Jurisdiction D News from Noridian Administrative Services, LLC.

Happenings

February 2008
Issue No. 10

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

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Jurisdiction D DME MAC Supplier Contacts and Resources

Phone Numbers		
Interactive Voice Response System	1-877-320-0390	24 hours a day, 7 days a week for all functions except Claim Status and Beneficiary Eligibility, which are available 6 am to 6 pm CT Monday – Friday
Supplier Contact Center	1-866-243-7272	8 am to 5:30 pm CT Monday – Friday
Beneficiary Customer Service	1-800-633-4227	24 hours a day/7 days a week
Telephone Reopenings	1-888-826-5708	8 am – 4 pm CT
Electronic Data Interchange Help Desk	1-866-224-3094	8 am – 5 pm CT

Web site: www.noridianmedicare.com

Fax	
Reopenings and Redeterminations	888-408-7405
Administrative Simplification Compliance Act (ASCA)	888-523-8449
Refunds to Medicare	888-529-3666
MSP Inquires and Refunds	888-535-5114

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

Mailing Addresses	
Claims, Redetermination Requests and Correspondence Noridian Administrative Services PO Box 6727 Fargo ND 58108-6727	**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	**Electronic Data Interchange** CIGNA Government Services Attn: DMERC EDI PO Box 690 Nashville TN 37202
Administrative Simplification Compliance Act Exception Requests Noridian Administrative Services PO Box 6737 Fargo ND 58108-6737 Fax: 888-523-8449	**Program Safeguard Contractor** Medical Review IntegriGuard, LLC 2121 N 117 Avenue Suite 200 Omaha NE 68164 Fax: 402-498-2306

Reconsiderations and Administrative Law Judge Requests	
Qualified Independent Contractor	
Mailing Address RiverTrust Solutions, Inc. PO Box 180208 Chattanooga TN 37401-7208	**Courier Address** RiverTrust Solutions, Inc. 801 Pine Street Chattanooga TN 37402

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
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 but the Contact Center will be closed and will not be receiving incoming calls. On those days, Contact Center staff will be attending internal training, but you may receive calls from our staff about claims processing or education.

Holiday	Date
President's Day *	February 18, 2008
Good Friday	March 21, 2008
Memorial Day	May 26, 2008
Forth 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 17	Administrative Law Judge (ALJ)	Changed amount in controversy to $120	1/17/08
Chapter 16	Modifiers	Added Q0 and Q1; Added end date to QA and QV	1/3/08
Chapter 1	What is Medicare?	Replaced 2007 deductible with 2008 deductible	1/3/08
Chapter 6	Example of Assigned Claim	Changed $100 to $135	1/3/08
Chapter 6	Time Limit for Filing Claims	Removed 2002-2003 information and added 2006-2007 information	1/3/08
Chapter 16	Level II HCPCS Codes	Updated with 2008 additions, deletions, narrative changes	1/3/08
Chapter 16	Level II HCPCS Codes	Removed all codes deleted prior to and on December 31, 2004	1/3/08

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."

CMS Seeks Provider Input on Satisfaction with Medicare Fee-for-Service Contractor Services

MLN Matters Number: SE0750

Provider Types Affected
Sample of 35,000 Medicare providers served by Medicare Fee-for-Service (FFS) Contractors, including Medicare Administrative Contractors (A/B MACs), carriers, fiscal intermediaries (FIs), durable medical equipment Medicare Administrative Contractors (DME/MACs) and regional home health intermediaries (RHHIs))

Provider Action Needed
CMS offers providers the opportunity to voice your opinions about the services you receive from your FFS contractors. CMS announced it has begun its third annual provider satisfaction survey of Medicare FFS contractors who process and pay more than $280 billion in Medicare claims each year. The Medicare Contractor Provider Satisfaction Survey (MCPSS) is designed to gather quantifiable data on provider satisfaction with the performance of FFS contractors as well as aid future process improvement efforts at the contractor level. The survey is used by CMS as an additional measure to evaluate contractor performance. In fact, all MACs will be required to achieve performance targets on the MCPSS as part of their contract requirements by 2009.

CMS is sending the 2008 survey to about 35,000 randomly selected providers, including physicians and other health care practitioners, suppliers and institutional facilities that serve Medicare beneficiaries across the country. Those providers selected to participate in the survey will be notified by December 2007. The survey is designed so that it can be completed in about 15 minutes. Providers can submit their responses via a secure website, mail, fax, or over the telephone. CMS is urging all Medicare providers selected to participate in the survey by completing and returning their surveys upon receipt.

Be alert for a notification via e-mail, phone or mail by the survey contractor, Westat. If you are selected to participate in the survey, please take the time to complete and submit your survey responses upon receipt.

Background
The 2008 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 -- which are available to health care providers and contractors on at http://www.cms.hhs.gov/MCPSS on the CMS website. Last year's findings showed that 85 percent of respondents rated their contractors between 4 and 6.

Further, 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.

Additional Information
CMS plans to make the survey results publicly available in July 2008. For questions or additional information about the MCPSS please visit: http://www.cms.hhs.gov/MCPSS on the CMS website.

Refunds to Medicare

When submitting a voluntary refund to Medicare, please include the Refunds to Medicare form. This form will provide Medicare with the necessary information to process the refund properly. When filling out the form, be sure to refer to the Refunds to Medicare form instructions. This is an interactive form, which NAS has created to make it easy for you to type and print out. We've included a highlight button to ensure you don't miss required fields. A separate interactive form has been created for MSP Inquiries & Refunds. Please use the MSP form for MSP issues.

Processing of the refund will be delayed if adequate information is not included. Medicare may contact the supplier directly to find out this information before processing the refund. If the specific patient name, HIC or claim number information is not provided, no appeal rights can be afforded.

Suppliers are also reminded that "The acceptance of a voluntary refund in no way affects or limits the rights of the Federal Government or any of its agencies or agents to pursue any appropriate criminal, civil, or administrative remedies arising from or relating to these or any other claims."

Update to Medicare Deductible, Coinsurance and Premium Rates for 2008

MLN Matters Number: MM5830
Related Change Request (CR) #: 5830
Related CR Release Date: December 14, 2007
Related CR Transmittal #: R49GI
Effective Date: January 1, 2008
Implementation Date: January 7, 2008

Provider Types Affected

Providers who bill Medicare contractors (fiscal intermediaries (FI), regional home health intermediaries (RHHI), Medicare Administrative Contractors (A/B MAC), durable medical equipment Medicare Administrative Contractors (DME MAC) and carriers) for care rendered to Medicare beneficiaries.

FYI CONT'D

What You Need to Know

CR5830, from which this article is taken, instructs Medicare contractors to update the claims processing system with new Medicare rates for deductible, coinsurance and premium payment amounts for CY 2008, as published in the Federal Register, CMS-8033-N, on October 2, 2007.

Background

The details of CR5830 follow:

2008 Part A – Hospital Insurance (HI)

Beneficiaries who use covered Part A services may be subject to deductible and coinsurance requirements.

Hospital

- A beneficiary is responsible for an inpatient hospital deductible amount, which is deducted from the amount that the Medicare program pays the hospital for inpatient hospital services it furnishes in an illness episode.
- When a beneficiary receives such services for more than 60 days during an illness encounter, he or she is responsible for a coinsurance amount that is equal to one-fourth of the inpatient hospital deductible per-day for the 61st-90th day spent in the hospital.

Please note that an individual has 60 lifetime reserve days of coverage, which they may elect to use after the 90th day in a spell of illness. The coinsurance amount for these days is equal to one-half of the inpatient hospital deductible.

Skilled Nursing Facility

A beneficiary is responsible for a coinsurance amount equal to one-eighth of the inpatient hospital deductible per day for the 21st through the 100th day of Skilled Nursing Facility (SNF) services furnished during a illness episode.

These details are summarized in table 1A, below.

Table 1A

2008 Part A – Hospital Insurance (HI)			
Deductible	$1,024.00		
Coinsurance	**Hospital**		**Skilled Nursing Facility**
	Days 61-90	Days 91-150 (Lifetime Reserve Days)	Days 21-100
	$256.00	$512.00	$128.00

Most individuals age 65 and older (and many disabled individuals under age 65) are insured for Health Insurance (HI) benefits without a premium payment. In addition, the Social Security Act provides that certain aged and disabled persons who are not insured may voluntarily enroll, but are subject to the payment of a monthly Part A premium.

Since 1994, voluntary enrollees may qualify for a reduced Part A premium if they have 30-39 quarters of covered employment. When voluntary enrollment takes place more than 12 months after a person's initial enrollment period, a 2-year 10% penalty is assessed for every year they had the opportunity to (but failed to) enroll in Part A.

Details of this coverage are summarized in table 1B, below.

Table 1B

Voluntary Enrollees Part A Premium Schedule	
Base Premium (BP)	$423.00 per month
Base Premium with 10% Surcharge	$465.30 per month
Base premium with 45% Reduction	$233.00 per month (for those who have 30-39 quarters of coverage)
Base premium with 45% Reduction and 10% surcharge	$256.30 per month

2008 Part B - Supplementary Medical Insurance (SMI)

Under Part B, the Supplementary Medical Insurance (SMI) program, all enrollees are subject to a monthly premium. In addition, most SMI services are subject to an annual deductible and coinsurance (percent of costs that the enrollee must pay), which are set by statute. Further, when Part B enrollment takes place more than 12 months after a person's initial enrollment period, there is a permanent 10% increase in the premium for each year the beneficiary had the opportunity to (but failed to) enroll.

For 2008, the standard premium for SMI services is $96.40 a month; the deductible is $135.00 a year; and the coinsurance is 20%.

You should be aware that the Part B premium is influenced by the beneficiary's income. This influence is summarized in Table 2.

Table 2

Income Parameters for Determining Part B Premium			
Premium per month	Individual Income*	Joint Income (Married)^	Married but file separate#
$96.40	$82,000.00 or less	$164,000.00 or less	$82,000.00 or less
$122.20	$82,000.01-$102,000.00	$164,000.01-$204,000.00	
$160.90	$102,000.01-$153,000.00	$204,000.01-$306,000.00	
$199.70	$153,000.01-$205,000.00	$306,000.01-$410,000.00	$82,000.01-$123,000.00
$238.40	$205,000.01 or more	$410,000.01 or more	$123,000.01 or more

***Individual Income** = Beneficiaries who file an individual tax return (including those who are single, head of household, qualifying widow(er) with dependent child, or married filing separately who lived apart from their spouse for the entire taxable year)

^Joint Income = Beneficiaries who are married and lived with their spouse at any time during the taxable year, and also file a joint tax return.

#Married but File Separate = Beneficiaries who are married and lived with their spouse at any time during the taxable year, but file a separate tax return from their spouse

Additional Information

You can find the official instruction, CR 5830, issued to your Medicare contractor by visiting http://www.cms.hhs.gov/Transmittals/downloads/R49GI.pdf on the CMS website.

Individuals Authorized Access to CMS Computer Services - Provider Community (IACS-PC): The Second in a Series of Articles on IACS

MLN Matters Number: SE0753 Revised

Note: This article was revised on January 15, 2008, to add another question and answer to emphasize that potential users should only register once in IACS.

This article contains:

- 4 questions and answers about the registration process for provider organizations. (See NOTE below.)
- Links to the Quick Reference Guides for completing the registration process for provider organizations. (See NOTE below.)

NOTE: For purposes of the IACS-PC, "Provider Organizations" include individual practitioners who will delegate IACS-PC work to staff as well as their staff using IACS-PC.

Provider Types Affected

Physicians, providers, and suppliers (collectively referred to as providers) who submit fee-for-service claims to Medicare contractors (carriers, fiscal intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), and Medicare Administrative Contractors (A/B MACs)).

Special Note for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) suppliers. Do not register for IACS -PC at this time. DMEPOS suppliers may want to review the first MLN Matters article in this new series on IACS-PC, which can be found at http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0747.pdf on the Centers for Medicare & Medicaid Services (CMS) website.

Provider Action Needed

Even though these new Internet applications are not yet available, CMS recommends that providers take the time now to set up their online account so they can access these applications as soon as they are available. The first step is for the provider and/or appropriate staff to register for access through a new CMS security system known as the Individuals Authorized Access to CMS Computer Services - Provider Community (IACS-PC).

What Providers Need to Know

In the near future, the CMS will be announcing new online enterprise applications that will allow Medicare fee-for-service providers to access, update, and submit information over the Internet. CMS enterprise applications are those hosted and managed by CMS and do not include FI/Carrier/MAC Internet applications. Details of these provider applications will be announced as they become available.

Registering in IACS-PC

The provider community is the first in a series of IACS communities which are the front-door to protecting and allowing access to CMS enterprise applications. Communities are comprised of groups of users who provide a similar service to CMS and who need access to similar applications (ex. Providers need access to provider-related CMS applications). The next community which will become available in early 2008 is the FI/Carrier/MAC community. It will be comprised of users who work within Medicare contracting organizations (FI's, Carriers and MACs). Since many IACS communities will be added in the future, the IACS community's user instructions are generic to allow use by multiple communities. The rules and concepts across communities are very similar.

When given a choice in IACS to select your community, please select the "Provider Community".

The first MLN Matters article in this series provided an overview of the IACS-PC registration process as well as registration instructions for Security Officials (SOs) and individual practitioners using IACS-PC personally. This article can be found at http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0747.pdf on the CMS website.

Four Questions and Answers about the Provider Organization Registration Process

1. **How can I get registered in IACS-PC? Can I just figure it out by myself?**

We recommend that you use the reference guides as they contain detailed explanations of the role responsibilities, acceptable data formats and interpretations of error messages. To directly access IACS-PC, go to https://applications.cms.hhs.gov and then click on Enter CMS Applications Portal.

2. **I want to register as an SO. I do not have my organization's IRS CP-575. What else can I send?**

In addition to the CP-575, SOs may also submit copies of other official IRS documentation. An official IRS document should have the following information:

Required:

- IRS letterhead;
- Legal Business Name (not handwritten); and
- TIN/EIN (not handwritten).

Optional:

- Form Number in upper right; and
- Reference to a letter or form number in body of text.

Examples of acceptable IRS documents include, but are not limited to:

- Copy of IRS CP-575;
- Copy of IRS 147C Letter; or
- Copy of Federal Tax Deposit Coupon.

All documents received must be legible.

3. I will work for more than one provider, or serve in multiple roles in the same organization. Do I need to register in IACS separately for each organization or role?

No. Each user will receive only one IACS-PC User ID and password. If you will work for more than one provider, or have multiple roles in the same provider, register in IACS for one role. Once you receive approval and your user ID and password, you can add additional roles to your account.

Instructions for modifying your IACS profile will be released shortly. In the meantime, questions may be directed to the help desk as shown in the "Additional Help "section at the end of this article.

4. My organization is too small to fill all these roles. What should I do?

As few as 2 staff can be registered in IACS-PC for a provider organization to access CMS enterprise applications. The first person must register as a Security Official (SO), the second registers as a User Group Administrator (UGA). The UGA may access CMS applications as approved by the SO.

The Backup Security Official is an optional role. End users are only required for provider organizations with 10 or more IACS-PC users.

If you are an individual practitioner who will be using IACS-PC personally, please refer to the first MLN article which may be found at http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0747.pdf on the CMS website.

Quick Reference Guides for Completing the Provider Organization Registration Process
See flowchart at www.noridianmedicare.com/dme/news/docs/2008/01_jan/SE0753.pdf.

IACS-PC Registration Approval Process
1. Backup Security Official (BSO) Guide

BSOs will request access to an organization using the BSO Registration Quick Reference Guide at http://www.cms.hhs.gov/MMAHelp/downloads/iacs_backup_security_official_registration_qrg_12_06_07.pdf on the CMS website.

2. User Group Administrator (UGA) Guide

UGAs are the first user type able to request access to CMS web-based applications. Their task, during the registration process, is to create a provider or surrogate user group, or associate with an existing provider or surrogate user group. A provider user group is a group that can be created by a UGA within an existing provider organization.

Once the user group is created and approved by the SO/BSO, end users can then submit a request to register in IACS-PC and join that user group. The UGA will either approve or deny their request to join their user group. This is a way for users within an organization to form groups that align with business needs or any other logical grouping that is appropriate for that organization and ensure that the UGA appropriately approves each end user into their user group. The important thing to keep in mind is that the UGA will need to approve the end users in the user group for which s/he is responsible, so they should know everyone in their user group.

The UGA Registration Quick Reference Guide may be found at http://www.cms.hhs.gov/MMAHelp/downloads/iacs_user_group_administrator_registration_qrg_12_06_07.pdf on the CMS website.

Special note for UGAs of Surrogate User Groups
A surrogate user group is established by individuals or a company outside of the provider organization which performs Medicare work on behalf of the provider organization (a contractor for a provider organization, billing company, etc.). If you will be creating a surrogate user group, the UGA of the surrogate user group must be approved by the SO or BSO in the provider organization on whose behalf it performs work. For example: *Surrogate Billing Company ABC will work on behalf of Provider Organization XYZ. Once the Provider Organization XYZ is approved in IACS-PC, the Surrogate Billing Company ABC can register in IACS-PC and request to create a surrogate user group under the Provider Organization XYZ*. Once approved, the UGA of a surrogate user group is issued an IACS user ID that enables the UGA to associate with other provider organizations for which it performs work without registering again.

At this time, a new surrogate user group must be created for each provider organization with which a UGA wishes to associate. If a surrogate user group performs work on behalf of 3 different provider organizations, the UGA for the surrogate user group will need to make 3 different requests to create 3 different surrogate user groups, one for each provider with which the UGA needs to associate. If a provider organization does not appear in IACS-PC, they have not yet registered/been approved and you should contact them. You will not be able to associate with them until the provider appears in IACS-PC.

If the provider organization does appear in IACS-PC, each provider's SO or BSO must approve the request to associate that surrogate user group with their organization. Remember, as a surrogate user group, you will only be able to associate with provider organizations after those respective provider organizations and SOs have been approved in IACS-PC.

In the future, CMS will explore options for simplifying this process for contractors which perform work on behalf of more than one provider organization and also to allow surrogate user groups to associate to Individual Practitioners within IACS-PC.

3. An End User Registration Quick Reference Guide may be found at http://www.cms.hhs.gov/MMAHelp/downloads/iacs_end_user_registration_qrg_12_06_07.pdf on the CMS website.

4. Approver Quick Reference Guide

The Approver Quick Reference Guide provides step-by-step instructions that SOs, BSOs and UGAs will use to approve or deny user requests to register in IACS-PC. The Approver Quick Reference Guide can be found at http://www.cms.hhs.gov/MMAHelp/downloads/iacs_approver_qrg_12_07_07.pdf on the CMS website.

Next Steps in Accessing a CMS Enterprise Application
A third MLN article discussing the final steps in accessing

FYI CONT'D

CMS enterprise applications has been released on this issue, and may be found at http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0754.pdf on the CMS website.

Additional Help
The CMS has established an External User Services (EUS) Help Desk to assist with your access to IACS-PC. The EUS Help Desk may be reached by E-mail at EUSSupport@cgi.com or by phone on 1-866-484-8049 or TTY/TDD on 1-866-523-4759.

In addition, you can find an informative reference chart outlining the steps for accessing CMS enterprise applications at http://www.cms.hhs.gov/MLNProducts/downloads/IACSchart.pdf on the CMS website.

EDUCATIONAL

Upcoming Ask the Contractor Teleconferences

Noridian Administrative Services (NAS) is pleased to announce our upcoming schedule of teleconferences for 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 > Schedule of Events > 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 teleconferences for 2008 will be held at 3:00 pm CT on:

- March 12, 2008
- June 11, 2008
- September 10, 2008
- December 10, 2008

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

Ask the Contractor Teleconferences for Small Suppliers

Noridian Administrative Services will conduct the DME Ask the Contractor Teleconference to assist **small suppliers**. 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 > Schedule of Events > 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 2008 teleconferences for **small suppliers** will be held at 3:00 pm CT on:

- February 13, 2008
- May 14, 2008
- August 13, 2008
- November 12, 2008

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

NAS Cautions Providers to be Wary of "Fake" Websites

Noridian Administrative Services (NAS) strives to deliver our Medicare provider/supplier community with access to accurate information and that our customers can trust the information they are receiving comes from NAS as their Medicare contractor or the Centers for Medicare & Medicaid Services (CMS). Due to the volume of website visitors our www.noridianmedicare.com website receives, some companies have launched websites with a modified spelling of our website address in the hopes people will misspell our website address and be redirected to their "mock" website

for non-Medicare related purposes. NAS is unable to control this business practice of other companies; however, we encourage our providers to look for the NAS and CMS logos on the website address they enter and/or visit to assure the legitimacy of the website and related content.

December 2007 FAQs

Frequently Asked Questions on heating pads, supplies, oxygen, wrist/hand orthotics, power mobility devices, and CPAPs are provided by the Program Safeguard Contractor.

Heating pads and pump

Q1: Where is there coverage criterion for HCPCS E0217 (water circulating heat pad with pump) and HCPCS E0249 (pad for water circulating heat unit)?

A1: There is no Local Coverage Determination (LCD) for coverage of these items. In the *Medicare National Coverage Determinations Manual* (NCD), Chapter 1, Part 4, Section 280.1 - Durable Medical Equipment Reference List (Effective May 5, 2005), it notes: 'Heating Pads - Covered if contractor's medical staff determines patient's medical condition is one for which the application of heat in the form of a heating pad is therapeutically effective.'

See Publication 100-08, the *Medicare Program Integrity Manual*, Chapter 5 - Items and Services Having Special DME Review Consideration, Section 5.8 - Supplier Documentation and 5.9 - Evidence of Medical Necessity, for guidelines to follow to support these codes.

Quantity of supplies and frequency

Q2: I cannot locate an updated listing of codes and quantities allowed by Medicare for codes A4314 (insertion tray with drainage bag with indwelling catheter, Foley type, two-way latex with coating) and A4358 (urinary drainage bag, leg or abdomen, vinyl, with or without tube, with straps, each). Where do I locate such a list in the Noridian system?

A2: Refer to the LCDs and Policy Articles to find current information on codes and quantities for Durable Medical Equipment (DME). To access the LCDs from the NAS website, www.noridianmedicare.com, choose 'Local Coverage Determinations' from the DME drop-down menu and accept the end user agreement. Under 'Helpful Links' select either 'CMS Medicare Coverage Database – Current LCDs' or 'CMS Medicare Coverage Database – Current Articles.' This navigates to the CMS website where the policies and articles are located.

To access the National Coverage Determinations from the CMS website, www.cms.hhs.gov/, select 'Regulations and Guidance.' Under 'Guidance' select 'Manuals.' Next, select 'Internet-Only Manuals' from the left side. Finally, select 100-03 - *Medicare National Coverage Determinations Manual*.

Quantity of tracheal supplies

Q3: Where can I find the policy regarding the coverage and quantity limits for procedure code A4605 (tracheal suction catheters, closed system)?

A3: Access the LCDs and Articles to find current information on codes and quantities for DME. Instructions are in A2.

Oxygen

Q4: Is there an LCD available for pulse oximeter? The only information that was found was under oxygen equipment and it is essentially not covered. Please advise.

A4: There is not a policy on pulse oximeter, and it is not covered by Medicare.

Per the Policy Article for Oxygen and Oxygen Equipment - Effective January 2007 (A33677): 'Oximeters (E0445) and replacement probes (A4606) will be denied as noncovered because they are monitoring devices that provide information to physicians to assist in managing the patient's treatment.'

Q5: What equipment is included in the code E0431; assuming that the portable gas system is a cart, regulator and tank? How many tanks are included in that code?

A5: According to the HCPCS Medicare's National Level II Codes, 2007, and the LCD for Oxygen and Oxygen Equipment, code E0431 is a Portable Gaseous Oxygen System, rental; and it includes a portable container, regulator, flowmeter, humidifier, cannula or mask, and tubing. This would be for only one tank. Please refer to the LCD for Oxygen and Oxygen Equipment, L11457, Effective Date 10/1/1993, Revision Date 1/1/2007.

Wrist/hand orthotics

Q6: I am looking for criteria information on wrist/hand orthotics, but I cannot find it on your site. Can you help me out and tell me where I might find this information?

A6: There is no specific LCD for wrist hand orthotics; however, there is an LCD for Ankle - Foot/Knee - Ankle - Foot Orthosis (L142). Within the policy is information that could apply to the wrist/hand orthotics. This is found under the sections of 'Indications and Limitations of Coverage and/or Medical Necessity.'

> "For any item to be covered by Medicare, it must 1) be eligible for a defined Medicare benefit category, 2) be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, and 3) meet all other applicable Medicare statutory and regulatory requirements. For the items addressed in this medical policy, the criteria for "reasonable and necessary" are defined by the following indications and limitations of coverage and/or medical necessity.
>
> For an item to be covered by Medicare, a written signed and dated order must be received by the supplier before a claim is submitted. If the supplier bills for an item addressed in this policy without first receiving the completed order, the item will be denied as not medically necessary."

