Jurisdiction D News from Noridian Administrative Services, LLC.

Happenings

April 2008
Issue No. 12

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

In This Issue…

FYI

EDUCATIONAL

NPI

ACCREDITATION

COMPETITIVE BIDDING

EDI

CERT

ASCA

FORMS

APPEALS

REIMBURSEMENT

CODING

BILLING

COVERAGE

OXYGEN

WHEELCHAIR/POWER MOBILITY DEVICE

Alphabetical Listing...

Jurisdiction D DME MAC Supplier Contacts and Resources

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

Web site: www.noridianmedicare.com

Fax	
Reopenings and Redeterminations	1-888-408-7405
Administrative Simplification Compliance Act (ASCA)	1-888-523-8449
Refunds to Medicare	1-888-529-3666
MSP Inquires and Refunds	1-888-535-5114
ADMC Requests/Documentation	1-877-662-8445
Medical Review Medical Documentation	1-866-465-0213
CERT Medical Documentation	1-877-436-4479

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

Mailing Addresses	
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
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 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		
Statistical Analysis DMERC	1-877-735-1326	www.palmettogba.com/sadmerc
National Supplier Clearinghouse	1-866-238-9652	www.palmettogba.com/nsc
Common Electronic Data Interchange Help Desk	1-866-311-9184	www.ngscedi.com
Centers for Medicare & Medicaid Services		www.cms.hhs.gov

Holiday Schedule

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

Holiday	Date
Memorial Day	May 26, 2008
Fourth of July Holiday	July 4, 2008
Labor Day	September 1, 2008
Columbus Day *	October 13, 2008
Veteran's Day *	November 11, 2008
Thanksgiving Day	November 27, 2008
Thanksgiving Holiday	November 28, 2008
Christmas Eve**	December 24, 2008
Christmas Day	December 25, 2008
** Partial day closure	

Sources for "Jurisdiction D Happenings" Articles

The purpose of "Jurisdiction D Happenings" is to educate Noridian Administrative Services' Durable Medical Equipment supplier community. The educational articles can be advice written by NAS staff or directives from the Centers for Medicare & Medicaid Services. 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, www.cms.hhs.gov/manuals. CMS Change Requests and the date issued will be referenced within the "Source" portion of applicable articles.

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

Summary of Supplier Manual Updates

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

Chapter	Subheading	Supplier Manual Update	Change Date
Chapter 16	HCPCS J and Q Codes	Added effective dates to J7611, J7612, J7613, J7614 and Q4099. Added discontinued dates to J7602 and J7603.	4/3/08
Chapter 16	Modifiers	Added modifier JW.	3/25/08
Chapter 3	Documentation Requirements	Removed all PSC references.	3/5/08
Chapter 4	Certificates of Medical Necessity	Removed all PSC references.	3/5/08
Chapter 9	Local Coverage Determinations (LCD) and Policy Articles	Removed all PSC references.	3/5/08
Chapter 15	Resources	Removed all PSC references.	3/5/08
Chapter 16	Level II HCPCS Codes	Added K0672, effective 04/01/08.	3/5/08

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

Medicare Learning Network Matters Disclaimer Statement

Below is the Centers for Medicare & Medicaid Services (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."

Opportunity to Participate in Third Annual Medicare Contractor Provider Satisfaction Survey Ends in April

MLN Matters Number: SE0804

Provider Types Affected
All Medicare physicians, providers, and suppliers billing the Medicare fee-for-service (FFS) program who were selected to participate in the MCPSS for 2008.

Provider Action Needed
Those Medicare providers who were selected by the Centers for Medicare & Medicaid Services (CMS) to participate in the MCPSS are asked to please take the time to complete the survey or respond to the survey contractor, Westat, follow-up calls. The survey is designed so that it can be completed in 15 minutes and responses may be submitted via a secure website, mail, fax or over the telephone. Currently the average response rate is 32%; CMS' goal is to reach a 65% response rate. Data collection ends in April.

Background
The MCPSS offers providers the opportunity to contribute directly to CMS' understanding of contractor performance as well as aid future process improvement efforts of Medicare contractors (carriers, fiscal intermediaries, Medicare Administrative Contractors, (A/B MACs), and Durable Medical Equipment Medicare Administrative Contractors (DME MACs). Specifically, the survey is used by CMS as an additional measure to evaluate contractor performance. In fact, all Medicare Administrative Contractors (MACs) will be required to achieve performance targets on the MCPSS as part of their contract requirements by 2009.

The MCPSS is designed to gather quantifiable data on provider satisfaction levels with the key services that comprise the provider-contractor relationship. The survey focuses on seven major parts of the relationship: provider inquiries, provider outreach and education, claims processing, appeals, provider enrollment, medical review, and provider audit and reimbursement.

Respondents are asked to rate their experience working with contractors using a scale of 1 to 6 with "1" representing "not at all satisfied" and "6" representing "completely satisfied." The results of the second MCPSS showed that 85 percent of respondents rated their contractors between 4 and 6.

The 2007 MCPSS results indicate that the provider inquiry function has the greatest influence on whether providers are satisfied with their contractors. This indicated a shift from 2006, when the claims processing function was the strongest predictor of a provider's overall satisfaction.

"CMS and the Medicare contractor community are committed to high quality relationships with the provider community," CMS Acting Administrator Kerry Weems said in a recent CMS press release. "The MCPSS provides contractors with greater insight into their provider communities, and allows them to make process improvements based on provider feedback."

"The shift from claims processing to provider inquiries as the top predictor of satisfaction is a perfect example of the type of trend data the MCPSS will reveal," Weems said. "Contractors are able to factor this insight into how they prioritize their provider-focused efforts."

Additional Information
To review the complete report of the second MCPSS refer to: http://www.cms.hhs.gov/mcpss/downloads/mcpss_report.pdf on the CMS website. To review a summary of the 2007 MCPSS refer to http://www.cms.hhs.gov/mlnmattersarticles/downloads/se0733.pdf on the CMS website. CMS plans to make the survey results publicly available in July 2008. Further information about the MCPSS is available at http://www.cms.hhs.gov/MCPSS on the CMS website.

Make Your Voice Heard by Participating in the Medicare Contractor Provider Satisfaction Survey

The Centers for Medicare & Medicaid Services (CMS) began distributing its annual Medicare Contractor Provider Satisfaction Survey (MCPSS) to a new sample of Medicare providers. The survey is designed to garner quantifiable data on provider satisfaction levels with key services provided by the Medicare fee-for-service contractors (FFS) who process and pay more than Medicare claims each year.

Providers selected to participate in the survey are being contacted by the survey contractor, Westat. The survey is designed so that it can be completed in about 15 minutes and providers can submit their responses via a secure Web site, mail, fax, or over the telephone. CMS is encouraging that if your organization was one of the selected sampled providers, **please take the time to complete the survey** or respond to Westat's follow-up calls if you have not already done so.

Your input is extremely important and the results of the study will help us improve the services we provide you and be used by CMS as an additional measure to evaluate performance of Medicare Administrative Contractors (MACs) and support process improvement efforts. **The views of every provider asked to participate are important to the success of this survey, as each one represents many other organizations that are similar in size, practice type and geographical location**.

Westat will contact non-respondents by telephone in the coming weeks to encourage their participation. **Data Collection ends in April**. MCPSS results will be available to contractors and the public in July 2008. Additional information about the MCPSS is available at: http://www.cms.hhs.gov/MCPSS/.

Addressing Correspondence and Paper Claims Correctly

NAS is requesting that suppliers mail claims and/or other written correspondence to the correct address. NAS processes claims for multiple contracts and states. Due to the large volume of mail that is received daily, it is very important when mailing claims or other correspondence to NAS that suppliers use the mailing guidelines outlined in this article:

Delays are Caused by Incorrect Addresses
Suppliers using a street address, faxing to the incorrect number or sending to the incorrect post office box, may experience delays in the processing of their claims or correspondence. This incorrect mailing may cause the claims or correspondence to be scanned incorrectly. When this occurs it takes additional time to retrieve claims or correspondence to rescan them correctly.

Correct Addressing
The Jurisdiction, to which the claims or correspondence must be sent, is the Jurisdiction in which the *beneficiary resides.* NAS processes DME claims and correspondence for Jurisdiction D only. States in Jurisdiction D are Alaska, Arizona, California, Hawaii, Idaho, Iowa, Kansas, Missouri, Montana, Nebraska, North Dakota, Nevada, Oregon, South Dakota, Utah, Washington and Wyoming.

When mailing new claims DO NOT:

- Mail a redetermination request form if your claim has previously been denied as unprocessable (remark code MA-130)
- Return Education Status letters with your claim/ correspondence
- Fax new claims

Please address DME correspondence and claims using the following template:

Noridian Administrative Services
PO Box XXXX
Fargo, ND 58108- XXXX
(Replace the XXXX with the PO Box indicated in the chart below.)

Jurisdiction D DME	PO Box	Fax #
Claims	6727	N/A
Correspondence, including redetermination/ reopening requests	6727	888-408-7405
Checks	6727	N/A
EFT	6728	N/A
ASCA	6737	888-523-8449
Medical Review CERT	6747	877-436-4779
Medical Review ADMC	6747	877-662-8445
Medical Review Medical Documentation	6727	866-465-0123
Refunds-Non-MSP	6727	888-529-3666
Refunds-MSP	6727	888-535-5114
Benefit Protection	6736	N/A

NAS' physical address should **only** be used when utilizing a courier service. Please address packages in the following manner:

Noridian Administrative Services
PO Box XXXX
901 40th St. S Suite 1
Fargo ND 58103-2146

Used DME Equipment

As follow-up to the March 12 Ask the Contractor Teleconference, this articles provides clarification and guidance on renting used equipment.

Suppliers are reminded that used equipment may be provided to a Medicare beneficiary. All DME claims must specify whether equipment is rented or purchased. For purchased equipment, the claim must also indicate whether equipment is new or used. The UE modifier should be reported when a beneficiary purchases any used equipment, which falls under the DME payment category of Inexpensive or Other Routinely Purchased (IRP). Suppliers also can provide used equipment for capped rental items, but the UE modifier is not required for capped rental items.

Used equipment is any equipment that has been purchased or rented by someone before the current purchase transaction. Used equipment also includes equipment that has been used under circumstances where there has been no commercial transaction, e.g., equipment used for trial periods or as a demonstrator.

To determine which equipment is categorized as IRP or capped rental, reference chapter 16 of the supplier manual for a listing of all DME HCPCS codes. The Level II HCPCS code tables list IRP items as category 5 and capped rental as category 1.

Some examples (not an all-inclusive list) of equipment which may be purchased as "used" are power wheelchairs, canes and walkers.

Source: *Medicare Claims Processing Manual*, Chapter 20, Sections 30.1.1 and 130.9

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 the Centers for Medicare & Medicaid Services (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.

Physician Letter

Suppliers may use this letter from Dr. Robert Szczys when requesting medical records from physicians.

NORIDIAN®
Administrative Services LLC

901 40th St S, Suite 1
Fargo, ND 58103-2146

Medicare

Dear Physician:

The Durable Medical Equipment Medicare Administrative Contractors (DME MACs) process claims and perform medical review for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) provided to Medicare beneficiaries. It is your responsibility as the ordering physician to determine and document the medical need for all healthcare services.

For any DMEPOS item to be covered by Medicare, the patient's medical record must contain sufficient documentation of the patient's medical condition to support the need for the type and quantity of items ordered and for the frequency of use or replacement (if applicable). The information should include the patient's diagnosis and other pertinent information, such as duration of the patient's condition, clinical course (worsening or improvement), prognosis, nature and extent of functional limitation, other therapeutic interventions and results, past experience with related items, etc. For selected claims, the DME MAC may request that the supplier obtain this information from you so that the DME MAC can verify that Medicare coverage criteria have been met.

DMEPOS suppliers are your partners in caring for your patient. They will not receive payment from Medicare for the items that are ordered if you do not provide information from your medical records when it is requested. Furthermore, not providing this information may result in your patients having to pay for the item themselves. Finally, your cooperation is a legal requirement as outlined in the Social Security Act, the law governing Medicare. Section 1842(p)(4) of the Act mandates that:

In case of an item or service…ordered by a physician or a practitioner…but furnished by another entity, if the Secretary (or fiscal agent of the Secretary) requires the entity furnishing the item or service to provide diagnostic or other medical information in order for payment to be made to the entity, the physician or practitioner shall provide that information to the entity at the time that the item or service is ordered by the physician or practitioner.

The Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule permits disclosure of protected health information without beneficiary authorization to carry out treatment, payment, or health care operations. The DME MACs perform health care operations as agents of the Centers for Medicare & Medicaid Services (CMS). Providing the requested documentation is in keeping with the HIPAA Privacy Rule. You cannot charge the supplier or the beneficiary to provide this information to the supplier.

Help your DMEPOS supplier continue to provide good service to your patients by promptly providing the information from your medical records that is requested.

Sincerely,

Robert F. Szczys, M.D., F.A.C.S.
Medical Director
DME Jurisdiction D

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

A CMS Contracted Carrier/Intermediary

Ask the Contractor Teleconference for Small Suppliers - May 14, 2008

NAS will conduct the DME Ask the Contractor Teleconference to assist **small suppliers on May 14, 2008.** CMS has defined a small supplier as a supplier with ten or fewer full time equivalent employees. During this teleconference, knowledgeable NAS staff representing a variety of functions will be available to answer your questions. If we cannot answer your question during the teleconference, we will research the issue and then call you with the answer.

Following the teleconference the questions and answers (Q&A) from the teleconference will be posted to our web site. You can view the Q&A from the NAS home page by choosing Durable Medical Equipment > Training > Ask the Contractor Teleconference > Ask the Contractor Questions & Answers.

To participate in this ACT for **small suppliers**, dial 1-866-233-3843. For those suppliers who may need an international number (American Samoa, Guam or the Northern Mariana Islands) dial 1-612-332-0819.

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

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

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

The remaining 2008 teleconferences for **small suppliers** will be held at 3:00 pm CT on:

- August 13, 2008
- November 12, 2008

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

Ask the Contractor Teleconference – June 11, 2008

NAS is pleased to announce the next Ask the Contractor Teleconference on June 11, 2008. We will be continuing with our current format of brief opening remarks followed by the question and answer (Q&A) session.

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

Following each teleconference the questions and answers (Q&A) for the teleconference will be posted to our web site. You can view the Q&A from the NAS home page by choosing Durable Medical Equipment > Training > Ask the Contractor Teleconference > Ask the Contractor Questions and Answers.

To participate in these ACT, dial 1-800-700-7414. For those suppliers who may need an international number (American Samoa, Guam or the Northern Mariana Islands) dial 1-612-332-0335.

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

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

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

The remaining teleconferences for 2008 will be held at 3:00 pm CT on:

- September 10, 2008
- December 10, 2008

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

Ask the Contractor Teleconference Q & A – February 13, 2008

Prior to taking questions, NAS provided the following updates:

NPI
Effective March 1, 2008, Medicare fee-for-service claims must include an NPI in the primary provider fields on the claim (i.e., the billing, pay-to provider, and rendering provider fields). You may continue to submit NPI/legacy pairs in these fields or submit only your NPI. The secondary provider fields (i.e., referring, ordering and supervising) may continue to include only your legacy number, if you choose. Failure to submit an NPI in the primary provider fields will result in your claim being rejected, as of March 1, 2008.

MR Transition
Effective March 1, 2008, medical review functions will be transitioned to the DME MAC jurisdictions. Until March 1, DME Program Safeguard Contractors are responsible for medical review.

The functions that will be transferring are:

- Comprehensive Error Rate Testing (CERT)
- Advance Determination of Medicare Coverage (ADMC) processing
- Medical Review of edits and claims (not for benefit integrity)

- Local Coverage Determination development
- Probe reviews
- Prepay/Postpay reviews

Beginning March 1, 2008, all medical review education and policy/article revisions and updates will be provided by NAS DME. All updates will be posted to the NAS DME website and sent in the email updates. All current email subscribers to SafeGuard Services, who have **not** subscribed to NAS DME emails, must subscribe to the NAS DME email in order to continue receiving medical review updates.

NAS will provide updates to changes that will occur, including mailing addresses and fax numbers, in the near future. Do not make any changes until notice and instructions are provided.

CEDI Transition
National Government Services, Inc. was awarded the DME Common Electronic Data Interchange (CEDI) front-end contract by CMS. With this contract, CEDI will provide a single front-end solution for the submission and retrieval of electronic transactions.

Suppliers in Jurisdiction D must transition to the common EDI front-end by April 30, 2008. With this change, DME MAC electronic submitters will send all electronic claims and Claim Status Inquiry transactions to CEDI. CEDI will return all electronic front-end reports directly to the submitter. CEDI will also receive the ERA and Claims Status Response transactions from the DME MACs and deliver them to the Trading Partner's CEDI mailbox.

Some key dates are:

February 1, 2008
The CEDI system went into production allowing testing to begin. Electronic submitters can move fully into production with CEDI ***before*** their final cutover date.

March 31, 2008
Jurisdiction D will no longer process new requests for submitter IDs or changes to an existing ID. All new setups and changes will be done by the CEDI Enrollment Team.

April 30, 2008
Last day for **Jurisdiction D** to process EDI transactions.

May 1, 2008
All **Jurisdiction D** EDI transactions will be processed by CEDI.

There is a Web site dedicated to CEDI as a resource for all CEDI documentation and communication. This website is www.NGSCEDI.com.

The CEDI Help Desk provides support for electronic submitters to resolve issues and answer questions about connectivity, receipt of files and electronic formats. The **CEDI Help Desk number** is **866-311-9184. Hours are 9:00 AM - 9:00 PM (ET)**. Email support is also available by sending an email to ngs.CEDIhelpdesk@wellpoint.com.

Electronic suppliers will want to join the CEDI list serve to receive important EDI information after transition. NAS will continue to send EDI related email list notices during the transition.

Some other key points:

- CEDI will use the existing submitter IDs established by each DME MAC Jurisdiction for current electronic submitters. Electronic submitters who have previously completed electronic registration or enrollment forms with a DME MAC do not need to re-enroll with CEDI.
- The CEDI system is now available for testing. Software vendors must test with CEDI prior to moving their customers to the CEDI. Suppliers, billing services and clearinghouses who use internally developed software and communications (in-house programmers) must also test with CEDI. Vendors and "in-house programmers" should contact the CEDI Help Desk by phone or e-mail to initiate the testing process.
- CEDI will maintain a list of software vendors who are approved for CEDI on the CEDI web site. This list will be updated daily.
- The Express Plus software will be modified to include new communication software. Additionally, the Express Plus manual will be updated. Once both the Express Plus software and manual are available on the CEDI Web site, a CEDI Listserv will be sent.

Accreditation Deadlines
Existing suppliers enrolled in Medicare prior to January 1, 2008, must be accredited by September 30, 2009.

DMEPOS suppliers submitting an enrollment application to the NSC on or after ***March 1, 2008*** must be accredited prior to submitting the application. The NSC shall reject the enrollment application unless the DMEPOS supplier provides supporting documentation that demonstrates that the supplier has an approved accreditation.

DMEPOS suppliers who are enrolled for the first time with the NSC between January 1, 2008 and February 29, 2008, must obtain and submit an approved accreditation to the NSC ***by January 1, 2009.***

For more information, see the CMS fact sheet posted on the NAS DME website, in the Enrollment/Accrediation section.

Contact Center Closures
When the call center is closed for training or federal holidays, we are only closed in the mornings. Afternoons are our busiest time for calls so we strive to limit our closure time to the mornings. Our call center closure schedule is posted on the right hand side of our website and is also included in our email list notices.

The following questions and answers are from the February 13, 2008, Ask-the-Contractor teleconference for small suppliers. In some cases, the original answers given during the call may have been expanded to provide further detail.

Q1. Are DME companies going to be allowed to perform in-home sleep diagnostic testing and if so, has there been a code established for that particular procedure?
A1. CMS has been conducting analysis and looking at various medical studies that have shown in-home sleep testing is as valid as going to a sleep lab, but at this time we have not heard that they have made a final decision to allow DME companies to do this. If there are any changes, we would get

notice of when it's going to go into effect from CMS and we would share it through our web site.

For more information about proposed changes to CPAP Therapy for OSA Medicare coverage, see http://www.cms.hhs.gov/HillNotifications/CHN/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=descending&itemID=CMS1206584&intNumPerPage=10. This information states that a final national coverage determination is planned to be issued in March, 2008.

Q2. It is my understanding that DME items are required to have a physician's order/prescription and also the history and physical notes for the patient. But often times there's specific coverage criteria required for those items. Is the supplier allowed to send the physician a medical necessity question set that the physician checks off or answers and signs? We are trying to get the coverage criteria mentioned in the notes so we're trying to figure out the most streamlined way of sending the doctor something to complete with the information for coverage criteria.

A2. Suppliers can provide a form to the physician and ask him to fill it out but that would not hold up as medical documentation when we review the claim. We would also have to receive the *actual* medical documentation from the physician that would back up what he put on that form. You can do this as a courtesy, and many suppliers do, but we would also need to get a copy of the actual medical documentation. It's very important to point the physician back to the LCDs to say this is what needs to be documented. The burden of proof always goes back to the medical documentation.

Follow-up Question: What part does a CMN play? Even though a CMN is not required for hospital beds, power wheelchairs, etc. no longer, if we have the CMN completed by the physician for those items, plus the history and physical and the prescription, would that be adequate? Customer service has said yes, as long as it's an item that has a CMN but it's not required anymore, it's completed correctly to show it meets medical necessity and we have the history and physical and the order/prescription.

A CMN or a DIF is not expected to provide all the documentation necessary to support medical necessity. Within the Documentation section of every LCD it states:

> "Section 1833(e) of the Social Security Act precludes payment to any provider of services unless "there has been furnished such information as may be necessary in order to determine the amounts due such provider" (42 U.S.C. section 1395l(e)). It is expected that the patient's medical records will reflect the need for the care provided. The patient's medical records include the physician's office records, hospital records, nursing home records, home health agency records, records from other healthcare professionals and test reports. This documentation must be available upon request."

Therefore NAS encourages suppliers to establish a thorough in-take process when dispensing covered DMEPOS items to a Medicare beneficiary. Although this is not a mandatory process, it is the first step in determining medical necessity. Asking the appropriate questions to Medicare beneficiaries and their ordering physician can help you determine if coverage criteria is met and whether medical records are available.

Supplier generated forms are not prohibited but in the event of an audit they need to be corroborated by medical records. Some coverage criteria may be received by the beneficiary, such as successful completion of training for the glucose monitor or compliant use of a CPAP. Determining coverage criteria and obtaining medical documentation is the supplier's responsibility and a business practice the supplier must develop.

Follow-up Question: For a patient lift, for example, to meet the coverage criteria, more than one person is required to transfer that patient. Very seldom a doctor will include that in the documentation. How do we get that information for Medicare?

