Jurisdiction D News from Noridian Administrative Services, LLC.

Happenings

September 2009
Issue No. 23

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

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

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Jurisdiction D DME MAC Supplier Contacts and Resources

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

web site: www.noridianmedicare.com

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

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

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

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

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

FYI

Holiday Schedule

NAS offices will be closed on 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	
Columbus Day *	October 12, 2009
Veterans Day *	November 11, 2009
Thanksgiving	November 26 and 27, 2009
Christmas Eve **	December 24, 2009
Christmas Day	December 25, 2009
** Partial day closure	

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.

DMERC Dialogue Articles Removal Notification

NAS analyzed and reviewed the articles published by CIGNA Government Services in the *DMERC Dialogue* prior to December 2006. These are currently posted to our web site under the Publications category and Bulletins section of our web site. Those articles which are not applicable to current DME MAC guidelines will be removed on October 1, 2009. The removal of the non-applicable articles will assist in more effective and accurate search results. Suppliers may request copies of these articles after October 1, 2009, by submitting an e-mailed request using the "Contact Us" feature on our web site. When requesting a DMERC Dialogue article, it is important to specify the article date and title within the e-mailed inquiry.

Customer Service Callback Authentication Requirements

Beginning Tuesday, September 8, 2009, CMS will require all DME MACs to authenticate suppliers when calling back regarding a previous inquiry. NAS DME customer service representatives will ask the supplier for specific information that will be required in order to continue with the callback.

Specific Claim Information
If the original inquiry was on a specific claim, customer service representatives will need to authenticate the supplier by obtaining the following information:

- National Provider Identifier (NPI)
- Provider Transaction Access Number (PTAN)
- Last five digits of Tax Identification Number (TIN)

Once authenticated the customer service representative will provide the name of the beneficiary and/or the date of birth in order for the supplier to retrieve the necessary information. This information includes:

- Beneficiary's Health Insurance Claim Number (HICN); and
- Date of service (DOS) or Healthcare Common Procedure Coding System (HCPCS) code

During the original call, if it is determined a callback will be needed, the customer service representatives will provide suppliers with the inquiry idID and remind suppliers to record the NPI, PTAN, and TIN as well as the HICN, DOSDOS and/or the HCPCS Ccode. This is to assist the supplier in efficiently and accurately responding to the callback. The following document is a guide for suppliers to retain this required information.

NAS DME Callback Form

Source: Change Request 6482: Provider Customer Service Program Updates

NORIDIAN® Administrative Services LLC

Durable Medical Equipment

Callback Form

Name of Company: ______________________________ **Inquiry ID** ______________

City: ____________________ State __________ Phone Number: __________________

NPI: __________________ **PTAN:** _____________ **Tax Id Number:** _____________

Beneficiary Name: _______________________ Date of Birth _____________________

Patient Account Number: __________________ **HICN:** ________________________

Date of Service: ____________________ **HCPCS Code:** _______________________

Name of Company: ______________________________ **Inquiry ID** ______________

City: ____________________ State __________ Phone Number: __________________

NPI: __________________ **PTAN:** _____________ **Tax Id Number:** _____________

Beneficiary Name: _______________________ Date of Birth _____________________

Patient Account Number: __________________ **HICN:** ________________________

Date of Service: ____________________ **HCPCS Code:** _______________________

Name of Company: ______________________________ **Inquiry ID** ______________

City: ____________________ State __________ Phone Number: __________________

NPI: __________________ **PTAN:** _____________ **Tax Id Number:** _____________

Beneficiary Name: _______________________ Date of Birth _____________________

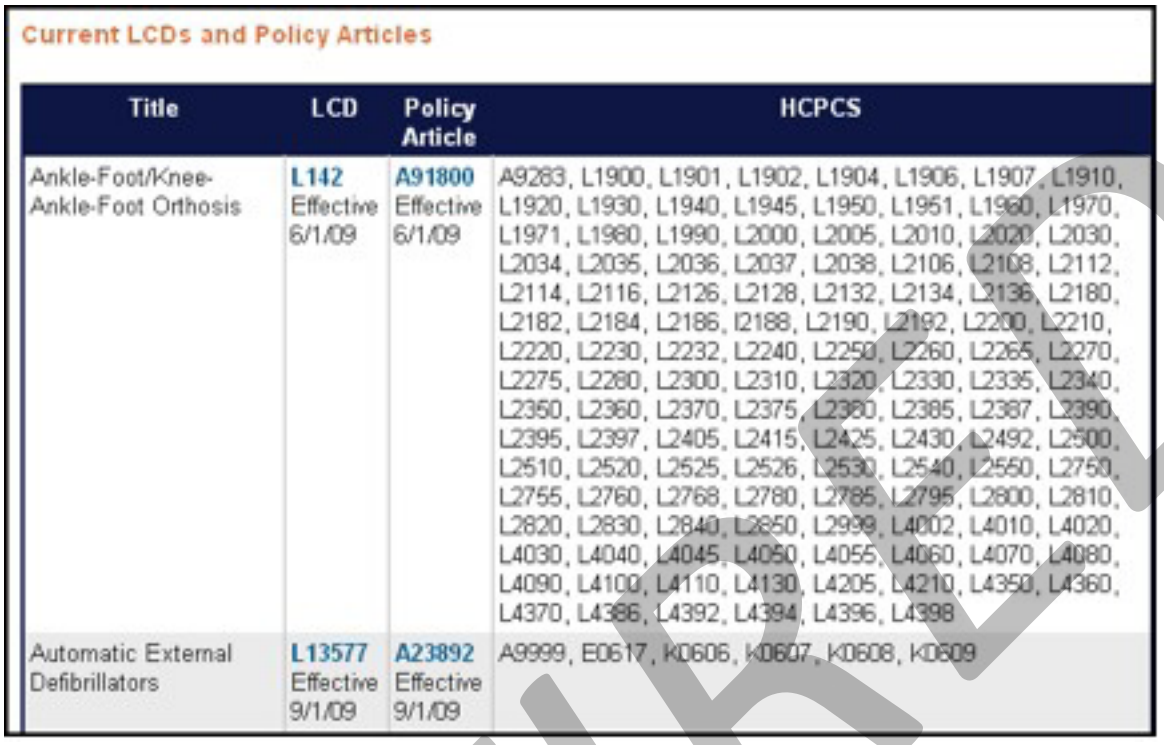
Patient Account Number: __________________ **HICN:** ________________________

Date of Service: ____________________ **HCPCS Code:** _______________________

CMS

LCDs and Policy Articles Now Available on NAS DME Web Site

Current DME Jurisdiction D Local Coverage Determinations (LCDs) and Policy Articles are now easily accessible on the Coverage/MR tab under Local Coverage Determinations. NAS provides the PDF version, HCPCS codes, along with the effective date of each.



Current LCDs and Policy Articles

Title	LCD	Policy Article	HCPCS
Ankle-Foot/Knee-Ankle-Foot Orthosis	L142 Effective 6/1/09	A91800 Effective 6/1/09	A9283, L1900, L1901, L1902, L1904, L1906, L1907, L1910, L1920, L1930, L1940, L1945, L1950, L1951, L1960, L1970, L1971, L1980, L1990, L2000, L2005, L2010, L2020, L2030, L2034, L2035, L2036, L2037, L2038, L2106, L2108, L2112, L2114, L2116, L2126, L2128, L2132, L2134, L2136, L2180, L2182, L2184, L2186, L2188, L2190, L2192, L2200, L2210, L2220, L2230, L2232, L2240, L2250, L2260, L2265, L2270, L2275, L2280, L2300, L2310, L2320, L2330, L2335, L2340, L2350, L2360, L2370, L2375, L2380, L2385, L2387, L2390, L2395, L2397, L2405, L2415, L2425, L2430, L2492, L2500, L2510, L2520, L2525, L2526, L2530, L2540, L2550, L2750, L2755, L2760, L2768, L2780, L2785, L2795, L2800, L2810, L2820, L2830, L2840, L2850, L2999, L4002, L4010, L4020, L4030, L4040, L4045, L4050, L4055, L4060, L4070, L4080, L4090, L4100, L4110, L4130, L4205, L4210, L4350, L4360, L4370, L4386, L4392, L4394, L4396, L4398
Automatic External Defibrillators	L13577 Effective 9/1/09	A23892 Effective 9/1/09	A9999, E0617, K0606, K0607, K0608, K0609

Draft, Future, and Retired policies are also accessible from this page. 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 NAS know your thoughts on this new page. NAS reviews each comment and score submitted and appreciates supplier's feedback.

Reminders from CMS: Competitive Bidding, Accreditation, Surety Bond

The DMEPOS Competitive Bidding Program Round 1 Rebid is Coming Soon!!

Summer 2009

CMS announces bidding schedule/schedule of education events

CMS begins bidder education campaign

Bidder registration period to obtain user ID and passwords begins

Fall 2009

- Bidding begins

If you are a supplier interested in bidding, prepare now – don't wait!

- **Update Your NSC Files**: DMEPOS supplier standard # 2 requires ALL suppliers to notify the National Supplier Clearinghouse (NSC) of any change to the information provided on the Medicare enrollment application (CMS-855S) within 30 days of the change. DMEPOS suppliers should use the 3/09 version of the CMS-855S and should review and update:
  - The list of products and services found in section 2.D;
  - The Authorized Official(s) information in sections 6A and 15; and
  - The correspondence address in section 2A2 of the CMS-855S.

This is especially important for suppliers who will be involved in the Medicare DMEPOS Competitive Bidding Program. These suppliers must ensure the information listed on their supplier files is accurate to enable participation in this program. Information and instructions on how to submit a change of information may be found on the NSC web site (http://www.palmettogba.com/nsc) and by following this path: Supplier Enrollment/Change of Information/Change of Information Guide.

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 NSC. As part of the bid evaluation we will verify with the NSC that the supplier has on file a copy of all applicable required state license(s).

Get Accredited: CMS would like to remind DMEPOS suppliers that time is running out to obtain accreditation by the September 30, 2009, deadline or risk having their Medicare Part B billing privileges revoked on October 1, 2009. Accreditation takes an average of 6 months to complete. DMEPOS suppliers should contact a CMS deemed accreditation organization to obtain information about the accreditation process and the application process. Suppliers must be accredited for a product category in order to submit a bid for that product category. CMS cannot contract with suppliers that are not accredited by a CMS-approved accreditation organization.

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 the CMS web site: http://www.cms.hhs.gov/MedicareProviderSupEnroll/01_Overview.asp.

Get Bonded: CMS would like to remind DMEPOS suppliers that certain suppliers will need to obtain and submit a surety bond by the October 2, 2009, deadline or risk having their Medicare Part B billing privileges revoked. Suppliers subject to the bonding requirement must be bonded in order to bid in the DMEPOS competitive bidding program. A list of sureties 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.

Visit the CMS web site at http://www.cms.hhs.gov/DMEPOSCompetitiveBid/ for the latest information on the DMEPOS competitive bidding program.

DMEPOS Supplier Accreditation and Surety Bond Requirement Deadlines Coming In October

Suppliers May Choose to Voluntarily Terminate Enrollment If They Do Not Plan To Comply

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 voluntary 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.

For additional information regarding DMEPOS accreditation or the provisions associated with a surety bond, go to http://www.cms.hhs.gov/MedicareProviderSupEnroll.

Frequently Asked Questions (FAQs) on the surety bond requirement can be found on the NSC's FAQ page at http://www.palmettogba.com/nsc.

Take Action Now to Prepare for the Medicare DMEPOS Competitive Bidding Program!

A Special Edition *MLN Matters* education article identifying steps suppliers should take in preparation for the DMEPOS Competitive Bidding Program to ensure successful bidder registration is available at http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0915.pdf.

Also recently released--MM6571 - Program Instructions Designating the Competitive Bidding Areas and Product Categories Included in the DMEPOS Competitive Bidding Program Round One Rebid in calendar year (CY) 2009. This article identifies the nine metropolitan statistical areas (MSAs) as well as product categories in which the DMEPOS competitive bidding round one re-bid will occur in CY 2009 under section 1847 of the Social Security Act. You can view this article at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6571.pdf.

Accreditation and Surety Bond Deadlines Approaching for DMEPOS Suppliers

Provided by the National Supplier Clearinghouse

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

What you need to do if you are in the process of being accredited or obtaining a surety bond?
CMS encourages all DMEPOS suppliers currently in the midst of the accreditation process to correct all outstanding deficiencies on your accreditation report so that a site visit or accreditation decision can be rendered by the October 1, 2009, deadline. CMS also encourages all DMEPOS suppliers, subject to the bonding requirements, to obtain a surety bond.

While the DMEPOS Accrediting Organization will notify the National Supplier Clearinghouse (NSC) that you are accredited, you will need to notify the NSC that you have

obtained your surety bond. When submitting your DMEPOS surety bond to the NSC, you should submit sections 1, 2A1, 12, and either 15 (if you are the authorized official) or 16 (if you are the delegated official) of the Medicare enrollment application (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.

What you need to do if you are not going to be accredited or get a surety bond?
If you have made the business decision not to obtain accreditation or a surety bond if required, you may want to voluntarily terminate your enrollment with the Medicare program as a DMEPOS supplier. If you decide to voluntarily terminate your enrollment and later decide to re-enroll in the Medicare program, you will only be able to bill for services furnished on or after the date the NSC issues a DMEPOS supplier number to you conveying billing privileges. In most cases, this will result in a period for which you, as a DMEPOS supplier, cannot bill for services furnished to Medicare beneficiaries.

You can voluntarily terminate your enrollment in the Medicare program by completing the sections associated with voluntary termination on page 4 of the CMS-855S. You can even notify the National Supplier Clearinghouse of a future date termination. After completing the applicable sections, the Authorized or Delegated Official should sign, date and mail the completed termination request to the NSC.

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

Additional Information
For additional information regarding DMEPOS accreditation or the provisions associated with a surety bond, go to http://www.cms.hhs.gov/MedicareProviderSupEnroll/. Frequently Asked Questions (FAQs) on the surety bond requirement can be found on the NSC's FAQ page at http://www.palmettogba.com/nsc.

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

FYI CONT'D

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

Quarterly Provider Updates

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

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

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

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

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

Interest on Clean Paid Claims

After date of receipt, if payment is not made within 30 days for clean claims, interest must be paid. The rate used is found on the Treasury Department's web page at http://fms.treas.gov/prompt/rates.html. The rate for July 2009 - December 2009 is 4.875%.

The following is a list of situations when interest is not paid (*not all-inclusive*):

- Claims requiring external investigation or development
- Claims on which no payment is due
- Full denials

Source: *Medicare Claims Processing Manual* 100-4, Chapter 1, Section 80.2.2 and Change Request 6542

Medicare FFS Emergency Preparedness Questions and Answers

CMS has updated the Medicare Fee-for-Service (FFS) Emergency Preparedness Questions and Answers (Qs & As). The Emergency Qs & As are posted in a document at http://www.cms.hhs.gov/Emergency/10_PandemicFlu.asp. These Qs & As include a section applicable to the H1N1 flu virus.

The document is dated to reflect the posting date. As additions and changes are made to the document, the download name will change to reflect the date. Please take note that these Qs & As do not address a Section 1135 waiver situation.

EDUCATIONAL

New Remittance Advice Tutorial Available

To help suppliers read and understand their remittance advice, a new remittance advice tutorial has been developed. 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. The tutorial and field descriptions are located on the Claims tab under Remittance Advices.

The last section of the remittance advice is the glossary. This section provides detailed descriptions of the reason and remark codes listed on each claim line of the remittance advice. If the remittance advice does not provide the glossary section, a list of the codes can be found on the Washington Publishing Company web site.

NAS notified suppliers on May 20, 2009, of the CMS requirement for suppliers to have the remittance advice available when contacting the NAS through the article Remittance Advice Requirements for Calling the Contact Center.

Top Ten Telephone Inquiries

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

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

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

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

To avoid receiving a same or similar denial, it is very important for suppliers to have a thorough intake process. Suppliers should ask the beneficiary if they currently have or have had an identical or similar piece of equipment.

Utilize the IVR to verify the same or similar information provided by the beneficiary. Be aware, failure to use the appropriate modifier when checking same or similar on the IVR may result in inaccurate or incomplete same or similar information being returned. For complete information on modifier usage see the article titled "Modifier Required When Using the IVR for Same or Similar Inquiries."

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

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

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

If a supplier receives a medical necessity denial, a signed written request to appeal the decision may be submitted. If an appeal is requested, NAS recommends using the DME Inquiry/Redetermination form. Submit the request along with all pertinent medical documentation supporting the need for the item to:

Noridian Administrative Services
PO Box 6727
Fargo ND 58108-6727

Signed requests and documentation may also be faxed to 1-888-408-7405.

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

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

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

It is the supplier's responsibility to determine whether the patient is entitled to receive Medicare benefits and to report the Medicare number and patient's name as shown on the patient's Medicare health insurance card.

