Jurisdiction D News from Noridian Administrative Services, LLC.

Happenings

July 2008
Issue No. 14

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

In This Issue…

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

CERT

MEDICAL REVIEW

FORMS

BILLING

REIMBURSEMENT

CODING

COVERAGE

WHEELCHAIR/POWER MOBILITY DEVICE

Alphabetical Listing...

Jurisdiction D DME MAC Supplier Contacts and Resources

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

Web site: www.noridianmedicare.com

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

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

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

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

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

Holiday Schedule

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

Holiday	Date
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.

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."

Payment Floor Available on IVR

To access payment floor information from the IVR Main Menu, use the voice activation option by saying "payment floor" or press 7 on the phone keypad.

In order to access payment floor information, you will need to provide the:

- NPI
- PTAN

The IVR will provide the following payment floor information:

- Number of pending claims
- Total dollar amount of pending claims
- Number of claims on the payment floor
- Total dollar amount on the payment floor

After payment floor information is provided, the IVR will explain the next options, which you can either speak or key:

- Repeat That (Press 1)
- Change PTAN (Press 2)
- Change NPI (Press 3)
- Main Menu (Press 8)

Benefits of contacting the IVR for payment floor inquiries are:

- No hold time!
- The ability to check multiple NPI and PTAN numbers
- Longer hours for the IVR as compared to the Contact Center. The IVR is available from 6 am - 6 pm CT, whereas the contact center hours are 8 am - 5:30 pm CT.

An updated IVR User Guide has been added to the Contact section of our web site.

IVR At-A-Glance Brochure

NAS has recently rolled out new enhancements to the IVR. Included in these enhancements is a new IVR quick reference guide with tips on how to use the IVR more effectively.

Here's a quick overview of the recent enhancements to the IVR:

Same and Similar Equipment:
The IVR will provide the following same or similar information:

- HCPCS on file that is considered same or similar to the HCPCS entered
- Initial date of the equipment on file
- A recertification date, if applicable
- Last day the item was billed
- Name of the supplier who billed the paid item
- Phone number of supplier who billed the paid item

For more information on accessing same or similar equipment on the IVR, refer to the article posted under What's New on May 19, 2008.

Payment Floor:
The IVR will provide the following payment floor information:

- Number of pending claims
- Total dollar amount of pending claims
- Number of claims on the payment floor
- Total dollar amount on the payment floor

For more information on accessing payment floor on the IVR, refer to the article posted under What's New on June 5, 2008.

IVR At-A-Glance and Updated User Guide:
The IVR At-A-Glance [PDF] is a quick reference guide which contains information on how to use each option available on the IVR. This guide includes the information contained in the IVR User Guide, but in a format that is easily printable for quick reference by the telephone. An updated IVR User Guide has been added to the web site under the Contact section. This user guide provides detailed instructions on how to use each option available on the IVR.

Tips and Reminders
Both the PTAN and NPI will be required before IVR information is released

- CMS mandates that all suppliers first access inquiries through the IVR.
- The IVR is available from 6am - 6 pm CT
- The same or similar option will only release information on equipment with an initial date within 5 years, from the date of inquiry.
- When using the IVR, do not press the pound key. Pressing this key will cause the system to end the call.

Beneficiaries Call 1-800-MEDICARE

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

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

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

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

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

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

- View claim status (excluding Part D claims)
- Order a duplicate Medicare Summary Notice (MSN) or replacement Medicare card

- View eligibility, entitlement and preventive services information
- View enrollment information including prescription drug plans
- View or modify their drug list and pharmacy information
- View address of record with Medicare and Part B deductible status
- Access online forms, publications and messages sent to them by CMS

Iowa Flooding

In light of recent flooding in Iowa, suppliers are reminded that the modifier CR signifies that a claim is due to a catastrophe or is related to a disaster. Reporting this modifier will indicate emergency health care needs and facilitate Medicare claims processing for victims of a disaster.

CMS established the CR modifier (Catastrophe/Disaster Related), effective August of 2005 (MLN Matters 4106).

Medicare will cover replacement of DMEPOS items due to a natural disaster as outlined in Chapter 5 of the Jurisdiction D Supplier Manual:

> "Replacement refers to the provision of an identical or nearly identical item. Equipment which the beneficiary owns or is a capped rental item may be replaced in cases of loss or irreparable damage. Irreparable damage refers to a specific accident or to a natural disaster (e.g., fire, flood, etc.)."

New capped rental periods will start for beneficiaries who need to replace equipment due to the flood. Repairs of equipment will also be covered, per the usual guidelines, also outlined in Chapter 5 of the Jurisdiction D Supplier Manual.

The US Department of Health and Human Services released the following on June 16, to help Medicare beneficiaries and providers in Iowa:

HHS Takes Action to Help Medicare Beneficiaries and Providers in Iowa and Indiana

HHS Secretary Mike Leavitt today declared a public health emergency in the flood-stricken states of Iowa and Indiana. The action gives HHS' Centers for Medicare & Medicaid Services' (CMS) Medicare beneficiaries and their health care providers greater flexibility in meeting emergency health needs.

"The flooding in Iowa and Indiana is devastating to each individual and to their communities," Secretary Leavitt said. "This designation will allow HHS to immediately assist our beneficiaries and providers in the areas where hospitals and other health care delivery systems have been disrupted. It will help ensure that medical assistance is provided promptly and effectively."

Secretary Leavitt acted under his authority in the Public Health Service Act.

Because of flood damage to local health care facilities, many beneficiaries have been evacuated to neighboring communities, where receiving hospitals and nursing homes may have no health care records, information on current health status or even verification of the person's status as a Medicare beneficiary.

CMS is assuring those facilities that in this circumstance, the normal burden of documentation will be waived and that they can act under a presumption of eligibility.

"In emergencies such as this, CMS has the flexibility to ensure that vital health care services can be maintained and utilized," said CMS Acting Administrator Kerry Weems. "Many of the agency's normal operating procedures will be relaxed to speed provision of health care services to the elderly and persons with disabilities who depend upon these services."

CMS will undertake the following actions to the extent necessary to ensure sufficient items and services are available to meet the needs of Medicare beneficiaries. The agency will make certain that health care providers that provide items and services in good faith are exempt from sanctions from noncompliance with otherwise applicable requirements, provided there is no fraud or abuse.

1. CMS will waive certain program requirements for the following institutional providers:
   - Critical Access Hospitals: Allow these hospitals to take more than the statutorily mandated limit of 25 patients and not count the expected longer lengths of stay for evacuated patients against the 96-hour average;
   - Skilled Nursing Facilities: Waive the three-day prior hospitalization requirement for admission for evacuated patients and relax limitations on the benefit period for those evacuated patients;
   - Long-Term Care Hospitals: Not count the evacuated patients in calculating the 25-day average length of stay;
   - Inpatient Rehabilitation Facilities: Not count the evacuated patients in determining compliance with the 60 percent rule requirement. The 60 percent rule says at least 60 percent of the population in a facility must be deemed eligible for that facility.
2. CMS will expand the definition of "home" to allow those Medicare beneficiaries who are receiving home health services to receive those services in alternative sites.
3. For the Medicare Part D prescription benefit, CMS will ensure that rules that prevent early refills are waived. This will assist those beneficiaries who left prescriptions in evacuated homes or lost their prescription during the evacuation.
4. Certain sanctions under the Emergency Medical Treatment and Labor Act (EMTALA) will not be imposed for 72 hours after a hospital implements a hospital disaster protocol so long as actions by the hospital do not discriminate among individuals on the basis of their source of payment, ability to pay, or on the basis of race, color, or national origin.

FYI CONT'D

5. Beneficiaries in health plans will be able to go out of network during this emergency. CMS is working with the health insurance industry to ensure there are no barriers to this service for those in plans.
6. The End Stage Renal Disease (ESRD) network has been activated, and CMS may grant further waivers if needed.
7. CMS will be working with the Federal Emergency Management Agency (FEMA) to manage lost, stolen, or left behind DME equipment.

More information about CMS'emergency relief activities will be made available on the CMS Web site, www.cms.gov in the coming days.

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In response to the emergencies resulting from the Midwest flooding, CMS is providing resources to ensure effective health care coverage and quality of care for beneficiaries. The **CMS** extreme weather and emergencies relief activities resource link for Midwest Floods is located by clicking: http://www.cms.hhs.gov/emergency/20_midwestflooding.asp

Questions and Answers on the Midwest Flood page can be downloaded by clicking on https://questions.cms.hhs.gov/cgi-bin/cmshhs.cfg/php/enduser/std_alp.php?p_pv=2.1019&p_prods=318%2C1019&prod_lvl1=318&prod_lvl2=1019 (click New -CMS Response to Midwest Floods Emergency go under File Attachments)

To read the **HHS** Public Health Emergency News Release issued click here: http://www.hhs.gov/news/press/2008pres/06/20080616a.html

Alert: FDA Heparin Recall for All Provider Types

Please help Food and Drug Administration (FDA) spread the word about recalls of injectable heparin products and heparin flush solutions that may be contaminated with oversulfated chondroitin sulfate (OSCS). Affected heparin products have been found in medical care facilities in one state since the recall announcement. Although product recall instructions were widely distributed, they may not have been fully acted upon at all sites where heparin is used. There have been many reports of deaths associated with allergic or hypotensive symptoms after heparin administration (see FDA link at http://www.fda.gov/cder/drug/infopage/heparin/adverse_events.htm).

We ask that health professionals and facilities please review and examine all drug/device storage areas, including emergency kits, dialysis units and automated drug storage cabinets to ensure that all of the recalled heparin products have been removed and are no longer available for patient use. In addition, FDA would like to inform health professionals about other types of medical devices that contain, or are coated with, heparin. To read this update, and to learn how to report these problems to FDA, please go to: http://www.fda.gov/cdrh/safety/heparin-healthcare-update.html.

Please report to FDA adverse reactions associated with these devices, as well as any reactions associated with heparin or heparin flush solutions. If you have questions or would like more information about this request, please contact the Division of Drug Information at 301-796-3400.

EDUCATIONAL

Ask the Contractor Q & A – May 14, 2008

Prior to taking questions, NAS provided the following updates:

NPI

NPI, as of May 23, 2008, only the NPI will be allowed for all HIPAA standard transactions. What this means to you as a small supplier is for all primary and secondary provider fields, only the NPI will be accepted and send on all HIPAA electronic transactions, paper claims, and paper remittances. Any claim with a Medicare legacy identifier, i.e. and NSC or UPIN, in any of the primary or secondary provider fields will result in rejection of the claim. Only the NPI can be reported in Item 32a when Item 32 is required, Item 33a and Item 17b. **If Item 33b or Item 17a contains any data the claim will be rejected**, as these fields are for non-NPI identifiers.

We request that you test now to allow time for the needed corrections before May 23, 2008, the date when only NPI will be accepted in all provider fields. For more information, see the article titled *Paper Claim Submission for NPI as of May 23, 2008,* posted to our web site on May 6th.

We also posted an article on May 6th regarding the EDI front-end edits for claims submitted as of May 23, 2008 when an NPI is not reported in any provider fields. Look for the article titled *"EDI Edits for May 23rd NPI Requirement".*

PTAN Requirements
Suppliers will also need to provide their NPI and Provider Transaction Access Number or PTAN when contacting Medicare for assistance as of May 23, 2008. For providers enrolled in Medicare before May 23, 2008, their PTAN is their legacy provider number or NSC number.

When calling the IVR or a contact center representative, both the NPI and PTAN will be required. When writing, including faxes, a provider name is required, along with either the NPI or PTAN. If the provider's name and address are included in the letterhead or e-mail attachment and clearly establish the provider's identity, an NPI or PTAN is not required.

For more information on the PTAN requirements, reference the MLN Matters article Special Edition 0814 (SE0814).

CEDI Transition-May 1, 2008
National Government Services, Inc. was awarded the DME Common Electronic Data Interchange or CEDI front-end contract. With this contract, CEDI provides a single front-end solution for the submission and retrieval of electronic transactions. With this change, DME MAC electronic submitters will send all electronic claims and Claim Status Inquiry transactions to CEDI. CEDI will return all electronic front-end reports directly to the submitter. CEDI will also receive the ERA and Claims Status Response transactions from the DME MACs and deliver them to the Trading Partner's CEDI mailbox.

Suppliers in Jurisdiction D had to transition to the common EDI front-end by April 30, 2008.

If you need to transition or need assistance in submitting claims or retrieving reports or remittance advices, contact the **CEDI Help Desk** at **866-311-9184 between the hours of 9 AM - 9 PM (ET)**. Email support is also available at ngs.CEDIhelpdesk@wellpoint.com. CEDI's web site is www.NGSCEDI.com.

