Jurisdiction D News from Noridian Administrative Services, LLC.

Happenings

June 2008
Issue No. 13

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…

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EDUCATIONAL

NPI

CEDI

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."

Alphabetical Listing...

Jurisdiction D DME MAC Supplier Contacts and Resources

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

Web site: www.noridianmedicare.com

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

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

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

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

Other Resources		
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

FYI

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

Sources for "Jurisdiction D Happenings" Articles

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

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

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."

Interactive Voice Response Enhancements

Same and similar item inquiries can now be done through the Interactive Voice Response (IVR) system! Recent statistical data shows same and similar inquiries are the top reason for calls to our contact center. From January through April 2008, NAS received just over 168,200 phone inquiries regarding same or similar, which averages to 2,000 inquires per day. We have added the same or similar functionality to the IVR to address this higher call volume, help reduce the number of calls to our Supplier Contact Center, reduce redetermination requests and to better serve our suppliers.

Benefits of contacting the IVR for same and similar items are:

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

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.

In order to access same or similar information, you will need to provide the:

- PTAN * (legacy # or NSC #)
- Patient's Medicare number
- Patient's first and last name
- Patient's date of birth
- HCPCS and modifier, if any, of equipment being provided

*After May 23, 2008, both the PTAN and NPI will be required before IVR information is released.

FYI CONT'D

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

After the same and similar information is provided, the IVR will explain your next options, which you can either speak or key:

- Repeat That (Press 1)
- Next HCPCS code (Press 2)
- Previous HCPCS code (Press 3)
- Change the HCPCS code (Press 4)
- Change the Medicare number (Press 5)
- Change the PTAN (Press 6)
- To repeat this list of options, press 7
- Main Menu (Press 8)

Reminders

- Our IVR only provides information from the Jurisdiction D claim files; it will not provide same and similar information for claims processed by other Jurisdictions. The IVR will access national claim information for DMEPOS that involve a CMN.
- CMS mandates that all suppliers first access inquiries through the IVR. By utilizing this automated system, the Supplier Contact Center can be available to help you with questions that require personal assistance.

The IVR User Guide, found in the Contact section of our website, will be updated soon. Watch our "What's New" section on our web site for announcements about additional IVR educational materials.

Summary of Supplier Manual Updates

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

Chapter	Subheading	Supplier Manual Update	Change Date
Chapter 16	HCPCS J and Q Codes	Added discontinued dates to J1751 and J1752. Added narrative and effective dates for Q4096, Q4097	5/1/08

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

New PO Box for DME Overpayment Redeterminations

In order to improve our customer service for suppliers requesting a review of an overpayment, NAS has added a new Post Office Box for DME Overpayment Redeterminations. NAS encourages suppliers to fill out the Redetermination Request form and mail to the address below with a copy of the overpayment letter.

The new address is:

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

A new check box has been added to the redetermination form to alert NAS staff that this is an appeal for an overpayment.

Provider Authentication by Medicare Provider Contact Centers

MLN Matters Number: SE0814

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

What You Need to Know
SE0814 covers the implementation of the National Provider Identifier (NPI) and the Provider Transaction Access Number (PTAN), effective May 23, 2008, as the provider authentication elements used when providers make telephone or written inquiries to the Medicare fee-for-service contractor provider contact centers.

FYI CONT'D

Note: For providers enrolled in Medicare before May 23, 2008, their PTAN initially will be their legacy provider number. New providers enrolling in Medicare on or after May 23, 2008, will be assigned a PTAN as part of the Medicare enrollment process.

Background
In order to protect the privacy of Medicare beneficiaries and to comply with the requirements of the Privacy Act of 1974 and the Health Insurance Portability and Accountability Act, customer service staff at Medicare provider contact centers (PCC) must properly authenticate the identity of providers/staff that call or write to request beneficiary protected health information before disclosing it to the requestor.

Please refer to the *Medicare Contractor Beneficiary and Provider Communications Manual* (Publication 100-9), chapter 3, section 30 and chapter 6, section 80 for a complete discussion of this PCC authentication update. You can find these manual sections at http://www.cms.hhs.gov/manuals/downloads/com109c03.pdf and http://www.cms.hhs.gov/manuals/downloads/com109c06.pdf on the Centers for Medicare & Medicaid Services (CMS) website.

Provider Authentication
The elements for provider authentication of telephone (either Customer Service Representative (CSR) or Interactive Voice Response (IVR)) and written inquiries are presented in the table below.

Provider Authentication Elements for Telephone & Written Inquiries

EFFECTIVE DATES	INQUIRY TYPE	PROVIDER ELEMENTS TO BE AUTHENTICATED (all elements must match unless otherwise specified)
On or after May 23, 2008	IVR	Provider NPI and PTAN
On or after May 23, 2008	CSR	Provider NPI and PTAN
On or after May 23, 2008	Written, including fax and email	Provider name, and either provider NPI or PTAN

Written Inquiries – Exception to above authentication requirements
CMS allows an exception for written or faxed inquiries submitted on a provider's official letterhead, and e-mail inquiries (with an attachment on letterhead). If the provider's name and address are included in the letterhead and clearly establish the provider's identity, no NPI or PTAN is required for authentication.

Quarterly Provider Update from CMS

CMS publishes a Quarterly Provider Update (QPU) to make it easier for suppliers to understand the proposed Medicare program changes by CMS. The QPU is published at the beginning of each quarter and provides information on regulations, major policies and manual instructions. Visit www.cms.hhs.gov/QuarterlyProviderUpdates/ for information regarding proposed regulations, public participation and comments, as well as past QPUs and Final Regulations, and the CMS-QPU Listserv availability.

EDUCATIONAL

Customize Your Web Site Content

Are you unable to read the text on our web site because of the size or color?

Instructions on how to change the text size of web site content using your web browser, how to magnify your screen and how to change the color of text and the background color to better suit your reading needs is available at: www.noridianmedicare.com/access/customize.html.

NAS also has a footer titled "Accessibility Help" to assist our supplier community as they access and view our site.

Two New OLC Lessons Available

Basics of Medicare and DME
This lesson is designed to introduce new suppliers and their staff to the basic concepts of Medicare and the DMEMAC. The participants will be introduced to the fundamentals of Medicare, the various contractors involved, general coverage criteria for DME items, benefit and fee schedule categories and basic documentation requirements. Upon completion of this lesson, the participant should have a better understanding of the structure of Medicare as well as the role of the DME MACs.