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

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

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

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

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

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

Many electronic claim billing software programs have a feature which allows an ERA to be received electronically, printed and/or posted to each beneficiary's account. Suppliers should contact the software vendor for the availability of these features.

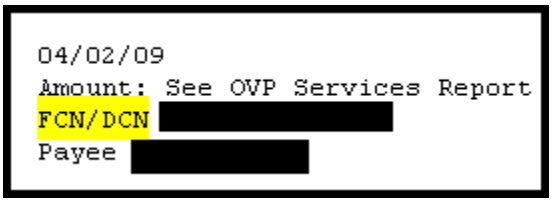
CEDI only keeps a copy of remittance advices for 45 days.

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

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

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

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


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

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

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

8. Appeal Status/Explanation/Resolution
NAS will send an acknowledgement letter within 10 calendar days of receiving a redetermination request. If a redetermination request was sent in and the supplier has not received an acknowledgement letter within 10 calendar days, they may wish to resubmit the request.

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

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

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

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

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

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

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

Top Ten Written Inquiries

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

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

Before sending a request, ensure all pertinent information has been included. NAS receives letters of medically necessity without a Health Insurance Claim Number (HICN), appeal request or date of service (DOS). Without this information, we are unable to identify the patient and/or claim in question. Lack of information may cause the inquiry to be returned as unprocessable.

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

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

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

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

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

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

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

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

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

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

Refer to the article "Non-Covered Items" for a list of Healthcare Common Procedure Coding System (HCPCS) codes which do not meet the definition of a Medicare benefit or are statutorily excluded.

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

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

Training/Events: links to presentations, the Online Learning Center (OLC), and upcoming workshops.

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

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

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

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

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

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

- Date of service (within same year)
- Place of service
- HCPCS codes
- Diagnoses
- Modifiers (with the exception of GA, GY or GZ which changes liability)
- Number of services
- Billed amount

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

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

EDUCATIONAL CONT'D

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

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

8. Misrouted Written Correspondence
Forms and requests must be sent to the correct entity. NAS has been receiving correspondence intended for the National Supplier Clearinghouse (NSC), Common Electronic Data Interchange (CEDI), and other DME MACs. Sending inquiries and information to the incorrect entity may cause a delay in processing.

For a list of addresses and phone numbers for these and other entities as well as links to the other DME MACs' web sites, visit the Contact section of our web site.

9. Provider Demographic Information Changes
NAS has seen an increase in the number of requests to update supplier addresses, telephone numbers, and participation status. This information cannot be changed by NAS or any other DME MAC. This information must be sent to the NSC.

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

The NSC may be reached at 1-866-238-9652, 9 am - 4 pm EST or via the addresses below.

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

Overnight Mailing Address

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

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

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

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

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

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

Many electronic claim billing software programs have a feature which allows an ERA to be received electronically, printed and/or posted to each beneficiary's account. Suppliers should contact the software vendor for the availability of these features.

Remember, CEDI only keeps a copy of remittance advices for 45 days.

CEDI

CEDI Password Reset Policy

According to HIPAA Security Standards, only the owner of the Trading Partner/Submitter ID may request the password for their Login ID be reset or unlocked. Additionally, a third party (including software vendors and billing services) may not be joined into the phone call. The CEDI Help Desk will only perform password resets or unlock suspended passwords for the owner of the Trading Partner/Submitter ID. Requests received with multiple parties on the call will be advised of this policy and to have the owner of the Trading Partner/Submitter ID make the request privately.

To request a password reset or unlock a suspended password, please have the following information available:

- Trading Partner/Submitter ID
- NPI number
- PTAN/NSC

Note for Vendors: The CEDI Help Desk will refer providers to contact their software vendor if the login process used to connect to CEDI is scripted. Vendors are responsible for educating their customers on how to change the scripted password settings. The CEDI Help Desk will only assist the provider in resetting or unlocking the password if they own the Trading Partner/Submitter ID.

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

Healthcare Provider Taxonomy Codes Updates Effective October 2009

The Health Insurance Portability and Accountability Act (HIPAA) requires that covered entities comply with the requirements in the electronic transaction format implementation guides adopted as national standards. The X12 837 Institutional and Professional Implementation Guides used for Medicare Part A and Medicare Part B claims requires the use of valid codes contained in the Healthcare Provider Taxonomy Codes (HPTC) set when there is a need to report provider type or physician, practitioner, or supplier specialty for a claim.

The HPTC set is maintained by the National Uniform Claim Committee (NUCC) for standardized classification of health care providers. The NUCC updates the code set twice a year with changes effective April 1 and October 1.

Valid HPTCs are those codes approved by the NUCC for current use. Terminated codes are not approved for use after a specific date and newly approved codes are not approved for use prior to the effective date of the code set update in which each new code first appears. Although the NUCC generally posts their updates on the WPC web page three months prior to the effective date, changes are not effective until April 1 or October 1 as indicated in each update. Specialty and/or provider type codes issued by any entity other than the NUCC are not valid and Medicare would be guilty of non-compliance with HIPAA if Medicare contractors accepted claims that contain invalid HPTCs.

For Medicare Part B, the taxonomy code is not required for processing Medicare claims. However, if a taxonomy code is submitted, it must be valid according to the HPTC code set. The HPTC code set is named in the 837 professional implementation guide, thus EDI must validate the inbound taxonomy codes against this HPTC maintained code source.

The HPTC list is available from the Washington Publishing Company (WPC). To view the October 2009 changes, visit the WPC web site at http://www.wpc-edi.com/codes/taxonomy, then select "New Codes" for a listing of new HPTCs or "Modifications" for a listing of modified HPTCs.

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

Returned CEDI Enrollment Form(s) Reminder

All CEDI enrollment form(s) returned for invalid or missing information will need to be re-entered electronically on the CEDI web site at http://www.ngscedi.com/forms/formsindex.htm.

CEDI requires all returned enrollment form(s) be resubmitted electronically before the corrected form is faxed to CEDI Enrollment for processing. Any returned form(s) that are resubmitted without completion of the electronic record will be returned without processing.

The top reasons for enrollment paperwork to be returned are:

- Missing or invalid NPIs, PTANS and/or submitter IDs
- The supplier's authorized signature(s) is missing.
- Any form with a signature that is dated over 30 days.
- The NPI(s), PTAN(s) and/or trading partner ID(s) are missing or invalid.
- The NPI or PTAN/NSC is not registered through NPPES web site and is not on the NPI crosswalk.
- The supplier's name on the form does not match the records at the national supplier clearinghouse.
- There is not an EDI Enrollment Form on file for the supplier's NPI and PTAN/NSC entered on the Supplier Authorization Form.
- The Submitter Action Request Form was not submitted to request a NEW trading partner/submitter ID.

To ensure that paperwork does not get returned, review it carefully before faxing it to the CEDI Enrollment department.

Please contact the CEDI Help Desk at ngs.cedihelpdesk@wellpoint.com or at 866-311-9184 for more information. Questions can also be sent to cedienrollment@wellpoint.com.

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 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.

CEDI CONT'D

- Although the CEDI NCPDP reports are returned before the DME MAC NCPDP 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.

NCPDP 5.1 Implementation Documentation Sent to CEDI Vendors

The CEDI recently forwarded documentation on the NCPDP technical changes to the CEDI Vendor Community. CEDI is working closely with the vendors to ensure they are preparing for these upcoming changes.

Updates will also be made to the *NCPDP Error Code Manual*. Sample reports and the updated manual will be provided to the DME MAC supplier community once available. Watch the CEDI Listserv for notification on when the documentation is in production on the web site.

If you are a software vendor that submits NCPDP claims to CEDI and did not receive the NCPDP technical documentation on the new edits, please send an e-mail to the CEDI Help Desk at ngs.cedihelpdesk@wellpoint.com.

ENROLLMENT

Compliance Standards for Consignment Closets and Stock Bill Arrangements

Recently CMS released Change Request (CR) 6528 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 September 8, 2009, 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.
- 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.

Published by the National Supplier Clearinghouse on 8/17/09.

Compliance Standards for Consignment Closets and Stock and Bill Arrangements

MLN Matters® Number: MM6528Revised
Related Change Request (CR) #: 6528
Related CR Release Date: September 1, 2009
Related CR Transmittal #: R300PI
Effective Date: September 8, 2009
Implementation Date: March 1, 2010

Note: This article was revised on September 2, 2009, to reflect the revised CR 6528, issued by the Centers for Medicare & Medicaid Services on September 1, 2009. The CR release date, transmittal number, implementation date, and the web address for accessing CR 6528 have been changed. All other information remains the same.

Provider Types Affected
Suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) which maintain inventory at a practice location owned by a physician or non-physician practitioner for the purpose of DMEPOS distribution and which submit claims to the National Supplier Clearinghouse Medicare Administrative Contractor (NSC-MAC) are affected. In addition, physicians and non-physician practitioners who maintain DMEPOS inventory at the physician or non-physician practitioner's practice location for the purpose of DMEPOS distribution should be aware of this issue.

Provider Action Needed
DMEPOS suppliers, physicians and non-physician practitioners who maintain consignment closets and stock and bill arrangements for DMEPOS must comply with current standards, which may be verified by the NSC-MAC. Providers should assure that their billing staff are advised of these billing and compliance standards.

Background
This article is based on CR 6528, which defines and prohibits certain arrangements where an enrolled DMEPOS supplier maintains inventory at a practice location that is not owned by the enrolled DMEPOS supplier, but rather, owned by a physician or non-physician practitioner for the purpose of DMEPOS distribution, commonly referred to as a consignment closet and/or stock and bill arrangement. A common practice example is that of an enrolled physician practice that allows DMEPOS owned by a separately enrolled DMEPOS supplier to be kept at the physician's practice location.

CR 6528 instructs the NSC-MAC that use of consignment closets and/or stock and bill arrangements, as defined in the background above, must be in compliance with current standards. In addition, the CR defines additional specific compliance standards for NSC-MAC validation for consignment closets and stock and bill arrangements added to the Medicare Program Integrity Manual (PIM), chapter 10, section 21.8, and viewable as an attachment to CR 6528 at http://www.cms.hhs.gov/Transmittals/downloads/R300PI.pdf on the Centers for Medicare & Medicaid Services (CMS) web site.

Medicare allows Medicare enrolled DMEPOS suppliers to maintain inventory at a practice location owned by a physician or non-physician practitioner for the purpose of DMEPOS distribution when the following conditions are met by the DMEPOS supplier and verified by the NSC-MAC:

- The title to the DMEPOS shall be transferred to the enrolled physician or non-physician practitioner's practice at the time the DMEPOS is furnished 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.
- 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.

The NSC-MAC shall verify that no more than one enrolled DMEPOS supplier shall be enrolled and/or located at the same practice location. (Note: This prohibition does not exist for one or more physicians enrolled as DMEPOS suppliers at the same physical location.) A practice location shall have a separate entrance and separate post office address, recognized by the United States Postal Service.

The NSC-MAC customer service personnel shall respond to direct provider and/or supplier questions concerning compliance with this policy. The responsibility for determining compliance with these provisions is the responsibility of the DMEPOS supplier, physician, or non-physician practitioner.

Additional Information
The official instruction, CR 6528, issued to the Medicare NSC-MAC regarding this change, may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R300PI.pdf on the CMS web site.

Medicare Provider Enrollment Reminder for Suppliers of DMEPOS

With the implementation of the surety bond requirements for certain suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) in October 2009, CMS reminds DMEPOS suppliers that each practice location of a DMEPOS supplier must be enrolled in the Medicare program. Each practice location of a DMEPOS supplier is required by Medicare regulations to be uniquely identified; as a result, each practice location must have its own unique National Provider Identifier (NPI) and its own Medicare-assigned Provider Transaction Access Number (PTAN). With the exception described below in the Important Note, there should be a 1-to-1 relationship between a DMEPOS supplier's NPI and its PTAN. The PTAN is assigned to a DMEPOS supplier by the National Supplier Clearinghouse (NSC) upon its enrollment in the Medicare program. (The PTAN has previously been referred to as the NSC Number.)

Important Note: DMEPOS suppliers who are sole proprietorship business structures with more than one practice location must ensure that each location is enrolled in Medicare. Each practice location would be assigned a PTAN upon its enrollment. However, as a sole proprietorship, the business is legally one and the same as the person who is the sole proprietor and, therefore, like any individual, is eligible for only a single NPI.

Surety Bond FAQs

CMS announced on December 29, 2008, some DMEPOS suppliers will be subject to a surety bond requirement to obtain/maintain Medicare billing privileges. In an attempt to keep the supplier community informed, CMS has released a series of frequently asked questions regarding the bonding requirement. This list will be updated as additional information becomes available. See the list of surety bond FAQs on the National Supplier Clearinghouse web site.

Registration Now Open for Suppliers Interested in Competitive Bidding for DMEPOS

Registration is now open and available to all suppliers interested in participating in the Round 1 Rebid of the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program. Interested suppliers will submit their bids using an on-line internet application. To help ensure bid security and privacy, suppliers must first register to obtain a user ID and password. Only suppliers that have a user ID and password will be able to use the on-line bidding system; suppliers that do not register will not be able to bid.

If you are a supplier interested in bidding, register now – don't wait. Designate one Authorized Official (AO) listed on the CMS-855S enrollment form to act as your AO for registration purposes. The AO must register first and must approve other supplier employee requests to register. 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 supplier employees to serve as Backup Authorized Officials (BAO) and/or End Users (EU). BAOs and EUs must also register in order to be able to use the on-line 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 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 strongly urge all AOs to register no later than September 14, 2009, to ensure that BAOs and EUs have time to register before bidding begins. 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 p.m. EST – no AOs, BAOs, or EUs can register after registration closes.

To register, go to the Competitive Bidding Implementation Contractor (CBIC) web site at http://www.dmecompetitivebid.com. Please review the ***IACS Reference Guide*** 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. For information about the competitive bidding areas and product categories included in the Round 1 Rebid, as well as bidder education materials, please visit the CBIC web site at http://www.dmecompetitivebid.com.

Program Instructions Designating the Competitive Bidding Areas and Product Categories Included in DMEPOS Competitive Bidding Program Round One Rebid

MLN Matters® Number: MM6571
Related Change Request (CR) #: 6571
Related CR Release Date: August 3, 2009
Related CR Transmittal #: R527OTN
Effective Date: August 3, 2009
Implementation Date: September 3, 2009

Provider Types Affected
Medicare DMEPOS suppliers that bill DME Medicare Administrative Contractors (DME MACs) as well as providers that bill Medicare Regional Home Health Intermediaries (RHHIs) or Part A/B Medicare Administrative Contractors (A/B MACs) whom refer or order DMEPOS for Medicare beneficiaries.

What You Need To Know
The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 6571 in order to identify the nine metropolitan statistical areas (MSAs) as well as product categories in which the DMEPOS competitive bidding round one re-bid will occur in CY 2009 under section 1847 of the Social Security Act.

Key Points of CR6571
As mandated by the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), the DMEPOS Competitive Bidding Round One rebid in 2009 will occur in the following 9 MSAs:

- Cincinnati - Middletown (Ohio, Kentucky and Indiana);
- Cleveland – Elyria - Mentor (Ohio);
- Charlotte – Gastonia - Concord (North Carolina and South Carolina);
- Dallas - Fort Worth - Arlington (Texas);
- Kansas City (Missouri and Kansas);
- Miami - Fort Lauderdale - Miami Beach (Florida);
- Orlando (Florida);
- Pittsburgh (Pennsylvania); and
- Riverside - San Bernardino - Ontario (California).

Further information on the boundaries and list of zip codes for each competitive bid area (CBA) and the Healthcare Common Procedure Coding System (HCPCS) codes for each product category are available by visiting http://www.cms.hhs.gov/DMEPOSCompetitiveBid/01_overview.asp on the CMS web site and following the link to Competitive Bidding Implementation Contractor (CBIC).

The DMEPOS Competitive Bidding Round One rebid in 2009 will include the following 9 product categories:

- Oxygen Supplies and Equipment;
- Standard Power Wheelchairs, Scooters, and Related Accessories;

- Complex Rehabilitative Power Wheelchairs and Related Accessories (Group 2);
- Mail-Order Diabetic Supplies;
- Enteral Nutrients, Equipment and Supplies;
- Continuous Positive Airway Pressure (CPAP), Respiratory Assist Devices (RADs), and Related Supplies and Accessories;
- Hospital Beds and Related Accessories;
- Walkers and Related Accessories; and
- Support Surfaces (Group 2 mattresses and overlays) in Miami

The MSAs and product categories that are included in the DMEPOS Competitive Bidding Round I rebid in 2009 can also be found at http://www.cms.hhs.gov/DMEPOSCompetitiveBid/01_overview.asp on the CMS web site.

Suppliers and providers may call the Provider Contact Centers with competitive bidding inquiries at the CBIC Competitive Bidding Program Helpdesk at 1-877-577-5331 or go to the "Contact Us" feature on the CBIC Competitive Bidding Program web site at http://www.dmecompetitivebid.com/ on the Internet to submit competitive bidding specific questions.