The LCD for a patient lift states "A lift, code E0630, is covered if transfer between bed and a chair, wheelchair or commode requires the assistance of more than one person and, without the use of a lift, the patient would be bed confined." This may be indicated by various items in the medical documentation, such as as the patient's weight, diagnosis, phrases such as unable to ambulate, unable to bear weight, unable to walk, bedridden, can't use legs, etc… There may not be a direct statement that the patient requires assistance in transferring and that they are bed-ridden but it can be implied from the medical record. However, a word of caution, on this, there must be some reference to this in the medical record for coverage of a patient lift.

The documentation checklists found on our Coverage page on our website are helpful. Many DMEPOS items for which there is an LCD have a checklist that provides assistance with what you need for documentation. This could also be helpful for physicians so they know what you need when they order a particular item.

Q3. If a patient orders their 30-day enteral formula and supplies on January 1st, and then because many of our patients are in rural areas, the beneficiary calls on January 27th to order their February supplies, is this allowed? If the ship date has to be the date of service, they were already given the 27th, 28th, 29th and 30th day's supplies. Technically what they're getting on January 27th is their February supply. What becomes the appropriate date of service in this instance?

A3. There is a five day window so you can ship five days in advance. The date of service is always the shipping date so billing January 27th is correct.

Per Chapter 3 of the Supplier Manual, "If a supplier utilizes a shipping service or mail order, suppliers shall use the shipping date as the date of service on the claim."

Chapter 3 also states "For DMEPOS products that are supplied as refills to the original order, suppliers must contact the beneficiary prior to dispensing the refill. This shall be done to ensure that the refilled item is necessary and to confirm any changes/modifications to the order. Contact with the beneficiary or designee regarding refills should take place no sooner than approximately seven days prior to the delivery/shipping date. For subsequent deliveries of refills, the supplier should deliver the DMEPOS product no sooner

than approximately five days prior to the end of usage for the current product. This is regardless of which delivery method is utilized. DME MACs shall allow for the processing of claims for refills delivered/shipped prior to the beneficiary exhausting his/her supply."

Q4. A patient was set up on oxygen back in June. We were told at the time of set up that she was Medicaid only. Recently, Idaho Medicaid informed us that she was actually Medicare/Medicaid. In talking with customer service, she said a new CMN needs to be completed because the patient's Medicare number and our Medicare supplier number need to be on the CMN. The patient met the qualifications for Medicare and a CMN was obtained at that time. Is this correct?
A4. A new CMN does not have to be obtained only to reflect the patient's Medicare number and the Medicare supplier number. According to Chapter four of our supplier manual, for this situation, an initial CMN is required and the initial date should be the date of Medicare eligibility if the patient has a Medicare qualifying test 30 days before the eligibility. If they did not get the qualifying test until after they became Medicare eligible, then the intial date should be the date of the qualifying test. The patient's Medicare number and the supplier's Medicare number can be added to the CMN that was completed when it was thought that the patient was on Medicaid.

Q5. We printed out all of the HCPCS codes that are covered under home health services. We have a patient that has home health services but they need supplies, for example, they are on a ventilator and a suction machine. A7509 (filter holder and integrated filter housing, and adhesive, for use as a tracheostoma heat and moisture exchange system, each) is under home health services, but the home health agency the patient has does not provide those filters. What can we do in this situation?
A5. The list of codes referenced are only those codes that will be paid by Medicare when a patient is in a home health episode. It is the home health's responsibility to provide items not on this list. The only option for the beneficiary is to switch to a home health that does follow these rules. You might be able to contract with the home health agency to provide those services but they would still have to bill for the filters as part of their claim. They would receive payment and then pay you.

You might also want to contact Part A, Rural Home Health Intermediary (RHHI), who has jurisdiction over those home health agencies to tell them what you're experiencing and maybe they can help educate home health agencies on their responsibilities. For contractor contact information, see www.cms.hhs.gov/apps/contacts/.

Q6. We recently set up a patient and acquired a CMN from the doctor and when we submitted the claim, the CMN was rejected because there had been a prior CMN through a different company. When we researched it we found out there had been a break in service of almost six months from the time the patient started using oxygen to the time they stopped using oxygen before we set her up. Is there anything we can put into the narrative about a break in service or is there any additional information we want to add to a claim to let the processor know there has been a break in service and this is a new initial CMN?
A6. In the narrative you can indicate "BIS" (Break In Service). Once we see that notation we will then look for that rejected CMN and load it into our system.

Follow-up Question: For those claims that have already been submitted and the CMN has rejected, how should we handle informing you there was a break in service?
These may be sent in as written reopenings. Adding Oxygen CMNs cannot be done over the telephone.

Q7. I billed for a L7520 (repair prosthetic device, labor component, per 15 minutes) in February of last year. There were some issues with other items on the explanation of benefits. I called yesterday and talked to customer service and I was told that the patient has moved to Jurisdiction C and when I rebill, I have to bill to Jurisdiction C. I don't understand why I would have to rebill something that happened in Jurisdiction D in February to Jurisdiction C just because they moved there in July.
A7. For DME, claims are processed by the jurisdiction for the state that is shown on the beneficiary's address on file with the Social Security Administration at the time the claim is processed. A beneficiary can only have one permanent address on file. Even though at the time the services were provided the beneficiary was in our jurisdiction, if he has now since moved to another jurisdiction or changed his address, you now have to bill to the other jurisdiction. For paper claims, you do need to send them to the correct jurisdiction. If you were billing electronically, you could submit it to any jurisdiction and it would get processed by the correct contractor.

Follow-up Question: I don't know where the beneficiary lives or in what state the beneficiary shows as their address. How can I get this information?
You will have contact the patient or a patient representative to find out that information. He may have not physically moved but if he has, for example, a family member or lawyer in charge of his affairs, that moved, they may have updated the address with Social Security.

Q8. After five years, capped rental items qualify for replacement if needed. What about items that are in maintenance and service after five years? Are those replaceable after five years and what would we need to address in the narrative to get those claims to go through?
A8. The only items that allow for maintenance and service are capped rental items and as stated above capped rental items qualify for replacement if needed after five years. Nothing is needed in the narrative to state that this is a replacement item as in general, if you're replacing a piece of equipment, it's like you're getting a brand new piece of equipment. It would have to meet all the coverage criteria just like if it was the first piece of equipment that patient had received.

Follow-up Question: For power wheelchairs, we've been told the patient has to go back and have a face-to-face with their physician and discuss their continued need. Also, there had to be a repair estimate that was at a certain percentage of repair versus replacement. Is that accurate as far as needing the face-to-face for the continuous need, rather than getting a brand new piece of equipment?

According to the Power Mobility Devices Policy Article:

> "For a power operated vehicle (POV) or power wheelchair (PWC) to be covered, the treating physician must conduct a face-to-face examination of the patient before writing the order and the supplier must receive a written report of this examination within 45 days after completion of the face-to-face examination and prior to delivery of the device. If this requirement is not met, the claim will be denied as noncovered. (Exceptions: If this examination is performed during a hospital or nursing home stay, the supplier must receive the report of the examination within 45 days after discharge. *If the POV or PWC is a replacement during the 5 year useful lifetime of an item in the same performance group that was previously covered by Medicare, a face-to-face examination is not required.* Note: Replacement during an item's useful lifetime is limited to situations involving loss or irreparable damage from a specific accident or natural disaster [e.g., fire, flood, etc.].)"

CMS also states in Section 5.9.2 of the Chapter 5 of the Program Integrity Manual the following in regards to replacing power mobility devices:

> "A replacement would have to be the same device as previously ordered. For instance, if a beneficiary had a POV but would like to replace the POV with a power wheelchair, then a face-to-face examination would be required."

For any replacement equipment, the coverage criteria needs to be met specific to that piece of equipment.

Q9. For those patients who do not have an intraocular lens implanted at the time of cataract surgery, aphakic, many of them wear a contact lens in the aphakic eye. We have been denied on claims and when I send the LCD with the redetermination request, they are paid. We are using diagnosis 379.31 and putting the date of surgery on the claim. Why are these denials occuring?
A9. The supplier provided one example of a denied claim that was paid upon appeal. The claim processing instructions for this situation have been revised to make coverage for lenses for aphakic lenses clearer and prevent future denials.

Q10. I haven't been paid for any DME since last October. I submitted the CMS 855S form to change the address which was received on December 3rd and it's still in process as of this morning. I have faxed and mailed over requested information in the mean time and was also told they have the doctor's Tax ID number instead of his Social Security number. The only answers I get are that it is still in process.
A10. NAS contacted the supplier and verified the NPI/legacy ID crosswalk is correct. This supplier was once a sole proprietor but is now incorporated. The supplier will submit a small number of test claims to ensure the crosswalk is successful.

Q11. We casted a patient for a custom ankle brace. Between the time we sent the casting off to be made and when it came back, the patient said he didn't want it anymore. Can we submit a claim for our cost to have this made? If we would normally submit a claim for $200, can we now submit a claim for $100 so the doctor can recover what he had to pay the lab?
A11. You can actually bill the full amount if you would like to in this situation or bill just a portion. Since it is custom made and cannot be used for any other patient, Medicare will consider this claim for coverage.

Q12. The minutes from a prior small supplier teleconference indicate that the length of need would be revised if a patient has a three month length of need for enteral formula and supplies and at three months it turns out they need it for another six months but I was told by customer service that it needed to be recertified. Which is correct?
A12. The only previous question regarding length of need being revised was in regards to oxygen claims. For the enteral DIF, if an initial DIF showed a length of need of six months, a recertification would need to occur at that time to show the next period of need.

Q13. When you talk about being accredited and it needs to be done by March 1st, what needs to be done? We're credentialed and we have all of our NSC numbers. Is there anything else that needs to be done?
A13. Accrediated means that you have been accredited by one of ten accrediting organizations. It's a process above and beyond enrolling with the NSC and it's quite a lengthy one. There are quality standards and other criteria that must be met. Additional information is available on our web site under the Enrollment section. Look for the Accreditation heading.

Q14. I wanted to let the other caller know that there's a letter that we can send the patient when we ship supplies that they send back with their signature and date to help with date of service and to show they received the item. It's either on the CMS web site or the NAS web site.
A14. NAS does not have a letter like this available. However, for clarification, the date of service is the shipping date. Also, it depends on where the letter is derived from for NAS to determine validity.

Q15. The owner is considering changing the name of the company. What does this mean for our documentation such as CMNs, etc.? Do we have to get new CMNs that reflect our name change?
A15. No, you do not. For more information about what steps are required to change a name, reference the Change of Information Guide found on the NSC website, www.palmettogba.com/nsc, under Quick Links.

Q16. When we send in a redetermination, NAS is now sending back letters with the patient's name, HICN and Claim Control Number (CCN). It would be really helpful if we could get the date of service on this letter so we didn't have to call the Contact Center and ask which letter is in response to which redetermination. It would also be helpful to have the date of when the letter was generated.
A16. NAS has fixed the problem that occurred for a short period of time where the date of the letter was missing. In regards to the redetermination receipt letters indicating the dates of service for which the redetermination was requested, these letters are automated and contain the CMS required elements. The dates of service involved in the redetermination are not easily accessible to the automated system which would

allow this data to be printed on the letters. Since suppliers are initiating the redetermination, the date of service is not a critical issue. If there are any questions on the date of service, they call center can provide assisstance.

Q17. On delivery slips, if the patient doesn't date it, can we date it for them or does it have to be in their handwriting?
A17. The supplier or an employee of the supplier can document the date. The most important piece of information on the delivery slip is the beneficiary signature.

Q18. Do we have to have documentation on file that the patient has been informed and we gave them the choice to either purchase or rent for routinely purchased items? Do we have to have this for capped rental items?
A18. For routinely purchased items, you do not have to have this on file. For capped rental items, this rule no longer applies, as the beneficiary owns the equipment after 13 months of rental and no longer is given the purchase or rental option.

Follow-up Question: Do we have to warranty everything we sell in the store?
This is not something under our direct jurisdiction. This is a good question for the accrediting organizations to clarify what types of products require a warranty.

> **Supplier standard #6 states**: "A supplier must notify beneficiaries of warranty coverage and honor all warranties under applicable State law, and repair or replace free of charge Medicare-covered items that are under warranty."

The quality standards that are part of the accreditation process state:

> "The supplier shall provide only durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) and other items that meet applicable Food and Drug Administration (FDA) regulations and medical device effectiveness and safety standards. The supplier shall obtain from the manufacturer copies of the features, warranties, and instructions for each type of non-custom-fabricated item."

Supplier Overpayments Now Available in OLC

Supplier Overpayments is a new lesson now available in the DME Online Learning Center. Suppliers will learn about refunds, offsetting, timelines and much more!

The OLC is a self-pace learning environment that allows suppliers to take pre and post-assessments, complete lessons, view resources and participate in surveys. Suppliers can take advantage of this self-service technology 24 hours a day/7 days a week and can participate in a course as often as they would like.

- Other available topics are:
- Benefit & Payment Categories
- Advance Beneficiary Notice
- Certificate of Medical Necessity and DME MAC Information Forms
- Appeals Process

To access the OLC, click on the chalkboard icon on the DME web site homepage or use the OLC link on the Training/Events page.

Additional courses are under development. Notification of the availability of new courses are provided through "What's New" and email updates. We encourage you to take advantage of this training tool.

Ask the Contractor Q & A – March 12, 2008

Prior to taking questions, NAS provided the following updates:

NPI-March 1
Effective March 1, 2008, Medicare fee-for-service claims must include an NPI in the primary provider fields on the claim (i.e., the billing, pay-to provider, and rendering provider fields). You may continue to submit NPI/legacy pairs in these fields or submit only your NPI. The secondary provider fields (i.e., referring, ordering and supervising) may continue to include only your legacy number, if you choose. Failure to submit an NPI in the primary provider fields will result in your claim being rejected, as of March 1, 2008.

MR Transition-March 1, 2008
Effective March 1, 2008, medical review functions were transitioned to the DME MAC jurisdictions. The functions that transferred include:

- Comprehensive Error Rate Testing (CERT)
- Advance Determination of Medicare Coverage (ADMC) processing
- Medical Review of edits and claims (not for benefit integrity)
- Local Coverage Determination development
- Probe reviews
- Prepay/Postpay reviews

As a result of this transition, all medical review education and policy/article revisions and updates will be provided by NAS DME. These updates will be posted to the NAS DME website and sent in the email updates. If you were subscribed to the SafeGuard Services email list but have **not** subscribed to NAS DME emails, you must subscribe to the NAS DME email in order to continue receiving medical review updates.

In addition, with this transition NAS established specific mailing addresses and fax numbers for ADMC requests, LCD reconsideration requests and medical review medical documentation. These addresses and fax numbers are located on the NAS DME website at www.noridianmedicare.com in the coverage section or in the contact section.

CEDI Transition-May 1, 2008
National Government Services, Inc. was awarded the DME Common Electronic Data Interchange (CEDI) front-end contract by CMS. With this contract, CEDI will provide a single front-end solution for the submission and retrieval of electronic transactions.

Suppliers in Jurisdiction D must transition to the common EDI front-end by April 30, 2008. With this change, DME MAC electronic submitters will send all electronic claims and Claim Status Inquiry transactions to CEDI. CEDI will return all electronic front-end reports directly to the submitter. CEDI will also receive the ERA and Claims Status Response transactions from the DME MACs and deliver them to the Trading Partner's CEDI mailbox.

Some key dates are:

February 1, 2008
The CEDI system went into production allowing testing to begin. Electronic submitters can move fully into production with CEDI ***before*** their final cutover date.

March 31, 2008
Jurisdiction D will no longer process new requests for submitter IDs or changes to an existing ID. All new setups and changes will be done by the CEDI Enrollment Team.

April 30, 2008
Last day for **Jurisdiction D** to process EDI transactions.

May 1, 2008
All **Jurisdiction D** EDI transactions will be processed by CEDI.

There is a Web site dedicated to CEDI as a resource for all CEDI documentation and communication. This website is www.NGSCEDI.com.

The CEDI Help Desk provides support for electronic submitters to resolve issues and answer questions about connectivity, receipt of files and electronic formats. The **CEDI Help Desk number** is **866-311-9184. Hours are 9:00 AM - 9:00 PM (ET)**. Email support is also available by sending an email to ngs.CEDIhelpdesk@wellpoint.com.

Electronic suppliers will want to join the CEDI list serve to receive important EDI information after transition. NAS will continue to send EDI related email list notices during the transition.

Some other key points:

- CEDI will use the existing submitter IDs established by each DME MAC Jurisdiction for current electronic submitters. Electronic submitters who have previously completed electronic registration or enrollment forms with a DME MAC do not need to re-enroll with CEDI.
- The CEDI system is now available for testing. Software vendors must test with CEDI prior to moving their customers to the CEDI. Suppliers, billing services and clearinghouses who use internally developed software and communications (in-house programmers) must also test with CEDI. Vendors and "in-house programmers" should contact the CEDI Help Desk by phone or e-mail to initiate the testing process.
- CEDI will maintain a list of software vendors who are approved for CEDI on the CEDI web site. This list will be updated daily.
- The Express Plus software will be modified to include new communication software. Additionally, the Express Plus manual will be updated. Once both the Express Plus software and manual are available on the CEDI Web site, a CEDI Listserv will be sent.

Accreditation Deadlines
Existing suppliers enrolled in Medicare prior to January 1, 2008, must be accredited by September 30, 2009.

DMEPOS suppliers who submitted an enrollment application to the NSC on or after *March 1, 2008* must be accredited prior to submitting the application. The NSC shall reject the enrollment application unless the

DMEPOS supplier provides supporting documentation that demonstrates that the supplier has an approved accreditation.

DMEPOS suppliers who are enrolled for the first time with the NSC between January 1, 2008 and February 29, 2008 must obtain and submit an approved accreditation to the NSC *by January 1, 2009*.

For more information, see the CMS fact sheet posted on the NAS DME website, in the Enrollment/Accrediation section.

Contact Center Closures
When the call center is closed for training or federal holidays, we are only closed in the mornings. Afternoons are our busiest time for calls so we strive to limit our closure time to the mornings. Our call center closure schedule is posted on the right hand side of our website and is also included in our email list notices.

The following questions and answers are from the March 12, 2008, Ask-the-Contractor Teleconference. In some cases, the original answers given during the call may have been expanded to provide further detail.

Q1. I've been waiting for a response from CMS' Open Door Forum on February 20th on clarification for billing supply kits and proof of delivery for enteral nutrition. Can I ask the question here?
A1. It is NAS' preference that you wait for clarification from CMS.

Q2. Will a DME MAC deny a power mobility device claim if the ordering physician's NPI is on the claim, but the physician does not have a UPIN?
A2. The claim will process with the NPI. Reporting of UPINs will be discontinued as of May 23, 2008, and only NPIs will be allowed to be reported for ordering physicians, per the NPI rules.

Q3. We have been furnishing a patient with a concentrator for six years and suddenly another national company starts billing for a concentrator. Their bill gets to Medicare first and is paid and ours is denied. I've been told by NAS this is correct, but it can't be as must ask for a pick-up ticket. If Medicare shows you're paying supplier A for eleven months of the year and December comes and another supplier bills it, that supplier has been told to put in the HA0 record "new supplier, wheelchair from XYZ Company picked-up on X/X/XX." You're paying without this information and I think that's unfair to providers. Jurisdiction D is the only contractor processing claims this way, according to my staff.
A3. NAS assumes the supplier has changed if a different supplier starts billing for the same type of oxygen equipment. The CMN belongs to the beneficiary so they can decide to go with another supplier. Chapter 3 of the supplier manual states that the new supplier must obtain a CMN for their files but this is not required to be submitted to the DME MAC. You can appeal these claims with your documentation and an explanation of the situation.

Q4. Are DME providers required to obtain a signature on the Medicare capped rental notification form for existing patients who are already on oxygen before January 1, 2006?
A4. This is not a requirement since oxygen is not considered a capped rental item or an inexpensive and routinely purchased item and does not require that a rental notification form is completed.

Q5. I bill supply items to Medicare for denial and then bill to Medicaid for payment. I do put a note in the HA0 field stating the patient is receiving a noncovered therapy for Medicare and that we are requesting a PR-204 denial. And even with that I continue to get CO-50 denial code which the state Medicaid program won't pay on. How do I stop this from continuing to happen?
A5. If the item is noncovered, which means it is statutorily excluded or does not meet the definition of a Medicare benefit, the supplier should append the GY modifier to the HCPCS code and include a statement in the NTE segment (formely the HA0 record) of the claim indicating why, i.e., urological supplies for temporary condition. If the item is a covered benefit but the beneficiary does not meet the coverage criteria, the GY modifier is not appropriate. Instead you should consider an ABN, in which case you will use the GA modifier.

Follow-up Question: In the HA0 field we are putting the note previously stated but there is a procedure section that is requesting a code and if I'm billing for A4221 or A4222 and a pump and a pole, what code do I put in there?
Suppliers should always bill all the codes that are being provided. Claims billed for denial only need to be filed with the pump code and DIF and pole, if applicable and per policy, the claim will process based on if the pump and the drugs are covered under Medicare.

Q6. In the February 14th CPAP workshop, it was stated that every four months and thereafter but no sooner than 61 days, we need to get a letter from the beneficiary stating they are still using the machine. Can you tell me where to find this in writing?
A6. Verification of continued use of CPAP does not need to be in writing like it does for the RAD. This information can be taken verbally as long as it is documented by the supplier and available upon request. It was recommended in the CPAP workshop to verify monthly that the beneficiary is using the device in the event an audit determined the beneficiary was not using the device. However, it is mandatory to verify use of the CPAP in the third month. In the Indication and Limitation section of the CPAP LCD under Continued Coverage it states:

> "Continued coverage of an E0601 device beyond the first three months of therapy requires that, no sooner than the 61st day after initiating therapy, the supplier ascertain from either the beneficiary or the treating physician that the beneficiary is continuing to use the CPAP device."
>
> "If the above criterion is not met, continued coverage of an E0601 device and related accessories will be denied as not medically necessary."

Q7. Your web site said that most of the nebulizer claims and corresponding dispensing fees for inhalation drugs that were denied in error would be adjusted by the end of the week of February 4th. We've still have many pending

per the IVR. What is the status of this mass adjustment?
A7. The supplier faxed examples of pending claims in to NAS and those have been processed.

Q8. We're still having problems with our NPI. I just need to know who I should call because somehow our NPI for DME was set up wrong.
A8. After contacting the supplier, it was determined they were unaware that their NSC number for both of their locations needed to be listed on the NPPES Website under "Other Provider Identifiers." NAS provided step-by-step instructions on how to add this to their NPI numbers respectively (one NPI per location/per NSC). The supplier was then informed that these updates take an average of two business days to appear in the claims processing system.