Comprehensive Error Rate Testing
What is CERT? Why are they requesting documentation? Who can I contact for help? All of these questions can be answered in this new CERT lesson. This topic is designed to help suppliers understand the CERT program. The contractors involved with CERT will be discussed as well as the important documentation they request. Direction will be provided if a claim is denied and money recouped. Additional valuable information includes contact address and phone numbers, NAS' role in the program and the type of errors found. After completion of this lesson participants will be better prepared for a CERT audit.

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

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

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

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

New Appeals Tab on the NAS Web Site

Based on feedback from the NAS supplier community, NAS is pleased to announce the new Appeals tab located on the toolbar throughout the NAS Web site www.noridianmedicare.com/.

The Appeals tab contains all appeal-related material, such as an overview of the appeals process (describes each level of appeal, timeframes, addresses, etc); medical documentation requirements; forms for requesting each level of appeal; frequently asked questions; a presentation developed by our Education staff that contains some helpful hints; and the redeterminations calculator.

As a reminder, NAS would like to encourage the use of the forms located on the web site to ensure requests are processed appropriately and timely. These forms may be periodically updated. Please be sure to frequently review the most current version of each form.

Please note: Each form should include only one claim review request.

How the Common Working File Impacts Claims

The Common Working File (CWF) is the master record of all Medicare beneficiary information and claim transactions, including both Medicare Part A, Part B and DME data. The claims processing systems interface with the CWF to verify the beneficiary's entitlement to Medicare, deductible status and available benefits. The CWF also reviews claims history to check for duplicate services, inpatient or Skilled Nursing Facility (SNF) stays, and other insurance that may pay primary to Medicare, secondary to Medicare or should pay in place of Medicare. As a final step in processing, most claims are sent to the CWF for review and validation of claim data.

How does the CWF work?

- The information for each beneficiary is stored in the CWF Master Record. Each CWF Master Record contains but is not limited to:
  - Complete entitlement
  - Utilization of Medicare benefits
  - Claim history
  - Medicare Secondary Payer (MSP) and Health Maintenance Organization (HMO) data
  - CMN information
  - Beneficiary demographics, such as address and date of birth
- The Master Record is updated daily. The data stored on the master record comes from government entities, such as the Social Security Administration, the Coordination of Benefits Contractor (COBC) and other entities involved with Medicare.
- The beneficiary must notify the SSA of name changes, changes of address and other beneficiary information in order for the CWF to be updated. Medicare contractors cannot update the CWF information.
- The CWF creates daily reports for Medicare contractors to use in determining when claims may have been paid in error, which results in overpayment requests to suppliers. This occurs for Home Health, SNF and HMO claims.

A supplier can access some CWF information through the Interactive Voice Response (IVR) system. The data obtained when calling the IVR is taken directly from the CWF. Suppliers can use the IVR by dialing 1-877-320-0390. For more details on what is available through the IVR, see the IVR User Guide at www.noridianmedicare.com/dme/contact/docs/ivr_guide.pdf.

HMO Claim Denials

Recent analysis shows a high percentage of claim denials due to the beneficiary being enrolled in a Health Maintenance Organization (HMO). The claim adjustment reason code for HMO denials is 109: Claim not covered by this payor/contractor. You must send the claim to the correct payer/contractor.

HMOs are also referred to as Medicare Advantage plans, Medicare Plus Choice plans, Private Fee-for-Service plans, Medicare Part C plans or Preferred Provider Organization (PPO) plans. The patient may choose to enroll in one of these plans because they provide additional Medicare coverage, in addition to the coverage provided under Medicare Part A and Part B. The patient is still enrolled in Medicare if they have a Medicare Advantage plan, but the claim is billed to the HMO, not the DME MAC.

Below are some tips on how to avoid or reduce HMO claim denials:

1. Suppliers should ask specific questions when providing items to Medicare patients. Suppliers should ask the beneficiary for their insurance card to verify the beneficiary's correct Health Insurance Claim Number (HICN) and ask the beneficiary if they are enrolled in an HMO plan.
2. We encourage suppliers to be familiar with the names of the HMO plans in their area. You can find a plan listing by state at www.medicare.gov. Under the Medicare Health Plans-2008 Plan Data page, there is a section with a drop-down box where you can locate plans by state. Once a state is chosen, you can select a county to narrow down the plan listing.
3. Verify eligibility on the Interactive Voice Recognition (IVR). The IVR provides the name of the HMO and the phone number. Note: Information regarding these services will only be provided if the patient is enrolled on the date of service given.

Beneficiaries can change enrollment in their Medicare health plans annually between November 15-March 31. It is recommended suppliers verify insurance coverage for their beneficiaries during these months.

MLN Product & Resource Guide Revised and Posted Online

If you've ever had difficulty locating information on specific Medicare topics, then the Medicare Learning Network (MLN) Product & Resource Guide can help! This valuable tool was designed to familiarize CMS staff and Medicare contractors with the inventory of MLN products available and includes a chart of MLN Products suggestions by provider type. The MLN Product & Resource Guide has recently been revised and posted on the CMS website at http://www.cms.hhs.gov/ContractorLearningResources/03_MLNContractorTraining&Education.asp in the Downloads section at the bottom of the Contractor Training Page.

We appreciate the assistance you provide us with spreading the word to the provider community about the availability of MLN products. Additionally, we value any feedback you can give us regarding our products either from you and your colleagues, or from the providers with whom you interact. You can send your feedback, questions or comments to our MLN feedback mailbox at: MLN@cms.hhs.gov

Visit NPI MLN Matters Educational Articles

As Medicare's May 23rd National Provider Identifier (NPI) implementation approaches, the Centers for Medicare & Medicaid Services (CMS) reminds providers to visit the NPI *MLN Matters* national provider education articles, courtesy of the *Medicare Learning Network*.

The National Provider Identifier (NPI) is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered health care providers. Covered health care providers and all health plans and health care clearinghouses will use the NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty.

The *Medicare Learning Network* has created many *MLN Matters* articles on the various aspects of Medicare's NPI implementation. A comprehensive list of the NPI articles is available at http://www.cms.hhs.gov/NationalProvIdentStand/Downloads/MMArticles_NPI.pdf on the CMS website.