In the section of 'General Information' under 'Documentation Requirements' 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". 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.

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

The order must list the unique features of the base code that is billed plus every addition that will be billed on a separate claim line. The medical record must contain information which supports the medical necessity of the item and all additions that are ordered. An order is not necessary for the repair of an orthosis."

"For custom-fabricated orthosis, there must be documentation in the supplier's records to support the medical necessity of that type device rather than a prefabricated orthosis. This information must be available upon request."

Power mobility devices

Q7: There is some confusion on the date from when the 120 days to deliver the PMD start when the physician refers out to have a LCMP do part of the examination. Does the 120 days start from the date the client first saw the physician at their initial visit? Is it the initial visit to the physician that we should be basing the 120 days on or when the physician signs and dates the LCMP evaluation?

A7: Per the Article for Power Mobility Devices:

"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."

"The physician may refer the patient to a licensed/certified medical professional, such as a physical therapist (PT) or occupational therapist (OT), who has experience and training in mobility evaluations to perform part of the face-to-face examination."

Per the LCD for Power Mobility Devices:

"If the report of a licensed/certified medical professional (LCMP) examination is to be considered as part of the face-to-face examination (see Policy Article), there must be a signed and dated attestation by the supplier that the LCMP has no financial relationship with the supplier. (Note: Evaluations performed by an LCMP who has a financial relationship with the supplier may be submitted to provide additional clinical information, but will not be considered as part of the face-to-face examination by the physician)."

"The delivery of the PMD must be within 120 days following completion of the face-to-face examination. (Exception: For PWCs that go through the Advance Determination of Medicare Coverage (ADMC) process and receive an affirmative determination, the delivery must be within 6 months following the determination.)"

Q8: We have electric wheelchair requests for patients who have physical and cognitive deficits and also have fulltime caregivers. Our problem is how to apply the Medicare criteria for mobility assistive equipment when a caregiver is involved. Approving an electric wheelchair for a patient that is physically and cognitively challenged will probably not improve the patient's ability to "participate" in activities of daily living. It would seem that the caregiver could "push" the patient from room to room to accomplish these activities. Is there more guidance regarding caregivers as related to evaluation of whether a power mobility device is appropriate? What does Medicare mean by "participate?"

A8: One of the requirements per the LCD for Power Mobility Devices is: A power wheelchair is covered if: "Use of a power wheelchair will significantly improve the patient's ability to participate in MRADLs and the patient will use it in the home. For patients with severe cognitive and/or physical impairments, participation in MRADLs may require the assistance of a caregiver."

"Physicians shall document the examination in a detailed narrative note in their charts in the format that they use for other entries. The note must clearly indicate that a major reason for the visit was a mobility examination."

"Many suppliers have created forms which have not been approved by CMS which they send to physicians and ask them to complete. Even if the physician completes this type of form and puts it in his/her chart, this supplier-generated form is not a substitute for the comprehensive medical record as noted above. Suppliers are encouraged to help educate physicians on the type of information that is needed to document a patient's mobility needs."

The definition of "participate" is "to have a part or share in something". Therefore, with a caregiver assisting a beneficiary, they are both sharing in the mobility related activities of daily living (MRADL). The medical record documentation by the physician should reflect how a power wheelchair with a caregiver can enable the beneficiary to participate in their MRADLs.

See Centers for Medicare & Medicaid Services (CMS) Publication 100-08, *Medicare Program Integrity Manual*, Chapter 5 - Items and Services Having Special DME Review Considerations and Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 20, Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS).

Q9: Can the one time face to face for a power wheelchair be done by a qualified physician who does not regularly see the patient, such as a physician or nurse practitioner (NP) who just travels around to patients' homes or the patients go to urgency care, outpatient care centers, etc. just for the face to face to be done? This happens a lot in rural areas as the patient cannot get out and the NPs go to their homes. Then additional medical documentation is

obtained and added to the file to support the face to face that was done.

A9: As long as you get a face to face for a power wheelchair from a physician or NP, it will meet the requirement of having a face to face as long as the documentation supports the need for the PMD and all documentation meets the requirements for coverage. The face to face should have a detailed narrative note in their charts in the format that they use for other entries for patients' office visits.

Q10: On the Mobility Equipment Guidelines, the 45 days between script face to face and the statement of ordering physician, is it 45 calendar days or 45 business "working days"? This would make a difference.

A10: The 45 days from the face to face would be calendar days, not business days.

Q11: I need help with billing manual w/c rentals with accessories. Here are examples:
K0004 RR KH KX - QTY 1
E0973 RR KH LT RT - QTY 2
E0971 RR KH LT RT - QTY 2
E0978 RR KH
How do I code this? Is this correct? I used to bill quantity of 2 on armrest with LT, RT modifiers. I have now been told that the quantity is greater than one and must be only one.

A11: The listed coding is correct. Two units for each HCPCS can be billed since left and right are indicated. Some bill these as armrests, each and 2 units.

Per the Coding Guidelines in the Policy Article for Wheelchair Options/Accessories - Effective January 2007 (A19846): "Armrests. There is no separate billing/payment if fixed, swingaway, or detachable non-adjustable height armrests with arm pad are provided. Adjustable height armrests may be billed separately."

Q12: Where does it state specifically that Medicare does not cover auto racks for a wheelchair? I cannot find it on the list of items not covered.

A12: Auto racks are not considered medical in nature and therefore are not covered by Medicare. Wheelchairs and accessories are covered when the intent is to maintain the beneficiary's independence within the home for their mobility related activities of daily living (MRADLs).

CPAP

Q13: Can you please direct me on how to locate coverage criteria for ventilators (E0450)? I have not been able to locate this information, and I have to think that I am missing it.

A13: There are no specific coverage criteria on ventilators. See Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 15 - Covered Medical and Other Health Services, Section 110 - Durable Medical Equipment, 100.1 - Definition of Durable Medical Equipment and 120 - Prosthetic Devices.

Q14: I am trying to find information on the documentation and billing requirements for the following DME supplied from a hospital sleep lab. We want to make sure we understand the documentation requirements and the correct way to bill for these services before they start this. Please direct me to information on this.
A7030 Full face mask NU
A7038 Disposable filter NU
A7033 Lg. nasal pillow, Pair NU
A7039 Non-disposable filter NU
A7037 Tubing NU
E0562 Humidifier, Heated RR
A7035 Headgear NU
E0562 Humidifier, Heated UE
A7036 Chinstrap NU
E0601 CPAP Device RR
A7034 Comfort Gel Mask (Nasal Interface) NU

A14: Documentation requirements can be found in the CPAP LCD (L171) under 'Documentation Requirements.' Also, review the section on 'Indication and Limitation of Coverage and/or Medical Necessity' as the sleep study with the AHI results is most important to determine the medical necessity for CPAP. The LCD can be found at www.edssafeguardservices.eds-gov.com/. You can also access this site through the Noridian website at www.noridianmedicare.com.

To bill the correct way for the CPAP and supplies the most appropriate HCPCS code needs to be used to describe the unit/s billed and this must be determined by the provider. Any other questions regarding billing need to be directed to the Noridian Supplier Contact Center at 866-243-7272.

FAQs from the Documentation Prior to DME Claim Submission Workshops

The following questions and answers are from the Documentation web-based workshops. In some cases, the original answers given during the workshops may have been expanded to provide further detail.

Orders

Q1. Can anyone take a verbal order, i.e., over the phone, or does the person have to be clinical, such as a pharmacist?

A1. In general, anyone can take a verbal order, unless Federal and state licensure and regulatory requirements state otherwise. Licensure requirements vary from state to state and locality to locality, so please check with your state and local governments for the licenses required for your type of business.

Q2. If a written order states that the length of need is lifetime and the details of the order do not change, is a new written order ever required? Will a written order for lifetime ever expire?

A2. If the policy states a new order is required (i.e., surgical dressing require a new order every three months) a new order would need to be obtained at that time. In addition, if state licensure or state practice regulations require a new written order, the state law applies. For other situations, a new order is not required when lifetime length of need is stated if no other details change.

Q3. Is a new written order required every six months for beneficiaries who over-utilize glucose monitor testing supplies?

A3. The requirement for a new written order every 12 months was eliminated as of 07/01/05. However, a new order is required if any of the details change on the written order or if state regulations require a new order on a periodic or annual basis.

Q4. If the supplier receives a verbal order from the patient's physician and the written order is signed by a nurse practitioner, which should be listed as the referring physician?

A4. The referring physician information provided on the claim must match the information on the detailed written order.

Q5. Can we accept a WOPD that is electronically signed and dated?

A5. Yes, electronically signed and dated orders are acceptable.

Q6. Is a written order required in addition to the statement from the certifying physician for Therapeutic Shoes for Persons with Diabetes?

A6. If the prescribing physician is also the supplier, a separate order is not required, but the item provided must be clearly noted in the patient's medical record and a certifying statement from the physician who is managing the patient's systemic diabetic condition is required. If the prescribing physician is not the supplier, a completely detailed written order is required, in addition to the certifying statement from the physician who is managing the patient's systemic diabetic condition.

Q7. If a beneficiary purchased an item that does not have a physician's order, are suppliers required under mandatory claims submission laws to file that claim?

A7. You do not have to file a claim for DMEPOS items that do not have a physician or other licensed health care provider order on file, unless the beneficiary requests a formal determination by Medicare. Claims submitted for items without a physician or other licensed health care provider order require the EY modifier to be appended to the HCPCS code. Most DMEPOS items submitted with the EY modifier will deny as not medically necessary and a properly executed ABN is recommended.

Q8. Is a new order required for a new piece of equipment?

A8. A new order is required when an item is being replaced because the item is worn out or the patient's condition has changed. A new physician's order is required before replacing lost, stolen or irreparably damaged items to reaffirm the medical necessity of the item.

Q9. Should all supplies or accessories (i.e., CPAP or nebulizers supplies) be listed on the written order?

A9. Yes, the detailed written order should include appropriate information on the quantity used, frequency of change, and duration of need.

Q10. If a beneficiary has an order for an item but specifically requests that Medicare not be billed, are we still required to bill Medicare?

A10. This is a business decision. Mandatory claim filing requirements apply to all suppliers who provide **covered services** to Medicare beneficiaries. An ABN would not protect a supplier from liability if the beneficiary later requests a formal determination, unless you have a specific reason to believe the item will deny as not medically necessary.

Q11. If the patient's medical record does not corroborate the information we gathered during the intake process and the beneficiary does not qualify for the item, can we obtain an ABN for future rental months? What can we do about the months that have already been submitted?

A11. An ABN can be executed for the future rental months; however, if rental months have already been paid and you know the beneficiary does not qualify for the item a voluntary refund is recommended.

Q12. Is it acceptable for a supplier to prepare the written order, based on the verbal order, and then send it to the physician to review, sign and date to ensure all the required written order elements are listed?

A12. Someone other than the physician may complete the detailed description of the item. The treating physician must review the detailed description and personally sign and date the order to indicate agreement. However, the Power Mobility Device guidelines require the ordering physician to complete the written order with all 7 elements as listed in the Documentation section of the Local Coverage Determination within 45 days after completion of the face-to-face examination and prior to delivery of the PMD. For items requiring a WOPD, there would be no verbal order to base the written order on and therefore this must be personally completed by the physician.

Q13. The Tennessee board of pharmacy dictates a supplier must have a new written order every year. Does that apply to Medicare?

A13. Yes, all state regulation must be followed.

Q14. Is a new order required for replacement batteries?

A14. Yes, a new order is required when an item is replaced.

Q15. Do we need a new order for each and every repair to a power wheelchair?

A15. An order is not required for repairs. Medically necessary repairs are covered up to the replacement cost of the item.

Q16. Can a physician's note pad prescription that does not contain all the required elements of a complete written order be used for items requiring a written order prior to delivery (WOPD)?

A16. No, items requiring a WOPD must have a completely detailed written order prior to delivery.

Q17. Does the purchase of a cane require duration on the written order?

A17. Canes are categorized as an inexpensive and routinely purchased item. Since these items are most often purchased, rather than rented, duration of need is not required. For

DMEPOS, only items that are provided on a periodic basis, such as drugs or nutrition, require duration of need.

Medical Records

Q18. When medical records are required per the medical policy, are electronically maintained records acceptable?

A18. The DME MAC and DME PSC will accept copied, faxed or electronically maintained medical records.

Q19. Must a supplier have the beneficiary's medical record on file or is a prescription with a diagnosis code acceptable?

A19. A prescription with a diagnosis code is not sufficient medical documentation. Before submitting a claim to the DME MAC, the supplier must have on file a dispensing order (if the item is dispensed based on a verbal/dispensing order), the completely detailed written order, the CMN (if applicable), the DIF (if applicable), information from the treating physician concerning the patient's diagnosis, and any information required for the use of specific modifiers or attestation statements as defined in the Local Coverage Determination for that item. The supplier should also obtain as much documentation from the patient's medical record as they deem necessary to assure that coverage criteria for the item is met. If the information in the patient's medical record does not adequately support the medical necessity for the item, the supplier will be liable for the dollar amount involved unless a properly executed ABN has been obtained.

Q20. May a physician charge a supplier for copies of the beneficiary's medical record?

A20. Charging for paper copies of medical records is a business decision made by the physician's office and does not fall under Medicare jurisdiction.

Q21. When supplying a patient an external infusion pump for chemotherapy, why would you have to maintain medical records when chemotherapy is diagnosis driven?

A21. Neither a physician's order, a CMN or DIF, a supplier prepared statement nor a physician attestation by itself provides sufficient documentation of medical necessity, even though it is signed by the treating physician or supplier. There must be information in the patient's medical record that supports the medical necessity for the item and substantiates the answers on the CMN (if applicable) or DIF (if applicable) or information on a supplier prepared statement or physician attestation (if applicable).

CMN & DIF

Q22. Are date stamps and signature stamps allowed on the written order and CMN?

A22. Yes.

Q23. If a supplier switches their portable oxygen patients from standard cylinders to home filled cylinders, is a revised CMN required?

A23. No, a new CMN or written order is not required when switching between standard portable oxygen cylinders (E0431) and portable cylinders filled from a home compressor (K0738).

Q24. An initial enteral DIF is dated 01/11/07 and has a 6-month length of need (LON). Since recertification is no longer required, do I need a revised DIF dated 07/11/07 to show continued medical necessity?

A24. Yes, a revised DIF would be needed to extend the LON.

Q25. Can a supplier use white-out on a CMN to correct an error and then have the doctor initial the error?

A25. No, the physician must signify approval of the change by making a line through the error, inserting the corrected information and then initialing and dating the correction.

Q26. If a physician's employee fills out section B, can that employee make corrections and initial corrections on behalf of the physician?

A26. Yes. NAS would advise that a notation be made that this correction was discussed with the physician and they agreed to the change, along with documenting when this discussion took place.

Q27. If a revised CMN or DIF needs to be submitted and the initial CMN or DIF was an older version of the form, does the supplier now need to use the new version for the revision?

A27. Yes, effective 07/01/07 only the new CMNs and/or DIFs will be accepted.

Q28. Does a CPAP require a CMN?

A28. The CMN requirement for CPAP was removed on 04/01/02.

Q29. If we have a CMN for enteral feeding that was in place before it changed to a DIF, do we have to complete a DIF form?

A29. If there is a change in calories, number of days per week administered, route of administration, or if the length of need changes, a revised DIF is required.

Q30. Where are the interactive CMNs located?

A30. Not all CMNs have been converted to be interactive, but the ones that are available can be located at www.noridianmedicare.com/dme/forms.

Q31. Can CMNs for dates of service prior to 10/01/06 for external infusion pump or PEN patients still be sent in electronically?

A31. CMNs for external infusion pumps or PEN are not accepted after 07/01/07. This change is processing date specific, not date of service, so a DIF will be required.

Q32. When a supplier has already received an old CMN from the physician for a December 2006 date of service and the item has not yet been billed, does the supplier need to obtain the new CMN because your system will not accept the old version?

A32. Yes, the change is processing date specific and the new version of the CMN is required after 07/01/07.

Q33. Is a physician's signature stamp valid on a CMN?

A33. Yes, signature and date stamps are allowed on the most recent revisions of the CMN forms.

Q34. Now that CMNs are not required for hospital beds and wheelchairs, are suppliers required to have medical records in our files?

A34. If the coverage criteria are met for these items, the supplier should append the KX modifier to the HCPCS code. The KX modifier states, "Specific required documentation on file." Refer to question 19 also.

Q35. We are having problems submitting DIFs electronically. Whom should we contact for assistance?

A35. Contact EDI at 1-866-224-3094, between the hours of 8:00 am – 5:00 pm CT.

Q36. Is the ordering physician required to sign a DIF?

A36. No, since suppliers complete the DIF, not the ordering physician.

ABN

Q37. Is an indication of time when the beneficiary signed the ABN required?

A37. Documentation of what time the beneficiary signed the ABN may be important when the ABN is provided on the same day of delivery of the item. Medicare beneficiaries cannot be coerced into signing an ABN and should be allowed ample time to make an informed consumer decision. Therefore, documenting when these events occur on the day of delivery is suggested. In addition, this shows that the ABN was provided before the service was provided, rather than after the fact.

Q38. What should we do if Medicare pays for an item that we believe should not be covered and for which we have obtained an ABN and have reported the GA modifier on the claim?

A38. If you feel the item is not medically necessary and you have a properly executed ABN, we recommend that you request a refund and include a copy of the ABN indicating why the item is not medically necessary.

Q39. Who can sign an ABN if the beneficiary is not able to, and how do we know for sure they are whom they say they are?

A39. The following comes from CMS Program Memorandum AB-02-168:

> "The beneficiary or their authorized representative should sign the ABN. An authorized representative is a person who is acting on the beneficiary's behalf and in the beneficiary's best interests, and who does not have a conflict of interests with the beneficiary, when the beneficiary is temporarily or permanently unable to act for him or herself. If you receive an allegation that the person (not the beneficiary) who signed an ABN was not a properly authorized representative, use the following guidance in deciding if the beneficiary can be held liable. Ultimately, if a situation arises in which a beneficiary simply cannot receive an ABN and notice cannot be given to an authorized representative, the beneficiary is protected by not having received an ABN. A physician's or supplier's inability to give notice to a beneficiary directly or through an authorized representative does not allow the physician or supplier to shift liability to the beneficiary.
>
> The first consideration with respect to an "authorized representative" is the most important. An individual authorized under state law to make health care decisions, e.g., a legally appointed representative or guardian of the beneficiary (if, for example, the beneficiary has been legally declared incompetent by a court), or an individual exercising explicit legal authority on the beneficiary's behalf (e.g., in accordance with a properly executed "durable medical power of attorney" statement or similar document), may be the authorized representative of the beneficiary with respect to receiving ABNs.
>
> The second consideration with respect to an authorized representative is that she/he should have the beneficiary's best interests at heart. The third consideration for an authorized representative is that she/he should have no relevant conflict of interests with the beneficiary. Another possible consideration with respect to an authorized representative is whether the person is someone (typically, a family member or close friend) whom the beneficiary has indicated may act for him or her, but who has not been named in any legally binding document conveying such a role to that person. Finally, another possible consideration with respect to an authorized representative is a disinterested third party. While a beneficiary who is temporarily unable to act for himself or herself should have an authorized representative who can make decisions and receive notices for him or her, it is entirely possible that, in any particular case, especially where the beneficiary's inability to act has arisen suddenly (e.g., a medical emergency, a traumatic accident, an emotionally traumatic incident, disabling drug interaction, stroke, etc.), there may be no one who can be genuinely considered to be the beneficiary's choice as his or her authorized representative. In such a case, recourse may be made to a disinterested third party, such as a public guardianship agency, taking care to avoid any conflicts of interest."

Q40. Must the ABN list the supplier address and phone number or is this just a suggestion?

A40. The supplier must include their name, address and telephone number in the header of the ABN form.

Q41. Does the lack of the beneficiary's HICN make the ABN invalid?

A41. The physician or supplier should enter the patient's Medicare HICN, however an ABN is not invalid solely due to the lack of a Medicare HICN.

Q42. I was under the impression that an ABN was not valid for over utilization now that MUEs (medically unlikely edits) are in place. Can you elaborate?

A42. When any item or service is to be furnished for which Medicare has established a statutory or regulatory frequency limitation on coverage, or a frequency limitation on coverage on the basis of a National Coverage Decision (NCD) or on the basis of the Local Coverage Determination (LCD), a supplier may give an ABN to the beneficiary. However, Medically Unnecessary edits for excess charges due to units of service greater than established frequency limitations, may not be billed to the beneficiary. These denials are a "provider

liability" and this provision cannot be waived and is not subject to an ABN. These are CMS guidelines that apply to all DME MACs.

If you have concerns regarding specific CCI edits, please submit your comments in writing to:

National Correct Coding Initiative
Correct Coding Solutions LLC
P.O. Box 907
Carmel, IN 46082-0907

Q43. Is the patient's name required on the ABN?

A43. The lack of a patient name on the ABN would not make the ABN invalid, if the HIC and patient's signature were present on the form. Suppliers can complete this portion of the form for the beneficiary to ensure that this field does not get missed, however do not substitute the patient's name for the authorized representative who may sign the form on behalf of the patient.

Q44. If a patient is approved for Medicare based on a disability and the supplier discovers that Medicare is now effective retroactively, how are claims handled that are denied not medically necessary when an ABN was not obtained due to the patient not having Medicare at the time the item was provided?

A44. The supplier may appeal on the basis that they did not know and could not reasonably have been expected to know that Medicare would not pay.

Q45. If a patient does not have an order for covered DMEPOS items and does not want a claim filed to Medicare, you recommended obtaining an ABN anyway. Please explain why.

A45. This is a recommendation only. A supplier is not required to submit a claim for a DMEPOS item that has not been ordered by a health care professional. However, if the patient requests a formal determination from Medicare, the supplier **must** submit a claim per mandatory claim submission law. The supplier should file this claim with an EY modifier (no physician or other licensed health care provider order for this item or service). Most items that are processed with an EY modifier deny not medically necessary with a provider contractual obligation (except items which require an order by statute). Therefore, in order to protect the supplier from liability in the event a beneficiary wishes a formal determination at a later time, an ABN is recommended.

Q46. Can an ABN be used if documentation is not available to support medical necessity?

A46. If there is no documentation to support medical necessity and the supplier has made a good faith effort to obtain this documentation, obtaining an ABN is acceptable.

Q47. For how long is an ABN valid?

A47. One year is the limit for use of a single ABN for an extended course of treatment; if the course of treatment extends beyond one year, a new ABN is required for the remainder of the course of treatment or supply.

Q48. If a claim is submitted with a GA modifier because the patient does not meet the medical criteria and an ABN was correctly obtained, and then later medical necessity is established, do we need to remove the GA modifier for future claims for the same item? Also if a claim with the GA modifier was paid and medical necessity is established, do we need to submit a corrected code without the GA modifier?

A48. If medical necessity can be established on future claims, the GA modifier should be removed. If a claim meets medical criteria and is paid, even with a GA modifier, the supplier does not need to send in a corrected claim. The ABN is only an indication that the supplier believes Medicare may not pay for the service; the GA modifier does not mean that the claim will get denied.

Q49. Is place of service (oxygen dispensed to a beneficiary in a skilled nursing facility) an acceptable reason to obtain an ABN?

A49. If the item is covered under another part of Medicare, such as consolidated billing for Part A services, then an ABN is not appropriate. The supplier should look to the SNF for payment in this instance.

Q50. What is an unsolicited telephone contact?

A50. An unsolicited telephone contact is contacting a beneficiary to furnish covered items without the beneficiary written permission or when the supplier has not previously provided the item to the beneficiary. Refer to the Social Security Act, Section 1834 (A)(17)(A) for more information.

Q51. Is there anywhere that we can obtain a list of acceptable "because" reasons why a DMEPOS item may be denied for an Advance Beneficiary Notice?

A51. Refer to the Centers for Medicare & Medicaid Services (CMS) Program Memorandum AB-02-168 regarding ABN standards, which can be found at www.cms.hhs.gov/transmittals/downloads/ab02168.pdf.

Proof of Delivery

Q52. May deliveries be made prior to the end of usage for refills? For example. if the end of the beneficiary's usage ends on a weekend, is it acceptable to deliver the Thursday or Friday before?

A52. 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.

Q53. When we ship a product to a patient, can we use the ship date and not the date the product reaches the patient, as the date of service?

A53. Yes, when a supplier utilizes a shipping service or mail order, suppliers should use the shipping date as the date of service on the claim.

Q54. If we print a delivery ticket today, but are unable to deliver for a couple of days, is it acceptable to bill the signature date as the date of service?