Q9. On the oxygen CMN, can question (1c), the date of the test, be 30 days before the initial date if question (2), how was the test performed, is answered 1, with the patient in a chronic stable state as an outpatient, or 3, under other circumstances?
A9. Yes. The policy states the test date must be within 30 days of the intial date:

"CERTIFICATION:
For Initial Certifications, the blood gas study reported on the Certificate of Medical Necessity (CMN) must be the most recent study obtained prior to the Initial Date indicated in Section A of the CMN and this study must be obtained within 30 days prior to that Initial Date."

If the answer is 3 the CMN should be non-qualifying because the basic coverage criterion 4 states:

"The qualifying blood gas study was obtained under the following conditions:

- If the qualifying blood gas study is performed during an inpatient hospital stay, the reported test must be the one obtained closest to, but no earlier than 2 days prior to the hospital discharge date, or
- If the qualifying blood gas study is not performed during an inpatient hospital stay, the reported test must be performed while the patient is in a chronic stable state – i.e., not during a period of acute illness or an exacerbation of their underlying disease"

Q10. After the 36 months for oxygen have been paid, how do we go about charging for the supplies, because we're not doing that right now?
A10. Our system reads that 36 months have been paid for and the beneficiary now owns the oxygen equipment. When the oxygen supply claims are billed, based on the closed oxygen equipment CMN, supplies will start paying.

Follow-up Questions: How do we bill for just the contents after the 36 months? We know Medicare will only pay for one months' supply of contents per month so, what if the patient uses five to eight tanks per month? We're using the S8120 for that because that's by the cubic foot.
The HCPCS codes for contents are E0441 – E0444. The code descriptions do not differenciate between how many tanks are required. It is a per month billing, regardless of if they use one tank or ten tanks. S8120 is not recognized by Medicare as a valid code.

Follow-up Question: Now that we aren't doing the purchase option letters and we have patient's equipment in the six-month maintence, will those items ever convert to purchase or will we continue billing maintenance every six months?
No, maintenance and servicing can still be billed on those items unless the patient receives a new piece of equipment. Then a new capped rental period would start.

Q11. After the 36 months for oxygen have been paid, do the tanks become property of the beneficiary? Some beneficiaries are thinking that after the 36 months, the tanks in their possession are now their property and they can go anywhere to get them filled.
A11.Once the 36 months is over, the beneficiary owns the equipment and they can take it anyplace to get it filled because it was part of the initial equipment.

According to the Medicare Program; Home Health Prospective Payment System Rate Update for Calendar Year 2007 and Deficit Reduction Act of 2005 Changes to Medicare Payment for Oxygen Equipment and Capped Rental Durable Medical Equipment; Final Rule:

> "In transferring title to gaseous or liquid oxygen equipment used during the 36-month rental period, we propose that suppliers must transfer title for all equipment that will meet the beneficiary's continued medical need, including those oxygen cylinders or vessels that are refilled at the supplier's place of business. Customary practice by suppliers for refilling oxygen contents is to deliver to the beneficiary cylinders filled with contents and take back the empty cylinders to the supplier's place of business to refill the oxygen contents. Under our proposal, title would transfer for both sets of cylinders, meaning the ones that are being used by the beneficiary for the month and the ones that the supplier refills in its business location and delivers for use during the next subsequent month. This policy would apply to both gaseous and liquid oxygen stationary equipment and portable systems. Similarly, in those cases where the beneficiary uses an oxygen equipment system which includes a compressor which fills portable gaseous cylinders in the beneficiary's home, we propose that suppliers must transfer title for this equipment to the beneficiary."

Q12. When we are billing maintenance and servicing, we find out that a wheelchair has been denied because the patient has gone to another supplier and obtained a power chair. What do we do with this wheelchair in maintenance because if the beneficiary wants it repaired, since we've collected maintenance, do we have to do that for free? Or, now that the beneficiary has transferred to a power chair, can we change it to a purchase? Or, should we automatically pick it up?
A12. Normally, beneficiaries can't upgrade to a power chair unless their medical condition supports the need. If the manual wheelchair no longer works for their needs, it would be appropriate to pick it up.

Q13. Region B came out with a ruling on back up ventilators allowing two ventilators if you have one of two extenuating circumstances. We'd like to bill for two but I'm afraid that if I put "2" in the units column, the claim will edit out as a duplicate. How do we bill for two ventilators, with one of them as the back up?
A13. Claims for this situation can be billed with the codes on two separate lines on the same claim with an explanation in the narrative. Backup equipment is addressed in Chapter 3 of the supplier manual.

Q14. When 15 months have been paid on a rental that's prior to the new capped rental policy and one of the first three months didn't get paid because the beneficiary was on a Medicare HMO, we've been allowed to extend the CMN timeframe to get 15 months paid. The CMN isn't closing and when we call to do a reopening we're told there's not a KI modifier. But I don't think that's part of the policy.
A14. The supplier should report the KI modifier on the second and third months when the patient had Medicare, not when they were on an HMO. NAS will also correct claims to allow the additional month when a comment is stated on the claim to extend the CMN. A system problem has been identified where the CMN is not closing and this is pending a solution.

Q15. We are a small optical dispensary, so basically all I bill are the glasses following cataract surgery. We thought accreditation was for metropolitan areas. Does this apply to all suppliers? Can you give a brief explanation of what accreditation is and how I can find out more about it? Also, is this separate from the National Supplier Clearinghouse standards?
A15. Accreditation applies to all DMEPOS suppliers. Under the Enrollment section of our web site, you'll find information on accreditation. Also, CMS has provided a DMEPOS Accreditation Fact Sheet that provides additional information and frequently asked questions. Accreditation Quality Standards are separate from the NSC Supplier Standards.

Q16. We are planning on becoming a DME supplier for our sleep lab, which would include CPAP and BiPAP supplies. We are having trouble learning how to bill this through Chapter 5 of the Jurisdiction D Supplier Manual. We are unsure which modifiers to use when billing new equipment as rental. Would that just be the RR and the K modifiers to indicate what rental month it is?
A16. That is correct. If used equipment were being rented, the RR modifier would be used. The KX modifier would also be used if they meet the coverage criteria and documentation is on file.

NAS would like to note that there is a conflict here. The DME supplier cannot be the sleep lab unless they are a hospital. The LCD states:

> "For the purpose of this policy, polysomnographic studies must not be performed by a DME supplier. This prohibition does not extend to the results of studies conducted by hospitals certified to do such tests."

Follow-up Question: I thought we could only go up to 13 months rental for capped rental items, but I was reading about 15 months of rental. Is that old information? Also, is there an email address we can send questions to?
For capped rental periods beginning prior to January 1, 2006, suppliers had to give beneficiaries the option of converting their rental equipment to purchase during the tenth continuous rental month or allowing them to rent up to 15 months. Under the new capped rental guidelines, payment for rental equipment may not exceed a period of continuous use longer than 13 months.

Suppliers can send emails to customer service at dme@noridian.com.

Q17. In MLN Matters 5890, it states that if we are unsuccessful in attempting to obtain the NPI of the ordering physician, we can report our own NPI. Can we report our NPI in the primary field and if we aren't able to obtain the physician's NPI, then we use our own NPI and how are claims going to be processed?
A17. In rare instances, suppliers may use their own NPI if they are unsuccessful in obtaining the NPI of the ordering physician. Claims will not be denied. To locate a physician's NPI, see the NPI Registry or contact the physician.

Q18. A physician orders oxygen for a patient and gives us the saturation level. At a later point, we find out this was a saturation level during exercise. What kind of timeframe are we or the physician given to obtain the remaining saturation levels?
A18. When oxygen is covered based on an oxygen study obtained during exercise, there must be documentation of three oxygen studies in the patient's medical record, i.e., testing at rest without oxygen, testing during exercise without oxygen, and testing during exercise with oxygen applied (to demonstrate the improvement of the hypoxemia). Only the qualifying test value (i.e., testing during exercise without oxygen) is reported on the CMN. The other results do not have to be routinely submitted but must be available on request. All three tests must be taken during the same visit to assure the supplemental oxygen improved the beneficiary's condition.

Q19. On April 12, 2007, we were issued a new supplier number. Claims were paid January 2007 through April 2007, but starting in May 2007 through the end of 2007, we are getting denials on some of our patients. Why may this be happening?
A19. It is appropriate to bill with the supplier number valid on the day of service. After researching examples provided by the supplier, two claims were reprocessed and direction was given to request reopenings on the others. Also, the supplier needed to correct information in NPPES.

Q20. Once an item, such as a wheelchair, has capped out after the 13 months have passed, am I as the original supplier, required to replace that equipment if it's not covered by Medicare and the patient calls back a year later with an issue on the wheelchair?
A20. Since the beneficiary now owns the equipment, you are under no obligation to replace it. If a capped rental piece of equipment has been in continuous use by the patient, on either a rental or purchase basis, for the equipment's useful lifetime or if the item is lost, stolen or irreparably damaged, the patient may elect to obtain a new piece of equipment. The

reasonable useful lifetime for capped rental equipment cannot be less then five years. In this situation, the five years has not occurred so a new capped rental period would not be covered. If repairs were needed, and the patient still qualifies for the wheelchair, parts/repairs would be covered. If a different type of wheelchair is required, based on changes in the patient's medical condition, a new capped rental period may also begin.

Follow-up Question: If a piece of DME, like a CPAP, is brand new, the RR is indicated. But if I was providing a used CPAP for a patient, do I put a RR UE? If so, where do the KH and KX go?
Indicating RR is correct. The system can take up to four modifiers so they can all be included on that line.

Used equipment may be provided to a Medicare beneficiary. All DME claims must specify whether equipment is rented or purchased. For purchased equipment, the claim must also indicate whether equipment is new or used. The UE modifier should be reported when a beneficiary purchases any used equipment, which falls under the DME payment category of Inexpensive or Other Routinely Purchased (IRP). Suppliers also can provide used equipment for capped rental items, but the UE modifier is not required for capped rental items.

Used equipment is any equipment that has been purchased or rented by someone before the current purchase transaction. Used equipment also includes equipment that has been used under circumstances where there has been no commercial transaction, e.g., equipment used for trial periods or as a demonstrator.

To determine which equipment is categorized as IRP or capped rental, reference chapter 16 of the supplier manual for a listing of all DME HCPCS codes. The Level II HCPCS code tables list IRP items as category 5 and capped rental as category 1.

Some examples (not an all-inclusive list) of equipment which may be purchased as "used" are powerwheelchairs, canes and walkers.

Q21. The recert date on a CMN is October 18, 2007, and the beneficiary sees the doctor on November 29, 2007. His oxygen saturation was decreased at 86% with activity. He did not see his doctor within 60 days of his recertification date. Are we going to have to write off that month we billed? If so, can we add that month to the back end so we still get paid the 36 months?
A21. The patient can be seen by their physician 30 days prior to the recert or anytime after the scheduled recert date.

If a Group I patient with a lifetime length of need was not seen and evaluated by the physician within 90 days prior to the 12 month Recertification but was subsequently seen, the date on Recertification CMN should be the date of the physician visit. Payment can be made for dates of service between the scheduled Recertification date and the physician visit date if the blood gas study criteria are met.

However, when a Group I patient with a length of need less than or equal to 12 months was not retested prior to Revised Certification/ Recertification, but a qualifying study was subsequently performed a new initial CMN is required. The Initial Date on this new CMN is the date of the subsequent qualifying blood gas study.

Q22. When a patient is on traditional Medicare for 11 months and they switch to an HMO for two months, are those two months recognized by Medicare? If not, do we need to bill those two months after they are back on traditional Medicare in order for it to cap out so we don't have problems down the road billing for repairs?
A22. Medicare does not see those two months the patient was on an HMO, so billing those two months when the patient is back on traditional Medicare is correct.

Q23. We had a patient who is on home health call us to sign up for ostomy supplies and wound care. We found a list stating these aren't covered by Medicare and should be supplied by the home health. But the home health said they aren't going to bill Medicare. They are going to bill straight to Medicaid because the patient is in assisted living.
A23. Medicaid is always the payer of last resort and if a patient has Medicare, the home health agency should be billing Medicare for these services. The home health agency is required to bill the claim to Medicare per the mandatory claims submission rules. Please note also that the home health receives payment from Medicare for all the home health services they provide to a patient during a home health episode and the supplies are not billed out separately.

Q24. When DME rented in January 2006 has converted to a purchase because the maximum number of months was paid, and an item breaks, do we bill the A9900 RPNU or the A9999 RPNU with the amount that we're charging, along with the repair code, E1340 RP? If it's a cord for a suction machine, do we put "purchased suction machine, cord bought at XYZ company, costs $50" in the HA0 record?
A24. We would suggest that code A9999, miscellaneous DME supply or accessory, is the most appropriate code for a suction machine cord. The important information in this situation is a narrative stating what is being replaced. The repair code should be submitted as E1340 for time spent in repairing the machine, with 15 minutes representing one unit. A modifier is not needed for the repair code, but modifier RP could be used with A9999. NAS would like to remind suppliers that when a valid code is available, the unlisted HCPCS will not be accepted.

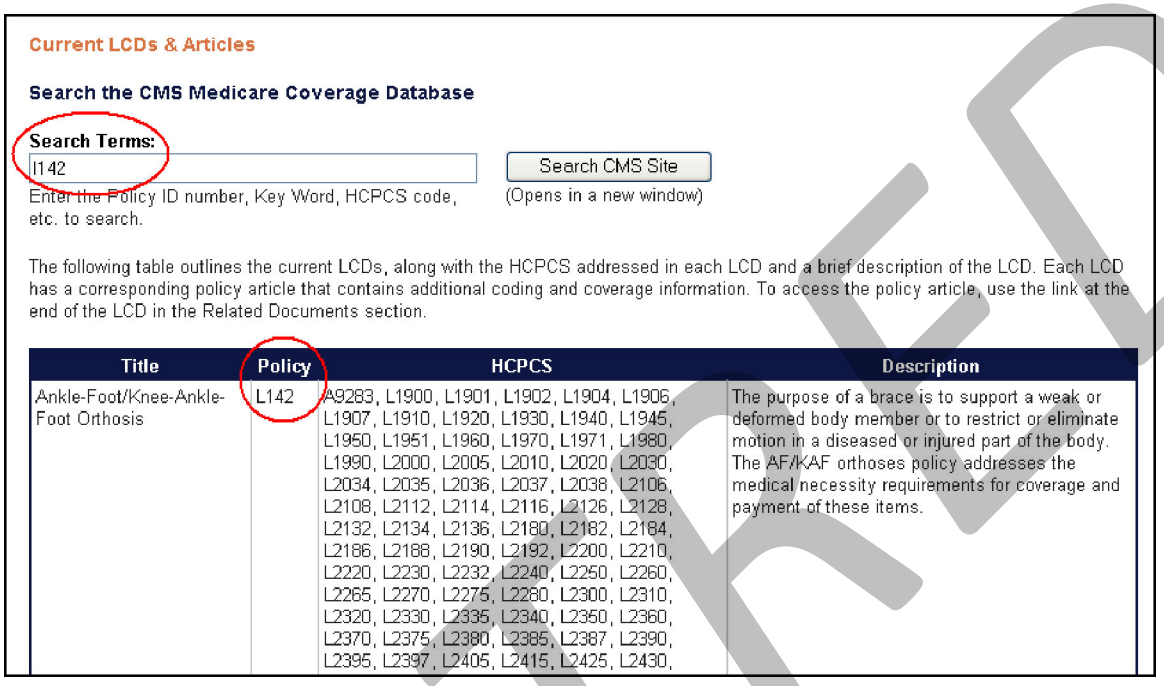
Q25. Can claims be submitted with partial units, 1.5 for example? Or must we round that up or down?
A25. Partial units cannot be billed. Units should always be rounded up.

New Search Function for LCDs

Due to supplier feedback and survey results, NAS has improved access to the DME Local Coverage Determinations and Policy Articles. In accordance with CMS regulations, the LCDs and Policy Articles are maintained in the CMS Medicare Coverage Database (MCD).

Suppliers may conduct a search using the policy numbers, HCPCS, titles or other relevant terms. **We strongly recommend searching by the policy number** to reduce the number of results and to ensure the correct item is found. Titles, LCD ID numbers and HCPCS codes are available in the table located below the Search.

NAS Web Site Search / Directs to CMS MCD



Current LCDs & Articles

Search the CMS Medicare Coverage Database

Search Terms: l142

Search CMS Site (Opens in a new window)

Enter the Policy ID number, Key Word, HCPCS code, etc. to search.

The following table outlines the current LCDs, along with the HCPCS addressed in each LCD and a brief description of the LCD. Each LCD has a corresponding policy article that contains additional coding and coverage information. To access the policy article, use the link at the end of the LCD in the Related Documents section.

Title	Policy	HCPCS	Description
Ankle-Foot/Knee-Ankle-Foot Orthosis	L142	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,	The purpose of a brace is to support a weak or deformed body member or to restrict or eliminate motion in a diseased or injured part of the body. The AF/KAF orthoses policy addresses the medical necessity requirements for coverage and payment of these items.

CMS MCD Results

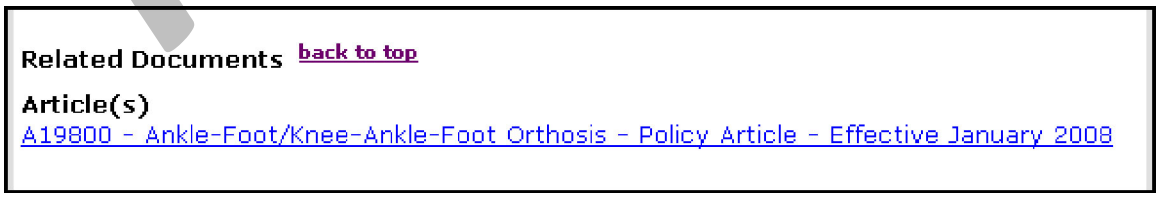
LCD

Sort by: LCD Title Go

LCD ID	LCD Title	Contractor Type	Contractor Name	Date Info
L142	Ankle-Foot/Knee-Ankle-Foot Orthosis	DME MAC	Noridian Administrative Services (19003)	Effective: 10/01/1993 Revision Eff: 01/01/2008 End: N/A Updated: 03/13/2008

Note: The redirection from the NAS LCD information page to the CMS MCD web site is almost immediate; however, the time it takes for the CMS MCD web site to display the result is not related to the functionality of the NAS website.

For efficiency, use the links to the related Policy Articles at the end of the LCDs to review additional important coding, billing and coverage information.

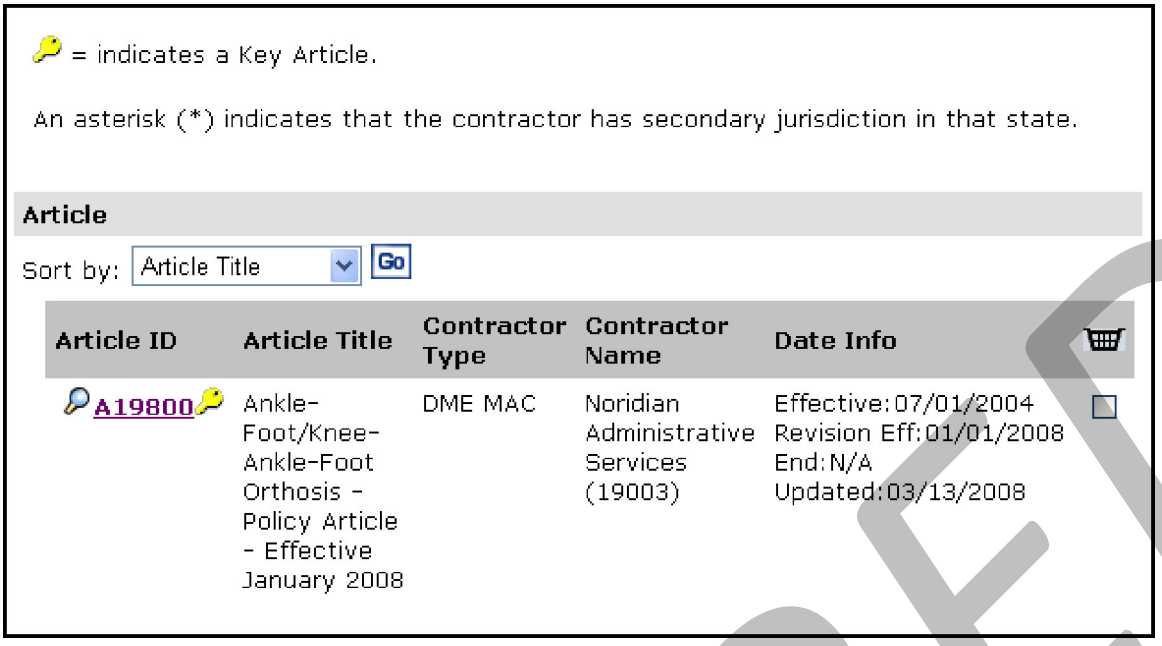


Related Documents back to top

Article(s)

A19800 - Ankle-Foot/Knee-Ankle-Foot Orthosis - Policy Article - Effective January 2008

When searching by HCPCS, titles and other terms, all articles in the MCD with that term will be provided in the results. A key symbol will indicate the applicable item for NAS.



= indicates a Key Article.

An asterisk (*) indicates that the contractor has secondary jurisdiction in that state.

Article

Sort by: Article Title Go

Article ID	Article Title	Contractor Type	Contractor Name	Date Info	
A19800	Ankle-Foot/Knee-Ankle-Foot Orthosis - Policy Article - Effective January 2008	DME MAC	Noridian Administrative Services (19003)	Effective: 07/01/2004 Revision Eff: 01/01/2008 End: N/A Updated: 03/13/2008	☐

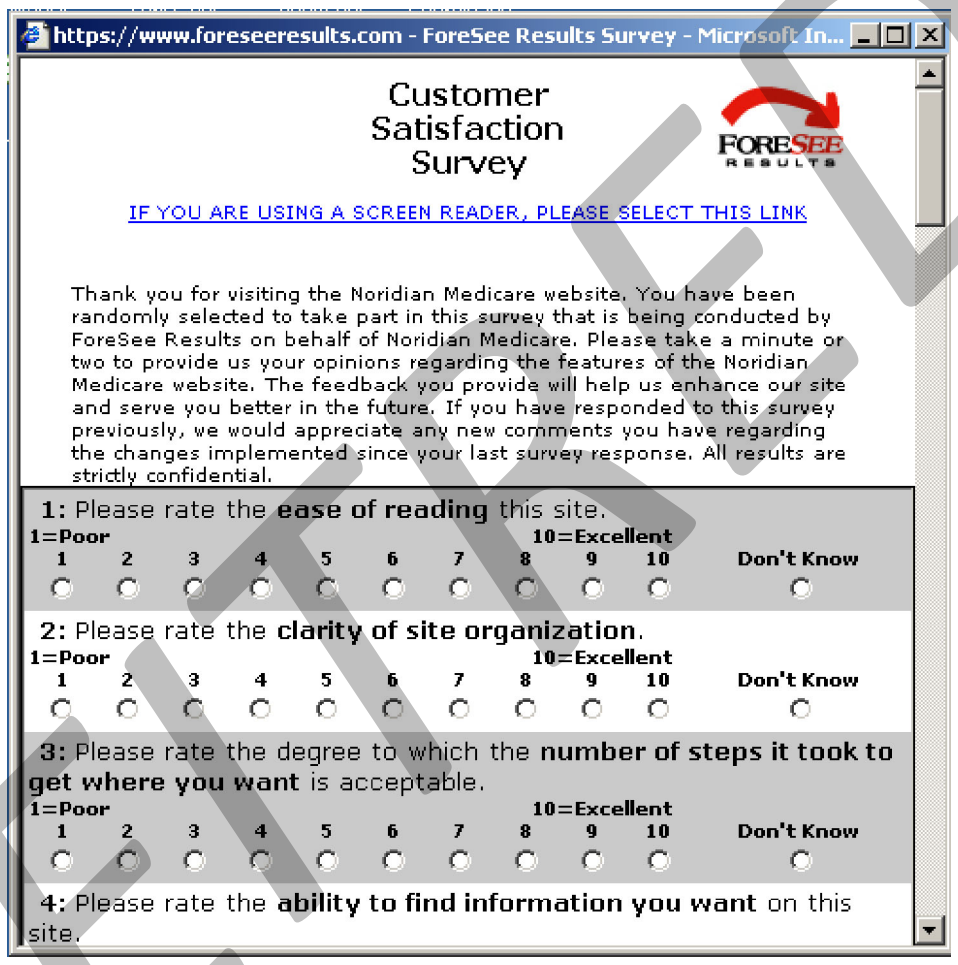
NAS appreciates the feedback our supplier community offers through the "Website Feedback" link as well as through the online, random survey coordinated at the request of CMS by a third party company. NAS encourages suppliers to complete this random web site survey so we may measure if this change in access has helped in searches related to LCDs and Policy Articles.