Background
The Medicare payment for most DMEPOS is currently based on fee schedules. However, section 302(b) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), which amended section 1847 of the Social Security Act (the Act), mandates a competitive bidding program to replace the current DMEPOS fee schedule payment amounts for selected items in selected areas.

The statute provides that competitive bidding will apply to DME meeting the definition of a "covered item" as specified in section 1834(a) (13) of the Act, including items used in infusion and drugs (other than inhalation drugs) and supplies used in conjunction with DME, but excluding class III devices under the Federal Food, Drug and Cosmetic Act. Competitive bidding will also apply to enteral nutrients, equipment, and supplies. Further, competitive bidding will apply to off-the-shelf orthotics described in section 1861(s)(9) for which payment would otherwise be made under Section 1834(h) which require minimal self-adjustment for appropriate use and do not require expertise in trimming, bending, molding, assembling, or customizing to fit the individual.

The statute, as amended by the MMA, also provided for phasing in competitive bidding beginning in 10 of the largest MSAs. Areas that may be exempt from the DMEPOS competitive bidding program include rural areas and areas with low population density within urban areas that are not competitive, unless there is a significant national market through mail order for a particular item or service.

Round One of the DMEPOS competitive bidding program was implemented on July 1, 2008, in ten competitive bidding areas, as mandated by the MMA. However, as part of MIPPA, Congress enacted a temporary delay in the competitive bidding program for Round One Competitive Bidding Areas. The law required CMS to terminate the existing contracts that were awarded in Round One and conduct a second Round One competition (the "Round One rebid") in 2009. The MIPPA also excluded certain Round One DMEPOS items and areas from the competitive bidding program. Section 154(a) of the MIPPA exempted group three complex rehabilitative power wheelchairs and related accessories when furnished in connection with such wheelchairs for the Round One rebid and subsequent rounds of the program, as well as, negative pressure wound therapy (NPWT) items and services from the Round One rebid competition. The MIPPA also excluded Puerto Rico as an area so that the Round One rebid competition covers nine, instead of ten of the largest MSAs. Except for the aforementioned exceptions, section 154(a) of the MIPPA requires that the Round One rebid occur in 2009 with the same items and services and the same areas as in Round One.

Additional Information
The official instruction (CR6571) issued to your Medicare DME/MAC, RHHI or A/B MAC is available at http://www.cms.hhs.gov/Transmittals/downloads/R527OTN.pdf on the CMS web site.

For clarification of the initial delay in the DMEPOS competitive bidding program you may review MM6203 at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6203.pdf on the CMS web site.

Medicare Announces Timeline for Bidding, Begins Supplier Education Campaign for DMEPOS Competitive Bidding Program

Bidding Timeline for the DMEPOS Competitive Bidding Program

CMS has announced the bidding timeline for the Round 1 Rebid of the Medicare DMEPOS Competitive Bidding Program. To view the timeline, please click: Timeline

Bidder Education Campaign
CMS is launching an intensive bidder education campaign designed to ensure that DMEPOS suppliers interested in bidding get all the information they need to submit a complete bid in a timely manner. CMS will focus initially on preparing suppliers for the registration period. As suppliers get registered for the competitive bidding process, CMS education and outreach efforts will intensify with particular focus on information specific to registered bidders and the bidding process.

CMS's Competitive Bidding Implementation Contractor (CBIC) will be the focal point for bidder education. The CBIC's dedicated web site, http://www.dmecompetitivebid.com/palmetto/cbic.nsf/DocsCat/Home, will include a comprehensive array of important information for suppliers, 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 now 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.

Visit the CMS web site at http://www.cms.hhs.gov/DMEPOSCompetitiveBid/ for the latest information on the DMEPOS Competitive Bidding Program.

To view the press release, please click: http://www.cms.hhs.gov/apps/media/press_releases.asp

New ZIP Code Tool on CBIC Web Site

The popular ZIP code look-up tool has been posted to the DMEPOS Competitive Bidding Program website. The tool will assist you with identifying the Competitive Bidding Areas (CBA) and ZIP codes for the Round 1 Rebid.

You will find the CBA tool on the homepage of the Competitive Bidding Implementation Contractor (CBIC) web site. You may search by entering the ZIP code or by selecting a state and CBA. When you enter a ZIP code, a screen will appear to notify you of whether the ZIP code is located within a CBA. If the ZIP code is included in a CBA, you will be directed to a page with a map of the CBA and a listing of the ZIP codes for mail-order diabetic testing supplies and for all other competitively bid items. To search for a CBA by state, select a state from the drop down box and then choose the CBA from the drop down box. Only the CBAs included in the rebid of the first round will appear in the drop down box. CBAs are identified by ZIP codes.

This tool will also be helpful in determining if a beneficiary's permanent address is located within a CBA. Remember, payment is always based on the permanent address of the beneficiary. Beneficiaries who permanently reside within a CBA must obtain competitively bid items from a contract supplier for that CBA.

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.

ICD-10

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

The revised publication titled "ICD-10-CM/PCS: An Introduction Fact Sheet" (August 2009), which was previously titled "ICD-10-Clinical Modification/Procedure Coding System Fact Sheet", is now available in downloadable format from the Centers for Medicare & Medicaid Services Medicare Learning Network at http://www.cms.hhs.gov/MLNProducts/downloads/ICD-10factsheet2009.pdf. This fact sheet 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.

ICD-10-CM/PCS Publications

The following ICD-10-CM/PCS publications are now available from the Centers for Medicare & Medicaid Services Medicare Learning Network:

- ICD-10-CM/PCS Myths & Facts (June 2009), which presents correct information in response to some myths regarding the ICD-10-Clinical Modification/Procedure

Coding System, is now available in print format. To place your order, visit http://www.cms.hhs.gov/MLNGenInfo/, scroll down to "Related Links Inside CMS" and select "MLN Product Ordering Page."

- ICD-10-CM-PCS Bookmark (revised August 2009), which provides information about the ICD-10-Clinical Modification/Procedure Coding System including the benefits of adopting the coding system, recommended steps to be taken in order to plan and prepare for implementation of the coding system, and where additional information about the coding system can be found, is now available in downloadable format at http://www.cms.hhs.gov/MLNProducts/downloads/ICD-10ClinModBookmrk.pdf

ICD-10-CM/PCS Bookmark

The revised *ICD-10-CM/PCS Bookmark* (August 2009), which provides information about the ICD-10-Clinical Modification/Procedure Coding System (ICD-10-CM/PCS) including the benefits of adopting the coding system, recommended steps to be taken in order to plan and prepare for implementation of the coding system, and where additional information about the coding system can be found, 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."

Quarterly Average Sales Price Drug Pricing Files and Prior Quarterly File Revisions – October 2009

MLN Matters® Number: MM6585
Related Change Request (CR) #: 6585
Related CR Release Date: August 14, 2009
Related CR Transmittal #: R1795CP
Effective Date: October 1, 2009
Implementation Date: October 5, 2009

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

Provider Action Needed
This article is based on Change Request (CR) 6585 and instructs Medicare contractors to download and implement the October 2009 ASP drug pricing file for Medicare Part B drugs; and if released by the Centers for Medicare & Medicaid Services (CMS), also the revised July 2009, April 2009, January 2009, and October 2008, files. Medicare will use the October 2009 ASP and not otherwise classified (NOC) drug pricing files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after October 5, 2009 with dates of service October 1, 2009, through December 31, 2009. See the Background and Additional Information Sections of this article for further details regarding these changes.

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

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

End Stage Renal Disease (ESRD) drugs (when separately billed by freestanding and hospital-based ESRD facilities); and

Specified covered outpatient drugs and drugs and biologicals with pass-through status under the Outpatient Prospective Payment System (OPPS).

Beginning January 1, 2008, under the OPPS, payment allowance limits for specified covered outpatient drugs are paid at ASP+5 percent. Beginning January 1, 2009, under the OPPS, payment allowance limits for specified covered outpatient drugs are paid at ASP+4 percent. Drugs and biologicals with pass-through status under the OPPS continue to have a payment allowance limit of 106 percent of the ASP. CMS will update the payment allowance limits quarterly. There are exceptions to this general rule and they are stated in the Medicare Claims Processing Manual, Chapter 17, Section 20.1.3 and may be reviewed at http://www.cms.hhs.gov/manuals/downloads/clm104c17.pdf on the CMS web site.

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

If a physician (or other practitioner) is prescribing medication for a patient with an implantable pump, a nurse may refill the pump if the medication administered is accepted as a safe and effective treatment of the patient's illness or injury; there is a medical reason that the medication cannot be taken orally; and the skills of the nurse are needed to infuse the medication safely and effectively. Payment for drugs furnished incident to the filling or refilling of an implantable pump or reservoir

is determined under the ASP methodology as described above, except that pricing for compounded drugs is done by your local Medicare contractor.

Use of Quarterly Payment Files
The following table shows how the quarterly payment files will be applied:

Files	Effective Dates of Service
October 2009 ASP and ASP NOC files	October 1, 2009 through December 31, 2009
July 2009 ASP and ASP NOC files	July 1, 2009 through September 30, 2009
April 2009 ASP and ASP NOC files	April 1, 2009 through June 30, 2009
January 2009 ASP and NOC Files	January 1, 2009 through March 31, 2009
October 2008 ASP and NOC Files	October 1, 2008 through December 31, 2008

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

Additional Information

The official instruction (CR6585) issued to your Medicare carrier, FI, RHHI, MAC, or DME MAC is available at http://www.cms.hhs.gov/Transmittals/downloads/R1795CP.pdf

CMS would like providers to be aware that the following MLN products are available through the MLN Catalogue:

1. The guide at http://www.cms.hhs.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf describes topics such as: types of Remittance Advice (RA), the purpose of the RA and types of codes that appear on the RA.
2. A fact sheet at http://www.cms.hhs.gov/PQRI/Downloads/PQRIEPrescribingFactSheet.pdf introduces the E-Prescribing Incentive Program as authorized by Medicare Improvements for Patients and Providers Act of 2008 (MIPPA).
3. The brochure at http://www.cms.hhs.gov/MLNProducts/downloads/Protectingpracbroch508-09.pdf highlights some the steps providers can employ to protect their practices from inappropriate Medicare business interactions.

APPEALS

Top Ten Reopenings

NAS is providing solutions to the top ten reopenings the Appeals staff received from January – May 2009. This includes denials for medical necessity, maximum amount paid, frequency, certificates of medical necessity, frequency, same/similar, noncovered charges, recertification, and duplicates.

1. **Medical Necessity (CO-50):** These are non-covered services because this is not deemed a "medical necessity" by the payer.

A written signed and dated order must be received by the supplier before a claim is submitted. If the supplier bills for an item addressed in a policy without first receiving the completed order, the item will be denied as not medically necessary.

Suppliers are encouraged to consult the Local Coverage Determination (LCD) and related Policy Article for medical policy coverage criteria. Suppliers are also encouraged to subscribe to the NAS DME electronic mailing list to receive updates regarding LCDs and policy articles.

2. **Maximum Amount Paid (CO-45):** This is the maxinum approved amount for this item.

The maximum payment has been allowed for this service. To minimize these types of claim errors when additional money should be allowed, review the claim before submitting it. Ensure the units, date span, place of service, etc., is correct on the initial claim submission.

3. **Frequency (CO-150):** Payment denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, this dosage or this day's supply.

Frequency guidelines are outlined in the applicable LCD and related Policy Articles. Tips to reduce the number of claims denying for this issue include:

- Ensure the dates are spanned, if applicable.
- Ensure the number of units are correct. If more units are necessary, proper documentation will need to be on file to support the increased units.

- Suppliers should review the documentation section of each individual medical policy to verify the utilization guidelines and the documentation requirements needed when billing for quantities of supplies greater than those described in the policy.

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

For a guide of what type of documentation is needed, refer to the Documentation Guide for DME Redeterminations. Additional information can also be found in Chapter 3 of the Supplier Manual on our web site.

4. **Noncovered Charges (PR-204):** Noncovered charges.

This service is not covered by Medicare. These denials are not based on policy criteria but are statutorily excluded items or the items do not meet the definition of a Medicare benefit.

5. **Same/Similar (CO-150):** Either you or another supplier are already furnishing the same or similar equipment to this patient.

In order to avoid a denial for same or similar equipment the supplier should begin speaking with the patient regarding same/similar items. The patient should know if they have used or owned a same or similar item in the past. To ensure the patient understands how items are grouped, we suggest explaining what items may be considered "similar." For example, walkers and wheelchairs are both considered mobility and therefore, would be considered similar equipment. A great tool to use is the Same or Similar Reference Chart located under the Claims section of our web site. Same and similar can be obtained on the Interactive Voice Response (IVR) system. In addition, suppliers may use the Suggested Intake Form available on our web site. Additional information can be found in Chapter 3 of the Supplier Manual found in the Publications section of our web site.

6. **Certification of Medical Necessity Needed (CO-176):** No Certification of Medical Necessity was received for this equipment.

Suppliers should be knowledgeable regarding the medical policies for items requiring a Certificate of Medical Necessity (CMN) or a DME Information Form (DIF). Ensure the CMN or DIF is submitted with the correct information on the initial claim submission.

Submit the initial claim and wait at least five days to submit consecutive months. This will ensure the initial claim has processed and the CMN was entered into the system for proper processing of additional claims.

The policies and related articles will aid in completing the CMNs and DIFs and also inform the supplier on the appropriate time to submit the CMN and DIF to the DME MACs.

All CMNs and DIFs are located on the DME web site under the Forms section. Additional information regarding CMN requirements can be found in the Internet Only Manual (IOM), Publication 100-4, *Medicare Claims Processing Manual*, Chapter 20, Section 100.2 and Chapter 4 of the Supplier Manual. **C**

7. **Billing Over Months Covered (CO-35):** Billing exceeds the rental months covered/approved by the payer.

A common type of service where this denial is seen frequently is oxygen and oxygen equipment when a new capped rental is needed due to a break in service or if the reasonable useful lifetime has been met. To minimize these types of denials send the CMN electronically with the initial claim.

8. **Recertification of Medical Necessity Needed (CO-176):** No recertification or revision of medical necessity was received for this equipment.

Ensure the recertification and/or revision is sent electronically with the claim when the claim requires this information.

Refer to the individual LCD and related Policy Articles for proper claims submission.

9. **No Prescription on File (CO-176):** Payment adjustment because this service was not prescribed by a physician, not prescribed prior to delivery, the prescription is incomplete, or the prescription is not current.

Ensure the prescriptions are current and the CMN or DIF is submitted with the correct information on the original submitted claim.

10. **Coordination of Benefits (CO-22):** A claim must be sent to the beneficiary's group health plan first. After the claim has been processed by that plan and if the bill has not been paid in full, resubmit this claim along with the beneficiary's bills and a copy of the notice the beneficiary received from the other insurance company. The services may be considered toward the beneficiary's deductible and for possible Medicare payment.

To minimize these types of denials, ensure a claim is sent to the beneficiary's primary insurance first. Suppliers are encouraged to use the Medicare Secondary Payer (MSP) Questionnaire located under the Claims section of our web site.

Top Ten Redeterminations

NAS is providing solutions to the top ten redeterminations the Appeals staff received from January – May 2009. This includes denials for medical necessity, maximum amount paid, frequency, certificates of medical necessity, frequency, same/similar, noncovered charges, recertification, and duplicates.

1. **Medical Necessity (CO-50):** These are non-covered services because this is not deemed a "medical necessity" by the payer.

A written signed and dated order must be received by the supplier before a claim is submitted. If the supplier bills for an item addressed in a policy without first receiving the completed order, the item will be denied as not medically necessary.

Suppliers are encouraged to consult the Local Coverage Determination (LCD) and related Policy Article for medical policy coverage criteria. Suppliers are also encouraged to subscribe to the NAS DME electronic mailing list to receive updates regarding LCDs and Policy Articles.

2. **Maximum Amount Paid (CO-45):** This is the maximum approved amount for this item.

The maximum payment has been allowed for this service. To minimize these types of claim errors when additional money should be allowed, ensure the proper units, date span, place of service, etc., is correct on the initial claim.

3. **Frequency (CO-150):** Payment denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, this dosage or this day's supply. **(CO-150)**

Frequency guidelines are outlined in the applicable LCD and related Policy Articles.

Tips to reduce the number of claims denying for this issue:

- Ensure the dates are spanned, if applicable.
- Ensure the number of units is correct. If more units are necessary, proper documentation will need to be on file to support the increased units.
- Suppliers should review the documentation section of each individual medical policy to verify the utilization guidelines and the documentation requirements needed when billing for quantities of supplies greater than those described in the policy.

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

For a guide of what type of documentation is needed, refer to the Documentation Guide for DME Redeterminations. Additional information can also be found in Chapter 3 of the Supplier Manual on our web site.