A54. If a supplier is delivering directly to the beneficiary, the date of signature on the delivery slip must be the date that the DMEPOS item was received by the beneficiary or designee.

Q55. Is a new signature required every time an item is delivered to a beneficiary?

A55.Yes, the signature is required to prove the beneficiary received that item. Proof of delivery is a supplier standard, specifically standard 12.

Q56. If I discover that there is no proof of delivery, am I required to treat this as an overpayment and send a refund?

A56. Suppliers are required to maintain proof of delivery documentation in their files and maintain this documentation for seven years. Proof of delivery is required in order to verify that the beneficiary received the DMEPOS and is one of the supplier standards as noted in 42 CFR, 424.57(12). Any services, which do not have proof of delivery from the supplier, will be denied and overpayments recovered. Suppliers who consistently do not provide documentation to support their services may be referred to the OIG for investigation and/or imposition of sanctions.

Q57. In the detailed description area of the proof of delivery document, what exactly is required? Is size and color required?

A57. The detailed description should provide enough information to prove the item was delivered and received by the beneficiary. This is a business practice decision but we recommend that the delivery slip include: the patient's name, quantity delivered, a detailed description of the item being delivered, brand name, and serial number.

Beneficiary Authorization

Q58. Is a specific authorization for each drug required when dispensing nebulizers?

A58. No, a general authorization is fine. Keep in mind that all drug claims processed by DME MACs must be assigned. For all claims submitted on or after 01/01/05, payment shall be made to physicians and suppliers who have not obtained signed assignment of benefits (AOB) forms from beneficiaries when the service can only be paid on an assignment related basis.

Q59. Does the one-time authorization (signature on file) cover all items that we dispense to a Medicare beneficiary?

A59. No, the one-time authorization is for current and future billing of the same item or service. A supplier must obtain a new authorization for a new item that will be rented or purchased. For more information, see Chapter 6 of the Jurisdiction D Supplier Manual.

Q60. Where can we find documentation about the signature on file for each month for non-assigned rental claims?

A60. CMS Internet Only Manual, Publication 100-4, Medicare Claims Processing Manual, Chapter 1, Section 50.1.6(A)(4)(E).

Q61. If we received a one-time (lifetime) authorization from a beneficiary for therapeutic shoes, will a new authorization be required for additional shoes later on?

A61. No, a new authorization would only be required for a new item that is rented or purchased.

Miscellaneous

Q62. Is it a requirement to have a copy of the Medicare ID card?

A62. No, but NAS encourages suppliers to make a copy of the Medicare ID card for future reference, in the event a number is transposed or the beneficiary's name is misspelled.

Q63. If a patient has an order for a capped rental item, but does not qualify for coverage and does not want to rent the item, but would rather just purchase it, can the item be billed to Medicare as a purchase?

A63. No, claims processing for items that fall into the capped rental payment category cannot be processed as a purchase.

Q64. What is the purpose of audits performed by IntegriGuard?

A64. IntegriGuard is the Program Safeguard Contractor for Jurisdiction D. They perform medical review functions including pre- and post-pay medical review of claims, Progressive Corrective Action (PCA) reviews, Local Coverage Determination (LCD) development in an effort to protect the Medicare trust fund from fraud, abuse and billing errors.

Q65. Does the redetermination fax line apply to Jurisdiction C?

A65. No, this is for Jurisdiction D only. Each contractor processes their own Redeterminations and will have specific guidelines on how they will accept redetermination requests.

Q66. Where can we find the reference for the updated Medicare requirements regarding home environment assessments for ALL wheelchairs (standard, hemi, lightweight, power, POV/scooter)?

A66. All coverage criteria and documentation requirements can be located in the Local Coverage Determinations (LCDs) at www.edssafeguardservices.eds-gov.com/providers/dme/lcdcurrent.asp. Reference both the Wheelchair Bases and Power Mobility Devices topics to cover all types of wheelchairs and PMDs.

Q67. Could you clarify whether a podiatrist can prescribe a PMD?

A67. A podiatrist may not order a PMD. The claim will be denied as non-covered.

Q68. Is a new sleep study required if a patient requires a new CPAP after 5 years?

A68. No, the sleep study does not expire and will continue to substantiate that the patient met the coverage requirements for this item.

FAQs from the PMD Workshops

The following frequently asked questions (FAQs) from the Power Mobility Device (PMD) workshops held November 1 and 6, 2007. In some cases, the original answers given during the workshop may have been expanded to provide further detail.

Q1. Will assistive technology practitioner (ATP) evaluations be required for all PMD's?

A1. This answer has been revised from the answer provided during the workshop based upon the article posted to the Program Safeguard Contractor's website on December 1, 2007, which states in part as follows:

The current LCD lists two requirements that were scheduled to be implemented for claims with dates of service on or after April 1, 2008:

1. The specialty evaluation for patients receiving a Group 2 single power option or multiple power option PWC, any Group 3 or Group 4 PWC, or a push rim activated power assist device for a manual wheelchair must be performed by a RESNA-certified Assistive Technology Practitioner (ATP) specializing in wheelchairs or a physician who is board-certified in Physical Medicine and Rehabilitation.

After consideration of the issues, the PSCs have decided to remove this requirement from the policy.

2. A Group 2 single power option or multiple power option PWC, any Group 3 or Group 4 PWC, or a push rim activated power assist device for a manual wheelchair must be provided by a supplier that employs a RESNA-certified Assistive Technology Supplier (ATS) or Assistive Technology Practitioner (ATP) who specializes in wheelchairs and who has direct, in-person involvement in the wheelchair selection for the patient.

This requirement is being retained and will be effective for claims with dates of service on or after April 1, 2008.

Q2. Will the supplier need to have an ATP or an ATS or both on staff?

A2. The supplier will need to employ either a RESNA certified ATS or ATP who specializes in wheelchairs and who has direct, in-person involvement in the wheelchair selection for the patient receiving a Group 2 single or multiple power PWC, any Group 3 or Group 4 PWC, or a push rim activated power assist device for a manual wheelchair provided on/after April 1, 2008.

Q3. We believe the April 1, 2008, ATP or ATS requirement pertains to Group 2 with single or multiple power options PMDs and above. The supplier will need to have an ATS on staff but the specialty evaluation will need to be done by an ATP who is not on staff. Is this correct?

A3. On the date of the workshop this was a correct statement. However, with the reconsideration to the policy as noted above, the ATP requirement for the more complex PMDs has been removed from the policy.

The current requirement which states that patients receiving a Group 2 single power option or multiple power option PWC, any Group 3 or 4 PWC, or a push rim activated power assist device for a manual wheelchair must have "a specialty evaluation performed by a licensed/certified medical professional such as a PT or OT or a physician who has specific training and experience in rehabilitation wheelchair evaluations and that documents the medical necessity for the wheelchair and its special features" will remain in place.

Q4. Will an ATS be able to sign off on the paper work or will they need to do the actual evaluation?

A4. Beginning on April 1, 2008, an ATS will need to be employed by suppliers who provide the Group 2 single and multiple power option wheelchairs, any Group 3 or 4 PWC, or push-rim activated power assist devices for manual WCs. The ATS will need to be directly involved in the wheelchair selection for the patient. At this time there has been no instruction regarding signing off on the paper work.

Q5. What modifier should be used if the biller is unable to fit all modifiers (more than four) in the reporting field (item 24D of the CMS-1500 claim or its electronic equivalent)?

A5. The KB modifier is used when billing for beneficiary upgraded items for DMEPOS where the supplier obtained an ABN and there are more than four modifiers on the claim line.

The 99 modifier is used in any other situation when a claim line has more than four modifiers. The 99 is then placed in the fourth postion and the balance of the modifiers are placed in item 19 of the CMS-1500 claim form or the narrative of the electronically submitted claim.

Q6. Is there a modifier requirement, such as RP or RR, for the code K0462 (billing for temporary replacement equipment)?

A6. The K0462 does not require a modifier; however, if either an RP or an RR is appended to the code, the code will continue processing and will not reject as a billing error.

Q7. Is there a requirement that the physician's order and the date of the face to face not be the same as the date stamp that the supplier places on these documents when the documents are received from the physician?

A7. There is no such requirement. What was stated during the workshop is that both the written order and the report of the face-to-face examination should be date stamped when received from the physician to show the actual receipt date. The date stamp shows that the written order was received within 45 days of the face-to-face examination and that the report of the face-to-face examination was received by the supplier within 45 days of completion and prior to delivery of the PMD.

Q8. It has been indicated that the order for the PMD must be on the physician's prescription pad. May suppliers have printed pads with their information for the physician to use? Is an order on a pad such as this acceptable?

A8. A detailed written order on a supplier's letterhead is not acceptable. A supplier can, however, provide the physician with a plain white form with the seven required written order elements noted as follows:

- Name:
- Description of item ordered:
- Date of face-to-face:
- Diagnoses/Conditions:
- Length of need:
- Signature:
- Date:

Again, this must be on a **plain** piece of paper, not letterhead or with any reference to the supplier. NAS recommends that if you choose to provide the physician with this blank form, that you accompany it with a letter explaining what is needed in the written order. **The supplier/biller cannot complete any portion of this blank form.** This was verified as acceptable with Dr. Pilley, Jurisdiction D DME Medical Director.

Q9. Can an upgrade be used for equipment within the same HCPCS code description?

A9. An upgrade may be from one item to another item within a single HCPCS code. When an upgrade is within a single code, the upgraded item must include features that exceed the official code descriptor for that item.

Ask the Contractor Questions and Answers December 11, 2007

Prior to taking questions, NAS provided the following updates:

NPI

Effective October 29, 2007, all DME MACs began editing the NPI/legacy ID combinations for validity against the NPI crosswalk file. Where a match cannot be located on the crosswalk, claims are rejected or returned.

When the claim is rejected, the supplier should first verify that the correct NPI was submitted. If correct, next verify that the legacy identifier (NSC) number corresponds with the information on file with the National Plan and Provider Enumeration System (NPPES). NPPES data may be checked on-line at https://nppes.cms.hhs.gov.

Suppliers are encouraged to send a small number of claims using only the NPI. If no claims are rejected, then suppliers can gradually increase the volume. If any claim is rejected, verify the correct NPI was submitted. If submitted correctly, then data in either NPPES or the Medicare provider files should be corrected and testing done again. It is critical to start testing with your NPI now. For more information, see MLN Matters 5452, 5595, SE0725 and SE0659.

Claims Must Include NPI March 1, 2008

Effective March 1, 2008, Medicare claims must include an NPI in the primary supplier fields on the claim (i.e., the billing, pay-to supplier, and rendering supplier fields) or the claim will be rejected. 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 the legacy (UPIN) number, if you choose.

If you already bill using the NPI/legacy pair in the primary supplier fields, and your claims are processing correctly, now is a good time to submit a small number of claims containing only the NPI in the primary supplier fields. This test will serve to assure your claims will successfully process when only the NPI is mandated on all claims.

New Appeals Features

Effective January 1, 2008, suppliers may email questions and concerns regarding reopenings and redeterminations to dmeredeterminations@noridian.com.

Questions and concerns may include but are not limited to:

- Timely filing inquiries
- Appeal regulations
- Coverage questions
- Appeal rights
- Documentation requirements for redeterminations
- Redetermination/reopening request forms
- Redetermination letter wording
- Social Security laws
- Interpretation of denial messages

Confidential information cannot be e-mailed. This includes Protected Health Information (PHI), such as patient names, claim information, Health Insurance Claim (HIC) numbers, Social Security numbers, claim control numbers (CCNs) or supplier numbers. If you have a question that would contain PHI, please call our Contact Center.

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

NAS has also developed a Redetermination Time Limit Calculator to assist suppliers in submitting timely redetermination requests. This calculator is located in the Claims section under Reopenings and Redeterminations, Appeals Overview of the www.noridianmedicare.com DME website. Simply enter the date of the initial claim determination (remittance advice date) and the calculator will return the date by which the request must be received in the Medicare office based on the 120 day filing limit.

Medical Review Transition

Effective March 1, 2008, medical review functions will be transitioning from the Program Safeguard Contractors to the DME MACs. Medical review functions include: review of claims, creating and updating Local Coverage Determinations, processing Advance Determination of Medicare Coverage (ADMC) requests and CERT functions. Watch for more information on our website and in our email notices as NAS communicates how this transition will affect suppliers.

The following questions and answers are from the December 11, 2007, Ask-the-Contractor teleconference. In some cases, the original answers given during the call may have been expanded to provide further detail. These answers were current as of this event. Please check our web site for updates.

Questions dependent on specific examples for a response, where information was not submitted to NAS, have been eliminated from the Q and A. These suppliers are encouraged to call the Supplier Contact Center at 866-243-7272 for assistance.

Q1. I am submitting claims to NAS with date spans for example of January 1 through January 15, 2007, but when I receive the remittance advice, it shows January 1 through January 1, 2007. As a result I contact NAS who in turn looks at the claim and sees the error. When this happens the claim needs to be reprocessed which delays our ability to bill secondary insurance. I am wondering if NAS has heard of this problem from any other suppliers?

A1. NAS did have a similar situation with another supplier. When that supplier's remittance advice was sent to NAS for research, we found that it had been generated by the supplier's software. It appeared that the software was dropping the last digits of the date field. However, when NAS researched this supplier's claims it was found that each claim billed with HCPCS code A4222 (infusion supplies for external drug infusion pump, per cassette or bag) was billed without a date span. This supplier's claims were submitted electronically so either there is problem with this supplier's software regarding the billing of date spans or this supplier's billing service or the clearinghouse changed the date from a span to a specific date.

Q2. Is there a specific code that is replacing HCPCS code L1858 [KO, molded plastic, polycentric knee joints, pneumatic knee pads (CTI), custom fabricated] on January 1, 2008?

A2. Current HCPCS code L1846 [knee orthosis, double upright, thigh and calf, with adjustable flexion and extension joint (unicentric or polycentric), medial-lateral and rotation control, with or without varus/valgus adjustment, custom fabricated] should be used in place of L1858 for services provided on/after January 1, 2008.

Follow-up Question: Are we to continue using L1858? Are other codes changing?

Continue to use L1858 for all services provided before/on December 31, 2007. For services provided on/after January 1, 2008, use L1846.

NAS recommends that suppliers purchase the 2008 HCPCS Level II coding manual to have the most current and accurate coding information available. However, NAS will be publishing a list of the December 31, 2007, deleted codes and the January 1, 2008, new codes. Chapter 16 of the Supplier Manual will also be updated with the new and deleted codes.

Q3. Jurisdiction B published an article titled "Continuous Positive Airway Pressure (CPAP) Devices" on November 28, 2007, which stated that there is now a specific ICD-9 code for obstructive sleep apnea (327.23). Are the other codes, 780.57 (unspecified sleep apnea) and 780.53 (hypersomnia with sleep apnea, unspecified), now going to be disallowed?

A3. This article was published by Jurisdiction B based upon several questions they had received regarding the CPAP medical policy and documentation requirements. This article states in part as follows:

> The last time the DME Medical Directors looked at the ICD-9 codes there was not a specific code for Obstructive Sleep Apnea. Since then the ICD-9 code 327.23 has been established for Obstructive Sleep Apnea. The policy is very specific regarding the diagnosis that is required in order to meet coverage criteria; therefore this ICD-9 code should be used for CPAP claims instead of the general sleep apnea code.

NAS did review the policy and there are no specific ICD-9 codes listed to support medical necessity. The supplier should, however, report the most specific diagnosis code to support medical necessity which is described as follows in the medical policy:

> The patient must have a diagnosis of obstructive sleep apnea (OSA) documented by an attended, facility-based polysomnogram and meets either of the following criteria (1 or 2):

1. The apnea-hypopnea index (AHI) is greater than or equal to 15 events per hour; or,
2. The AHI is from 5 to 14 events per hour with documented symptoms of:
   a. Excessive daytime sleepiness, impaired cognition, mood disorders, or insomnia; or,
   b. Hypertension, ischemic heart disease, or history of stroke.

Q4. For some reason some of our CMNs are not going through even though we are putting information on them; we've been getting some denials with CO16 (Claim/service lacks information which is needed for adjudication). When I call the Supplier Contact Center, I am told to rebill electronically and not go through the redetermination process. However, when I follow this direction, the CMN still does not go through and by then the redetermination deadline is past. I also sent one CO16 denial to redeterminations but they returned it to me saying it did not require a redetermination and needed to be resubmitted. What do you suggest I do?

A4. A CO16 denial is given to unprocessable claims and no appeal rights are granted with these denials. Therefore, the claim needs to be corrected and rebilled.

NAS researched the two examples this supplier provided and found that in the first example the beneficiary had an active CMN on file for the same item beginning in 2006. When this happens the second CMN for the same HCPCS code will deny as a duplicate. In this case either the supplier is revising the initial CMN because there has been some change in the beneficiary's condition that warrants a revised CMN, or the beneficiary is getting the same item from a different supplier. If the beneficiary's condition has changed, then the supplier should resubmit the claim with a revised CMN.

If this is the first billing by the current supplier for the item requiring a CMN, then there needs to be information in the Medicare processing system that the original item corresponding to the initial CMN has been returned. Once that happens, the initial CMN will be given an end date and then the second supplier can rebill his claim with the new initial CMN.

The second issue involved a HCPCS code that always requires a narrative when it is billed. In this case it appears from the information provided that although the supplier instructed the biller on the required narrative, the narrative was not included when the claim was submitted electronically. Therefore, this charge should also be rebilled with the required narrative.

Q5. At a local conference I was told that I should have provided my existing oxygen patients with new or like new oxygen equipment when the new capped rental rules went into affect on January 1, 2006. Is that true and if so, where is it written?

A5. Section 5101(b) of the Deficit Reduction Act (DRA) of 2005 established a 36-month (3-year) limit or cap on monthly payments for stationary and portable oxygen equipment. This cap applies to oxygen equipment furnished on or after January 1, 2006. There is no mention in this section or in the CMS instructions addressing oxygen equipment that beneficiaries needed to be provided new equipment on January 1, 2006, if they had been provided oxygen equipment prior to that date.

Q6. We are located in Jurisdiction D, and we have some claims that are being denied saying that they have to be filed in Jurisdiction C. Am I to file these claims based on where the patient resides or where the services were rendered?

A6. Suppliers file DME claims to the appropriate jurisdiction based upon the beneficiary's permanent address. Jurisdiction D processes claims for basically everything west of the Mississippi River with the exception of Minnesota, Colorado, New Mexico, Oklahoma, Texas, Arkansas, and Louisiana. Minnesota is located in Jurisdiction B and the other states are located in Jurisdiction C. Claims for Jurisdiction C should be filed to CIGNA Government Services, PO Box 20010, Nashville, TN 37202.

If you are an electronic submitter, you should contact the EDI Help Desk at 1-866-224-3094 and advise them that you also submit claims to Jurisdiction C for processing. Once you are set up for this crossover, Jurisdiction D will forward your electronic claims to Jurisdiction C for processing. This is one of the many benefits of being an electronic claim submitter.

Q7. We are getting letters regarding claims related to a home health episode. The letters are stating the paid amount for these claims needs to be refunded to Medicare. Shortly thereafter, we receive another letter stating Medicare has offset the paid amount. When we receive the remittance advice after the first letter, we assume that Medicare has already taken the money back through the offset process, but later we receive yet another letter stating we owe the original overpaid amount plus interest. Can you explain how we are to know when to send the refund back and when Medicare has already taken the money back?

A7. When NAS receives notification from CMS that a particular, for example home health related, claim was paid in error by DME; we adjust that claim to basically say the claim was paid in error. This adjustment creates two forms, which are mailed within a few days of each other. One form is the remittance advice, which simply shows the supplier that there has been a change in the status of the claim. The other form is a letter containing details about the overpayment, including the reason for the overpayment. This letter requests repayment from the supplier within 30 days of the letter date and informs the supplier that interest will be assessed if repayment is not received by the thirtieth day. If NAS does not receive repayment within the 30 days, interest is applied to the accounts receivable (AR) and a second letter is sent requesting repayment of the new total (original amount plus interest). If repayment is not received by the fortieth day and the supplier has new claims to be paid by Medicare, that payment can be used to pay the AR. This is called an "offset." This type of offset will not occur before the fortieth day unless the supplier requests immediate offset.

If NAS receives a check after an offset has occurred on the fortieth day, Medicare guidelines dictate how the money from this check is used. If the check is postmarked within 30 days of the first letter date, it is re-issued to the supplier. Any interest that might have been added by mistake is also reissued. If the postmark date is after the 30 days and the supplier has another open AR, the check must be held by NAS until the second AR is 30 days old. If NAS does not receive a check for the second AR by the end of the 30-day period, the first check must be applied to the second AR.

A supplier can choose to use a future payment to offset the AR instead of mailing NAS a check. To do this, write the word "Offset" on the initial request letter and fax to 1-888-529-3666. The only page that NAS needs to process the offset is the page that contains both the supplier number **and** the DCN at the bottom. Generally this is the second page of the first request letter or the first page of the second request letter.

Q8. When is EDI going to transition to the Common Electronic Data Interchange (CEDI) system, and where can I go to download the user ID forms?

A8. Transition to the CEDI is planned for the spring of 2008. At this point the CEDI contractor has not been chosen and new forms have not been developed. Therefore, you should continue monitoring the Email list serve and the NAS web site for updates as they become available.

Q9. MLN Matters article SE0738 specified requirements that are no longer in the Glucose Monitors Medical Policy, such as the number of lancets and test strips needed per month and that a new prescription was needed every 12 months for lancets and test strips. These requirements are different from the current policy. Is the local coverage determination (LCD) for glucose monitors changing in the future to match this direction?

A9. SE0738 was revised on December 12, 2007, to remove the portions indicating the intial prescription needed to specify how many lancets and test strips were needed per month and that a new prescription for lancets and test strips

was needed every 12 months. The revised MLN Matters SE0738 was posted to the NAS website on December 27, 2007.

Q10. Is this teleconference going to address the requirements in getting RESNA certification, which will be a requirement for suppliers of higher-level power wheelchairs for services provided on/after April 1, 2008?

A10. NAS will not be addressing the requirements for RESNA certification. Instead, NAS recommends that you utilize the RESNA website at http://www.resna.org/ to address the certification requirements.

In addition, NAS provided the following update regarding a change to the Power Mobility Device LCD:

> The DME PSC medical directors received LCD reconsideration requests to revise the Power Mobility Devices LCD from the American Occupation Therapy Association, the American Physical Therapy Association, and the American Association for Homecare. Each group asked for deletion of the requirement that patients receiving rehab power wheelchairs on or after April 1, 2008, be evaluated by a RESNA-certified Assistive Technology Practitioner.
>
> The current LCD lists two requirements that were scheduled to be implemented for claims with dates of service on or after April 1, 2008:

1. The specialty evaluation for patients receiving a Group 2 single power option or multiple power option PWC, any Group 3 or Group 4 PWC, or a push rim activated power assist device for a manual wheelchair must be performed by a RESNA-certified Assistive Technology Practitioner (ATP) specializing in wheelchairs or a physician who is board-certified in Physical Medicine and Rehabilitation.

   After consideration of the issues, the PSCs have decided to remove this requirement from the policy.

2. A Group 2 single power option or multiple power option PWC, any Group 3 or Group 4 PWC, or a push rim activated power assist device for a manual wheelchair must be provided by a supplier that employs a RESNA-certified Assistive Technology Supplier (ATS) or Assistive Technology Practitioner (ATP) who specializes in wheelchairs and who has direct, in-person involvement in the wheelchair selection for the patient.

   This requirement is being retained and will be effective for claims with dates of service on or after April 1, 2008.

The following requirement which is in the current LCD will remain in place: Patients receiving a Group 2 single power option or multiple power option PWC, any Group 3 or Group 4 PWC, or a push rim activated power assist device for a manual wheelchair must have a "specialty evaluation that was performed by a licensed/certified medical professional, such as a PT or OT, or physician who has specific training and experience in rehabilitation wheelchair evaluations and that documents the medical necessity for the wheelchair and its special features."

Q11. What is the difference between hospital bed codes E0250 (hospital bed, fixed height, with any type side rails, with mattress) and E0290 (hospital bed, fixed height, without side rails, with mattress)? Is there a place on Noridian website to find out the monthly rental payment we would receive from Medicare for these items?

A11. The difference between the two hospital beds is that E0250 has side rails and E0290 does not have side rails.

You can locate the fees for DMEPOS on the Noridian website at www.noridianmedicare.com/dme/news/fees/index.html.