DME Web Site Satisfaction Survey

Your Feedback is Important and Heard!!

Visitors to the NAS DME web site, www.noridianmedicare.com/dme, have an opportunity to complete a "Web Site Satisfaction Survey" randomly presented as visitors navigate the web site. The survey is the result of the Centers for Medicare & Medicaid Services contract with Foresee Results, an independent third party survey company, to assess the effectiveness of Medicare contractor web sites.

Please take the time to complete the survey when presented to you. NAS evaluates all input received from this survey. The feedback you provide will help us improve and enhance our web site and help us serve you better in the future. Below is the manner in which the survey appears.



The survey tracks the electronic signature of who responds to the survey. Those who participate and complete the survey will not see the survey again for 30 days. If you have responded to the survey previously, we would appreciate any new comments you have regarding the changes implemented since your last survey responses; feel free to take the survey more than once.

All survey results are strictly confidential. NAS is provided only with the statistical survey results and comments; not visitor information.

NAS highly values your feedback and suggestions. We greatly appreciate the time you invested in taking the survey and providing your feedback.

Updated Appeals Process Brochure Available

The Medicare Appeals Process: Five Levels to Protect Providers, Physicians and Other Suppliers brochure has been updated and is now available to order print copies or as a downloadable PDF file.

To view the PDF file, go to http://www.cms.hhs.gov/MLNProducts/downloads/MedicareAppealsProcess.pdf or to order hard copies, please visit the MLN Product Ordering Page at http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5 on the CMS website.

DVD: Our Health, Our Community: Medicare, Medicaid and SCHIP Outreach to American Indians/Alaskan Natives

The Centers for Medicare & Medicaid Services (CMS) is making the following DVD available for Indian Health providers: *Our Health, Our Community: Medicare, Medicaid and SCHIP outreach to American Indians/Alaskan Natives* is a brief informational DVD on the benefits of enrolling in Medicare, Medicaid and SCHIP for the American Indian/Alaskan Native audience. This DVD can be used in hospital, clinic, and physician office waiting rooms, local TV stations, exhibits, training events, or any place American Indians and Alaskan Natives are gathered. (ICN# 6940) (Dec 2007) Run time is 7mins, 51 seconds.

This product is only for those providers that serve the American Indian and Alaskan Native populations. To order a free copy, go to the Medicare Learning Network *MLN Product Ordering Page* http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5 and select the DVD title from the product list.

Medicare Claims Review Program (MR, NCCI Edits, MUEs, CERT and RAC): New Educational Product is Available!

CMS is pleased to announce that a new educational resource discussing the Medicare Claims Review Program is now available on the CMS website. This booklet provides an overview of the several initiatives implemented by CMS to prevent improper payments before a claim is processed and identify and recoup improper payments after a claim has been processed. To access this new product, visit http://www.cms.hhs.gov/MLNProducts/downloads/MCRP_Booklet.pdf on the CMS website. Printed copies will be available at a later date.

CMS Online Manual System Brochure Has Been Updated

The CMS Online Manual System: A Web-based Manual System for Medicare Contractors, Providers and State Agencies brochure has been updated and is now available to order print copies or to download as a PDF file. This brochure explains how to navigate the CMS Online Manual System.

To view the PDF file, go to http://www.cms.hhs.gov/MLNProducts/downloads/on-linebrochure.pdf. Print copies may be ordered by visiting the MLN Product Ordering Page at http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5 on the CMS website.

Instructions for NPI Claim Rejects

The NPI is here. The NPI is now. Are you using it?

Verifying NPPES Data
CMS has found a significant number of instances where either the Legal Business Name (LBN) and/or Employer Identification Number (EIN) of an organization health care provider who has been assigned an NPI do not match Internal Revenue Service (IRS) records. In some cases, this is caused by health care providers who are individuals who erroneously applied for NPIs as organizations and who reported their Social Security Numbers in the EIN field. As a first step to improving the quality of information in the National Plan and Provider Enumeration System (NPPES), we are requesting that organization health care providers verify their LBN and EIN within NPPES. This is especially important if the organization health care provider is experiencing any Medicare claims processing issues.

Important Information for Medicare FFS Providers

Effective March 1, 2008, all 837P and CMS-1500 claims received must have an NPI or NPI/legacy pair in the required primary provider fields. Failure to include an NPI will cause the claim to reject!

What to do if your 837P or CMS-1500 Claim Rejects

- Check your record in the National Plan and Provider Enumeration System (NPPES)
    - Validate that the legacy identifier sent on the claim is reported in your NPPES record. If the legacy identifier is not there, it needs to be added.
    - Validate that the Legal Business Name (for a provider/supplier who is an organization) or the Legal Name (for a provider/supplier who is an individual or a sole proprietorship) is correct.
    - Validate that the correct Entity type was selected at the time of NPI application. Individuals obtain an NPI as Entity Type 1. Organizations obtain an NPI as Entity Type 2 NPI.

NPI CONT'D

(**Note**: If you enumerated through the EFI alternative or submitted a paper NPI application, you should use the NPI Registry to check the content of your NPPES record. Make sure to have the Customer Service Representative at your Medicare contractor verify your Employer Identification Number (EIN) because the NPI Registry does not display EINs.)

- If the above validation is successful and your claims continue to reject, call the Customer Service Representative at your Medicare Contractor.
    - Have a copy of your NPPES record or your NPI Registry record in hand. A copy of your NPPES record can be printed from NPPES by going online at https://nppes.cms.hhs.gov and using the User ID and password selected when you applied for your NPI. If you obtained your NPI through the EFI alternative or submitted a paper NPI application, you should print your record from the NPI Registry at https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do. EINs and Social Security Numbers (SSNs) are not displayed in the NPI Registry.
    - Have the claim reject number and message
    - Be prepared to give the following information:
        1. Legal Business Name of the organization or LegalName of the individual
        2. Contractor Tracking Number (if known)
        3. Approximate date (month/year) when the CMS-855 enrollment application was submitted or last updated
        4. Provider/Supplier Tax Identification Number (EIN or SSN)
        5. National Provider Identifier (NPI)
        6. Medicare legacy Identifier
        7. Practice location on claim (i.e., where is the practice located (e.g., 100 Main St., New Orleans, LA)
        8. Contact Information where you can be reached if further discussion is needed

Some Clearinghouses Continue to Strip Information from Medicare Claims

It has come to CMS' attention that some clearinghouses continue to strip NPIs, as well as other information, from Medicare claims. If your clearinghouse continues to strip your NPI from your claims for any reason, notify your Medicare Contractor immediately so that CMS can work with your clearinghouse to resolve the issue.

In some cases, clearinghouses are stripping the SY qualifier and the SSN from claims that contain an NPI. Based on business requirement 4320.17 (outlined in Transmittal number 204, dated February 1, 2006), the qualifier SY is an acceptable qualifier for use on Medicare claims. See below block for specific details. You should share this information with your clearinghouse if you suspect they are stripping the SY qualifier and the SSN from your claims.

4320.17	Shared systems shall reject as non-compliant with the implementation guide any 837 version 4010A1 claim that contains XX in NM108, the NPI in NM109, and 1C or 1G as applicable in REF01of the same loop, but which lacks another REF01 in the billing or pay-to-provider loop with the EI (Employer Identification Number) qualifier and number or the SY (SSN, applies to carriers & DMERCs only) qualifier and number to convey the taxpayer identifier.

TEST NPI-only NOW

If you have been submitting claims with both an NPI and a Medicare legacy number and those claims have been paid, you need to test your ability to get paid using only your NPI by submitting one or two claims today with just the NPI (i.e., no Medicare legacy number). If the Medicare NPI Crosswalk cannot match your NPI to your Medicare legacy number, the claim with an NPI-only will reject. You can and should do this test now! If the claim is processed and you are paid, continue to increase the volume of claims sent with only your NPI. If the claims reject, go into your NPPES record and validate that the information you are sending on the claim is consistent with the information in NPPES. If it is different, make the updates in NPPES and resend a small batch of claims 3-4 days later. If your claims are still rejecting, you may need to update your Medicare enrollment information to correct this problem. Call your Medicare carrier, FI, or A/B MAC enrollment staff or your DME MAC. Have a copy of your NPPES record or your NPI Registry record available. The contractor telephone numbers are likely to be quite busy, so don't wait.

Need More Information?

Still not sure what an NPI is and how you can get it, share it and use it? As always, more information and education on the NPI can be found through the CMS NPI page www.cms.hhs.gov/NationalProvIdentStand on the CMS website. Providers can apply for an NPI online at https://nppes.cms.hhs.gov or can call the NPI enumerator to request a paper application at 1-800-465-3203. Having trouble viewing any of the URLs in this message? If so, try to cut and paste any URL in this message into your web browser to view the intended information.

Note: All current and past CMS NPI communications are available by clicking "CMS Communications" in the left column of the www.cms.hhs.gov/NationalProvIdentStand CMS webpage.

Understanding the Readiness of Other Health Plans, Steps to a Smooth Transition & More!

Information for all Health Care Providers

Medicare & Non-Medicare
CMS encourages all health care providers to ensure they understand the readiness of other health plans with which they interact, especially if those health plans may be primary or secondary to Medicare. Medicare will only accept/send NPI-only transactions beginning May 23rd and providers need to understand from these other plans what will happen if they are unable to send/receive NPI-only transactions.

Important Information for Medicare FFS Providers
CMS is pleased to announce that Medicare is receiving more than 98% of claims with an NPI. The next milestone - May 23rd- requires providers to take the next step so they do not risk disruption in cash flow. Begin billing with **NPI-only** now to test how May 23rd will impact you.

CMS is concerned that the percentage of Medicare claims with NPI-only is not growing fast enough.

Steps to Facilitate a Smooth Transition to NPI-Only

1. Bill with Medicare legacy ID & NPI
    - Once claims are successfully processed, move to Step 2.
2. Bill with NPI –Only
    - Start with a small batch of claims. If, or when, the results are positive, begin sending a greater volume and move to Step 3.
    - Billing with NPI-only also tests the ability to receive the NPI on 835 transactions.
3. Test NPI-Only on Other HIPAA Transactions
    - CMS will require use of the NPI on the 270/271, 276/277 and NCPDP transactions. Providers should begin testing the use of the NPI on these transactions, in small quantities, prior to May 23rd to ensure a smooth transition. Also, be prepared to accept the NPI-only on the 835 remittance advice transaction.

Encourage Clearinghouses to Allow Testing of NPI-Only
It has come to CMS' attention that some clearinghouses may not allow important NPI-only testing prior to May 23rd. CMS encourages Medicare providers to work with their clearinghouses to allow use of the NPI-only to facilitate this testing. If you do not test, you will not be aware, in advance, of any problems that could prohibit Medicare from processing and paying claims.

Get Accredited for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Competitive Bidding!

In order to participate in the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program, suppliers must meet quality standards and be accredited by a CMS-approved Deemed Accreditation Organization. Suppliers that are interested in bidding in the second round of the program must be aware of two key deadlines:

- Suppliers must be accredited or have applied for accreditation by May 14, 2008, to submit a bid for the second round of competitive bidding. CMS cannot accept a bid from any supplier that is not accredited or that has not applied for accreditation by May 14, 2008.
- Suppliers will need to be accredited to be awarded a contract. The accreditation deadline for the second round of competitive bidding is October 31, 2008. Suppliers must be accredited before this date to be awarded a contract. Suppliers should apply for accreditation immediately to allow adequate time to process their applications.

For a list of the CMS-approved Deemed Accreditation Organizations, visit http://www.cms.hhs.gov/MedicareProviderSupEnroll/01_Overview.asp. For information about the Medicare DMEPOS Competitive Bidding program, visit http://www.cms.hhs.gov/CompetitiveAcqforDMEPOS/

Round 1 of the Medicare DMEPOS Competitive Bidding Program

CMS has announced the single payment amounts for Round 1 of the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding Program.

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

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

Important DMEPOS Competitive Bidding Information

Now Available! The Medicare Learning Network (MLN) Matters Special Edition Article # SE0805 entitled – "Overview of New Medicare Competitive Bidding Program for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) – The first in a series of articles on the implementation of this program." - is now posted on the CMS Website at http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0805.pdf.

This is the first in a series of educational articles that will assist you in understanding this new DMEPOS program and help you interact with your patients. The new program begins July 1, 2008 and additional educational materials will be made available to you as we approach this date.

This article will be of particular interest to any provider that that may order, refer, or supply durable medical equipment to a Medicare beneficiary affected by the new Medicare DMEPOS Competitive Bidding Program.

The Centers for Medicare and Medicaid Services (CMS) has developed a fact sheet that explains the program for Medicare beneficiaries. This fact sheet, entitled, "What You Should Know if You Need Medicare-covered Equipment or Supplies" is available at, http://www.medicare.gov/Publications/Pubs/pdf/11307.pdf. You may want to provide this fact sheet to your Medicare patients.

Second MLN Matters Article Now Available on Implementation of the DMEPOS Competitive Bid Program

CMS is pleased to announce that the *MLN Matters Special Edition Article # SE0806* entitled "Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program: Grandfathering, Repair and Replacement, Mail Order Diabetic Supplies and Advanced Beneficiary Notices (ABNs) – the second in a series of articles on the new DMEPOS Competitive Bidding Program." is now posted on the CMS Website at http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0806.pdf.

This is the second in a series of educational articles that will assist you in understanding details on four areas of this new DMEPOS program. As a reminder, the new program begins July 1, 2008. Additional educational materials will be made available to you in the coming weeks.

This article will be of particular interest to any provider that may order, refer, or supply durable medical equipment to a Medicare beneficiary affected by the new Medicare DMEPOS Competitive Bidding Program.

New Information for DME Suppliers Who Are Planning to Bid in Round 2 of Competitive Bidding Program

While the Centers for Medicare & Medicaid Services (CMS) has not yet announced the bidding timeframe for Round 2 of the DMEPOS Competitive Bidding Program, CMS urges suppliers who are planning to bid in the upcoming 2008 bidding cycle to take action now to make sure their National Supplier Clearinghouse (NSC) enrollment record is current. Specifically, suppliers should verify that their most recent CMS-855S, Medicare Enrollment Application, has the correct Authorized Official (AO) listed in section 15; the AO's date of birth and Social Security number is correctly listed in section 6A; and the correct address is listed in section 2A2.

To assist potential bidders, CMS has issued *MLN Matters* Special Edition Article # SE0811 entitled, "Pre-Bidding Activities for the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program" which is now posted on the CMS Website at http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0811.pdf.

EDI

Common Electronic Data Interchange Testing Status and Important Transition Updates

National Government Services, Inc., the Common Electronic Data Interchange (CEDI) contractor contacted all DME MAC software vendors, clearinghouses and billing services currently on file with the DME MACs to initiate the transaction testing process which includes verifying the appropriate CEDI communication protocols. Software vendors must complete testing with CEDI prior to converting any of their electronic customers to CEDI. Once a software vendor is approved, any of their customers can begin submitting their electronic claims to CEDI.

The following vendors have completed testing with CEDI:

Care Centric, Inc.
Compulink Business Systems
Diabco
E Rx Network/Allwin Data
GCS Health
Noble House
Omnisys LLC
PC Solutions
QS/1 Data Systems
Reimbursement Services, Inc.
Team DME

A current list of the approved vendors is maintained on the CEDI Web site at www.ngscedi.com. This list will be updated as vendors complete the testing process with CEDI.

EDI CONT'D

If you are an electronic Trading Partner (Submitter) who uses an approved vendor listed above:

- You must obtain the necessary software and/or communications changes from your vendor to interact with the CEDI system.
- Your vendor shall advise you when you can begin exchanging files with CEDI.
- Your vendor shall also provide your initial password for logging into CEDI.
- Your Trading Partner (Submitter/Sender ID) will not change.
- Your Trading Partner (Submitter/Sender ID) will become your Login ID to connect to CEDI.

NOTE: Once an Electronic Trading Partner begins sending to CEDI, CEDI will deliver the following back to the Trading Partner:

- TA1, 997. GenResponse Report for Implementation Guide file/batch-level errors
- Medicare Pre-Pass Edit Report (This is the report you currently receive showing accepted and rejected claims for 837 claims, NCPDP claims and 276 claims status requests.)
- Electronic Remittance Advices (ERAs)
- 277 claim status responses

If you are an electronic submitter using a vendor that is not yet approved to exchange files with CEDI:

- Please contact your software vendor to determine when they will complete testing with CEDI.
- Confirm that you are exchanging files with the CEDI prior to the transition dates listed below.

If you are a Software Vendor, Billing Service and/or Clearinghouse:

- Contact the CEDI Help Desk immediately to initiate the testing process.
- Contact the CEDI Help Desk at 866-311-9184 or via E-mail at NGS.CEDIHelpdesk@wellpoint.com.
- Visit the CEDI Web site at www.ngscedi.com, go to "Telecommunications" and download the FTP or Asynchronous Communication Manual.
- Begin testing with CEDI as soon as possible to avoid any disruption in DME electronic exchange of files for you and your customers.

Express Plus Users:

CEDI will update the communication package used within the Express Plus software currently provided by Jurisdictions A, B and D.

Express Plus users will be instructed when the updated version is available to download from the CEDI Web site at www.ngscedi.com.

Until Express Plus users receive further notification, no changes should be made.

- Contact the CEDI Help Desk at 866-311-9184 or via E-mail at NGS.CEDIHelpdesk@wellpoint.com regarding questions on upgrade availability.

PC-Ace Pro32 Users:

- Visit the CEDI Web site at www.ngscedi.com, go to "Telecommunications" and download the Asynchronous Communication Manual.
- Contact the CEDI Help Desk at 866-311-9184 or via E-mail at NGS.CEDIHelpdesk@wellpoint.com to obtain the CEDI phone number and your password.
- Follow the instructions in the Asynchronous Communication Manual to change the dial-in phone number to the CEDI phone number obtained from the CEDI Help Desk.
- Follow the instructions in the manual to dial, login, connect and begin exchanging files with CEDI.
- Once the dial in number is updated within the software, PC-Ace Pro 32 users will begin submitting all DME MAC electronic claims to CEDI.
- PCAce Pro32 users will also receive their front-end report and ERAs from CEDI.
- For CEDI support, contact the CEDI Help Desk at 866-311-9184 or via E-mail at NGS.CEDIHelpdesk@wellpoint.com.

As a reminder, the key dates of the CEDI implementation are:

March 31, 2008	Jurisdiction A and Jurisdiction D will no longer process new requests for submitter IDs or changes to an existing ID. All new setups and changes will be done by the CEDI Enrollment Team. Details on how to get setup with the CEDI Enrollment Team will be available soon.
April 30, 2008	Jurisdiction B and Jurisdiction C will no longer process new requests for submitter IDs or changes to an existing ID. All new setups and changes will be done by the CEDI Enrollment Team. Details on how to get setup with the CEDI Enrollment Team will be available soon.
April 30, 2008	Last day for Jurisdiction A and Jurisdiction D to process EDI transactions.
May 1, 2008	All Jurisdiction A and Jurisdiction D EDI transactions will be processed by CEDI.
May 31, 2008	Last day for Jurisdiction B and Jurisdiction C to process EDI transactions.
June 1, 2008	All Jurisdiction B and Jurisdiction C EDI transactions will be processed by CEDI.

To stay informed of all CEDI updates, visit the CEDI Web site at www.ngscedi.com and sign up for the CEDI Listserv. The CEDI Help Desk is also available from 9 am to 9 pm Eastern Time at 1-866-311-9184 or via e-mail at NGS.CEDIHelpdesk@wellpoint.com.

DME MAC Express Plus Upgrade for CEDI

National Government Services has upgraded the Express Plus software program to connect and exchange transactions with CEDI. The Express Plus software is provided by Jurisdiction A, Jurisdiction B and Jurisdiction D as their low cost electronic billing software.

All Express Plus users must download the upgrade (Version 4.3.8) and follow the instructions below to communicate with CEDI. To download and begin using the new Version 4.3.8 of Express Plus, you need to:

1. Access the CEDI Web site at: www.ngscedi.com.
2. Select "Software Downloads".
3. On the "Software Downloads" page, print ALL of the following documents:
    - Express Plus Upgrade - These instructions will guide you through the process of running the Express Plus upgrade program.
    - Express Plus CEDI Script - These instructions will guide you through the procedures to create the communications' scripts to connect to and send/receive files with CEDI.
    - Express Plus CEDI Connection and Login - These instructions will assist you in logging into CEDI and sending/receiving files with CEDI.
4. Follow the instruction documents listed in the order above.

If you experience any problems installing the upgrade, updating your Express Plus communication scripts or have any questions, contact the CEDI Help Desk at ngs.cedihelpdesk@wellpoint.com or 1-866-311-9184. The CEDI Help Desk is available from 9 am to 9 pm ET Monday through Friday.

Once Version 4.3.8 of the Express Plus program is installed and the additional instructions are complete, electronic submitters using this software will become a CEDI Production Submitter. As a CEDI Production Submitter, Express Plus users can submit all DME MAC claims for all Jurisdictions to CEDI. Electronic Front End Reports for claims submitted to any DME MAC Jurisdiction will be available through the CEDI connection with the Express Plus software Version 4.3.8. Electronic submitters using this software will not have to dial in separately with each Jurisdiction to send or receive electronic data. If you are currently setup to receive an Electronic Remittance Advice (ERA), you will also dial in to CEDI to receive these files.