New MLN Quarterly Journal Ad—NPI MLN Matters Articles - This quarter's journal ad features the MLN Matters articles available regarding Medicare's implementation of the National Provider Identifier (NPI).

Each calendar quarter, the *Medicare Learning Network* creates a journal advertisement based on an initiative or new product of particular importance during that time frame. National, state and local associations are encouraged to use this journal ad in their publications and/or newsletters and websites, as appropriate.

The files for this quarter's ad, as well as future ads, can be found at www.cms.hhs.gov/MLNGenInfo on the CMS Website. Once on the page, click on Quarterly MLN Journal Ad (zip file) in the Downloads Section.

Medicare Learning Network (MLN) Bookmark Now Available!

The MLN Bookmark lists: the topics covered by the educational products and services of the MLN, the various product types available to the learner, as well as the web address for the MLN. This product is appropriate for distribution at health care professional conferences, provider outreach and education activities and other appropriate types of provider/supplier events.

The MLN Bookmark is available for download at http://www.cms.hhs.gov/MLNProducts/downloads/MLNBookmrk-006960.pdf on the CMS website. You can also order hard copies of the bookmark through the MLN Product Ordering page at http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5 on the web.

A version of the MLN Bookmark is also available for distribution to Indian Health Care Professionals. To view this bookmark, go to http://www.cms.hhs.gov/MLNProducts/downloads/MLN-AIANBookmrk006954.pdf or to order hard copies go to http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5 on the web.

The NPI is Here. The NPI is Now. Are You Using It?

Important Information for Medicare FFS Providers
As of May 23, Medicare FFS will require and send NPI-Only in ALL provider identifier fields for all HIPAA and paper transactions where a provider identifier is required. **If you send Medicare a transaction with a Medicare legacy identifier in any of the provider fields, your claim will be rejected.** These transactions include all electronic and paper claims (837I, 837P, NCPDP, DDE and paper CMS-1500 and UB-04), the 276/277 claims status transaction, the 270/271 eligibility transaction, 835 remittance advice and SPR paper remittance.

If your billing software is set up to continue to send both the NPI and the legacy identifier, and your clearinghouse or billing service will not be stripping the legacy identifier from your claim as of May 23rd, the responsibility falls to the provider to send in the Medicare claim with NPI-only, i.e., NO legacy identifiers.

Additional Guidance and Clarification for Identifying Secondary Providers in Medicare Claims
In accordance with the NPI final rule, when an identifier is reported on a paper or electronically submitted claim for ordering/ referring/ attending/ operating/ supervising/ purchased service/ other/ service facility provider (in the x12N 837 claims transactions) or for prescriber (in the NCPDP 5.1 retail drug claim transaction), that identifier must be an NPI. For Medicare purposes, this requirement is effective May 23, 2008. If the entity to be identified as the ordering/referring/attending/operating/supervising/ purchased service/other/service facility provider or prescriber does not furnish an NPI at the time of the order/referral/ purchase or time of service, the billing provider must attempt to obtain that NPI in order to use it in the claim. The billing provider may use the NPI Registry or may need to contact the ordering/referring/ attending/operating/supervising/ purchased service/other/service facility or presciber in order to obtain the NPI. While the Implementation guides for the X12N claims transactions permit the reporting of the Social Security Number (SSN) for some secondary providers if there is no NPI, we do not believe the billing provider will be successful in the obtaining the SSN.

- If unable to obtain the NPI of the entity to be identified in the service facility location loop, no identifier should be reported in that loop.
- If unable to obtain the NPI of the ordering/ referring/ attending/ operating/ supervising/ purchased service/ other or prescriber, the billing provider (in the X12N 837 transactions) or the service provider (in the NCPDP 5.1 transaction) shall use its own NPI to identify those secondary providers. Medicare will not pay these claims if these secondary providers are not identified by NPIs.

Clarification of 4/3/2008 Statement "Institutional Providers Submitting Taxonomy Codes to Identify Subparts –What Medicare is using to Obtain NPI/OSCAR Match"
Providers who submit Medicare claims may continue to send their Medicare Provider Taxonomy Codes. However, Medicare Fee-For-Service claims processing systems will not use this data to adjudicate claims. The taxonomy codes will be crossed over to the secondary payers as CMS understands that some payers may use this information to adjudicate claims.

When to Update NPPES if an Update to Medicare Enrollment Information is Also Needed
The NPI Final Rule requires covered providers to update their required NPPES data within 30 days of the change. If a Medicare provider needs to update information in NPPES, it will also need to update the corresponding information in its Medicare enrollment record via the CMS-855. Providers should not make updates to NPPES data until after their CMS-855s are processed and those updates are effective in the Medicare enrollment system (PECOS, or the NSC for Medicare DMEPOS suppliers). After the update is effective in PECOS or the NSC (whichever is appropriate), providers have up to 30 days to make the corresponding updates in NPPES. In a change of ownership (CHOW) situation, for example, the new owner would not make changes in the NPPES record of the provider that is being sold until after the CMS-855 is processed and its changes are effective in the Medicare enrollment system. If a new NPI is to be obtained as part of the CHOW and an existing NPI is to be deactivated (those decisions are up to the buyer and the seller), the NPI should not be deactivated until after all claims using that NPI reach final settlement (this could involve health plans in addition to Medicare).

New FAQ Available Regarding Use of an NPI in the Prescriber ID field on NCPDP Transactions
View this FAQ at http://questions.cms.hhs.gov/cgi-bin/cmshhs.cfg/php/enduser/std_adp.php?p_faqid=9100&p_created=1208980030&p_sid=kyH43F3j&p_accessibility=0&p_lva=&p_

Paper Claim Submission for NPI as of May 23, 2008

As of May 23, 2008, only the NPI will be allowed for all HIPAA standard transactions.

This means:

- For all primary and secondary provider fields only the NPI will be accepted and sent on all HIPAA electronic transactions (837P, NCPDP, 276/277, 270/271 and 835), paper claims (CMS-1500) and standard paper remittance (SPR).
- Any claim with Medicare legacy (NSC/UPIN) identifiers in any primary or secondary provider field will result in rejection of the claim as unprocessable. 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 are fields for non-NPI identifiers.

Claims denied when the NPI is not submitted in Item 33a or the NPI is invalid or incomplete will contain the N257 message on the remittance advice:

> N257 Missing/incomplete/invalid billing provider/ supplier primary identifier.