Q12. I had a recent situation where a long-term patient had a revised DME Information Form (DIF) that was not attaching to the claims I was submitting. As a result I needed to send a number of these claims to redeterminations. All the claims, with the exception of one with a date span of June 1 through June 6, 2007, processed beautifully. On the exception, Medicare processed and paid four of the six dates at issue but denied the other two dates on the basis that the patient was hospitalized for those two days. When I billed for those six days in June, I had no idea the patient was going into the hospital. Furthermore, I have never heard of Medicare going back and taking money away if they find out the patient was hospitalized during a billing period. In this case, the patient did receive a week's worth of supplies and perhaps even took that supply to the hospital to use while she was there. How would I know when I billed for those days that the patient would be in the hospital at the time? I can understand if I billed the supply (B4185 – parenteral nutrition solution, per 10 grams lipids) at the end of month knowing that the patient had been hospitalized; then I would be double billing.

A12. If this claim had processed prior to Medicare receiving the claim for the Part A covered hospital stay and it was determined that the service was payable, Medicare would have paid for the supply. However, because the claim initially denied, it needed to go through the redetermination process. At that point it was discovered that the patient was in a covered Part A stay. Parenteral nutrition services are considered part of the inpatient hospital payment and cannot be paid separately. Once this was discovered, there was no way that NAS could pay for the services at issue; the processing system will not allow payment in this situation, no matter what steps the adjudicator takes to process for payment. Based on this scenario, it would be to the supplier's benefit to not bill for services until the end of the month when it was known that the patient had been in a covered Part A hospital stay.

Q13. We received a notice from one of the DME regions advising us that we are going to be expected to keep a log for all CPAP patients stating that we have contacted the patient monthly and have checked off that they are using their CPAP equipment. Is Jurisdiction D going to require that we provide you this log whenever you do a review of one of our claims?

A13. Yes, when we complete a medical review of the a CPAP claim for continued coverage beyond the first three months of therapy, we need some kind of documentation that shows that you are communicating with the patient and know the patient is utilizing the equipment regularly. The LCD for the

CPAP states as follows regarding continued coverage beyond the first three months of therapy:

> On the fourth month's claim (and any month thereafter), the supplier must add a KX modifier to codes for equipment (E0601) and accessories only if both the "Initial Coverage" criteria and the "Continued Coverage" criteria in the "Indications and Limitations of Coverage and/or Medical Necessity" section of this policy have been met. **Suppliers must maintain documentation in their records that these criteria have been met and this must be available upon request**.
>
> If the supplier does not obtain information that the beneficiary is continuing to use the CPAP device in time for submission of the fourth or succeeding months' claims, the supplier may still submit the claims, but a KX modifier must not be added. However, if the supplier chooses to hold claims for the fourth and succeeding months until they determine that the beneficiary is continuing to use the device, those claims may then be submitted with the KX modifier.

Follow-up Question: If we do a 90-day download on compliance that is submitted to the sleep lab for follow up, would this be sufficient instead of the monthly log?

Yes, either the 90-day download on compliance or the monthly log will work. NAS just needs to know that the supplier is in contact with the beneficiary to assure the CPAP is being used and that the mask is working properly. If the beneficiary is not utilizing the CPAP, then billing for the service needs to be discontinued.

Q14. We have been billing E0424 (stationary compressed gaseous oxygen system, rental; includes container, contents, regulator, flowmeter, humidifier, nebulizer, cannula or mask and tubing) for one of our patients for at least two or three years. Recently, however, our claims are being denied on the basis that the number of days or units exceeds maximum. We initially billed for one tank but recently this patient has required up to four tanks over a period of three or four months. The patient also lives in an area without electricity. If the tank total is under the allowable, why are we getting denied?

A14. Oxygen is billed by the month and cannot be billed with span dates. What this means is that oxygen cannot be billed with more than one number of units. Therefore, if you are providing your patient with oxygen to last for more than one month, you will need to bill each month with the corresponding HCPCS code either on separate claims or on separate claim lines. Remember, you cannot bill oxygen into the future, so if you choose to bill for more than one month on the same claim, you will need to do that at the time of the final month.

Follow-up Question: What happens if the patient requires more than one tank of oxygen in a month? Shouldn't we be allowed up to the maximum allowance for the month regardless of how many tanks we provide?

The allowed amount for 2007 for the stationary gaseous system (E0424) is $198.40 per month regardless of how many tanks are supplied in the month. If the patient owns the system and the supplier is only providing the gaseous contents (E0441), Medicare's allowance for a month's worth of contents is $77.45, regardless of the number of tanks provided.

Q15. We are a hospital based DME company and have a patient in the nursing home that is no longer receiving skilled care. The patient is, however, using a wound therapy pump. We are continually getting conflicting billing answers such as not being able to bill while the patient is in the nursing home and another saying yes, we can if the patient is not receiving skilled care. Do I have to report the patient's residence as a skilled nursing facility or can I say it's the patient's home?

A15. You need to use the place of service that is most appropriate for your patient. The place of service for a patient in a nursing home not receiving skilled care is 32 (nursing facility) while a patient in a nursing home receiving skilled care is place of service code 31. There are only certain DMEPOS that are covered by Medicare in POS 31 or 32. In researching the billing of a negative pressure wound therapy pump (E2402), NAS found this item cannot be billed separately when the patient is in either POS 31 or 32. The nursing facility includes this item with their monthly billing.

Q16. When billing for labor, is it appropriate to bill the base labor charge of 60 minutes with 4 units, and then add units as appropriate for additional 15-minute increments? How do shipping charges get addressed when billing for labor and repairs?

A16. It is not appropriate to bill a base labor charge for 60 minutes and then add the actual time spent in additional 15 minutes increments. Medicare allows for the actual time spent on the repair in 15 minutes increments. Medicare will also allow for replacement parts. Any shipping and handling charges incurred when ordering a part from a manufacturer are included into Medicare's allowance for the replacement part; there is not separate allowance or codes for shipping and handling.

Follow-up Question: We contract with another company for our repairs, and the people we contract with bill us a base rate plus time. How am I to know exactly how long that repair took?

As a supplier it is your responsibility to understand the contract that you have established for the repair work you are billing. You are ultimately responsible for all the charges you bill to Medicare for payment.

Q17. I am having a problem with the way Medicare is crossing my claims over to Missouri Medicaid. MO Medicaid requires a header, which contains Noridian's payer information. The payer information consists of what was billed, what was allowed, what was paid, and what was charged to the patient. Recently some of these headers have also listed MO Medicaid secondary payer with no additional information. Because of this secondary payer information, we are getting errors from MO Medicaid saying they are unable to process our claim because of missing information.

A17. NAS researched the examples and found the problem was a result of the way the initial claim was submitted to NAS for processing. This electronic media claim (EMC)

was sent to NAS with the 2320 and 2330B loops reported. These loops should only be reported if the beneficiary has a Medigap insurance or if another insurance is primary and has also paid on the claim. When the supplier reported Missouri Medicaid in this loop, the processsing system sent this information to the Coordination of Benefits Contractor (COBC) who in turn sent it to MO Medicaid for processing. MO Medicaid couldn't process the claim because there were no allowed or paid amounts noted. Remember, Loops 2320 and 2330B should only be reported if another insurance has processed and paid on the claim or if a Medigap insurance is involved. Medicaid is not considered either.

Q18. We are not an ambulatory surgery center, but we do have the ability to perform some minor surgeries in our facility. When we do these minor surgeries, are we able to charge the DME MAC for the supplies we use?

A18. No, those supplies cannot be billed to the DME MAC. The definition of DMEPOS states that the item provided must be appropriate for use in the home. Surgical supplies are not appropriate for home use. When Medicare Part B reimburses you for performing the surgical procedure, any supplies that you use are included in the allowance for the surgical code that you billed.

Follow-up Question: Sometimes we need to give patients extra supplies when they run out, such as a catheter or drainage bag. Am I to assume that those can be billed to DME?

Those extra supplies cannot be billed to the DME MAC. Normally any additional supplies that you provide the patient following a surgery are also included in the allowance for the surgery and additional postoperative care.

Q19. Has a form letter been developed that suppliers can use to educate our oxygen patients regarding the new oxygen capped rental regulations?

A19. No, a letter has not been developed.

Follow-up Question: How do we go about telling our patients that after 36 months the oxygen equipment will belong to them?

You would do this education as you would with any DME item that you are providing. In addition, there are no regulations that say you cannot develop your own form letter if that would help explain the capped rental regulations regarding oxygen equipment to your patients.

Q20. The CPAP policy requires two hours of recorded sleep and the respiratory assist device (RAD) policy requires two hours of recording time to determine the apnea-hypopnea index (AHI). Is it possible that this is an unintended discrepancy? If not, then how do we rule out CPAP without following the CPAP guidelines?

A20. NAS is aware of this difference.

The CPAP is generally used to treat patients with obstructive sleep apnea (OSA) by providing single levels of air pressure from a flow generator, via a nose mask, through the nares to prevent the collapse of the oropharyngeal walls and the obstruction of airflow during sleep, while the RAD is used to provide non-invasive positive pressure respiratory assistance (NPPRA) therapy to patients with restrictive thoracic disorders, severe chronic obstructive pulmonary disease (COPD), central sleep apnea (CSA), or OSA. The two hours of recorded sleep time for CPAP coverage is based on the wording from Section 240.4 of the National Coverage Determination (NCD) Manual (Publication 100-03 of the Internet Only Manual), while the recording time for the RAD was changed in 2004 in the RAD policy. NCD wording cannot be changed without CMS direction.

Follow-up Question: The RAD policy under several diagnoses requires the ruling out of CPAP therapy prior to moving to a RAD. How do we do this if we cannot meet the CPAP criteria in the two hours recorded sleep? Is this conflict being addressed?

The RAD policy states in part as follows regarding the CPAP:

- Prior to initiating therapy (for severe COPD), OSA (and treatment with CPAP) has been considered and ruled out; and
- The ruling out of CPAP as effective therapy [for central sleep apnea (CSA) or complex sleep apnea] if either CSA or OSA is a component of the initially observed sleep-associated hypoventilation; and
- A single level device (E0601, CPAP device) has been tried and proven ineffective (for the treatment of OSA)

The physician ordering the RAD would make the decision regarding treatment with the CPAP in the first two instances above with documentation in the medical record supporting why treatment with a CPAP was ruled out without requiring a sleep study. In the final instance above, the patient would have needed to meet the guidelines as written in the CPAP policy to determine that the CPAP had been tried and proven ineffective. In this case, there would be two hours of sleep time, which means that at least two hours of recorded time occurred which meets the RAD criteria.

Q21. I have a question regarding crossovers from Medicare to Kansas Medicaid. The remittance advice I receive from Medicare tells me the claim is crossing over to Medicaid, however I still need to manually go to the Kansas Medicaid website to post the transactions or process those claims. Do you know when this might be resolved?

A21. The supplier provided examples for NAS to research. What we found is that the claim did crossover to Medicaid, however, it takes two cycles at the COBC after they receive the crossover claim for it to either process or reject; 90% of the crossover claims process. Therefore, allow ample time from the the time the remittance advice is received from Medicare to verify that Medicaid received and processed the claim. If a supplier checks within a few days of receiving the Medicare Remittance Advice, it might appear that the claim did not crossover, when in actuality it will be crossing shortly.

Q22. I have a question regarding the continuous passive motion (CPM) exercise device (E0935) for total knee replacement. Is there a reason why Medicare will not pay for CPMs for other joint replacements other than the total knee?

A22. Section 280.1 of the National Coverage Determinations manual states as follows regarding this device:

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.

Based upon this NCD, Medicare cannot allow for a CPM for other applications.

Ask the Contractor Questions and Answers December 19, 2007

Prior to taking questions, NAS provided the following updates:

NPI

Effective October 29, 2007, all DME MACs began editing the NPI/legacy ID combinations for validity against the NPI crosswalk file. Where a match cannot be located on the crosswalk, claims are rejected or returned.

When the claim is rejected, the supplier should first verify that the correct NPI was submitted. If correct, next verify that the legacy identifier (NSC) number corresponds with the information on file with the National Plan and Provider Enumeration System (NPPES). NPPES data may be checked on-line at https://nppes.cms.hhs.gov.

Suppliers are encouraged to send a small number of claims using only the NPI. If no claims are rejected, then suppliers can gradually increase the volume. If any claim is rejected, verify the correct NPI was submitted. If submitted correctly, then data in either NPPES or the Medicare provider files should be corrected and testing done again. It is critical to start testing with your NPI now. For more information, see MLN Matters 5452, 5595, SE0725 and SE0659.

Claims Must Include NPI March 1, 2008

Effective March 1, 2008, Medicare claims must include an NPI in the primary supplier fields on the claim (i.e., the billing, pay-to supplier, and rendering supplier fields) or the claim will be rejected. 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 the legacy (UPIN) number, if you choose.

If you already bill using the NPI/legacy pair in the primary supplier fields, and your claims are processing correctly, now is a good time to submit a small number of claims containing only the NPI in the primary supplier fields. This test will serve to assure your claims will successfully process when only the NPI is mandated on all claims.

New Appeals Features

Effective January 1, 2008, suppliers may email questions and concerns regarding reopenings and redeterminations to dmeredeterminations@noridian.com.

Questions and concerns may include but are not limited to:

- Timely filing inquiries
- Appeal regulations
- Coverage questions
- Appeal rights
- Documentation requirements for redeterminations
- Redetermination/reopening request forms
- Redetermination letter wording
- Social Security laws
- Interpretation of denial messages

Confidential information cannot be e-mailed. This includes Protected Health Information (PHI), such as patient names, claim information, Health Insurance Claim (HIC) numbers, Social Security numbers, claim control numbers (CCNs) or supplier numbers. If you have a question that would contain PHI, please call our Contact Center.

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

NAS has also developed a Redetermination Time Limit Calculator to assist suppliers in submitting timely redetermination requests. This calculator is located in the Claims section under Reopenings and Redeterminations, Appeals Overview of the www.noridianmedicare.com DME website. Simply enter the date of the initial claim determination (remittance advice date) and the calculator will return the date by which the request must be received in the Medicare office based on the 120 day filing limit.

Medical Review Transition

Effective March 1, 2008, medical review functions will be transitioning from the Program Safeguard Contractors to the DME MACs. Medical review functions include: review of claims, creating and updating Local Coverage Determinations, processing Advance Determination of Medicare Coverage (ADMC) requests and CERT functions. Watch for more information on our website and in our email notices as NAS communicates how this transition will affect suppliers.

The following questions and answers are from the December 19, 2007, 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. These answers were current as of this event. Please check our web site for updates.

Q1. I have a question regarding HCPCS code E0482 (cough stimulating device, alternating positive and negative airway pressure). This item is in the capped rental payment category and is made to be used with a circuit. Unfortunately after the 13 months of rental these circuits tend to wear out. How do I go about billing for a replacement circuit when there is no HCPCS code describing the circuit?

A1. When billing for a replacement part without an assigned HCPCS code, suppliers should use E1399 (durable medical

equipment, miscellanous) and provide a detailed description of what E1399 represents. An invoice for the replacement part would also be helpful for NAS to determine an appropriate allowance for that replacement part.

Q2. I have a question about Supplier Standard 15 which addresses accepting returns from beneficiaries. We have patients calling us ten months to a year after receiving a power wheelchair. The power wheelchairs these patients received were the ones that met their medical necessity qualifications at the time of issue. These patients now want to return these original wheelchairs and have them replaced with scooters. Are suppliers required to accept these returns if the wheelchairs the beneficiaries received were appropriate at the time of issue and there is nothing wrong with the equipment?

A2. You are not required to accept these wheelchairs as returns if they were appropriate at the time of issue and they are not substandard equipment. The abbreviated version of Supplier Standard 15 states as follows:

> A supplier must accept returns of substandard (less than full quality for the particular item) or unsuitable items (inappropriate for the beneficiary at the time it was fitted and rented or sold) from beneficiaries.

Top Ten Telephone Inquiries and Solutions

The purpose of this article is to assist suppliers with solutions to the "Top Ten" telephone inquiries that our Supplier Contact Center received from October - December 2007. Our web site, www.noridianmedicare.com, contains excellent information to assist with supplier inquiries.

1. DME Same or Similar Equipment

Suppliers should ask the beneficiary specific questions during the intake process to help determine whether a beneficiary may have received a similar item in the past. For example, if the beneficiary asks for a walker, the supplier should ask the beneficiary if they have ever been provided a walker in the past by another supplier. The next series of questions would be asking about the use of a cane, wheelchair or other mobility devices.

The Interactive Voice Response (IVR) system also provides CMN information on specific HCPCS codes. Call the IVR by dialing 1-877-320-0390. To check for CMN status, enter the beneficiary's HICN, first and last name, birth date and a HCPCS code. The IVR will provide the initial certification date, date of recertification, and length of need.

2. Frequency/Dollar Amount Limitation

Suppliers should review the documentation section of each individual medical policy to verify the utilization guidelines and the documentation requirements needed when billing for quantities of supplies greater than those described in the policy. Each claim submitted for quantities of supplies greater than those described in the policy must have documentation supporting the medical necessity of the higher utilization. This supporting information should be reported in item 19 on the CMS-1500 or the narrative field of an electronic claim. The policies can be accessed from the Coverage Section of the NAS DME website by going to the subsection titled "Local Coverage Determinations" and clicking on the link to the "CMS Medicare Coverage Database – Current LCDs."

3. Entitlement

The IVR provides beneficiary eligibility information including when the beneficiary became eligible for Medicare. By entering the same information listed in item one, the IVR will provide the Parts A and B effective and termination dates and if the Part B deductible has been met for the current and prior years. The IVR will also provide a new Medicare number if applicable, HMO information, MSP information, and home health and hospice information based on the date of service entered.

It is the supplier's responsibility to determine whether the patient is entitled to receive Medicare benefits. It is also imperative to report the Medicare number or HICN as listed on the beneficiary's Medicare Health Insurance Card.

4. CWF Rejects

During the intake process, suppliers should be asking beneficiaries very specific questions, especially regarding home health. For example, ask the beneficiary if anyone is coming into the home to aid in any way. If your patient is in a covered home health episode, some of the items you provide may be included in the home health prospective payment system (PPS) regardless of the reason the beneficiary is receiving home health benefits. A list of the items included in a covered home health episode is found at www.cms.hhs.gov/HomeHealthPPS/03_coding&billing.asp#TopOfPage

5. Certification Requirements

Oxygen, pneumatic compression devices, osteogenesis stimulators, transcutaneous electrical nerve stimulators, and seat left mechanisms require CMNs, and external infusion pumps and enteral and parenteral nutrition require DIFs. Suppliers should be knowledgeable regarding the medical policies for these items, which in turn will aid in completing the CMNs and DIFs. In addition, the forms contain instructions for completing the form. All CMNs and DIFs are located on the DME website, www.noridianmedicare.com, under the Coverage or the Forms section. The medical policies can be accessed from the Coverage section of the NAS DME website.

Additional information regarding CMN requirements can be found in Chapter 4 of the Supplier Manual found on the DME website in the News and Publications section.

6. Payment Explanation/Calculation

Most DMEPOS are paid based on a fee schedule established by CMS for each state or territory. The beneficiary's permanent address will determine the amount allowed by Medicare for a particular service. Drugs, however, have the same allowance regardless of where the beneficiary resides. Medicare pays 80% of the allowed amount for DMEPOS and drugs and biologicals. The most current fee schedules are located in the News and Publications section the NAS DME website.

In addition, the remittance advice message may also help to explain the Medicare payment amount.

7. Claim Not on File

Medicare will not process or may return claims due to incomplete or invalid information and will notify suppliers of the errors through education status letters. These claims are considered unprocessable; they must be corrected and submitted as new claims. If you call the IVR for the status of a claim and no claim is on file, verify that you have completed the claim form appropriately by looking at a copy of the submitted claim and checking the following items:

- Item 1A – Verify the HICN is correct. Most HICNs have 9 digits and either leading or ending alpha character(s)
- Item 11 – Completed with either NONE or a policy number
- Item 17, 17a and/or 17b – Physician name, UPIN with 1G qualifier and/or NPI
- Item 21 – Diagnosis coded to the highest specificity
- Item 24E – One diagnosis code pointer (1 or 2 or 3 or 4)
- Item 33a and or 33b – NPI in correct format, legacy number, if billed, in the correct format and preceded with the 1C qualifier and one space

If you bill electronically, verify that the claim was transmitted and not rejected during EDI front-end processing as listed on an error report.

8. Other Issues

Suppliers are encouraged to visit the NAS DME website frequently to stay abreast of Medicare changes. The latest news regarding policy changes, claim filing issues and other important information is found in the "What's New" section of the website.

Suppliers should also subscribe to the NAS email list to receive emails with the latest news and information twice a week on Tuesdays and Fridays.

9. Eligibility

It is the supplier's responsibility to determine whether the patient is entitled to receive Medicare benefits and to report the Medicare number as shown on the patient's Medicare Health Insurance card. The easiest way to do this is to make a copy of the patient's Medicare card when service is requested and keep this copy in the patient's file.

When submitting claims for payment, verify that you are submitting a nine numeric plus alpha suffix or prefix Medicare number and that there are no transposition errors. The claim also must be submitted with the patient's name exactly as it is shown on the Medicare card; no nicknames will be accepted.

10. Duplicate Remittance Advice (RA)

Change Request (CR) 5308, effective October 23, 2006, updated the Medicare Claims Processing Manual (Publication 100-04) for ending the contingency plan for Electronic Remittance Advice (ERA) and instructed contractors about charging for Medicare Remit Easy Print (MREP) or a duplicate Remittance Advice (RA). Please see MLN Matter 5308 for additional information.

Therefore, Noridian recommends all suppliers download the MREP software that is offered free of charge to read and print Health Insurance Portability and Accountability Act (HIPAA) compliant electronic RAs for accounts reconciliation and crossover claims submission to secondary/tertiary payers. The software is updated annually along with three additional updates to implement the Claim Adjust Reason and Remittance Advice Remark Code (CARC and RARC) changes and allows the supplier to:

- Print paper documentation that can be used to reconcile accounts receivable; and
- Create document(s) that can be included with claim submissions to Coordination of Benefits (COB) payers.

For additional information on downloading MREP, visit the EDI Helpdesk website or call 866-224-3094 from 8:00 a.m. – 5:00 p.m. CT, Monday through Friday.

NPI

Start Testing Your Medicare Claims Now

Reminder: Clarification on NPI Enumerator's Responsibilities

The topics with which the NPI Enumerator can assist providers are listed below:

- Status of an NPI application, update, or deactivation
- How to apply, update, or deactivate
- Forgotten/lost NPI
- Lost NPI notification
- Trouble accessing NPPES
- Forgotten password/User ID
- Need to request a paper application

Health care providers should not contact the NPI Enumerator for questions other than those related to the above topics. A new MLN Matters article clarifies the specific responsibilities of the NPI Enumerator. This article is located at http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0751.pdf on the CMS website.

Important Information for Medicare Providers

Reminder: NPI Requirement on Medicare Electronic and Paper Institutional Claims Begins 1/1/08!

Effective January 1, 2008, NPIs will be required to identify the primary providers (the Billing and Pay-to Providers) in Medicare electronic and paper institutional claims (i.e. 837I and UB-04 claims). You may continue to use the legacy identifier in these fields as long as you also use the NPI in these fields. This means that 837I and UB-04 claims with ONLY legacy identifiers in the Billing and Pay-to Provider fields will be rejected starting on January 1, 2008. (Pay-to Provider is identified only if it is different from the Billing Provider.)

You may continue to use only legacy identifiers for the

NPI CONT'D

secondary provider fields in the 837I and UB-04 claims until May 23, 3008, if you choose.

Urgent: Test Your Claims Now!

After you have submitted claims containing both NPIs and legacy identifiers and those claims have been paid, Medicare urges you to send a small batch of claims now with **only the NPI** in the primary provider fields. If the results are positive, begin increasing the number of claims in the batch.

(**Reminder:** For institutional claims, the primary provider fields are the Billing and Pay-to Provider fields. For professional claims, the primary provider fields are the Billing, Pay-to, and Rendering Provider fields. If the Pay-to Provider is the same as the Billing Provider, the Pay-to Provider does not need to be identified.)

If Your Claims Are Rejecting

If you are submitting an NPI and a legacy identifier pair on your claims and they are being rejected, first go into the NPPES website located at https://nppes.cms.hhs.gov/ and validate that your NPPES information is correct and that you reported your Medicare legacy identifier in the appropriate Medicare sections of the "Other Provider Identification Numbers" field. Your Medicare legacy identifier is the identifier that Medicare assigned to you upon enrollment.

Sometimes Medicare assigned multiple identifiers to a single provider, usually because the provider had multiple locations or if the provider is an individual and worked in multiple locations. An enrolled physician/non-physician practitioner and the group practice to which the physician/non-physician practitioner assigns his/her benefits would both have unique legacy identifiers. Legacy identifiers are the ones that were used prior to using NPIs to identify Billing/Pay-to and Rendering Providers.