For tips in contacting CEDI, reference the article titled "Helpful Tips for Contacting CEDI During Transition" posted to our website on May 5th. Electronic suppliers will want to join the CEDI list serve to receive important EDI information. If you are an Express Plus user, an upgrade to Version 4.3.8 is required to submit claims to CEDI.

PO Box for Overpayment Appeals
In order to improve our customer service for suppliers requesting an appeal of an overpayment, NAS has specified a new Post Office Box for DME Overpayment Redeterminations. We encourage you to complete the Redetermination Request form and mail to PO Box 6728, with an attention line of DME Overpayment Redeterminations, along with a copy of the overpayment letter. A new checkbox has been added for the redetermination form to alert NAS staff that this is an appeal for an overpayment.

Online Learning Center
NAS DME Education staff is pleased to announce the availability of our Online Learning Center or OLC. The OLC is a self-paced learning environment that allows suppliers to take pre and post-assessments, complete lessons, view resources and participate in surveys, 24 hours a day/ 7 days a week.

Our OLC provides two courses: Medicare and DME Fundmentals and DME Coverage and Specialties. Currently, only lessons are available under the Medicare and DME Fundamentals course. These lessons are: Benefit & Payment Categories, Advance Beneficiary Notice, Certificate of Medical Necessity and DME MAC Information Forms, Appeals Process and Supplier Overpayments. The DME Coverage and Specialties course is under construction.

To access the OLC, select the link located on the Training/ Events page or the OLC icon on our DME website home page. The training page also has step-by-step instructions on how to access the courses and topics. We encourage you to take advantage of this new training tool. This is a great way to educate new staff or take refresher training on these topics.

The following questions and answers are from the May 14, 2008, Ask-the-Contractor Teleconference. In some cases, the original answers given during the call may have been expanded to provide further detail. These were current as of this event. Please check our web site for updates.

Q1. We have been going through medical review now for a while. We are not getting any kind of payment. This is really hard on our business and we cannot make payments to our suppliers. They're threatening to take us to court because Medicare has not paid us yet. We keep getting this letter from Medicare denying any equipment that we supply, even walkers, commodes or beds. Whatever we supply, there is a letter requesting medical documentation. We send the documentation, but the claims are still denied. I don't know what else to do and we're getting very frustrated. It's not good for our business. We're beginning to get worried to even do business with new customers.
A1. Education staff contacted this supplier to hear their concerns. This supplier's claims are under review by the Program Safeguard Contractor so the supplier was advised to contact them for further information.

Q2. I just started sending claims to CEDI on May 1. I know before on our front-end edits, we'd always get errors, for example, if there was a modifier wrong or a diagnosis wrong or anything wrong with the claim, it wouldn't go on to Medicare, and I'd have to correct it first. I have sent four batches and none of them had any errors. This is good, but I'm just wondering, in the two years that I've done this, there's always one that has an error. I'm wondering if you are going to be doing the same type of editing as EDI did and kick them out before they went on to Medicare?
A2. Yes, CEDI has the same kind of errors. CEDI has three different level one reports: a TRN report, a 997 and a Gen Response. The actual front-end edit reports always start with RPT. If you are not getting any errors on these reports, fax your Submitter ID and dates you submitted claims to the CEDI to 317-595-4999, Attn. Julie.

Q3. Why is it so difficult to get a connection with CEDI when before I didn't have that with EDI? It would connect automatically.
A3. We have a lot of people that are trying to convert to CEDI all at once, which is causing both the phone lines to get into the helpdesk to be overwhelmed, as well as the lines for claim submission.

As of this weekend, there are several things that are going to be taking place. More modem lines are going in for asynchronous connections, as well as 23 new lines for FTP.

At the end of May, additional lines will be going in on a new T1 line. This Friday, a new option will be put on the front-end for the call tree for password resets. This will increase availability for associates on the help desk to be able to take calls and get answers to questions.

Q4. I sent a batch on May 1, 2008, and it came back as rejected saying the billing provider is not authorized for the submitter. Why is this occurring and how should this be resolved?
A4. The B108 error is telling you there is not a link in the CEDI translator for the provider to the submitter ID. There are a number of things that could be causing this. In some cases, we've got the provider number, but we don't have the NPI number in our translator. Linking issues for getting the NPI and NSC or PTAN number linked through the crosswalk usually cause that. We also have a large number of providers that when we pulled all our information between the four DME MAC jurisdictions, the information attaching provider numbers submitter IDs didn't get communicated to CEDI.

CEDI is running updates with the NPI crosswalk to make sure if NSC numbers and NPIs are successfully linked through that, the information will be pulled into the CEDI records and this will eliminate the B108 error. You may only be seeing this error if you were sending NPI only. If you've been sending the legacy PTAN number and the NPI both for awhile and you're still getting that error, if we can determine through the reports that you actually were submitting this before, that's something that can be fixed by CEDI.

If you are receiving the B108 error, send an email to cedienrollment@wellpoint.com. In the subject field, put CEDI B108. In the e-mail, please provide your sender ID, the name of the sender for that sender ID, PTAN and NPI numbers, a contact name, phone number, e-mail and fax number. The enrollment team will review and respond.

Q5. I was calling to see how we could bill for respiratory care services. I know it's not a Medicare covered benefit, but for beneficiaries who have a secondary insurance that may consider payment for this, how do we get a denial from Medicare?
A5. You cannot bill it through DME because our responsibility is for the supplies that are used. Anything that is a service that is provided to a patient, such as an evaluation or office visit, would be a Medicare Part B benefit.

There are suppliers that will bill those types of services to DME for a denial. You would get a denial that it was sent to the wrong carrier, which may not be a denial that supplemental insurances will recognize and consider for payment. You would have to review the CPT book and try and find the procedure that meets what you are doing. We do not help providers code for any type of service or item.

Q6. I've been having trouble getting my PTAN to connect with my NPI. I was told I needed to change some addresses, but when I'm in the NPPES web site, it's not letting me do this and I don't know who could help me on this.
A6. NAS contacted the supplier and walked her through the NPPES web site. The claims have since processed.

Q7. When will the approved vender list next be updated? It looks like currently on the web site, the last update was April 24.
A7. CEDI stated that this vendor list should have been updated on May 12.

Q8. Now that CMS had released the unattended sleep studies decision, is it true that DME suppliers can now do these?
A8. The national coverage determination revision allows for some types of home sleep studies, but we are still waiting for additional direction from CMS on how that affects DME for the coverage of the actual equipment and who can do those tests and so on. We anticipate DME suppliers will not be allowed to do those tests. As soon as we have any information, we will be updating our LCDs and sharing that information with suppliers through our website and email list messages.

Q9. This is regarding the report that we are getting back from CEDI. Can we have it on landscape because it is really hard to play around with it in its current format? I addressed this to my software, Care Centric. They said to contact CEDI.
A9. Please fax your sender ID to 317-595-4999 for CEDI to look into this.

Follow-up Questions: What's an exit code one when I'm sending my claims? I'm not sure if my claims went through. I'm not getting back an RPT report, but I'm afraid to send claims through again as I don't want to cause duplicate claims.
Please send an example to CEDI to research by faxing your information to them.

Q10. I billed for a hospital bed January 15, 2008, February 15, 2008, and March 15, 2008, and received payments. Later, I received a letter from Medicare stating that the patient went into a skilled nursing facility for date of service February 15th and therefore the payment for the bed must be returned. When I called customer service, the patient was in a SNF from February 10th until February 15th. Can I re-bill February 9th or either February 16th so as to not lose my February payment?
A10. In this situation, the correct action would be to resubmit the claim with a date of service of February 16, 2008. For more information regarding SNF billing, please see the Supplier Manual, Chapter 5, subheading "Consolidated Billing", paragraph titled "SNF Consolidated Billing – Capped Rental DME".

Q11. I have a question regarding the accreditation standards for suppliers. It appears that there are two dates in question. I know everybody needs to be accredited by September 1, 2009. I also heard something about September 1, 2008. Would you clarify the dates for us?
A11. All suppliers have to be accredited by September 30, 2009. There are other accreditation dates for suppliers who wish to participate in the second round of competitive bidding but these are not September dates.

Follow-up Questions: I am an optician and am certified by the American Board of Opticianry. All of the accreditors on the approved list look like they don't know one thing about optical or eyeglasses. Has any thought been given to the capabilities of these accreditors?

Those accreditors were chosen by CMS. There are some accrediting organizations that specialize in certain types of DME, for example, prosthetics and orthotics. There are other organizations that do general accreditation for all types of DMEPOS and there are general accreditation standards that all suppliers need to meet. In your case, you would want to meet the general standards.

Q12. We're a very small, orthopedic practice, and if we choose not to be accredited for Medicare, we can still bill other insurances for DME products, correct?
A12. Yes.

Follow-up Question: We are in a rural area and the chances that a supplier in our area would be awarded a contract for competitive bidding are slim. If we give the Medicare patients a prescription, they can go to any one of the supply companies and get the prescribed item, correct?
Yes.

Follow-up Question: As long as we don't bill to Medicare, we are fine, if we choose not to be accredited.
Yes.

Q13. I want to know what's going on with oxygen, Are there any set rules on what's going to happen when concentrators are capped out?
A13. CMS is going to be providing some direction on that, but we're not sure how soon. CMS is aware of the supplier concerns.

Follow-up Question: So we will be hearing on that, but it still stands that the three years will be up at the end of this year?
Yes. It would take an act of Congress or legislation to change the 36-month cap.

Q14. We are a small provider in a rural area and we're in the process of getting an ATS . We want to know if we subcontract an ATP that's in the area for the period beforehand, as long as they have direct patient contact. Then once their services are no longer needed, can we terminate this contract and use our ATS in the future?
A14. Yes, you can subcontract out for ATP/ATS services. Last week, NAS published on our web site FAQs on PMDs and the ATS/ATP requirements, which you should find helpful.

Q15. I billed a hospital bed for 13 rental months and was paid for all 13 months. The family called me and said their mother had passed away and asked if I could come and pick up the bed. Should I pick up the bed or not, because the bed looks like new? If I do pick it up, can I rent it to another patient or not?
A15. It is the beneficiary's family's choice of what they want to do with the bed because the title belongs to the beneficiary. We do not know of any Medicare rules that state you could not pick up the bed and resell it as used.

Q16. Is there an alternative way of speaking with somebody at CEDI rather than being on hold for so many hours?
A16. You can either send an e-mail to ngs.cedihelpdesk@wellpoint.com or fax your issue to 317-595-4999 to the attention of Julie. Make sure to state exactly what your question is and provide your submitter ID, contact information and other pertinent details.

Follow-up Question: Are you going to have more lines that people can get a hold of you on if they need to call?
Yes. We are also getting more employees for the CEDI help desk.

Follow-up Question: Do you think this is just a temporary situation?
Yes, because of the number of people trying to transition to CEDI all at the same time.

Follow-up Question: Are you still going to go ahead and transition the other two jurisdictions to CEDI on the first of June?
Yes, plans are proceeding this way, at the time of this call.

Follow-up Question: My concern is that I have to dial hundreds of times to get a connection. Each time I need to transmit, I get a busy signal for hours at a time.
We are hoping with the 69 new lines that are going in for asynchronous submission and taking password resets out of the help desk queue, it is going to help free up the associates on the help desk to be able to take more calls.

Q17. I am brand new to DME and I know you need to meet the 21 standards. I'm not sure if you have to have that all in your notes. I am not sure how that all works. Can you explain this to me?
A17. There is a supplier standard that states you need to disclose all 25 supplier standards to every beneficiary you service and to which you provide covered items to. Many of the supplier standards involved educating a beneficiary or obtaining their signature stating that they have received the information. This information is kept in the supplier's files and is not required to be sent with the claim.

Follow-up Question: Does it matter which accreditation organization a supplier uses?
No, you can choose one of the ten.

Q18. I have a question related to enteral feedings. We have a patient we started billing for in 2002 and we've been billing Medicare and no disclosure of any other coverage was given at the time of start of care. The consents were signed stating the patient only had Medicare insurance. The person who is now handling the patient's finances has just informed me that he has an L&I (Labor & Industry) case pending. Where does responsibility for the claim lie? How do I manage all the payments I've received from Medicare?
A18. These instructions apply to any situation where Medicare paid primary, but subsequently it was discovered that another insurance should have been primary.

1. Submit a refund request to Medicare. Please use the Refunds to Medicare form located under the forms section of our web site. Attach all relevant documentation, including the supplier's NPI and NSC number, the beneficiary's HICN, all claim numbers OR dates of service, and if only specific services are to be recouped (not the entire claim), NAS requires the specific HCPCS codes as well. NAS will also need the exact name, address and phone number of the primary insurer. If services are the result of an injury, Medicare also needs the date of injury.
2. The supplier submits the claim(s) to the primary insurer.