DME MAC Electronic Trading Partners Must Transition to CEDI Soon

All DME MAC electronic Trading Partners (submitters) must begin sending to the new National Government Services Common Electronic Data Interchange (CEDI) front end. Jurisdiction A and D must be transitioned by May 1, 2008 and Jurisdiction B and C must be transitioned by June 1, 2008. CEDI and the DME MACs **strongly** encourage all electronic Trading Partners to transition to CEDI prior to the cutover dates listed above. To become a CEDI production submitter, you must:

1. Make sure your software vendor has completed testing with CEDI. A list of approved CEDI vendors can be found by clicking on the following link: www.ngscedi.com/outreach_materials/Approved_CEDI_Vendor.pdf
2. Obtain the necessary software and/or communications changes from your vendor to interact with the CEDI system.
3. Contact your vendor to determine the date when you can begin exchanging files with CEDI.

Note: CEDI will continue to update the CEDI approved vendor list. To view this list, click on or paste the following into your Internet browser: www.ngscedi.com/outreach_materials/Approved_CEDI_Vendor.pdf. The list can also be accessed by going to www.ngscedi.com. Click on Outreach Materials and then click on Approved Vendor List.

CEDI Production Submitters

National Government Services' CEDI and the DME MACs EDI departments are coordinating to ensure that electronic submitters successfully submitting electronic claims to the CEDI are no longer submitting electronic claims to other DME MACs EDI front end systems. National Government Services CEDI is providing daily lists of CEDI production submitters to the DME MAC EDI departments. The DME MAC EDI departments are then terminating those Submitter IDs. This means **that once a Trading Partner (submitter) is approved to submit production claims to CEDI, they will no longer be authorized to submit DME claims to any of the DME MACs**.

Trading Partners (submitters) who have submitted production claims to CEDI must submit any additional EDI materials and requests to CEDI for processing. The DME MAC EDI departments will not process EDI materials for Trading Partners (submitters) who are in production with CEDI.

Trading Partners using a vendor who has been approved for production with CEDI should submit EDI enrollment materials ONLY to CEDI for processing. The DME MAC EDI departments may not process administrative requests for a vendor's customers once the vendor has been approved to submit production claims to the CEDI.

EDI products and services handled by CEDI include:

EDI CONT'D

- Electronic submission of all DME MAC claims;
- Changes to EDI trading partner (submitter) information, including passwords
- Delivery of all electronic front end reports;
- Electronic Remittance Advice enrollment, changes to enrollment and delivery of ERA files; and
- 276/277 transactions enrollment, changes to enrollment and collection and delivery of 276/277 files.

Note: CEDI will not process Claim Status Inquiry (CSI) or Electronic Funds Transfer (EFT) applications. CSI and EFT will continue to be handled by the appropriate DME MAC Jurisdictions and will not transition to CEDI.

Please direct questions regarding this notification to the CEDI Help Desk via e-mail at ngs.cedihelpdesk@wellpoint.com or by telephone at 1-866-311-9184.

CERT

Comprehensive Error Rate Testing Documentation Requests

The Centers for Medicare & Medicaid Services (CMS) strives to pay claims accurately. The Comprehensive Error Rate Testing (CERT) program was established by CMS to monitor and report the accuracy of Medicare Fee-For-Service (FFS) payments. The CERT program calculates the paid claims error rate for Medicare claims submitted to Carriers, Durable Medical Equipment Medicare Administrative Contractors (MACs) and Fiscal Intermediaries.

The major reason for CERT errors is insufficient documentation and/or no documentation. One of the ways to decrease this error is to submit correct information including beneficiary name, Social Security number, Medicare number, and date of service. Submit records that are legible and complete including dates and required signatures.

Please follow these guidelines when receiving a request for documentation from the CERT contractor.

Requests for Documentation
The CRC (CERT Review Contractor), AdvanceMed, will select a random sample claims processed by each Medicare contractor every month. When a Medicare supplier's claims are selected for the sample, that supplier will receive a request from the CDC (CERT Documentation Contractor), Livanta, for supporting documentation. These documents will be reviewed in order to verify that the services billed were delivered and medically necessary and that the claims processing procedures were appropriate.

Federal regulations require that all physicians/providers/suppliers, upon request, provide evidence that the service billed is medically necessary. The CDC will send an initial request letter to each supplier. The request, with the official CMS logo, will contain the following:

- Request letter
- Claim Attachment Cover Sheet
- Medical Records/Documentation Pull List
- Instructions for Submitting Requested Medical Records/Documentation sheet containing the list of the medical documentation requested and contact information.

If the CRC does not receive the requested documentation within 30 days of the initial letter, it will be followed by a series of letters and phone calls to the supplier. Samples of these letters are available on the CERT provider website: http://www.certcdc.com/certproviderportal/

Responding To Requests
It is imperative that providers respond to the documentation request. A response is required even if records for the sampled beneficiary dates of service cannot be provided. In accordance with 42 U.S.C. § 1320C-5 (a)(3) and § 1833 of the Social Security Act, as a Medicare provider, suppliers must provide documentation and medical records to the CERT contractor upon request to support claims for Medicare services. It is the suppliers responsibility to obtain additional supporting documentation from a third party (hospital, nursing home, etc.), as necessary. Providing medical records of Medicare patients to the CERT contractor is within the scope of compliance with the Health Insurance Portability and Accountability Act (HIPAA).

If the requested documentation is not received within the requested time period, the CERT CDC will assume the services on the claim were not rendered. Failure to produce the documentation will count as an error in the calculation of the CERT program error rate and will result in the computation of an overpayment. The Medicare contractor will pursue overpayment recoupment for these undocumented services.

Submitting Documentation

The preferred method for submission of medical records/documentation is via FAX.

1. Please adhere to the following directions when faxing:
2. Send the specific documents listed on the Bar Coded Cover Sheet to support the services of each claim identified on the Medical Records/Documentation Pull List.
3. Place the bar coded cover sheet in front of the medical records/documentation being submitted for review. Submit multiple records with the corresponding Bar Coded Cover Sheet as separator pages.
4. Please make sure all pages are complete, legible, and include both sides and page edges where applicable.

If unable to FAX documents, please contact the CERT Documentation Office.

Livanta
CERT Documentation Contractor
9090 Junction Drive Suite 9
Annapolis Junction MD 20701

Phone: (888) 779-7477 or (301) 957-2380
Fax: (240) 568-6222

Please adhere to the following directions if you are mailing the requested documentation:

1. Send the specific records listed on the Bar Coded Cover Sheet to support the services on the claim identified on the Medical Records/Documentation Pull List.
2. Photocopy each record. Please make sure all copies are complete and legible; include both sides of each page, including page edges.
3. Place the bar coded cover sheet in front of the medical records/documentation being submitted for review. Submit multiple records with the corresponding Bar Coded Cover Sheet as separator pages.

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.

REMEMBER:
CERT reviews of documentation can result in identification of overpayments, as well as underpayments. If the CERT contractor changes the payment decision on your claim by denying or reducing payment, you can still file an appeal with your Medicare contractor.

It is in everyone's interest to code and pay claims correctly. Your support of this process helps protect the solvency of the Medicare program.

Your cooperation also allows your Medicare contractor to provide individualized education to you on your specific CERT errors.

All public reports produced by the CERT program are available on the CMS website.

Administrative Simplification Compliance Act

This article describes the purpose of the Administrative Simplification Compliance Act (ASCA), discusses the supplier's responsibility regarding ASCA requirements, defines the circumstances under which a supplier may submit paper claims, summarizes the ASCA quarterly review process, and provides claim processing information.

Purpose
The Administrative Simplification Compliance Act requires that every Medicare supplier submit claims electronically (with a few exceptions, discussed below). The Act was implemented to improve efficiency and reduce the costs associated with processing claims.

Supplier Responsibility
Suppliers are expected to self-assess to determine if they must submit claims electronically. If the supplier's self-assessment indicates that their claims fall into one of the eleven categories below or one of the four "unusual circumstances" exists, the supplier may submit claims on paper without requesting permission from the Medicare contractor.

Circumstances Allowing Submission of Paper Claims
The following claims may be submitted on paper rather than electronically:

1. Claims submitted by small providers - A physician, practitioner, or supplier required to use a CMS-1500 (08/05) form when submitting claims on paper shall have fewer than 10 full-time equivalent employees (FTEs). A small provider can elect to submit all, some, or none of their claims electronically;
2. Dental claims;
3. Claims submitted by participants in a Medicare demonstration project for services or items covered under that demonstration project, when paper claim filing is required as a result of the inability of the HIPAA claim implementation guide to handle data essential for that demonstration;
4. Roster claims for mass immunizations, such as flu or pneumonia injections - paper roster bills cover multiple beneficiaries on the same claim. This exception applies to providers who do not have an agreement in place with a Medicare contractor that commits them to electronic submission of mass immunization claims;
5. Claims sent to Medicare when more than one other insurer was liable for payment prior to Medicare;
6. Claims submitted by providers that rarely treat Medicare patients and that submit fewer than 10 claims a month to Medicare in total (total of all claims sent to all Medicare contractors including the Railroad Medicare Carrier);
7. Home oxygen therapy claims for which the CR5 segment is required in an X12 837 version 4010A1 claim but for which the requirement notes in either

CR513, CR514, and/or CR515 do not apply, e.g., oxygen saturation is not greater than 88%, arterial PO_2 is more than 60 mmHG;

8. Claims submitted by beneficiaries;
9. Claims from providers that only furnish services outside of the United States;
10. Claims from providers experiencing a disruption in their electricity or communication connection that is outside of their control and is expected to last longer than two days. This exception applies only while electricity or electronic communication is disrupted; and
11. Providers that can establish that some other "unusual circumstance" exists that precludes submission of claims electronically.

The Centers for Medicare & Medicaid Services (CMS) interprets an "unusual circumstance" to be a temporary or long-term situation outside of a provider's control that precludes submission of claims electronically and as a result, it would be against equity and good conscience for CMS to require claims affected by the circumstance to be submitted electronically. Examples of "unusual circumstances" include:

a. Periods when a Medicare contractor's claim system might temporarily reject a particular type of electronically submitted claim, pending system modifications (individual Medicare claims processing contractors notify their providers of these situations if they apply);
b. Documented disability of each employee of a provider prevents use of a computer to enable electronic submission of claims;
c. Entities that can demonstrate that information necessary for adjudication of a type of Medicare claim that does not involve a medical record or other claim attachment cannot be submitted electronically using the claims formats adopted under the Health Insurance Portability and Accountability Act (HIPAA); and
d. Other circumstances documented by a provider, generally in rare cases, where a provider can establish that, due to conditions outside of the provider's control, it would be against equity and good conscience for CMS to enforce the electronic claim submission requirement.

Again, if the supplier's self-assessment indicates that their claims fall into any of the eleven general categories listed above OR one of the four unusual circumstances, the supplier may submit paper claims without contacting their Medicare contractor.

Quarterly Review Process

CMS monitors the suppliers submitting paper claims on a post-payment basis. Each Medicare contractor produces a quarterly report listing every supplier submitting paper claims. Per CMS guidelines, a percentage of the suppliers appearing on that report will be part of the quarterly ASCA Review process. The Medicare contractor sends a letter to the supplier requesting documentation that the supplier meets one or more of the conditions necessary to be excused from submitting claims electronically. The subject line of the letter is "Exhibit C—Request for Documentation From Provider Selected For Review to Establish Entitlement to Submit Claims on Paper".

This letter outlines the circumstances under which a claim may be submitted on paper instead of electronically. The supplier is required to self-assess whether their claims meet any of the listed criteria. If so, the supplier is instructed to respond to the Medicare contractor by requesting an ASCA waiver, within 30 days of the Review letter and include documentation to support their response.

A reminder letter is sent around the 30th day from the date of the initial letter.

The Medicare contractor will evaluate the supplier's response to the Review letter and the supporting documentation. If the ASCA waiver is granted, the supplier is notified in writing. If the supporting documents are not sufficient to prove the supplier's position, the supplier is notified in writing and may provide additional documentation.

If the supplier does not submit a response to the Request for Documentation letter or doesn't include appropriate documentation, an ASCA denial will be assigned to the supplier's file on the 91st day after the date of the initial letter. From that date, all paper claims will be denied unless/until a waiver request and documentation are provided. The Medicare contractor will approve paper claims retroactively if a waiver is granted.

If a supplier is permitted to submit paper claims, the contractor will not review eligibility to submit paper claims again for at least two years.

Responding to or Requesting ASCA Waiver

When responding to a request, fax all applicable documentation to:

Fax: 888-523-8449

Documentation can also be mailed to:

Noridian Administrative Services
PO Box 6737
Fargo, ND 58108-6737

Documentation examples include:

- Small supplier - Copies of payroll records for all employees that list the number of hours worked
- Quarterly worker's compensation or unemployment tax documents
- If an office has no employees (sole proprietors), send a copy of the Schedule C used for federal income tax purposes. Identifying information, such as personal information or Social Security numbers, can be blacked out when submitting this documentation.

Claims Processing

When a supplier who has not been granted an ASCA waiver submits a paper claim, it will deny with remark codes M117 (Not covered unless submitted via electronic claim) and MA44 (No appeal rights. Adjudicative decision based on law).

ASCA CONT'D

Suppliers that submit paper claims to multiple Medicare contractors, including both Railroad and non-Railroad Medicare contractors, could have an ASCA Enforcement Review conducted by each of those contractors. If a non-Railroad Medicare contractor determines that a supplier does not meet any criteria which would permit submitting paper claims to Medicare and notifies a supplier that all paper claims submitted on or after a specific date will be denied, that same decision is to be applied to that supplier if submitting paper claims to Railroad Medicare.

Resources
MLN Matters 3440 - Administrative Simplification Compliance Act Enforcement of Mandatory Electronic Submission of Medicare Claims

Medicare Claims Processing Manual, Chapter 24, Section 90

FORMS

Refund Form

It has come to our attention that some DME suppliers are using the incorrect Refund Form when submitting voluntary refunds to NAS Medicare. The refund form specific to Part B and the DME Inquiry/Redetermination forms are being used in place of the DME Refunds to Medicare form. When the inappropriate form is used the processing of the refund is delayed. Please be sure you are using the refund form that is titled "Refunds to Medicare – DME".

The appropriate Refund to Medicare form for DME can be found at www.noridianmedicare.com/dme/forms/ under Recoupment and Overpayments. This is an interactive form, which NAS has created to make it easy for you to enter the information and print the form for faxing or mailing to NAS.

Please ensure your office is using the correct DME refund form and share this information with all billing staff. We appreciate your cooperation.

Announcing the Release of the Revised CMS-855 Medicare Enrollment Applications

MLN Matters Number: SE0810

Provider Types Affected
All Medicare physicians, providers, and suppliers

Background
The Centers for Medicare & Medicaid Services (CMS) issued revised CMS-855 Medicare enrollment applications in March 2008. With the exception of providers enrolling as a specialty hospital on the CMS-855A, Medicare contractors will continue to accept the 2006 version of the Medicare enrollment application through June 2008. **Providers and suppliers should begin to use the new Medicare enrollment applications immediately**. Initially, these applications will be available only from the CMS provider enrollment web site. The link for that CMS web site is listed in the *Additional Information* section of this article.

Over the last year, CMS has received numerous comments and suggestions regarding the proposed revisions to the Medicare enrollment applications. CMS reviewed the comments and adopted many of the suggested revisions. Also, CMS incorporated a number of enhancements and changes (see *Key Points* below) to clarify the enrollment process and to reduce the burden imposed on the provider and supplier communities.

Key Points
This Special Edition outlines the significant revisions to the Medicare enrollment applications and they are as follows:

Application-Specific Changes for Physicians and Non-Physician Practitioners (CMS-855I)

- Removed the requirement in Section 17 that providers attached their National Provider Identifier notification that is received from the National Plan and Provider Enumeration System.

Application-Specific Changes for Clinics/Group Practices and Certain Other Suppliers (CMS-855B)

- Removed the supplier type "Voluntary Health/Charitable Agency" from Section 2A.
- Clarified reporting timeframes throughout the CMS-855B.
- Added additional information about the National Provider Identifier (NPI)-legacy association and expanded the number of NPI – legacy combinations that a provider may enter in Section 4A from one to five.
- Removed the requirement in Section 17 that providers attach their National Provider Identifier notification that is received from the National Plan and Provider Enumeration System.
- Required that an Independent Diagnostic Testing Facility (IDTF) submit copies of its comprehensive liability insurance policy in Section 17.
- Added a list of the new IDTF standards found in 42 CFR 410.33(g) on a separate page in Attachment 2.
- Added instructions that explain the IDTF liability insurance requirements in 42 CFR 410.33(g)(6) to Attachment 2.

Application-Specific Changes for Institutional Providers (CMS-855A)

- Revised Section 2A2 to include a specific box that specialty hospitals must check when completing the application. Instructions explaining the definition of a "specialty hospital" were also added to the form.
- Clarified the term "primary practice location" in the instructions in Section 4. (The clarification did not change any data elements on the form.)
- Added additional information about the National Provider Identifier (NPI)-legacy association and expanded the number of NPI – legacy combinations that a provider may enter in Section 4A from one to five.

- Removed the data element "Medicare Year-End Cost Report Date" from Section 2.
- Removed the requirement in Section 17 that providers attach their National Provider Identifier notification that is received from the National Plan and Provider Enumeration System

Application-Specific Changes for DMEPOS Suppliers (CMS-855S)

- Added supplier standards 22 – 25 to the list of DMEPOS supplier standards found on page 31.

Additional Information
For additional information regarding the Medicare enrollment process, including the mailing address and telephone number for the carrier or FI serving your area, visit http://www.cms.hhs.gov/MedicareProviderSupEnroll on the CMS website.

Special Edition article SE0612 contains helpful information about the Medicare enrollment process. You may review that article at http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0612.pdf on the CMS website.

ALJ Requests Change of Address

The addresses for sending Administrative Law Judge (ALJ) requests have been changed.

If an appellant is dissatisfied with a reconsideration decision and the amount remaining in controversy is at least $120, the appellant is entitled to an in-person or an on-the-record hearing before an ALJ of the Social Security Administration. To request an ALJ hearing, the request must be made in writing within 60 days following the date on which the appellant received the reconsideration decision. All requests should be mailed to the appropriate Office of Medicare Hearings and Appeals (OMHA). Requests should be mailed to the address below based on the appellant's address of record:

Office of Medicare Hearings and Appeals (OMHA)
BP Tower & Garage
200 Public Square Suite 1300
Cleveland OH 44114-2316

HHS Region I: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont
HHS Region II: New York, New Jersey, Puerto Rico, Virgin Islands
HHS Region III: Delaware, Maryland, Pennsylvania, Virginia, West Virginia, District of Columbia
HHS Region V: Illinois, Indiana, Ohio, Michigan, Minnesota, Wisconsin

Office of Medicare Hearings and Appeals (OMHA)
100 SE 2nd Street Suite 1700
Miami FL 33131-2100

HHS Region IV: Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee
HHS Region VI: Arkansas, Louisiana, New Mexico, Oklahoma, Texas

Office of Medicare Hearings and Appeals (OMHA)
27 Technology Drive Suite 100
Irvine CA 92618-2364

HHS Region VII: Iowa, Kansas, Missouri, Nebraska
HHS Region VIII: Colorado, Montana, North Dakota, South Dakota, Utah, Wyoming
HHS Region IX: Arizona, California, Hawaii, Nevada, Guam, Trust Territory of the Pacific Islands, American Samoa
HHS Region X: Alaska, Idaho, Oregon, Washington

April 2008 Quarterly Average Sales Price Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files

MLN Matters Number: MM5982
Related Change Request (CR) #: 5982
Related CR Release Date: March 26, 2008
Related CR Transmittal #: R1484CP
Effective Date: April 1, 2008
Implementation Date: April 7, 2008

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

What You Need to Know
CR 5982, from which this article is taken, instructs Medicare contractors to download and implement the April 2008 Average Sales Price (ASP) drug pricing file for Medicare Part B drugs; and if released by CMS, also the revised January 2008, January 2007, April 2007, July 2007, October 2007, and October 2006 files.

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

Additionally, beginning in 2006, all end-stage renal disease (ESRD) drugs (that both independent and hospital-based ESRD facilities furnish), as well as specified covered outpatient drugs, and drugs and biologicals with pass-through status under the Outpatient Prospective Payment System (OPPS), are paid based on the ASP methodology.

The ASP methodology is based on quarterly data that drug manufacturers submit to the Centers for Medicare & Medicaid Services (CMS), which CMS then provides (quarterly) to Medicare contractors (carriers, DME MACs, FIs, A/B MACs, and/or RHHIs) through the ASP drug pricing files for Medicare Part B drugs.

As announced in late 2006, CMS has been working further to ensure that accurate and separate payment is made for single source drugs and biologicals as required by Section 1847A of the Social Security Act. As part of the effort to ensure compliance with this requirement, CMS has also reviewed how the terms "single source drug," "multiple source drug," and "biological product" have been operationalized in the context of payment under section 1847A.

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

- The FDA approval,
- Therapeutic equivalents as determined by the FDA, and
- The date of first sale in the United States.

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

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

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

ASP Methodology
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 the following:

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

Beginning January 1, 2008, under the OPPS, payment allowance limits for specified covered outpatient drugs are paid based on 105 percent of the ASP. 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.

Exceptions are summarized as follows:

- The payment allowance limits for blood and blood products (other than blood clotting factors) that are not paid on a prospective payment basis are 95 percent of the average wholesale price (AWP) as reflected in the published compendia. The payment allowance limits are updated on a quarterly basis. Blood and blood products furnished in the hospital outpatient department are paid under OPPS at the amount specified for the Ambulatory Payment Class (APC) to which the product is assigned.
- Payment allowance limits for infusion drugs furnished through a covered item of durable medical equipment on or after January 1, 2005, will continue to be 95 percent of the AWP reflected in the published compendia as of October 1, 2003, unless the drug is compounded or the drug is furnished incident to a professional service. The payment allowance limits will not be updated in 2008. The payment allowance limits for infusion drugs furnished through a covered item of durable medical equipment that were not listed in the published compendia as of

October 1, 2003, (i.e., new drugs) are 95 percent of the first published AWP unless the drug is compounded or the drug is furnished incident to a professional service.