Claims denied for no NPI or when an invalid/incomplete NPI was reported in Item 17b will be denied with the remittance advice message N286:

N286 Missing/incomplete/invalid/ referring provider primary identifier.

TEST NPI-only Submission NOW
CMS requires the NPI on all Medicare claims in the primary provider fields. CMS has instructed providers to begin submitting a small number of claims as NPI-only (i.e., no legacy number/ NSC/UPIN.) After submitting, providers must ensure claims process through the Medicare payment system. If claims process as expected, continue increasing the volume of claims sent with the NPI-only until all claims are sent with NPI-only. **Don't Wait!** This testing process must begin now.

Rejections
Claims with NPI-only will reject if the Medicare NPI Crosswalk cannot match the NPI to the Medicare legacy number. Suppliers should verify the NPPES record to determine that the information sent on the claim is consistent with the information in NPPES. If different, make the necessary changes in the NPPES record and re-test a small batch of claims a few days later. If claims still reject, providers may need to update their Medicare enrollment information. Please contact the Supplier Contact Center at 1-866-243-7272 for assistance. At the time of the call, please have a copy of the NPPES record or the NPI Registry record in hand, along with examples of claims that were rejected.

Test now to allow time for needed corrections **before** May 23, 2008, the date when only the NPI will be accepted in all provider fields.

EDI Edits for May 23 NPI Requirement

Effective May 23, 2008, the National Provider Identifier (NPI) is the only provider identifier allowed on Medicare claims. The following new and modified front-end EDI edits will be implemented for claims received on/after May 23, 2008 to validate that only the NPI is reported for all provider identifier fields.

4010A1 Claim Edits

EDIT #	*EDIT DESCRIPTION*	*ELEMENT/ SEGMENT ID*	*EDIT EXPLANATION*
20138	SUPER PROV ID QUALIFIER INVALID	2420D. NM108	As of May 23, 2008, the Supervising Provider ID Qualifier (NM108) must be "XX" to reflect the NPI in the NM109. Qualifiers for legacy ID numbers (EIN or SSN) will no longer be allowed in NM108.
20177	REFERRING PROVIDER INVALID	2310A. NM108	As of May 23, 2008, the Referring Provider ID Qualifier (NM108) must be "XX" to reflect the NPI in the NM109. Qualifiers for legacy ID numbers (EIN or SSN) will no longer be allowed in NM108.
20179	PURCHASED SERVICE PROV INVALID	2310C. NM108	As of May 23, 2008, the Purchased Services Provider ID Qualifier (NM108) must be "XX" to reflect the NPI in the NM109. Qualifiers for legacy ID numbers (EIN or SSN) will no longer be allowed in NM108.
20180	SERVICE FACILITY LOC INVALID	2310D. NM108	As of May 23, 2008, the Service Facility Location ID Qualifier (NM108) must be "XX" to reflect the NPI in the NM109. Qualifiers for legacy ID numbers (EIN or SSN) will no longer be allowed in NM108.
20181	SUPERVISING PROVIDER INVALID	2310E. NM108	As of May 23, 2008, the Supervising Provider ID Qualifier (NM108) must be "XX" to reflect the NPI in the NM109. Qualifiers for legacy ID numbers (EIN or SSN) will no longer be allowed in NM108.

EDIT #	EDIT DESCRIPTION	ELEMENT/ SEGMENT ID	EDIT EXPLANATION
20183	PURCHASED SERVICE PROV INVALID	2420B. NM108	As of May 23, 2008, the Purchased Services Provider ID Qualifier (NM108) must be "XX" to reflect the NPI in the NM109. Qualifiers for legacy ID numbers (EIN or SSN) will no longer be allowed in NM108.
20184	SERVICE FACILITY LOC INVALID	2420C. NM108	As of May 23, 2008, the Service Facility Location ID Qualifier (NM108) must be "XX" to reflect the NPI in the NM109. Qualifiers for legacy ID numbers (EIN or SSN) will no longer be allowed in NM108.
20185	ORDERING PROV ID QUAL INVALID	2420E. NM108	As of May 23, 2008, the Ordering Provider ID Qualifier (NM108) must be "XX" to reflect the NPI in the NM109. Qualifiers for legacy ID numbers (EIN or SSN) will no longer be allowed in NM108.
20186	REFERRING PROVIDER INVALID	2420F. NM108	As of May 23, 2008, the Referring Provider ID Qualifier (NM108) must be "XX" to reflect the NPI in the NM109. Qualifiers for legacy ID numbers (EIN or SSN) will no longer be allowed in NM108.
20348	OTHER PAYER REFERRING PROV ID INVALID	2330D. REF01	As of May 23, 2008, the qualifier "1C" (Medicare Provider Number) or "1G" (Provider UPIN Number) will no longer be allowed.
20349	OTHER PAYER PURCHASED SERV PROV ID INVAL	2330F. REF01	As of May 23, 2008, the qualifier "1C" (Medicare Provider Number) or "1G" (Provider UPIN Number) will no longer be allowed.
20350	OTHER PAYER SERV FACILIT PROV ID INVALID	2330G. REF01	As of May 23, 2008, the qualifier "1C" (Medicare Provider Number) or "1G" (Provider UPIN Number) will no longer be allowed.
20351	OTHER PAYER SUPERVISING PROVIDER INVALID	2330H. REF01	As of May 23, 2008, the qualifier "1C" (Medicare Provider Number) or "1G" (Provider UPIN Number) will no longer be allowed.
20352	REFERRING PROVIDER SECONDARY ID INVALID	2310A. REF01	As of May 23, 2008, the qualifier "1C" (Medicare Provider Number) or "1G" (Provider UPIN Number) will no longer be allowed.
20353	PURCHASED SERVICE PROV SECOND ID INVALID	2310C. REF01	As of May 23, 2008, the qualifier "1C" (Medicare Provider Number) or "1G" (Provider UPIN Number) will no longer be allowed.
20354	SERVICE FACILITY LOCATION SEC ID INVALID	2310D. REF01	As of May 23, 2008, the qualifier "1C" (Medicare Provider Number) or "1G" (Provider UPIN Number) will no longer be allowed.
20355	SUPERVISING PROVIDER SECONDARY ID INVALID	2310E. REF01	As of May 23, 2008, the qualifier "1C" (Medicare Provider Number) or "1G" (Provider UPIN Number) will no longer be allowed.
20356	PURCHASED SERVICE PROV SECOND ID INVALID	2420B. REF01	As of May 23, 2008, the qualifier "1C" (Medicare Provider Number) or "1G" (Provider UPIN Number) will no longer be allowed.

