeSee Results survey displays while navigating our site, please take a few moments to let us know your thoughts on this new page. We review each comment and score submitted and appreciates supplier's feedback.

GA/GY/GZ/KX Modifier

Many policies use the KX modifier to indicate compliance with specified coverage criteria. The following LCDs have revised instructions on modifier use:

- Automatic External Defibrillators
- Cervical Traction Devices
- Commodes
- Epoetin
- High Frequency Chest Wall Oscillation Devices
- Home Dialysis Supplies and Equipment
- Hospital Beds
- Manual Wheelchair Bases
- Negative Pressure Wound Therapy
- Orthopedic Footwear
- Positive Airway Pressure Devices
- Power Mobility Devices
- Refractive Lenses
- Respiratory Assist Devices
- Therapeutic Shoes for Persons with Diabetes

Effective with these LCD revisions, the contractors will use the presence of a KX, GA, GZ or GY modifier to indicate whether the coverage criteria are or are not met. The revised information is contained in the Documentation Section and outlines the use of additional modifiers to indicate that an item is statutorily noncovered or not medically necessary and whether or not a waiver of liability statement (i.e., Advance Beneficiary Notice or ABN) is on file for an expected medical necessity denial. Review the entire LCD and each related Policy Article for complete information.

Remittance Advice Tutorial

There is a new Remittance Advice Tutorial located on the Claims page of our Web site to help you better understand your remittance advice. This tutorial has a hover and click feature. When hovering over a field, a brief description will display. By clicking on the field the full description will display. If you have any questions regarding the remittance advice, please reference this tutorial.

Competitive Bid

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

Surety Bond

On December 29, 2008, CMS announced regulations requiring certain DMEPOS suppliers of certain DMEPOS to post a surety bond as a condition of new or continued Medicare enrollment. The regulation states that beginning May 4, 2009, suppliers seeking to enroll or changing the ownership of a DMEPOS supplier must submit a $50,000 surety bond for each assigned NPI for which the DMEPOS supplier is seeking to obtain Medicare billing privileges. Existing DMEPOS suppliers must submit to the NSC a $50,000 surety bond for each assigned NPI no later than October 2, 2009.

In addition, a DMEPOS supplier enrolling a new practice location must submit to the NSC a new surety bond or an amendment or rider to the existing bond, showing the new practice location is covered by an additional base surety bond of $50,000. For more information on this topic, see the Surety Bond section on our Publications web page, listed under Upcoming Changes.

Q1. We submitted our accreditation application in January, had a survey in June, and were denied in July. I'm working on our denial issues so I can reapply but I don't think my accreditation will be complete by the September 30, 2009, deadline. Am I going to have to voluntarily terminate my supplier number before September 30th?

A1. The caller was referred to the NSC for assistance; however, the NSC recently posted an article titled "Accreditation and Surety Bond Deadlines Approaching for DMEPOS Suppliers," which is on our Web site on the Accreditation page under Publications.

By voluntarily terminating Medicare enrollment, suppliers preserve the right to re-enroll in Medicare once the requirements to participate in the Medicare program are met. If a supplier does not comply with the accreditation and surety bond requirements and does not submit a voluntary termination, Medicare billing privileges will be revoked. A revocation will bar the supplier from re-enrolling in Medicare for at least one year after the date of revocation.

Follow-up Question: Are there only specific surety bond carriers that must be used or can we choose any company offers a surety bond?

A. There are several surety bond companies approved for use by CMS as listed on the Department of Treasury's Web site at http://www.fms.treas.gov/c570/c570_a-z.html. Also, on our Web site, on the Publications tab, we have a page dedicated to surety bonds that includes information and resources.

Q2. Can neurosurgeons who treat patients for multi-level fusions prescribe an osteogenesis stimulator (E0748) and bill DME without violating any Medicare rules?

A2. NAS is not in the position to give legal advice. Dr. Whitten contacted this supplier and suggested discussing this with the supplier's own council a neurosurgery association.

Follow-up Question: Because NAS is processing and paying these claims, is that sufficient ground to indicate this is okay?

A. Just because a claim is paid does not mean the Medicare rules were followed in ordering and providing an item.

Q3. If a patient becomes compliant with a Positive Airway Pressure (PAP) device one day after the 90-day trial, does Medicare require the patient go through another sleep study, including another face-to-face evaluation, because they weren't technically compliant until after the 90-day trial?

A3. Yes. The trial period is the first three months. If the patient is not adhering to therapy, which is four hours, 70% of 30 consecutive days, then the patient fails the trial period. If the physician's visit occurs after the 91st day, the patient is compliant with the hours or usage and the symptoms of OSA are improved, then the coverage would begin once that evaluation occurs.

Follow-up Question: If a patient fails the 90-day trial for PAP, returns the equipment, and a month later the physician prescribes a bi-level (E0470), can we dispense the bi-level or does the patient have to have the face-to-face exam and sleep study at that point as well?

A. For treatment of OSA, if the patient failed the trial period, they would need to start with a new face-to-face exam and sleep study.

Q4. We are concerned about not getting enough documentation from the physician for power wheelchairs (K0823 - Power wheelchair, Group 2 standard, captains chair, patient weight capacity up to and including 300 pounds). If their chart notes are not sufficiently detailed, can they write a letter afterwards?

A4. If the physician writes a letter after the fact, it is considered an attestation statement and not part of the patient's medical records. The physician needs to be very explicit in what the patient's deficits are that he feels would qualify them for the power mobility device (PMD). Each different type of wheelchair carries its own criteria in the LCD.

If a patient is able to walk or get around with the assistance of a walker or person, more than likely a K0823 will not be approved. If a patient can walk a short distance, for example from the bedroom to the bathroom but not from the bedroom to the kitchen, it is taken into account but more than likely the patient could use a lightweight manual wheelchair. We encourage suppliers to educate physicians on what should be documented for PMDs as outlined in the LCD. There is a Physician Letter – PWC/POV on our Coverage/MR Web page under Physician Resources that outlines these requirements written by our Medical Director to physicians that can be helpful in this education.

Q5. After the trial period, if the mask doesn't fit, does the patient have to do a new sleep study?

A5. If the patient is not compliant in the first month, for example, the supplier could suggest using a different mask.

Follow-up Question: Patients tend to wait until after the three months to tell us the mask isn't working.

A. It's important to follow-up with the patient during the three months so this doesn't happen. This is the reason for the three-month trial period. Adjustments and follow-up may be made during this time because from Medicare's point of view, payment for an item should not be made for three months if it isn't functional.

Q6. If we have a patient who is not compliant within the first month due to mask issues, are we allowed to bill Medicare for a new mask during the trial period instead of waiting until after the 90-day trial period?

A6. At the current time suppliers may only bill one mask in three months.

More than a single mask in a 90 day period may result in a denial, but when there is sufficient justification for the medical necessity as with this circumstance, the additional mask(s) should be able to be covered on appeal.

Follow-up Question: Does sleep time no longer play a role in qualifying someone for PAP as long as they have the required apnea-hypopnea index (AHI)? For example, if the patient only has 59 minutes during the sleep study but the AHI is 30 during that 59 minutes of sleep, can we dispense supplies or a PAP device?

A. Yes, that is correct, as long as the patient has the minimum qualifying number of events during a study, they qualify.

Q7. How many PAP trials are suppliers able to bill Medicare for? For example, if a patient fails the initial 90-day trial, they have a repeat sleep study and face-to-face exam, and then they fail another 90-day trial.

A7. There are no limits in the DME policy as far the trial, sleep studies and face to face exams; however, we suggest checking what the Part A limitations are for sleep studies.

Q8. If a verbal order is received and it contains all of the elements of a written order, do we have to have two separate documents or can the one fulfill both requirements?

A8. If an order is taken verbally and sent to the physician for a signature and date, there are two documents: the verbal order and the written order with the physician's signature and date.

If a patient comes in with a prescription containing all of the elements of a detailed written order, then one document is on file.

It's important to remember that if an item is dispensed based on a verbal order and a written order is provided afterwards, both orders must be retained. It is not adequate to only have a written order after dispensing an item. There must be documentation to show the verbal order was received prior to dispensing the item.

Q9. After the five-year useful lifetime of oxygen equipment, I understand new testing is not needed, but a Certificate of Medical Necessity (CMN) is required. What date is put on the CMN?

A9. The initial date on the CMN is the date the new equipment is dispensed. The testing date should be the most recent test that occurred before the new equipment was dispensed, i.e., before the initial date on the CMN.

Reminders when providing new oxygen equipment after the reasonable useful lifetime:

- RA modifier is used only on the initial claim
- New initial CMN is submitted with initial claim
- Narrative on claim explaining situation

Follow-up Question: What is required for billing maintenance and servicing?

A. Maintenance and service must be provided six months after the 36-month capped rental. Actual maintenance must be performed and documented in the supplier's file.

Q10. One of the requirements when a PAP device is purchased by another insurance company prior to the beneficiary becoming Medicare eligible is that they have to be compliantly using their device and have a physician document that. The problem we are seeing is that the patient wants to begin using the device again, they are trying to get a working mask, but since they aren't compliant, they don't meet the requirement listed in the LCD. Can we dispense a mask and bill Medicare even though they aren't compliantly using the device at the time we give them the mask?

A10. If there is nothing to support the beneficiary is benefiting from the PAP device and the coverage criteria is not met, an ABN can be obtained.