4. **Certification of Medical Necessity Needed (CO-176):** No Certification of Medical Necessity was received for this equipment.

Suppliers should be knowledgeable regarding the medical policies for items requiring a Certificate of Medical Necessity (CMN) or a DME Information Form (DIF). Ensure the CMN or DIF is submitted with the correct information on the initial claim submission.

Another suggestion is to submit the initial claim and wait at least five days to submit consecutive months. This will ensure the initial claim has processed and the CMN entered into the system for proper processing of additional claims.

The policies and related articles will aid in completing the CMNs and DIFs and also inform the supplier when it is appropriate to submit the CMN and DIF with the claim.

All CMNs and DIFs are located on the DME web site under the Forms section. Additional information regarding CMN and DIF requirements can be found in the CMS Internet Only Manual (IOM) Publication 100-4, *Medicare Claims Processing Manual*, Chapter 20, Section 100.2 and Chapter 4 of the Supplier Manual found in the Publications section of our web site. **C**

5. **Same/Similar (CO-150):** Either you or another supplier is already furnishing the same or similar equipment to this patient.

In order to avoid a denial for same or similar equipment the supplier should ask the patient whether they used or owned a same/similar item in the past. The patient should know if they have used or owned a same or similar item in the past. To ensure the patient understands how items are grouped, we suggest explaining what items may be considered "similar." Additional information can be found in Chapter 3 of the Supplier Manual. There is also a Same or Similar Reference Chart located under the Claims section of our web site. Same and similar can be obtained on the Interactive Voice Response (IVR) system. In addition, suppliers may use the Suggested Intake Form available on our web site.

6. **Noncovered Charges (PR-204):** Noncovered charges.

This service is not covered by Medicare. These denials are not based on policy criteria but are statutorily excluded items or the items do not meet the definition of a Medicare benefit.

7. **Recertification of Medical Necessity Needed (CO-176):** No recertification or revision of medical necessity was received for this equipment.

Ensure the recertification and/or revision is sent electronically with the claim when the claim requires this information.

Again, refer to the individual LCD and related Policy Article for proper claim submission.

8. **Main Equipment Claim Denials/Accessories Also Denied (CO-96):** Medicare cannot pay for supplies or accessories used with equipment for which payment has been denied.

Supplies and accessories will not be paid if the qualifying (main) equipment is not paid. To ensure the qualifying equipment is submitted correctly based on policy, review the appropriate LCDs and Articles. If the beneficiary owns the equipment or is getting this from another entity, ensure a narrative is added to the claim to document this. Frequent types of service receiving this denial would include, but are not limited to, wheelchair accessories, enteral nutrition supply kits, Positive Airway Pressure (PAP) accessories and drug infusion catheter maintenance supplies.

9. **No Prescription on File (CO-176):** Payment adjustment because this service was not prescribed by a physician, not prescribed prior to delivery, the prescription is incomplete, or the prescription is not current.

Ensure the prescriptions are current and the CMN or DIF is submitted with the correct information on the original submitted claim.

10. **Duplicate (CO-18):** 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.

Common types of services that deny for duplicate include, but are not limited to:

- Drugs: Specify different drug names in the narrative of the claim.
- Wheelchair accessories not otherwise specified: Add a narrative in the comment section of the line item describing the accessory.

APPEALS CONT'D

This will help to avoid the frequency of duplicate denials.

Use the IVR system to check on the status of any outstanding claims. The IVR can provide the remittance advice date, check number, and amount paid on these items. An IVR Quick Reference Guide is available: https://www.noridianmedicare.com/dme/contact/docs/ivr_at_a_glance.pdf

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

FORMS

Fax Number and MSP Inquiry & Refunds Form Changes

This article describes changes to the Medicare Secondary Payer (MSP) Inquiry & Refunds form, effective September 1, 2009. The changes include a change in the appearance of the Required Information section and a new fax number for MSP Inquiry & Refunds forms and other MSP correspondence.

The font size of the following fill-in fields has been increased:

- Patient Name
- Medicare Claim Number
- Date of Service
- HIC Number
- Total Billed Amount

The larger font size will only apply to information completed by the supplier, not to the field titles. This change is designed to improve the legibility of information after faxing.

The second change is that there is a new fax number for MSP Inquiry and Refunds form and all other MSP correspondence. The new number is 1-888-408-7405. Using the new number may speed sorting, resulting in fewer delays in processing. The old MSP fax line will be monitored until further notice, but it is to the supplier's advantage to use the new number.

The interactive MSP Inquiry and Refunds form is located at https://www.noridianmedicare.com/dme/forms/docs/msp_inq_dme.pdf

For general information on Medicare Secondary Payer claims, please see the article located at https://www.noridianmedicare.com/dme/news/docs/2009/06_june/msp.html

CODING

HCPCS Code A9283 – Devices Used for Edema or Ulcer Healing

HCPCS code A9283 (Foot pressure off loading/ supportive device, any type, each) was developed to describe various devices used for the treatment of edema or for a lower extremity ulcer or for the prevention of ulcers.

When products are used solely to treat edema or ulcers or to prevent an ulcer of the lower extremity, suppliers should code them based on the patient's condition. For example, walking boots are coded L4360 and L4386 when they are used as a brace for the treatment of orthopedic conditions. However, if walking boots are used solely for the prevention or treatment of a lower extremity ulcer or edema reduction, they shall be coded A9283.

When using code A9283, there is no separate billing using addition codes. Replacement liners for devices billed with A9283 must be billed with code A9270 (noncovered item or service).

The instructions in the Ankle-Foot, Knee-Ankle-Foot Orthoses LCD, Documentation Requirements section, concerning the use of the GY modifier no longer apply and will be deleted in a future revision of the policy.

Charcot Restraint Orthotic Walker - CROW Boot – Coding

The Charcot Restraint Orthotic Walker also referred to as CROW boot or walker, was developed for patients with severe deformity of the foot and ankle due to a sensory neuropathic arthropathy - most commonly caused by diabetes. The device is a bi-valved copolymer full foot enclosure, totally encapsulated around the ankle and foot with a rocker bottom sole built into the device. The orthosis is custom fabricated to a positive model made from an impression of the patient's affected limb. It is fully lined and uses a custom foot insert. Appropriate modifications are performed to the impression, which permits for equal weight distribution through the limb and provides support of the ankle joint, tibia, and fibula. The CROW boot can be modified to accommodate changes by flaring, adding padding, and trimming where and when appropriate.

A CROW boot is billed using the following codes:

L1960 ANKLE FOOT ORTHOSIS, POSTERIOR SOLID ANKLE, PLASTIC, CUSTOM-FABRICATED

L2232 ADDITION TO LOWER EXTREMITY ORTHOSIS, ROCKER BOTTOM FOR TOTAL CONTACT ANKLE FOOTORTHOSIS, FOR CUSTOM FABRICATED ORTHOSIS ONLY

L2275 ADDITION TO LOWER EXTREMITY, VARUS/VALGUS CORRECTION, PLASTIC MODIFICATION, PADDED/LINED

L2340 ADDITION TO LOWER EXTREMITY, PRE-TIBIAL SHELL, MOLDED TO PATIENT MODEL

L2820 ADDITION TO LOWER EXTREMITY

CODING CONT'D

ORTHOSIS, SOFT INTERFACE FOR MOLDED PLASTIC, BELOW KNEE SECTION

L3010 FOOT, INSERT, REMOVABLE, MOLDED TO PATIENT MODEL, LONGITUDINAL ARCH SUPPORT, EACH

No other codes may be billed for a CROW boot. There is no separate billing for any modifications, fitting, or adjustments.

When these products are used solely to treat edema or ulcers or to prevent an ulcer of the lower extremity, suppliers should code them based on the patient's condition. HCPCS code A9283 (Foot pressure off loading/ supportive device, any type, each) was developed to describe various devices used for the treatment of edema or for a lower extremity ulcer or for the prevention of ulcers. If the CROW boot is used for these conditions and the patient does not have Charcot arthropathy, then it should be coded A9283.

Suppliers should contact the Pricing, Data Analysis, and Coding contractor (PDAC) for guidance on the correct coding of specific items.

BILLING

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

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 4, 2009, to add clarifying language to reflect that this expansion applies to claims submitted on the ANSI X12N 837P standard electronic claims format and paper claims submitted on the CMS-1500. It does not apply to retail pharmacy claims that are submitted using the NCPDP standard claim format.

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

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

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.

2009 DMEPOS HCPCS Codes Jurisdiction List

MLN Matters® Number: MM6522
Related Change Request (CR) #: 6522
Related CR Release Date: July 10, 2009
Related CR Transmittal #: R1765CP
Effective Date: August 10, 2009
Implementation Date: August 10, 2009

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

Impact on Providers
This article is informational and is based on Change Request (CR) 6522 that notifies providers that the spreadsheet containing an updated list of the HCPCS codes for DME MAC, Part B carrier, or A/B MAC jurisdictions is updated annually to reflect codes that have been added or discontinued (deleted) each year. The spreadsheet is helpful to billing staff by showing the appropriate Medicare contractor to be billed for HCPCS appearing on the spreadsheet. The spreadsheet for the 2009 Jurisdiction List is an Excel® spreadsheet and is available at http://www.cms.hhs.gov/center/dme.asp on the Centers for Medicare & Medicaid Services (CMS) web site.

Additional Information
To see the official instruction (CR6522) issued to your Medicare DME MAC, carrier, or A/B MAC, visit http://www.cms.hhs.gov/Transmittals/downloads/R1765CP.pdf on the CMS web site. The 2009 Jurisdiction List is attached to CR 6522.

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

2009 Jurisdiction List for DMEPOS HCPCS Codes

Note: Deleted codes are valid for dates of service on or before the date of deletion.

HCPCS	DESCRIPTION	JURISDICTION
A0021 - A0999	Ambulance Services	Local Carrier
A4206 - A4209	Medical, Surgical, and Self-Administered Injection Supplies	Local Carrier if incident to a physician's service (not separately payable). If other DME MAC.
A4210	Needle Free Injection Device	DME MAC

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

HCPCS	DESCRIPTION	JURISDICTION
A4470	Gravlee Jet Washer	Local Carrier
A4480	Vabra Aspirator	Local Carrier
A4481	Tracheostomy Supply	Local Carrier if incident to a physician's service (not separately payable). If other DME MAC.
A4483	Moisture Exchanger	DME MAC
A4490 - A4510	Surgical Stockings	DME MAC
A4520	Diapers	DME MAC
A4550	Surgical Trays	Local Carrier
A4554	Disposable Underpads	DME MAC
A4556 - A4558	Electrodes; Lead Wires; Conductive Paste	Local Carrier if incident to a physician's service (not separately payable). If other DME MAC.
A4559	Coupling Gel	Local Carrier if incident to a physician's service (not separately payable). If other DME MAC.
A4561 - A4562	Pessary	Local Carrier
A4565	Sling	Local Carrier
A4570	Splint	Local Carrier
A4575	Topical Hyperbaric Oxygen Chamber, Disposable	DME MAC
A4580 - A4590	Casting Supplies & Material	Local Carrier
A4595	TENS Supplies	Local Carrier if incident to a physician's service (not separately payable). If other DME MAC.
A4600	Sleeve for Intermittent Limb Compression Device	DME MAC
A4601	Lithium Ion Battery for Non-Prosthetic Use	DME MAC
A4604	Tubing for Positive Airway Pressure Device	DME MAC
A4605	Tracheal Suction Catheter	DME MAC
A4606	Oxygen Probe for Oximeter	DME MAC
A4608	Transtracheal Oxygen Catheter	DME MAC
A4611 - A4613	Oxygen Equipment Batteries and Supplies	DME MAC
A4614	Peak Flow Rate Meter	Local Carrier if incident to a physician's service (not separately payable). If other DME MAC.
A4615 - A4629	Oxygen & Tracheostomy Supplies	Local Carrier if incident to a physician's service (not separately payable). If other DME MAC.
A4630 - A4640	DME Supplies	DME MAC
A4641 - A4642	Imaging Agent; Contrast Material	Local Carrier
A4648	Tissue Marker, Implanted	Local Carrier

HCPCS	DESCRIPTION	JURISDICTION
A4649	Miscellaneous Surgical Supplies	Local Carrier if incident to a physician's service (not separately payable) or if supply for implanted prosthetic device or implanted DME. If other DME MAC.
A4650	Implantable Radiation Dosimeter	Local Carrier
A4651 - A4932	Supplies for ESRD	DME MAC
A5051 - A5093	Additional Ostomy Supplies	If provided in the physician's office for a temporary condition, the item is incident to the physician's service & billed to the Local Carrier. If provided in the physician's office or other place of service for a permanent condition, the item is a prosthetic device & billed to the DME MAC.
A5102 - A5200	Additional Incontinence and Ostomy Supplies	If provided in the physician's office for a temporary condition, the item is incident to the physician's service & billed to the Local Carrier. If provided in the physician's office or other place of service for a permanent condition, the item is a prosthetic device & billed to the DME MAC.
A5500 - A5513	Therapeutic Shoes	DME MAC
A6000	Non-Contact Wound Warming Cover	DME MAC
A6010-A6024	Surgical Dressing	Local Carrier if incident to a physician's service (not separately payable) or if supply for implanted prosthetic device or implanted DME. If other DME MAC.
A6025	Silicone Gel Sheet	Local Carrier if incident to a physician's service (not separately payable) or if supply for implanted prosthetic device or implanted DME. If other DME MAC.
A6154 - A6411	Surgical Dressing	Local Carrier if incident to a physician's service (not separately payable) or if supply for implanted prosthetic device or implanted DME. If other DME MAC.
A6412	Eye Patch	Local Carrier if incident to a physician's service (not separately payable) or if supply for implanted prosthetic device or implanted DME. If other DME MAC.
A6413	Adhesive Bandage	Local Carrier if incident to a physician's service (not separately payable) or if supply for implanted prosthetic device or implanted DME. If other DME MAC.
A6441 - A6512	Surgical Dressings	Local Carrier if incident to a physician's service (not separately payable) or if supply for implanted prosthetic device or implanted DME. If other DME MAC.

HCPCS	DESCRIPTION	JURISDICTION
A6513	Compression Burn Mask	DME MAC
A6530 - A6549	Compression Gradient Stockings	DME MAC
A6550	Supplies for Negative Pressure Wound Therapy Electrical Pump	DME MAC
A7000 - A7002	Accessories for Suction Pumps	DME MAC
A7003 - A7039	Accessories for Nebulizers, Aspirators and Ventilators	DME MAC
A7040 - A7041	Chest Drainage Supplies	Local Carrier
A7042 - A7043	Pleural Catheter	Local Carrier
A7044 - A7046	Respiratory Accessories	DME MAC
A7501-A7527	Tracheostomy Supplies	DME MAC
A8000-A8004	Protective Helmets	DME MAC
A9150	Non-Prescription Drugs	Local Carrier
A9152 - A9153	Vitamins	Local Carrier
A9155	Artificial Saliva	Local Carrier
A9180	Lice Infestation Treatment	Local Carrier
A9270	Noncovered Items or Services	DME MAC
A9274 - A9278	Glucose Monitoring	DME MAC
A9279	Monitoring Feature/Device	DME MAC
A9280	Alarm Device	DME MAC
A9281	Reaching/Grabbing Device	DME MAC
A9282	Wig	DME MAC
A9283	Foot Off Loading Device	DME MAC
A9284	Non-electric Spirometer	DME MAC
A9300	Exercise Equipment	DME MAC
A9500 - A9700	Supplies for Radiology Procedures	Local Carrier
A9900	Miscellaneous DME Supply or Accessory	Local Carrier if used with implanted DME. If other DME MAC.
A9901	Delivery	DME MAC
A9999	Miscellaneous DME Supply or Accessory	Local Carrier if used with implanted DME. If other DME MAC.
B4034 - B9999	Enteral and Parenteral Therapy	DME MAC
D0120 - D9999	Dental Procedures	Local Carrier
E0100 - E0105	Canes	DME MAC
E0110 - E0118	Crutches	DME MAC
E0130 - E0159	Walkers	DME MAC
E0160 - E0175	Commodes	DME MAC
E0181 - E0199	Decubitus Care Equipment	DME MAC
E0200 - E0239	Heat/Cold Applications	DME MAC
E0240 - E0248	Bath and Toilet Aids	DME MAC