EDIT #	*EDIT DESCRIPTION*	*ELEMENT/ SEGMENT ID*	*EDIT EXPLANATION*
20357	SERVICE FACILITY LOCATION SEC ID INVALID	2420C. REF01	As of May 23, 2008, the qualifier "1C" (Medicare Provider Number) or "1G" (Provider UPIN Number) will no longer be allowed.
20358	SUPERVISING PROVIDER SECONDARY ID INVALID	2420D. REF01	As of May 23, 2008, the qualifier "1C" (Medicare Provider Number) or "1G" (Provider UPIN Number) will no longer be allowed.
20359	ORDERING PROVIDER SECONDARY ID INVALID	2420E. REF01	As of May 23, 2008, the qualifier "1C" (Medicare Provider Number) or "1G" (Provider UPIN Number) will no longer be allowed.
20360	REFERRING PROVIDER SECONDARY ID INVALID	2420F. REF01	As of May 23, 2008, the qualifier "1C" (Medicare Provider Number) or "1G" (Provider UPIN Number) will no longer be allowed.
20361	PS101 REFID NOT EQ PURCH SRV PROV SEC ID	2420B. NM109	The NPI submitted in the 2420B NM109 must equal the identifier submitted in 2400.PS101.
20362	BILLING PROVIDER SECONDARY ID INVALID	2010AA. REF01	As of May 23, 2008, the qualifier "1C" (Medicare Provider Number) or "1G" (Provider UPIN Number) will no longer be allowed.
20363	PAY-TO PROVIDER SECONDARY ID INVALID	2010AB. REF01	As of May 23, 2008, the qualifier "1C" (Medicare Provider Number) or "1G" (Provider UPIN Number) will no longer be allowed.
20364	RENDERING PROVIDER SECONDARY ID INVALID	2310B. REF01	As of May 23, 2008, the qualifier "1C" (Medicare Provider Number) or "1G" (Provider UPIN Number) will no longer be allowed.
20365	RENDERING PROV SECONDARY ID INVALID	2420A. REF01	As of May 23, 2008, the qualifier "1C" (Medicare Provider Number) or "1G" (Provider UPIN Number) will no longer be allowed.
20366	OTHER PAYER RENDERING SECONDARY ID INVALID	2330E. REF01	As of May 23, 2008, the qualifier "1C" (Medicare Provider Number) or "1G" (Provider UPIN Number) will no longer be allowed.

Below is an additional front-end EDI edit that will be modified to require the NPI:

Edit **40014**, for the 2420E loop, Ordering Provider Name, will set when NM108=24 (employer's identification number) or 34 (Social Security Number). NM108 must equal XX and NM109 must contain a 10-digit NPI.

NCPDP Claim Edits

Below are new front end EDI edits that will occur for NCPDP claims received on/after May 23, 2008 when an NPI is not reported. The edit number, description of the edit and reject code is provided.

Edit #	Description	Reject Code
65091	Provider ID Qualifier (465-EY) field contains a value other than '05' (NPI)	EY
65092	Primary Care Provider ID Qualifier (468-2E) field contains a value other than '01' (NPI)	2E
65093	Provider ID Qualifier (465-EY) field contains value '05' (NPI) and the value in the Provider ID (444-E9) field has an invalid first digit or is not 10 numeric characters	E9

NPI CONT'D

The following new front-EDI edits will occur for NCPDP claims received on/after May 23, 2008 when the NPI is not reported.

Edit #	Description
65010	Service Provider ID Qualifier (202-B2) field on the Transaction Header segment contains values other than '01' (NPI)
65028	Prescriber ID Qualifier (466-EZ) field on the Prescriber segment contains values other than '01' (NPI)

As a reminder, current NCPDP edits that will remain after May 23, 2008 are as follows:

Edit #	Description	Reject Code
65094	Provider ID Qualifier (465-EY) field contains value '05' (NPI) and the value in the Provider ID (444-E9) field has an invalid check digit	E9
65095	Primary Care Provider ID Qualifier (468-2E) field contains value '01' (NPI) and the value in the Primary Care Provider ID (421-DL) field has an invalid first digit or is not 10 numeric characters	35.

CEDI

CEDI Resources and Frequently Asked Questions

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

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

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

CEDI will be working with DME suppliers, clearinghouses, billing services and vendors to minimize any disruption to the current EDI processes. Listed below are some key dates and important information to facilitate the transition to the CEDI system. NOTE: Trading Partners (Electronic Submitters) can move fully into production with CEDI before their final cutover date listed below.

Key Dates

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

April 30, 2008 Jurisdiction B and Jurisdiction C no longer process new requests for submitter IDs or changes to an existing ID. All new setups and changes are done by the CEDI Enrollment Team.

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

May 1, 2008 All Jurisdiction A and Jurisdiction D EDI transactions are processed by CEDI.

May 31, 2008 Last day Jurisdiction B and Jurisdiction C processed EDI transactions.

June 1, 2008 All Jurisdiction B and Jurisdiction C EDI transactions are processed by CEDI.

Resources

CEDI Help Desk
The CEDI Help Desk is available from 9:00 a.m. – 9:00 p.m. (ET) Monday through Friday.

E-mail: NGS.CEDIHelpdesk@wellpoint.com
Phone: 866-311-9184

The CEDI Help Desk will provide support for electronic transactions exchanged with CEDI including claims, reports, ERAs and 276/277 transactions.

The DME MAC Jurisdictions will continue to provide support for the online Claim Status Inquiry (referred to as CSI, VPIQ, or PINQ) and Electronic Funds Transfer (EFT)

CEDI Web Site
The CEDI Web site is located at www.ngscedi.com/ with the following information.

- EDI Enrollment
- Help Desk Contact Information including the E-mail address and phone number.
- Implementation Schedule for the CEDI transition.
- Listserv Registration to be notified of important CEDI information.
- Outreach Materials including Listserv messages and the listing of vendors, billing services and clearinghouses who have passed testing with CEDI.
- Software Downloads including the Express Plus upgrade for Jurisdiction A, Jurisdiction B and Jurisdiction D Express Plus users. The upgrade has the updated communications software for exchanging transactions with CEDI. Also included are instructions on installing the upgrade, making the necessary changes to the communications program, and how to login, send and receive transactions with CEDI.