3. The primary insurer pays the claim(s) and provides the supplier with an Explanation of Benefits (EOB). If an unpaid balance remains and the circumstances qualify for Medicare secondary payment, the supplier submits the claim(s) and the primary insurer's EOB to Medicare for processing.

For more information on Medicare Secondary Payer, please see the NAS web site at www.noridianmedicare.com/dme/.

Q19. I had a question about the unattended sleep studies. You mentioned earlier that you anticipate DME suppliers will not be paid for doing them. When can we accept unattended sleep studies to provide CPAPs?
A19. The Change Request (CR), when it is final, will have an effective date of March 13, 2008. Since this date has already past, we cannot say for sure how this will be handled until more information is provided by CMS.

Follow-up Question: Do you have any anticipation of when we can get a final answer on that?
Those are decisions CMS publishes and we have no control over how quickly they move on those decisions.

Q20. I have a patient for whom we've been supplying an airless mattress and hospital bed. The first month billing was March 14th and I got paid. The bill for April 14th was denied, stating that the patient was under Jurisdiction C. I double-checked where the patient lives with the family. They said they never moved and the patient still lives in California. They said they are going to update whatever the problem is with Social Security. When I called a week after I originally called Medicare, they said this patient now shows an address in Jurisdiction D. Should I re-bill that date of service, April 14th that was denied under Jurisdiction C or do I still need to send it to Jurisdiction C?
A20. If the patient's file has been updated to correct their address to California, then it would be appropriate to re-bill it to us. You can verify this by calling the supplier contact center at 1-866-243-7272.

Q21. I have a patient for whom we supplied a nebulizer, but the claim was rejected for same or similar. The patient says she's never had a nebulizer before, but she has had her identity stolen, and we're trying to report that to Medicare. How do we go about doing that?
A21. The patient should call 1-800-MEDICARE (1-800-633-4227) to report this.

Q22. We're a small orthopedic practice, and with this new accreditation that's going on, I'm wondering if all braces, splints, back braces, and supplies that are used in lieu of casting, are going to require accreditation?
A22. If you are a DME supplier, billing for these types of services currently, you will need to be accredited.

Follow-up Question: Where can I find the information on who the accreditation organizations are? I am also being told there is a $3000 charge to be accredited. Is that correct?
It's possible. Every accreditation organization may have different fees. If you go to the enrollment section of our web site, we have a section on accreditation that provides link for where you can find more information on the ten accreditation organizations and how to contact them.

Q23. I have a store in Thousand Oaks, California. Am I included in the second round of competitive bid for which accreditation is due today?
A23. We suggest you go to the Competitive Bidding web site where they list the counties that are involved in round 2 of competitive bidding. You can also call the CBIC at 877-577-5331.

Q24. I had a question about diabetic testing strips. I'm not clear on when a patient is required to keep a log of their testing. I thought it was when they were non-insulin treated and were needing more strips than the guidelines, but I'm not sure.
A24. The coverage guidelines for diabetic test strips specifically state that if the beneficiary is over-utilizing their supplies, you need to have proof of the amount that they're testing, such as a log. Please refer to the actual LCD on glucose monitors and testing supplies which discusses over-utilization. A patient is over-utilizing if not being treated with insulin and they test more than once a day. If they are being treated with insulin, it's more than three times a day, before they are considered over-utilizing.

Q25. I've got a question regarding the overnight pulse oximetry studies. Are we allowed to work with an independent diagnostic testing facility, like Web Ox or Power Ox, where we send the encrypted data to them from our overnight pulse oximetry study, and then they encrypt it and read it and send it to the physician?
A25. Yes, the Oxygen medical policy states the following regarding home sleep oximetry studies:

"Beneficiaries may self-administer home based overnight oximetry tests under the direction of a Medicare-enrolled Independent Diagnostic Testing Facility (IDTF). A DME supplier or another shipping entity may deliver a pulse oximetry test unit and related technology, used to collect and transmit test results to the IDTF, to a beneficiary's home under the following circumstances:

1. The beneficiary's treating physician has contacted the IDTF to order an overnight pulse oximetry test before the test is performed.
2. The test is performed under the direction and/or instruction of a Medicare-approved IDTF. Because it is the beneficiary who self-administers this test, the IDTF must provide clear written instructions to the beneficiary on proper operation of the test equipment and must include access to the IDTF in order to address other concerns that may arise. The DME supplier may not create this written instruction, provide verbal instructions, answer questions from the beneficiary, apply or demonstrate the application of the testing equipment to the beneficiary, or otherwise participate in the conduct of the test.
3. The test unit is sealed and tamper-proof such that test results cannot be accessed by anyone other than the IDTF who is responsible for transmitting a test report to the treating physician. The DME supplier may use related technology to download test results from the testing unit and transmit those results to the IDTF. In no cases may the DME supplier access or manipulate the test results in any form.

The IDTF may send the test results only to the physician. It must not send them to the supplier."

Q26. I forgot to attach the CMN when I sent the claim in the first time. I was wondering if it would be appropriate just to re-bill and do it correctly the second time or to send it to redeterminations?
A26. The best way to handle this situation would be to request a written reopening to attach the CMN to the claim. Since the actual CMN must be submitted so we can enter this into the claims processing system, this request and a copy of the CMN must be submitted in writing. Please indicate on your request that the CMN was omitted in error.

Ask the Contractor Teleconference for Small Suppliers – August 13, 2008

NAS will conduct the next DME Ask the Contractor Teleconference to assist **small suppliers** on August 13, 2008. CMS has defined a small supplier as a supplier with ten or fewer full time equivalent employees. During this teleconference, knowledgeable NAS staff representing a variety of functions will be available to answer your questions. If we cannot answer your question during the teleconference, we will research the issue and then call you with the answer.

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

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

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

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

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

The remaining 2008 teleconference for **small suppliers** will be held at 3:00 pm CT on November 12, 2008.

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

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 January - March 2008. Our web site, www.noridianmedicare.com/, contains excellent information to assist with supplier inquiries.

DME Same or Similar Equipment
NAS receives an average of 2,000 inquires per day for same or similar equipment. We have added the same or similar functionality to the IVR to address this higher call volume. To access same or similar information from the IVR Main Menu, use the voice activation option by saying "same or similar" or press 6 on the phone keypad. The IVR will determine HCPCS on file that is considered same/similar, initial date of the equipment on file, recertification date, last day equipment was billed, name and phone number of the supplier who billed the paid equipment. The IVR will also state CMNs that are posted to the Common Working File. To access CMNs on file, say "CMN" or press 4 on the phone keypad.

Suppliers should also have a very thorough intake assessment. Suppliers should ask the beneficiary if they currently have or had an identical or similar piece of equipment. A Suggested Intake Form can be accessed on our Web Site under the Forms tab.

Entitlement
CMS mandates suppliers check beneficiary eligibility through the IVR. The IVR provides beneficiary eligibility information including when the beneficiary became eligible for Medicare, Part A and B effective and termination dates, a new Medicare number if applicable, HMO information, MSP information, and home health and hospice information based on the date of service entered.

Frequency/Dollar Amount Limitation
Utilization guidelines can be found in the documentation section of each individual medical policy. Quantities of supplies greater than the allowable must have documentation supporting the medical necessity. There must be clear documentaion in the patient's medical rcord that coorborates the order and any additional documentation that pertains to the medical necessity of the items and quantities billed. This supporting information should be reported in item 19 on the CMS-1500 or the narrative field of an electronic claim.

In situations of possible same or similar equipment, suppliers can verify on the IVR if the beneficiary owns, or previously owned same or similar equipment.

CWF Rejects
During the intake process, suppliers should ask beneficiaries very specific questions:

- Does the beneficiary live in a skilled nursing facility
- Has the beneficiary recently been hospitalized. If so, ask for admission and discharge dates. Refer to Chapter 5 of the Supplier Manual for specifics on billing around hospital discharge dates.
- Does the beneficiary have home health services. Ask if anyone is coming into the home to aid the

beneficiary. A list of the items included in a covered home health episode can be found at www.cms.hhs.gov/HomeHealthPPS/03_coding&billing.asp. These items cannot be billed to the DMEMAC during a home health episode.

- Verify the beneficiary is not covered under an HMO plan. Make a copy of their insurance card.
- Verify the beneficiary's Medicare name and HICN on the Medicare card. Make a copy of their Medicare card for reference. Always submit claims with the beneficiary's name exactly how it is listed on their Medicare card, i.e., include middle name or initial of middle name, Jr or Sr, if listed on the Medicare card.

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. Access the NAS DME website for:

- Fee schedules located under the News and Publications tab.
- MSP calculator located under the Appeals tab.
- Remittance advice codes under the Claims tab.

Certification Requirements
Suppliers should be knowledgeable in the medical policies for items that require a CMN or DIF. Refer to the NAS DME website for:

- Local Coverage Determinations, Documentation Checklists and Policy Decision Trees located under the Coverage tab.
- CMN and DIF Forms located under the Forms tab.
- Chapter 4 of the Supplier Manual gives additional information regarding CMN requirements.

Reminders:

- If a claim denies due to CMN missing, verify through the IVR, under the CMN option, if there is a CMN on file for the specified item you are billing for.
- If there was a break in service, or an extension is needed for the item you are billing for, a narrative needs to be added in Item 19 on the CMS-1500 or the narrative field of an electronic claim. Indicate by "BIS", or "extend CMN" and the reason for the extension.

Claim Not on File
Claims that are incomplete or have invalid information will not process or the supplier may receive an education status letter. These claims are considered unprocessable. Claims must be corrected and submitted as new claims. If the IVR states no claim is on file, verify the claim form was completed appropriately by looking at a copy of the submitted claim and check 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 the word "NONE" if Medicare is primary. If Medicare is seconary, enter the policy or group. This item must be completed.
- Item 17, 17a and/or 17b - Name of the referring or ordering physician and physician's NPI
- Item 21 - Diagnosis is coded to the highest specificity
- Item 24E - Claim has only one diagnosis code pointer per claim line (1, 2 , 3 or 4)
- Item 33a and or 33b - NPI of billing provider. This is a required field.

Reference:

- Refer to the CMS 1500 claim form tutorial located on the NAS DME website under the Claims tab.

If billing electronically, verify the claim was transmitted and not rejected during CEDI front-end processing as listed on an error report.

Offsets
Suppliers are notified by a demand letter when an overpayment has been identified and a refund is requested. Refer to the demand letter for the DCN, which gives the reason for the offset. The DCN number is the same as the FCN on the remittance advice.

Refer to the NAS DME website for:

- The DME Online Learning Center and take the lesson on Supplier Overpayments.
- The Claims tab for information on Recoupment and Supplier Overpayments.
- Chapter 12 of the Supplier Manual for information on Offsets and Overpayments.

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 claim must be submitted with the patient's name exactly as it is shown on the Medicare card. Utilize the IVR to verify Part B entitlement, possible HMO coverage or possible Date of Death information.

Status/Explanation/Resolution
Suppliers are mandated by CMS to utilize the IVR for claim status. The IVR is available between the hours of 6 am and 6 pm CT. The IVR will report if the claim has processed, denied, or is pending. The IVR will also give details such as the submitted amount for a denied claim or the allowed/payment amount for a paid claim, the payment or denial date, and the check number. If the claim denied, the IVR will provide the claim control number, the number of line items, the detail of each line item, and the diagnosis.

Refer to the NAS DME website for:

- Information regarding telephone and written reopenings and redeterminations under the Appeals tab
- Chapter 13 of the Supplier Manual for the Appeals process

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 Medicare E-Mail List to receive emails with the latest news and information.

Top Ten Written Inquiries

The top written inquiries for January through March are listed below along with tips and reminders about submitting these requests to NAS.

1. **Reference Resources Referral/Request**
   There are several ways to locate information on our web site.

   The Search function is available in the upper right corner on all pages of the web site. The Quick Search looks for the keyword on the entire web site. By using the Advanced Search, the user can narrow the search down to a specific area of the web site.

   On the DME homepage, each of the categories of our web site is listed with an arrow next to it. When the mouse is hovered over the arrow, the contents of that category are listed.

   A Site Map is available on every page near the Search tool. This index has been alphabetized for each category on our web site.