HCPCS	DESCRIPTION	JURISDICTION
E0249	Pad for Heating Unit	DME MAC
E0250 - E0304	Hospital Beds	DME MAC
E0305 - E0326	Hospital Bed Accessories	DME MAC
E0328 - E0329	Pediatric Hospital Beds	DME MAC
E0350 - E0352	Electronic Bowel Irrigation System	DME MAC
E0370	Heel Pad	DME MAC
E0371 - E0373	Decubitus Care Equipment	DME MAC
E0424 - E0484	Oxygen and Related Respiratory Equipment	DME MAC
E0485 - E0486	Oral Device to Reduce Airway Collapsibility	DME MAC
E0487	Electric Spirometer	DME MAC
E0500	IPPB Machine	DME MAC
E0550 - E0585	Compressors/Nebulizers	DME MAC
E0600	Suction Pump	DME MAC
E0601	CPAP Device	DME MAC
E0602 - E0604	Breast Pump	DME MAC
E0605	Vaporizer	DME MAC
E0606	Drainage Board	DME MAC
E0607	Home Blood Glucose Monitor	DME MAC
E0610 - E0615	Pacemaker Monitor	DME MAC
E0616	Implantable Cardiac Event Recorder	Local Carrier
E0617	External Defibrillator	DME MAC
E0618 - E0619	Apnea Monitor	DME MAC
E0620	Skin Piercing Device	DME MAC
E0621 - E0636	Patient Lifts	DME MAC
E0637 - E0642	Standing Devices/Lifts	DME MAC
E0650 - E0676	Pneumatic Compressor and Appliances	DME MAC
E0691 - E0694	Ultraviolet Light Therapy Systems	DME MAC
E0700	Safety Equipment	DME MAC
E0705	Transfer Board	DME MAC
E0710	Restraints	DME MAC
E0720 - E0745	Electrical Nerve Stimulators	DME MAC
E0746	EMG Device	Local Carrier
E0747 - E0748	Osteogenic Stimulators	DME MAC
E0749	Implantable Osteogenic Stimulators	Local Carrier

HCPCS	DESCRIPTION	JURISDICTION
E0755	Reflex Stimulator	DME MAC
E0760	Ultrasonic Osteogenic Stimulator	DME MAC
E0761	Electromagnetic Treatment Device	DME MAC
E0762	Electrical Joint Stimulation Device	DME MAC
E0764	Functional Neuromuscular Stimulator	DME MAC
E0765	Nerve Stimulator	DME MAC
E0769	Electrical Wound Treatment Device	DME MAC
E0770	Functional Electrical Stimulator	DME MAC
E0776	IV Pole	DME MAC
E0779 - E0780	External Infusion Pumps	DME MAC
E0781	Ambulatory Infusion Pump	Billable to both the local carrier and the DME MAC. This item may be billed to the DME MAC whenever the infusion is initiated in the physician's office but the patient does not return during the same business day.
E0782 - E0783	Infusion Pumps, Implantable	Local Carrier
E0784	Infusion Pumps, Insulin	DME MAC
E0785 - E0786	Implantable Infusion Pump Catheter	Local Carrier
E0791	Parenteral Infusion Pump	DME MAC
E0830	Ambulatory Traction Device	DME MAC
E0840 - E0900	Traction Equipment	DME MAC
E0910 - E0930	Trapeze/Fracture Frame	DME MAC
E0935 - E0936	Passive Motion Exercise Device	DME MAC
E0940	Trapeze Equipment	DME MAC
E0941	Traction Equipment	DME MAC
E0942 - E0945	Orthopedic Devices	DME MAC
E0946 - E0948	Fracture Frame	DME MAC
E0950 - E1298	Wheelchairs	DME MAC
E1300 - E1310	Whirlpool Equipment	DME MAC
E1353 - E1392	Additional Oxygen Related Equipment	DME MAC
E1399	Miscellaneous DME	Local Carrier if implanted DME. If other DME MAC.
E1340	Repair or Non-Routine Service for DME (deactivated as of 4/1/09)	
E1405 - E1406	Additional Oxygen Equipment	DME MAC
E1500 - E1699	Artificial Kidney Machines and Accessories	DME MAC

HCPCS	DESCRIPTION	JURISDICTION
E1700 - E1702	TMJ Device and Supplies	DME MAC
E1800 - E1841	Dynamic Flexion Devices	DME MAC
E1902	Communication Board	DME MAC
E2000	Gastric Suction Pump	DME MAC
E2100 - E2101	Blood Glucose Monitors with Special Features	DME MAC
E2120	Pulse Generator for Tympanic Treatment of Inner Ear	DME MAC
E2201 - E2399	Wheelchair Accessories	DME MAC
E2402	Negative Pressure Wound Therapy Pump	DME MAC
E2500 - E2599	Speech Generating Device	DME MAC
E2601 - E2621	Wheelchair Cushions	DME MAC
E8000 - E8002	Gait Trainers	DME MAC
G0008 - G0329	Misc. Professional Services	Local Carrier
G0333	Dispensing Fee	DME MAC
G0337 - G0365	Misc. Professional Services	Local Carrier
G0372	Misc. Professional Services	Local Carrier
G0378 - G9140	Misc. Professional Services	Local Carrier
J0120 - J3570	Injection	Local Carrier if incident to a physician's service or used in an implanted infusion pump. If other DME MAC.
J3590	Unclassified Biologicals	Local Carrier
J7030 - J7130	Miscellaneous Drugs and Solutions	Local Carrier if incident to a physician's service or used in an implanted infusion pump. If other DME MAC.
J7186 - J7195	Antihemophilic Factor	Local Carrier
J7197	Antithrombin III	Local Carrier
J7198	Anti-inhibitor; per I.U.	Local Carrier
J7199	Other Hemophilia Clotting Factors	Local Carrier
J7300 - J7307	Intrauterine Copper Contraceptive	Local Carrier
J7308	Aminolevulinic Acid HCL	Local Carrier
J7310	Ganciclovir, Long-Acting Implant	Local Carrier
J7311	Fluocinolone Acetonide, intravitreal implant	Local Carrier
J7321 - J7324	Hyaluronan	Local Carrier
J7330	Autologous Cultured Chondrocytes, Implant	Local Carrier
J7500 - J7599	Immunosuppressive Drugs	Local Carrier if incident to a physician's service or used in an implanted infusion pump. If other, DME MAC.

HCPCS	DESCRIPTION	JURISDICTION
J7604 - J7699	Inhalation Solutions	Local Carrier if incident to a physician's service. If other DME MAC.
J7799	NOC, Other than Inhalation Drugs through DME	Local carrier if incident to a physician's service. If other DME MAC.
J8498	Anti-emetic Drug	DME MAC
J8499	Prescription Drug, Oral, Non Chemotherapeutic	Local carrier if incident to a physician's service. If other, DME MAC.
J8501 - J8999	Oral Anti-Cancer Drugs	DME MAC
J9000 - J9999	Chemotherapy Drugs	Local Carrier if incident to a physician's service or used in an implanted infusion pump. If other DME MAC.
K0001 - K0108	Wheelchairs	DME MAC
K0195	Elevating Leg Rests	DME MAC
K0455	Infusion Pump used for Uninterrupted Administration of Epoprostenal	DME MAC
K0462	Loaner Equipment	DME MAC
K0552	External Infusion Pump Supplies	DME MAC
K0601 - K0605	External Infusion Pump Batteries	DME MAC
K0606 - K0609	Defibrillator Accessories	DME MAC
K0669	Wheelchair Cushion	DME MAC
K0672	Soft Interface for Orthosis	DME MAC
K0730	Inhalation Drug Delivery System	DME MAC
K0733	Power Wheelchair Accessory	DME MAC
K0734 - K0737	Power Wheelchair Seat Cushions	DME MAC
K0738	Oxygen Equipment	DME MAC
K0739	Repair or Nonroutine Service for DME	Local Carrier if implanted DME. If other DME MAC
K0740	Repair or Nonroutine Service for Oxygen Equipment	DME MAC
K0800 - K0899	Power Mobility Devices	DME MAC
L0112 - L2090	Orthotics	DME MAC
L2106 - L2116	Orthotics	DME MAC
L2126 - L4398	Orthotics	DME MAC
L5000 - L5999	Lower Limb Prosthetics	DME MAC
L6000 - L7499	Upper Limb Prosthetics	DME MAC
L7500 - L7520	Repair of Prosthetic Device	Local Carrier if repair of implanted prosthetic device. If other DME MAC.
L7600	Prosthetic Donning Sleeve	DME MAC
L7900	Vacuum Erection System	DME MAC
L8000 - L8485	Prosthetics	DME MAC

HCPCS	DESCRIPTION	JURISDICTION
L8499	Unlisted Procedure for Miscellaneous Prosthetic Services	Local Carrier if implanted prosthetic device. If other DME MAC.
L8500 - L8501	Artificial Larynx; Tracheostomy Speaking Valve	DME MAC
L8505	Artificial Larynx Accessory	DME MAC
L8507 - L8515	Voice Prosthesis	DME MAC
L8600 - L8699	Prosthetic Implants	Local Carrier
L9900	Miscellaneous Orthotic or Prosthetic Component or Accessory	Local Carrier if used with implanted prosthetic device. If other DME MAC.
M0064 - M0301	Medical Services	Local Carrier
P2028 - P9615	Laboratory Tests	Local Carrier
Q0035	Influenza Vaccine; Cardiokymography	Local Carrier
Q0081	Infusion Therapy	Local Carrier
Q0083 - Q0085	Chemotherapy Administration	Local Carrier
Q0091	Smear Preparation	Local Carrier
Q0092	Portable X-ray Setup	Local Carrier
Q0111 - Q0115	Miscellaneous Lab Services	Local Carrier
Q0144	Azithromycin Dihydrate	Local Carrier if incident to a physician's service. If other DME MAC.
Q0163 - Q0181	Anti-emetic	DME MAC
Q0480 - Q0505	Ventricular Assist Devices	Local Carrier
Q0510 - Q0514	Drug Dispensing Fees	DME MAC
Q0515	Sermorelin Acetate	Local Carrier
Q1003 - Q1005	New Technology IOL	Local Carrier
Q2004	Irrigation Solution	Local Carrier
Q2009	Fosphenytoin	Local Carrier
Q2017	Teniposide	Local Carrier
Q2023	Antihemophilic Factor	Local Carrier
Q3001	Radio Elements for Brachytherapy	Local Carrier
Q3014	Telehealth Originating Site Facility Fee	Local Carrier
Q3025 - Q3026	Vaccines	Local Carrier
Q3031	Collagen Skin Test	Local Carrier
Q4001 - Q4051	Splints and Casts	Local Carrier
Q4080	Inhalation Drug	Local Carrier if incident to a physician's service. If other DME MAC.
Q4081	Epoetin	DME MAC for method II home dialysis. If other Local Carrier.
Q4082	Drug Subject to Competitive Acquisition Program	Local Carrier

HCPCS	DESCRIPTION	JURISDICTION
Q4100-Q4116	Skin Substitutes	Local Carrier
Q5001 - Q5009	Hospice Services	Local Carrier
Q9951 - Q9954	Imaging Agents	Local Carrier
Q9955 - Q9957	Microspheres	Local Carrier
Q9958 - Q9967	Imaging Agents	Local Carrier
R0070 - R0076	Diagnostic Radiology Services	Local Carrier
V2020 - V2025	Frames	DME MAC
V2100 - V2513	Lenses	DME MAC
V2520 - V2523	Hydrophilic Contact Lenses	Local Carrier if incident to a physician's service. If other DME MAC.
V2530 - V2531	Contact Lenses, Scleral	DME MAC
V2599	Contact Lens, Other Type	Local Carrier if incident to a physician's service. If other DME MAC.
V2600 - V2615	Low Vision Aids	DME MAC
V2623 - V2629	Prosthetic Eyes	DME MAC
V2630 - V2632	Intraocular Lenses	Local Carrier
V2700 - V2780	Miscellaneous Vision Service	DME MAC
V2781	Progressive Lens	DME MAC
V2782 - V2784	Lenses	DME MAC
V2785	Processing--Corneal Tissue	Local Carrier
V2786	Lens	DME MAC
V2787 - V2788	Intraocular Lenses	Local Carrier
V2790	Amniotic Membrane	Local Carrier
V2797	Vision Supply	DME MAC
V2799	Miscellaneous Vision Service	DME MAC
V5008 - V5299	Hearing Services	Local Carrier
V5336	Repair/Modification of Augmentative Communicative System or Device	DME MAC
V5362 - V5364	Speech Screening	Local Carrier

Revised: April 2009

Noncovered Items

In order for an item to be covered by the Durable Medical Equipment Medicare Administrative Contractor (DME MAC), it must fall within one of ten benefit categories as outlined in Chapter 9 of the Jurisdiction D Supplier Manual. Some items may not meet the definition of a Medicare benefit or may be statutorily excluded. The items listed below will always be denied as non-covered.

The Medicare National Coverage Determinations (NCD) Manual provides a list of items that are noncovered with the reason for denial. The following items will be denied as noncovered when submitted to your DME MAC.

HCPCS Code	DESCRIPTION
A4210	Needle-free injection device, each

HCPCS Code	DESCRIPTION
A4250	Urine test or reagent strips or tablets (100 tablets or strips)
A4490	Surgical stockings above knee length, each
A4495	Surgical stockings thigh length, each
A4500	Surgical stockings below knee length, each
A4510	Surgical stockings full-length, each
A4520	Incontinence garment, any type, (e.g. brief, diaper), each
A4554	Disposable underpads, all sizes
A4575	Topical hyperbaric oxygen chamber, disposable
A4627	Spacer, bag or reservoir, with or without mask, for use with metered dose inhaler
A6000	Non contact wound-warming wound cover for use with the non contact wound-warming device and warming card
A6530	Gradient compression stocking, below knee, 18-30 mmHg, each
A6533	Gradient compression stocking, thigh length, 18-30 mmHg, each
A6534	Gradient compression stocking, thigh length, 30-40 mmHg, each
A6535	Gradient compression stocking, thigh length, 40-50 mmHg, each
A6536	Gradient compression stocking, full length/chap style, 18-30 mmHg, each
A6537	Gradient compression stocking, full length/chap style, 30-40 mmHg, each
A6538	Gradient compression stocking, full length/chap style, 40-50 mmHg, each
A6540	Gradient compression stocking, waist length, 30-40 mmHg, each
A6541	Gradient compression stocking, waist length, 40-50 mmHg, each
A6542	Gradient compression stocking, custom made
A6543	Gradient compression stocking, lymphedema
A6544	Gradient compression stocking, garter belt
A6549	Gradient compression stocking, not otherwise specified
A9270	Noncovered item or service
A9275	Home glucose disposable monitor, includes test strips
A9276	Sensor; invasive (e.g. subcutaneous), disposable, for use with interstitial continuous glucose monitoring system, one unit = 1 day supply
A9277	Transmitter; external, for use with interstitial continuous glucose monitoring system
A9278	Receiver (monitor); external, for use with interstitial continuous glucose monitoring system
A9280	Alert or alarm device, not otherwise classified
A9281	Reaching/grabbing device, any type, any length, each
A9282	Wig, any type, each
A9300	Exercise equipment
B4100	Food thickener, administered orally, per ounce
E0172	Seat lift mechanism placed over or on top of toilet, and type
E0191	Heel or elbow protector, each

HCPCS Code	DESCRIPTION
E0203	Therapeutic lightbox, minimum 10,000 lux, table top model
E0220	Hot water bottle
E0230	Cap or collar
E0231	Non-contact wound warming device (temperature control unit, AC adapter and power cord) for use with warming card and wound cover
E0232	Warming card for use with the non-contact wound warming device and non-contact wound warming wound cover
E0240	Bath/shower chair, with or without wheels, any size
E0241	Bath tub wall rail, each
E0242	Bath tub rail, floor base
E0243	Toilet rail, each
E0244	Raised toilet seat
E0245	Tub stool or bench
E0246	Transfer tub rail attachment
E0247	Transfer bench for tub or toilet with or without commode opening
E0248	Transfer bench, heavy duty, for tub or toilet with or without commode opening
E0270	Hospital bed, institutional type includes: oscillating, circulating and stryker frame with mattress
E0273	Bed board
E0274	Over-bed table
E0315	Bed accessory: board, table, or support device, any type
E0481	Intrapulmonary percussive ventilation system and related accessories
E0625	Patient lift, bathroom or toilet, not otherwise classified
E0637	Combination sit to stand system, any size including pediatric, with seatlift feature, with or without wheels
E0638	Standing frame system, one position (e.g. upright, supine or prone stander), any size including pediatric, with or without wheels
E0641	Standing frame system, multi-position (e.g. three-way stander), any size including pediatric, with or without wheels
E0642	Standing frame system, mobile (dynamic stander), any size including pediatric
E0700	Safety equipment (e.g., belt, harness or vest)
E0710	Restraints, any type (body, chest, wrist or ankle)
E0936	Continuous passive motion exercise device for use other than knee
E1300	Whirlpool, portable (overtub type)
J1055	Injection, medroxyprogesterone acetate for contraceptive use, 150 mg
J3520	Edetate disodium, per 150 mg
J3535	Drug administered through a metered dose inhaler
J3570	Laetrile, amygdalin, vitamin B-17

HCPCS Code	DESCRIPTION
J8499	Prescription drug, oral, nonchemotherapeutic, NOS
J8515	Cabergoline, oral, 0.25 mg
L0210	Thoracic rib belt
L1800	Knee orthosis, elastic with stays, prefabricated
L1815	Knee orthosis, elastic or other elastic type material, with condylar pads, prefabricated
L1825	Knee orthosis, elastic knee cap, prefabricated
L1901	Ankle orthosis, elastic, prefabricated
L3651	Shoulder orthosis, single shoulder, elastic, prefabricated
L3652	Shoulder orthosis, double shoulder, elastic, prefabricated
L3700	Elbow orthosis elastic with stays, prefabricated
L3701	Elbow orthosis, elastic, prefabricated
L3909	Wrist orthosis, elastic, prefabricated
L3911	Wrist hand finger orthosis, elastic, prefabricated
L3215	Orthopedic footwear, ladies shoes, oxford, each
L3216	Orthopedic footwear, ladies shoes, depth inlay, each
L3217	Orthopedic footwear, ladies shoes, hightop, depth inlay, each
L3219	Orthopedic footwear, mens shoes, oxford, each
L3221	Orthopedic footwear, mens shoes, depth inlay, each
L3222	Orthopedic footwear, mens shoes, hightop, depth inlay, each
L7600	Prosthetic donning sleeve, any material, each
Q0144	Azithromycin dehydrate, oral, capsules/powder, 1 gram
V2025	Deluxe frame
V2600	Hand held low vision aids and other nonspectacle mounted aids
V2610	Single lens spectacle mounted low vision aids
V2615	Telescopic and other compound lens system, including distance vision telescopic, near vision telescopes and compound microscopic lens system
V2702	Deluxe lens feature
V2760	Scratch resistant coating, per lens
V5336	Repair/modification of augmentative communicative system or device (excludes adaptive hearing aid)

Reference: *Medicare NCD Manual* 100-3, Ch 1, Part 4, Section 280.1

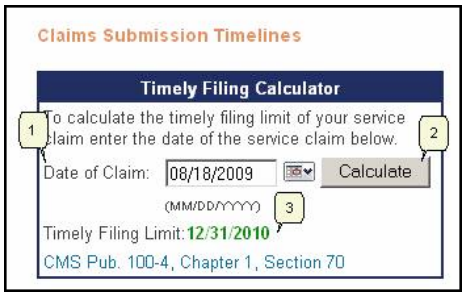
Claim Filing Timeline - Tool Available

NAS offers a timely filing calculator on the Claims tab to assist suppliers in determining the limit for submitting claims to Jurisdiction D.