- The payment allowance limits for influenza, Pneumococcal and Hepatitis B vaccines are 95 percent of the AWP as reflected in the published compendia except where the vaccine is furnished in a hospital outpatient department. Where the vaccine is administered in the hospital outpatient department, the vaccine is paid at reasonable cost.
- The payment allowance limits for drugs and biologicals that are not included in the ASP Medicare Part B Drug Pricing File or NOC Pricing File, other than new drugs and biologicals that are produced or distributed under a new drug application (or other application) approved by the FDA, are based on the published wholesale acquisition cost (WAC) or invoice pricing, except under OPPS where the payment allowance limit is 95 percent of the published AWP. In determining the payment limit based on WAC, the contractors follow the methodology specified in Pub. 100-04, Chapter 17, Drugs and Biologicals, for calculating the AWP but substitute WAC for AWP. The payment limit is 100 percent of the lesser of the lowest-priced brand or median generic WAC. For 2006, the blood clotting furnishing factor of $0.146 per I.U. is added to the payment amount for the blood clotting factor when the blood clotting factor is not included on the ASP file. For 2007, the blood clotting furnishing factor of $0.152 per I.U. is added to the payment amount for the blood clotting factor when the blood clotting factor is not included on the ASP file. For 2008, the blood clotting furnishing factor of $0.158 per I.U. is added to the payment amount for the blood clotting factor when the blood clotting factor is not included on the ASP file.
- The payment allowance limits for new drugs and biologicals that are produced or distributed under a new drug application (or other new application) approved by the FDA and that are not included in the ASP Medicare Part B Drug Pricing File or NOC Pricing File are based on 106 percent of the WAC, or invoice pricing if the WAC is not published, except under OPPS where the payment allowance limit is 95 percent of the published AWP. This policy applies only to new drugs and biologicals that were first sold on or after January 1, 2005.
- The payment allowance limits for radiopharmaceuticals are not subject to the ASP payment methodology. Medicare contractors determine payment limits for radiopharmaceuticals based on the methodology in place as of November 2003 in the case of radiopharmaceuticals furnished in other than the hospital outpatient department. Radiopharmaceuticals furnished in the hospital outpatient department are paid charges reduced to cost by the hospital's overall cost to charge ratio.

On or after March 18, 2008, the April 2008 ASP file will be available for download along with revisions to prior ASP payment files, if CMS determines that revisions to these prior files are necessary. On or after March 18, 2008, the April 2008 ASP NOC files will be available for retrieval from the CMS ASP webpage along with revisions to prior ASP NOC files, if CMS determines that revisions to these prior files are necessary. The payment limits included in revised ASP and NOC payment files supersede the payment limits for these codes in any publication published prior to this document.

The payment files will be applied to claims processed or reprocessed on or after the implementation date of CR5982 for the dates of service noted in the following table:

Payment Allowance Limit Revision Date	Applicable Dates of Service
April 2008 ASP and ASP NOC files	April 1, 2008, through June 30, 2008
January 2008 ASP and ASP NOC files	January 1, 2008, through March 31, 2008
October 2007 ASP and ASP NOC files	October 1, 2007, through December 31, 2007
July 2007 ASP and ASP NOC files	July 1, 2007, through September 30, 2007
April 2007 ASP and ASP NOC files	April 1, 2007, through June 30, 2007
January 2007 ASP and ASP NOC files	January 1, 2007, through March 31, 2007
October 2006 ASP and ASP NOC files	October 1, 2006, through December 31, 2006

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

Drugs Furnished During Filling or Refilling an Implantable Pump or Reservoir

Physicians 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. Note that pricing for compounded drugs is done by your local Medicare contractor.

Additional Information
To see the official instruction (CR5982) issued to your Medicare contractor visit http://www.cms.hhs.gov/Transmittals/downloads/R1484CP.pdf on the CMS website.

CODING

Nebulizers – HCPCS Code Changes

The following codes will be valid for claims with dates of service on or after April 1, 2008:

J7611 Albuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, concentrated form, 1 mg

J7612 Levalbuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, concentrated form, 0.5 mg

J7613 Albuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose, 1 mg

J7614 Levalbuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose, 0.5 mg

Q4099 Formoterol fumarate, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose form, 20 micrograms

The following codes, which became valid for claims with dates of service on or after January 1, 2008 will be discontinued. These codes will be invalid for claims with dates of service on or after April 1, 2008.

J7602 Albuterol, all formulations including separated isomers, inhalation solution, FDA-approved final product, non-compounded, administered through DME, concentrated form, per 1 mg (albuterol) or per 0.5 mg (levalbuterol)

J7603 Albuterol, all formulations including separated isomers, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose, per 1 mg (albuterol) or per 0.5 mg (levalbuterol)

The new codes will be included in a future revision of the Nebulizers LCD and Policy Article.

Nebulizers - Brovana and Perforomist - Instructions for New HCPCS Codes, April 2008

New HCPCS codes have been created for Perforomist (formoterol, Q4099), effective April 1, 2008, and Brovana (arformoterol, J7605), effective January 1, 2008.

- J7605 Arformoterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose form, 15 micrograms
- Q4099 Formoterol fumarate, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose form, 20 micrograms

In August 2007, an article, Nebulizers – Perforomist and Brovana – Coverage Criteria and Billing Instructions, was published providing guidance on coverage and coding of these drugs. The updated article below includes instructions for each new product.

Coverage Criteria

FDA-approved inhalation solutions of formoterol (Q4099) or arformoterol (J7605) are covered when the following criteria are met:

1. It is medically necessary for the management of chronic obstructive pulmonary disease (ICD-9 diagnosis codes 491.0-492.8, 496); and
2. The patient has a documented history of routine use of at least four doses per day of an FDA-approved albuterol or metaproterenol inhalation solution or at least three doses per day of an FDA-approved levalbuterol inhalation solution.

If the above coverage criteria are not met, formoterol and arformoterol will be denied as not medically necessary.

Formoterol and arformoterol are administered using a pneumatic compressor (E0570, E0571) and a small volume nebulizer (A7003, A7004, A7005).

A maximum of two vials of formoterol (20 micrograms each) or two vials of arformoterol (15 micrograms each) are covered per day.

Short-acting beta-adrenergic agonists (SABAs) may be covered as rescue/supplemental medication in addition to formoterol or arformoterol. However, when formoterol or arformoterol is used, the maximum amount of SABA inhalation solutions that will be covered is an average of one dose per day (31 doses per month).

Coding and Billing Guidelines

When submitting claims for formoterol or arformoterol, use the following codes:

- Q4099 for Perforomist (formoterol), effective April 1, 2008
- J7605 for Brovana (arformoterol), effective January 1, 2008

CODING CONT'D

Append the KO modifier when submitting claims for formoterol or arformoterol.

A KX modifier must be appended to these codes ***only*** when the coverage criteria stated above have been met.

When billing for Perforomist, 1 unit of service = 1 vial (20 micrograms).

When billing for Brovana, 1 unit of service = 1 vial (15 micrograms).

Also, remember that the LCD requires that an ICD-9 code, describing the condition which necessitates nebulizer therapy, must be included on each claim for equipment, accessories, and/or drugs.

Refer to the Nebulizers LCD and Policy Article for additional information on coverage, coding, and billing of inhalation solutions.

The Nebulizers policy has been revised to incorporate this information.

Continuous Passive Motion Machine Coding Guidelines

The following article was provided by the SADMERC:

Continuous Passive Motion (CPM) devices are used to exercise joints following injury or surgery.

E0935-continuous passive motion exercise device for use on knee only

E0936-continous passive motion exercise device for use other than knee.

Recent questions regarding the exact nature of these devices reveal confusion regarding the nature and functionality of these devices. These coding guidelines clarify the types of products described by the CPM codes.

The first test of any durable medical equipment (DME) is that it be durable and capable of repeated use over the expected five year useful life expectancy. Elastic, fabric, single use, or light plastic devices are not durable and do not meet the test for DME.

Secondly, the equipment must be capable of continuous passive motion of the affected limb. These characteristics mean that the device must have inherent within itself the ability to move the affected limb:

- in an appropriate plane of motion
- in a continuous fashion
- at the same rate of speed
- for a prescribed length of time
- with adjustable limits of range of motion
- with an identical range of motion in each cycle
- without any input from the patient by the contralateral or other limbs
- with easily accessible safety or cutoff switches

These characteristics require that the device be electrically powered, either by AC current or battery. Battery powered models must have an AC adapter for long-term use. CPM machines must meet all these characteristics in order to be coded as E0935 or E0936.

BILLING

Timely Filing of Medicare Claim Submission

Medicare claims must be submitted by certain dates to avoid a reduction in payment or denial. Electronic claims must be received before 5:00 pm Eastern Standard Time to be collected in that day's file. Anything submitted after 5:00 pm will be included in the next business day. Also, when the end of the year falls on a weekend, in order to be filed within the current year, claims must be received before 5:00 pm Eastern Standard Time on the last business day.

Payment on assigned claims submitted after 12 months from the date of service will be reduced by 10% from the amount that would have been paid.

In order for claim to be considered to have been filed timely in accordance with CMS instructions, the claim **must not be considered to be unprocessable** under the definition of an unprocessable claim found in the Medicare Claims Processing Manual, Chapter 1, Section 80.3.1.

The table that follows illustrates the timely filing limit for dates of service in each calendar 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.

Break in Service and Extending CMNs

This article provides guidance on how to report a break in service or extend CMNs for capped rental items.

When a break in service occurs for a capped rental period, it is very important that this is reported on the claim. This can be done by entering a comment of "BIS" in Item 19 on the CMS-1500 claim form or the NTE segment, 2400 loop for electronic claims. A comment of BIS allows claims processing staff to ensure that a new rental period begins and to enter the "new"initial CMN or DIF. This will prevent claim denials and the need for requesting a redetermination on denied claims.

A break in service is defined by CMS as an interruption in medical necessity for a 60-plus consecutive day interruption, including two full rental months **plus** whatever days are remaining in the rental month during which the need ends. An interruption in medical necessity is defined as a resolution of the condition that created the first period of medical necessity and the subsequent development of a second event that creates a new period of medical necessity.

BIS Reminders:

- If a supplier is billing for a new capped rental period, the code must have the KH modifier and, if a CMN is required for the code, an *initial* CMN must accompany the claim.
- If there is an interruption in the billing of a capped rental DME item to the DME MAC because the patient is in a hospital and/or nursing facility or enrolls in a Health Maintenance Organization (HMO) or hospice program, a new capped rental period does not automatically begin if/when billing to the DME MAC resumes.A change in medical necessity for the break in service timeframe described above is required.

- Enrollment in an HMO for 60 or more days qualifies as an interruption in medical necessity.
- **For an item described by a different code, a new capped rental period would begin if there is a substantive change in the patient's condition that necessitates a significantly different item.**

For additional information on BIS, reference Chapter 3 of our supplier manual.

Extending CMNs

When requesting that a CMN be extended, a comment must be reported on the claim in Item 19 on the CMS-1500 claim form or the NTE segment for electronic claims. Suppliers can use the terminology 'extend CMN for xx months' or "extend to allow 13 months" where xx equals the number of months to be extended. This will allow claims processing staff to efficiently and correctly process the claim and CMN and also prevent claim denials and redetermination requests.

If a break in service of less than 60 days occurs or a new capped rental period is not allowed, the end date on the existing CMN may need to be extended to allow the remaining months to be paid. The CMN can be extended for one of the following reasons:

1. Delay in delivery of an item
2. Item provided before beneficiary had Medicare eligiblity
3. Break in service due to a stay in a hospital/nursing home or Medicare HMO coverage

Reminder: Per CMS guidelines, as of January 1, 2006, capped rental items are paid on a monthly rental basis not to exceed a period of continuous use of 13 months. Rental periods starting before 1/1/06 allowed 15 months of rental.

Continuous Passive Motion Machines Claim Submission

To process E0935 (Continuous passive motion exercise device for use on knee only) claims correctly and efficiently, the following information is required in Item 19 on the CMS-1500 claim form or in the NTE segment (2400 loop) for electronic claims:

- Date of surgery (DOS),
- Onset date (OD), and
- Date of discharge (DOD)

Failure to include the start date of usage of the CPM machine, the date of surgery and the discharge date will result in claims being denied as unprocessable for missing information. Claims will need to be corrected and resubmitted, rather than reopened or appealed.

The information in Item 19 or the NTE segment can be reported as follows:

DOS 1/15/08, OD 1/16/08, DOD 1/17/08

The above is an example of how this information can be abbreviated. The important thing is that these three key pieces of information, date of surgery, onset date and date of discharge, are reported.

Coverage for E0935 is outlined in Section 280.1 of the National Coverage Determinations Manual as follows:

> "Continuous passive motion devices are devices covered for patients who have received a total knee replacement. To qualify for coverage, use of the device must commence within 2 days following surgery. In addition, coverage is limited to that portion of the 3-week period following surgery during which the device is used in the patient's home. There is insufficient evidence to justify coverage for longer periods of time or for other applications."

Important Reminders:

- The day of surgery counts as the first day of usage.
- Only 21 days (three weeks) in total are covered.
- Sheepskin pads are denied as included in the rental of the device.
- Bill the dates of usage, the From and To dates, in Item 24A on the CMS-1500 claim form and bill the corresponding number of units in Item 24G.

Additional Clarification to Chapter 17, Section 40, Regarding Processing of Drug Claims with the JW Modifier

MLN Matters Number: MM5923
Related Change Request (CR) #: 5923
Related CR Release Date: March 14, 2008
Related CR Transmittal #: R1478CP
Effective Date: January 1, 2008
Implementation Date: April 14, 2008

Provider Types Affected
Physicians, providers and suppliers billing Medicare Contractors (Medicare Administrative Contractors (A/B MACs), fiscal intermediaries (FIs), carriers and/or Durable Medical Equipment Medicare Administrative Contractors

(DME MACs)) for drugs or biologicals provided to Medicare beneficiaries.

Impact on Providers
When processing all drugs **except those provided under the Competitive Acquisition Program (CAP)** for Part B drugs and biologicals, Medicare contractors may require the use of the modifier JW to identify unused drug or biologicals from single use vials or single use packages that are appropriately discarded. This **modifier will provide payment for the discarded drug or biological.**

Background
The Centers for Medicare & Medicaid Services (CMS) issued this CR 5923 to notify providers of the Medicare Claims Processing Manual update that clarifies the use of the JW modifier when processing all drugs except CAP drugs.

Additional Information
To see the official instruction (CR5923) issued to your Medicare Carrier, DME/MAC, FI and/or A/B MAC, visit http://www.cms.hhs.gov/Transmittals/downloads/R1478CP.pdf on the CMS website.

Remittance Advice Remark Code and Claim Adjustment Reason Code Update

MLN Matters Number: MM5942
Related Change Request (CR) #: 5942
Related CR Release Date: March7, 2008
Effective Date: April 1, 2008
Implementation Date: April 7, 2008

Provider Types Affected
Physicians, providers, and suppliers who submit claims to Medicare contractors (carriers, fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), Part A/B Medicare Administrative Contractors (A/B MACs), durable medical equipment Medicare Administrative Contractors (DME MACs)) for services

Provider Action Needed
CR 5942, from which this article is taken, announces the latest update of Remittance Advice Remark Codes (RARCs) and Claim Adjustment Reason Codes (CARCs), effective April 1, 2008. Be sure billing staff are aware of these changes.

Background
Two code sets - the reason and remark code sets - must be used to report payment adjustments in remittance advice transactions. The reason codes are also used in some coordination-of-benefits (COB) transactions. The RARC list is maintained by the Centers for Medicare & Medicaid Service (CMS), and used by all payers; and additions, deactivations, and modifications to it may be initiated by any health care organization. The CARC list is maintained by a national Code Maintenance committee that meets when X12 meets for their trimester meetings to make decisions about additions, modifications, and retirement of existing reason codes.

Both code lists are updated three times a year, and are posted at http://www.wpc-edi.com/Codes on the Internet. The lists at the end of this article summarize the latest changes to these lists, as announced in CR 5942.

CMS has also developed a new tool to help you search for a specific category of code and that tool is available at http://www.cmsremarkcodes.info on the Internet. Note that this website does not replace the WPC site and, should there be any discrepancies in what is posted at this site and the WPC site, consider the WPC site to be correct.

Additional Information
To see the official instruction (CR5942) issued to your Medicare Carrier, RHHI, DME/MAC, FI and/or A/B MAC refer to http://www.cms.hhs.gov/Transmittals/downloads/R1475CP.pdf on the CMS website.

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

Remittance Advice Remark Code Changes

New Codes

Code	Current Narrative	Medicare Initiated
N430	Procedure code is inconsistent with the units billed. Start: 11/5/2007 Note: (New Code 11/5/07)	YES
N431	Service is not covered with this procedure. Start: 11/5/2007 Note: (New Code 11/5/07)	YES
N432	Adjustment based on a Recovery Audit. Start: 11/5/2007 Note: (New Code 11/5/07)	YES

Modified Codes

Code	Current Modified Narrative	Last Modification Date
M25	The information furnished does not substantiate the need for this level of service. If you believe the service should have been fully covered as billed, or if you did not know and could not reasonably have been expected to know that we would not pay for this level of service, or if you notified the patient in writing in advance that we would not pay for this level of service and he/she agreed in writing to pay, ask us to review your claim within 120 days of the date of this notice. If you do not request a appeal, we will, upon application from the patient, reimburse him/her for the amount you have collected from him/her in excess of any deductible and coinsurance amounts. We will recover the reimbursement from you as an overpayment.	11/5/2007
M26	The information furnished does not substantiate the need for this level of service. If you have collected any amount from the patient for this level of service /any amount that exceeds the limiting charge for the less extensive service, the law requires you to refund that amount to the patient within 30 days of receiving this notice. The requirements for refund are in 1824(I) of the Social Security Act and 42CFR411.408. The section specifies that physicians who knowingly and willfully fail to make appropriate refunds may be subject to civil monetary penalties and/or exclusion from the program. If you have any questions about this notice, please contact this office.	11/5/2007
M75	Multiple automated multichannel tests performed on the same day combined for payment.	11/5/2007
M112	Reimbursement for this item is based on the single payment amount required under the DMEPOS Competitive Bidding Program for the area where the patient resides.	11/5/2007
M113	Our records indicate that this patient began using this item/service prior to the current contract period for the DMEPOS Competitive Bidding Program.	11/5/2007
M114	This service was processed in accordance with rules and guidelines under the DMEPOS Competitive Bidding Program or a Demonstration Project. For more information regarding these projects, contact your local contractor.	11/5/2007
M115	This item is denied when provided to this patient by a non-contract or non-demonstration supplier.	11/5/2007
N70	Consolidated billing and payment applies.	11/5/2007
N367	Alert: The claim information has been forwarded to a Consumer Account Fund processor for review.	11/5/2007
N377	Payment based on a processed replacement claim.	11/5/2007
N385	Notification of admission was not timely according to published plan procedures.	11/5/2007

Deactivated Codes

Code	Current Narrative	Modification Date
MA119	Provider level adjustment for late claim filing applies to this claim. Start: 1/1/1997 | Stop: 5/1/2008 | Last Modified: 11/5/2007 Note: (Deactivated eff. 5/1/08) Consider using Reason Code B4.)	Deactivated eff. 5/1/08

Claim Adjustment Reason Codes

New Codes

Code	Current Narrative	Implementation Date
212	Administrative surcharges are not covered Start: 11/05/2007	11/05/2007

Modified Codes

Code	Modified Narrative	Implementation Date
121	Indemnification adjustment - compensation for outstanding member responsibility. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
192	Non standard adjustment code from paper remittance. Note: This code is to be used by providers/payers providing Coordination of Benefits information to another payer in the 837 transaction only. This code is only used when the non-standard code cannot be reasonably mapped to an existing Claims Adjustment Reason Code, specifically Deductible, Coinsurance and Co-payment. Start: 10/31/2005 | Last Modified: 09/30/2007	4/1/2008
206	National Provider Identifier - missing. Start: 07/09/2007 | Last Modified: 09/30/2007	4/1/2008
207	National Provider identifier - Invalid format Start: 07/09/2007 | Stop: 05/23/2008 | Last Modified: 09/30/2007	4/1/2008
208	National Provider Identifier - Not matched. Start: 07/09/2007 | Last Modified: 09/30/2007	4/1/2008
15	The authorization number is missing, invalid, or does not apply to the billed services or provider. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
17	Requested information was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.) Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
19	This is a work-related injury/illness and thus the liability of the Worker's Compensation Carrier. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
20	This injury/illness is covered by the liability carrier. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/200
21	This injury/illness is the liability of the no-fault carrier. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
22	This care may be covered by another payer per coordination of benefits. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
23	The impact of prior payer(s) adjudication including payments and/or adjustments. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
24	Charges are covered under a capitation agreement/managed care plan. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
31	Patient cannot be identified as our insured. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
33	Insured has no dependent coverage. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008

34	Insured has no coverage for newborns. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
55	Procedure/treatment is deemed experimental/investigational by the payer. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
56	Procedure/treatment has not been deemed `proven to be effective' by the payer. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
58	Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
59	Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
61	Penalty for failure to obtain second surgical opinion. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
95	Plan procedures not followed. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
97	The benefit for this service is included in the payment/allowance for another service/ procedure that has already been adjudicated. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
107	The related or qualifying claim/service was not identified on this claim. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
108	Rent/purchase guidelines were not met. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
112	Service not furnished directly to the patient and/or not documented. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
115	Procedure postponed, canceled, or delayed. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
116	The advance indemnification notice signed by the patient did not comply with requirements. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
117	Transportation is only covered to the closest facility that can provide the necessary care. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
118	ESRD network support adjustment. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.) Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
129	Prior processing information appears incorrect. Start: 02/28/1997 | Last Modified: 09/30/2007	4/1/2008
135	Interim bills cannot be processed. Start: 10/31/1998 | Last Modified: 09/30/2007	4/1/2008
136	Failure to follow prior payer's coverage rules. (Use Group Code OA). Start: 10/31/1998 | Last Modified: 09/30/2007	4/1/2008
137	Regulatory Surcharges, Assessments, Allowances or Health Related Taxes. Start: 02/28/1999 | Last Modified: 09/30/2007	4/1/2008
138	Appeal procedures not followed or time limits not met. Start: 06/30/1999 | Last Modified: 09/30/2007	4/1/2008
141	Claim spans eligible and ineligible periods of coverage. Start: 06/30/1999 | Last Modified: 09/30/2007	4/1/2008
142	Monthly Medicaid patient liability amount. Start: 06/30/2000 | Last Modified: 09/30/2007	4/1/2008