   The following are a few search hints:

   - Not all HCPCS codes will result in matches, as some codes do not have published coverage or billing guidelines. If you cannot find information when searching with a specific HCPCS code, try using a narrative to search for the type of equipment or supply.
   - Specific HCPCS codes, i.e., K0003, will not be provided as a result if the search term is "K0001 - K0005." If searching for a specific HCPCS code, do not search by a range of codes.
   - The list of Local Coverage Determinations by type can be found on the Coverage/MR web page, by selecting the Local Coverage Determinations link. The LCD table provides the Title, Policy #, HCPCS contained in each policy and a short description. Type the policy #, HCPCS or other search term in the Search Terms box on the LCD page to locate the policy and policy article in the CMS coverage database.
   - The search function does not spell check keywords so be sure these are spelled correctly.
   - Two letter words, such as modifiers, are searchable.
   - Try switching the order of your terms if you are not finding a match when looking for information on a modifier, i.e., try both "modifier GA" and "GA modifier."
   - All allowed amounts, prices, and reimbursement amounts are located on the Fee Schedule section of our web site, which can be found in the News/ Publication section.

1. **Medical Review**
   Suppliers are encouraged to consult the LCD and policy article for individual medical policy coverage criteria. The LCDs can be accessed from the NAS DME web site, Coverage/MR section, by selecting "Local Coverage Determinations (LCDs)" followed by "CMS Medicare Coverage Database - Current LCDs."

   Be sure to watch whether or not your denial is for medical necessity. If the denial is not for medical necessity, you are unable to appeal the decision and must do a reopening. However, if you receive a medical necessity denial on a claim, you have the option to submit a written signed request to appeal the decision. If you make this choice, NAS recommends using the "DME Inquiry/ Redetermination" interactive form located on our web site and submitting it along with all pertinent medical documentation supporting the need for the item at issue to:

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

   You may also fax your signed request with all documentation to 1-888-408-7405.

2. **Misrouted Written Correspondence**
   When submitting claims, please be sure you are submitting them to the appropriate Jurisdiction. The state the beneficiary resides in determines the Jurisdiction the claim should be sent to. If you are unsure what Jurisdiction the state belongs to, please see the DME Jurisdiction Coverage Map located under "Other DME and Medicare Resource Links" on the Contact page of our web site or contact the NSC.

   Many suppliers are mailing claims and correspondence to the street or physical address rather than to the appropriate PO Box, which in turn delays the processing of the claims and correspondence. Therefore, to expedite processing, we encourage you to send your claims and correspondence to the appropriate PO Box. The street address should only be used in rare instances where your correspondence absolutely needs to be sent via a courier service. A list of appropriate PO Box numbers are located under the "Phone Numbers and Addresses" section on the Contact page.

   If you submit claims or send correspondence to Part B, use the appropriate Part B PO Box for those items. DME items and Part B items should never be intermixed. If you are not aware of the correct Part B PO Box numbers, they can be located on the NAS web site under Part B and whichever state for which you have an interest.

   Also, we have been seeing suppliers submit refunds using either the Part B Refunds to Medicare form or the DME Inquiry / Redetermination form. Please make sure you are submitting the correct form so processing is not delayed.

EDUCATIONAL CONT'D

3. **1500 Form Item**
   NAS provides a CMS-1500 (08-05) claim form tutorial to assist in completing each item of the claim. By hovering the mouse over a specific item, a box will appear with the required information for that Item. Clicking on an item in the tutorial provides complete claim form instructions.

4. **Issue Not Identified/Incomplete Information Provider**
   When sending inquiries to NAS, clearly state the question. This will ensure NAS has all of the information needed to answer the request. If information is submitted without a specific request, the Written Correspondence staff will reply with a letter indicating the inquiry was incomplete, causing a delay in receiving a response.

   NAS also receives letters stating an item is medically necessary with no HIC, no appeals request, DOS etc. or sending in a CMN with nothing else included. Please ensure you provide the appropriate information so the inquiry can be completed. Lack of required information may cause a delay in processing.

5. **Other Issues**
   Suppliers are encouraged to visit the NAS DME web site frequently to stay up to date with 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 web site.

6. Suppliers should also subscribe to the NAS email list to receive the latest news and information on Tuesdays and Fridays via email. Subscribe today by going to the "News/Publications" section of our web site or by simply clicking on the Sign-up for the DME Email List hyperlink.

7. **Claim Information Change**
   Please be sure to use the correct information when submitting your claim. Double check the information you are providing is correct including the date of service, procedure code, modifiers, etc. This will stop potential claims from going to Reopenings or Redeterminations.

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

   a. Date of Service (within same year)

   b. Place of Service

   c. HCPCS Codes

   d. Diagnoses

   e. Modifiers (with the exception of GA)

   f. Number of Services

   g. Billed amount

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

a. Limitation of Liability issues, i.e., adding a GA modifier

b. Requesting payment due to a break in service

c. Certificate of Medical Necessity (CMN) or DME Information Form (DIF) corrections

8. **Filing/Billing Instructions**
   When resubmitting a claim, do not attach any type of correspondence, such as a reopening, redetermination or inquiry form or include unnecessary narratives on the claim, such as "corrected claim". Doing so may delay the processing of the claim.

9. **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.

10. **ATP Amount/Check Information**
    Prior to submitting an appeal, please be sure to call the IVR to verify the status of your claim. Check if the claim was paid or denied. We have been seeing appeals on claims that have already been paid. This is happening because the claim was resubmitted and the system allowed payment or a previous appeal had gone through. Submitting an appeal prior to knowing the status of your claim, may delay the processing of your request.

COMPETITIVE BIDDING

The Medicare Improvements for Patients and Providers Act of 2008, enacted on July 15, 2008, has delayed the Medicare DMEPOS Competitive Bidding Program. Items that had been included in the first round of the DMEPOS Competitive Bidding Program can be furnished by any enrolled DMEPOS supplier in accordance with existing Medicare rules. Payment for these items will be made under the fee schedule. Additional guidance regarding this new law will be forthcoming.

CEDI Web Site: Reorganization and Updated Documents

National Government Services, Common Electronic Data Interchange (CEDI) has reorganized the CEDI Web site page and updated several documents. There are two new sections available from the home page of the CEDI Web site. One new section is titled, "News". This section contains all CEDI listserv's, the date posted and title of the listserv article. This page can be accessed using the following link: http://www.ngscedi.com/News/newsindex.htm.

Another new section is titled, "Resource Materials". This section contains the following information:

DME MAC Front End Edit Error Code Manual (06/27/08) - Provides all DME MAC Level II front end error codes, including the edit number, description, segment ID and edit explanations. Level II report examples are also included at the end of this manual.

CEDI Frequently Asked Questions (06/27/08) - This document just recently updated, includes frequently asked questions received by CEDI from the DME MAC supplier community.

CEDI Front End Reports Reference Document (06/10/08) - Provides a description of the CEDI Level I reports, instructions on what to do when the report is received and report examples. Level I reports include the TA1, TRN, 997 and GenResponse.

DME MAC Express Plus Upgrade for CEDI (04/01/08) - Upgrade instructions for all Express Plus users not currently using Version 4.3.8.

Help Desk Support - CEDI Help Desk contact information and a list of the types of questions that are handled by the CEDI team.

Approved Vendor List (05/28/08) - A listing of all software vendors, billing services and clearinghouses that have completed testing with CEDI.

The "Resource Materials" section can be accessed using the following link:
http://www.ngscedi.com/outreach_materials/outreachindex.htm

CEDI Transition for Jurisdictions B and C Extended

The date for Jurisdiction B and Jurisdiction C DME MAC Trading Partners (suppliers) to transition to CEDI was originally scheduled to occur on June 1, 2008. **CEDI and CMS have extended the Jurisdiction B and Jurisdiction C transition through Friday, June 6, 2008**.

This extension will allow the Trading Partners currently exchanging transactions with Jurisdiction B and Jurisdiction C who have not yet moved to CEDI to work with CEDI and/or their vendor to complete their transition. The Jurisdiction B and Jurisdiction C Trading Partners (submitters) who have not completely transitioned to the CEDI may continue to send to the current Jurisdiction B and Jurisdiction C DME MAC EDI Front End systems **until June 6, 2008**.

Note: Trading Partners (submitters) who have fully transitioned to CEDI are not affected by this extension. Effective May 1, 2008, Jurisdiction A and Jurisdiction D DME MAC Trading Partners (submitters) transitioned to the Common Electronic Data Interchange (CEDI) for the exchange of all electronic transactions.

CEDI Listserv
To stay informed of all CEDI updates, visit the CEDI Web site at www.ngscedi.com and sign up for the CEDI Listserv by selecting the Listserv Registration Link. You will then be prompted to submit your email address and name to subscribe. This listserv is for all entities participating with CEDI whether you are a third-party billing agency or a supplier performing your own EDI transmissions.

VMS Modifications to Implement the CEDI System - Part II

MLN Matters Number: MM6026
Related Change Request (CR) #: 6026
Related CR Release Date: May 23, 2008
Related CR Transmittal #: R344OTN
Effective Date: October 1, 2008
Implementation Date: October 6, 2008

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

Provider Action Needed
This article is based on Change Request (CR) 6026 which provides VMS modification details needed to implement the Common Electronic Data Interchange (CEDI) system. The article is informational purposes for suppliers. Suppliers should note that the claims control number (CCN) format for X12 (837) claims will be CYYJJJBBBBSS000, where C=Century, YY = Year, JJJ = Julian Day, BBBB = Batch Number, SS = Sequence Number, and 000 is a number for internal CMS system use only. This format will be in the system changes implemented on October 6, 2008 as a result of CR6026.

Background
Currently, front end electronic data interchange (EDI) processing for Durable Medical Equipment (DME) claims occurs in four separate systems. Two of these systems are operated by DME MACs, and two are operated by data services contractors under direct contract with the Centers for Medicare & Medicaid Services (CMS). These front-end EDI systems perform edits on incoming Medicare DME claims and forward the output data from transactions that pass edits to the core of the VMS shared system claims processing environment. Each of the four systems used for DME front end transaction processing has been developed as a proprietary system to meet its developer's own business objectives, and logic specific to Medicare requirements was added to accommodate the Medicare claims transactions.

CEDI CONT'D

Since each system is owned and developed by separate entities, variations exist in the way in which individual front end systems process claims and in the results they produce. This creates confusion with suppliers and beneficiaries, and can also lead to the rejection of eligible claims as well as the payment of ineligible claims depending upon which front end system processed the transaction.

CR 6026 provides business requirements regarding system changes necessary to prepare for the implementation of the DME MAC CEDI front end system. The business requirements associated with CR 6026 are effective on October 1, 2008 regardless of the date of service or date of receipt of the claim.

Note: CR 6026 does not affect providers billing carriers, Fiscal intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), or Part A/B MACs.

Additional Information
The official instruction, CR 6026, issued to your DME MAC regarding this change may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R344OTN.pdf on the CMS website.

NPI

NPPES/IRS Data Match

In an effort to ensure that the data submitted to the National Plan and Provider Enumeration System (NPPES) for organization health care providers is accurate, CMS initiated an NPPES - Internal Revenue Service (IRS) data match to ensure that the legal business name (LBN) and employer identification number (EIN) in NPPES are consistent with IRS data.

This week, CMS will mail out letters to organization health care providers that have an EIN/LBN combination in NPPES that are different from the information maintained by the IRS. These letters request that the health care providers review and update their LBN and/or EIN in NPPES. If health care providers can not furnish data that are consistent with the IRS, we will deactivate the National Provider Identifier in NPPES. CMS will continue to match these health care provider data in NPPES against IRS data to ensure the accuracy of NPPES data.

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

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

Medicare FFS NPI Update & Part B Issues Identified

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

NPI News for Medicare FFS Providers

Medicare FFS NPI Update & Part B Issues Identified
As of 5/23/08, the National Provider Identifier (NPI) became mandatory on all HIPAA claims transactions and on Medicare paper transactions as well. All transactions must be submitted with the NPI in fields requiring a provider identifier (see items 1-3 below concerning the reporting of the Taxpayer Identification Number (TIN)). The Centers for Medicare & Medicaid Services (CMS) continues to see progress with NPI compliance and most Medicare contractors are reporting over 95 percent of claims contain only NPI. However, for some of the relatively few claims which continue to reject, we have determined that some of the reasons are related to the following issues identified for Part B claims:

1. The Employer Identification Number (EIN) or Social Security Number (SSN) being submitted in the 2010AA / REF02 (Billing Provider Secondary Identifier), 2010AB / REF02 (Pay to Provider Secondary Identifier) and/or 2310B / REF02 (Rendering Provider Secondary Identifier) of the Medicare X12N 837P transaction does not match the TIN information on the Medicare crosswalk.
2. While EIN or SSN is not required to be submitted in the 2310B loop for Medicare claims, if submitted, the appropriate qualifier must be submitted in the 2310B / REF01.
   - Qualifier EI must be submitted in the 2310B / REF01 when an EIN is being submitted in the REF02.
   - Qualifier SY must be submitted in the 2310B / REF01 when an SSN is being submitted in the REF02.
3. The Medicare legacy provider identifier is being submitted in the primary and/or secondary provider loops. Legacy provider numbers are no longer allowed on ANY Medicare claim or transaction. If sent, the claim or transaction will reject.