Q11. When billing for diabetic shoes and inserts, we are required to have a statement from the certifying physician on file. When we bill Medicare, do we put the physician who signed the certifying statement or who referred the beneficiary with the prescription?

A11. The referring/ordering physician's National Provider Identifier (NPI) is used.

EDUCATIONAL CONT'D

Follow-up Question: The LCD states one pair of shoes and three inserts are allowed per year. Can we bill for all three inserts at one time or does the patient have to receive inserts every three months?

A. All inserts can be billed at one time as long as they are all dispensed at one time.

Q12. Is the Refractive Lenses LCD updated on the Web site with the KX/GY/GZ modifier changes?

A12. That LCD is currently listed on the Future LCD page and is scheduled to be updated on October 1, 2009.

Q13. Can you tell me where you receive the diagnoses of a hospice patient? We've had a few denials stating the diagnosis is directly related to the terminal condition. When we talk to the nursing home, they tell us the diagnosis billed is not directly related.

A13. NAS receives this information from the Common Working File (CWF). The CWF obtains this diagnosis from the hospice provider as submitted to Medicare.

Q14. Is there a place on your Web site that I can find instructions on how to bill for a Transcutaneous Electrical Nerve Stimulator (TENS) unit and instructions on how to advise a podiatrist on the guidelines for this item?

A14. The first place to look is the LCD on the Coverage/MR tab. It contains the coverage guidelines, HCPCS codes, documentation requirements and more. The second place is the Policy Article, which contains additional information. Also, in Chapter 3 of the Supplier Manual it references what is allowed by a podiatrist and it specifically references state statutes governing the scope of practice for podiatry.

Q15. You now have the LCDs on your Web site and that is wonderful because they load faster, but before you could find which policy a HCPCS code belongs to. Will that be added again?

A15. This is currently being reviewed and updated and will be posted back to the Web site shortly.

The next Small Supplier ACT is on November 12, 2009, at 3 p.m. CT.

CERT

CERT Documentation

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

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

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

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

Mail all requested documentation to:

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

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

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

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

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

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

CEDI

CEDI Change to Acceptable Diagnosis Code Pointers

The ASC X12N 837 version 4010A1 claim format allows a maximum of eight diagnosis codes to be reported for each claim in accordance with standards established by the Health Insurance Portability and Accountability Act (HIPAA). Currently, eight diagnosis codes can be submitted on a DME claim; however, only diagnosis code pointers 1 – 4 are accepted by the Common Electronic Data Interchange (CEDI) front end edits.

On Sunday October 4, 2009, during the CEDI maintenance window, CEDI edit A531 will be modified to allow diagnosis code pointers 1–8.

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

CEDI Reminder: Final Implementation Dates on NCPDP 5.1 Transition

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

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

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

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

The CEDI NCPDP reports will be returned in a real time mode (immediately after a file is sent) and the DME MAC NCPDP reports will continue to be available within 24-48 hours after a file is sent.

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

CEDI will be comparing the reports produced by CEDI and the DME MAC to make any changes to the CEDI NCPDP editing and/or reporting process. CEDI will look for feedback from the NCPDP submitters and software vendors on the new CEDI process.

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

A new CEDI NCPDP Front-End Manual is being developed to include the changes. The new manual will be posted to the CEDI Web site (http://www.ngscedi.com) and a Listserv will be sent once available.

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

Implementation of HIPAA Transaction 835 version 5010 Implementation

MLN Matters® Number: MM6589
Related Change Request (CR) #: 6589
Related CR Release Date: September 4, 2009
Related CR Transmittal #: R550OTN
Effective Date: January 1, 2010
Implementation Date: January 4, 2010

Provider Types Affected

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

What You Need to Know

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

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

Background

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

CR 6589, from which this article is taken, instructs the Medicare Contractors to implement transaction 835 v5010 and to update the Standard Paper Remittance Advice (SPR).

CR 6589 provides business requirements for the Medicare Contractors so they can be ready to generate transaction 835 in version 5010 for testing with trading partners and in production for early adopters effective January 1, 2011.

Compliance Details

Please note that there are two levels of compliance:

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

CEDI CONT'D

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

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

Additional Information

You can find the official instruction, CR6589, issued to your Medicare Contractor by visiting http://www.cms.hhs.gov/Transmittals/downloads/R550OTN.pdf on the CMS Web site.

COMPETITIVE BIDDING

Bid Window Target Date for Round 1 Rebid of Medicare DMEPOS Competitive Bidding Program

On August 3, 2009, CMS issued the bidding timeline for the Round 1 Rebid of the Medicare DMEPOS Competitive Bidding Program and initiated a comprehensive bidder education campaign. The bidding timeline includes a target bid window opening date of October 21, 2009. CMS is currently on schedule to meet this target date. The official opening of the 60-day bid window will be announced via a listserv (e-mail) message.

In order to avoid any overlap of the Round 1 Rebid contract period for mail-order diabetic supplies and a possible contract period resulting from a national mail-order competition, the Round 1 Rebid contract period for mail-order diabetic supplies will be two years. The contract period for all other Round 1 Rebid product categories will be three years.

The Competitive Bidding Implementation Contractor (CBIC) is the focal point for bidder education. Please review this Web site for important information, including bidding rules, user guides, frequently asked questions, policy fact sheets, checklists, and bidding information charts. The CBIC toll-free help desk, 1-877-577-5331, is open to help bidders with all of their questions and concerns. All suppliers interested in bidding are urged to sign up for E-Mail Updates on the home page of this Web site.

Time is Running Out for Authorized Officials to Register for DMEPOS Competitive Bidding

The target deadline for Authorized Officials (AOs) to register for the Round 1 Rebid of the Medicare DMEPOS Competitive Bidding Program was September 14, 2009. All suppliers interested in bidding must designate one AO from those listed on the CMS-855S enrollment form to act as their AO for registration purposes. If you are a supplier interested in bidding and your designated AO has not yet registered, he or she should register now. Suppliers whose AOs do not register will not be able to bid when bidding opens. AOs who do not register now may not have time to designate other employees to assist with bidding.

Remember, the AO must be listed on the CMS-855S enrollment form. Once the AO registers, then the AO's user ID and password will be sent by mail and should be delivered within 10 days after successful registration. After an AO successfully registers, the AO may designate other employees to serve as Backup Authorized Officials (BAOs) and/or End Users (EUs). BAOs and EUs must also register in order to be able to use the online bidding system. The legal name, date of birth, and Social Security number (SSN) of the AO and BAOs must match exactly with what is on file with the National Supplier Clearinghouse (NSC) in order to register successfully. Legal names, dates of birth, and SSNs of all users must match what is on file with the Social Security Administration.

We recommend that BAOs register no later than October 9, 2009, so that they will be able to assist AOs with approving EU registration. Registration will close on November 4, 2009, at 9:00 p.m. EST – no AOs, BAOs, or EUs can register after registration closes.

To register, go to the Registration section of the CBIC Web site. Please review the *IACS Reference Guide* located in the Registration section for step-by-step instructions on how to register. This Web site also has the following useful tools: a registration checklist, Quick Step guides, and frequently asked questions. All suppliers interested in bidding are urged to sign up for E-Mail Updates on the home page of this Web site. If you have any questions about the registration process, please contact the Competitive Bidding Implementation Contractor (CBIC) Customer Service Center at 1-877-577-5331.

Source: Competitive Bidding Implementation Contractor

Important Medicare Information about DMEPOS Supplier Accreditation and Round 1 Rebid of DMEPOS Competitive Bidding Program

MLN Matters Number: SE0925 Revised

Note: This article was revised on September 28, 2009, to include (and emphasize) on page 3 an important section regarding voluntary and non-voluntary terminations/enrollments.

Provider Types Affected

This article is for all suppliers that furnish Medicare Part B durable medical equipment, prosthetic devices, prosthetic

or orthotic items and supplies (DMEPOS) to Medicare beneficiaries. Critical changes are coming that will affect the way Medicare pays for DMEPOS and how Medicare determines who can bill for DMEPOS. This article provides important reminders about some of these changes, which will be occurring in the very near future and how these changes affect suppliers who will participate in the DMEPOS competitive bidding program. Suppliers are urged to review this article and be sure they are prepared for these changes in order to continue providing DMEPOS to Medicare patients.

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) reminds Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) suppliers enrolled with the National Supplier Clearinghouse (NSC) they are required to obtain accreditation by October 1, 2009, unless exempt, and obtain a surety bond by October 2, 2009. Suppliers must be accredited for a product category in order to submit a bid for that product category. CMS will not accept bids from and will not contract with suppliers that are not accredited by a CMS-approved accreditation organization for the applicable product categories.

If you have made the decision not to obtain accreditation or a surety bond when required, you may want to voluntarily terminate your enrollment in the Medicare program before the implementation dates above. Voluntary termination allows you to re enroll once you meet the requirements to participate in the Medicare program. If you do not comply with the accreditation and surety bond requirements and do not submit a voluntary termination, your Medicare billing privileges will be revoked. A revocation will bar you from re-enrolling in Medicare for at least one year after the date of revocation.

Whether or not you plan to remain as a Medicare supplier, it is recommended that you review this information. **Suppliers who do not plan to stay enrolled in Medicare are strongly encouraged to notify their beneficiaries as soon as possible so the beneficiary can find another supplier.**

Background

This article includes important reminder information for suppliers who will continue to serve as suppliers for Medicare beneficiaries on and after October 1, 2009.