Steps:

1. Enter the date of service
2. Click on Calculate

3. The date the claim needs to be received at NAS is displayed.



The CMS Internet Only Manual reference regarding timely filing is also provided.

NAS also provides the timely filing limits for dates of service in each month:

Date of service in:	Jan	Feb	Mar	Apr	May	June
Timely Filing Date	Dec 31: Service year plus 1 year	Dec 31: Service year plus 1 year	Dec 31: Service year plus 1 year	Dec 31: Service year plus 1 year	Dec 31: Service year plus 1 year	Dec 31: Service year plus 1 year
Months to File*	23	22	21	20	19	18

Date of service in:	July	Aug	Sept	Oct	Nov	Dec
Timely Filing Date	Dec 31: Service year plus 1 year	Dec 31: Service year plus 1 year	Dec 31: Service year plus 1 year	Dec 31: Service year plus 2 years	Dec 31: Service year plus 2 years	Dec 31: Service year plus 2 years
Months to File*	17	16	15	26	25	24

* The number specified in "Months to file" represents the number of full months remaining after the month in which the service was rendered.

2009 Annual Update of HCPCS Codes for SNF CB

MLN Matters® Number: MM6619
Related Change Request (CR) #: 6619
Related CR Release Date: September 4, 2009
Related CR Transmittal #: R1814CP
Effective Date: January 1, 2010
Implementation Date: January 4, 2010

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 Medicare Administrative Contractors (A/B MACs)) for services provided to Medicare beneficiaries who are in a Part A covered SNF stay.

Provider Action Needed
This article is based on Change Request (CR) 6619 which provides the 2010 annual update of Healthcare Common Procedure Coding System (HCPCS) Codes for Skilled Nursing Facility Consolidated Billing (SNF CB) that will be used in Medicare claims processing systems. Be sure billing staff are aware of these updates.

Background
Medicare's claims processing systems currently have edits in place for claims received for beneficiaries in a Part A covered SNF stay as well as for beneficiaries in a non-covered stay. These edits only allow services that are excluded from SNF CB to be separately paid by Medicare contractors. The related policy is contained in the Medicare Claims Processing Manual (Chapter 6, Section 110.4.1 and Chapter 6, Section 20.6) which is available at http://www.cms.hhs.gov/manuals/downloads/clm104c06.pdf on the Centers for Medicare & Medicaid Services (CMS) web site.

Physicians and providers are advised that, by the first week in December 2009, new code files will be posted at http://www.cms.hhs.gov/SNFConsolidatedBilling/ on the CMS web site.

Institutional providers should note that this site will include new Excel® and PDF format files. It is important and necessary for the provider community to view the "General Explanation of the Major Categories" PDF file located at the bottom of each year's FI update listed at http://www.cms.hhs.gov/SNFConsolidatedBilling/ on the CMS web site in order to understand the Major Categories including additional exclusions not driven by HCPCS codes.

Additional Information
You can find information related to SNFs and Medicare on the CMS Skilled Nursing Facility Center at http://www.cms.hhs.gov/center/snf.asp.

The official instruction, CR 6619, issued to your carrier, FI, A/B MAC, and DME MAC regarding this change may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R1814CP.pdf.

Claims for Beneficiaries in Custody Under Penal Authority

MLN Matters® Number: MM6544
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

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

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
- The second transmittal amends the Medicare Benefit Policy Manual and it may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R110BP.pdf

Additional Instructions on Processing Claims for DMEPOS Items Submitted Under the Guidelines Established in CR 5917

MLN Matters® Number: MM6573
Related Change Request (CR) #: 6573
Related CR Release Date: August 14, 2009
Related CR Transmittal #: R531OTN
Effective Date: January 1, 2010
Implementation Date: January 4, 2010

Provider Types Affected
Providers and suppliers billing Medicare Carriers and Medicare Administrative Contractors (A/B MACs) for certain DME products provided to Medicare beneficiaries.

Provider Action Needed
The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 6573 in order to augment previously issued CR 5917. In CR 5917 CMS instructed Medicare contractors to process and pay claims for replacement parts, accessories and supplies for prosthetic implants and surgically implanted DME when submitted by suppliers that are enrolled with both the National Supplier Clearinghouse (NSC) and with their local carrier/MAC. Although CR 5917 reinstated the local carrier/A/B MAC jurisdiction for claims for these items, the instruction was not clear about the jurisdiction or payment rules to apply when the beneficiary resides outside of the local carrier/A/B Medicare Administrative Contractor's (A/B MAC) jurisdiction. Be sure billing staff are aware of the changes.

Background
CR 6573 clarifies the claims filing jurisdiction and payment policies for claims submitted under the guidelines established in CR 5917 when the beneficiary is located outside of the local carrier/A/B Mac's jurisdiction. Payment of DMEPOS items is based on the fee schedule amount for the State where the beneficiary maintains their permanent residence.

CR 6573 also makes a correction to CR 5917 to replace the list of codes that may be billed, originally included as Attachment A to CR 5917, with the revised list of HCPCS codes attached to CR6573 and available at http://www.cms.hhs.gov/Transmittals/downloads/R531OTN.pdf on the CMS web site. (In CR 5917 this list included codes for implanted devices, which may not be separately billed to the carrier/MAC by DMEPOS suppliers.)

Key Points of CR 6573

- Suppliers that are enrolled with the NSC as a DMEPOS supplier may enroll with and bill claims to their local carrier/A/B MAC for any of the attached list of DMEPOS items when billed under the guidelines established in CR 5917, including items furnished to beneficiaries who reside in other States.
- Medicare contractors will determine the claims filing jurisdiction for items billed under the guidelines established in CR 5917 based on the location of the supplier, in accordance with Chapter 1, section 10 of the *Medicare Claims Processing Manual* available at http://www.cms.hhs.gov/manuals/downloads/clm104c01.pdf on the CMS web site.
- Medicare contractors will pay claims for items submitted under the guidelines established in CR 5917 by applying the appropriate fee schedule amount for the State where the beneficiary maintains his or her permanent residence.
- Under no circumstances may any entity enrolled as a DMEPOS supplier with the NSC, that is not the physician or provider that implants the device, bill the carrier/A/B MAC for an implanted device. However, DMEPOS suppliers may bill for any of the replacement parts, accessories or supplies for prosthetic implants and surgically implanted DME included in the attached revised list of HCPCS codes, under the guidelines established in CR 5917.

Additional Information
The official instruction (CR 6573) issued to your Medicare Carrier or A/B MAC is available at http://www.cms.hhs.gov/Transmittals/downloads/R531OTN.pdf on the CMS web site. CR 6573 contains the *DMEPOS Fee Schedule HCPCS Codes Payable as a Replacement Part, Accessory or Supply for Prosthetic Implants and Surgically Implanted DME (Rev. March 2009)* and that list is an attachment to CR 6573.

To review MM5917, the MLN Matters® article related to CR 5917, go to http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5917.pdf on the CMS web site.

Addition/Deletion of HCPCS Codes – October 2009

MLN Matters® Number: MM6594
Related Change Request (CR) #: 6594
Related CR Release Date: August 28, 2009
Related CR Transmittal #: R1805CP
Effective Date: October 1, 2009
Implementation Date: October 5, 2009

Provider Types Affected
Physicians, hospitals, suppliers, and other providers who submit bills to Medicare carriers, fiscal intermediaries (FIs), Medicare Administrative Contractors (MACs), and Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for services provided to Medicare beneficiaries.

Provider Action Needed
This article explains updates, effective for dates of service on or after October 1, 2009 (unless otherwise specified), to the Healthcare Common Procedure Coding System (HCPCS) codes for certain drugs and biologicals. Ensure that your staffs are aware of these changes.

Background
The HCPCS code set is updated on a quarterly basis. This article describes updates for specific HCPCS codes and the October 2009 update has only one new code payable for Medicare. Effective for claims with dates of service on or after October 1, 2009, the following HCPCS code will be payable for Medicare:

- HCPCS Code Q2024 with short description of Bevacizumab injection and long description of INJECTION, BEVACIZUMAB, 0.25 MG, a Type of Service Code 1or P and a Medicare Physician Fee Schedule Data Base Status Indicator of E

There are no deletions of HCPCS codes effective for October 1, 2009.

Additional Information
The official instruction, CR6594, issued to your Medicare carrier, FI, DME MAC and/or MAC regarding this change, may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R1805CP.pdf.

Claim Status Category Code and Claim Status Code Update

MLN Matters® Number: MM6609
Related Change Request (CR) #: 6609
Related CR Release Date: August 14, 2009
Related CR Transmittal #: R1797CP
Effective Date: October 1, 2009
Implementation Date: October 5, 2009

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

Provider Action Needed
This article, based on CR6609, explains that the Claim Status Codes and Claim Status Category Codes for use by Medicare contractors with the Health Claim Status Request and Response ASC X12N 276/277 were updated during the June 2009 meeting of the national Code Maintenance Committee and code changes approved at that meeting were posted at http://www.wpc-edi.com/content/view/180/223/ on the Internet on or about June 30, 2009. All providers should ensure that their billing staffs are aware of the updated codes.

Background
The Health Insurance Portability and Accountability Act (HIPAA) requires all health care benefit payers to use only Claim Status Category Codes and Claim Status Codes approved by the national Code Maintenance Committee in the X12 276/277 Health Care Claim Status Request and Response format adopted as the standard for national use (004010X093A1). These codes explain the status of submitted claim(s). Proprietary codes may not be used in the X12 276/277 to report claim status.

Additional Information
The official instruction, CR6609, issued to your Medicare contractor regarding this change may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R1797CP.pdf.

Use of CR Modifier and DR Condition Code on Disaster/ Emergency-Related Claims

MLN Matters® Number: MM6451
Related Change Request (CR) #: 6451
Related CR Release Date: July 31, 2009
Related CR Transmittal #: R1784CP
Effective Date: August 31, 2009
Implementation Date: August 31, 2009

Provider Types Affected
Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs), and/or Part A/B Medicare Administrative Contractors (MACs)) for disaster/emergency-related services provided to Medicare beneficiaries.

Provider Action Needed
This article is based on CR 6451, which updates and amends claims processing requirements for the use of condition codes and modifiers on Medicare fee-for-service claims when the furnishing of an item or service to a Medicare beneficiary was affected by a disaster or other general public emergency. CR 6451 also establishes a new chapter in the Medicare Claims Processing Manual dedicated to standing policies and procedures applicable to disasters and other public emergencies. Please make sure your billing staff is familiar with these changes, especially if they submit claims affected by emergencies to Medicare.

Background
As part of its response to the 2005 Katrina hurricane emergency, the Centers for Medicare & Medicaid Services (CMS) developed the "DR" condition code and the "CR" modifier to facilitate the processing of claims affected by that emergency. The DR condition code and CR modifier were also authorized for use on claims for items and services affected by subsequent emergencies. Based on that experience, the Medicare fee-for-service program is refining the uses of both the code and the modifier to ensure that program operations are sufficiently flexible to accommodate the emergency health care needs of beneficiaries and the delivery of health care items and services by health care providers/ suppliers in emergency situations without adding undue administrative burden associated with claim submission. The use of the "CR" modifier and "DR" condition code indicates not only that the item/service/claim was affected by the emergency/disaster, but also that the provider has met all of the requirements CMS has issued to Medicare contractors regarding the emergency/disaster.

Key Points of CR 6451

The DR Condition Code: The title of the DR condition code is "disaster related" and its definition requires it to be "used to identify claims that are or may be impacted by specific payer/health plan policies related to a national or regional disaster." The DR condition code is used only for institutional billing, i.e., claims submitted by providers on an institutional paper claim form CMS-1450/UB-04 or in the electronic format ANSI ASC X12 837I. In previous emergencies, use of the DR condition code was entirely discretionary with the billing provider or supplier. It no longer may be used at the provider or supplier's discretion. Effective August 31, 2009, use of the DR condition code will be mandatory for any claim for which Medicare payment is conditioned directly or indirectly on the presence of a "formal waiver."

The CR Modifier: Both the short and long descriptors of the CR modifier are "catastrophe/disaster related." The CR modifier is used in relation to Part B items and services for both institutional and non-institutional billing. Non-institutional billing, i.e., claims submitted by "physicians and other suppliers", are submitted either on a professional paper claim form CMS-1500 or in the electronic format ANSI ASC X12 837P or – for pharmacies – in the NCPDP format. In previous emergencies, use of the CR modifier was entirely discretionary with the billing provider or supplier. It no longer may be used at the provider or supplier's discretion. Effective August 31, 2009, use of the CR modifier will be mandatory for applicable HCPCS codes on any claim for which Medicare Part B payment is conditioned directly or indirectly on the presence of a "formal waiver."

Formal Waivers: A "formal waiver" is a waiver of a program requirement that otherwise would apply by statute or regulation. There are two types of formal waivers. One type is a waiver of a requirement specified in Section 1135(b) of the Social Security Act (Act). Although Medicare payment rules themselves are not "waivable" under this statutory provision, the waiver of a Section 1135(b) requirement may permit Medicare payment in a circumstance where such payment would otherwise be barred. The second type of formal waiver is a waiver based on a provision of Title XVIII of the Act or its implementing regulations. The most commonly employed waiver in this latter category is the waiver of the "3-day qualifying hospital stay" requirement that is a precondition for Medicare payment for skilled nursing facility services. This requirement may be waived under Section 1812(f) of the Social Security Act.

Further Instructions in the Event of a Disaster or Emergency: In the event of a disaster or emergency, CMS will issue specific guidance to Medicare contractors that will contain a summary of the Secretary's declaration (if any); specify the geographic areas affected by any declarations of a disaster or emergency; specify what formal waivers and/or informal waivers, if any, have been authorized; specify the beginning and end dates that apply to the use of the DR condition code and/or the CR modifier; and specify what other uses of the condition code and/or modifier, if any, will be mandatory for the particular disaster/emergency.

Additional Information

The official instruction, CR 6451, issued to your carrier, FI, and/or A/B MAC regarding this change may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R1784CP.pdf on the CMS web site.

LCD and Policy Article Revisions - Summary for July 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.