If the information in your NPPES record is correct and contains your Medicare legacy identifier(s), print the screen (so you have a copy of this portion of your NPPES record on paper), call your Medicare contractor, and ask that they confirm that this information is present in the Medicare NPI Crosswalk. If your contractor confirms you are not on the crosswalk, please ask them to validate what information they have in their provider file.

Reminder - Medicare's Key Dates

Date	Implementation Steps
January 1, 2008	837I electronic claims, UB-04 paper claims and DDE claims without an NPI in fields identifying the primary provider (billing and pay-to) will be rejected. Legacy identifiers paired with NPIs in the primary provider fields on the claim will still be acceptable as will legacy-only numbers in secondary provider fields.
March 1, 2008	Medicare FFS 837P and CMS-1500 claims must include an NPI in the primary fields on the claim (i.e., the billing, pay-to, and rendering fields). You may continue to submit NPI/legacy pairs in these fields or submit only your NPI on the claim. You may not submit claims containing only a legacy identifier in the primary fields. Failure to submit an NPI in the primary fields will result in your claim being rejected or returned as unprocessable. Until further notice, you may continue to include legacy identifiers only for the provider secondary fields.
May 23, 2008	In keeping with the Contingency Guidance issued on April 3, 2007, CMS will lift its NPI contingency plan, meaning that for all primary and secondary provider fields, only the NPI will be accepted and sent on all HIPAA electronic transactions (837I, 837P, NCPDP, DDE, 276/277, 270/271 and 835), paper claims (UB-04 and CMS-1500) and SPR remittance advice. • The reporting of legacy identifiers will result in the rejection of the transaction. • CMS will also stop sending legacy identifiers on COB crossover claims at this time.

Need More Information?

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.

Getting an NPI is free – not having one can be costly.

How to Handle NPI for Ordering/ Referring and Attending/ Operating/ Other/ Service Facility for Medicare Claims

MLN Matters Number: MM5674 Revised
Related Change Request (CR) #: 5674
Related CR Release Date: October 26, 2007
Related CR Transmittal #: R225PI
Effective Date: May 23, 2008
Implementation Date: April 7, 2008

Note: This article was revised on December 18, 2007, to add DME MACs as affected providers. In addition, references to CR5328, CR5416 and CR4169 at the end of the article were remove. These CRs were incorrect. All other information remains unchanged.

Provider Types Affected

Physicians and providers who bill Medicare Carriers, Fiscal Intermediaries (FIs), Durable Medical Equipment Medicare Administrative Contractors (DME MACs) and Part A/B MACs for claims for services provided to Medicare beneficiaries.

What Providers Need to Know

Be cognizant of the fact that in accordance with the NPI final rule, when an identifier is reported on a claim for ordering/ referring/attending provider, operating/other/service facility provider, or for any provider that is not a billing, pay-to or rendering provider, that identifier **must be an NPI. For Medicare purposes, this means that submission of an NPI for an ordering/referring provider is mandatory effective May 23, 2008. Legacy numbers cannot be reported on any claims sent to Medicare on or after May 23, 2008**.

Medicare has always required that a provider identifier be reported for ordering/referring providers. Effective May 23, 2008, that number **must be an NPI**, regardless of whether that referring or ordering provider participates in the Medicare program or not or is a covered entity.

Key Points

- Medicare will not pay for referred/ordered services or items unless the name and NPI number of the referring/ ordering/attending/operating/other/service facility provider is on the claim.
- It is the responsibility of the claim/bill submitter to obtain the ordering/referring/attending/operating/other/service facility NPI for health care providers.
- Providers whose business is largely based upon provision of services or items referred/ordered by other providers must be careful furnishing such services/items unless they first obtain the NPI of the referring/ordering individual. If they furnish services/items and do not obtain that person's NPI prior to billing Medicare, their claim will be denied.
- If the NPI is not directly furnished by the ordering/ referring provider at the time of the order, the provider expected to furnish the services or items should contact that provider for his/her NPI prior to delivery of the services/items.
- Providers who have not obtained an NPI by May 23, 2008, are not permitted to refer/order services or items for Medicare beneficiaries.
- Legacy numbers, such as provider identification numbers (PINs) or unique physician identification numbers (UPINs), cannot be reported on any claims sent to Medicare on or after May 23, 2008.
- Physicians and the following non physician practitioners are the only types of providers allowed to refer/order services or items for beneficiaries:
  - Nurse practitioners (NP);
  - Clinical nurse specialists (CNS);
  - Physician assistants (PA); and
  - Certified nurse midwives (CNM).

Background

This article is based on Change Request (CR) 5674. Please note that the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandate the adoption of a standard unique health identifier for each health care provider. The (NPI) final rule, published on January 23, 2004, establishes the NPI as this standard. All health care providers covered under HIPAA must comply with the requirements of the NPI final rule (45 CFR Part 162, CMS-045-F). All entities covered under HIPAA must comply with the requirements of the NPI final rule.

Additional Information

You may see the official instruction (CR5674) issued to your Medicare A/B MAC, DME MAC, FI, or carrier by going to http://www.cms.hhs.gov/Transmittals/downloads/R225PI.pdf on the CMS website.

Clarification on NPI Enumerator's Responsibilities

MLN Matters Number: SE0751

Provider Types Affected

All physicians, providers, and suppliers who submit claims to Medicare Contractors (Fiscal Intermediaries (FIs), Carriers, and Medicare Administrative Contractors (A/B MACs))

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) is issuing this Special Edition (SE) 0751 article to clarify the type of assistance that the NPI Enumerator can and cannot provide to health care providers.

CMS is providing this information so you and your staff will know what issues should be referred to the NPI Enumerator and to identify issues on which the NPI Enumerator will not be able to help you. This will save you valuable time in resolving your Medicare questions.

NPI CONT'D

Background

The NPI Enumerator is responsible for assisting health care providers in applying for their NPIs and updating their information in the National Plan and Provider Enumeration System (NPPES). The NPI Enumerator's responsibilities include:

- Processing NPI applications/updates/deactivations;
- Providing blank NPI application forms to health care providers upon request;
- Assisting health care providers with questions or problems regarding the processing of their NPI applications, updates, or deactivations (web-based or paper);
- Resolving errors on applications/updates/deactivations;
- Investigating potential duplicate applications/updates/deactivations to ensure the uniqueness of the provider;
- Resetting web users' NPPES passwords;
- Tracking NPPES accessibility and reporting NPPES inaccessibility issues to the CMS;
- Maintaining a call center for health care providers' questions regarding NPI application processing; and
- Working with Electronic File Interchange Organizations (EFIOs) (approval of EFIOs, resolving problems with EFI files).

Health care providers needing the above types of assistance may contact the NPI Enumerator at 1-800-465-3203, TTY 1-800-692-2326 or email the request to the NPI Enumerator at CustomerService@NPIEnumerator.com on the Internet. Please note that application processing times may vary based on current inventories. Please allow 15 working days to process your application/updates before contacting the NPI Enumerator.

Health care providers should **NOT contact** the NPI Enumerator for the following issues:

- The NPI Enumerator cannot provide assistance with the Medicare NPI Crosswalk and Medicare claims processing issues.
  - The NPI Enumerator does **not** generate, maintain or have access to the Medicare NPI Crosswalk.
  - The NPI Enumerator does **not** have the means/authority to alter/add/remove any information on the Medicare NPI Crosswalk.
  - The NPI Enumerator **cannot** report problems to CMS or to the Medicare Fee-for-Service contractors concerning the Medicare NPI Crosswalk or claims processing problems.
  - The NPI Enumerator does **not** send updates to the Medicare NPI Crosswalk.
  - The NPI Enumerator does **not** know how/when the Medicare NPI Crosswalk will be updated.
  - The NPI Enumerator **cannot** advise a provider as to how to complete the paper or electronic claim.
  - The NPI Enumerator **cannot** tell a provider how many legacy numbers to report on the NPPES record in order to assist in populating information on the Medicare NPI Crosswalk.
- The NPI Enumerator cannot provide assistance with information disseminated or not disseminated via the NPI Registry or the NPPES downloadable file:
  - The NPI Enumerator **cannot** assist providers with questions regarding "temporarily suppressed" information found on the NPI Registry or downloadable file.
  - Although the NPI Enumerator can confirm whether or not the information still exists in the provider's active NPPES record; this confirmation is limited to the health care provider or contact person on the provider's NPPES record. Third party sources, including Medicare contractors, **cannot** call the NPI Enumerator for confirmation of information in a health care provider's NPPES record. If this type of confirmation is needed, the third party should request the information from the provider directly.
- The NPI Enumerator cannot provide assistance with Medicare-related provider enrollment information:
  - The NPI Enumerator **cannot** determine how providers are enrolled with Medicare (e.g., as an individual or as a group).
  - The NPI Enumerator **cannot** determine which identifiers (Unique Physician Identification Number (UPIN), Provider Identification Number (PIN), Online Survey Certification and Reporting System (OSCAR), or National Supplier Clearinghouse (NSC)) should be included on health care providers' NPPES records.
  - The NPI Enumerator has no way of knowing which type(s) of legacy number(s) were assigned to a provider by the Medicare contractor(s).
  - The NPI Enumerator **cannot** tell a provider how many legacy numbers to report on the NPPES record in order to assist in populating information on the Medicare NPI Crosswalk.
- The NPI Enumerator cannot provide assistance with NPI-to-legacy number linkages (i.e., how to properly link multiple legacy numbers to one NPI or how to properly link one legacy number to multiple NPIs).
- The NPI Enumerator cannot provide assistance with questions related to:
  - Defining subparts;
  - Which subparts should receive NPIs;
  - Where NPIs or legacy identifiers are to be placed in claims transactions;
  - Health Insurance Portability and Accountability Action (HIPAA) regulations or regulatory policies;
  - Proper use of NPIs in transactions with health plans; and

NPI CONT'D

- Determining if the provider is a sole proprietor or an incorporated individual.

Additional Information

CMS advises providers to read the information available at http://www.cms.hhs.gov/NationalProvIdentStand/ on the CMS NPI website. Included on this site are NPI Frequently Asked Questions and Answers that can assist you with issues for which the NPI Enumerator is not responsible.

In addition, the NPI Application/Update form itself is also a good source of information. Providers should refer to the instructions (they are part of the form) for clarification on information to be submitted in order to obtain NPIs or update their records. You can also refer to the *"Application Help"* tab located at: https://nppes.cms.hhs.gov on the NPPES website for additional assistance when you are online.

BILLING

Break In Service for Capped Rental Items

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.

For an item described by the same code, a new capped rental period begins if there has been an interruption in the medical necessity for the item and the interruption lasted for 60-plus consecutive days. CMS defines a 60-plus consecutive day interruption as a period including two full rental months **plus** whatever days are remaining in the rental month during which the need ends.

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. The claim for these items must include, but is not limited to:

1. A description of the patient's prior medical condition that necessitated the previous item;
2. A statement explaining when and why the medical necessity for the previous item ended; and,
3. A statement explaining the patient's new or changed medical condition and when the new need began.

Note: The items listed above should be present in the patient's medical documentation and sent with redetermination requests for these types of claims.

The dates for the break in service or extended service along with a notation 'BIS', which stands for break-in-service, must be entered in the NTE segment on an electronic claim or in Item 19 on the CMS 1500 claim form. This will ensure accurate processing of this capped rental claim based on the information submitted.

If a new capped rental period is not allowed, the end date on the existing Certificate of Medical Necessity (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 eligiblity
3. Break in service due to a stay in a hospital/nursing home or Medicare HMO coverage

When extending the length of the CMN, the terminology 'extend CMN for xx months' where xx equals the number of months to be extended, should be entered in Item 19 on the CMS 1500 form or the NTE segment for electronic claims to ensure accurate claim processing.

Handling Personally Identifiable Information on the Medicare Summary Notice

MLN Matters Number: MM5770
Related Change Request (CR) #: 5770
Related CR Release Date: December 19, 2007
Related CR Transmittal #: R1399CP
Effective Date: January 7, 2008
Implementation Date: January 7, 2008

Provider Types Affected

Physicians, providers, and suppliers who submit claims to Medicare Carriers, Fiscal Intermediaries, (FIs), Medicare Administrative Contractors (A/B MACs), and Durable Medical Equipment Medicare Administrative Contractors (DME MACs)

What You Need to Know

When the Health Insurance Claim Number (HICN) and name of the beneficiary do not match on the submitted claim, Medicare carriers, intermediaries, and A/B MACs will return the claim to the provider as unprocessable. When non-institutional providers submit claims to Medicare carriers or A/B MACs that do not result in a match on name and HICN, the claim is returned with reason code 140 (Patient/ Insured health identification number and name do not match).

In addition, effective January 7, 2008, on ALL MSNs, the first 5 digits of the HICN will be replaced with "XXX-XX" to avoid displaying the Medicare beneficiary's personally identifiable information (PII). This applies to pay, no-pay, and duplicate copies of the MSN.

Background

This article is based on CR5770, which describes new procedures resulting from the Centers for Medicare & Medicaid Services (CMS) implementation of the Privacy Act and the Health Insurance Portability and Accountability Act (HIPAA). CR 5770 ensures that (1) MSNs are not issued when the HICN and name do not match, and (2) beneficiaries' PII is protected on the MSN.

Additional Information

You may see the official instruction, CR5770, issued to your Medicare Carrier, FI, A/B MAC or DME MAC at http://www.cms.hhs.gov/Transmittals/downloads/R1399CP.pdf on the CMS website.

Reporting of Hematocrit or Hemoglobin Levels on All Claims for the Administration of Erythropoiesis Stimulating Agents, Implementation of New Modifiers for Non-ESRD ESA Indications, and Reporting of Hematocrit or Hemoglobin Levels on all Non-ESRD, Non-ESA Claims Requesting Payment for Anti-Anemia Drugs

MLN Matters Number: MM5699
Related Change Request (CR) #: 5699
Related CR Release Date: January 11, 2008
Related CR Transmittal #: R1412CP
Effective Date: January 1, 2008
Implementation Date: April 7, 2008

Provider Types Affected

Physicians, providers, and suppliers who bill Medicare contractors (carriers, including durable medical equipment Medicare administrative contractors (DME MACs), fiscal intermediaries (FIs), Competitive Acquisition Plan (CAP) Designated Carriers, and A/B Medicare administrative contractors (A/B MACs)) for providing ESAs and related anti-anemia administration services to Medicare beneficiaries.

Impact on Providers

Effective for services on or after January 1, 2008, you must report the most recent hemoglobin or hematocrit levels on any claim for a Medicare patient receiving: (1) ESA administrations, or (2) Part B anti-anemia drugs other than ESAs used in the treatment of cancer that are not self-administered. In addition, non-ESRD claims for the administration of ESAs must also contain one of three new Healthcare Common Procedure Coding System (HCPCS) modifiers effective January 1, 2008. Failure to report this information will result in your claim being returned as unprocessed. **(Note that renal dialysis facilities are already reporting this information on claim types 72X, so CR5699 applies to providers billing with other types of bills.)** See the rest of this article for reporting details.

Background

Medicare Part B provides payment for certain drugs used to treat anemia caused by the cancer itself or by various anti-cancer treatments, including chemotherapy, radiation, and surgical therapy. The treatment of anemia in cancer patients commonly includes the use of drugs, specifically ESAs such as recombinant erythropoietin and darbepoetin. Emerging data and recent research has raised the possibility that ESAs administered for a number of clinical indications may be associated with significant adverse effects, including a higher risk of mortality in some populations.

Most recently, section 110 of Division B of the Tax Relief and Health Care Act (TRHCA) of 2006 directs the Secretary to amend Section 1842 of the Social Security Act by adding at the end the following new subsection: *"Each request for payment, or bill submitted, for a drug furnished to an individual for the treatment of anemia in connection with the treatment of cancer shall include (in a form and manner specified by the Secretary) information on the hemoglobin or hematocrit levels for the individual."*

In light of the health and safety factors and the TRHCA legislation, effective January 1, 2008, the Centers for Medicare & Medicaid Services (CMS) is implementing an expanded reporting requirement for all claims billing for administrations of an ESA. Hematocrit and /or hemoglobin readings are already required for ESRD claims for administrations of an ESA. Effective with the implementation of change request (CR) 5699, all other claims for ESA administrations will also require the reporting of the most recent hematocrit or hemoglobin reading, along with one of three new HCPCS modifiers effective January 1, 2008.

In addition, CR 5699 requires the reporting of the most recent hematocrit or hemoglobin readings on all claims for the administration of Part B anti-anemia drugs OTHER THAN ESAs used in the treatment of cancer that are not self-administered.

What you Need to Know

CR 5699, from which this article is taken, instructs all providers and suppliers that:

1. Effective January 1, 2008, all claims billing for the administration of an ESA with HCPCS codes J0881, J0882, J0885, J0886 and Q4081 must report the most recent hematocrit or hemoglobin reading.

   - For institutional claims, the hemoglobin reading is reported with a value code 48 and a hematocrit reading is reported with the value code 49. Such claims for ESAs not reporting a value code 48 or 49 will be returned to the provider.
   - Effective for services on or after January 1, 2008, for professional paper claims, test results are reported in item 19 of the CMS-1500 claim form. For professional electronic claims (837P) billed to carriers or A/B MACs, providers report the hemoglobin or hematocrit readings in Loop 2400 MEA segment. The specifics are MEA01=TR (for test results), MEA02=R1 (for hemoglobin) or R2 (for hematocrit), and MEA03=the test results. The test results should be entered as follows: TR= test results, R1=hemoglobin or R2=hematocrit (a 2-position alpha-numeric element), and the most recent numeric test result (a 3-position numeric element, decimal implied [xx.x]). Results exceeding 3-position numeric elements (10.50) are reported as 10.5.

     Examples: If the most recent hemoglobin test results are 10.50, providers should enter: TR/R1/10.5, or, if the most recent hematocrit results are 32.3, providers would enter: TR/R2/32.3.
   - Effective for dates of service on and after January 1, 2008, contractors will return to provider paper and electronic professional claims, or return as unprocessable paper and electronic institutional

claims for ESAs when the most recent hemoglobin or hematocrit test results are not reported.

- When Medicare returns a claim as unprocessable for ESAs with HCPCS codes J0881, J0882, J0885, J0886, or Q4081 for failure to report the most recent hemoglobin or hematocrit test results, it will include Claim Adjustment Reason Code 16 (Claim/service lacks information which is needed for adjudication.) and Remittance Advice Code MA130 (Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with complete/correct information.)

2. Effective January 1, 2008, all non-ESRD ESA claims billing HCPCS J0881 and J0885 must begin reporting one (**and only one**) of the following three modifiers on the same line as the ESA HCPCS:
   - EA: ESA, anemia, chemo-induced;
   - EB: ESA, anemia, radio-induced; or
   - EC: ESA, anemia, non-chemo/radio

- Non-ESRD ESA institutional claims that do not report one of the above three modifiers along with HCPCS J0881 or J0885 will be returned to the provider.
- Non-ESRD ESA professional claims that are billed without one of the three required modifiers as line items along with HCPCS J0881 or J0885 will be returned as unprocessable with reason code 4 and remark code MA130. If more than one modifier is reported, the claim will be returned with reason code 125 and remark code N63.

3. Effective January 1, 2008, all non-ESRD, non-ESA claims billing for the administration of Part B anti-anemia drugs used in the treatment of cancer that are not self-administered must report the most recent hematocrit or hemoglobin reading.

- Institutional claims that do not report the most recent hematocrit or hemoglobin reading will be returned to the provider.
- Professional claims that do not report the most recent hematocrit or hemoglobin reading will be returned as unprocessable using Reason Code 16, and Remarks Codes MA130 and N395
- Your Medicare contractor will not search for claims with dates of service on or after January 1, 2008, processed prior to implementation of this CR, but will adjust such claims when you bring them to the attention of your contractor.

Additional Information

For complete details regarding this CR please see the official instruction (CR5699) issued to your Medicare carrier, FI, DME MAC, CAP Designated Carrier, and A/B MAC. That instruction may be viewed by going to http://www.cms.hhs.gov/Transmittals/downloads/R1412CP.pdf on the CMS website.

CERT Documentation

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

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

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

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

Mail all requested documentation to:
CERT Documentation Office
Attn: CID #:xxxxxx
9090 Junction Drive, Suite 9
Annapolis Junction, MD 20701

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

Suppliers may call the CDC at (888) 779-7477 or (301) 957-2380 with questions regarding specific documentation to submit.

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

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

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

FORMS

Revised Guidance for Completing Form CMS-1500

MLN Matters Number: MM5749 Revised
Related Change Request (CR) #: 5749
Related CR Release Date: December 14, 2007
Related CR Transmittal #: R1393CP
Effective Date: January 1, 2008
Implementation Date: January 7, 2008

Note: This article was revised on January 8, 2008, to show that items 32a and 32b are completed if required by Medicare claims processing policy. All other information remains the same.

Provider Types Affected

All physicians, providers, and suppliers who submit claims using Form CMS-1500 to Medicare contractors (carriers, Medicare Administrative Contractors (A/B MACs), and durable medical equipment Medicare Administrative Contractors (DME/MACs)).

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 5749 that notifies physicians and suppliers who use Claim Form CMS-1500 (those providers who qualify for a waiver from the Administrative Simplification Compliance Act (ASCA)) that changes are being made to submission instructions for completing boxes 32a and 32b of Form CMS-1500.

The Key Points section of this CR outlines the changes required in the Form CMS-1500.

Background

The Form CMS-1500 claim completion instructions are being revised in order to provide guidance **related to the submission of service facility identifiers**.

The Form CMS-1500 answers the needs of many health insurers. It is the basic form prescribed by CMS for the Medicare program and is only accepted from physicians and suppliers that are excluded from the mandatory electronic claims submission requirements set forth in the Administrative Simplification Compliance Act (ASCA) and the implementing regulation at 42 CFR 424.32.

Key Points

Providers note the changes in Chapter 26 of the *Medicare Claims Processing Manual* that impact the Form CMS-1500 boxes 32a and 32b.

Box 32a: If required by Medicare claims processing policy, enter the National Provider Identifier (NPI) of the service facility.

Box 32b: If required by Medicare claims processing policy, **enter the legacy Provider Identification Number (PIN)** of the service facility preceded by the **ID qualifier 1C**. There should be one blank space between the qualifier and the PIN.

Additional Information

To see the official instruction (CR5749) issued to your carrier, DME/MAC, or A/B MAC refer to http://www.cms.hhs.gov/Transmittals/downloads/R1393CP.pdf on the CMS website.

EDI

CSI/DDE Medicare System Security Semi-Annual Review

In accordance with the Centers for Medicare & Medicaid Services (CMS), NAS is required to perform a semi-annual review of system access for all Claims Status Inquiry (CSI)/ Direct Data Entry (DDE) users.

During the month of January, each supplier will be faxed a listing of their active users along with the supplier numbers to which each user has access. It is the responsibility of the supplier and/or their facility contact person to respond to the NAS CSI/DDE user listing. Failure to respond within the allotted timeframe will result in removal of access for all users.

The facility contact person is the individual responsible for reviewing, coordinating signatures, and returning the fax to NAS within 14 calendar days from the date of the fax. Suppliers will not receive additional notice of this review. This article, along with the fax, serves as notice.

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

If your facility does not receive a fax from NAS within the month of January, please email NAS immediately at externalsecuritydme@noridian.com.

Reminder: Providers who do not return the listing within the allotted timeframe will have all access removed.

DME Common Electronic Data Interchange Front-End

National Government Services, Inc. has been awarded the DME Common Electronic Data Interchange (CEDI) front-end contract by the Centers for Medicare & Medicaid Services. With this contract, CEDI will provide a single front-end solution for the submission and retrieval of electronic transactions.

With this change, DME MAC Trading Partners (Electronic Submitters) will send all electronic claims (X12 837 and NCPDP) and 276 Claim Status Inquiry transactions to CEDI. CEDI will return all electronic front-end reports directly to the submitter.

CEDI will also receive the X12N 835 Electronic Remittance Advice (ERA) and 277 Claims Status Response transactions from the DME MACs and deliver them to the Trading Partner's (Electronic Submitters) CEDI mailbox.

CEDI will be working with DME suppliers, clearinghouses, billing services and vendors to minimize any disruption to the current EDI processes. Listed below are some key dates

and important information to facilitate the transition to the CEDI system.

Key Dates

February 1, 2008

The CEDI system will be in production for suppliers, billing services, clearinghouses and vendors to begin testing. **NOTE**: Trading Partners (Electronic Submitters) can move fully into production with CEDI **before** their final cutover date.

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.

There will be a Web site dedicated to CEDI as a resource for all CEDI documentation and communication. Each DME MAC will offer a link to the CEDI Web site. In addition to the CEDI Web site, CEDI outreach materials will be distributed through each of the DME MAC Jurisdictions.