Voluntary and Non-Voluntary Terminations/Enrollment

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

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

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

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

Accreditation

In a previous MLN Matters® article, SE0903, CMS informed suppliers of the importance of accreditation and the consequences of not being accredited on or before September 30, 2009. That article is at http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0903.pdf on the CMS Web site.

If you have already been notified by an approved accrediting organization that each of your practice locations has been accredited, the accreditation organization will notify the NSC that your DMEPOS supplier practice locations have been accredited. However, DMEPOS suppliers who obtained accreditation after September 1, 2009 but before October 1, 2009, should submit proof of accreditation to the NSC via submission of an amendment to their CMS-855S.

Further information on the DMEPOS accreditation requirements along with a list of the accreditation organizations and those professionals and other persons exempted from accreditation may be found at http://www.cms.hhs.gov/MedicareProviderSupEnroll/01_Overview.asp on the CMS Web site.

Accreditation and DMEPOS Competitive Bidding

Suppliers choosing to participate in the DMEPOS Competitive Bidding Program must be accredited for a product category in order to submit a bid for that product category. CMS will not accept bids from and will not contract with suppliers that are not accredited by a CMS-approved accreditation organization for the applicable product categories.

- **Get Licensed**: Suppliers submitting a bid for a product category in a competitive bidding area (CBA) must meet all DMEPOS state licensure requirements and other applicable state licensure requirements, if any, for that product category for every state in that CBA. Prior to submitting a bid for a CBA and product category, the supplier must have a copy of the applicable state licenses on file with the National Supplier Clearinghouse (NSC). As part of the bid evaluation, CMS will verify with the NSC that the supplier has on file a copy of all applicable required state license(s).
- **Get Accredited:** Medicare DMEPOS suppliers, unless exempt, must be accredited by October 1, 2009. Suppliers must be accredited for a product category in order to submit a bid for that product category. CMS will not accept bids from and will not contract with suppliers that are not accredited by a CMS-approved accreditation organization for the applicable product categories.

Get Bonded: Medicare DMEPOS suppliers, unless exempt,

COMPETITIVE BIDDING CONT'D

must obtain and submit a surety bond by October 2, 2009. Suppliers subject to the bonding requirement must be bonded in order to bid in the DMEPOS competitive bidding program. A list of surety companies from which a bond can be secured is found at the Department of the Treasury's "List of Certified (Surety Bond) Companies;" the Web site is located at http://www.fms.treas.gov/c570/c570_a-z.html on the Internet. When submitting your DMEPOS surety bond to the NSC, you are required to submit sections 1, 2A1, 12, and either 15 (if you are the AO) or 16 (if you are the delegated official) of the CMS-855S. By submitting the required sections of the CMS-855S, you will help to ensure that NSC is able to correctly associate your DMEPOS surety bond to your enrollment record.

Accessing the Processes for the Round 1 Rebid

On August 3, 2009 CMS issued the bidding timeline for the Round 1 Rebid of the DMEPOS competitive bidding program and initiated a comprehensive bidder education campaign. The CMS contractor, CBIC, is the focal point for bidder education. Please visit the CBIC's dedicated Web site, http://www.dmecompetitivebid.com/, for important information, including bidding rules, user guides, frequently asked questions, policy fact sheets, checklists, and bidding information charts. The CBIC toll-free help desk, 1-877-577-5331, is open to help bidders with all of their questions and concerns. All suppliers interested in bidding are urged to sign up for e-mail updates on the home page of the CBIC Web site. The Round 1 Rebid will result in significant changes in the way Medicare pays for certain types of DMEPOS and it is critical that suppliers understand the process and what it takes to be eligible to bid.

In prior communications, CMS has described the processes for registering to use CMS systems. (See the MLN Matters® article, SE0915, at http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0915.pdf on the CMS Web site.) For the Round 1 Rebid, it is imperative that suppliers register so they will be able to participate in the bidding process for the categories of DMEPOS to be obtained only through the competitive bidding program.

Round 1 Rebid Registration Milestones

Suppliers should be well into, if not completely through, this registration process. Registering now allows the AO and/or BAO time to correct the supplier's NSC records if their name, date of birth, and SSN does not match what is on file with NSC. CMS recommends that BAOs register no later than October 9, 2009, so that they will be able to assist AOs with approving EU registration. Registration will close on November 4, 2009, at 9:00 p.m. EST – no AOs, BAOs, or EUs can register after registration closes. The legal name, date of birth, and Social Security number (SSN) of the AO and BAOs must match what is on file with the NSC in order to register successfully. To register, go to http://www.dmecompetitivebid.com/ on the Competitive Bidding Implementation Contractor (CBIC) Web site.

If you have not started this process, please review the *Individuals Authorized Access to the CMS Computer Services (IACS) Reference Guide* at http://www.dmecompetitivebid.com/Palmetto/Cbic.nsf/files/IACS_Reference_Guide.pdf/$FIle/IACS_Reference_Guide.pdf?Open&cat=Suppliers for step-by-step instructions on registration. The CBIC Web site also has the following useful tools:

- A registration checklist;
- Quick Step guides; and frequently asked questions.
- All suppliers interested in bidding are urged to sign up for E-mail Updates on the home page of the CBIC Web site. If you have any questions about the registration process, please contact the CBIC Customer Service Center at 1-877-577-5331.

The target deadline for Authorized Officials interested in participating in the Round 1 Rebid to register was September 14, 2009. If you are an AO who has not yet registered – do it TODAY! Visit http://www.dmecompetitivebid.com/ to register.

Additional Information

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

ENROLLMENT

CMS Updates Compliance Standards for Consignment Closets and Stock Bill Arrangements

Recently CMS released Change Request (CR) 6528a outlining guidelines for DMEPOS that are maintained at a location owned by a physician or non-physician practitioner with a purpose to distribute products to Medicare beneficiaries. Suppliers involved in these arrangements, commonly referred to as consignment closets or stock/bill arrangements are required to meet current standards. CR 6528 also details additional guidelines for these arrangements that are included in the *Program Integrity Manual* (PIM), Chapter 10, Section 21.8.

Effective March 1, 2010, Medicare will allow enrolled suppliers to maintain inventory at a practice location or a physician or a non-physician practitioner when the following conditions are met:

- The title to the DMEPOS shall be transferred to the enrolled physician or non-physician practitioner's practice at the time the DMEPOS is distributed to the beneficiary.
- The physician or non-physician practitioner's practice shall bill for the DMEPOS supplies and services using their own enrolled DMEPOS billing number.
- All services provided to a Medicare beneficiary concerning fitting or use of the DMEPOS shall be performed by individuals being paid by the physician or non-physician practitioner's practice, not by any other DMEPOS supplier.

ENROLLMENT CONT'D

- The beneficiary shall be advised that, if they have a problem or questions with the DMEPOS, they should contact the physician or non-physician practitioner's practice, not the DMEPOS supplier who placed the DMEPOS at the physician or non-physician practitioner's practice.

For more information, suppliers can read the MLN Matters article in its entirety at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6528.pdf.

Source: National Supplier Clearinghouse

FORMS

New Form for DME RAC Overpayment Redeterminations

In order to improve our customer service for suppliers requesting a review of a Recovery Audit Contractor (RAC) overpayment, NAS has created a new DME RAC Overpayment Redetermination Form. NAS encourages suppliers to complete the new form and mail to the address below with a copy of the overpayment letter.

The address is:

Noridian Administrative Services
Attention: DME RAC Overpayment Redeterminations
PO Box 6728
Fargo ND 58108-6728

The form and instructions are available on the Forms tab under RAC Forms.

CODING

Male External Catheter - A4326 - Coding and Utilization Guidelines

Code A4326 describes a special type of male exdwelling catheter.

A4326 - Male external catheter with integral collection chamber, any type, each

Products described by this code are made of plastic or rubber. They are designed to be washed and reused. One product described by this code is the AlphaDry System by AlphaDry Medical. The manufacturer's recommendation is that this product be replaced every 15 days.

Effective for claims submitted on or after November 1, 2009, the only products that may be billed using code A4326 are those that have undergone Coding Verification Review by the Pricing, Data Analysis, and Coding (PDAC) Contractor and that are listed in the DMECS Product Classification List on the PDAC Web site.

Data analysis suggests that suppliers may be using this code incorrectly when they should be using code A4349 which is a standard male external catheter that is typically changed daily.

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

Questions concerning the coding of these products should be referred to the PDAC.

BILLING

Medical Necessity Denials – Appeal, Do Not Resubmit

According to CMS regulations, resubmitting medical necessity denials will cause duplicate claim denials.

Any necessary changes to a claim that denied as not medically necessary should be requested via a telephone or written reopening or a redetermination. To determine which option is appropriate, visit our Web site at https://www.noridianmedicare.com/dme/news/docs/2009/02_feb/what_can_cannot_be_requested.html.

Note: If an appellant is wishing to appeal a duplicate denial, according to CMS regulations, no appeal rights will be afforded to the claim unless the duplicate denial can be proven to not be a duplicate.

In addition, claims where refunds have been requested due to a review by Medicare or the Comprehensive Error Rate Testing (CERT) contractor shall not be resubmitted for payment. In all cases mentioned, claims must be appealed or reopened if a supplier does not agree with Medicare's decision.