High Frequency Chest Wall Oscillation Devices
LCD
Revision Effective Date: 10/01/2009

INDICATIONS AND LIMITATIONS OF COVERAGE:
Clarified: Coverage criterion #2

HCPCS CODES AND MODIFIERS:
Added: GA, GZ
Revised: KX

DOCUMENTATION REQUIREMENTS:
Added: Instructions for GA and GZ modifiers

Hospital Beds
LCD
Revision Effective Date: 10/01/2009

HCPCS CODES AND MODIFIERS:
Revised: KX modifier

DOCUMENTATION REQUIREMENTS:
Added: Instructions for the use of GA and GZ modifiers

Policy Article
Revision Effective Date: 10/01/2009

CODING GUIDELINES:
Changed: SADMERC to PDAC

Infrared Heating Pad Systems
Policy Article
Revision Effective Date: 08/01/2009

CODING GUIDELINES:
Changed: SADMERC to PDAC

Intrapulmonary Percussive Ventilation Systems
Policy Article
Revision Effective Date: 08/01/2009

CODING GUIDELINES:
Changed: SADMERC to PDAC

Manual Wheelchair Bases
LCD
Revision Effective Date: 10/01/2009

HCPCS CODES AND MODIFIERS:
Added: GA and GZ modifiers
Revised: KX modifier

DOCUMENTATION REQUIREMENTS:
Added: Instructions for use of GA and GZ modifiers

Policy Article
Revision Effective Date: 10/01/2009

CODING GUIDELINES:
Deleted E1161 from range of codes E1070-E1200
Changed SADMERC to PDAC

Mechanical In-exsufflation Devices
Policy Article
Revision Effective Date: 08/01/2009

CODING GUIDELINES:
Changed: SADMERC to PDAC

Negative Pressure Wound Therapy
LCD
Revision Effective Date: 10/01/2009

INDICATIONS AND LIMITATIONS OF COVERAGE:
Added: Program Integrity Manual instructions on refills of supplies
Changed: SADMERC to PDAC

HCPCS CODES AND MODIFIERS:
Added: GA and GZ modifiers
Revised: KX modifier

DOCUMENTATION REQUIREMENTS:
Added: Instructions for the use of GA and GZ modifiers

APPENDICES:
Revised pressure ulcer staging based on NPUAP guidelines

SOURCES OF INFORMATION AND BASIS FOR DECISION:
Added: Reference to NPUAP guidelines for pressure ulcer staging

Policy Article
Revision Effective Date: 10/01/2009

CODING GUIDELINES:
Changed SADMERC to PDAC

Orthopedic Footwear
LCD
Revision Effective Date: 10/01/2009

HCPCS CODES AND MODIFIERS:
Added: GY modifier
Revised: KX modifier

DOCUMENTATION REQUIREMENTS:
Added: GY modifier instructions

Policy Article
Revision Effective Date: 10/01/2009

CODING GUIDELINES:
Revised: RT/LT modifier instructions
Changed: SADMERC to PDAC

Osteogenesis Stimulators
LCD
Revision Effective Date: 08/01/2009

DOCUMENTATION REQUIREMENTS:
Included: Ultrasonic in statement regarding correct CMN to use for electrical osteogenesis stimulators

Policy Article
Revision Effective Date: 08/01/2009

CODING GUIDELINES:
Changed: SADMERC to PDAC

Parenteral Nutrition
LCD
Revision Effective Date: 10/01/2009

DOCUMENTATION REQUIREMENTS:
Revised: Instructions for submitting a revised DIF

Policy Article
Revision Effective Date: 10/01/2009

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Revised: DMERC to DME MAC

CODING GUIDELINES:
Revised: SADMERC to PDAC

Power Mobility Devices
LCD
Revision Effective Date: 10/01/2009

HCPCS MODIFIERS:
Added: GA and GZ modifiers
Revised: KX modifier

DOCUMENTATION REQUIREMENTS:
Revised: Requirements for detailed product description
Added: Instructions for use of the GA and GZ modifiers

Refractive Lenses
LCD
Revision Effective Date: 10/01/2009

HCPCS MODIFIERS:
Added: GA and GZ modifiers
Revised: KX modifier

DOCUMENTATION REQUIREMENTS:
Added: Instructions for use of GA and GZ modifiers

Policy Article
Revision Effective Date: 10/01/2009

CODING GUIDELINES:
Revised: RT/LT modifier instructions
Changed: SADMERC to PDAC

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

LCD and Policy Article Revisions - Summary for September 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.

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

COVERAGE CONT'D

APPENDICES:
Revised: Definitions of pressure ulcer stages

SOURCES OF INFORMATION AND BASIS FOR DECISION:
Added: Reference to NPUAP guidelines for pressure ulcer staging

Policy Article
Revision Effective Date: 12/01/2009

CODING GUIDELINES:
Changed: SADMERC to PDAC

Seat Lift Mechanisms
Policy Article
Revision Effective Date: 09/01/2009

CODING GUIDELINES:
Changed: SADMERC to PDAC

Speech Generating Devices
LCD
Revision Effective Date: 12/01/2009

HCPCS CODES AND MODIFIERS:
Added: GA and GZ modifiers
Revised: KX modifier

DOCUMENTATION REQUIREMENTS:
Added: Multicomponent instructions
Added: Instructions for the use of GA and GZ modifiers

Policy Article
Revision Effective Date: 12/01/2009

CODING GUIDELINES:
Revised: Instructions for mounting systems
Changed: SADMERC to PDAC

Suction Pumps
Policy Article
Revision Effective Date: 09/01/2009

CODING GUIDELINES:
Changed: SADMERC to PDAC

Surgical Dressings
Policy Article
Revision Effective Date: 01/01/2009
(September 2009 Publication)

CODING GUIDELINES:
Added: A6545 to list of codes requiring the AW modifier
Added: A6545 to list of codes requiring the RT and/or LT modifier(s)
Revised: RT/LT modifier instructions

Therapeutic Shoes for Persons with Diabetes
Policy Article
Revision Effective Date: 09/01/2009

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Clarified: Documentation of qualifying conditions must be in the medical records of the certifying physician. (This requirement has always been included in the national policy. The 09/1/09 effective date does not apply.)

CODING GUIDELINES:
Revised: Billing instructions for the RT and LT modifiers.
Revised: Statement concerning which products billed with code A5513 must have PDAC Coding Verification Review.

Tracheostomy Care Supplies
Policy Article
Revision Effective Date: 09/01/2009

CODING GUIDELINES:
Changed: SADMERC to PDAC

Transcutaneous Electrical Nerve Stimulation (TENS)
LCD
Revision Effective Date: 12/01/2009

INDICATIONS AND LIMITATIONS OF COVERAGE:
Revised: Additional supply quantities denial statement

HCPCS CODES AND MODIFIERS:
Added: GA and GZ modifiers
Revised: KX modifier

DOCUMENTATION REQUIREMENTS:
Removed: Instructions for additional quantities
Added: Instructions for the use of GA and GZ modifiers

Policy Article
Revision Effective Date: 12/01/2009

CODING GUIDELINES:
Changed: SADMERC to PDAC

Urological Supplies
LCD
Revision Effective Date: 12/01/2009

INDICATIONS AND LIMITATIONS OF COVERAGE:
Revised: Additional quantity denial statements for tape, anchoring devices and leg-bag straps

HCPCS CODES and MODIFIERS:
Revised: KX modifier

DOCUMENTATION REQUIREMENTS:
Added: Instructions for the use of the GY modifier
Removed: Instructions for additional quantities

Policy Article
Revision Effective Date: 12/01/2009

CODING GUIDELINES:
Clarified: A4353
Changed: SADMERC to PDAC

Walkers
LCD
Revision Effective Date: 12/01/2009

HCPCS CODES AND MODIFIERS:
Added: GA and GZ modifiers
Revised: KX modifier

DOCUMENTATION REQUIREMENTS:
Added: Instructions for the use of GA and GZ modifiers

Policy Article
Revision Effective Date: 12/01/2009

CODING GUIDELINES:
Changed: SADMERC to PDAC

Wheelchair Seating
LCD
Revision Effective Date: 12/01/2009

INDICATIONS AND LIMITATIONS OF COVERAGE:
Added: Hemiplegia, Huntington's chorea, idiopathic torsion dystonia, and cerebral palsy to the list of covered conditions for skin protection seat cushions
Added: Above knee amputations, osteogenesis imperfecta, and transverse myelitis to the list of covered conditions for positioning seat and back cushions and positioning accessories

ICD-9 CODES THAT SUPPORT MEDICAL NECESSITY:
Added: Corresponding ICD-9 codes
Moved: 359.0, 359.1 from second group of codes to the first group of codes for E2607, E2608, K0736, K0737

HCPCS MODIFIERS:
Added: GA, GZ
Revised: KX modifier

DOCUMENTATION REQUIREMENTS:
Added: Instructions for use of GA and GZ modifiers

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.

PAP Supplier FAQ Revised – September 2009

Four new Questions and Answers have been added to the *Positive Airway Pressure (PAP) Devices - Supplier Frequently Asked Questions* published in July 2009 based on questions received from the provider community. The new Q & A's read as follows:

12. Question: The PAP LCD states "Adherence to therapy is defined as use of PAP ≥ 4 hours per night on 70% of nights during a consecutive thirty (30) day period anytime during the first three (3) months of initial usage." Can you please clarify whether the ≥ 4 hours per night is continuous use or cumulative use in a 24 hour period? Would a patient who uses the device for 4 hours a night, but has a break in usage of 45 minutes still satisfy the requirements of the LCD?
Answer: The ≥ 4 hours per night is based on continuous use, with allowances for short breaks (e.g., toileting).

13. Question: A patient was placed on PAP therapy and during the course of their 12 week trial period they were hospitalized for two weeks. How does this impact the requirement for adherence monitoring and timing of the face-to-face follow-up evaluation?
Answer: The 12 week trial period applies to PAP use in the home setting. If a patient is admitted to an inpatient hospital or skilled nursing facility (SNF), the trial period is suspended. The trial period, including the requirement for adherence monitoring and the timing of the face-to-face re-evaluation (i.e., between the 31st and 91st day) resumes when the patient returns home.

14. Question: Can continued coverage of PAP therapy be extended to patients who come close to meeting the adherence metric requirements but don't quite achieve all of them in the 90 day timeframe?
Answer: No. All of the requirements must be met within the 90 day time frame. CMS' national coverage determination contained specific language that benefit from PAP therapy must be demonstrated in the first 12 weeks in order to provide continued coverage beyond that time. Compliance is a major issue with CPAP; failure of therapy is often related to mask fit, humidification, ramp time, etc. Most of these issues arise in the first few days of treatment and must be aggressively addressed by the supplier and/or treating physician. Even if that takes 4-6 weeks there is still adequate time to achieve the liberal local coverage determination metric of ≥ 4 hours per night on 70% of the nights in a 30 day period.

19. Question: If compliance is not documented in the first 90 days and the patient then has a new facility-based polysomnogram and face-to-face evaluation with a physician and a new trial period is begun, does a new capped rental period start?
Answer: No. Standard break-in-need rules apply because there has been no change in the underlying condition that necessitates the PAP therapy. Consequently, a new capped rental period does not begin.

Intravenous Immune Globulin Coverage

This article provides reminders on the coverage of intravenous immune globulin (IVIG), J1459, J1561, J1566, J1568, J1569 and J1572 (2009 HCPCS). IVIG can be administered via methods other than through an infusion pump to be covered by Medicare.

The Medicare Benefit Policy Manual, Chapter 15, Section 50.6 states the following:

'Beginning for dates of service on or after January 1, 2004, The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 provides coverage of intravenous immune globulin (IVIG) for the treatment of primary immune deficiency diseases (ICD-9 diagnosis codes 279.04, 279.05, 279.06, 279.12, and 279.2) in the home. The corresponding HCPCS codes are J1563 and J1564*. The Act defines "intravenous immune globulin" as an approved pooled plasma derivative for the treatment of primary immune deficiency disease. It is covered under this benefit when the patient has a diagnosed primary immune deficiency disease, it is administered in the home of a patient with a diagnosed primary immune deficiency disease, and the physician determines that administration of the derivative in the patient's home is medically appropriate. The benefit does not include coverage for items or services related to the administration of the derivative. For coverage of IVIG under this benefit, it is not necessary for the derivative to be administered through a piece of durable medical equipment."

NAS recently modified our claims processing system to ensure IVIG not administered through a pump is allowed when appropriate. If a supplier determines previous claims were denied in error, NAS will adjust these claims when brought to our attention. Suppliers can contact the Supplier Contact Center at 1-866-243-7272 for assistance.

Suppliers are also reminded of the following when billing IVIG, pump and supplies:

COVERAGE CONT'D

- If the coverage criteria are not met, i.e. diagnosis is not one of the covered diagnoses, and intravenous immune globulin was administered through a pump, the IVIG will deny as not medically necessary. An ABN should be obtained to transfer liability to the beneficiary.
- If coverage criteria is not met and IVIG is not administered through a pump, the IVIG claim will deny as non-covered, no benefit category. An ABN is not needed.
- When coverage criteria is not met for a patient receiving IVIG through a pump, if the pump is not being billed to Medicare, i.e., the beneficiary owns their pump, suppliers should include a narrative on their claim that IVIG is being administered through a pump so the appropriate denial can be applied.
- If the IVIG is administered using an infusion pump, the infusion pump and related administration supplies are denied as not medically necessary.
- When IVIG is not administered through a pump and supplies are billed, code A4223 should be used for the supplies. A4223 will deny as not covered.

For additional intravenous immune globulin coverage requirements, reference the Intravenous Immune Globulin Local Coverage Determination and corresponding policy article.

*The Medicare Benefit Policy Manual reflects previous HCPCS codes previously used for intravenous immune globulin. Other codes also used for intravenous immune globulin are J1567, Q4087-Q4089, Q4091-Q4092 and Q9941-Q9944.

OXYGEN

Oxygen CMN Reminder

NAS is seeing oxygen Certificates of Medical Necessity (CMNs) for replacement equipment with a testing date noted in Section B as after the initial date noted in Section A. The oxygen CMN states, "Enter the result of the most recent test taken on or before the certification date listed in Section A."

The Local Coverage Determination (LCD) for oxygen and oxygen equipment clarifies what is needed for replacement oxygen and states that an initial CMN is required when equipment is replaced due to the reasonable useful lifetime of the equipment being met or when equipment is replaced due to irreparable damage, theft, or loss of the originally dispensed equipment. The LCD further states that repeat blood gas testing is not required. Physicians are to enter the most recent qualifying value and test date. This test does not have to be within 30 days prior to the "Initial Date" shown on the CMN. It could be the test result reported on the most recent prior CMN.

Remember, if a recent qualifying value is reported, that testing date must be prior to the initial date on the CMN. Any claim with a CMN having a test date after the initial date on the CMN will be denied.

Oxygen Ask the Contractor Q&A - June 30, 2009

Prior to taking questions, NAS provided the following updates and responses to questions submitted in advance of the call:

Policy Updates
The Oxygen LCD and Policy Article have been revised to address the new payment rules currently in effect with specific instruction regarding the supplier's responsibility during and after the 36 month rental period and documentation requirements for replacement of oxygen equipment.

Maintenance and Servicing
CMS has determined that, for services furnished during calendar year 2009, it is reasonable and necessary to make payment for periodic, in-home visits by suppliers to inspect certain oxygen equipment and provide general maintenance and servicing after the 36 month rental cap. These payments only apply to concentrators and transfill equipment (E1390, E1391, E1392 and K0738) and only when the supplier physically makes an in-home visit to inspect the equipment and provide any necessary maintenance and servicing. Payment may be made no more than every six months, beginning six months after the 36 month rental cap (as early as July 1, 2009, in some cases). The allowed amount for each visit is equal to the 2009 fee for code K0739, multiplied by two, for the state in which the in-home visit takes place.

Oxygen Contents
The supplier who furnished liquid or gaseous oxygen equipment during the 36 month rental period is responsible for furnishing oxygen contents used with the supplier-owned equipment for any period of medical necessity following the 36 month cap for the remainder of the reasonable useful lifetime (RUL) of the equipment. Suppliers should use HCPCS codes E0441 through E0444 to bill oxygen contents, depending on the type of system with one unit of service for a one month supply.

Questions received prior to the call:

Q1: Are we able to charge a patient for additional travel equipment if they are traveling for leisure and they take a portable oxygen concentrator in addition to the equipment we are currently billing? They have requested an Eclipse Concentrator to take while they are traveling and we are billing for a standard concentrator.
A1: You must continue to provide the beneficiary with what was ordered and dispensed. If you chose to provide the beneficiary with a more convenient system, you may not collect any additional payment. You must also make arrangements for the beneficiary to continue to receive oxygen and oxygen equipment when traveling for those months you receive payment.

Q2: A hospital-based physician writes an order for oxygen upon discharge with qualifying room air stats and documentation. A few days later, we asked the ordering physician to complete the Certificate of Medical Necessity (CMN). The hospital-based physician has not responded favorably to filling out the CMN. The patient then goes to her primary care physician (PCP) for a follow-up. The PCP agrees that the patient has a

need for oxygen and orders comprehensive oxygen test files. The test results show that the patient continues to qualify for oxygen. The patient has now had oxygen for over a month. What date do we use for the initial date on the CMN, the date the oxygen was delivered or the date the PCP ordered the oxygen and completed the CMN?
A2: The "Initial Date" found in Section A of the CMN should be either the date that the physician gives as the start of medical necessity or if the physician does not give a start date, the "Initial Date" would be the date of the order. The hospital-based physician gave the original order; therefore the initial date on the CMN should be the delivery date. The physician who ordered the oxygen upon discharge should complete sections B and D of the CMN. The PCP who is taking over the patient's care should complete a revised CMN showing them as the treating physician. This revised CMN should NOT be submitted to the DME MAC, but kept in the supplier's files. Furthermore, NAS has a letter available for suppliers to assist them, when requesting information from physicians, in order to provide the necessary information needed to process Medicare claims.