Medicare providers should review this list and take appropriate actions to resolve problems they may be experiencing. As a result, providers may decide to stop sending non-required segments, such as the TIN in 2310B/ REF02 of the X12N 837P transaction. Providers may also want to consult their clearinghouses or software vendors for additional advice to solve the issues listed in this message.

Medicare Fee-For-Service Update & Medicare Reminder Regarding Accelerated/Advance Payments

Medicare FFS Update
Medicare FFS has made excellent progress over the past week, since fully implementing the NPI. In fact, the favorable trend in NPI compliance is better than we expected with most of the Medicare contractors reporting that over 90 percent of claims are NPI-compliant, with some reporting 100 percent compliance. Furthermore, we have experienced relatively few problems to date and we are working daily with our contractors to help resolve those issues that exist.

We would like to point out that, on May 23, there were a number of rejections for claims with legacy numbers in the SECONDARY provider identifier field. As indicated, we are seeing this particular issue rapidly improve as more and more providers realize the need for NPI-only in secondary identifier fields and the relative ease in which they can appropriately complete these fields.

In the way of background, Medicare allowed legacy-only numbers in the secondary fields up until May 23. To assist those billing providers which, after reasonable effort, are still unable to obtain NPIs for secondary providers, Medicare has instituted a temporary measure that allows billing providers to use their own NPI in secondary identifier fields. Thus, providers are not unduly burdened to ensure secondary identifier fields have an NPI.

While CMS is seeing some issues in some areas of the country, we are continuing to monitor and assist providers in becoming fully NPI-compliant. Progress has been substantial in recent days and weeks and this favorable trend is expected to continue. We would also like to mention that we monitor Medicare Part C (Medicare Advantage) and Part D (Prescription Drug Program) and we have received no reports of NPI problems.

ENROLLMENT

Disclosure of the 25 Supplier Standards

The revised version of the CMS 855S Medicare enrollment form added supplier standards 22-25 requiring all DMEPOS suppliers to be accredited by an approved accrediting organization to obtain or retain Medicare billing privileges. DMEPOS suppliers must therefore meet specific accreditation deadlines to avoid billing interruption.

DMEPOS suppliers are not required to disclose the 25 supplier standards to Medicare beneficiaries until the full implementation date - September 30, 2009. Suppliers are encouraged however, to release the updated list of standards as existing reserves are depleted. Supplier Standard 16 requires DMEPOS suppliers to disclose all supplier standards to each beneficiary to whom it provides a Medicare-covered item.

NSC Appeal Process

When billing privileges have been denied or revoked, the applicant/supplier has two options available to contest the determination. The applicant/supplier may submit a Corrective Action Plan (CAP) or submit a request for reconsideration (formerly a Contractor Hearing). However, a supplier may not request both simultaneously. When submitting your request, please keep in mind the following:

- The applicant/supplier must submit a CAP within 30 days from the postmark of the denial or revocation letter.
- The request for reconsideration must be made within 90 days from the postmark denial or revocation letter.
- The request must specify you are either requesting a CAP or reconsideration. An applicant/supplier may not choose both simultaneously.
- The request must have the original signature of the authorized official, owner or partner on file.
- The request must include an authorization letter, signed by the authorized official, allowing the NSC to communicate with an attorney, if these services have been obtained.

NOTE: According to Pub 100-8, Chapter 10, Section 6.2, a provider or supplier that is denied enrollment in the Medicare program or whose billing privileges have been revoked cannot submit a new enrollment application until the following has occurred:

- If the denial or revocation was not appealed, the provider or supplier may reapply after its appeal rights have lapsed.
- If the denial or revocation was appealed, the provider or supplier may reapply after it has received notification the determination was upheld.

Corrective Action Plan (CAP)
If you feel the NSC has made a factual mistake or the noncompliance issue has been corrected, the supplier may submit a Corrective Action Plan (CAP). The CAP is to ensure the business, at the location in question, is in compliance with the current supplier standards (42CFR424.57). Submission of a CAP shall contain, at a minimum, verifiable evidence of compliance and the sufficient assurance of the intent to comply fully with the supplier standards in the future.

The CAP and the acceptability of the plan is negotiated between the NSC/CMS and the applicant/supplier (42CFR422.57{d}). However, it is important to note that denials and revocations are generally based on noncompliance with the Supplier Standards. Being in compliance is non-negotiable.

If the NSC/CMS is satisfied the issues of noncompliance have been resolved, billing privileges may be issued or reinstated. If the applicant has been denied, the effective date of the billing privileges will be the day the NSC releases the number (1834 J of the Social Security Act and 42CFR422.57). If revoked, reinstatement will be effective the date CMS approves the CAP and the supplier has been determined to be in compliance with the supplier standards.

If the NSC/CMS upholds either a denial or a revocation, the applicant/supplier may request a reconsideration. Please note

ENROLLMENT CONT'D

this request must be made within 90 days from the postmark of the letter issuing the initial determination, not 90 days from the letter upholding the denial or revocation.

Reconsiderations (formerly Contractor Hearings)
A reconsideration request is specifically for an on-the-record hearing before a Hearing Officer (HO) not involved in the initial decision to deny or revoke billing privileges. Upon the receipt of a timely request, the NSC has fifteen (15) days to forward the hearing package to the HO. The HO then has 90 days to schedule, conduct and render a decision.

Please note, any decision from the HO concerning a denial or revocation rendered on or after 12/08/04, where the next level of appeal would have been a review by a CMS Reviewing Official, shall now be sent to the Administrative Law Judge level. Please follow the directions listed on the HO's decision letter.

If you have any questions regarding this information, please contact the NSC Customer Line at (866) 238-9652.

OVERPAYMENTS

Refunds to Medicare Process

When a supplier submits the Refunds to Medicare form with the complete and correct information, an examiner from the Recoupment Team adjusts the claim(s) according to the supplier's instructions. An Accounts Receivable (AR) entry is created and a refund request letter is mailed to the supplier.

The overpayment letter contains information that is important to the supplier including:

- Amount of the overpayment
- Date that repayment is due (30 days from the date of the letter)
- Date interest will accrue on the AR (31 days from the date of the letter) and every 31 days after that
- Applicable interest rate
- Date offset will automatically be turned on and claim payments withheld (if payment is not received by 40 days after the letter date, offset will begin on the 41st day)
- Information about appeals rights
- Information about Extended Repayment Plans (ERPs) and an ERP checklist
- Details of the claim or claims being recouped
- Reason for the overpayment

Timelines in the Refund Process
Day 1 – Accounts Receivable (AR) is set up and the first refund request letter is mailed.

Day 31 – If there is still an open balance on the AR, interest accrues and a second letter is sent. The second refund request reminds the supplier that payment is past due and details the current balance including the amount of interest. If a partial payment has been applied to the AR, the current amount due will be reflected on the second letter.

Day 40 – If payment is not received, offset begins automatically on Day 41.

Between Days 50 and 60 – If there is still an open balance on the AR, RCP team members attempt to contact the supplier by phone to verify that the first and second overpayment letters were received. The letters may be re-sent at that time.

Between Days 110 and 120 – If there is still an open balance in the AR, RCP team members research the debt and determine if it could be referred to the Treasury Department for collection. If the case qualifies for referral, a third letter is sent to the supplier. This is called the Intent to Refer Letter (IRL). The IRL informs the supplier that the debt is delinquent and will be referred to the Treasury Department for collection if not paid in full (with all accrued interest) by the date specified in the letter. The IRL also informs the supplier of their rights and options for repayment.

Day 180 – In the absence of any extenuating circumstances, and if there is still an open balance on the AR, NAS is required to refer the delinquent debt to the Treasury Department. The next communication to the supplier will come directly from the Treasury Department.

Repaying Medicare
There are three ways that a supplier may choose to repay Medicare for an overpayment.

1. Mail a repayment check with the Refunds To Medicare form. This check is applied to the AR when the claim is adjusted. Because the AR created by the adjustment is immediately paid by the check, no refund request letter is sent to the supplier.
2. Write "Immediate Offset" on their Refunds To Medicare form. This allows NAS to use future payments for claims to repay the overpayment. A refund request letter is sent to the supplier, even though offset is requested. This letter serves as a reminder that the supplier owes the amount referenced, in case the claim payments available for offset are insufficient, and lists the supplier's appeal rights.
3. Wait to receive a refund request letter after submitting the Refunds To Medicare form and then submit a check or offset request after receiving the overpayment letter. To speed processing, suppliers should include the first two pages of the overpayment letter with their check. This information includes the supplier's number and the AR of the overpayment, which allows the RCP examiners responsible for checks to match each check to the correct AR. Suppliers may also write the words "Offset Requested" on the overpayment letter and submit. RCP examiners will update the AR to allow offset.

Extended Repayment Plan
When the repayment of an overpayment will cause financial hardship to a supplier, an Extended Repayment Plan (ERP) may be requested. The refund request letter will include an ERP checklist that can be filled out and returned to NAS for consideration.

Overpayment Process

There are many circumstances when a supplier may owe Medicare a refund after being paid for a claim. Adjustments to a processed claim may cause the original paid amount to decrease.

- Wrong supplier paid for services
- Beneficiary returns items after the supplier was paid by Medicare
- Billed Medicare in error
- Beneficiary had other insurance that should have paid before Medicare

The department that processes overpayments at NAS is called the Recoupment (RCP) Team. Examiners on this team are responsible for making adjustments to correct claims, sending refund request letters to suppliers and beneficiaries and applying checks refunded to Medicare.

NAS is notified of potential overpayments in various ways:

- Supplier notifies NAS by mail or phone
- Beneficiary notifies NAS by mail
- Redetermination staff requests a recoupment
- Beneficiary was in a Skilled Nursing Facility (SNF)
- Beneficiary was in an episode of Home Heath (HH) care
- Beneficiary was participating in a Managed Care Organization (MCO) [also known as a Health Maintenance Organization (HMO)]

Full Claim Adjustments
If an entire claim was billed incorrectly the entire claim must be denied. When NAS adjusts an entire claim to deny, it is a Full Claim Adjustment. This results in an overpayment that must be refunded to Medicare. When submitting a claim to be fully recouped, the supplier is responsible to provide (at a minimum):

- Supplier number and National Provider Identifier (NPI)
- Beneficiary Health Insurance Claim Number (HICN)
- Claim Control Number (CCN)
- Date of Service (DOS)
- Reason for the overpayment

Partial Claim Adjustments
If only a portion of a claim needs to be denied (some of the dressings are returned, only one service on a claim was billed in error, the wrong code was billed) then only part of a claim is denied. This is a Partial Claim Adjustment. It is critical to note that if the specific HCPCS and quantity information is not included in the refund notification and the RCP examiner cannot determine which services should be denied, the entire claim will be denied and the supplier will receive a refund request letter for the full amount. The supplier will then need to re-submit the claim to be paid correctly. Submitting a dollar amount to be recouped without HCPCS and quantity information is not acceptable. The following must be included on the Refunds to Medicare form.

- Healthcare Common Procedure Coding System (HCPCS) of the service or supplies in question,
- Quantity(ies)
- Supplier number and NPI
- Beneficiary's HICN
- CCN or DOS
- Reason for the overpayment

Failure to provide this information may lead to delays in processing or a request to resubmit the refund with complete information. CMS requires suppliers to provide this information to the contractors who process overpayments or lose their appeal rights for that particular recoupment.

Refunds to Medicare Form
Use the Refunds to Medicare form to report an overpayment. The form can be mailed or faxed to:

Noridian Administrative Services
PO Box 6727
Fargo ND 58108-6727
Fax: 888-529-3666

CERT

CERT Documentation

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

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

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

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

Mail all requested documentation to:

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

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

CERT CONT'D

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.

Appeal CERT Errors

Have you received a CERT error?
Has a claim or line been denied due to a CERT review?

If you answered yes to either of these questions and you have documentation to support the services that were denied, an appeal should be requested. Just follow the appeal process at www.noridianmedicare.com/dme/appeals/. Be sure you include the CID reference # on your appeal.

If you have questions on the appeal process, please call the DME Supplier Contact Center for additional information at 1-866-243-7272.

Is Your CERT Point of Contact Current?

It is important that all providers have a CERT Point of Contact (POC). Your POC will receive CERT mailings such as documentation requests and CERT error statistics for your facility. Having a current POC will ensure timeliness in reviewing and processing CERT information. This will assist in decreasing the CERT error rate.

For your convenience, NAS will share any changes to your POC information, including address changes, with the CERT contractors (AdvanceMed and Livanta).