Remember, submitting duplicate claims:

1. May delay payment;
2. Could cause a supplier to be identified as an abusive biller; or
3. May result in an investigation for fraud if a pattern of duplicate billing is identified.

For tips to avoid duplicate denials, visit our Web site at: https://www.noridianmedicare.com/dme/news/docs/2008/04_apr/eliminating_duplicate_denials.html

Wheelchair Accessory Billing- Each and Pair

This article reminds suppliers how to bill for wheelchair accessories when billing an accessory which is described as "each" or a "pair" when provided for both sides (right and left) of a wheelchair.

When billing for a wheelchair accessory, the right (RT) and left (LT) modifiers must be used when appropriate.

- If bilateral items (left and right) are provided as a purchase and the unit of service of the code is "each", bill both items on the same claim line using the LTRT modifiers and 2 units of service.
- If bilateral items are provided as a rental and the unit of service is "each", bill the items on two separate claim lines with the RT modifier on one line and the LT modifier on the other.
- If bilateral items are provided as a purchase or rental and the unit of service is "pair", bill both items on the same claim line using the LTRT modifiers and 1 unit of service.

When billing for more than 2 units, these would need to be submitted on separate lines. For example, when replacing caster tires, HCPCS E2391, for both the front and back

caster on each side of the wheelchair, this would require billing 4 units. You would bill two lines with RT and LT on each line and units of two on each line.

Suppliers should contact the Pricing, Data Analysis, and Coding contractor (PDAC) for questions concerning the correct coding of specific products.

Refer to the Supplier Manual, Chapter 3, for more information on documentation requirements.

Source: Wheelchair Options and Accessories Policy Article (A19846)

Expansion of Current Scope of Editing for Ordering/Referring Providers for DMEPOS Suppliers Claims

MLN Matters® Number: MM6421 Revised
Related Change Request (CR) #: 6421
Related CR Release Date: April 24, 2009
Related CR Transmittal #: R480OTN
Effective Dates: Phase 1 – October 1, 2009, Phase 2 – January 1, 2010
Implementation Date: Phase 1 – October 5, 2009, Phase 2 – January 4, 2010

Note: This article was revised on September 14 2009, to add clarifying language to emphasize that billed services requiring an ordering/referring provider on the claim must contain the ordering/referring provider under both phases of this change or the claim will not be paid.

Provider Types Affected

Suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) submitting claims to Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for items or services provided to Medicare beneficiaries.

Provider Action Needed

This article is based on change request (CR) 6421, which requires Medicare implementation of system edits to assure that DMEPOS suppliers bill for items or services only when those items or services are ordered or referred by physician and non-physician practitioners who are eligible to order/refer such services. Physician and non-physician practitioners must be enrolled in the Medicare Provider Enrollment, Chain and Ownership System (PECOS) and of the type/specialty eligible to order/refer services for Medicare beneficiaries. Be sure billing staff are aware of these changes that will impact DMEPOS claims received and processed on or after October 5, 2009.

Background

CMS is expanding claim editing to meet the Social Security Act requirements for ordering and referring providers. Section 1833(q) of the Social Security Act requires that all ordering and referring physicians and non-physician practitioners meet the definitions at section 1861(r) and 1842(b)(18)(C) and be uniquely identified in all claims for items and services that are the results of orders or referrals. Effective January 1, 1992, a provider or supplier who bills Medicare for an item or service that was ordered or referred must show the name and unique identifier of the ordering/referring provider on the claim.

The providers who can order/refer are:

- Doctor of Medicine or Osteopathy;
- Dental Medicine;
- Dental Surgery;
- Podiatric Medicine;
- Optometry;
- Chiropractic Medicine;
- Physician Assistant;
- Certified Clinical Nurse Specialist;
- Nurse Practitioner;
- Clinical Psychologist;
- Certified Nurse Midwife; and
- Clinical Social Worker

Claims that are the result of an order or a referral must contain the National Provider Identifier (NPI) and the name of the ordering/referring provider and the ordering/referring provider must be in PECOS with one of the above specialties.

Key Points

- **During Phase 1 (October 5, 2009-January 3, 2010)**: If the ordering/referring provider is on the claim, Medicare will verify that the ordering/referring provider is in PECOS and is eligible to order/refer in Medicare. **If the ordering/referring provider is not in PECOS or is in PECOS but is not of the type/specialty to order or refer, the claim will continue to process.**
  1. If the DMEPOS supplier claim is an ANSI X12N 837P standard electronic claim, the DMEPOS supplier will receive a warning message on the Common Electronic Data Interchange (CEDI) GenResponse Report.
  2. If the DMEPOS supplier claim is a paper CMS-1500 claim, the DMEPOS supplier will not receive a warning and will not know that the claim did not pass these edits.
- **During Phase 2, (January 4, 2010 and thereafter)**: If the ordering/referring provider is not on the claim, the claim will not be paid. If the ordering/referring provider is on the claim, Medicare will verify that the ordering/referring provider is in PECOS and eligible to order and refer. **If the ordering/referring provider is not in PECOS or is in PECOS but is not of the specialty to order or refer, the claim will not be paid. It will be rejected.**
  1. If the DMEPOS supplier claim is an ANSI X12N 837P standard electronic claim, the DMEPOS supplier will receive a rejection message on the CEDI GenResponse Report.
  2. If the DMEPOS supplier claim is a paper CMS-1500 claim, the DMEPOS supplier will see the rejection indicated on the Remittance Advice.

- In **both phases**, Medicare will verify the NPI and the name of the ordering/referring provider reported on the ANSI X12N 837P standard electronic claim against PECOS.
- When furnishing names on the paper claims, be sure not to use periods or commas within the name. Hyphenated names are permissible.

Providers who order or refer may want to verify their enrollment in PECOS. They may do so by accessing Internet-based PECOS at https://pecos.cms.hhs.gov/pecos/login.do on the CMS Web site. Before using Internet-based PECOS, providers should read the educational material about Internet-based PECOS that is available at http://www.cms.hhs.gov/MedicareProviderSupEnroll/04_InternetbasedPECOS.asp on the CMS Web site. Once at that site, scroll to the downloads section of that page and click on the materials that apply to you and your practice.

Additional Information

The official instruction, CR6421, issued to your Medicare DME MAC regarding this change, may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R480OTN.pdf on the CMS Web site.

Claim Adjustment Reason Code, Remittance Advice Remark Code, and Medicare Remit Easy Print Update

MLN Matters® Number: MM6604
Related Change Request (CR) #: 6604
Related CR Release Date: August 28, 2009
Related CR Transmittal #: R1804CP
Effective Date: October 1, 2009
Implementation Date: October 5, 2009

Provider Types Affected

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

Provider Action Needed

CR 6604, from which this article is taken, announces the latest update of Remittance Advice Remark Codes (RARCs) and Claim Adjustment Reason Codes (CARCs), effective October 1, 2009. Be sure billing staff are aware of these changes.

Background

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

The CARC list is maintained by a national Code Maintenance committee that meets when X12 meets for their trimester meetings (occurring in January/February, June, and September/October) to make decisions about additions, modifications, and retirement of existing reason codes.

Both code lists are posted at http://www.wpc-edi.com/Codes on the Internet. The lists following the end of the "Additional Information" section of this article summarize the latest changes to these lists, as announced in CR 6604.

Additional Information

To see the official instruction (CR6604) issued to your Medicare Carrier, RHHI, DME/MAC, FI and/or MAC refer to http://www.cms.hhs.gov/Transmittals/downloads/R1804CP.pdf on the CMS Web site.

For additional information about Remittance Advice, please refer to Understanding the Remittance Advice (RA): A Guide for Medicare Providers, Physicians, Suppliers, and Billers at http://www.cms.hhs.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf on the CMS Web site.

New Codes - CARC

Code	Current Narrative	Effective Date (per WPC posting)
231	Mutually exclusive procedures cannot be done in the same day/setting. Note: Refer to the 835 Healthcare Policy Identification Segment, if present.	1/1/2010

Modified Codes - CARC

Code	Current Narrative	Effective Date (per WPC posting)
40	Charges do not meet qualifications for emergent/urgent care. This change to be effective 04/01/2010: Charges do not meet qualifications for emergent/urgent care. Note: Refer to the 835 Healthcare Policy Identification Segment, if present.	4/1/2010
50	These are non-covered services because this is not deemed a 'medical necessity' by the payer. This change to be effective 04/01/2010: These are non-covered services because this is not deemed a 'medical necessity' by the payer. Note: Refer to the 835 Healthcare Policy Identification Segment, if present.	4/1/2010

54	Multiple physicians/assistants are not covered in this case. This change to be effective 04/01/2010: Multiple physicians/assistants are not covered in this case. Note: Refer to the 835 Healthcare Policy Identification Segment, if present.	4/1/2010
55	Procedure/treatment is deemed experimental/investigational by the payer. This change to be effective 04/01/2010: Procedure/ treatment is deemed experimental/investigational by the payer. Note: Refer to the 835 Healthcare Policy Identification Segment, if present.	4/1/2010
56	Procedure/treatment has not been deemed 'proven to be effective' by the payer. This change to be effective 04/01/2010: Procedure/ treatment has not been deemed `proven to be effective' by the payer. Note: Refer to the 835 Healthcare Policy Identification Segment, if present.	4/1/2010
58	Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. This change to be effective 04/01/2010: Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. Note: Refer to the 835 Healthcare Policy Identification Segment, if present.	4/1/2010
59	Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) This change to be effective 04/01/2010: Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) Note: Refer to the 835 Healthcare Policy Identification Segment, if present.	4/1/2010
90	Ingredient cost adjustment. This change to be effective 04/01/2010: Ingredient cost adjustment. Note: To be used for pharmaceuticals only.	4/1/2010