Q3: We have a patient who initially received oxygen on May 9, 2002, and had a private insurance before becoming Medicare eligible. The patient became Medicare eligible and was tested on July 1, 2004, and a new initial CMN was obtained. We received 36 months of payments since January 2006. The 36th month payment was for December 1, 2008. The patient received new equipment on February 15, 2009, because of the initial date the patient received his equipment. In the oxygen policy article (A33750) it states the RUL for oxygen equipment is five years and the RUL is not based on the chronological age of the equipment. It starts on the "Initial date of service and runs for five years from that date". It does not state initial date of Medicare service. Could we get clarification on this as we have this same scenario with other beneficiaries? If the answer is that RUL is based on the initial date of Medicare service, could you please tell us where to find that in available documentation?
A3: Medicare does not coordinate with other insurance companies prior to the beneficiary's Medicare eligibility. Medicare entitlement begins when the member becomes eligible, therefore Medicare will begin counting the RUL upon eligibility.

Q4: For what HCPCS codes can the QE, QF and QG modifiers be used? Is it just the E0424, E0439, E1390 and E1391 codes?
A4: Correct, the QE, QF or QG modifiers may only be used on the stationary system codes E0424, E0439, E1390 or E1391.

Q5: What is the purpose of the QH modifier and is there a pricing differential?
A5: This is only an informational modifier to document that an oxygen conserving device has been prescribed and dispensed. QH will not change the allowed amount when reported on oxygen equipment.

Q6: After a patient has met their five year RUL and they are set up on new equipment, is that literally new equipment or can it be refurbished used equipment?
A6: This can be new or used equipment.

Questions and answers taken during the call:

Q7: We have two different National Provider Identifier (NPI) numbers for two different locations. One of our locations is going to close. How do we transfer those patients at the location that is closing to our other location?
A7: You need to complete a revised CMN to show the new location. This revised CMN does not need to be submitted to the DME MAC, but must be kept on file. In the event of an audit, the revised CMN will show the beneficiaries were transferred to a different location. You would want to contact the National Supplier Clearinghouse (NSC) to update the supplier number, as well as close out your NPI with NPPES for the location that is closing down.

Follow-up: Do we need to include a narrative on the claims that says we are a new supplier?
A: No. NAS will see that there is a new supplier billing and we will update our records based on that new supplier number.

Q8: We have received conflicting information when the patient is discharged from the hospital. Do we have to have a blood gas study or an oximetry?
A8: It can be either/or but must be the most recent test within two days prior to discharge.

Q9: Is maintenance and service allowed for the concentrator (E1390) but not the portable system (E0431)?
A9: Correct. Maintenance and servicing is allowed for concentrators and transfill equipment only. For calendar year 2009, suppliers may bill for maintenance and servicing no sooner then six months after the 36 month cap has been reached and paid. The date of service is the date the actual maintenance and service was performed. In addition, the day after the 36 month cap is reached for the portable gaseous system (E0431), the supplier may begin billing gaseous contents (E0443) but not maintenance and servicing. The supplier is also required to continue providing the beneficiary with all accessories such as cannula, tubing and mouth piece but may not bill for those items.

Q10: I understand the answer provided regarding when the count begins for the RUL of oxygen equipment but I did not hear the source document or the CMS publication reference that speaks directly to this requirement. Can you provide that please?
A10: There is no specific source document; however Medicare entitlement begins when the beneficiary becomes eligible. Medicare claim processing begins with a new initial CMN, as well as a new initial claim. This is what initiates the count of the RUL.

Q11: We have a number of patients that have transitioned to our service from another DME company while on Medicare. We have called the contact center to determine how far into the RUL a Medicare patient is. The only information we are receiving from the contact center is how long the patient has been receiving service

with our company. How do we determine the total months billed for oxygen equipment including other DME companies to determine the RUL?
A11: NAS goes by the initial date on the CMN as the start of the RUL. The Supplier Contact Center (1-866-243-7272) can provide that information to you.

Q12: Are there any updates on billing maintenance and servicing after 2009?
A12: Maintenance and servicing instruction has been provided by CMS for calendar year 2009 only. We are waiting for further instruction from CMS regarding maintenance and servicing in 2010 and later.

Q13: Can portable contents be paid during the same month as the portable gaseous or liquid system if there is no stationary system? If a stationary system is capped out but the portable system is not, can portable contents be paid at the same time as the portable system?
A13: Yes. If the beneficiary does not use a stationary system, if the stationary system has reached the 36 month cap or the beneficiary owns their own stationary system, payment can be made for the portable liquid or gaseous system, as well as portable contents until the portable system has reached its 36 month cap, when just contents are paid. If the capped stationary system is a liquid or gaseous system, contents can be paid for both the stationary and portable liquid or gaseous system.

Q14: A concentrator has reached its 36 month cap but the portable gaseous system has not. We submitted a claim for the portable system and contents and it was denied. Is that incorrect?
A14: NAS requested examples of this denial but none were received at the time of this publication.

Q15: I sent in a claim for a patient who has had oxygen more than five years and we gave them a new machine. This was back on April 10, 2009. I still have not been paid for it. The contact center is telling me that claims processing has a large inventory of claims for the replacement oxygen equipment. I do not want to bill additional months until I know the replacement is paid. Can you tell me when it will be paid?
A15: NAS requested examples of this denial, but none were received at the time of this publication.

Q16: Could you provide me with further clarification on the pricing differential for the QE, QF and QG modifiers?
A16: There is an additional allowance when the beneficiary is using greater than four liters per minute (LPM) of oxygen and was tested on four LPM of oxygen. The QF modifier indicates the beneficiary meets this requirement and a portable system is prescribed. The QG modifier indicates the same, except a portable system is not prescribed. The reimbursement is increased by 50% of the standard allowance for both QF and QG. The QE modifier indicates the beneficiary is using less than one LPM. The reimbursement is 50% less then the standard allowance.

Q17: I am providing a portable concentrator system using E1390 and E1392. Are you saying that after the cap I continue to bill for content fills?
A17: No. A portable concentrator generates its own oxygen. If you are not dispensing liquid or gaseous contents, contents cannot be billed. Contents only apply to liquid or gaseous systems.

Q18: If a beneficiary travels for their own convenience, not for a medical purpose, do we still have to provide oxygen to them?
A18: If you are getting paid for that month's oxygen you are responsible to make sure the beneficiary has the equipment they need regardless if they are at home or traveling.

Q19: If the beneficiary has reached the 36 month cap and are driving cross-country for the next six months, you are telling me that I have to pay for their travel wherever they are going, even though it is travel for convenience? I thought oxygen was to be provided in the home, not on a cruise or a vacation.
A19: The supplier, who provided oxygen equipment during the 36 month cap rental period, must continue to provide whatever is ordered or make arrangements to provide what is ordered until the end of the RUL. Coverage criteria are based on home use but that does not restrict the beneficiary to the home only.

Q20: We are getting multiple denials for contents of the portable equipment or portable oxygen with the reasons of CO96 (non-covered change) and M124 (missing indication of whether the patient owns the equipment that requires the part or supply), non-covered charge. The second one is missing indication of whether the patient owns the equipment that requires the part or supply. Is there a modifier missing that is causing these denials?
A20: Please verify the equipment has actually capped and all 36 months have paid. If they have, you would need to provide examples.

Q21: Is there any direction you can give suppliers when a beneficiary travels or moves during the 36 month cap period? How can a supplier assist that beneficiary in obtaining services from another supplier out of our service area?
A21: Suppliers are encouraged to assist beneficiaries in finding another supplier who will accept their patient for future months, possibly a supplier you know or have worked with regarding another beneficiary. Although suppliers are responsible for the month billed, it is only encouraged to assist and not a requirement during the first 36 months.

Follow-up question: My difficulty is getting a supplier willing to take that customer who's in, for example, the 30th or 34th month where they are only going to receive a few months of reimbursement and two years of no reimbursement. I understand that the policy is written this way but are there plans to assist suppliers to be more willing to take that customer on?
A: NAS has not heard of any plans. CMS will notify the DME MACs regarding any changes. NAS posts any updates to our email list and the What New section of our web site.

Q22: If a beneficiary has exceeded the 36 months and we were the supplier who received the 36 month payment, can we turn the responsibility over to another supplier or if the 36 month has been exceeded, are we required to bill?
A22: There are no further payments for oxygen equipment after 36 rental payments have been made. The supplier may bill for contents if providing a liquid or gaseous system. The supplier who provided the equipment during the 36th rental month is required to continue to provide the equipment, accessories, content (if applicable), maintenance and repairs of the equipment during the five year RUL or make arrangements with another supplier to provide the oxygen required by the beneficiary.

Q23: A patient who has met the 36 month cap is now on an extended vacation lasting several months. We are the supplier that received the 36 month cap payment. The patient is using portable and stationary gaseous systems and we provided contents for those systems, which we billed for after the 36 month cap. If we stop providing and billing for the months, while they are on the road, can at that point the patient be responsible for procuring their own oxygen while they are outside of our service area?
A23: After the 36 month cap, either short-term travel, extended temporary relocation or permanent relocation, the home supplier is required to either provide the equipment, which was ordered, related items, services, accessories and contents, or make arrangements with a different supplier to provide that equipment.

Q24: It was mentioned that a supplier had to get paid for all 36 months during the cap before they could start billing for contents. What happens if, on January 1, 2009, 34 months are billed and two of them are past timely filing and the supplier does not want to bill two more months. Do 36 months have to be paid before contents can be paid?
A24: Yes. 36 payments must be made before you can start billing for contents.

Q25: Many of our beneficiaries are not aware of the oxygen rules and their responsibility, after 36 months have been paid. Sometimes the secondary insurance is telling these beneficiaries that they need to pay additional amounts over Medicare's 36 month payments. How much education are beneficiaries receiving on this payment category?
A25: The DME MACs are not contracted to educate beneficiaries; however there are various state organizations, as well as Medicare.gov to assist them with their concerns. NAS will pass beneficiary education issues on to CMS and let them know of your concerns and the need for beneficiary assistance.

Q26: When a beneficiary transfers from a Medicare Advantage Plan to Medicare fee-for-service, the supplier manual states that a new initial CMN must be obtained and the patient does not have to obtain a new blood gas study or oximetry test. The supplier manual also states that the testing does not have to be within 30 days of the initial date on the CMN. We are receiving denials in these situations indicating our testing is not within the 30 days of the initial date. How can we avoid those denials?
A26: These claims should suspend for review by our claims processing staff. NAS suggests that a narrative be used in the claim line item. (For example: Medicare Advantage or HMO transfer). NAS requested examples of these denials, but none were received at the time of this publication.

Q27: We have some patients who travel but refuse to take the equipment we provided. What is our responsibility?
A27: The home supplier is only obligated to provide the beneficiary with oxygen equipment that has been ordered or make arrangements with a different supplier. For months 1 through 36, the home supplier is responsible for the remainder of the rental month for which was paid. For months 37 through 60, the home supplier is responsible until the RUL is reached.

Follow up question: What will happen if the beneficiary goes to a different supplier?
A: If the beneficiary goes to another supplier and this supplier submits their claim first, this claim may be paid. In this case, the home supplier's claim if processed second, for the same month would be denied as same/similar. Medicare will only pay one supplier per month for oxygen rental or contents.

Q28: If I am providing a home unit and tank and the beneficiary decides to get on an airplane and fly to Las Vegas, what am I obligated to do? Does this mean I have to purchase a portable air-worthy concentrator for that beneficiary?
A28: No. The home supplier is only obligated to provide the beneficiary with the oxygen equipment that has been ordered and are not obligated to provide oxygen while the beneficiary is in flight. Airplane oxygen is non-covered and the responsibility of the beneficiary.

Q29: After the 36 month cap is reached, if a beneficiary had a portable system and a concentrator and refused to take them on their travels, what do we do? How can we be responsible? Will the beneficiary now be liable?
A29: If the beneficiary relocates outside the supplier's service area between months 37 and 60, the home supplier is required to either provide the equipment and related items/services, or make arrangements with a different supplier to provide the equipment.

Q30: What about travel outside of the country? If a beneficiary is going on a cruise to Canada, are we responsible for equipment for use in Canada?
A30: Medicare does not cover items or services provided/used outside the United States and its territories. The supplier is not required to provide or arrange for oxygen use in those situations.

Q31: When did the Medicare policy change regarding taking care of a patient in their home and not even allowing portable oxygen to go to a physician's visit and now suddenly Medicare is paying for travel oxygen. Can beneficiaries now use scooters outside of the home?
A31: Coverage criteria is based on appropriate use in the home as it always has been, however a beneficiary is not restricted to only using DME and oxygen in their home. Just

like a beneficiary qualifies for a scooter to accomplish their activities of daily living inside the home, it may also be used outside the home, BUT coverage criteria for in home use must be met.

Per CMS comments: The DME benefit is a benefit for equipment used in the patient's home. There has to be a medical need for using oxygen in the home, but that does not mean a beneficiary is not allowed to take the equipment outside of the home.

An example of this would be that a beneficiary can take a scooter out of the home, along with power mobility devices, manual wheelchairs and other ambulation devices that allow someone to leave their home. This would be the same for oxygen. Medicare pays suppliers to furnish equipment that is used both in the home and outside the home, but there is also a requirement that the equipment be medically necessary for use in the home. That does not mean that it is only to be used inside the home and only covered for use in the home. The Medicare Improvements for Patients and Providers Act (MIPPA), the Deficit Reduction Act (DRA) and other legislation has not changed this policy.

Q32: Was there any resolution for a patient who was receiving oxygen from a small oxygen company that went bankrupt. The beneficiary is capped out on their oxygen and they have to find a new supplier but the suppliers might be hesitant to take them on because they will not get paid. Has anything been worked out regarding this scenario?
A32: Unfortunately, a new 36 month cap cannot be started in this circumstance. There is currently no additional information available on how to deal with this situation but if anything changes, notification will be sent out through the NAS email list.

Q33: If a patient comes to our service area who is on continuous oxygen and their concentrator caps but their portable system has not, will we be reimbursed for the portable system and/or gaseous contents if provided?
A33: Yes. Once the stationary system caps out, if the portable system has not capped out Medicare allows for the portable system, as well as the portable contents. The portable system will also cap out at 36 months but payments for contents (if applicable) will continue as long as a new capped rental period for the stationary system does not begin.

Q34: How do we bill for maintenance and service after the 36 month cap for an E1390?
A34: Bill E1390MS with one unit of service. Reimbursement will be based on the repair code K0739 for two units of service. For calendar year 2009, maintenance and service is only covered for concentrators and transfill equipment for actual maintenance and servicing performed six months after the 36 month cap has been reached. The date of service is the date the maintenance and servicing was performed.

E2399 – Power Wheelchair – Not Otherwise Classified Interface

Code E2399 describes an interface for a power wheelchair drive control system that is not described by any other HCPCS code. At the time of initial issue of a power wheelchair, this code would only be used for very uncommon types of drive control mechanisms – e.g., a fiber optic switch array.

The DME MAC receives a number of claims in which code E2399 is used for various joystick "upgrades", including but not limited to the Pride Mobility Products Q-Logic Drive Control System or the Permobil R-net Remote Joystick. This is incorrect coding. Code E2399 (or K0108 – wheelchair component or accessory, not otherwise specified) must never be used for a component or feature of a joystick at the time of initial issue of a wheelchair.

Reimbursement for a standard proportional remote joystick with a non-expandable controller is included in the allowance for a power wheelchair base. When a joystick with an expandable controller is provided at the time of initial issue, the following two codes are billed:

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

E2377 Power wheelchair accessory, expandable controller, including all related electronics and mounting hardware, upgrade provided at initial issue

The reimbursement for these two codes includes payment for any additional "upgrade" component or feature of a proportional or nonproportional joystick. Although separate billing is discouraged, if a supplier elects to bill separately, code A9900 (Miscellaneous DME supply, accessory, and/or service component of another HCPCS code) must be used.

Claim lines for E2399 billed at the time of initial issue of a power wheelchair for an "upgrade" of a joystick or other drive control interface will be denied as not separately payable if they are billed with E2313 and/or E2377. If E2313 and E2377 are not billed, code E2399 will be rejected as incorrect billing.

Refer to the Wheelchair Options and Accessories Policy Article for definitions of expandable and non-expandable controllers and various types of drive control interfaces. The Policy Article also contains guidance concerning the use of code E2399 for replacement components.

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