To update your CERT Point of Contact, please select the link below.
www.certcdc.com/certproviderportal/verifyAddress.aspx

MEDICAL REVIEW

New Supplier Medical Review

CMS has implemented several initiatives to prevent improper payments before a claim is processed and identify and recoup improper payments after a claim has been processed. The overall goal of CMS' claim review programs is to reduce payment errors by identifying and addressing billing errors concerning coverage and coding made by suppliers.

One strategy utilized to reduce payment error is a pre-payment review conducted on new suppliers, which is performed by medical review. NAS performs pre-payment reviews in accordance with CMS' Progressive Corrective Action (PCA) Plan. This review involves 20-40 claims that are randomly selected for a pre-payment review. The supplier is asked to provide the requested medical documentation to support the services billed. When medical records are requested, the provider must submit them within the specified time frame or the claim will be denied.

The review of claims will focus on accurate billing and are subject to medical review before payment can be authorized. Once suppliers have established the practice of billing correctly, they are removed from pre-payment review. Suppliers will be notified of a review by letter, beginning with a notification letter. Education will be provided to the supplier if the review indicates a need. Education will be done by mail, phone or referral to suppliers.

Resources

1. *Medicare Program Integrity Manual*, Chapter 3, Section 3.4.7
2. Medicare Claim Review Program Booklet: www.cms.hhs.gov/MLNProducts/downloads/MCRP_Booklet.pdf

FORMS

Revised ADMC Form

Medical Review has revised the Advance Determination of Medicare Coverage (ADMC) Request Form as a response to supplier feedback. The form now requests only the supplier and beneficiary information along with the base HCPCS code. The ordering physician information and accessory codes have been removed.

The new form also indicates whether documentation is for a manual wheelchair, a power wheelchair or both.

Medical Review requests suppliers start using this form immediately; however, the old forms will still be accepted. The new ADMC Request Form is found on both the Coverage/MR section and Forms section of the NAS DME web site.

Revised DME Refunds to Medicare Form

Two new options were added to the DME Refunds to Medicare form on June 16, 2008 in response to supplier feedback.

1. "Item(s) returned" has been added under the Miscellaneous column in the Reason Code for Claim Adjustment section.
2. The option for "Immediate Offset Requested - Yes or No" is located directly below the Reason Code for Claim Adjustment section.

All suppliers are encouraged to begin using the revised Refunds to Medicare - DME form immediately: www.noridianmedicare.com/dme/forms/docs/ref_med_dme.pdf. This form is interactive so it can be completed online and printed with no handwriting required.

To notify Medicare of a non-MSP overpayment situation, choose on of the following options:

1. Request an immediate offset by completing the Refunds to Medicare – DME form, indicate "Immediate Offset" and fax to 888-529-3666.
2. Mail the completed Refunds to Medicare – DME form with a check to:

   Medicare Refunds – DME
   PO Box 6727
   Fargo ND 58108-6727

3. 3. Submit a completed Refunds to Medicare – DME form without a check by fax or mail. NAS will then send an overpayment letter informing the supplier of the exact dollar amount to be paid to Medicare for the refund.

If a supplier has received an overpayment request from NAS and would like to request an immediate offset, fax the first two pages of the overpayment request letter and indicate in large letters "Immediate Offset" in the space between the address and the date information.

Addendum to Break in Service and Extending CMNs

NAS would like to provide some further information on the subject of claims where a Break in Service applies or a CMN needs to be extended. We published an article on this topic in the "What's New" section of our web site on April 10, 2008.

We were seeing suppliers submitting electronic claims with comments of "Break in Service, please extend." These are two different requests. NAS requests that claims contain either the comment "BIS" or a comment requesting an extension of the CMN, but not both.

Break in Service involves creating a new "initial" CMN in the claims processing system for the new rental period that begins, whereas extending a CMN is just adjusting the rental paid dates on the CMN that has already been established for the equipment.

We also want to clarify that the following information is also required for BIS claims in the narrative section of the claim (Item 19 for a paper claim or the NTE segment for electronic claims):

- "BIS" comment
- Pick up dates for previous equipment
- SNF or hospital stay or an explanation for the break in service

For further information, see Chapter 3 of the supplier manual.

Continuous Billing

NAS DME staff has noticed that some suppliers bill the same claim repeatedly or bill weekly for items that can only be billed monthly. Chapter 6 of the Supplier Manual explains the timeframes for releasing claim payment as follows, based on CMS requirements.

> Suppliers who file paper claims will not be paid before the 29th day after the date of receipt of their claims (i.e., a 28-day payment floor). However, clean claims filed electronically can be paid as early as 14 days after receipt (i.e., a 13-day payment floor)

Suppliers should not consider rebilling claims until the payment floor has been reached. Patterns of billing "duplicate" claims may result in a referral to our fraud investigative unit.

To check on the status of a claim that was submitted, but which has not yet been paid after the payment floor timeframe has been reached, use the Interactive Voice Response system. The IVR is available from 6 am-6 pm CT, Monday-Friday, by dialing 1-877-320-0390. The IVR instructions for checking the status of claims can be found in the IVR Guide located in the Contact section of our DME web site, www.noridianmedicare.com/dme.

If questions remain on the status of claims after using the IVR, our supplier contact center representatives can be reached by dialing 1-866-243-7272.

Vision Items Requiring EY Modifier Must be Filed Separately

On December 5, 2007 NAS published MLN Matters 5771 that outlined proper billing procedures for items dispensed without a physician order. NAS would like to reiterate those guidelines as they relate to vision suppliers.

When submitting Medicare for items dispensed without a physician order, the supplier must append the EY modifier to the HCPCS code. This includes patient preference items such as anti-reflective coating (V2750), polycarbonate or Trivex tm lenses (V2784), tints (V2744, V2745) or oversized lenses (V2780), as described in the Refractive Lenses Local Coverage Determination.

As instructed in MM5771:

- Suppliers must report their own name and NPI number as the ordering/referring physician on claims submitted without a physician order.
- The EY modifier must be on **all** line items for that claim.
- The claim cannot contain a mixture of order and non-ordered items. Ordered items must be billed separately.

Claims submitted with a mixture of ordered and non-ordered items will be denied as unprocessable. The remittance advice message reported on these denied claims is CO-4: "The procedure code is inconsistent with the modifier used or a required modifier is missing".

Clarification on Billing Diabetic Testing Supplies

The following are reminders when billing for diabetic testing supplies. For complete information regarding coverage, coding and documentation requirements, please refer to the Glucose Monitor policy located on the Coverage/MR page of our web site.

HCPCS
A4253 – Test strips (1 unit = 50 strips)
A4259 – Lancets (1 unit = 100 lancets)

Do not bill for the number of strips or lancets but convert the number provided to the correct number of units.

Modifiers
The KX modifier must be added to the code for the monitor and each related supply on every claim submitted when the patient is being treated with insulin injections.

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

Utilization Guidelines
Non-Insulin Treated (3 month supply)
100 test strips (once/day testing)
100 lancets (once/day testing)

Insulin Treated (3 month supply)
300 test strips (three times/day testing)
300 lancets (three times/day testing)

Claim Status Category Code and Claim Status Code Update

MLN Matters Number: MM6090
Related Change Request (CR) #: 6090
Related CR Release Date: June 13, 2008
Related CR Transmittal #: R1533CP
Effective Date: October 1, 2008
Implementation Date: October 6, 2008

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

What You Need to Know
CR 6090, from which this article is taken, reminds providers of the periodic updates to the Claim Status Codes and Claim Status Category Codes that Medicare contractors use with the Health Care Claim Status Request (ASC X12N 276), and the Health Care Claim Response (ASC X12N 277).

Background
The Claim Category and Claim Status Codes explain the status of submitted claims. The Health Insurance Portability and Accountability Act (HIPAA) requires all health care benefit payers to use only national Code Maintenance Committee-approved codes in the X12 276/277 Health Care Claim Status Request and Response format adopted as the standard for national use (004010X093A1).

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

CR 6090, from which this article is taken, updates the changes in the Claim Status Codes and Claim Status Category Codes from the February 2008 committee meeting, which were posted at http://www.wpc-edi.com/content/view/180/223/ on February 29, 2008 (previously referenced by http://www.wpc-edi.com/codes). CR6090 reminds Medicare contractors that they must have completed the entry of all applicable code text changes and new codes, and terminated the use of deactivated codes by its implementation date (October 6, 2008). On and after this date, these code changes are to be used in editing of all X12 276 transactions processed, and to be reflected in the X12 277 transactions issued.

Additional Information
You can find the official instruction, CR6090, issued to your carrier, FI, RHHI, A/B MAC, or DME MAC by visiting http://www.cms.hhs.gov/Transmittals/downloads/R1533CP.pdf on the CMS website.

October Quarterly Update to 2008 Annual Update of HCPCS Codes Used for SNF Consolidated Billing Enforcement

MLN Matters Number: MM6111
Related Change Request (CR) #: 6111
Related CR Release Date: June 20, 2008
Related CR Transmittal #: R1537CP
Effective Date: October 1, 2008
Implementation Date: October 6, 2008

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

Provider Action Needed
This article is based on Change Request (CR) 6111 which provides the October quarterly update to the 2008 Healthcare Common Procedure Coding System (HCPCS) codes for Skilled Nursing Facility (SNF) consolidated billing (CB) enforcement.

Background
The Social Security Act (Section 1888; see http://www.ssa.gov/OP_Home/ssact/title18/1888.htm on the Internet) codifies Skilled Nursing Facility (SNF) Prospective Payment System (PPS) and Consolidated Billing (CB), and the Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of Healthcare Common Procedure Coding System (HCPCS) codes that are subject to the CB provision of the SNF PPS. The new coding identified in each update describes the same services that are subject to SNF PPS payment by law.

Services appearing on this list of updated HCPCS codes that are submitted on claims to Medicare Fiscal Intermediaries, Carriers, or A/B MACs will not be paid by Medicare to any providers other than a Skilled Nursing Facility (SNF) **when included** in SNF Consolidated Billing (CB).

For non-therapy services, SNF CB applies only when the services are furnished to a SNF resident during a covered Part A stay. However, SNF CB applies to physical and occupational therapies and speech-language pathology services whenever they are furnished to a SNF resident, regardless of whether Part A covers the stay.

Services excluded from SNF PPS and CB may be paid to providers, other than SNFs, for beneficiaries, even when in a SNF stay. In order to assure proper payment in all settings, Medicare systems must edit for services provided to SNF beneficiaries both included and excluded from SNF CB.

For October 1, 2008, the only change is that Medicare systems will add HCPCS code L5670 (ADDITION TO LOWER EXTREMITY, BELOW KNEE, MOLDED SUPRACONDYLAR SUSPENSION ('PTS' OR SIMILAR)) to the File 1 Coding list. Your Medicare contractor will reopen and reprocess claims with dates of service on or after January 1, 2008 that are affected by this change if you bring such claims to their attention.

Additional Information
The official instruction, CR 6111, issued to your carrier or A/B MAC regarding this change may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R1537CP.pdf on the CMS website.

Medicare Remit Easy Print New Version Available

Medicare Remittance Easy Print (MREP) version 2.4 is now available for download and includes the following changes:

- Updated Codes.ini file
- MREP User Manual Updates - Guidance on Retrieving Files
- Update to correct the "Other Adjustments Report" which was not functioning properly

Remember: You can save time and money by taking advantage of **FREE** Medicare Remit Easy Print software available to view and print the HIPAA compliant 835!

REIMBURSEMENT

Nebulizers LCD – Policy Revision

The Nebulizers local coverage determination (LCD), effective for dates of service on or after July 1, 2008, is being revised. The provision applying least costly alternative to levalbuterol (Xopenex) is being withdrawn pending further review by CMS.

The effective date for applying least costly alternative to the unit dose combination solution of albuterol and ipratropium (DuoNeb – J7620) is being revised. The effective date is delayed and will be implemented for claims with dates of service on or after November 1, 2008.

Suppliers should become familiar with the new Nebulizers Policy prior to its effective date to minimize effects on their billing process.

Levalbuterol—Correction

An article was posted to our web site on June 12, 2008, regarding reimbursement of Levalbutrol. This article was updated on June 13, 2008. The corrected version states:

In December 2007, Congress enacted the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA). Section 112(b) of MMSEA (which added section 1847A(b)(7) of the Social Security Act) provides that the average sales price (ASP)-based payment rate for single source inhalation drugs that are treated as multiple source under the grandfathering provision is the lower of the payment amount determined when the grandfathering clause is applied or when the grandfathering clause is not applied. Section 112(b) also provides that the ASP-based payment rate for multiple source inhalation drugs is the lower of the amount determined taking the grandfathering clause into account, or not applying the grandfathering clause.