Deactivated Codes - CARC

Code	Current Narrative	Effective Date
156 *	Flexible spending account payments. Note: Use code 187.	10/1/2009

- Also included in CR 6453

New Codes - RARC

Code	Current Narrative	Medicare Initiated
N519	Invalid combination of HCPCS modifiers.	NO
N520	Alert: Payment made from a Consumer Spending Account.	NO

Modified Codes – RARC
None

Deactivated Codes – RARC
None

Activation of New COBA Trading Partner Dispute Error Code Within National Crossover Process

MLN Matters® Number: MM6640
Related Change Request (CR) #: 6640
Related CR Release Date: September 25, 2009
Related CR Transmittal #: R562OTN
Effective Date: October 26, 2009
Implementation Date: October 26, 2009

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 6640, which conveys a new COBA trading partner dispute error code that the Coordination of Benefits Contractor (COBC) will return to Medicare contractors when certain claims are not accepted by supplemental payers. Billing staff should be aware of this change.

Background

The Coordination of Benefits Contractor (COBC) consolidates the activities that support the collection, management, and reporting of other insurance coverage for Medicare beneficiaries. The Centers for Medicare &

Medicaid Services (CMS) developed and further refined the COBC Detailed Error Report process through the issuance of Change Request 3709 (See Transmittals 474, dated February 11, 2005, at http://www.cms.hhs.gov/transmittals/downloads/R474CP.pdf on the CMS Web site) and CR 5472 (See Transmittal 1189 dated February 28, 2007, at http://www.cms.hhs.gov/Transmittals/Downloads/R1189CP.pdf on the CMS Web site).

Under the COBC Detailed Error Report process, the COBC reports to Medicare contractors, via a standard Detailed Error Report layout, any of the following error conditions that resulted in their claims not being crossed over:

- Incoming flat file contained structural problems ("111" flat file errors);
- Incoming flat file contained claims with Health Insurance Portability and Accountability Act (HIPAA) American National Standards Institute (ANSI) compliance errors ("222" errors); and
- The COBA trading partner rejected the contractors' claims ("333" trading partner dispute errors).

Note: Crossover is the transfer of processed claim data from Medicare operations to commercial insurance companies that sell supplemental insurance benefits to Medicare beneficiaries and to Medicaid (or state) agencies.

Depending upon the error percentage encountered in association with errored claims, Medicare contractors then, after five (5) business days, automatically generate special provider notification letters informing the affected physician/supplier/provider that the beneficiary's claim(s) cannot be crossed over.

In earlier instructions CMS directed Medicare contractors to suppress creation of their standard provider notification letters when they receive any of the following "333" dispute reason codes via the COBC Detailed Error Reports:

- 00100—duplicate claim;
- 000110—duplicate claim within the same ISA-IEA loop; and
- 000120—duplicate claim within the same ST-SE loop.

CMS made this decision primarily for two reasons:

1. It was believed that these particular error conditions were out of the control of the billing provider; and
2. It would be futile for the provider to bill the claims to the COBA trading partner outside the crossover process given that the entity had already received the claim, as witnessed by its lodging of a dispute on the basis of duplicate claim receipt.

Currently, the only in-use "333" dispute codes that will trigger provider notification letters are the following:

- 000200 - Claim for provider ID/state should have been excluded; 000300—beneficiary not on eligibility-file;
- 000500 - Incorrect claim count; 000600—claim does not meet selection criteria;
- 000700 - HIPAA Error; and
- 009999 - Other.

Through CR 6640, the COBC will activate dispute reason code 000400 (previously reserved for future use) as a new "333" trading partner dispute code. As a result of this action, the COBC will:

1. Transmit error code 000400 to Medicare contractor when indicated via the COBC Detailed Error Report; and
2. Include within the error description field on the COBC Detailed Error Report the following standard message: "No provider agreement with Medicaid/other payer; claims crossover not possible."

Also, as a result of CR664 0, all Medicare contractors will generate error code 000400 when received via their COBC Detailed Error Report with accompanying error message on their outgoing notification letters to providers, physicians, or suppliers. As indicated in CR 6640, upon receipt of the contractor-generated special letters, affected providers, physicians, or suppliers may wish to contact their patient's indicated supplemental payer to determine next steps.

Additional Information

The official instruction, CR 6640, issued to your carrier, FI, A/B MAC, RHHI, and DME MAC regarding this change may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R562OTN.pdf on the CMS Web site.

Claims Submitted for Items or Services Furnished to Medicare Beneficiaries in State or Local Custody

MLN Matters® Number: MM6544 Revised
Related Change Request (CR) #: 6544
Related CR Release Date: September 4, 2009
Related CR Transmittal #: R1812CP and R110BP
Effective Date: December 7, 2009
Implementation Date: December 7, 2009

Note: This article was revised on September 14, 2009, to add DME MACs in the "Provider Affected" section. DME MACs may also receive claims and are included in Change Request 6544. All other information remains unchanged.

Provider Types Affected

This article is for physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, DME Medicare Administrative Contractors (DME MACs), Fiscal Intermediaries (FIs), and/or A/B MACs) for services provided to individuals or groups of individuals who are in "custody" under a penal statute or rule.

Provider Action Needed

This article is based on Change Request (CR) 6544, which describes special conditions that must be met in order for Medicare to make payment for services provided to individuals or groups of individuals who are in the custody of the police or other penal authorities or in the custody of a government agency under a penal statute or rule.

CR 6544 instructs Medicare contractors that "payment may be made for services furnished to individuals or groups of individuals who are in the custody of the police or other penal

authorities or in the custody of a government agency under a penal statute only if the following conditions are met: State or local law requires those individuals or groups of individuals to repay the cost of medical services they receive while in custody, and the State or local government entity enforces the requirement to pay by billing all such individuals, whether or not covered by Medicare or any other health insurance, and by pursuing the collection of the amounts they owe in the same way and with the same vigor that it pursues the collection of other debts."

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

Background

Under the Social Security Act (Section 1862(a)(2); see http://www.ssa.gov/OP_Home/ssact/title18/1862.htm on the Internet), the Medicare program does not pay for services if:

- The beneficiary has no legal obligation to pay for the services, and
- No other person or organization has a legal obligation to provide or pay for that service.

In addition, under the Social Security Act (Section 1862(a)(3)), if services are paid for directly or indirectly by a governmental entity, Medicare does not pay for the services.

In the Fiscal Year (FY) 2008 Inpatient Prospective Payment System (IPPS) final rule published in the Federal Register, Volume 72, Number 162 (72 FR 47409 and 47410 – August 22, 2007; see http://edocket.access.gpo.gov/2007/07-3820.htm on the Internet), the Centers for Medicare & Medicaid Services (CMS) clarified the regulations at 42 CFR Section 411.4(b) (See http://edocket.access.gpo.gov/cfr_2002/octqtr/42cfr411.4.htm on the Internet) by stating that for purposes of Medicare payment, individuals who are in "custody" include, but are not limited to, individuals who are:

- Under arrest;
- Incarcerated;
- Imprisoned;
- Escaped from confinement;
- Under supervised release;
- On medical furlough;
- Required to reside in mental health facilities;
- Required to reside in halfway houses;
- Required to live under home detention; or
- Confined completely or partially in any way under a penal statute or rule.

The *Medicare Claims Processing Manual*, Chapter 1, Section 10.4 describes the **special conditions that must be met** in order for Medicare to make payment for individuals who are in custody as follows:

"Payment may be made for services furnished to individuals or groups of individuals who are in the custody of the police or other penal authorities or in the custody of a government agency under a penal statute only if the following conditions are met:

1. State or local law requires those individuals or groups of individuals to repay the cost of medical services they receive while in custody, and
2. The State or local government entity enforces the requirement to pay by billing all such individuals, whether or not covered by Medicare or any other health insurance, and by pursuing the collection of the amounts they owe in the same way and with the same vigor that it pursues the collection of other debts."

Providers and suppliers are reminded that if they render services or items to a prisoner or patient in a jurisdiction that meets these conditions of 42 CFR 411.4(b), they are to include modifier QJ on claims submitted to carriers, A/B MACs, or DME MACs or use condition code 63 on institutional claims sent to Medicare FIs or A/B MACs.

Change Request (CR) 6544 also amends the Medicare Benefit Policy Manual (Chapter 16, Section 50.3.3) and the Medicare Claims Processing Manual (Chapter 1, Section 10.4) in order to be consistent with 42 CFR Section 411.4(b). These revisions are included as attachments to CR 6544.

Additional Information

There are two transmittals associated with the official instruction, CR 6544, issued to your carrier, FI, and A/B MAC regarding this change. The first transmittal amends the *Medicare Claims Processing Manual* and it may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R1812CP.pdf on the CMS Web site. The second transmittal amends the Medicare Benefit Policy Manual and it may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R110BP.pdf on the CMS Web site.