146	Diagnosis was invalid for the date(s) of service reported. Start: 06/30/2002 | Last Modified: 09/30/2007	4/1/2008
148	Information from another provider was not provided or was insufficient/incomplete. Start: 06/30/2002 | Last Modified: 09/30/2007	4/1/2008
150	Payer deems the information submitted does not support this level of service. Start: 10/31/2002 | Last Modified: 09/30/2007	4/1/2008
151	Payer deems the information submitted does not support this many services. Start: 10/31/2002 | Last Modified: 09/30/2007	4/1/2008
152	Payer deems the information submitted does not support this length of service. Start: 10/31/2002 | Last Modified: 09/30/2007	4/1/2008
153	Payer deems the information submitted does not support this dosage. Start: 10/31/2002 | Last Modified: 09/30/2007	4/1/2008
154	Payer deems the information submitted does not support this day's supply. Start: 10/31/2002 | Last Modified: 09/30/2007	4/1/2008
155	Patient refused the service/procedure. Start: 06/30/2003 | Last Modified: 09/30/2007	4/1/2008
157	Service/procedure was provided as a result of an act of war. Start: 09/30/2003 | Last Modified: 09/30/2007	4/1/2008
158	Service/procedure was provided outside of the United States. Start: 09/30/2003 | Last Modified: 09/30/2007	4/1/2008
159	Service/procedure was provided as a result of terrorism. Start: 09/30/2003 | Last Modified: 09/30/2007	4/1/2008
160	Injury/illness was the result of an activity that is a benefit exclusion. Start: 09/30/2003 | Last Modified: 09/30/2007	4/1/2008
163	Attachment referenced on the claim was not received. Start: 06/30/2004 | Last Modified: 09/30/2007	4/1/2008
164	Attachment referenced on the claim was not received in a timely fashion. Start: 06/30/2004 | Last Modified: 09/30/2007	4/1/2008
165	Referral absent or exceeded. Start: 10/31/2004 | Last Modified: 09/30/2007	4/1/2008
168	Service(s) have been considered under the patient's medical plan. Benefits are not available under this dental plan. Start: 06/30/2005 | Last Modified: 09/30/2007	4/1/2008
169	Alternate benefit has been provided. Start: 06/30/2005 | Last Modified: 09/30/2007	4/1/2008
173	Service was not prescribed by a physician. Start: 06/30/2005 | Last Modified: 09/30/2007	4/1/2008
174	Service was not prescribed prior to delivery. Start: 06/30/2005 | Last Modified: 09/30/2007	4/1/2008
175	Prescription is incomplete. Start: 06/30/2005 | Last Modified: 09/30/2007	4/1/2008
176	Prescription is not current. Start: 06/30/2005 | Last Modified: 09/30/2007	4/1/2008
177	Patient has not met the required eligibility requirements. Start: 06/30/2005 | Last Modified: 09/30/2007	4/1/2008
178	Patient has not met the required spend down requirements. Start: 06/30/2005 | Last Modified: 09/30/2007	4/1/2008
179	Patient has not met the required waiting requirements. Start: 06/30/2005 | Last Modified: 09/30/2007	4/1/2008
180	Patient has not met the required residency requirements. Start: 06/30/2005 | Last Modified: 09/30/2007	4/1/2008
181	Procedure code was invalid on the date of service. Start: 06/30/2005 | Last Modified: 09/30/2007	4/1/2008
182	Procedure modifier was invalid on the date of service. Start: 06/30/2005 | Last Modified: 09/30/2007	4/1/2008

186	Level of care change adjustment. Start: 06/30/2005 | Last Modified: 09/30/2007	4/1/2008
191	Not a work related injury/illness and thus not the liability of the workers' compensation carrier. Start: 10/31/2005 | Last Modified: 09/30/2007	4/1/2008
194	Anesthesia performed by the operating physician, the assistant surgeon or the attending physician. Start: 02/28/2006 | Last Modified: 09/30/2007	4/1/2008
195	Refund issued to an erroneous priority payer for this claim/service. Start: 02/28/2006 | Last Modified: 09/30/2007	4/1/2008
197	Precertification/authorization/notification absent. Start: 10/31/2006 | Last Modified: 09/30/2007	4/1/2008
198	Precertification/authorization exceeded. Start: 10/31/2006 | Last Modified: 09/30/2007	4/1/2008
202	Precertification/authorization exceeded. Start: 10/31/2006 | Last Modified: 09/30/2007	4/1/2008
203	Discontinued or reduced service. Start: 02/28/2007 | Last Modified: 09/30/2007	4/1/2008
A8	Ungroupable DRG. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
B5	Coverage/program guidelines were not met or were exceeded. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
B8	Alternative services were available, and should have been utilized. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
B9	Patient is enrolled in a Hospice. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
B14	Only one visit or consultation per physician per day is covered. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
B16	`New Patient' qualifications were not met. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
B18	This procedure code and modifier were invalid on the date of service. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
B20	Procedure/service was partially or fully furnished by another provider. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
B23	Procedure billed is not authorized per your Clinical Laboratory Improvement Amendment (CLIA) proficiency test. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008

Deactivated Codes

Code	Current Narrative	Implementation Date
25	Payment denied. Your Stop loss deductible has not been met. Start: 01/01/1995 | Stop: 04/01/2008	4/1/2008
126	Deductible -- Major Medical Start: 02/28/1997 | Stop: 04/01/2008 | Last Modified: 09/30/2007 Notes: Use Group Code PR and code 1.	4/1/2008
127	Coinsurance -- Major Medical Start: 02/28/1997 | Stop: 04/01/2008 | Last Modified: 09/30/2007 Notes: Use Group Code PR and code 2.	4/1/2008
145	Premium payment withholding Start: 06/30/2002 | Stop: 04/01/2008 | Last Modified: 09/30/2007 Notes: Use Group Code CO and code 45.	4/1/2008
A4	Medicare Claim PPS Capital Day Outlier Amount. Start: 01/01/1995 | Stop: 04/01/2008 | Last Modified: 09/30/2007	4/1/2008

Claim Status Category Code and Claim Status Code Update

MLN Matters Number: MM5947
Related Change Request (CR) #: 5947
Related CR Release Date: February 29, 2008
Related CR Transmittal #: R1468CP
Effective Date: April 1, 2008
Implementation Date: April 7, 2008

Provider Types Affected
Physicians, providers, and suppliers who submit Health Care Claim Status Transactions to Medicare contractors (carriers, Medicare Administrative Contractors (A/B MACs), Durable Medical Equipment Medicare Administrative Contractors (DME MACs), fiscal intermediaries (FIs), and Regional Home Health Intermediaries (RHHIs)).

Provider Action Needed
This article is based on Change Request (CR) 5947 which indicates there have been updates to the Claim Status Category Codes and Claim Status Codes.

All code changes approved during the October 2007 meeting of the national Code Maintenance Committee have been posted at http://www.wpc-edi.com/content/view/180/223/ and will become effective April 1, 2008.

Background
The Health Insurance Portability and Accountability Act (HIPPA) requires all health care benefit payers, including Medicare, to use only Claim Status Category Codes and Claim Status Codes approved by the national Code Maintenance Committee. These codes are used in the X12 276/277 Health Care Claim Status Request and Response format to explain the status of submitted claim(s).

The decisions about additions, modifications, and retirement of existing Claim Status Category and Claim Status codes made at the October 2007 meeting of the national Code Maintenance Committee were posted at http://www.wpc-edi.com/content/view/180/223/ on November 5, 2007. These updates are effective April 1, 2008 and are to be used in editing of all X12 276 transactions processed by Medicare contractors on or after April 7, 2008.

Additional Information
To see the official instruction (CR5947) issued to your Medicare FI, carrier, DME MAC, or A/B MAC, refer to http://www.cms.hhs.gov/Transmittals/downloads/R1468CP.pdf on the CMS website.

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

Importance of Supplying Correct Provider Identification Information Required in Items 17, 17a, 24K, and 33 of the Form CMS-1500 (12-90), and the Electronic Equivalent

MLN Matters Number: SE0529 Revised

This article was revised on March 11, 2008, to clarify that all references to the form should state CMS-1500 (12-90). Providers may also want to refer to MLN Matters article MM5060 at http://www.cms.hhs.gov/MLNMattersArticles/downloads/mm5060.pdf, which states the requirements for the newer form, CMS-1500 (08-05). The previous revision to the article added a reference to MLN Matters MM5890 (http://www.cms.hhs.gov/MLNMattersArticles/downloads/mm5890.pdf). MM5890 stated that effective with claims received on or after May 23, 2008, Medicare will not pay for referred or ordered services or items, unless the fields for the name and NPI of the ordering, referring and attending, operating, other, or service facility providers are completed on the claims.

Provider Types Affected
Physicians, providers, and suppliers who bill Medicare Carriers, including Durable Medical Equipment Medicare Administrative Contractors (DME MACs)

Provider Action Needed
The Centers for Medicare & Medicaid Services (CMS) would like to remind providers and their billing staffs of the importance of reporting the correct provider identification information in items 17, 17a, 24K, and 33 of the Form CMS-1500 (12-90), or the electronic equivalent. This information is critical for accurate and timely processing and payment of your claims.

Additional Information
Please be aware of the following instructions:

Items 17 and 17a
On the Form CMS-1500 (12-90), or electronic equivalent, the provider must submit the appropriate referring or ordering physician name in item 17, and the Unique Physician Identification Number (UPIN) of that referring/ordering physician in item 17a. These are required fields when a service was ordered or referred by a physician. When a claim involves multiple referring and/or ordering physicians, you must prepare a separate claim submission for each ordering/referring physician.

Item 17
Enter the name of the referring or ordering physician if the service or item was ordered or referred by a physician.

Item 17a
Enter the UPIN of the referring/ordering physician listed in item 17.

- **Referring physician** - is a physician who requests an item or service for the beneficiary for which payment may be made under the Medicare program.
- **Ordering physician** - is a physician or, when appropriate, a non-physician practitioner who orders nonphysician services for the patient. See

Pub. 100-02, *Medicare Benefit Policy Manual*, Chapter 15 for non-physician practitioner rules. Examples of services that might be ordered include diagnostic laboratory tests, clinical laboratory tests, pharmaceutical services, durable medical equipment, and services incident to that physician's or non-physician practitioner's service.

The ordering/referring requirement became effective January 1, 1992, and is required by §1833(q) of the Act. All claims for Medicare covered services and items that are the result of a physician's order or referral shall include the ordering/referring physician's name and UPIN. This includes parenteral and enteral nutrition, immunosuppressive drug claims, and the following:

- Diagnostic laboratory services
- Diagnostic radiology services
- Portable x-ray services
- Consultative services
- Durable medical equipment

Claims for other ordered/referred services not included in the preceding list shall also show the ordering/referring physician's name and UPIN. For example, a surgeon shall complete items 17 and 17a when a physician refers the patient. When the ordering physician is also the performing physician (as often is the case with in-office clinical laboratory tests), the performing physician's name and assigned UPIN appear in items 17 and 17a.

When a service is incident to the service of a physician or non-physician practitioner, the name and assigned UPIN of the physician or non-physician practitioner who performs the initial service and orders the non-physician service must appear in items 17 and 17a.

All physicians who order or refer Medicare beneficiaries or services must obtain a UPIN even though they may never bill Medicare directly. A physician who has not been assigned a UPIN must contact the local Medicare carrier to obtain the UPIN. A list of toll free numbers of the Medicare carriers is available at: http://www.cms.hhs.gov/apps/contacts/ on the CMS website.

When a physician extender or other limited licensed practitioner refers a patient for consultative service, the name and UPIN of the physician supervising the limited licensed practitioner must appear in items 17 and 17a.

When a patient is referred to a physician who also orders and performs a diagnostic service, a separate claim form is required for the diagnostic service. Enter the original ordering/referring physician's name and UPIN in items 17 and 17a of the first claim form. Enter the ordering (performing) physician's name and UPIN in items 17 and 17a of the second claim form (the claim for reimbursement for the diagnostic service).

Item 24K (See note above to reference MM5060, which changes the requirement for Item 24K.)
Enter the **provider identification number (PIN)** of the performing provider of service/supplier in item 24K if the provider is a member of a group practice. When several different providers of service or suppliers within a group are billing on the same Form CMS-1500 (12-90), or electronic equivalent, show the individual PIN of each performing provider in the corresponding line item. In the case of a service provided incident to the service of a physician or non-physician practitioner, when the person who ordered the service is not supervising, enter the PIN of the supervisor in item 24K.

UPINs are not appropriate identifiers for item 24K.

Item 33
Enter the provider of service/supplier's billing name, address, ZIP code, and telephone number. **This is a required field**.

For a provider who is **not** a member of a group practice (e.g., private practice), enter the PIN at the bottom of item 33 for paper claims. The PIN should be entered on the **left** side, next to the PIN# field.

If a group practice is billing, then the **group PIN** is to be placed in item 33 for paper claims. Enter the group PIN at the bottom of item 33 on the **right** side, next to the GRP# field. Enter the PIN for the performing provider of service/supplier who is a member of that group practice in item 24K.

Suppliers billing a DME MAC will use the National Supplier Clearinghouse (NSC) number in this item.

Note: When implemented, the National Provider Identification (NPI) number will replace the PIN and UPIN. At that time, you will use the NPI number in items 17a, 24K, and 33.

The above instructions are included Chapter 26 of the *Medicare Claims Processing Manual*. That manual is available at http://www.cms.hhs.gov/Manuals/IOM/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS018912 on the CMS website.

The *Medicare Benefit Policy Manual* may be found at http://www.cms.hhs.gov/Manuals/IOM/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS012673 on the CMS website.

COVERAGE

Platform Crutch Clarification

In an article titled "Platform Crutch Not Covered Effective April 1, 2008" published by NAS on February 19, 2008, it was noted HCPCS code E0118 would be denied as noncovered. After careful consideration, NAS determined that a noncovered denial was not the correct denial type for this item. The correct denial is a medical necessity denial.

Effective for services provided on/after April 1, 2008, E0118, crutch substitute, lower leg platform, with or without wheels, each, sometimes referred to as a Roll-A-Bout, will be denied not medically necessary and will be denied as supplier liable, unless a valid ABN is obtained and the GA modifier is reported on the claim.

COVERAGE CONT'D

LCD Revisions Summary

Summary Article for March 2008

Outlined below is a summary of the principal changes to the DME Local Coverage Determinations (LCDs) and Policy Articles (PAs) that have been revised for the March 2008 Publication. Please review the entire LCD and each related Policy Article for complete information.

****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 policy and/or article.**

AFO/KAFO	**LCD** Revision Effective Date: 01/01/2008 HCPCS CODES AND MODIFIERS: Added: A9283 **Policy Article** Revision Effective Date: 01/01/2008 NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES: Added: Noncoverage statement regarding A9283. CODING GUIDELINES: Added: Definition of A9283
Cervical Traction Devices	**LCD** Revision Effective Date: 01/01/2008 INDICATIONS AND LIMITATIONS OF COVERAGE Added: Coverage statement regarding E0856. HCPCS CODES AND MODIFIERS: Added: E0856
Continuous Positive Airway Pressure System (CPAP)	**LCD** Revision Effective Date: 01/01/2008 INDICATIONS AND LIMITATIONS OF COVERAGE: Added: Usual maximum quantity parameters for new codes A7027, A7028, A7029 HCPCS CODES: Added: A7027, A7028, A7029 Removed: K0553, K0554, K0555 **Policy Article** Revision Effective Date: 01/01/2008 CODING GUIDELINES: Substituted: New code A7027
Enteral Nutrition	**LCD** Revision Effective Date: 01/01/2008 INDICATIONS AND LIMITATIONS OF COVERAGE: Added B4087, B4088 to utilization statement Deleted B4086 from utilization statement HCPCS CODES AND MODIFIERS: Added B4087, B4088 Deleted B4086 Revised narrative for B4034
External Infusion Pumps	**LCD** Revision Effective Date: 01/01/2008 INDICATIONS AND LIMITATIONS OF COVERAGE: Removed statements about coverage of supplies used with insulin pumps from general coverage section. Moved statement about appropriate pump for use with epoprostinol/treprostinil from general coverage section to epoprostenol/treprostinil section. Moved statement about back-up pumps to Policy Article. Added statements about the appropriate pump for use with subcutaneous immunoglobulin, insulin pumps, and pump for use with epoprostinol/treprostinil based upon the coding guidelines. HCPCS CODES: Added: A9274 Revised J1562 DOCUMENTATION REQUIREMENTS: Removed ICD-9 requirement for insulin pump claims from paragraph describing general pump criteria. **Policy Article** Revision effective date: 01/01/2008 NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES: Added A9274 to statement about disposable infusion systems. Added a statement about backup equipment. CODING GUIDELINES: Modified the definition of disposable infusion systems to include A9274. Corrected subcutaneous immuneglobulin pump code to E0779 in paragraph that addresses K0552.

COVERAGE CONT'D

Glucose Monitors	**LCD** Revision Effective Date: 01/01/2008 HCPCS CODES: Added: A9276-A9278 **Policy Article** Revision Effective Date: 01/01/2008 NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES: Added: Codes for continuous glucose monitors.
Hospital Beds	**LCD** Revision Effective Date: 01/01/2008 INDICATIONS AND LIMITATIONS OF COVERAGE: Added E0328 and E0329 HCPCS CODES AND MODIFIERS: Added E0328 and E0329 **Policy Article** Revision Effective Date: 01/01/2008 CODING GUIDELINES: Added E0328 and E0329
Intravenous Immunoglobulin	New LCD and Policy Article.
Knee Orthoses	New LCD and Policy Article.
Oral Anticancer Drugs	**LCD** Revision Effective Date: 04/01/2008 HCPCS CODES AND MODIFIERS: Added Topotecan. **Policy Article** Revision Effective Date: 04/01/2008 NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES: Expanded range of payable codes. Added V58.11 ICD-9 CODES THAT ARE COVERED Removed V58.0-V58.10, V58.12. Added section for Topotecan. Added 162.2-162.9 for Topotecan
Orthopedic Footwear	**LCD** Revision Effective Date: 01/01/2008 HCPCS CODES: Added: A9283 **Policy Article** Revision Effective Date: 01/01/2008 NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES: Added: Noncoverage of A9283 CODING GUIDELINES: Added: Definition of A9283
Ostomy Supplies	**LCD** Revision Effective Date: 01/01/2008 INDICATIONS AND LIMITATIONS OF COVERAGE: Added: Usual maximum quantity for A5083 HCPCS CODES AND MODIFIERS: Added: A5083 **Policy Article** Revision Effective Date: 01/01/2008 Removed DMERC references
Oxygen	**LCD** Revision Effective Date: 01/01/2008 CMS NATIONAL COVERAGE POLICY: Added: NCD 240.2.1 HCPCS CODES AND MODIFIERS: Deleted: QR modifier DOCUMENTATION REQUIREMENTS: Deleted: Instructions for use of QR modifier
Patient Lifts	**LCD** Revision Effective Date: 0/01/2008 INDICATIONS AND LIMITATIONS OF COVERAGE: Added E1035 HCPCS CODES AND MODIFIERS: Added E1035 Revised E0630 DOCUMENTATION REQUIREMENTS: Added KX modifier instructions. Added Upgrade instructions **Policy Article** Revision Effective Date: 01/01/2008 CODING GUIDELINES: Added E1035.
Power Mobility Devices	**LCD** Revision Effective Date: 04/01/2008 INDICATIONS AND LIMITATIONS OF COVERAGE: Deleted: Requirement for ATP-certified individual to perform specialty evaluation. Clarified: Requirement for ATS or ATP-certified individual to be involved with the evaluation of patients for rehab PWCs.

COVERAGE CONT'D

Respiratory Assist Devices	**LCD** Revision Effective Date 01/01/2008 INDICATIONS AND LIMITATIONS OF COVERAGE: Revised Least Costly Alternative statements for E0741 and E0740 to reflect changed payment category for E0741. Removed 1999 transition criteria. Added A7027-A7029 to usual quantities table Removed K0553-K0555 from usual quantities table. Added E0471 to humidifier coverage statement. HCPCS CODES AND MODIFIERS: Added A7027-A7029 Removed K0553-K0555 DOCUMENTATION REQUIREMENTS: Removed 1999 transition requirements. **Policy Article** Revision Effective Date: 01/01/2008 CODING GUIDELINES: Removed definition for K0553 Added definition of A7027
Surgical Dressings	**LCD** Revision Effective Date: 01/01/2008 HCPCS CODES: Added: A6413 **Policy Article** Revision Effective Date: 01/01/2008 NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES: Added: Noncoverage of A6413 Added: Policy concerning payment for surgical dressings that are covered under other benefits. CODING GUIDELINES: Removed: Guidelines concerning dressings that slightly exceed the upper limits of the size range for a code. Added: Definition of A6413 Added: Instructions on coding dressings that contain silver. Revised: Guidelines concerning coding of surgical dressings that are covered under other benefits.
Urological Supplies	**LCD** Revision effective date: 04/01/2008 INDICATIONS AND LIMITATIONS OF COVERAGE: Revised indications for intermittent catheterization HCPCS CODES: Revised A5105 (Code effective 01/01/2008) APPENDICES: Removed definitions. **Policy Article** Revision Effective Date: 01/01/2008 CODING GUIDELINES: Revised guidelines for A5105. Added A4326.
Wheelchair Options and Accessories	**LCD** Revision Effective Date: 01/01/2008 INDICATIONS AND LIMITATIONS OF COVERAGE: Added: Coverage criteria for gear reduction wheel for manual wheelchair (E2227) Added: Replacement guidelines for lithium-based battery (E2397) HCPCS CODES: Added: E2227, E2228, E2312, E2313, E2397 Revised: E0705, E2205, E2373 **Policy Article** Revision Effective Date: 01/01/2008: NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES: Added: Statement concerning dual mode battery chargers. CODING GUIDELINES: Added: Guidelines for codes E2227, E2228, E2312, E2313, E2377 Added: Guidelines for standard proportional remote joysticks. Revised: Guidelines for E2373

Intravenous Immune Globulin – New Policy

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 provided a new benefit for intravenous immune globulin (IVIG) administered in the home setting effective for dates of service on or after January 1, 2004. Since this benefit was created there have been numerous HCPCS code changes for the drugs. In addition, questions about reimbursement for costs associated with administration are common.

This Local Coverage Determination (LCD) and related Policy Article (PA) summarize the statutory coverage requirements and provide HCPCS coding information and documentation requirements.

For complete information on the coverage of intravenous immune globulin, refer to the LCD (L27261) and PA (A47177).

Knee Orthoses – New Policy

On March 20, 2008, notice was posted for the new Knee Orthoses LCD and Policy Article. The effective date will be July 1, 2008, for all DME MAC jurisdictions.

The comment period for this policy draft began on September 9, 2004, and ended on October 25, 2004. After a thorough review of the comments presented, this policy was finalized by the contractors.

It is recommended that suppliers become familiar with the new Knee Orthoses Policy (L27058 and A47178) prior to its effective date to minimize effects on their billing process.

Nebulizers – Policy Revisions

Revisions of the Nebulizers Local Coverage Determination (LCD) and Policy Article (PA) have been released by the DME MACs. The major changes from the current policy are:

- HCPCS Code Changes
  - 2008 HCPCS Update
  - April changes to coding for albuterol and levalbuterol
- Coverage Changes
  - Claims for levalbuterol will be paid comparable to albuterol
  - Claims for DuoNeb will be paid comparable to individual unit dose vials of albuterol and ipratropium

HCPCS Code Changes

The 2008 HCPCS Update included new codes for non-compounded formoterol and compounded acetylcysteine, cromolyn, and pentamidine and revised narrative descriptions for non-compounded acetylcysteine, cromolyn, dornase alpha, iloprost, and pentamidine. These codes are effective for claims with dates of service on or after January 1, 2008.