The CEDI Help Desk will provide support for Trading Partners (Electronic Submitters), vendors, clearinghouses and billing services to resolve issues and answer questions about connectivity, receipt of files and electronic formats. The **CEDI Help Desk number** will be **866-311-9184** and will be **operational beginning February 1, 2008 from 9:00 AM - 9:00 PM (ET)**. National Government Services CEDI is putting the final touches on the CEDI email address and Web site and we will notify you of these shortly.

More detailed and additional information will be provided regarding the transition to the CEDI system throughout the implementation period.

VMS Modifications to Implement Common Electronic Data Interchange System

MLN Matters Number: MM5755
Related Change Request (CR) #: 5755
Related CR Release Date: December 21, 2007
Related CR Transmittal #: R1402CP
Effective Date: April 1, 2008
Implementation Date: April 7, 2008

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 5755 prescribes the requirements for the system changes necessary to prepare for the implementation of the DME MAC CEDI front end. CR5755 does not affect Fiscal intermediaries (FIs), carriers, Regional Home Health Intermediaries (RHHIs), the Fiscal Intermediary Standard System (FISS), or the Multi-Carrier System (MCS). **This article is informational only for suppliers and suppliers need not make any changes to their claim submission processes.**

Background

Currently, front- end electronic data interchange (EDI) processing for Durable Medical Equipment (DME) claims occurs in 4 separate systems. Two of these systems are operated by DME Medicare Administrative Contractor (MACs), and two are operated by data center services contractors under direct contract with the Centers for Medicare & Medicaid Services (CMS).

The front-end EDI systems perform edits on incoming Medicare DME claims, and then it forwards the output data (from transactions that pass edits) to the core of the ViPS Medicare Shared System (VMS) claims processing environment. ViPS maintains the claim processing system used by your Durable Medical Equipment Medicare Administrative Contractor (DME MAC).

Each of the 4 systems used for DME front end transaction processing has been developed as a proprietary system, and logic specific to Medicare requirements was added to accommodate the Medicare claims transactions. Since each system is owned and developed by separate entities, variations exist in how individual front end systems process claims and in the results they produce. This can creates confusion for suppliers and beneficiaries.

Therefore, CMS requested a system analysis from ViPS regarding the system changes that would be required in order to remove or disable certain functionality of the current EDI front end systems. Removing or disabling certain functionality of the EDI front end systems would be in preparation for the implementation of the Common Electronic Data Interchange (CEDI) System, a common EDI front end at the DME MACs.

EDI CONT'D

As a result of that analysis, CR5755 provides the requirements for the system changes necessary to prepare for the implementation of the DME MAC CEDI front end.

Note: CR5755 does not affect claims submitted to Medicare Fiscal intermediaries (FIs), carriers, Regional Home Health Intermediaries (RHHIs), or Part A/B MACs.

Additional Information

The official instruction, CR5755, issued to your DME MAC regarding this change may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R1402CP.pdf on the CMS web site.

CODING

HCPCS Code Update – 2008

The following list identifies changes to the Level II Healthcare Common Procedure Coding System (HCPCS) for 2008.

Added:

Codes that have been added are effective only for dates of service on/after January 1, 2008. Footnote (N) is used for items that are statutorily noncovered by Medicare for reasons on the than medical necessity. Footnote (X) is used for items that are denied as not medically necessary based on Medicare National Policy.

Discontinued:

Codes that are discontinued will continue to be valid for claims with dates of service on/before December 31, 2007, regardless of the date of claim submission. If there is a direct crosswalk for a discontinued code, it is listed in the table. If the crosswalk is not an exact crosswalk (i.e., if there has been a significant change in the narrative description or unit of service), the phrase "with changes" follows the code. Most of the crosswalked codes are also "added" codes that are effective for dates of service on/after January 1, 2008.

There is no grace period that would allow submission of a discontinued code for dates of service in 2008.

K codes that were previously published or codes that have been invalid for claim submission to the DME MAC and that are being officially discontinued in 2008 are not listed in this article.

Changed:

A description change for an existing code is effective for dates of service on/after January 1, 2008.

The appearance of a code in this list does not necessarily indicate coverage.

Ankle-Foot and Knee-Ankle-Foot Orthoses

	Added Code
Code	**Narrative**
A9283	Foot pressure off loading/supportive device, any type, each (Footnote: N

Cervical Traction Devices

	Added Code
Code	**Narrative**
E0856	Cervical traction device cervical collar with inflatable air bladder (Footnote: X)

Continuous Positive Airway Pressure (CPAP) System

	Added Codes
Code	**Narrative**
A7027	Combination oral/nasal mask, used with continuous positive airway pressure device, each
A7028	Oral cushion for combination oral/nasal mask, replacement only, each
A7029	Nasal pillows for combination oral/nasal mask, replacement only, pair

	Discontinued Codes	
Code	**Narrative**	**Crosswalk to Code**
K0553	Combination oral/nasal mask, used with continuous positive airway pressure device, each	A7027
K0554	Oral cushion for combination oral/nasal mask, replacement only, each	A7028
K0555	Nasal pillows for combination oral/nasal mask, replacement only, pair	A7029

Enteral Nutrition

	Added Codes
Code	**Narrative**
B4087	Gastrostomy/jejunostomy tube, standard, any material, any type, each
B4088	Gastrostomy/jejunostomy tube, low-profile, any material, any type, each

	Discontinued Code	
Code	**Narrative**	**Crosswalk to Code**
B4086	Gastrostomy/jejunostomy tube, any material, any type, (standard or low profile), each	B4087 or B4088

	Narrative Change	
Code	**Old Narrative**	**New Narrative**
B4034	Enteral feeding supply; syringe, per day	Enteral feeding supply kit; syringe fed, per day

CODING CONT'D

External Infusion Pumps

	Narrative Change	
Code	**Old Narrative**	**New Narrative**
J1562	Injection, immune globulin, subcutaneous, 100 mg	Injection, immune globulin (Vivaglobin), 100 MG

Glucose Monitors

	Added Code
Code	**Narrative**
A9274	External ambulatory insulin delivery system, disposable, each, includes all supplies and accessories (Footnote: N)

Hospital Beds

	Added Codes
Code	**Narrative**
E0328	Hospital bed, pediatric, manual, 360 degree side enclosures, top of headboard, footboard and side rails up to 24 inches above the spring, includes mattress
E0329	Hospital bed, pediatric, electric or semi-electric, 360 degree side enclosures, top of headboard, footboard and side rails up to 24 inches above the spring, includes mattress

Lower Limb Orthoses

	Discontinued Codes	
Code	**Narrative**	**Crosswalk to Code**
L1855	Knee orthosis, molded plastic, thigh and calf sections, with double upright knee joints, custom-fabricated	L1846
L1858	Knee orthosis, molded plastic, polycentric knee joints, pneumatic knee pads (CTI), custom-fabricated	L1846
L1870	Knee orthosis, double upright, thigh and calf lacers with knee joints, custom-fabricated	L1846
L1880	Knee orthosis, double upright, non-molded thigh and calf cuffs/ lacers with knee joints, custom-fabricated	L1846

Miscellaneous

	Added Codes
Code	**Narrative**
J1561	Injection, immune globulin, (Gamunex), intravenous, non-lyophilized (e.g. liquid), 500 mg
J1568	Injection, immune globulin, (Octogam), intravenous, non-lyophilized (e.g. liquid), 500 mg
J1569	Injection, immune globulin, (Gammagard liquid), intravenous, non-lyophilized, (e.g. liquid), 500 mg
J1572	Injection, immune globulin, (Flebogamma), intravenous, non-lyophilized (e.g. liquid), 500 mg

	Narrative Changes	
Code	**Old Narrative**	**New Narrative**
E0705	Transfer board or device, any type, each	Transfer device, any type, each
E1801	Bi-directional static progressive stretch elbow device with range of motion adjustment, includes cuffs	Static progressive stretch elbow device, extension and/or flexion, with or without range of motion adjustment, includes all components and accessories
E1806	Bi-directional static progressive stretch wrist device with range of motion adjustment, includes cuffs	Static progressive stretch wrist device, flexion and/or extension, with or without range of motion adjustment, includes all components and accessories
E1811	Bi-directional static progressive stretch knee device with range of motion adjustment, includes cuffs	Static progressive stretch knee device, extension and/or flexion, with or without range of motion adjustment, includes all components and accessories
E1816	Bi-directional static progressive stretch ankle device with range of motion adjustment, includes cuffs	Static progressive stretch ankle device, flexion and/or extension, with or without range of motion adjustment, includes all components and accessories
E1818	Bi-directional static progressive stretch forearm pronation/ supination device with range of motion adjustment, includes cuffs	Static progressive stretch forearm pronation/supination device, with or without range of motion adjustment, includes all components and accessories
E1841	Multi-directional static progressive stretch shoulder device, with range of motion adjustability, includes cuffs	Static progressive stretch shoulder device, with or without range of motion adjustment, includes all components and accessories

J1566	Injection, immune globulin, intravenous, lyophilized (e.g. powder), 500 mg	Injection, immune globulin, intravenous, lyophilized (e.g. powder), not otherwise specified, 500 mg

	Discontinued Codes	
Code	**Narrative**	
Q4087	Injection, immune globulin, (Octogam), intravenous, non-lyophilized (e.g. liquid), 500 mg	J1568
Q4088	Injection, immune globulin, (Gammagard liquid), intravenous, non-lyophilized, (e.g. liquid), 500 mg	J1569
Q4091	Injection, immune globulin, (Flebogamma), intravenous, non-lyophilized, (e.g. liquid), 500 mg	J1572
Q4092	Injection, immune globulin, (Gamunex), intravenous, non-lyophilized (e.g. liquid), 500 mg	J1561

Nebulizers

	Added Code
Code	**Narrative**
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 per0.5 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 (Levalbuterol)
J7604	Acetylcysteine, inhalation solution, compounded product, administered through DME, unit dose form, per gram
J7605	Arformoterol, inhalation solution, FDA approved final product, non-compounded, administered through DME, unit dose form, 15 micrograms
J7632	Cromolyn sodium, inhalation solution, compounded product, administered through DME, unit dose form, per 10 milligrams
J7676	Pentamidine isethionate, inhalation solution, compounded product, administered through DME, unit dose form, per 300 mg

	Narrative Changes	
Code	**Old Narrative**	**New Narrative**
J2545	Pentamidine isethionate, inhalation solution, per 300 mg, administered through DME	Pentamidine isethionate, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose form, per 300 mg
J7608	Acetylcysteine, inhalation solution administered through DME, unit dose form, per gram	Acetylcysteine, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose form, per gram
J7631	Cromolyn sodium, inhalation solution administered through DME, unit dose form, per 10 milligrams	Cromolyn sodium, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit does form, per 10 milligrams
J7639	Dornase alpha, inhalation solution administered through DME, unit dose form, per milligram	Dornase alpha, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose form, per milligram
Q4080	Iloprost, inhalation solution, administered through DME, up to 20 micrograms	Iloprost, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose form, 20 micrograms

	Discontinued Codes	
Code	**Narrative**	**Crosswalk to Code**
Q4093	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)	J7602

Q4094	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)	J7603

Orthopedic Footwear

	Added Code
Code	**Narrative**
A9283	Foot pressure off loading/supportive device, any type, each (Footnote: N)

Ostomy Supplies

	Added Code
Code	**Narrative**
A5083	Continent device, stoma absorptive cover for continent stoma

Patient Lifts

	Narrative Change	
Code	**Old Narrative**	**New Narrative**
E0630	Patient lift, hydraulic, with seat or sling	Patient lift, hydraulic or mechanical, includes any seat, sling, strap(s) or pad(s)

Surgical Dressings

	Added Code
Code	**Narrative**
A6413	Adhesive bandage, first-aid type, any size, each (Footnote: N)

Upper Limb Orthoses

	Added Codes
Code	**Narrative**
L3925	Finger orthosis, proximal interphalangeal (PIP)/ distal interphalangeal (DIP), nontorsion joint/ spring, extension/flexion, may included soft interface material, prefabricated, includes fitting and adjustment
L3927	Finger orthosis, proximal interphalangeal (PIP)/ distal interphalangeal (DIP), without joint/spring, extension/flexion (e.g. static or ring type), may include soft interface material, prefabricated, includes fitting and adjustment
L3929	Hand finger orthosis, includes one or more nontorsion joint(s), turnbuckles, elastic bands/ springs, may include soft interface material, straps, prefabricated, includes fitting and adjustment
L3931	Wrist hand finger orthosis, includes one or more nontorsion joint(s), turnbuckles, elastic bands/ springs, may include soft interface material, straps, prefabricated, includes fitting and adjustment

	Narrative Change	
Code	**Old Narrative**	**New Narrative**
L3806	Wrist hand finger orthosis, includes one or more nontorsion joint(s), turnbuckles, elastic bands, may include soft interface material, straps, custom fabricated, includes fitting and adjustment	Wrist hand finger orthosis, includes one or more nontorsion joint(s), turnbuckles, elastic bands/springs, may include soft interface material, straps, custom fabricated, includes fitting and adjustment

	Discontinued Codes	
Code	**Narrative**	**Crosswalk to Code**
L3800	Wrist hand finger orthosis, short opponens, no attachments, custom-fabricated	L3808
L3805	Wrist hand finger orthosis, long opponens, no attachment, custom-fabricated	L3808
L3810	WHFO, addition to short and long opponens, thumb abduction (C) bar	Included in allowance for the base code
L3815	WHFO, addition to short and long opponens, second M.P. abduction assist	Included in allowance for the base code
L3820	WHFO, addition to short and long opponens, I.P. extension assist, with M.P. extension stop	Included in allowance for the base code
L3825	WHFO, addition to short and long opponens, M.P. extension stop	Included in allowance for the base code
L3830	WHFO, addition to short and long opponens, M.P. extension assist	Included in allowance for the base code
L3835	WHFO, addition to short and long opponens, M.P. spring extension assist	Included in allowance for the base code

CODING CONT'D

L3840	WHFO, addition to short and long opponens, spring swivel thumb	Included in allowance for the base code
L3845	WHFO, addition to short and long opponens, thumb I.P. extension assist, with M.P. stop	Included in allowance for the base code
L3850	WHO, addition to short and long opponens, action wrist, with dorsiflexion assist	Included in allowance for the base code
L3855	WHFO, addition to short and long opponens, adjustable M.P. flexion control	Included in allowance for the base code
L3860	WHFO, addition to short and long opponens, adjustable M.P. flexion control and I.P.	Included in allowance for the base code
L3907	Wrist hand finger orthosis, wrist gauntlet with thumb spica, molded to patient model, custom fabricated	L3808
L3910	Wrist hand finger orthosis, Swanson design, prefabricated, includes fitting and adjustment	L3931
L3916	Wrist hand finger orthosis, wrist extension cock-up with outrigger prefabricated, includes fitting and adjustment	L3931
L3918	Hand finger orthosis, knuckle bender, prefabricated, includes fitting and adjustment	L3929
L3920	Hand finger orthosis knuckle bender with outrigger, prefabricated, includes fitting and adjustment	L3929
L3922	Hand finger orthosis, knuckle bender, two segment to flex joints, prefabricated, includes fitting and adjustment	L3929
L3924	Wrist hand finger orthosis, Oppenheimer, prefabricated, includes fitting and adjustment	L3931
L3926	Wrist hand finger orthosis, Thomas suspension, prefabricated, includes fitting and adjustment	L3931
L3928	Hand finger orthosis, finger extension, with clock spring, prefabricated, includes fitting and adjustment	L3929
L3930	Wrist hand finger orthosis, finger extension, with wrist support, prefabricated, includes fitting and adjustment	L3931
L3932	Finger orthosis, safety pin, spring wire, prefabricated, includes fitting and adjustment	L3925
L3934	Finger orthosis, safety pin, modified, prefabricated, includes fitting and adjustment	L3925
L3936	Wrist hand finger orthosis, Palmer, prefabricated, includes fitting and adjustment	L3931
L3938	Wrist hand finger orthosis, dorsal wrist, prefabricated, includes fitting and adjustment	L3931
L3940	Wrist hand finger orthosis, dorsal wrist, with outrigger attachment, prefabricated, includes fitting and adjustment	L3931
L3942	Hand finger orthosis, reverse knuckle bender, prefabricated, includes fitting and adjustment	L3929
L3944	Hand finger orthosis, reverse knuckle bender, with outrigger, prefabricated, includes fitting and adjustment	L3929
L3946	Hand finger orthosis, composite elastic, prefabricated, includes fitting and adjustment	L3929
L3948	Finger orthosis, finger knuckle bender, prefabricated, includes fitting and adjustment	L3925
L3950	Wrist hand finger orthosis, combination Oppenheimer with knuckle bender and two attachments, prefabricated, includes fitting and adjustment	L3931
L3952	Wrist hand finger orthosis, combination Oppenheimer, with reverse knuckle and two attachments, prefabricated, includes fitting and adjustment	L3931
L3954	Hand finger orthosis, spreading hand, prefabricated, includes fitting and adjustment	L3923
L3985	Upper extremity fracture orthosis, forearm, hand with wrist hinge, custom-fabricated	L3764
L3986	Upper extremity fracture orthosis, combination of humeral, radius/ ulnar, wrist, (example: Colles' fracture), custom fabricated	L3763

Upper Limb Prostheses

	Added Codes
Code	**Narrative**
L7611	Terminal device, hook, mechanical, voluntary opening, any material, any size, lined or unlined, pediatric
L7612	Terminal device, hook, mechanical, voluntary closing, any material, any size, lined or unlined, pediatric
L7613	Terminal device, hand, mechanical, voluntary opening, any material, any size, pediatric
L7614	Terminal device, hand, mechanical, voluntary closing, any material, any size, pediatric
L7621	Terminal device, hook or hand, heavy duty, mechanical, voluntary opening, any material, any size, lined or unlined
L7622	Terminal device, hook or hand, heavy duty, mechanical, voluntary closing, any material, any size, lined or unlined

Urological Supplies

	Narrative Change	
Code	**Old Narrative**	**New Narrative**
A5105	Urinary suspensory, with or without leg bag, with or without tube, each	Urinary suspensory with leg bag, with or without tube, each

Wheelchair Options and Accessories

	Added Codes
Code	**Narrative**
E2227	Manual wheelchair accessory, gear reduction drive wheel, each
E2228	Manual wheelchair accessory, wheel braking system and lock, complete, each
E2312	Power wheelchair accessory, hand or chin control interface, mini-proportional remote joystick, proportional, including fixed mounting hardware
E2313	Power wheelchair accessory, harness for upgrade to expandable controller, including all fasteners, connectors and mounting hardware, each
E2397	Power wheelchair accessory, lithium-based battery, each

	Narrative Changes	
Code	**Old Narrative**	**New Narrative**
E2205	Manual wheelchair accessory, handrim without projections, any type, replacement only, each	Manual wheelchair accessory, handrim without projections (includes ergonomic or contoured), any type, replacement only, each
E2373	Power wheelchair accessory, hand or chin control interface, mini-proportional, compact, or short throw remote joystick or touchpad, proportional, including all related electronics and fixed mounting hardware	Power wheelchair accessory, hand or chin control interface, compact remote joystick, proportional, including fixed mounting hardware

Wheelchair Seating

	Discontinued Code	
Code	**Old Narrative**	**Crosswalk to Code**
E2618	Wheelchair accessory, solid seat support base (replaces sling seat), for use with manual wheelchair or lightweight power wheelchair, includes any type mounting hardware	For manual wheelchairs and replacement on power wheelchairs: K0108 or For power wheelchairs at initial issue: not separately billable

Fee Schedule Update for 2008 for DMEPOS

MLN Matters Number: MM5803
Related Change Request (CR) #: 5803
Related CR Release Date: December 7, 2007
Related CR Transmittal #: R1388CP
Effective Date: January 1, 2008
Implementation Date: January 7, 2008

Provider Types Affected

Providers and suppliers submitting claims to Medicare contractors (carriers, DME Medicare Administrative Contractors (DME MACs), Fiscal Intermediaries (FIs), Part A/B Medicare Administrative Contractors (A/B MACs), and/or Regional Home Health Intermediaries (RHHIs)) for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) provided to Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 5803, which provides the annual update to the 2008 DMEPOS fee schedules in order to implement fee schedule amounts for new codes and to revise any fee schedule amounts for existing codes that were calculated in error. Be sure your billing staff are aware of these changes.

CODING CONT'D

Background

This recurring update notification, CR5803, provides specific instructions regarding the 2008 annual update for the DMEPOS fee schedule. Payment on a fee schedule basis is required for durable medical equipment (DME), prosthetic devices, orthotics, prosthetics, and surgical dressings by §1834(a), (h), and (i) of the Social Security Act. Payment on a fee schedule basis is required for parenteral and enteral nutrition (PEN) by regulations contained at 42 CFR 414.102.

The update process for the DMEPOS fee schedule is located in the *Medicare Claims Processing Manual* (Publication 100-04), Chapter 23, Section 60; http://www.cms.hhs.gov/manuals/downloads/clm104c23.pdf) on the Centers for Medicare & Medicaid Services (CMS) website. Other information on the fee schedule, including access to the DMEPOS fee schedules is at http://www.cms.hhs.gov/DMEPOSFeeSched/01_overview.asp on the CMS website.

Key Points

The following codes are being **deleted** from the HCPCS effective January 1, 2008, and are therefore being removed from the DMEPOS and PEN fee schedule files:

B4086	L3800	L3850	L3926	L3946
E2618	L3805	L3855	L3928	L3948
K0553	L3810	L3860	L3930	L3950
K0554	L3815	L3907	L3932	L3952
K0555	L3820	L3910	L3934	L3954
L0960	L3825	L3916	L3936	L3985
L1855	L3830	L3918	L3938	L3986
L1858	L3835	L3820	L3940	
L1870	L3840	L3922	L3942	
L1880	L3845	L3924	L3944	

- The payment category for code K0730 is revised to move the controlled dose inhalation drug delivery system from the DME payment category for capped rental items to the DME payment category for inexpensive and routinely purchased items, effective January 1, 2008. The total payment for inexpensive and/or routinely purchased items may not exceed the fee schedule amount for purchase of the equipment. In the case of controlled dose inhalation drug delivery systems furnished on a purchase basis on or after January 1, 2008, the allowed payment amount will be reduced by the total rental payments previously made for the item.
- The fee schedule amounts established for HCPCS codes K0553, K0554 and K0555 will directly crosswalk to new HCPCS codes A7027, A7028 and A7029, respectively.
- As of the July 2007 HCPCS Quarterly Update, the following composite dressing HCPCS codes are non-covered by Medicare, effective July 1, 2007: A6200, A6201 and A6202. To reflect this change, the fee schedule amounts for codes A6200, A6201 and A6202 will be removed from the fee schedule file as part of this update. Medicare Contractors will deny claims for A6200, A6201 and A6202 with dates of service July 1, 2007 through December 31, 2007.
- CMS will establish fee schedule amounts for the following HCPCS codes : B4087, B4088, E2312, E2312KC, E2373, E2313, L1846, L3808, L3923, L3764, L3763, L3925, L3929, and L3931. These fee schedule amounts will be added to the fee schedule file on January 1, 2008, and are effective for claims with dates of service on or after January 1, 2008. The existing fee schedule amounts for HCPCS code E2373 will become the full replacement E2373 KC fees, effective January 1, 2008.
- Suppliers are to submit the KC modifier when billing for the full replacement of HCPCS power wheelchair interface codes E2373 and E2312.
- Note that HCPCS codes E0328 and E0329 are rarely appropriate for Medicare billings, payment for pediatric beds represented by these codes will be based on individual Medicare contractor consideration.
- As part of this update, CMS is implementing the 2008 national monthly payment rates for stationary oxygen equipment, (HCPCS codes E0424, E0439, E1390 and E1391), effective for claims with dates of service on or after January 1, 2008. CMS is revising the fee schedule file to include the new 2008 monthly payment rate of $199.28 for stationary oxygen equipment. As required by statute, these payment rates are adjusted annually to assure budget neutrality on the addition of the new oxygen generating portable equipment class. Accordingly, a reduction to the national monthly payment amount for stationary oxygen equipment for 2008 that is necessary to offset payments under the new class will be slightly lower ($0.56) (from $199.84 to $199.28) than previously announced.
- As a result of the above adjustments, CMS is also revising the fee schedule amounts for HCPCS codes E1405 and E1406 as part of this update. Since 1989, the fees for codes E1405 and E1406 have been established based on a combination of the Medicare payment amounts for stationary oxygen equipment and nebulizer codes E0585 and E0570, respectively.
- The following are the new HCPCS codes, effective January 1, 2008:

A4252	A9276	E0329	L3925	L7614
A5083	A9277	E0856	L3927	L7621
A6413	A9278	E2227	L3929	L7622
A7027	A9283	E2228	L3931	V2787
A7028	B4087	E2312	L7611	
A7029	B4088	E2313	L7612	
A9274	E0328	E2397	L7613	

Additional Information

You may see the official instruction (CR5803) issued to your Medicare A/B MAC, FI, DMERC, DME/MAC, RHHI or carrier by going to http://www.cms.hhs.gov/Transmittals/downloads/R1388CP.pdf on the CMS website.