Section 112(b) of MMSEA is drafted to apply to a very specific subset of drugs reimbursed under the ASP methodology. By its terms, it applies only to those inhalation drugs or biologicals furnished through an item of durable medical equipment that the ASP grandfathering clause affects. Due to the specificity of section 112(b), and the implications that it may have on how the Centers for Medicare & Medicaid Services (CMS) pays for certain drugs, CMS would like to review this provision further. Contractors shall withdraw the least costly alternative (LCA) policies for levalbuterol and shall take no further action before December 31, 2008. Contractors shall take no further action thereafter, until receipt of further guidance from CMS.

FDA - Approved Unit Dose Combination of Albuterol and Ipratropium

The following instruction was provided by CMS on June 20, 2008:

Contractors shall not implement the least costly alternative (LCA) policies for the Food and Drug Administration (FDA) - approved unit dose combination of albuterol and ipratropium (J7620) until November 1, 2008.

Average Sales Price Updates

MLN Matters Number: MM5798
Related Change Request (CR) #: 5798
Related CR Release Date: May 23, 2008
Related CR Transmittal #: R1513CP
Effective Date: June 23, 2008
Implementation Date: June 23, 2008

Provider Types Affected
Physicians, providers, and suppliers who submit claims to Medicare contractors (carriers, fiscal intermediaries (FIs), Part A/B Medicare Administrative Contractors (A/B MACs), and DME Medicare Administrative Contractors (DME MACs)) for services provided to Medicare beneficiaries.

Provider Action Needed
This article is based on Change Request (CR) 5798 and provides you with updates and additions to language in the Medicare Claims Processing Manual relating to the ASP drug pricing and payment methodology. This article is informational to advise providers that the information is now in the Medicare manual and this information has been supplied in prior MLN Matters articles.

Key Points
The Centers for Medicare & Medicaid Services (CMS) provides an ASP file to each FI, carrier, DME MAC, and A/B MAC for pricing drugs. Each FI, carrier, DME MAC, and A/B MAC must accept the ASP files made available by CMS for pricing bills/claims for any drug identified on the price files as **these files are the single national payment limit established by CMS.**

- The payment limits included in the revised ASP and Not Otherwise Classified (NOC) payment files supersede the payment limits for these codes in any earlier publication.

ASP Payment Methodology

- The ASP methodology is based on quarterly data submitted to CMS by manufacturers and the updated and new guidelines established that relate to ASP pricing, payment methodology, and exceptions, are stated in Chapter 17, Section 20 of the Medicare Claims Processing Manual at http://www.cms.hhs.gov/manuals/downloads/clm104c17.pdf on the CMS website.
- The absence or presence of a Healthcare Common Procedure Coding System (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. Your local Medicare contractor processing the claim will make these determinations.
- The vast majority of drugs and biologicals not priced on a cost or prospective payment basis will be priced based on the ASP methodology.
- Pricing for compounded drugs is done by your local contractor.
- End Stage Renal Disease (ESRD) drugs furnished by both independent and hospital-based ESRD facilities, as well as specified covered outpatient drugs, and drugs and biologicals with pass-through status under the Outpatient Prospective Payment System (OPPS), will be priced based on the ASP methodology.
- The payment allowance limits for Medicare Part B drugs and biologicals that are not paid on a cost or prospective payment basis are 106 percent of the ASP.
- The payment allowance limits for ESRD drugs when separately billed by freestanding and hospital-based ESRD facilities, as well as specified covered outpatient drugs, and drugs and biologicals with pass-through status under the OPPS, will be paid based on 106 percent of the ASP.
- For the purposes of identifying "single source drugs" and "biological products" subject to payment under Section 1847A, generally CMS (and its contractors) will utilize a multi-step process, in which CMS considers:
  1. The Food & Drug Administration (FDA) approval;
  2. Therapeutic equivalents as determined by the FDA; and
  3. The date of first sale in the United States.
- For a biological product (as evidenced by a new FDA Biologic License Application or other relevant FDA approval) or a single source drug (that is, not a drug for which there are 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, the payment limit for a biological product or single source drug will be based on the pricing information for products marketed or sold under the applicable FDA approval. As appropriate, a unique

HCPCS code will be assigned to facilitate separate payment, which may be made operational through use of "not otherwise classified" HCPCS codes.

Exceptions to the ASP Payment Methodology

- The payment allowance limits for blood and blood products (other than blood clotting factors) that are not paid on a reasonable charge or prospective payment basis, are determined in the same manner the payment allowance limits were determined on October 1, 2003. Specifically, the payment allowance limits for blood and blood products are 95 percent of the average wholesale price (AWP) as reflected in the published compendia.
- The payment allowance limits for infusion drugs furnished through a covered item of durable medical equipment on or after January 1, 2005, will continue to be 95 percent of the AWP reflected in the published compendia as of October 1, 2003, unless the drug is compounded or the drug is furnished incident to a professional service. The payment allowance limits for infusion drugs furnished through a covered item of durable medical equipment that were not listed in the published compendia as of October 1, 2003, (i.e., new drugs) are 95 percent of the first published AWP unless the drug is compounded or the drug is furnished incident to a professional service.
- The payment allowance limits for influenza, Pneumococcal and Hepatitis B vaccines are 95 percent of the AWP as reflected in the published compendia except where the vaccine is furnished in a hospital outpatient department. Where the vaccine is administered in the hospital outpatient department, the vaccine is paid at reasonable cost.
- The payment allowance limits for drugs and biologicals that are not included in the ASP Medicare Part B Drug Pricing File or Not Otherwise Classified (NOC) Pricing File, other than new drugs that are produced or distributed under a new drug application (or other application) approved by the FDA, are based on the published Wholesale Acquisition Cost (WAC) or invoice pricing, except under OPPS where the payment allowance limit is 95 percent of the published AWP. In determining the payment limit based on WAC, the contractors follow the methodology specified in the *Medicare Claims Processing Manual*, Chapter 17, Drugs and Biologicals, http://www.cms.hhs.gov/manuals/downloads/clm104c17.pdf on the CMS website, for calculating the AWP, but substitutes WAC for AWP. The payment limit is 100 percent of the lesser of the lowest-priced brand or median generic WAC.
- Carriers, DME MACs, and A/B MACs will develop payment allowance limits for covered drugs when CMS does not supply the payment allowance limit on the ASP drug pricing file.
- The payment allowance limits for new drugs and biologicals that are produced or distributed under a new drug application (or other new application) approved by the FDA, and that are not included in the ASP Medicare Part B Drug Pricing File or Not Otherwise Classified (NOC) Pricing File, are based on 106 percent of the WAC, or invoice pricing if the WAC is not published, except under OPPS where the payment allowance limit is 95 percent of the published AWP.
- The payment allowance limits for radiopharmaceuticals are not subject to ASP. Carriers will 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. Please refer to Chapter 17, Section 90.2 of the *Medicare Claims Processing Manual* regarding radiopharmaceuticals furnished in the hospital outpatient department.

Additional Information

You may see the official instruction (CR5798) issued to your Medicare contractor by visiting http://www.cms.hhs.gov/Transmittals/downloads/R1513CP.pdf on the CMS website.

The ASP methodology files are posted at http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/ on the CMS website.

July Quarterly Update for 2008 DMEPOS Fee Schedule

MLN Matters Number: MM6022 Revised
Related Change Request (CR) #: 6022
Related CR Release Date: May 23, 2008
Related CR Transmittal #: R1516CP
Effective Date: January 1, 2008
Implementation Date: July 7, 2008

Note: This article was revised on June 2, 2008, to reflect an effective date (see above) of January 1, 2008. All other information remains the same.

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 DMEPOS provided to Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 6022, which provides the quarterly update to the July 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 staffs are aware of these changes.

Background

This recurring update notification, CR6022, provides specific instructions regarding the July quarterly update for 2008 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 Section 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, Chapter 23, Section 60, which is available at 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 Healthcare Common Procedure Coding System (HCPCS) codes were added to the HCPCS file effective January 1, 2008 and the fee schedule amounts for these HCPCS codes may be established as part of this update and are effective for claims with dates of service on or after January 1, 2008.

Code	Description	Code	Description
A5083	Continent device, stoma absorptive cover for continent stoma.	E0856	Cervical traction device, cervical collar with inflatable air bladder.
E2227	Manual wheelchair accessory, gear reduction drive wheel, each.	E2228	Manual wheelchair accessory, wheel braking system and lock, complete, each.
E2397	Power wheelchair accessory, lithium-based battery, each.	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.
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.

- The above codes were paid on a local fee schedule basis prior to implementation of the fee schedule amounts established in accordance with this update. Claims for these codes with dates of service on or after January 1, 2008 that have already been processed will not be adjusted to reflect the newly established fees if they are resubmitted for adjustment.
- The fee schedule amounts for the following codes are being revised as part of this quarterly update to correct fee schedule calculation errors and the revised fee schedule amounts will be added to the fee schedule file as part of this update.

Code	Description	Code	Description
L3905	Wrist hand orthosis, includes one or more nontorsion joints, elastic bands. Turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment.	L3806	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.
L3808	Wrist hand finger orthosis, rigid without joints, may include soft interface material; straps, custom fabricated, includes fitting and adjustment.		

- Your Medicare contractor will adjust previously processed claims for codes L3905, L3806 and L3808 with dates of service on or after January 1, 2008 if they are resubmitted for adjustments.
- HCPCS code K0672 (Addition to Lower Extremity Orthosis, Removable Soft Interface, All Components, Replacement Only, Each) was added to the HCPCS file effective April 1, 2008.
- The fee schedule amounts for HCPCS code E0461 (Volume Control Ventilator, Without Pressure Support Mode, May Include Pressure Control Mode, Used with Non-Invasive Interface (e.g. Mask)) were inadvertently dropped from the January 2008 DMEPOS fee schedule file and the file was subsequently revised to add the fee schedule amounts for code E0461.

Additional Information
For complete details regarding this CR please see the official instruction (CR6022) issued to your Medicare contractor. That instruction may be viewed by going to http://www.cms.hhs.gov/Transmittals/downloads/R1516CP.pdf on the CMS website.

July 2008 Quarterly ASP Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files

MLN Matters Number: MM6049
Related Change Request (CR) #: 6049
Related CR Release Date: June 6, 2008
Related CR Transmittal #: R1529CP
Effective Date: July 1, 2008
Implementation Date: July 7, 2008

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

What You Need to Know
CR 6049, from which this article is taken, instructs Medicare contractors to download and implement the July 2008 Average Sales Price (ASP) drug pricing file for Medicare Part B drugs; and if released by CMS, also the revised April 2008, January 2008, January 2007, April 2007, July 2007, and October 2007 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 methodol*ogy* is based on quarterly data that drug manufacturers submit to the Centers for Medicare & Medicaid Services (CMS), which CMS then provides (quarterly) to Medicare contractors (carriers, *DME* MACs, FIs, A/B MACs, and/or RHHIs) through the ASP drug pricing files for Medicare Part B drugs.

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

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

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

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

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

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

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

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

Beginning January 1, 2008, under the OPPS, payment allowance limits for specified covered outpatient drugs are paid based on 105 percent of the ASP. Drugs and biologicals with pass-through status under the OPPS continue to have a payment allowance limit of 106 percent of the ASP. CMS will update the payment allowance limits quarterly.

Exceptions are summarized as follows:

- The payment allowance limits for blood and blood products (other than blood clotting factors) that are not paid on a prospective payment basis are 95 percent of the average wholesale price (AWP) as reflected in the published compendia. The payment allowance limits are updated on a quarterly basis. Blood and blood products furnished in the hospital outpatient department are paid under OPPS at the amount specified for the Ambulatory Payment Class (APC) to which the product is assigned.
- Payment allowance limits for infusion drugs furnished through a covered item of durable medical equipment on

or after January 1, 2005, will continue to be 95 percent of the AWP reflected in the published compendia as of October 1, 2003, unless the drug is compounded or the drug is furnished incident to a professional service. **The payment allowance limits are not being updated in 2008**. The payment allowance limits for infusion drugs furnished through a covered item of durable medical equipment that were not listed in the published compendia as of October 1, 2003, (i.e., new drugs) are 95 percent of the first published AWP unless the drug is compounded or the drug is furnished incident to a professional service.

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

On or after June 16, 2008, the July 2008 ASP file will be available for download along with revisions to prior ASP payment files, if CMS determines that revisions to these prior files are necessary. On or after June 16, 2008, the July 2008 ASP NOC files will be available for retrieval from the CMS ASP webpage along with revisions to prior ASP NOC files, if CMS determines that revisions to these prior files are necessary. The payment limits included in revised ASP and NOC payment files supersede the payment limits for these codes in any publication published prior to this document.