The policy also includes codes J7611-J7614 for albuterol and Levalbuterol, which became effective on April 1, 2008. These codes replace codes J7602 and J7603, which were valid for claims with dates of service from January 1, 2008, to March 31, 2008. These codes changes were discussed in more detail in a recently published bulletin article titled Nebulizers – HCPCS Coding Changes.

Code Q4099 has been established for FDA-approved, non-compounded, unit dose formoterol fumarate inhalation solution (Perforomist). It is valid for claims with dates of service on or after April 1, 2008. One unit of service = 20 micrograms.

Coverage Changes

Because coverage changes in the Nebulizers LCD have been implemented in stages, it is helpful to provide some historical background. In March 2006, a draft revision of the Nebulizers policy was sent out for public comment. The major provisions of that draft policy were the downcoding of levalbuterol and DuoNeb and the elimination of coverage for compounded inhalation solutions. In December 2006, CMS initiated a National Coverage Analysis on beta adrenergic agonist inhalation solutions. As a result of this, the DME MACs and PSCs deferred addressing levalbuterol and DuoNeb downcoding. A revised Nebulizers policy was published in March 2007 and became effective on July 1, 2007. That revised policy eliminated coverage for compounded inhalation solutions. In September 2007, CMS published its final Decision Memo stating that it would not establish a national policy for beta agonist inhalation solutions. As a result of that determination, the DME MACs are now addressing the downcoding of levalbuterol and DuoNeb.

Effective for claims with dates of service on or after July 1, 2008, claims for non-compounded levalbuterol will be paid based on the allowance for the least costly medically appropriate alternative, non-compounded albuterol. One unit of service of code J7612 or J7614 will be paid comparable to one unit of service of code J7611 or J7613, respectively.

Claims for DuoNeb (J7620) will be paid based on the allowance for the least costly medically appropriate alternative, individual non-compounded unit dose vials of albuterol and ipratropium. One unit of service of code J7620 will be paid comparable to 2.5 units of service of code J7613 plus 0.5 units of service of code J7644 (ipratropium).

Glucose Monitors and Related Accessories and Supplies

Comprehensive Error Rate Testing (CERT) data and reports show glucose monitor supplies to have a high paid claims error rate in Jurisdiction D. Medicare contractors are required by the Centers for Medicare & Medicaid Services (CMS) to take appropriate actions to reduce the Medicare payment error rate.

NAS is required to monitor the utilization patterns of providers and perform medical review to determine medical necessity and proper coding practices. Claims related to these edits may be subject to the claims processing system edits that may suspend the claims. In the future, if data analysis of these service specific criteria indicates variance in billing practices, claims may be subject to medical review for validation of data analysis findings. Such reviews will require the supplier to provide additional documentation as described in the Local Coverage Determination (LCD) and shown below.

For all glucose monitors and related accessories and supplies, if the basic coverage criteria (1)-(5) are not met, the items will be denied as not medically necessary.

To be eligible for coverage, the patient must meet all of the following basic criteria:

1. The patient has diabetes (ICD-9 codes 250.00-250.93) which is being treated by a physician; and
2. The glucose monitor and related accessories and supplies have been ordered by the physician who is treating the patient's diabetes and the treating physician maintains records reflecting the care provided including, but not limited to, evidence of medical necessity for the prescribed frequency of testing; and
3. The patient (or the patient's caregiver) has successfully completed training or is scheduled to begin training in the use of the monitor, test strips, and lancing devices; and
4. The patient (or the patient's caregiver) is capable of using the test results to assure the patient's appropriate glycemic control; and
5. The device is designed for home use.

For all glucose monitors and related accessories and supplies, if the basic coverage criteria (1)-(5) are not met, the items will be denied as not medically necessary.

The quantity of test strips (A4253), lancets (A4259), and replacement lens shield cartridges (A4257) that are covered depends on the usual medical needs of the diabetic patient according to the following guidelines:

For a patient who is not currently being treated with insulin injections, up to 100 test strips and up to 100 lancets or one lens shield cartridge every 3 months are covered if criteria (a)-(c) are met:

For a patient who is currently being treated with insulin injections, up to 100 test strips and up to 100 lancets or one lens shield cartridge every month are covered if criteria (a)-(c) are met:

For a patient who is not currently being treated with insulin injections, more than 100 test strips and more than 100 lancets or one lens shield cartridge every 3 months are covered if criteria (a)-(f) are met:

For a patient who is currently being treated with insulin injections, more than 100 test strips and more than 100 lancets or one lens shield cartridge every month are covered if criteria (a)-(f) are met:

a. Coverage criteria (1)-(5) listed above for a glucose monitor are met.

b. The supplier of the test strips and lancets, or lens shield cartridge maintains in its records the order from the treating physician.

c. The beneficiary has nearly exhausted the supply of test strips and lancets, or useful life of one lens shield cartridge previously dispensed.

d. The treating physician has ordered a frequency of testing that exceeds the utilization guidelines and has documented in the patient's medical record the specific reason for the additional materials for that particular patient.

e. The treating physician has seen the patient and has evaluated their diabetes control within 6 months prior to ordering quantities of strips and lancets, or lens shield cartridges that exceed the utilization guidelines.

f. If refills of quantities of supplies that exceed the utilization guidelines are narrative statement that adequately documents the frequency at which the patient is actually testing or a copy of the beneficiary's log) or in the supplier's records (e.g., a copy of the beneficiary's log) that the patient is actually testing at a frequency that corroborates the quantity of supplies that have been dispensed. If the patient is regularly using quantities of supplies that exceed the utilization guidelines, new documentation must be present at least every six months.

If criteria (a)-(c) are not met, all testing supplies will be denied as not medically necessary. If quantities of test strips, lancets or lens shield cartridges that exceed the utilization guidelines are provided and criteria (d)-(f) are not met, the amount in excess will be denied as not medically necessary.

Suppliers must not dispense a quantity of supplies exceeding a beneficiary's expected utilization. Suppliers should stay attuned to atypical utilization patterns on behalf of their clients and verify with the ordering physicians that the atypical utilization is, in fact, warranted. Regardless of utilization, a supplier must not dispense more than a three-month quantity of glucose testing supplies at a time.

An order refill does not have to be approved by the ordering physician; however, a beneficiary or their caregiver must specifically request refills of glucose monitor supplies before

they are dispensed. The supplier must not automatically dispense a quantity of supplies on a predetermined regular basis, even if the beneficiary has "authorized" this in advance.

An order that only states "as needed" will result in those items being denied as not medically necessary.

A new order must be obtained when there is a change in the testing frequency.

The ICD-9 diagnosis code describing the condition that necessitates glucose testing must be included on each claim for the monitor, accessories and supplies.

If the patient is being treated with insulin injections, the KX modifier must be added to the code for the monitor and each related supply on every claim submitted. The KX modifier must not be used for a patient who is not treated with insulin injections.

If the patient is not being treated with insulin injections, the KS modifier must be added to the code for the monitor and each related supply on every claim submitted.

Additional documentation requirements apply to:

6. A diabetic patient who is not insulin-treated (KS modifier present) and whose prescribed frequency of testing is more often than once per day, or
7. A diabetic patient who is insulin-treated (KX modifier present) and whose prescribed frequency of testing is more often than three times per day.

When refills for quantities of supplies that exceed the utilization guidelines are dispensed, the documentation as described in criteria (d)-(f) in the Indications and Limitations of Coverage and/or Medical Necessity section must be available upon request.

Please refer to the LCD, Glucose Monitors number L196 for further information.

Erythropoiesis Stimulating Agents in Cancer and Related Neoplastic Conditions

MLN Matters Number: MM5818 Revised
Related Change Request (CR) #: 5818
Related CR Release Date: January 14, 2008
Related CR Transmittal #: R80NCD and R1413CP
Effective Date: July 30, 2007
Implementation Date: April 7, 2008

Note: This article was March 18, 2008, to correct the bullet on page 3 regarding the "Maintenance of ESA therapy" (See bullet in **bold**). It should have stated that the "starting dose if the hemoglobin level remains below 10 g/dL (or hematocrit is < 30%) 4 weeks after initiation of therapy and the rise in hemoglobin is > 1g/dL (hematocrit > 3%)." All other information remains the same.

Provider Types Affected
Providers and suppliers who bill Medicare contractors (carriers, fiscal intermediaries (FI), Regional Home Health Intermediaries (RHHI), Medicare Administrative Contractors (A/B MAC) and Durable Medical Equipment Medicare Administrative Contractors (DME MAC)) for administering or supplying Erythropoiesis Stimulating Agents (ESAs) for cancer and related neoplastic conditions to Medicare beneficiaries.

What You Need to Know
Following a National Coverage Analysis (NCA) to evaluate the uses ESAs in non-renal disease applications, the Centers for Medicare & Medicaid Services (CMS), on July 30, 2007, issued a Decision Memorandum (DM) that addressed ESA use in non-renal disease applications (specifically in cancer and other neoplastic conditions).

CR 5818 communicates the NCA findings and the coverage policy in the National Coverage Determination (NCD). Specifically, CMS determines that ESA treatment is reasonable and necessary for anemia secondary to myelosuppressive anticancer chemotherapy in solid tumors, multiple myeloma, lymphoma, and lymphocytic leukemia under specified conditions; and not reasonable and necessary for beneficiaries with certain other clinical conditions, as listed below.

The HCPCS codes specific to non-end-stage renal disease (ESRD) ESA use are J0881 and J0885. Claims processed with dates of service July 30, 2007, through December 31, 2007,do not have to include the ESA modifiers as the modifiers are not effective until January 1, 2008. However, providers are to begin using the modifiers as of January 1, 2008, even though full implementation of related system edits are not effective until April 7, 2008.

Make sure that your billing staffs are aware of this guidance regarding ESA use.

Background
Emerging safety concerns (thrombosis, cardiovascular events, tumor progression, and reduced survival) derived from clinical trials in several cancer and non-cancer populations prompted CMS to review its coverage of ESAs. In so doing, on March 14, 2007, CMS opened an NCA to evaluate the uses of ESAs in non-renal disease applications, and on July 30, 2007, issued a DM specifically narrowed to the use of ESAs in cancer and other neoplastic conditions.

Reasonable and Necessary ESA Use
CMS has determined that ESA treatment for the anemia secondary to a regimen of myelosuppressive anticancer chemotherapy in solid tumors, multiple myeloma, lymphoma, and lymphocytic leukemia is reasonable and necessary only under the following specified conditions:

- The hemoglobin level immediately prior to the first administration is < 10 g/dL (or the hematocrit is < 30%) and the hemoglobin level prior to any maintenance administration is < 10g/dL (or the hematocrit is < 30%.);
- The starting dose for ESA treatment is up to either of the recommended Food and Drug Administration (FDA) approved label starting doses for cancer patients receiving chemotherapy, which includes the,150 U/kg/3 times weekly or the 40,000 U weekly doses for epoetin alfa and the 2.25 mcg/kg/weekly or the 500 mcg once every three week dose for darbepoetin alpha;

COVERAGE CONT'D

- **Maintenance of ESA therapy is the starting dose if the hemoglobin level remains below 10 g/dL (or hematocrit is < 30%) 4 weeks after initiation of therapy and the rise in hemoglobin is > 1g/dL (hematocrit > 3%)**;
- For patients whose hemoglobin rises < 1 g/dl (hematocrit rise < 3%) compared to pretreatment baseline over 4 weeks of treatment and whose hemoglobin level remains < 10 g/dL after 4 weeks of treatment (or the hematocrit is < 30%), the recommended FDA label starting dose may be increased once by 25%. Continued use of the drug is not reasonable and necessary if the hemoglobin rises < 1 g/dl (hematocrit rise < 3%) compared to pretreatment baseline by 8 weeks of treatment;
- Continued administration of the drug is not reasonable and necessary if there is a rapid rise in hemoglobin > 1 g/dl (hematocrit > 3%) over any 2 week period of treatment unless the hemoglobin remains below or subsequently falls to < 10 g/dL (or the hematocrit is < 30%). Continuation and reinstitution of ESA therapy must include a dose reduction of 25% from the previously administered dose; and
- ESA treatment duration for each course of chemotherapy includes the 8 weeks following the final dose of myelosuppressive chemotherapy in a chemotherapy regimen.

Not Reasonable and Necessary ESA Use
Either because of a deleterious effect of ESAs on the underlying disease, or because the underlying disease increases the risk of adverse effects related to ESA use, CMS has also determined that ESA treatment is not reasonable and necessary for beneficiaries with the following clinical conditions:

- Any anemia in cancer or cancer treatment patients due to folate deficiency (diagnosis code 281.2), B-12 deficiency (281.1 or 281.3), iron deficiency (280.0-280.9), hemolysis (282.0, 282.2, 282.9, 283.0, 283.2, 283.9, 283.10, 283.19), bleeding (280.0 or 285.1), or bone marrow fibrosis;
- Anemia associated with the treatment of acute and chronic myelogenous leukemias (CML, AML) (205.00-205.21, 205.80-205.91), or erythroid cancers (207.00-207.81);
- Anemia of cancer not related to cancer treatment;
- Any anemia associated only with radiotherapy;
- Prophylactic use to prevent chemotherapy-induced anemia;
- Prophylactic use to reduce tumor hypoxia;
- Erythropoietin-type resistance due to neutralizing antibodies; and
- Anemia due to cancer treatment if patients have uncontrolled hypertension.

Claims Processing
Effective for claims with dates of service on or after January 1, 2008, Medicare will deny non-ESRD ESA services for J0881 or J0885 when:

- Billed with modifier EC (ESA, anemia, non-chemo/radio) when a diagnosis on the claim is present for any anemia in cancer or cancer treatment patients due to folate deficiency (diagnosis code 281.2), B-12 deficiency (281.1 or 281.3), iron deficiency (280.0-280.9), hemolysis (282.0, 282.2, 282.9, 283.0, 283.2, 283.9, 283.10, 283.19), bleeding (280.0 or 285.1), anemia associated with the treatment of acute and chronic myelogenous leukemias (CML, AML) (205.00-205.21, 205.80-205.91), or erythroid cancers (207.00-207.81).
- Billed with modifier EC for any anemia in cancer or cancer treatment patients due to bone marrow fibrosis, anemia of cancer not related to cancer treatment, prophylactic use to prevent cancer-induced anemia, prophylactic use to reduce tumor hypoxia, erythropoietin-type resistance due to neutralizing antibodies, and anemia due to cancer treatment if patients have uncontrolled hypertension.
- Billed with modifier EA (ESA, anemia, chemo-induced) for anemia secondary to myelosuppressive anticancer chemotherapy in solid tumors, multiple myeloma, lymphoma, and lymphocytic leukemia when a hemoglobin 10.0g/dL or greater or hematocrit 30.0% or greater is reported.
- Billed with modifier EB (ESA, anemia, radio-induced).

Note: Denial of claims for non-ESRD ESAs for cancer and related neoplastic indications as outlined in NCD 110.21 are based on reasonable and necessary determinations. A provider may have the beneficiary sign an Advance Beneficiary Notice (ABN), making the beneficiary liable for services not covered by Medicare. When denying ESA claims, contractors will use Medicare Summary Notice 15.20, *The following policies [NCD 110.21] were used when we made this decisio*n, and remittance reason code 50, *These are non-covered services because this is not deemed a `medical necessity' by the payer*. However, standard systems shall assign liability for the denied charges to the provider unless documentation of the ABN is present on the claim. Denials are subject to appeal and standard systems shall allow for medical review override of denials. Contractors may reverse the denial if the review results in a determination of clinical necessity.

Medicare contractors have discretion to establish local coverage policies for those indications not included in NCD 110.21

Medicare contractors will not search files to retract payment for claims paid prior to April 7, 2008. However, contractors shall adjust claims brought to their attention.

COVERAGE CONT'D

Additional Information
This addition/revision of section 110.21 of Pub.100-03 is an NCD. NCDs are binding on all carriers, FIs, quality improvement organizations, qualified independent contractors, the Medicare Appeals Council, and administrative law judges (ALJs) (see 42 CFR section 405.1060(a)(4) (2005)). An NCD that expands coverage is also binding on a Medicare advantage organization. In addition, an ALJ may not review an NCD. (See section 1869(f)(1)(A)(i) of the Social Security Act.)

The official instruction, CR5818, was issued to your contractor in two transmittals. The first is the NCD transmittal and that is available at http://www.cms.hhs.gov/Transmittals/downloads/R80NCD.pdf on the CMS website. The second transmittal revises the *Medicare Claims Processing Manual* and it is at http://www.cms.hhs.gov/Transmittals/downloads/R1413CP.pdf on the same site.

OXYGEN

Oxygen Certification Requirement Implemented

Effective for claims with dates of service on/after April 1, 2008, if an oxygen license/certification is required in the supplier's state and the supplier does not have an oxygen license/certification on file with the NSC, oxygen claims will be denied until the supplier updates its file and provides the correct licensure/certification to the NSC. The NSC requires a copy of the oxygen licensure/certification for proof of compliance with the state licensing/certification requirements. Suppliers will receive the claim adjustment reason code C0-172: Payment is adjusted when performed/billed by a provider of this specialty.

Suppliers can find the licensure/certification requirements on the NSC website at www.palmettogba.com/nsc. Select the Licensure Information link in the Tools and Top Links section. Then select the Licensure Information link and scroll down to find the link for the DMEPOS State License Directory.

Thirty-eight states require licenses and/or certifications to provide oxygen and/or oxygen related equipment. The NSC assigns an oxygen specialty code to all DMEPOS suppliers who have indicated they will be providing oxygen and/or oxygen related equipment on their Form CMS-855S enrollment application.

CMS regulations (see 42 CFR 424.57(c)) require all DMEPOS suppliers wishing to bill Medicare to meet all supplier standards. The standard in 42 CFR 424.57(c)(1) requires DMEPOS suppliers to operate their business and furnish Medicare-covered items in compliance with all applicable Federal and State licensure and regulatory requirements.

If a supplier should need to update its' file with its' intention of supplying oxygen and/or oxygen related equipment, the supplier must submit a "Change of Information" on the Medicare enrollment application (CMS-855S) application to the NSC along with any applicable licenses and/or certifications. The NSC is responsible for maintaining a central data repository for information regarding DMEPOS suppliers, which is transmitted to the four DME MACs.

The effective date for the specialty code annotation in the supplier's files will be the date that the NSC assigns the new or revised specialty code for newly enrolled DMEPOS suppliers or the date a DMEPOS supplier initially adds the specialty to their file via a CMS 855S Change of Information submission providing all required licensure/certification is valid. The effective date of the specialty code for existing DMEPOS suppliers is the date the DMEPOS supplier added or enrolled the specialty with the NSC, providing all required licensure/certification was and is valid.

Below is the table of HCPCS that are considered oxygen for purposes of the license/certification editing.

Oxygen HCPCS

HCPCS	Short Description
A4575	Hyperbaric O2 chamber disps
A4606	Oxygen probe used w oximeter
A4608	Transtracheal oxygen cath
A4616	Tubing (oxygen) per foot
E0400	Oxygen and related respirato
E0424	Stationary compressed gas 02
E0430	Oxygen system gas portable
E0431	Portable gaseous 02
E0434	Portable liquid 02
E0435	Oxygen system liquid portabl
E0439	Stationary liquid 02
E0440	Oxygen system liquid station
E0441	Oxygen contents, gaseous
E0442	Oxygen contents, liquid
E0443	Portable 02 contents, gas
E0444	Portable 02 contents, liquid
E0445	Oximeter non-invasive
E0455	Oxygen tent excl croup/ped t
E1353	Oxygen supplies regulator
E1355	Oxygen supplies stand/rack
E1375	Oxygen suppl nebulizer porta
E1377	Oxygen concentrator to 244 c
E1378	Oxygen concentrator to 488 c
E1379	Oxygen concentrator to 732 c
E1380	Oxygen concentrator to 976 c
E1381	Oxygen concentrat to 1220 cu
E1382	Oxygen concentrat to 1464 cu
E1383	Oxygen concentrat to 1708 cu
E1384	Oxygen concentrat to 1952 cu
E1385	Oxygen concentrator > 1952 c
E1388	Oxygen concentrator to 244 c

E1389	Oxygen concentrator to 488 c
E1390	Oxygen concentrator
E1391	Oxygen concentrator, dual
E1392	Portable oxygen concentrator
E1393	Oxygen concentrat to 1464 cu
E1394	Oxygen concentrat to 1708 cu
E1395	Oxygen concentrat to 1952 cu
E1396	Oxygen concentrator > 1952 c
E1400	Oxygen concentrator < 2 lite
E1401	Oxygen concentrator 2-3 lite
E1402	Oxygen concentrator 3-4 lite
E1403	Oxygen concentrator 4-5 lite
E1404	Oxygen concentrator > 5 lite
E1405	O2/water vapor enrich w/heat
E1406	O2/water vapor enrich w/o he
K0671	Portable oxygen concentrator
K0738	Portable gas oxygen system
Q0043	Stationary liquid oxygen sys
Q0046	Portable liquid oxygen sys r

Advance Determination of Medicare Coverage FAQs

Medical Review staff received the following questions about the Advance Determination of Medicare Coverage process in March.

Q1: Is an Advance Determination of Medicare Coverage (ADMC) required?

A1: No, this is a voluntary program. Beneficiaries and suppliers are not required to submit ADMC requests in order to submit claims.

Q2: What DME is eligible for an ADMC?

A2: The list of HCPCS for which an ADMC can be requested is located at www.noridianmedicare.com/dme/coverage/docs/admc_hcpcs_list.pdf

Q3: What is the life expectancy of a wheelchair?

A3: According to the Medicare Benefit Policy Manual, Publication 100-02, Chapter 15, Section 110.2 (C), "The reasonable useful lifetime of durable medical equipment is determined through program instructions. In the absence of program instructions, carriers may determine the reasonable useful lifetime of equipment, but in no case can it be less than 5 years. Computation of the useful lifetime is based on when the equipment is delivered to the beneficiary, not the age of the equipment. Replacement due to wear is not covered during the reasonable useful lifetime of the equipment. During the reasonable useful lifetime, Medicare does cover repair up to the cost of replacement (but not actual replacement) for medically necessary equipment owned by the beneficiary."

A new physician's order is required before replacing lost, stolen or irreparably damaged items to reaffirm the medical necessity of the item. Proof of loss or damage through documentation such as a police report, picture, or corroborating statement should be submitted or noted on the claim.

Q4: When submitting an ADMC, may we use Not Otherwise Classified codes?

A4: Yes, if there is not a code assigned to the item, you may use a NOC code. Please provide a detailed description of the item requested and explain why this item is medically necessary. An example of using a NOC code would be a customized item for the beneficiary's needs.

If you are uncertain about proper codes for DMEPOS items, please reference the SADMERC web site at www.palmettogba.com/sadmerc.