- Telecommunications has the guides for setting up and using asynchronous and/or FTP connections with CEDI.
- Trading Partner Agreements provide information for vendors to exchange transactions with CEDI.

Frequently Asked Questions

Communications

1. Can zipped files be sent to CEDI?
Yes. Zipped files can be sent to CEDI. Notification must be given to CEDI prior to sending a zipped file. All zipped files must come in Binary mode.

2. Is there a limit to the length of a filename sent to CEDI?
Yes. File names sent to CEDI cannot be longer than 57 characters.

3. What should I do if I am having trouble connecting with CEDI?
If you have consistent trouble connecting to CEDI, you may want to consider using one of the Network Service Vendors. These network service vendors provide a continuous connection to the CEDI gateway. The Network Service Vendors are:

a. IVANS can be contacted at 800-548-2675. Select option 1, and enter extension 3742

b. Nebo can be contacted at 630-916-8818, extension 261

c. VisionShare can be contacted at 888-895-2649 or via e-mail at info@visionshareinc.com.

d. MedXpress can be contacted via their Web site: www.icssoftware.net/MedXpress

Enrollment

1. Do I need to re-enroll with CEDI?
No. CEDI has received all EDI enrollment information from the DME MAC Jurisdictions. Your Trading Partner/Submitter ID will remain the same.

CEDI will perform validation that the Trading Partner/Submitter is authorized to submit claims for the supplier in the transmitted file. You can confirm the Supplier to Trading Partner relationship is established by sending an e-mail to the CEDI Help Desk at ngs.cedihelpdesk@wellpoint.com. Be sure to include your Trading Partner/Submitter ID and the supplier numbers that should be linked to that Submitter ID.

2. I have multiple Trading Partner/Submitter IDs. Can I combine these into one to exchange transaction with CEDI?
Yes. If you have multiple Trading Partner/Submitter IDs and you wish to combine them into one ID, you can contact the CEDI Help Desk at ngs.cedihelpdesk@wellpoint.com to obtain the appropriate form to submit to CEDI.

3. Will there be one standardized EDI form for all 4 regions?
Yes. CEDI will maintain the EDI setup forms and they will be located on the CEDI Web page (www.ngscedi.com). You will be able to submit them electronically. CEDI will also have you fax and efax the EDI enrollment Form so the actual signature is on file with CEDI.
You will only need to submit one set of forms and CEDI will process them for all four DME MAC Jurisdictions.

4. What will happen to EDI enrollment paperwork that is already in the process at the DME MACs when CEDI goes into production?
The current DME MAC EDI setup areas will discontinue new EDI setups or changes to existing EDI setups one month prior to cutover (see the Key Dates above). Any new EDI setups or changes not completed by the DME MAC Jurisdictions one month before cutover will be sent to and processed by CEDI.

5. What is the turnaround time for CEDI to process enrollment requests?
CEDI will process new EDI enrollment requests within 10 business days of receipt. Requests to combine data for multiple Trading Partners IDs into one ID may take longer depending on the size of the request.

Exchanging Electronic Transactions with CEDI

1. What happens if I submit claims to CEDI and continue submitting claims to my DME MAC Jurisdiction?
For those submitters running in dual mode (sending to both CEDI and the DME MACs) until 4/30/08 and 5/31/08 – Electronic front end reports and remittance files will be delivered by the company that received the incoming electronic file. Suppliers will receive front end edit reports and remit advices from a Jurisdiction, if the incoming electronic file was submitted directly to that Jurisdiction. Suppliers will receive front end edit reports and remittances from CEDI, if the electronic files were sent directly to CEDI.

2. Will my Trading Partner/Submitter ID change?
No. Your Trading Partner/Submitter ID will not change. You will continue to use the A08######, B08######, C08######, or D08###### Trading Partner/Submitter ID assigned to you by a DME MAC Jurisdiction.

3. Will my Login ID and Password change?
Yes. The Login ID you used to connect to a DME MAC Jurisdiction's EDI Front End cannot be used to connect to CEDI. You will use your current Trading Partner/Submitter ID as your Login ID at CEDI. You will also need a new password. Contact the CEDI Help Desk at ngs.cedihelpdesk@wellpoint.com to obtain the initial password to be used when you first connect to CEDI. When you login to CEDI for the first time, you will be required to change your password. Please provide your Trading Partner/Submitter ID and your Trading Partner name when requesting your initial password.

4. Will the format of the reports stay the same?
CEDI will initially only perform the Implementation Guide edits for X12 transactions and return the TA1 and 997. The pre-pass edit reports will initially stay the same and be generated by the DME MACs. CEDI will receive the pre-pass edit reports from the DME MAC and provide them to the electronic submitter/trading partner via their CEDI mailbox.

5. Can I submit with one Trading Partner/Submitter ID but have my ERAs returned to another ID?
Yes. Please complete the forms on the CEDI Web site to advise our CEDI Enrollment team how to setup your supplier numbers for Electronic Remittance Advices (ERAs).

CEDICONT'D

6. How long will Front End Edit Reports and Electronic Remittance Advice (ERA) files be available at CEDI for me to retrieve?
Front End Edit Reports and ERA files will be available on your CEDI login for 45 days.

7. Do I have to submit separate files to CEDI for each Jurisdiction?
Electronic Submitters/Trading Partners sending ANSI 837 files, can send only one file to CEDI with claims for multiple Jurisdictions. CEDI will route all 837 claims to the appropriate DME MAC Jurisdiction based on the beneficiary address on each claim. NOTE: NCPDP Files must be sent separately and contain claims for only one Jurisdiction. NCPDP files will be delivered to the DME MAC Jurisdiction based on the contractor code in the header record of the NCPDP file. CEDI will simply pass the NCPDP files through to the DME MAC as indicated on the header record.