COVERAGE

LCD and Policy Article Revisions Summary for October 2009

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

Ankle Foot/Knee Ankle Foot Orthosis
LCD
Revision Effective Date: 12/01/2009
HCPCS CODES AND MODIFIERS:
Added: GA and GZ modifiers
Deleted: GY modifier
DOCUMENTATION REQUIREMENTS:
Added: Instructions for the use of GA and GZ modifiers

Policy Article
Revision Effective Date: 12/01/2009
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: Information on code A9283
CODING GUIDELINES:
Revised: Instructions for coding A9283
Revised: Instructions for code L2770
Revised: Instructions for coding concentric adjustable torsion joints
Revised: Instructions for RT/LT modifiers

COVERAGE CONT'D

Knee Orthoses
LCD
Revision Effective Date: 12/01/2009
HCPCS CODES AND MODIFIERS:
Added: GA and GZ modifiers
Revised: RT/LT descriptors
DOCUMENTATION REQUIREMENTS:
Added: Instructions for the use of GA and GZ modifiers

Policy Article
Revision Effective Date: 12/01/2009
CODING GUIDELINES:
Revised: Instructions for code L2770
Revised: Instructions for coding concentric adjustable torsion joints
Revised: Instructions for RT/LT modifiers

Nebulizers
LCD
Revision Effective Date: 12/01/2009
INDICATIONS AND LIMITATIONS OF COVERAGE:
Added: Language from Program Integrity Manual on timing of refills and shipping of supplies/medications
Revised: Coverage criteria for long-acting bronchodilators
HCPCS CODES AND MODIFIERS:
Added: GA and GZ modifiers
Revised: KX modifier descriptor
ICD-9 CODES:
Revised: ICD-9 codes that support medical necessity for J7605, J7606
DOCUMENTATION:
Deleted: KX requirements from J7605, J7606
Added: Instructions for use of GA and GZ modifiers

Oral Anticancer Drugs
Policy Article
Revision Effective Date: 10/01/2009
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: 208.92-209.36, 209.70-209.79 to accepted diagnoses for busulfan, capecitabine, cyclophosphamide, etoposide, melphalan, methotrexate, or temozolomide
CODING GUIDELINES:
Changed: SADMERC to PDAC
ICD-9 CODES THAT ARE COVERED:
Added: 208.92-209.36, 209.70-209.79 to accepted diagnoses for busulfan, capecitabine, cyclophosphamide, etoposide, melphalan, methotrexate, or temozolomide

Oral Antiemetic Drugs
LCD
Revision Effective Date: 12/01/2009
HCPCS CODES AND MODIFIERS:
Added: GA and GZ modifiers
Revised: KX modifier
DOCUMENTATION REQUIREMENTS:
Added: Instructions for use of the GA and GZ modifiers

Policy Article
Revision Effective Date: 10/01/2009
CODING GUIDELINES:
Changed: SADMERC to PDAC
ICD-9 CODES THAT ARE COVERED:
Added: 208.92-209.36, 209.70-209.79

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

Additional LCD Revision - September 2009

Principal changes to the Pressure Reducing Support Surfaces - Group 1 Local Coverage Determination (LCD) are outlined below. Please review the entire LCD and related Policy Article for complete information.

Pressure Reducing Support Surfaces - Group 1
LCD
Revision Effective Date: 12/01/2009
INDICATION AND LIMITATIONS OF COVERAGE:
Revised: Criteria for coverage of Group 1 Mattress
HCPCS CODES:
Added: GA and GZ modifiers
Revised: KX modifier
DOCUMENTATION REQUIREMENTS:
Added: Instructions for the use of GA and GZ modifiers
APPENDICES:
Revised: Definitions of pressure ulcer stages
SOURCES OF INFORMATION AND BASIS FOR DECISION:
Added: Reference to NPUAP guidelines for pressure ulcer staging

ENTERAL NUTRITION

Enteral Nutrition: Quantity and Shipping Reminders

Suppliers are reminded that prior to dispensing enteral nutrition and supplies, contact must be made with the beneficiary or caregiver to determine the quantities that remain from the previous delivery. **The supplier must then modify the quantity delivered or the delivery date based on the quantity remaining**. Refills cannot be delivered sooner than approximately five days prior to the end of usage for the current product. The from (beginning) date of service on the claim should reflect the shipping date or date the items were physically delivered to the patient, when delivering directly to the patient.

The Enteral Nutrition Policy Article states:

> The supplier is responsible for assessing how much enteral nutrition and supplies the beneficiary is actually using. The supplier must contact the beneficiary or caregiver prior to dispensing nutrients or supplies to determine the quantities that remain from previous delivery and modify the quantity delivered or delivery date accordingly. The supplier must not automatically dispense a quantity of items on a predetermined regular basis, even if the beneficiary has "authorized" this in advance. As referenced in the Program Integrity Manual (Internet-Only Manual, CMS Pub. 100-8, Chapter 4.26.1) "**Contact with the beneficiary or designee regarding refills should take place no sooner than approximately 7 days prior to the delivery/shipping**

date. For subsequent deliveries of refills, the supplier should deliver the DMEPOS product no sooner than approximately 5 days prior to the end of usage for the current product."

Suppliers with claims that have not been processed according to these guidelines resulting in a CO-150 denial or CO-18 with a reason code of N111 should send a written reopening by fax or mail using the DME Reopening form. Suppliers with a large number of claims that have not been processed according to these guidelines may call the Supplier Contact Center at 1-866-243-7272 for more information on reprocessing.

CO-150 Payer deems the information submitted does not support the level of service

CO-18 Duplicate claim/service

N111 This service was included in a claim that was previously billed and adjudicated. No appeal rights attached except with regard to whether the service/item is a duplicate.

Note: The 7 day contact and 5 day delivery guidelines also apply to parenteral nutrition, as these guidelines apply to all DMEPOS. The parenteral LCD policy article will be updated in the future to include this wording.

Enteral Nutrition Questions and Answers

The following questions and answers have been categorized to assist in understanding Medicare enteral billing. Suppliers are encouraged to access the following resources for additional information:

- Medicare Claims Processing Manual, Chapter 20
- Medicare Benefit Policy Manual, Chapter 15
- Jurisdiction D DME Supplier Manual, Chapters 3-5
- Enteral Nutrition LCD (L11568)
- Enteral Nutrition Policy Article (A25361)
- NAS Enteral PowerPoint: https://www.noridianmedicare.com/dme/train/presentations/index.html

Documentation, DME Information Form and Orders

Q1. What resources are available for suppliers to obtain better documentation from prescribing physicians?

Our DME Medical Director has worked with the other DME Medical Directors to develop letters written to physicians that suppliers can reference and use to obtain documentation. These letters are located under the Coverage/MR tab of our Web site under the category of Physician's Resources. See https://www.noridianmedicare.com/dme/coverage/.

Q2. When should a new, initial DIF be used and when is a revised DIF needed?

A new, initial nutrition DIF is needed in the situations where:

- A new order for a formula with a different code is received
- A two consecutive month break in need was resumed
- There has been a change from syringe or gravity method to pump (DIF needed for a pump in this situation)

A revised DIF is needed when:

- A length of need needs to be extended
- There is a change in calories per day
- There is a change in the number of days per week administered
- The method of administration is changed (syringe, gravity, pump)
- There is a change from tube feedings to oral (supplier billing for a denial)

Q3. Can a dietician do the evaluation to determine the patient needs and requirements, i.e., calories required and specialty formula?

A registered dietician can evaluate a patient to determine what type of nutrition is required to maintain weight and strength commensurate with the patient's overall health status. The dietician would then contact the physician to share this information and make a recommendation to the physician and the physician would then evaluate, write the order, and document the medical necessity in the patient's chart.

Q4. What does Medicare require for a special nutrient formula?

When a physician orders a special nutrient formula they need to document why the patient requires this type of formula vs. formula, such as B4150. A diagnosis alone does not automatically qualify a patient for a special formula. The physician needs to indicate in the medical record why the patient needs the special formula.

Q5. For the special nutrient formulas, what documentation does Medicare require? For example, is the diagnosis of dysphagia or acute pancreatitis enough for B4153 without documentation?

A diagnosis is important, however there needs to be additional clinical and medical documentation, from the physician, to substantiate why the patient requires a special formula (B4149, B4153-B4157, B4161 and B4162).

The Enteral Nutrition LCD (L11568) in the CPT/HCPCS Codes section states "The appearance of a code in this section does not necessarily indicate coverage."

Q6. What documentation is required for special nutrition provided to a patient with the diagnosis of malabsorption/ small gut syndrome?

A diagnosis alone does not qualify a patient for enteral nutrition. The physician needs to provide medical documentation to support the diagnosis. "Short gut syndrome" is a permanent impairment and often a result of removal of a large portion of the colon. In these situations, there should be a surgical record or other documentation that would support the above diagnosis and provide the medical necessity for the nutrition ordered.

The enteral nutrition LCD (L11568) under the heading CPT/HCPCS Codes states "The appearance of a code in this section does not necessarily indicate coverage."

Q7. What documentation is required for special formula provided to a patient who has Crohn's Disease?