The payment files will be applied to claims processed or reprocessed on or after the implementation date of CR6049 for the dates of service noted in the following table:

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

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

Drugs Furnished During Filling or Refilling an Implantable Pump or Reservoir

Physicians may be paid for filling or refilling an implantable pump or reservoir when it is medically necessary for the physician (or other practitioner) to perform the service. Medicare contractors must find the use of the implantable pump or reservoir medically reasonable and necessary in order to allow payment for the professional service to fill or refill the implantable pump or reservoir and to allow payment for drugs furnished incident to the professional service.

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

REIMBURSEMENT CONT'D

the filling or refilling of an implantable pump or reservoir is determined under the ASP methodology as described above. Note that pricing for compounded drugs is done by your local Medicare contractor.

Additional Information
To see the official instruction (CR6049) issued to your Medicare contractor visit http://www.cms.hhs.gov/Transmittals/downloads/R1529CP.pdf on the CMS website.

CODING

Coding Instructions – Otto Bock C-Leg®

Recently during a claim review, it was noted that suppliers were billing the miscellaneous code L5999 for two functions of the Otto Bock C-Leg® lower extremity prosthesis - "continuous gait assessment, computerized MKP prosthesis" and "electronically controlled static stance regulator, adjustable." This coding is not correct. The on-board, real-time gait analysis and stance regulation are accomplished by the microprocessors in the Otto Bock knee (code L5856). There is no separate billing and reimbursement for these functions since the allowance for these functions are included in the reimbursement for code L5856.

According to the SADMERC, the following are the only HCPCS codes billable for the Otto Bock C-Leg®:

- L5828 – Addition, endoskeletal knee-shin system, single axis, fluid swing and stance phase control
- L5845 – Addition, endoskeletal knee-shin system, stance flexion feature, adjustable
- L5848 – Addition to endoskeletal knee-shin system, fluid stance extension, dampening feature, with or without adjustability
- L5856 – Addition to lower extremity prosthesis, endoskeletal knee-shin system, microprocessor control feature, swing and stance phase, includes electronic sensor(s), any type
- L5920 – Addition, endoskeletal system, above knee or hip disarticulation, alignable system
- L5930 – Addition, endoskeletal system, high activity knee control frame
- L5950 – Addition, endoskeletal system, above knee, ultra-light material (titanium, carbon fiber or equal)

Suppliers are reminded that for any questions regarding the correct coding of products to access the Durable Medical Equipment Coding System (DMECS) at http://www3.palmettogba.com/dmecs/jsp/index.jsp or contact the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) Coding Helpline at 1-877-735-1326.

COVERAGE

Immunosuppressive Drugs LCD Revision – KX Modifier Requirement Added

The Immunosuppressive Drugs LCD has been revised to include a requirement for the supplier to obtain the date of the qualifying transplant and affirm that the transplant date precedes the date of service for the immunosuppressive drug claim. If these criteria are met, the KX modifier must be added to the claim.

The Documentation Requirements section of the LCD states,

> For claims received on or after July 1, 2008, the KX modifier must be added to the claim line(s) for the immunosuppressive drug(s) only if the supplier obtains from the ordering physician the date of the organ transplant and the transplant date precedes the date of service on the claim. If these requirements are not met, the KX modifier may not be added to the claim.

Please note that this requirement is effective for **claims received** on or after July 1, 2008. Refer to the LCD for additional information.

Negative Pressure Wound Therapy Pumps

Comprehensive Error Rate Testing (CERT) data analysis shows some negative pressure wound therapy pumps are being billed incorrectly. This article is to inform suppliers on the coverage criteria and documentation requirements for negative pressure wound therapy pumps.

Initial Coverage
A Negative Pressure Wound Therapy (NPWT) pump and supplies are covered when either criterion A or B is met:

A) Ulcers and Wounds in the Home Setting:

The patient has a chronic Stage III or IV pressure ulcer (see Appendices Section), neuropathic (for example, diabetic) ulcer, venous or arterial insufficiency ulcer, or a chronic (being present for at least 30 days) ulcer of mixed etiology. A complete wound therapy program described by criterion 1 and criteria 2, 3, or 4, as applicable depending on the type of wound, should have been tried or considered and ruled out prior to application of NPWT.

1. For all ulcers or wounds, the following components of a wound therapy program must include a minimum of all of the following general measures, which should either be addressed, applied, or considered and ruled out prior to application of NPWT:
    a. Documentation in the patient's medical record of evaluation, care, and wound measurements by a licensed medical professional, and
    b. Application of dressings to maintain a moist wound environment, and
    c. Debridement of necrotic tissue if present, and
    d. Evaluation of and provision for adequate nutritional status.

COVERAGE CONT'D

2. For Stage III or IV pressure ulcers:
    a. The patient has been appropriately turned and positioned, and
    b. The patient has used a group 2 or 3 support surface if the pressure ulcer is on the posterior trunk or pelvis (see LCD on support surfaces),
    c. The patient's moisture and incontinence have been appropriately managed.
3. For neuropathic (for example, diabetic) ulcers:
    a. The patient has been on a comprehensive diabetic management program, and
    b. Reduction in pressure on a foot ulcer has been accomplished with appropriate modalities.
4. For venous insufficiency ulcers:
    a. Compression bandages and/or garments have been consistently applied, and
    b. Leg elevation and ambulation have been encouraged.

B) Ulcers and Wounds Encountered in an Inpatient Setting:

1. An ulcer or wound (described under A above) is encountered in the inpatient setting and, after wound treatments described under A-1 through A-4 have been tried or considered and ruled out, NPWT is initiated because it is considered in the judgment of the treating physician, the best available treatment option.
2. The patient has complications of a surgically created wound (for example, dehiscence) or a traumatic wound (for example, pre-operative flap or graft) where there is documentation of the medical necessity for accelerated formation of granulation tissue which cannot be achieved by other available topical wound treatments (for example, other conditions of the patient that will not allow for healing times achievable with other topical wound treatments).

In either situation B-1 or B-2, NPWT will be covered when treatment continuation is ordered beyond discharge to the home setting.

If criterion A or B above is not met, the NPWT pump and supplies will be denied as not medically necessary.

NPWT pumps (E2402) must be capable of accommodating more than one wound dressing set for multiple wounds on a patient. Therefore, more than one E2402 billed per patient for the same time period will be denied as not medically necessary.

A licensed health care professional, for the purposes of this policy, may be a physician, physician's assistant (PA), registered nurse (RN), licensed practical nurse (LPN), or physical therapist (PT). The practitioner should be licensed to assess wounds and/or administer wound care within the state where the beneficiary is receiving NPWT.

Other Exclusions from Coverage

An NPWT pump and supplies will be denied at any time as not medically necessary if one or more of the following are present:

- Presence in the wound of necrotic tissue with eschar, if debridement is not attempted;
- Untreated osteomyelitis within the vicinity of the wound;
- Cancer present in the wound;
- Presence of a fistula to an organ or body cavity within the vicinity of the wound.

Documentation Requirements

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

Documentation of the history, previous treatment regimens (if applicable), and current wound management for which an NPWT pump is being billed must be present in the patient's medical record and be available for review upon request. This documentation must include such elements as length of sessions of use, dressing types and frequency of change, and changes in wound conditions, including precise measurements, quantity of exudates, presence of granulation and necrotic tissue and concurrent measures being addressed relevant to wound therapy (debridement, nutritional concerns, support surfaces in use, positioning, incontinence control, etc.).

Documentation of wound evaluation and treatment, recorded in the patient's medical record, must indicate regular evaluation and treatment of the patient's wounds, as detailed in the Indications and Limitations of Coverage Section. Documentation of quantitative measurements of wound characteristics including wound length and width (surface area), and depth, and amount of wound exudate (drainage), indicating progress of healing must be entered at least monthly. The supplier of the NPWT equipment and supplies must obtain from the treating clinician, an assessment of wound healing progress, based upon the wound measurement as documented in the patient's medical record, in order to determine whether the equipment and supplies continue to qualify for Medicare coverage. (The supplier need not view the medical records in order to bill for continued use of NPWT. Whether the supplier ascertains that wound healing is occurring from month to month via verbal or written communication is left to the discretion of the supplier. However, the patient's medical records may be requested in order to corroborate that wound healing is/was occurring as represented on the supplier's claims for reimbursement.)

When billing for NPWT, an ICD-9-CM diagnosis code (specific to the 5th digit or narrative diagnosis), describing the wound being treated by NPWT, must be included on each claim for the equipment and related supplies.

For each subsequent month, the medical record must include updated wound measurements and what changes are being applied to effect wound healing.

When NPWT therapy exceeds four months on the most recent wound and reimbursement ends, individual consideration for additional months may be sought using the appeals process. Documentation should be submitted with the appeal explaining the special circumstances necessitating the extended therapy time.

When billing for quantities of supplies greater than those described in the policy as the usual maximum amounts, there must be clear documentation in the medical record corroborating the medical necessity for the additional quantities.

COVERAGE CONT'D

Reference
Local Coverage Determination for Negative Pressure Wound Therapy Pumps (L11489)
Effective July 01, 2007

Article for Negative Pressure Wound Therapy Pumps (A35425)
Effective January 2006

WHEELCHAIR/POWER MOBILITY DEVICE

Wheelchair Options and Accessories – Remote Joysticks and Controllers – FAQ

Q. What is the correct coding when a standard proportional remote joystick is provided at the time of initial issue of a power wheelchair?

A. There is no separate billing for a standard proportional remote joystick when it is provided at the time of initial issue of a power wheelchair. Payment is included in the allowance for the power wheelchair base. If a nonexpandable controller is provided at the time of initial issue, payment is also included in the allowance for the wheelchair base and there is no separate billing.

If an expandable controller is provided at the time of initial issue, codes E2377 (expandable controller) and E2313 (harness for upgrade to expandable controller) are separately billable and payable. If a power seating system is provided and if the system is controlled through the drive control interface, code E2310 or E2311 is used. There is no additional separate billing using code E2399 or K0108 for any components of a nonexpandable or an expandable controller.

Refer to the Coding Guidelines section of the Wheelchair Options and Accessories Policy Article for definitions of the components described above and additional coding information.

Preventing Duplicate ADMC Requests

NAS would like to remind suppliers that an Advance Determination of Medicare Coverage (ADMC) request may only be submitted once in a six month period. If additional medical documentation is obtained that would affect the ADMC decision, then the request can be submitted once more in that six month period. Any requests above and beyond these are duplicates.

NAS Medical Review asks that suppliers avoid submitting a second request until you have received a determination on the initial submission. Decisions on ADMC are made within 30 days of receipt at NAS. Your cooperation will assist DME medical review in processing all requests efficiently and timely.

NAS suggests that if you have not received a decision letter after 30 days from the initial request and are concerned about your ADMC, please call the contact center at 1-866-243-7272.

Manual Wheelchair CERT Error Rates High

Manual wheelchairs have a high CERT provider compliance error rate in Jurisdiction D. NAS would like to review the indications, limitations of coverage and the medical necessity required for a manual wheelchair.

As with all DMEPOS, a written and signed physician order must be received by the supplier before the supplier can bill for the item, otherwise the item will be denied as not medically necessary.

A manual wheelchair is covered if a patient has a mobility limitation that significantly impairs his/her ability to participate in one or more mobility related activities of daily living (MRADLs) such as toileting, feeding, dressing, grooming, and bathing in customary locations in the home.

A mobility limitation must prevent a patient from accomplishing an MRADL entirely, or place the patient at a reasonably determined heightened risk of morbidity or mortality secondary to the attempts to perform an MRADL, or prevents the patient from completing an MRADL within a reasonable time frame.

The following criteria must also be met, in addition to the above, in order to qualify for a manual wheelchair:

- A patient's mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker.
- The patient's home must provide adequate access between rooms with maneuvering space and proper surfaces for the use of the manual wheelchair.
- The use of the wheelchair must significantly improve the patient's ability to participate in MRADLs and the patient will use it on a regular basis in the home.
- The patient has not expressed an unwillingness to use the manual wheelchair that is provided.
- The patient must have sufficient upper extremity function and other physical and mental capabilities needed to safely self-propel the manual wheelchair that is provided. If not, the patient must have a caregiver who is available, willing, and able to provide assistance with the wheelchair.

Information that is helpful to assess upper extremity function include: limitations of the patients' strength, endurance, range of motion, or coordination, presence of pain, or deformity or absence of one or both upper extremities.

Documentation for individual consideration might include information on the patient's diagnosis and the patient's capabilities and limitations as they relate to the equipment (e.g., degree of independence, dependence, frequency, and nature of the activities the patient performs, etc.), the duration of the condition, the expected prognosis, and past experience using similar equipment.

Source: Manual Wheelchair Bases Local Coverage Determination (L11454)