8. What contractor code do I use when submitting my claim file to CEDI?
All incoming ANSI X12N 837 claim files to CEDI can be submitted with any one of the four DME MAC Jurisdiction's contractor code. The DME MAC Contractor Codes are:

- Jurisdiction A – 16003
- Jurisdiction B – 17003
- Jurisdiction C – 18003
- Jurisdiction D – 19003

9. When downloading my Electronic Remittance Advice (ERA/835) Files from CEDI, will I be able to determine which Jurisdiction created that ERA?
The ERA files delivered by CEDI will have the contractor code for the DME MAC that created the file in the ISA06. The Jurisdiction's contractor code will not be in the file name. The DME MAC Contractor Codes are:

- Jurisdiction A – 16003
- Jurisdiction B – 17003
- Jurisdiction C – 18003
- Jurisdiction D – 19003

10. When downloading the Pre-pass edit reports from CEDI, will I be able to determine which Jurisdiction created that report?
Reports delivered by CEDI that were created by the DME MAC Jurisdictions will have an .RPT in the file name. Report formats should not be any different than what they are currently.

NOTE: CEDI will create a GenResponse report that will indicate the DME MAC Jurisdiction contractor code where the claims were delivered. The DME MAC Contractor Codes are:

- Jurisdiction A – 16003
- Jurisdiction B – 17003
- Jurisdiction C – 18003
- Jurisdiction D – 19003

Testing Process
1. Where do I get information to start the testing process?
Contact the CEDI Help Desk via e-mail at ngs.cedihelpdesk@wellpoint.com or via telephone at 1-866-311-9184.

2. Who must test with CEDI, the electronic submitter/ trading partner or the software vendor?
The software vendor, clearinghouse or billing service must test connectivity with CEDI. Once a vendor, clearinghouse or billing service has successfully connected to CEDI, sent in a file and received a front end edit report back, they will be approved.

Vendors, clearinghouses and billing services may continue to send in test files even after they are approved. CEDI strongly encourages vendors, clearinghouses and billing services to start the testing process immediately.

Once a vendor, clearinghouse or billing services have passed testing with CEDI, their customers can begin to move into production to send claims (837), receive remits (835), send NCPDP files or 276s and receive electronic reports prior to the final cutover dates.

3. Will vendors, clearinghouses and billing services get a specific Submitter ID to use when testing?
Vendors, clearinghouses and billing services will be assigned a specific Trading Partner/Submitter ID to be used for testing. This ID will be in the format "V089#####". ** This V089 ID cannot be used to submit production claims.

4. I am a software vendor. Where can I get information on the CEDI Communications?
The CEDI Communications Manual for Asynchronous (Async) and FTP is available on the CEDI Web site, www.ngscedi.com/.

5. Where do I find a list of approved CEDI vendors, clearinghouses and billing services?
The CEDI Approved Entities Vendor list is posted to the CEDI Web site at www.ngscedi.com/ under Outreach Materials.

PCAce Pro32 Software
1. I use the PCAce Pro32 software. What is needed to update my software to communicate with CEDI?
All PC-Ace Pro32 Users must complete the following instructions to communicate with CEDI.

a. Visit the CEDI Web site at www.ngscedi.com/, go to "Telecommunications" and download the Asynchronous Communication Manual

b. Contact the CEDI Help Desk at 866-311-9184 or via e-mail at NGS.CEDIHelpdesk@wellpoint.com to obtain the CEDI phone number and your password.

c. Follow the instructions in the Asynchronous Communication Manual to change the dial-in phone number to the CEDI phone number obtained from the CEDI Help Desk.

d. Follow the instructions in the manual to dial, login, connect and begin sending and receiving files with CEDI.

e. PCAce Pro32 users can continue to use the January release as the most current version. CEDI will notify PCAce Pro32 users when the next upgrade is available to download from the CEDI Web site.

Express Plus Software

1. I use Express Plus, how do I get my software updated to communicate with CEDI?

CEDI has upgraded the Express Plus software program to connect and exchange transactions with CEDI. Jurisdiction A, Jurisdiction B, and Jurisdiction D offer the Express Plus software as their low cost electronic billing software.

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

a. Access the CEDI Web site at: www.ngscedi.com

b. Select "Software Downloads"

c. On the "Software Downloads" page, print ALL of the following documents:

- Express Plus Upgrade Instructions - These instructions will guide you through the process of running the Express Plus upgrade program.
- Express Plus CEDI Script - These instructions will guide you through the procedures to create the communications' scripts to connect to and send/receive files with CEDI.
- Express Plus CEDI Connection and Login - These instructions will assist you in logging into CEDI and sending/receiving files with CEDI.

d. Follow the instruction documents listed in the order above.

Helpful Tips for Contacting CEDI During Transition

Due to the transition of Jurisdiction A and D Trading Partners/Submitters on May 1, 2008, CEDI is experiencing an increase in connections to the CEDI Gateway and support calls into the CEDI Help Desk. CEDI is anticipating that the upcoming transition of Jurisdiction B and C Trading Partners/Submitters on June 1, 2008 will have a similar impact. Please use the tips below to expedite all CEDI requests.

Tips When Contacting the CEDI Help Desk

CEDI is aware of the increased hold times on the CEDI Help Desk telephone line and is working diligently to assist everyone in an efficient manner. Use the following tips to avoid long wait times on the CEDI Help Desk telephone line.

REMEMBER, PERSONAL HEALTH INFORMATION (PHI) CANNOT BE SUBMITTED VIA E-MAIL.

1. **Contact the CEDI Help Desk via e-mail at ngs.cedihelpdesk@wellpoint.com for the following:**
   - PC-ACE and Express Plus software users to obtain the initial password and phone number to login to CEDI
   - PC-ACE and Express Plus software users with CEDI questions
   - Trading Partners currently testing with CEDI
   - Questions regarding NPI rejections on your RPT reports, i.e., DME MAC Front Edits 20322 and 20324
   - Trading Partners who are experiencing multiple issues or who have multiple concerns or questions

Please do not contact the CEDI Help Desk by both e-mail and telephone regarding the same issue(s)/question(s).

2. **Contact the CEDI Enrollment Team via e-mail at ngs.edi.setups@anthem.com to check on the status of the following:**
   - Request for a new Trading Partner ID
   - Request to process an EDI Enrollment Form agreement
   - Request to receive ERA
   - Request to add a supplier's NSC and NPI to a Trading Partner/Submitter ID

NOTE: Electronic Trading Partners should allow 2 business days for a response from the CEDI Help Desk and/or Enrollment Team via e-mail.