ENTERAL NUTRITION CONT'D

Crohn's disease is a disease causing malabsorption; however, not every patient with this diagnosis suffers from malabsorption that would require enteral feedings to provide sufficient nutrients to maintain weight and strength commensurate with the patient's overall health status. Therefore, the physician needs to provide clinical justification for the special formula ordered for this specific patient.

The enteral nutrition LCD (L11568) under the heading CPT/HCPCS Codes states "The appearance of a code in this section does not necessarily indicate coverage." A diagnosis alone does not qualify a patient for enteral nutrition. The physician needs to provide documentation to support the diagnosis.

Q8. For special formulas, such as Glucerna, what additional documentation besides the diagnosis of diabetes is needed? Does there have to be documentation that another formula was tried unsuccessfully before administering Glucerna?

A diagnosis is important, however there needs to be clinical documentation, such as patient blood sugar levels, laboratory results, medication lists, weight, or other physician documentation to substantiate why a patient with diabetes requires a special enteral formula. There is no trial required at this time.

Q9. What documentation is needed for "severe" dysphagia? By definition dysphagia is inability to swallow. Is Medicare looking for swallow studies?

Documentation should clearly support the diagnosis of severe dysphagia to warrant feeding tube placement, such as:

a. Physician clinical documentation supporting the patient's deficits

b. Dysphagia evaluation

c. Dietary documentation of how the patient tolerates different textures of food

d. Nursing documentation that shows difficulty in eating, expressions of pain, choking, etc…

Q10. What documentation is required for patients receiving calories fewer than 750 or over 2000?

The physician needs to justify why the patient requires nutrition outside the caloric range described in the *Medicare Claims Processing Manual*, Chapter 20, Section 100.2.2.2: "Generally, daily enteral intake of 750 to 2,000 calories is considered sufficient to maintain body weight. Patients with medical complications may require an intake outside the range. The attending physician must document the reason for prescribing less than 750 calories per day or more than 2000 calories per day."

Q11. What documentation is required for patients who have a calorie intake per day of 750 via small bites?

The patient must require tube feedings to maintain weight and strength commensurate with the patient's overall health status. Adequate nutrition must not be possible by dietary adjustment and/or oral supplements. Coverage is possible for patients with partial impairments, e.g., a patient with dysphagia who can swallow small amounts of food or a patient with Crohn's disease who requires prolonged infusion of enteral nutrients to overcome a problem with absorption. Generally, daily intake of 750 to 2,000 calories is considered sufficient to maintain body weight. The majority of the patient's caloric intake should be from the enteral feedings to allow coverage under Medicare.

Q12. Does the IV pole have to be listed on the detailed written order? We are having trouble with a doctor that does not want to sign the order because the IV pole is listed. This particular patient's administration is via enteral pump.

The enteral nutrition LCD (L11568) states the following in the "General Information Documentation Requirements" section:

"An order for each item billed must be signed and dated by the treating physician, kept on file by the supplier, and made available upon request. Items billed before a signed and dated order has been received by the supplier must be submitted with an EY modifier added to each affected HCPCS code."

Suppliers must have an order for all items provided to the patient.

Q13. What should a supplier do if the doctor switches formula after the first order has been filled and billed?

A new order needs to be obtained for the switch in formula. Also, if the calories, route of administration, or HCPCS for the formula have been changed, a revised DIF should be submitted to Medicare with the first claim that corresponds to these changes.

Q14. Is it acceptable to have a DIF for the nutrition and a separate DIF for the pump?

Yes, if the nutrition is being administered through a pump, it is appropriate to submit a DIF for each item.

Q15. Are the LCDs going to be changed or updated to reflect more specific documentation requirements regarding SNF enteral patients?

Documentation requirements **are not specific to the place of service.** Physician clinical documentation needs to provide medical necessity to support the service(s) billed for that specific patient.

Q16. What information should a supplier look for when a pump has been ordered?

Please see the documentation checklist for enteral nutrition found at: https://www.noridianmedicare.com/dme/coverage/docs/checklists/enteral_nutrition.pdf. A portion of the checklist relating to pumps, which is based on the LCD, is as follows:

Claims for Enteral Infusion Pumps (B9000, B9002)
Documentation in medical record must justify the need:

- Gravity feeding is not satisfactory due to reflux and/or aspiration; **or**
- Severe diarrhea; **or**
- Dumping syndrome; **or**
- Administration rate less than 100 ml/hr; **or**
- Blood glucose fluctuations; **or**
- Circulatory overload; **or**
- Gastrostomy/jejunostomy tube used for feeding.

Q17. If the number of calories was increased for two consecutive months by the physician for weight and to increase protein intake, is this covered?

Yes. The physician needs to write an order to indicate the caloric increase, the DIF needs to be revised to reflect the new caloric amount and clinical documentation needs to support the reason for the increase in calories.

Q18. If we have an initial DIF for a patient receiving enteral therapy via gravity or syringe and the patient is switched to pump administration, do we do a new initial DIF or do we do a revision to the existing DIF? Slide 39 states "change from syringe or gravity method to pump, new initial DIF for pump". Slide 40 states "Revised DIF if the method of administration is changed syringe, gravity, pump".

A revised enteral nutrition DIF is required to show that the method of administration has changed from syringe or gravity to pump. In addition, a new initial DIF for the pump should be submitted. Two DIFs are required in this situation.

Coverage

Q19. What does Medicare consider a small amount of food to sustain life?

Caloric needs are based on patient specific information, including disease processes, energy expenditures and a dietary evaluation. A "small amount of food" will vary based on individual needs.

According to the *Medicare Claims Processing Manual*, Chapter 20, Section 100.2.2.2, generally, daily intake of 750 to 2,000 calories is considered sufficient to maintain body weight. Patients receiving less than 750 calories per day must have documentation from the physician to explain why.

In addition, per the Enteral LCD Policy Article, coverage is possible for patients with partial impairments, e.g., a patient with dysphagia who can swallow small amounts of food or a patient with Crohn's disease who requires prolonged infusion of enteral nutrients to overcome a problem with absorption.

Q20. Is Medicare still paying for the maintenance and servicing (MS) of the IV Pole for rentals before 2006?

Maintenance and servicing is only paid for capped rental items. An IV pole for enteral nutrition is not a capped rental item.

Q21. What is the definition of "end stage"? Is this failure to thrive or hospice? Is enteral nutrition covered for a patient who is "end stage" or on hospice?

End stage disease describes an active or malignant disease that cannot be cured or adequately treated or maximally treated and that is reasonably expected to result in the death of the patient. This term is most commonly used for progressive diseases, such as cancer or advanced heart or kidney disease. It indicates a disease which will end life.

A patient who has such an illness may be referred to as a terminal patient or terminally ill. Often, a patient is considered to be terminally ill when the life expectancy is estimated to be six months or less, under the assumption that the disease will run its normal course.

Enteral nutrition is non-covered for patients with a functioning gastrointestinal tract whose need for enteral nutrition is due to reasons such as anorexia or nausea associated with mood disorder, end-stage disease, etc.

Failure to thrive is often a symptom of an end stage disease. End stage disease patients may be referred to hospice for care during this stage of their life. Refer to the next question for coverage of enteral nutrition in a hospice.

Q22. If a patient is on hospice for a condition not relating to the need for enteral, is the enteral billable to Medicare?

Any covered Medicare service not related to the treatment of the terminal hospice condition, and which is furnished during a hospice election period, may be billed to Medicare for payment. Services should be coded with the GW modifier "service not related to the hospice patient's terminal condition". We also compare the hospice diagnosis to the diagnosis on the enteral claim and if they are the same, the enteral claim will be denied. DME MACs process services coded with the GW modifier in the normal manner for coverage and payment determinations. This information can be found in Chapter 6 of the Supplier Manual at: https://www.noridianmedicare.com/dme/news/manual/chapter6.html.

Pump and Supplies

Q23. If patient has chosen to blend their own food and not have Medicare pay for formula, can the supplier still bill for a supply kit?

No. The enteral policy article states that if the coverage requirements for enteral nutrition are met, medically necessary nutrients, administration supplies, and equipment are covered. The policy article also states that self-blenderized formulas are not covered by Medicare and that food thickeners, baby food, and other regular grocery products that can be blenderized and used with the enteral system will be denied as non-covered. In this situation, since the nutrition is not covered, the supply kit is also non-covered.

Q24. How should a supplier bill a g-tube outside the feeding kit? Can a supplier bill a B4088 or B4087 code in addition to the supply kit?

G-tubes are not considered part of the daily supplies needed for enteral feeding and may be billed with the B4087 and B4088 codes. Per the enteral policy article:

> "The codes for enteral feeding supplies (B4034-B4036) include all supplies, other than the feeding tube itself, required for the administration of enteral nutrients to the patient for one day."

The enteral LCD also states that more than one gastrostomy/jejunostomy tube (B4087-B4088) every three months is rarely medically necessary.

Nutrition

Q25. Is a trial required for B4150 prior to ordering a diabetic formula? We understood that a supplier was required to try B4150.

There is no trial required at this time. NAS looks for documentation to justify the need of the formula provided to the patient.

Delivery

Q26. What is the date of service when nutrition or related products are shipped?

The date of service is the date the products were shipped. The date of service is not the date the products arrive at the patient's home or location.

Q27. What is the date of service when the product is delivered directly to the patient?

The date of service is the date products were physically delivered to the patient.

Q28. Can you deliver enteral nutrition or supplies on the 29th of July for August?