Supply Kit Billing Reminder

The External Infusion Pumps Local Coverage Determination Policy Article, article number A19834, outlines in the coding guidelines section what is included with a supply kit for maintenance of a drug infusion catheter and external drug infusion pumps, codes A4221 and A4222, respectively. These guidelines are as follows:

> "Code A4221 includes dressings for the catheter site and flush solutions not directly related to drug infusion. The catheter site may be a peripheral intravenous line, a peripherally inserted central catheter (PICC), a centrally inserted intravenous line with either an external or a subcutaneous port or an epidural catheter. Code A4221 also includes all cannulas, needles, dressings and infusion supplies (excluding the insulin reservoir) related to continuous subcutaneous insulin infusion via external insulin infusion pump (E0784) and the infusion sets and dressings related to subcutaneous immune globulin administration. Billing for more than 1 unit of service per week is incorrect use of the code and will be denied accordingly.
>
> Code A4222 includes the cassette or bag, diluting solutions, tubing and other administration supplies, port cap changes, compounding charges and preparation charges. This code is not used for a syringe-type reservoir.
>
> All supplies (including dressings) used in conjunction with a durable infusion pump (E0779, E0780, E0781, E0784, E0791, K0455) are billed with (1) codes A4221 and A4222 or (2) codes A4221 and K0552. Other codes should not be used for the separate billing of these supplies. Codes A4230 (infusion set for external insulin pump, non-needle cannulas type) and A4231 (infusion set for external insulin pump, needle type) are not valid for claim submission to the DME MAC because they are included in code A4221."

Items included in the kit which are billed separately (not as code A4221 or A4222) will be denied as bundled. These separately billed items will be denied as supplier responsibility (contractual obligation).

Annual Update of HCPCS Codes Used for Home Health Consolidated Billing Enforcement

MLN Matters Number: MM5829
Related Change Request (CR) #: 5829
Related CR Release Date: December 14, 2007
Related CR Transmittal #: R1391CP
Effective Date: January 1, 2008
Implementation Date: January 7, 2008

Provider Types Affected

Physicians, suppliers, and providers who bill Medicare contractors (Fiscal Intermediaries (FIs), carriers, regional home health intermediaries (RHHIs), and DME Medicare Administrative Contractors (DME MACs) and Part A/B Medicare Administrative Contractors (A/B MACs)) for medical supply or therapy services.

What Providers Need to Know

The Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of Healthcare Common Procedure Codes System (HCPCS) codes subject to the consolidated billing provision of the Home Health Prospective Payment System (HH PPS). This article provides the annual HH consolidated billing update effective January 1, 2008. Affected providers may note the changes in the table listed within this article or consult the instruction issued to the Medicare contractors as listed in the *Additional information* section of this article.

Background

Section 1842(b)(6) of the Social Security Act (SSA) requires that payment for home health services provided under a home health plan of care be made to the home health agency (HHA.) As a result, billing for all such items and services is to be done by a single HHA overseeing that plan. This HHA is known as the primary agency for HH PPS for billing purposes. Services appearing on this list that are submitted on claims to Medicare contractors will not be paid separately on dates when a beneficiary for whom such a service is being billed is in a home health episode (i.e., under a home health plan of care administered by an HHA). Exceptions include the following:

- Therapies performed by physicians;
- Supplies incidental to physician services; and
- Supplies used in institutional settings.

Medicare has issued a Recurring Update Notification, which provides the annual HH consolidated billing updates for non-routine supplies and therapies effective January 1, 2008. These lists are updated annually, effective each January 1, to reflect the annual changes to the HCPCS code set. The lists may also be updated as frequently as quarterly if required by the creation of temporary HCPCS codes during the year.

CR5829 provides the annual HH consolidated billing update effective January 1, 2008. The following tables describe the HCPCS codes and the specific changes to each that this notification is implementing for claims with dates of service on or after January 1, 2008.

Table 1: Non Routine Supplies

Code	Description	Action
A5083	Continent device, stoma, absorptive cover for continent stoma	Add
A5105	Urinary suspensory with leg bag with or without tube, each	Redefine
A6200	Composite dressing, pad size 16 sq. in. or less, without adhesive border, each dressing	Delete

A6201	Composite dressing, pad size more than 16 sq. in. but less than or equal to 48 sq. in., without adhesive border, each dressing	Delete
A6202	Composite dressing, pad size more than 48 sq. in., without adhesive border, each dressing	Delete
A6413	Adhesive bandage, first-aid type, any size, each	Add

Table 2: Therapies

Code	Description	Action	Replacement Code or Code being Replaced
96125	Standardized cognitive performance testing per hour	Add	96125

Additional Information

For details regarding this CR, please see the official instruction issued to your Medicare FI, carrier, A/B MAC, RHHI, or DME MAC. This may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R1391CP.pdf on the CMS website.

A complete historical listing of codes subject to HH consolidated billing can be found at http://www.cms.hhs.gov/HomeHealthPPS/03_coding&billing.asp on the CMS website.

To review the Medicare manual instructions discussed in this article see the *Medicare Claims Processing Manual*, Chapter 10, Section 20.1 at http://www.cms.hhs.gov/manuals/downloads/clm104c10.pdf on the CMS website.

REIMBURSEMENT

Payment for Q4094 for Fourth Quarter 2007

Claims for Q4094KO, Albuterol, non-compounded, unit dose, per 1 mg (Albuterol) or per 0.5 mg (Levalbuterol), processed for dates of service in October and part of November 2007, were paid the third quarter allowed amount for this drug, rather than the fourth quarter amount. Correct pricing was loaded into the claims processing system in mid-November. The price decreased between the third and fourth quarter of 2007, based on pricing supplied by CMS. Since this was an NAS oversight, suppliers will not be required to submit the overpayment difference for this drug as a refund.

If suppliers have already voluntarily requested a refund for these claims, NAS will honor this request. Per CMS regulations, NAS must process all voluntary refunds.

COVERAGE

Nebulizer Drug Non-Covered Denials-Claim Adjustment Update

Suppliers were notified via the NAS DME website on 1/16/08 that some nebulizer claims and corresponding dispensing fees for inhalation drugs were recently denied in error and that the claims would be adjusted. **NAS will be adjusting these claims during the week of February 4 and we anticipate that many of these claims will be finalized and payment issued by the end of this week.** Some claims may suspend for other type of editing and will take additional time to finalize. We appreciate your patience as we complete these claim adjustments.

Below is the 1/16/08 posting which describes the claim denials: Some suppliers billing for nebulizer drugs may have received denials that the drugs are not covered, in error. NAS notified suppliers of this through a web posting on NAS recently implemented system changes to ensure that the beneficiary had a nebulizer code on file or a comment stating that the patient owns the nebulizer, in order to pay for all nebulizer drugs. In implementing this system logic on December 20, 2007, we missed looking for one type of information in the claims processing system. This oversight was corrected on January 10 and NAS will be adjusting the claims that denied in error due to this oversight. We will be adjusting claims with dates of service 7/1/07-1/10/08.

Suppliers should be aware that if a second non-covered nebulizer drug denial is received in **mid-late January** that this is a valid denial. (Claims that have been adjusted will have an ICN that ends in 001, rather than 000). This means that there was no evidence in the patient's claim history or on the claim submitted that the beneficiary has a nebulizer to administer these drugs. In this situation, suppliers should submit a written reopening asking for the claim to be reprocessed, along with documentation showing that the patient was receiving the drugs via a nebulizer. If the patient owns their nebulizer and therefore a nebulizer code was not ever billed to Medicare or if another insurance company paid for the nebulizer in the past, please include documentation that explains the situation, along with the purchase date, make/model and serial # of the nebulizer.

Dispensing fees for inhalation drugs, HCPCS Q0513 and Q0514, will also be adjusted automatically by NAS, if denied because the corresponding drug was denied in error, due to the issue described above.

Overview of Medicare Covered Diabetes Supplies and Services

MLN Matters Number: SE0738 Revised

Note: This article was revised on December 12, 2007, to remove a bullet point on page 3 which indicated an initial prescription needed to specify how many lancets and test strips were needed for a month and to remove a second bullet from the same page that stated a new prescription is needed every 12 months for lancets and test strips. Both of these requirements were eliminated from local policy.

Provider Types Affected

Physicians, providers, suppliers, and other health care professionals who furnish or provide referrals for and/or file claims to Medicare contractors (carriers, DME Medicare Administrative Contractors (DME MACs), Fiscal Intermediaries (FIs), and/or Part A/B Medicare Administrative Contractors (A/B MACs)) for Medicare-covered diabetes benefits.

Provider Action Needed

This article is informational only and represents no Medicare policy changes.

Background

Diabetes is the sixth leading cause of death in the United States, and approximately 20 million Americans have diabetes with an estimated 20.9 percent of the senior population age 60 and older being affected. Millions of people have diabetes and do not know it. Left undiagnosed, diabetes can lead to severe complications such as heart disease, stroke, blindness, kidney failure, leg and foot amputations, and death related to pneumonia and flu. Scientific evidence now shows that early detection and treatment of diabetes with diet, physical activity, and new medicines can prevent or delay much of the illness and complications associated with diabetes.

This special edition article presents an overview of the diabetes services and supplies covered by Medicare (Part B and Part D) to assist physicians, providers, suppliers, and other health care professionals who provide diabetic supplies and services to Medicare beneficiaries.

Medicare Part B Covered Diabetic Supplies

Medicare covers certain supplies if a beneficiary has Medicare Part B and has diabetes. These supplies include:

- Blood glucose self-testing equipment and supplies;
- Therapeutic shoes and inserts; and
- Insulin pumps and the insulin used in the pumps

Blood Glucose Self-testing Equipment and Supplies

Blood glucose self-testing equipment and supplies are covered for all people with Medicare Part B who have diabetes. This includes those who use insulin and those who do not use insulin. These supplies include:

- Blood glucose monitors;
- Blood glucose test strips;
- Lancet devices and lancets; and
- Glucose control solutions for checking the accuracy of testing equipment and test strips.

Medicare Part B covers the same type of blood glucose testing supplies for people with diabetes whether or not they use insulin. However, the amount of supplies that are covered varies.

If the beneficiary

- **Uses insulin**, they may be able to get up to 100 test strips and lancets every month, and 1 lancet device every 6 months.
- **Does not use insulin**, they may be able to get 100 test strips and lancets every 3 months, and 1 lancet device every 6 months.

If a beneficiary's doctor documents why it is medically necessary, Medicare will cover additional test strips and lancets for the beneficiary.

Medicare will only cover a beneficiary's blood glucose self-testing equipment and supplies if they get a prescription from their doctor.

Their prescription should include the following information:

- That they have diabetes;
- What kind of blood glucose monitor they need and why they need it (i.e., if they need a special monitor because of vision problems, their doctor must explain that.);
- Whether they use insulin; and
- How often they should test their blood glucose.

A beneficiary needing blood glucose testing equipment and/or supplies:

- Can order and pick up their supplies at their pharmacy;
- Can order their supplies from a medical equipment supplier, but they will need a prescription from their doctor to place their order; and
- Must ask for refills for their supplies.

Note: Medicare will not pay for any supplies not asked for, or for any supplies that were sent to a beneficiary automatically from suppliers. This includes blood glucose monitors, test strips, and lancets. Also, if a beneficiary goes to a pharmacy or supplier that is not enrolled in Medicare, Medicare will not pay. The beneficiary will have to pay the entire bill for any supplies from non-enrolled pharmacies or non-enrolled suppliers.

All Medicare-enrolled pharmacies and suppliers must submit claims for blood glucose monitor test strips. A beneficiary cannot submit a claim for blood glucose monitor test strips themselves. The beneficiary should make sure that the pharmacy or supplier accepts assignment for Medicare-covered supplies. If the pharmacy or supplier accepts assignment, Medicare will pay the pharmacy or supplier directly. Beneficiaries should only pay their coinsurance amount when they get their supply from their pharmacy or supplier for assigned claims. If a beneficiary's pharmacy or supplier **does not** accept assignment, charges may be higher, and the beneficiary may pay more. They may also have to pay the entire charge at the time of service and wait for Medicare to send them its share of the cost.

Before a beneficiary gets a supply, it is important for them to ask the supplier or pharmacy the following questions:

- Are you enrolled in Medicare?
- Do you accept assignment?

If the answer to either of these two (2) questions is "no," they should call another supplier or pharmacy in their area who answers "yes" to be sure their purchase is covered by Medicare, and to save them money.

COVERAGE CONT'D

If a beneficiary can not find a supplier or pharmacy in their area that is enrolled in Medicare and accepts assignment, they may want to order their supplies through the mail, which may also save them money.

Therapeutic Shoes and Inserts

If a beneficiary has Medicare Part B, has diabetes, and meets certain conditions (see below), Medicare will cover therapeutic shoes if they need them. The types of shoes that are covered each year include one of the following:

- One pair of depth-inlay shoes **and** three pairs of inserts; or
- One pair of custom-molded shoes (including inserts) if the beneficiary cannot wear depth-inlay shoes because of a foot deformity **and** two additional pairs of inserts.

Note: In certain cases, Medicare may also cover shoe modifications instead of inserts.

In order for Medicare to pay for the beneficiary's therapeutic shoes, the doctor treating their diabetes must certify that they meet **all** of the following three conditions:

- They have diabetes;
- They have at least 1 of the following conditions in one or both feet:
    - Partial or complete foot amputation;
    - Past foot ulcers;
    - Calluses that could lead to foot ulcers;
    - Nerve damage because of diabetes with signs of problems with calluses;
    - Poor circulation; or
    - Deformed foot;
- They are being treated under a comprehensive diabetes care plan and need therapeutic shoes and/or inserts because of diabetes.

Medicare also requires the following:

- A podiatrist or other qualified doctor must prescribe the shoes, and
- A doctor or other qualified individual like a pedorthist, orthotist, or prosthetist must fit and provide the shoes to the beneficiary.

Medicare helps pay for one pair of therapeutic shoes and inserts per calendar year, and the fitting of the shoes or inserts is covered in the Medicare payment for the shoes.

Insulin Pumps and the Insulin Used in the Pumps

Insulin pumps worn outside the body (external), including the insulin used with the pump, may be covered for some people with Medicare Part B who have diabetes and who meet certain conditions. If a beneficiary needs to use an insulin pump, their doctor will need to prescribe it. In the Original Medicare Plan, the beneficiary pays 20% of the Medicare-approved amount after the yearly Part B deductible. Medicare will pay 80% of the cost of the insulin pump. Medicare will also pay for the insulin that is used with the insulin pump.

Medicare Part B covers the cost of insulin pumps and the insulin used in the pumps. However, if the beneficiary injects their insulin with a needle (syringe), Medicare Part B does not cover the cost of the insulin, but the Medicare prescription drug benefit (Part D) covers the insulin and the supplies necessary to inject it. This includes syringes, needles, alcohol swabs and gauze. The Medicare Part D plan will cover the insulin and any other medications to treat diabetes at home as long as the beneficiary is on the Medicare Part D plan's formulary.

Coverage for diabetes-related durable medical equipment (DME) is provided as a Medicare Part B benefit. The Medicare Part B deductible and coinsurance or copayment applies after the yearly Medicare part B deductible has been met. In the Original Medicare Plan, Medicare covers 80% of the Medicare-approved amount (after the beneficiary meets their annual Medicare Part B deductible of $131 in 2007), and the beneficiary pays 20% of the total payment amount (after the annual Part B deductible of $131 in 2007). This amount can be higher if the beneficiary's doctor does not accept assignment, and the beneficiary may have to pay the entire amount at the time of service. Medicare will then send the beneficiary its share of the charge.

Medicare Part D Covered Diabetic Supplies and Medications

This section provides information about Medicare prescription drug coverage (Part D) for beneficiaries with Medicare who have or are at risk for diabetes. If a beneficiary wants Medicare prescription drug coverage, they must join a Medicare drug plan. The following diabetic medications and supplies are covered under Medicare drug plans:

- Diabetes supplies;
- Insulin; and
- Anti-diabetic drugs.

Diabetes Supplies

Diabetes supplies associated with the administration of insulin may be covered for all people with Medicare Part D who have diabetes. These medical supplies include the following:

- Syringes;
- Needles;
- Alcohol swabs;
- Gauze; and
- Inhaled insulin devices.

Insulin

Injectable insulin **not** associated with the use of an insulin infusion pump is covered under Medicare Part D drug plans.

Anti-diabetic Drugs

Medicare drug plans can cover anti-diabetic drugs such as:

- Sulfonylureas (i.e. Glipizide, Glyburide);
- Biguanides (i.e. metformin);
- Thiazolidinediones (i.e. Starlix® and Prandin®); and
- Alpha glucosidase inhibitors (i.e. Precose®).

COVERAGE CONT'D

Medicare Part B Covered Diabetic Services

All of the diabetes services listed in this section are covered by Medicare Part B unless otherwise noted. For people with diabetes, Medicare covers certain services. A doctor must write an order or referral for the beneficiary to get these services. These services include the following:

- Diabetes screenings;
- Diabetes self-management training;
- Medical nutrition therapy services;
- Hemoglobin A1c tests; and
- Special eye exams.

Diabetes Screenings

Medicare pays for a beneficiary to get diabetes screening tests if they are at risk for diabetes. These tests are used to detect diabetes early, and some, but not all, of the conditions that may qualify a beneficiary as being at risk for diabetes include:

- High blood pressure;
- Dyslipidemia (history of abnormal cholesterol and triglyceride levels);
- Obesity (with certain conditions);
- Impaired blood glucose tolerance; and
- High fasting blood glucose.

Diabetes screening tests are also covered if a beneficiary answers "yes" to two or more of the following questions:

- Are you age 65 or older?
- Are you overweight?
- Do you have a family history of diabetes (parents, siblings)?
- Do you have a history of gestational diabetes (diabetes during pregnancy),or
- Did you deliver a baby weighing more than 9 pounds?

Based on the results of these tests, a beneficiary may be eligible for up to 2 diabetes screenings every year at no cost (no coinsurance, or copayment or Part B deductible). Medicare will pay for a beneficiary to get 2 diabetes screening tests in a 12-month period, but not less than 6 months apart. After the initial diabetes screening test, the beneficiary's doctor will determine when to do the second test. Diabetes screening tests that are covered include the following:

- Fasting blood glucose tests; and
- Other tests approved by Medicare as appropriate.

Diabetes Self-management Training (DSMT)

Diabetes self-management training helps a beneficiary learn how to successfully manage their diabetes. Their doctor or qualified non-physician practitioner must prescribe this training for them for Medicare to cover it. A beneficiary can get diabetes self-management training if they met one (1) of the following conditions during the last twelve (12) months:

- They were diagnosed with diabetes;
- They changed from taking no diabetes medication to taking diabetes medication, or from oral diabetes medication to insulin;
- They have diabetes and have recently become eligible for Medicare;
- They are at risk for complications from diabetes. A doctor may consider the beneficiary at increased risk if they have any of the following:
    - They had problems controlling their blood glucose, have been treated in an emergency room or have stayed overnight in a hospital because of their diabetes,
    - They have been diagnosed with eye disease related to diabetes,
    - They had a lack of feeling in their feet or some other foot problems like ulcers, deformities, or have had an amputation, or
    - Been diagnosed with kidney disease related to diabetes.

A beneficiary must get this training from an accredited diabetes self-management education program as part of a plan of care prepared by their doctor or qualified non-physician practitioner. These programs are accredited by the American Diabetes Association or the Indian Health Service. Classes are taught by health care providers who have special training in diabetes education.

A beneficiary is covered by Medicare to get a total of 10 hours of initial training within a continuous 12-month period. One of the hours can be given on a one-on-one basis. The other 9 hours must be training in a group class. The initial training must be completed no more than 12 months from the time the beneficiary starts the training.

A doctor or qualified non-physician practitioner may prescribe 10 hours of individual training if the beneficiary is blind or deaf, has language limitations, or no group classes have been available within 2 months of the doctor's order. To be eligible for 2 more hours of follow-up training each year after the year the beneficiary received initial training, they must get another written order from their doctor. The 2 hours of follow-up training can be with a group or they may have one-on-one sessions. A doctor or qualified non-physician practitioner must prescribe the follow-up training each year for Medicare to cover it.

Beneficiaries learn how to successfully manage their diabetes in DSMT classes, and the training includes information on self-care and making lifestyle changes. The first session consists of an individual assessment to help the instructors better understand the beneficiary's needs. Classroom training includes topics such as the following:

- General information about diabetes, and the benefits and risks of blood glucose control;
- Nutrition and how to manage ones diet;
- Options to manage and improve blood glucose control;
- Exercise and why it is important to ones health;

- How to take ones medications properly;
- Blood glucose testing and how to use the information to improve ones diabetes control;
- How to prevent, recognize, and treat acute and chronic complications from ones diabetes;
- Foot, skin, and dental care;
- How diet, exercise, and medication affect blood glucose;
- How to adjust emotionally to having diabetes;
- Family involvement and support; and
- The use of the health care system and community resources.

Note: If a patient lives in a rural area, they may be able to get DSMT in a Federally Qualified Health Center (FQHC). For more information about FQHCs, visit http://www.cms.hhs.gov/center/fqhc.asp on the CMS website. FQHCs are special health centers, usually located in urban or rural areas, and they can give routine health care at a lower cost. Some FQHCs are Community Health Centers, Tribal FQHC Clinics, Certified Rural Health Clinics, Migrant Health Centers, and Health Care for the Homeless Programs.

Medical Nutrition Therapy (MNT) Services

In addition to DSMT, medical nutrition therapy services are also covered for beneficiaries with diabetes or renal disease. To be eligible for this service, a beneficiary's fasting blood glucose has to meet certain criteria. Also, their doctor must prescribe these services for them. These services can be given by a registered dietitian or certain nutrition professionals. MNT services covered by Medicare include the following:

- An initial nutrition and lifestyle assessment;
- Nutrition counseling (what foods to eat and how to follow an individualized diabetic meal plan);
- How to manage lifestyle factors that affect diabetics; and
- Follow-up visits to check on progress in managing diet.

Medicare covers 3 hours of one-on-one medical nutrition therapy services the first year the service is provided, and 2 hours each year after that. Additional MNT hours of service may be obtained if the beneficiary's doctor determines there is a change in their diagnosis, medical condition, or treatment regimen related to diabetes or renal disease and orders additional MNT hours during that episode of care.

Foot Exams and Treatment

If a beneficiary has diabetes-related nerve damage in either of their feet, Medicare will cover 1 foot exam every 6 months by a podiatrist or other foot care specialist, unless they have seen a foot care specialist for some other foot problem during the past 6 months. Medicare may cover more frequent visits to a foot care specialist if a beneficiary has had a non-traumatic (not because of an injury) amputation of all or part of their foot or their feet have changed in appearance which may indicate they have serious foot disease.

Hemoglobin A1c Tests

A hemoglobin A1c test is a lab test ordered by the beneficiary's doctor. It measures how well a beneficiary's blood glucose has been controlled over the past 3 months. Anyone with diabetes is covered for this test if it is ordered by their doctor. Medicare may cover this test when a beneficiary's doctor orders it.

Glaucoma Tests

Medicare will pay for a beneficiary to have their eyes checked for glaucoma once every 12 months. This test must be done or supervised by an eye doctor who is legally allowed to give this service in their state.

Special Eye Exam

People with Medicare who have diabetes can get special eye exams to check for eye disease (called a dilated eye exam). These exams must be done by an eye doctor who is legally allowed to provide this service in their state. The dilated eye exam is recommended once a year and must be performed by an eye doctor who is legally allowed to provide this service in the beneficiary's state.

Supplies and Services Not Covered by Medicare

The Original Medicare Plan and Medicare drug plans (Part D) don't cover everything. Diabetes supplies and services not covered by Medicare include:

- Eye exams for glasses (eye refraction);
- Orthopedic shoes;
- Routine or yearly physical exams (Medicare will cover a one-time initial preventive physical exam (the "Welcome to Medicare" physical exam) within the first 6 months of the beneficiary enrolling in Part B—coinsurance and Part B deductible applies.); and
- Weight loss programs.