A supplier can deliver or ship enteral nutrition on the date of their choosing as long as it fulfills the requirement of the Enteral Nutrition LCD Policy Article (A25361) in relation to the following statement:

> "Contact with the beneficiary or designee regarding refills should take place no sooner than approximately 7 days prior to the delivery/shipping date. For subsequent deliveries of refills, the supplier should deliver the DMEPOS product no sooner than approximately 5 days prior to the end of usage for the current product."

Q29. Do we have a five day window to deliver our product for a date of service?

Yes, a five day window is allowed for delivery of enteral nutrition and related supplies, based on CMS direction that suppliers should deliver DMEPOS no sooner than five days prior to the end of usage. Therefore, there can be a five day overlap from the previous DOS billed and the current DOS being billed.

Q30. Sometimes when monthly supplies are dispensed, it calculates to 32 days of supplies. Will Medicare pay for 32 days or does the supplier need to bill for 30 days on one claim and 2 days on a separate claim?

A supplier is permitted to only bill 1 unit/day per the policy, with five days overlap allowed for delivery purposes. In addition, only one month's product can be dispensed in advance. Therefore, when billing prospectively, the maximum units that can be billed on a claim is 31.

Q31. Can a supplier bill with a date span for a 31 day month?

Yes, if the month has 31 days. When counting for February or months that have 30, rather than 31 days, you must factor this into your calculations. The claims processing system knows how many days are in each month so it can correctly calculate the date span.

Q32. If a supplier delivers five days in advance of when the patient needs their nutrition and related supplies and bills the shipping date as the date of service, California Medicaid denies our claim for overlapping of date of service. Can we deliver five days earlier but still bill for the date after 30 days?

At this time, suppliers should bill the date of shipping or delivery as the date of service. NAS Medicare will allow for a five day overlap, per CMS instruction. We cannot control how Medicaid handles these claims, but would suggest that you educate them on the Medicare guidelines so they can consider this when processing their claims.

Q33. If a supplier ships within five days prior to the end of previous usage and our shipment arrives early, the delivery date will not equal the next start date of service. What does a supplier do in this situation?

The date the item arrives at the patient's home is not a factor when shipping DME items. The date of shipping or delivery directly to the patient (which is the date of service) can overlap the previous billed date span by approximately five days, per CMS instruction. Suppliers should always bill the date of shipping as the date of service, when using this method of getting products to a patient. In addition, suppliers are reminded that contact with the beneficiary must occur before shipping products to determine the amount of product needed and when.

Q34. When delivering to a nursing home, should the supplier's invoice include the patient names even when it is a bulk order and two different patients may need to use the same product from one case of products?

Yes. The enteral nutrition policy article (A25361) states that if a delivery is being made to a nursing home the delivery must be designated for each individual beneficiary, not as a general delivery. Therefore, the invoice should indicate what patients will be utilizing the nutrition in that delivery.

Q35. Does a supplier need to maintain monthly nursing treatment records that show the enteral product was used daily and during which shift for proof of delivery in a nursing home?

Yes, proof of enteral product given to a nursing home patient is required, but this does not need to be documented by shift. A daily note or log could show this usage, although documentation for each shift would also suffice. The enteral nutrition policy article (A25361) states that if a delivery is being made to a nursing home the delivery must be designated for each individual beneficiary, not as a general delivery. To support proof-of-delivery, nursing records such as treatment log or medication administration records can be submitted as they support that the patient has received the nutrition.

Q36. Can a supplier use the packing slip of a common carrier (mail/package) which is signed by the nursing home employee as proof of delivery or does the supplier also need to print out the common (mail/package) carrier online shipping document?

The packing slip which is signed and dated by the nursing home employee can serve as proof of delivery. An online shipping document is not also required as proof of delivery. Either document could show proof of delivery, but both are not required.

Q37. We ship to skilled nursing facilities. According to the enteral Web-based workshop presentation, the date of service is the day that the product is given to the resident. Is that the same for all four regions or is that specific to Jurisdiction D?

There is a misunderstanding to what was indicated at the presentation. For clarification, the enteral nutrition Policy Article (A25361) states that:

> "If a delivery is being made to a nursing home the delivery must be designated for each individual beneficiary, not as a general delivery. Therefore the

delivery should be for the amount required for each individual patient as a supplier can only provide enough supplies for one month usage."

The proof of this usage is supplied in the form of a medication administration record or treatment record which shows that the patient has received the enteral nutrition. The date-of-service reported on the claim is the shipping date that the enteral supplies were sent to the nursing home or the actual date of delivery to the nursing home.

Claim Submission and Modifiers

Q38. Is a break in service considered 60 days from the last billed through date or last billed from date?

The break of service would start from the last billed through date.

Q39. Does a supplier need to include the KH, KI, KJ, etc., rental month modifier when billing the IV pole?

No, these modifiers are used only for a capped rental item. An IV pole is not a capped rental item.

Q40. Should a GZ modifier be submitted to indicate the supplier attempted to obtain an Advance Beneficiary Notice of Noncoverage (ABN), however, the ABN was not returned to the supplier?

Yes, the GZ modifier could be used in this situation. The supplier would receive a Medicare denial that is supplier liable, contractual obligation (CO).

Q41. How should a supplier bill and document enteral in assisted living facilities?

Documentation requirements are not specific to the place of service.

When submitting a claim to Medicare for a patient living in an assisted living facility, the place of service code 13 should be used with the HCPCS Code of the enteral nutrition prescribed for the patient. In addition, in Item 32 on the CMS 1500 form or the electronic equivalent, **enter the name and address information of where the services were furnished in the following format:**

1st Line - Name
2nd Line - Address
3rd Line - City, State Postal Code, and ZIP Code

All other billing guidelines for DME, i.e., beneficiary authorization, proof of delivery, and documentation to support the need for enteral nutrition, i.e., the medical necessity, apply. There are no other unique requirements for billing enteral for a resident in an assisted living facility.

Q42. For a pump rental that is medically necessary, should the KX modifier be reported?

A KX modifier is not required for any type of nutrition when administered through a pump. Neither the enteral or parenteral nutrition LCD or the infusion pump LCD address KX modifier usage at this time. Suppliers are encouraged to only use the KX modifier as instructed in the LCD or Policy Article.

Q43. How should wastage be billed?

There should be no need to bill for wastage for a nutrition patient. The supplier provides nutrition in accordance with the physician's order.

Suppliers are reminded that only one month of nutrition should be shipped at a time, per the LCD. Suppliers are to calculate the number of units needed based on the calories and formula ordered. Rounding up based on "full bags", "full cans" or "full cases" is not allowed.

OXYGEN

Oxygen FAQs

Q1. Please clarify the date of service to be used when billing maintenance and service for oxygen. Does the date of service have to be the actual date of the visit? For example: The patient has oxygen stationary equipment that "capped out" on 12/01/08 which would make the first allowable maintenance and service billable on 07/01/09. However, the equipment was serviced on 06/15/09. May a supplier bill for the 06/15/09 M&S visit on 07/01/09 or do they have to wait until maintenance is required again?

A1. The 2009 6-month maintenance and servicing payment for oxygen concentrators and transfilling equipment only applies when the supplier physically makes an in-home visit to inspect the equipment and the date of the visit falls on or after the 6 month anniversary date. In the example provided, the supplier would not be able to bill for an M&S payment on 7/1/09 for a service visit that occurred on 6/15/09. In this particular case, if the supplier physically makes another in-home visit to inspect the equipment between 7/1/09 and 12/31/09, they would be eligible to bill for the 6 month M&S payment. The date of service on the claim would be the date of the actual visit.

Q2. If a patient is past the 36 month rental period for oxygen equipment (i.e., payment for the equipment has capped) and the patient has a stationary concentrator, stationary liquid tank, and portable liquid cylinders in the home, what code(s) may be billed?

A2. Per the Oxygen Policy Article: If the patient has a stationary concentrator, portable liquid equipment, and a stationary liquid tank to fill the portable cylinders, when payment for contents begins, payment will only be made for portable liquid contents. The only code that may be billed is E0444 (portable liquid contents). Code E0442 (stationary liquid contents) must not be billed in this situation because the stationary tank is just used to fill the portable cylinders.

Q3. The Oxygen LCD includes a requirement that the patient be seen and re-evaluated by the treating physician within 90 days prior to recertification. The revision of the LCD that was released in June included a change in the coverage of oxygen if the required re-evaluation was not performed within the 90 day time frame but was performed at a later date. The previous policy stated that, in that situation, payment could be made for dates of service between the scheduled recertification date and the date of the late physician visit if the blood gas

study criteria were met. The revised policy states that, in that situation, coverage would end when the Initial Certification period ended and would resume beginning with the date of the late physician visit. The effective date of the LCD revision was given as 1/1/09. Did these revised coverage criteria take effect on that date?

A3. Because of the short notice given for the policy revision and the change in payment rules, the effective date of this specific requirement will be claims with dates of service on or after August 1, 2009. This date is based on the June 19, 2009, public release date of the policy revision. This clarification will be incorporated in a future revision of the LCD.

Q4. If the required physician re-evaluation is not performed within 90 days prior to recertification but is performed at a later date, what should be entered as the Recertification Date on the Oxygen CMN?

A4. In that situation, the date of the late physician visit should be entered as the Recertification Date on the CMN.