Additional Information

- The Centers for Medicare & Medicaid Services (CMS) has developed a variety of educational resources for use by health care professionals and their staff as part of a broad outreach campaign to promote awareness and increase utilization of preventive services covered by Medicare. For more information about coverage, coding, billing, and reimbursement of Medicare-covered preventive services and screenings, visit http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp#TopOfPage on the CMS website.
- **Medicare Learning Network** - The Medicare Learning Network (MLN) is the brand name for official CMS educational products and information for Medicare fee-for-service providers. For additional information visit the Medicare Learning Network's web page at http://www.cms.hhs.gov/MLNGenInfo on the CMS website.
- **Patient Resources** - For literature to share with Medicare patients, please visit http://www.medicare.gov on the Internet.

- **The National Diabetes Education Program** - NDEP (http://ndep.nih.gov/) provides a wealth of resources for health care professionals, educators, business professionals, and patients about diabetes, its complications, and self-management.

Medicare Provides Coverage for Many Preventive Services and Screenings

MLN Matters Number: SE0752

Provider Types Affected

All Medicare fee-for-service (FFS) physicians, providers, suppliers, and other health care professionals, who furnish or provide referrals for and/or file claims for Medicare-covered preventive services and screenings provided to Medicare beneficiaries

Provider Action Needed

This article conveys no new Medicare policy but serves as a reminder of the many preventive services and screenings now covered by Medicare and provides a list of related provider educational resources developed by the Centers for Medicare & Medicaid Services (CMS) to inform FFS health care professionals and their staff about the preventive services and screenings now covered by Medicare. CMS needs your help in spreading the word about preventive health care and ensuring that people with Medicare take full advantage of preventive benefits covered by Medicare that are appropriate for them.

- Keep this Special Edition *MLN Matters* article and refer to it often.
- Order appropriate provider resources for yourself and your staff.
- Talk with your Medicare patients about their risk factors for disease and benefits of preventive health care, and encourage utilization of appropriate preventive services covered by Medicare for which they may be eligible.

Introduction

Heart disease, stroke, cancer, diabetes, osteoporosis, influenza, pneumonia, and other chronic diseases have a significant impact on the health and well-being of seniors in the United States. Yet the reality is, many of these diseases can be prevented and complications can be reduced. Medicare now provides coverage for a full range of preventive services and screenings that can help seniors and other people with Medicare stay healthy, detect disease early, and manage conditions to reduce complications. Preventive services and screenings now covered by Medicare include:

Medicare Provides Coverage for the Following Preventive Services and Screenings (subject to certain eligibility and other limitations)

- **Adult Immunizations**
  - Influenza (Flu)
  - Pneumococcal
  - Hepatitis B
- **Bone Mass Measurements**
- **Cancer Screenings**
  - Breast (mammogram and clinical breast exam)
  - Cervical & Vaginal (Pap test & pelvic exam)
  - Colorectal
  - Prostate
- **Cartiovascular Disease Screening**
- **Diabetes Screening**
- **Diabetes Self – Management Training**
- **Diabetes Supplies**
- **Medical Nutrition Therapy (beneficiaries diagnosed with diabetes or renal disease)**
- **Glaucoma Screening**
- **Initial Preventive Physical Exam (IPPE) ("Welcome to Medicare" Physical Exam)**
- **Smoking and Tobacco – Use Cessation Counseling Services**
- **Ultrasound Screening for Abdominal Aortic Aneurysms (AAA)**

Help in Spreading the Word

CMS recognizes the crucial role that health care professionals play in promoting, providing, and educating Medicare patients about potentially life saving preventive services and screenings. While Medicare now helps to pay for more preventive benefits than ever before, many Medicare beneficiaries are not yet taking full advantage of them, leaving significant gaps in their preventive health program. Statistics show that while Medicare beneficiaries visit their physician on an average of six or more times a year, many of them are not aware of their risk for disease or even that they may already have a condition that preventive services are intended to detect. As a health care professional, you can help your patients with Medicare understand the importance of disease prevention, early detection, and lifestyle modifications that support a healthier life.

CMS hopes that you will join with us in spreading the word about preventive health care by educating your patients about their risk for disease. Talk with them about the importance of preventive health care, early detection, and the preventive services covered by Medicare that are right for them, and encourage utilization of these benefits when appropriate. As people with Medicare increase their knowledge of their risk for disease and understand the benefits of early detection and disease prevention, they will be better prepared to take full advantage of the preventive benefits covered by Medicare.

Educational Products and Informational Resources for Health Care Professionals

As a trusted source, a physician's recommendation is one of the most important factors in increasing the use of preventive services and screenings by people with Medicare. However, we know the discussion can be complicated. Therefore, CMS has developed a variety of educational products to:

1. Help increase your awareness of Medicare's coverage of disease prevention and early detection;

2. Provide you with information and tools to help you communicate with your Medicare patients about these potentially life saving benefits for which they may be eligible; and
3. Give you resources to help you effectively file claims for these services.

These provider education products may be ordered, free of charge, from the CMS ***Medicare Learning Network*** (MLN). All print products are available as downloadable PDF files and may be viewed online, reprinted, and redistributed as needed. Some print products may only be available as a downloadable PDF file. To order MLN products, 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.

ATTENTION: The following educational products have been developed by CMS to be used by Medicare FFS health care professionals and their staff and **are not** intended for distribution to Medicare beneficiaries.

Bookmark

Medicare Preventive Services Bookmark - This bookmark, available at http://www.cms.hhs.gov/MLNProducts/downloads/medprevsrvcesbkmrk.pdf on the CMS website, lists the preventive services and screenings covered by Medicare and serves as a handy reminder to health care professionals and their staff about the many preventive benefits covered by Medicare. Appropriate for use as a give away at conferences and other provider/supplier related education and outreach events. Available in print or as a downloadable PDF file.

Brochures

The Medicare Preventive Services Brochure Series for Physicians, Providers, Suppliers, and Other Health Care Professionals - This series of seven tri-fold brochures provides an overview of Medicare's coverage of preventive services and screenings. Available in print and as downloadable PDF files.

- **Adult Immunizations** (influenza, pneumococcal, and hepatitis B) available at http://www.cms.hhs.gov/MLNProducts/downloads/adult_immunization.pdf;
- **Bone Mass Measurements** available at http://www.cms.hhs.gov/MLNProducts/downloads/bone_mass.pdf;
- **Cancer Screenings** (colorectal, prostate, and breast cancer screenings, and pap tests and pelvic examinations) available at http://www.cms.hhs.gov/MLNProducts/downloads/cancer_screening.pdf;
- **Diabetes-Related Services** (diabetes screening tests, diabetes self-management training, medical nutrition therapy, and supplies and other covered services for beneficiaries with diabetes) available at http://www.cms.hhs.gov/MLNProducts/downloads/DiabetesSvcs.pdf;
- **Expanded Benefits** (initial preventive physical examination (IPPE), ultrasound screening for abdominal aortic aneurysms, and cardiovascular screening blood tests) available at http://www.cms.hhs.gov/MLNProducts/downloads/expanded_benefits.pdf;
- **Glaucoma Screening** available at http://www.cms.hhs.gov/MLNProducts/downloads/expanded_benefits.pdf; and
- **Smoking and Tobacco-Use Cessation Counseling Services** available at http://www.cms.hhs.gov/MLNProducts/downloads/smoking.pdf on the CMS website.

Guide

The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals, 2nd Edition - This updated comprehensive guide, available at http://www.cms.hhs.gov/MLNProducts/downloads/mps_guide_web-061305.pdf, for Medicare FFS providers/suppliers and their staff provides information on coverage, coding, billing, and reimbursement guidelines for preventive services and screenings covered by Medicare. Available as a downloadable PDF file.

Quick Reference Information Charts

Medicare Preventive Services - This two-sided laminated chart, available at http://www.cms.hhs.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf, gives Medicare FFS physicians, providers, suppliers, and other health care professionals a quick reference to Medicare's preventive services and screenings, identifies coding requirements, eligibility, frequency parameters, and copayment/coinsurance and deductible information for each benefit. Available in print or as a downloadable PDF file.

Medicare Immunization Billing - This two-sided laminated chart at http://www.cms.hhs.gov/MLNProducts/downloads/qr_immun_bill.pdf provides Medicare FFS physicians, providers, suppliers, and other health care professionals with quick information to assist with filing claims for the influenza, pneumococcal, and hepatitis B vaccines and their administration. Available in print and as a downloadable PDF file.

The ABCs of Providing the Initial Preventive Physical Examination - This two-sided laminated chart at http://www.cms.hhs.gov/MLNProducts/downloads/MPS_QRI_IPPE001a.pdf can be used by Medicare FFS physicians and qualified non-physician practitioners as a guide when providing the initial preventive physical examination (IPPE). This handy tool identifies the components and elements of the IPPE, and provides eligibility requirements, procedure codes to use when filing claims, FAQs, suggestions for preparing patients for the IPPE, and lists references for additional information. Available in print and as a downloadable PDF file.

Video Program

An Overview of Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals - This educational video program provides health care professionals and their staff with an overview of preventive services and screenings covered by Medicare. This educational video has been approved for .1 IACET* CEU for successful completion. This video program can be ordered, free of charge, through the MLN Product Ordering web page at http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5 on the CMS website.

Web-Based Training Courses

Medicare Preventive Services Series Web-Based Training (WBT) Course - This series of three WBT courses has been designed to help fee-for-services providers/suppliers and their staff understand Medicare's coverage and billing guidelines for preventive services and screenings covered by Medicare. (To register, to take these WBT courses, free of charge, visit the MLN Product Ordering Page - http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5

- **Medicare Preventive Services Series: Part 1 Adult Immunizations Web-Based Training (WBT) Course** - This WBT course contains four learning modules that provide information about Medicare's coverage of influenza, pneumococcal, and hepatitis B vaccines and their administration. Information is also included about mass immunizers, roster billing, and centralized billing. This course was updated September 2007 and has been approved for .1 IACET* CEU for successful completion.
- **Medicare Preventive Services Series: Part 2 Women's Health Web-Based Training (WBT) Course** - This WBT course contains five learning modules that provide information about Medicare's coverage of mammography services, pap tests, pelvic exams, colorectal cancer screenings, and bone mass measurements. This course was updated October 2007 and has been approved for .2 IACET* CEUs for successful completion.
- **Medicare Preventive Services Series: Part 3 Expanded Benefits Web-Based Training (WBT) Course** - This WBT course contains seven learning modules that provide information about Medicare's coverage and billing guidelines for the three services added to the Medicare program in 2005, as a result of the Medicare Modernization Act of 2003: the initial preventive physical exam (a.k.a. "Welcome to Medicare" physical exam), and diabetes and cardiovascular disease screenings. The course also includes information about diabetes self management training, medical nutrition therapy and diabetes supplies covered by Medicare as well as detailed information on colorectal, prostate, and glaucoma screenings, and bone mass measurement services. This course was updated November 2007 and has been approved for .2 IACET* CEUs for successful completion.

Web Page

MLN Preventive Services Educational Products Web Page - This Medicare Learning Network (MLN) web page provides descriptions of all MLN preventive services related educational products and resources designed specifically for use by Medicare FFS providers/suppliers. PDF files provide product ordering information and links to all downloadable products. This web page is updated as new product information becomes available. Bookmark this page for easy access. http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp#TopOfPage on the CMS website.

Other Useful Provider Resources:

The Medicare Learning Network (MLN) - is the brand name for official CMS educational products and information for Medicare fee-for-service providers. For additional information, visit the Medicare Learning Network's web page at http://www.cms.hhs.gov/MLNGenInfo on the CMS website.

CMS Prevention Web Pages - CMS has created preventive services web pages. For additional information, visit http://www.cms.hhs.gov/home/medicare.asp and scroll down to the "Prevention" section.

Preventive Benefit Information for Medicare Beneficiaries - For literature to share with your Medicare patients, please visit http://www.medicare.gov. Medicare beneficiaries can also obtain information about Medicare preventive benefits at this website or they may call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

*The Centers for Medicare & Medicaid Services (CMS) has been reviewed and approved as an Authorized provider by the International Association for Continuing Education and Training (IACET), 8405 Greensboro Drive, Suite 800, McLean, VA 22102. The authors of the video program and web-based training course have no conflicts of interest to disclose. The video program and web-based training course were developed without any commercial support.

Nebulized Beta Adrenergic Agonist Therapy for Lung Diseases

MLN Matters Number: MM5820
Related Change Request (CR) #: 5820
Related CR Release Date: December 21, 2007
Related CR Transmittal #: R79NCD
Effective Date: September 10, 2007
Implementation Date: January 22, 2008

Provider Types Affected

Providers and suppliers who bill Medicare contractors (fiscal intermediaries (FI), regional home health intermediaries (RHHI), carriers, Medicare Administrative Contractors (A/B MAC), and Durable Medical Equipment Contractors (DME MAC) for nebulized beta adrenergic agonist therapy services for lung diseases.

What You Need to Know

CR 5820, from which this article is taken, provides that (effective September 10, 2007) no National Coverage Determination (NCD) for nebulized beta adrenergic agonist therapy for lung diseases is appropriate. Therefore, you should make sure that your billing staffs are aware that local contractors will continue to make Section 1862(a)(1)(A) reasonable and necessary decisions through a local coverage determination process or case-by-case adjudication.

Note: No changes to process or policy are being made with CR5820.

Background

Lung diseases such as chronic obstructive pulmonary disease (COPD) and asthma are characterized by airflow limitation that may be partially or completely reversible. Pharmacologic treatment with bronchodilators (intended to improve the movement of air into and from the lungs by relaxing and dilating the bronchial passageways) is used to prevent and/or

control daily symptoms that may cause disability for persons with these diseases.

Beta adrenergic agonists (which can be administered via nebulizer, metered dose inhaler, orally, or dry powdered inhaler) are a commonly prescribed class of bronchodilator drug. For example, nebulized beta adrenergic agonist with racemic albuterol has been used for many years, and more recently, levalbuterol, the (R) enantiomer of racemic albuterol, has been used in some patient populations.

Because of concerns regarding the appropriate use of nebulized beta adrenergic agonist therapy for lung disease, the Centers for Medicare & Medicaid Services (CMS) internally generated a formal request for a national coverage determination (NCD) to determine when treatment with a nebulized beta adrenergic agonist is reasonable and necessary for Medicare beneficiaries with COPD.

The examination of the published medical evidence did not provide sufficient information that would enable CMS to define, at this time, specific populations of patients who would benefit from a particular treatment with particular medications. Moreover, because an NCD is defined, in part, as including "whether or not a particular item or service is covered nationally" under title XVIII, sections 1862(l), 1869(f)(1)(B); CMS does not believe a national policy is possible or prudent at this time.

Therefore, effective with dates of service on and after September 10, 2007, Medicare contractors will continue to make 1862(a)(1)(A) reasonable and necessary decisions and process claims for nebulized beta adrenergic agonist therapy for lung disease through their local coverage determination process or case-by-case adjudication.

Note: No changes to process or policy are being made with CR5820.

Additional Information

You can find the official instruction, CR 5820, issued to your FI, RHHI, Carrier, A/B MAC, or DME MAC by visiting http://www.cms.hhs.gov/Transmittals/downloads/R79NCD.pdf on the CMS website. You will find the *Medicare National Coverage Determinations Manual*, Chapter 1, Part 4 (Sections 200 – 310.1) Coverage Determinations, Section 200.2 - Nebulized Beta Adrenergic Agonist Therapy for Lung Diseases – (Effective September 10, 2007) as an attachment to that CR.

APPEALS

Modification to the Model Medicare Redetermination Notice (for partly or fully unfavorable redeterminations)

MLN Matters Number: MM5836
Related Change Request (CR) #: 5836
Related CR Release Date: January 11, 2008
Related CR Transmittal #: R1408CP
Effective Date: January 1, 2008
Implementation Date: February 11, 2008

Provider Types Affected

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

What You Need to Know

CR 5836, from which this article is taken, modifies the Reconsideration Request Form that is included with the model Medicare Redetermination Notice (for partly or fully unfavorable redeterminations), to clarify the minimum set of elements on the form that you must complete in order for the request to be considered valid for reconsideration.

You should make sure that your billing staffs are aware that they must complete items 1, 2a, 6, 7, 11 & 12 on this Reconsideration Request Form.

Background

The Reconsideration Request Form modification that CR 5836 requires is necessary because the current Medicare manual instructions do not clearly identify all of the elements required for a reconsideration request to be considered valid in accordance with Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) Section 405.964(b).

The modification to the form is as follows:
"Directions: If you wish to appeal this decision, please fill out the required information below and mail this form to the address shown below. At a minimum, you must complete/include information for items 1, 2a, 6, 7, 11 & 12 but to help us serve you better, please include a copy of the redetermination notice with your request."

Those elements that, as a minimum, you must complete in the form are:

1. Name of Beneficiary
2a. Medicare Number
6. Item or service you wish to appeal
7. Date of the service (From and To dates)
11. Name of Person Appealing
12. Signature of Person Appealing/Date

Additional Information

You can find more information about the modification to the model Medicare Redetermination Notice (for partly or fully unfavorable redeterminations) by going to CR 5836, located at http://www.cms.hhs.gov/Transmittals/downloads/R1408CP.pdf on the CMS website. The updated *Medicare Claims Processing Manual*, Chapter 29, Section 320.7 (Medicare Redetermination Notice (for partly or fully unfavorable redeterminations)) is an attachment to that CR. The Reconsideration Request Form is also attached to CR5836.

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

MLN Matters Number: MM5852
Related Change Request (CR) #: 5852
Related CR Release Date: January 8, 2008
Related CR Transmittal #: R1406CP
Effective Date: January 1, 2008
Implementation Date: January 7, 2008

Provider Types Affected

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

What You Need to Know

CR 5852, from which this article is taken, instructs Medicare contractors to download and implement the January 2008 Average Sales Price (ASP) drug pricing file for Medicare Part B drugs; and if released by CMS, also the revised January 2007, April 2007, July 2007, October 2007, April 2006, July 2006, 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:

1. The FDA approval,
2. Therapeutic equivalents as determined by the FDA, and
3. 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

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

Summary of Exceptions to this General Rule

1. Except for blood clotting factors, the payment allowance limits for **blood and blood products** (that are not paid on a prospective payment basis) are determined in the same manner they were determined on October 1, 2003. Specifically, the payment allowance limits for blood and blood products are 95% of the average wholesale price (AWP) as reflected in the published compendia; and will be 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 APC to which the product is assigned.

   Note: 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 a new blood clotting factor when a new blood clotting factor is not included on the ASP file. For 2008, a separate fee of $0.158 per I.U. of blood clotting factor furnished is payable when separate payment for the blood clotting factor is made. The furnishing fee will be included in the payment amounts on the quarterly ASP pricing files.

2. Payment allowance limits for **infusion drugs furnished through a covered item of durable medical equipment (DME)** on or after January 1, 2005, will continue to be 95% of the AWP reflected in the published compendia as of October 1, 2003, unless the drug is compounded or incident to a professional service. **The payment allowance limits will not be updated in 2008.**

   Similarly, payment allowance limits for **infusion drugs furnished through a covered item of DME** that were not listed in the published compendia as of October 1, 2003, (i.e., new drugs) are 95 percent (95%) of the first published AWP unless the drug is compounded or furnished incident to a professional service.

3. The payment allowance limits for **influenza, Pneumococcal and Hepatitis B vaccines** are 95% of the AWP as reflected in the published compendia except, when administered in a hospital outpatient department, the vaccines are paid at reasonable cost.

4. Except for new drugs and biologicals that are produced, or distributed, under a new drug application (or other application) approved by the Food and Drug Administration (FDA), the payment allowance limits for **drugs and biologicals that are not included in the ASP Medicare Part B Drug Pricing File or Not Otherwise Classified (NOC) Pricing File**, are based on the published wholesale acquisition cost (WAC) or invoice pricing (except under OPPS in which the payment allowance limit is 95% of the published AWP).

   In determining the payment limit based on WAC, contractors will follow the methodology specified in the *Medicare Claims Processing Manual*, Chapter 17, Drugs and Biologicals, for calculating the AWP but will substitute WAC for AWP. The payment limit is 100% of the lesser of the lowest-priced brand or median generic WAC.

5. The payment allowance limits for **new drugs and biologicals** that were first sold on or after January 1, 2005; and are: 1) Produced or distributed under a new drug application (or other new application) approved by the Food and Drug Administration, and 2) Not included in the ASP Medicare Part B Drug Pricing File or Not Otherwise Classified (NOC) Pricing File; are based on 106% of the WAC (or invoice pricing if the WAC is not published) except under OPPS in which the payment allowance limit is 95% of the published AWP.

6. The payment allowance limits for **radiopharmaceuticals** are not subject to the ASP payment methodology. Contractors should 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.

7. The payment methodology for **drugs furnished incident to the filling or refilling of an implantable pump or reservoir** is determined under the ASP methodology (as described above) unless the drug furnished incident to the filling or refilling of an implantable pump or reservoir is a compounded drug, then pricing is performed by the local contractor.

   Physicians (or a practitioner described in Section 1842(b) (18) (C)) may be paid for filling or refilling an implantable pump or reservoir when it is medically necessary that they perform the service. 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.

   On or after December 18, 2007, the January 2008 ASP file and ASP NOC files will be available for retrieval from the CMS ASP webpage. If CMS determines that revisions to the January 2007, April 2007, July 2007, October 2007, April 2006, July 2006 and October 2006 ASP payment files are necessary, the revised files will also be available for retrieval from the CMS webpage on or after December 18, 2007. The revised payment files will be applied to claims processed or reprocessed on or after this CR's (5852) effective date.

   Table 1 below displays the payment allowance limit revision dates, and the applicable dates of service.

Table 1

Payment Allowance Limit Revision Date	Applicable Dates of Service
January 2008	January 1, 2008 through March 31, 2008
Revised January 2007*	January 1, 2007 through March 31, 2007
Revised April 2007*	April 1, 2007 through June 30, 2007;
Revised July 2007*	July 1, 2007, through September 30, 2007
Revised October 2007*	October 1, 2007 through December 31, 2007
Revised April 2006*	April 1, 2006 through June 30, 2006;
Revised July 2006*	July 1, 2006, through September 30, 2006
Revised October 2006*	October 1, 2006, through December 31, 2006

*If made available by CMS

DRUGS/BIOLOGICALS CONT'D

Note: *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.*

Final Notes: 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 will make these determinations.

Contractors (at their discretion) may contact CMS to obtain payment limits for drugs and biologicals not included in the quarterly ASP or NOC files, or that CMS has not otherwise made available on its website. If the payment limit is available from CMS, contractors will substitute CMS-provided payment limits for pricing based on WAC or invoice pricing.

Contractors will not search for, and adjust, a claim that has already been processed unless you bring it to their attention.

Additional Information

For complete details, please see the official instruction (CR 5852) issued to your carriers, DME MACs, FIs, A/B MACs, and/or RHHIs regarding this change, by visiting http://www.cms.hhs.gov/Transmittals/downloads/R1406CP.pdf on the CMS website.

WHEELCHAIR/POWER MOBILITY DEVICE

ATP Requirement on Power Wheelchairs – Revised

This is a revision to a recently published article. It adds a sentence from the policy prohibiting any financial relationship between the supplier and the clinician who performs the specialty evaluation.

The DME PSC medical directors received LCD reconsideration requests to revise the Power Mobility Devices LCD from the American Occupation Therapy Association, the American Physical Therapy Association, and the American Association for Homecare. Each group asked for deletion of the requirement that patients receiving rehab power wheelchairs on or after April 1, 2008, be evaluated by a RESNA-certified Assistive Technology Practitioner.

The current LCD lists two requirements that were scheduled to be implemented for claims with dates of service on or after April 1, 2008:

1. The specialty evaluation for patients receiving a Group 2 single power option or multiple power option PWC, any Group 3 or Group 4 PWC, or a push rim activated power assist device for a manual wheelchair must be performed by a RESNA-certified Assistive Technology Practitioner (ATP) specializing in wheelchairs or a physician who is board-certified in Physical Medicine and Rehabilitation.

   After consideration of the issues, the PSCs have decided to remove this requirement from the policy.

2. A Group 2 single power option or multiple power option PWC, any Group 3 or Group 4 PWC, or a push rim activated power assist device for a manual wheelchair must be provided by a supplier that employs a RESNA-certified Assistive Technology Supplier (ATS) or Assistive Technology Practitioner (ATP) who specializes in wheelchairs and who has direct, in-person involvement in the wheelchair selection for the patient.

   This requirement is being retained and will be effective for claims with dates of service on or after April 1, 2008.

The following requirement which is in the current LCD will remain in place: Patients receiving a Group 2 single power option or multiple power option PWC, any Group 3 or Group 4 PWC, or a push rim activated power assist device for a manual wheelchair must have a "specialty evaluation that was performed by a licensed/certified medical professional, such as a PT or OT, or physician who has specific training and experience in rehabilitation wheelchair evaluations and that documents the medical necessity for the wheelchair and its special features. **The PT, OT, or physician may have no financial relationship with the supplier**."

This information will be incorporated in a future revision of the Power Mobility Devices LCD.