3. **Contact your software vendor or clearinghouse for the following:**
   - Determining if your vendor has completed testing with CEDI
   - Questions regarding your vendor's software product
   - Obtaining your initial password and telephone number to connect to CEDI
   - Instructions on how to connect and exchange transaction with CEDI
   - Questions regarding rejections on your CEDI TRN and/or 997 report

Tips When Connecting to the CEDI Gateway

CEDI experienced problems with screens freezing when trading partners are trying to connect. CEDI worked on this issue and some improvements have been made. CEDI will continue to monitor this issue until it is completely resolved.

Electronic Trading Partners using dial up services (asynchronous or FTP) who are currently experiencing busy signals when trying to connect with CEDI to send or receive electronic transactions may consider submitting during off-peak hours. The CEDI front- end off-peak hours are 8 pm – 6 am ET.

Suppliers can also consider using a Network Service Vendor to bypass busy signals when exchanging transactions with CEDI. Network Service Vendors allow electronic transactions to come in through a higher speed connection. The current network service vendors are:

ICS Software

Web site: www.icssoftware.net/medxpress or medxpress@icssoftware.net
Customer Service: (516) 208-6475

IVANS
Web site: www.ivans.com
Customer Service: 800-548-2675

VisionShare
Web site: www.visionshareinc.com
Customer Service: 612-460-4327

How to Request Zipped Outbound Files
NOTE: The default setup for all Trading Partners/Submitters is for their outbound files to be returned unzipped. To request outbound files be delivered in a zipped format, submit an e-mail request to the CEDI Enrollment Team as follows:

- The E-mail address is: NGS.EDI.Setups@Anthem.com
- The E-mail subject must be: CEDI Request for Zipped Files
- Include the following information
    - Trading Partner/Submitter ID
    - Trading Partner/Submitter Name
    - Contact Name
    - Contact Phone Number
    - Contact e-mail Address
- You will be notified via e-mail when your request has been completed.
- The zipped file format for outbound files will not go into effect until Monday, May 12, 2008.

We appreciate your patience during the CEDI transition and assure you that CEDI is actively working with the DME MAC software vendors, billing services, clearinghouses and electronic submitters to support all of their CEDI transition needs.

CEDI Help Desk Modifications

Effective Friday, May 16, 2008, the CEDI Helpdesk will modify the options callers will hear when they contact the CEDI Help Desk by telephone at 866-311-9184. The following changes are being made to better serve our CEDI customers.

Press 1 to hear the hours of operation and e-mail address:

- To report issues via e-mail, submit issue to ngs.cedihelpdesk@wellpoint.com
- Hours of operation are Monday-Friday, 8 am - 8 pm CT

Press 2 to speak to a DME CEDI Help Desk Technician:

Please be prepared to provide your submitter or sender ID.

Press 3 for Password Resets:

For all CEDI password resets

CEDI Outreach and Education for DME Trading Partners

National Government Services CEDI will provide the following outreach and education for DME suppliers, billing services, clearinghouses and vendors who exchange electronic transactions with CEDI.

- The CEDI Help Desk will answer questions from Trading Partners regarding all levels of edits. These edits include those Level 1 edits performed by CEDI, Level 2 edits currently performed by the DME MACs and the Level 2 edits once they are moved to CEDI. The Help Desk Technicians will provide support as to why the edit fired and how to correct the error.
- CEDI will provide outreach and educational materials for new front end edits, changes to existing edits or the removal of edits. These materials will be distributed to the CEDI Web site and CEDI listserv and provided to the DME MACs for their distribution.
- CEDI will analyze the front end edits and will provide education on the top edits that fired from the previous month through the CEDI Web site, CEDI listserv and to the DME MACs for their distribution.
- CEDI will prepare Frequently Asked Questions (FAQs) to be distributed through the CEDI Web site and CEDI listserv.
- CEDI will be available to attend the DME MAC Ask the Contractor Teleconference (ACT) calls and their Advisory Council Meetings via conference call. CEDI will also host monthly vendor conference calls to address concerns, issues and questions.

Express Plus and PCAce Pro32 Software Instructions for Transitioning to CEDI

PCAce Pro32 and Express Plus Trading Partners in Jurisdictions A and D should have already transitioned to CEDI as of May 1, 2008. PCAce Pro32 and Express Plus Trading Partners in Jurisdictions B and C must be transitioned to CEDI before June 1, 2008.

All PCAce Pro32 and Express Plus Trading Partners who have not already begun exchanging electronic transactions with CEDI must follow the instructions below for their software product.

PC-Ace Pro32 Software Users

4. All PC-Ace Pro32 users must complete the following instructions to communicate with CEDI.
5. **Visit the CEDI Web site at www.ngscedi.com. Select "Telecommunications" and download the Asynchronous Communication Manual.**
6. **Contact the CEDI Help Desk at** NGS.CEDIHelpdesk@wellpoint.com **to obtain the CEDI phone number and your password. Be sure to provide your Trading Partner/Submitter ID and your company name.**

7. Follow the instructions in the Asynchronous Communication Manual to change the dial-in phone number to the CEDI phone number obtained from the CEDI Help Desk.
8. Follow the instructions in the Asynchronous Communication Manual to dial, login, connect and begin sending and receiving files with CEDI.
9. The January 2008 version of PC-Ace Pro32 is the most current version. There was not an upgrade release for April 2008.

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

1. Access the CEDI Web site at: www.ngscedi.com
2. Select "Software Downloads"
3. On the "Software Downloads" page, print ALL of the following documents:
   - Express Plus Upgrade Instructions - These instructions will guide you through the process of running the Express Plus upgrade program.
   - Express Plus CEDI Script - These instructions will guide you through the procedures to create the communications' scripts to connect to and send/receive files with CEDI.
   - Express Plus CEDI Connection and Login - These instructions will assist you in logging into CEDI and sending/receiving files with CEDI.
4. Follow the instruction documents listed in the order above.
5. You may also download the updated DME Express Plus User Manual from the "Software Downloads" page.
6. **Contact the CEDI Help Desk at NGS.CEDIHelpdesk@wellpoint.com to obtain the CEDI phone number and your password. Be sure to provide your Trading Partner/Submitter ID and your company name.**

Front End Edit Reports and Electronic Remittance Advice
CEDI is currently receiving all Front End Edit Reports and Electronic Remittance Advice (ERA) files produced by the DME MAC Jurisdictions regardless of whether the claims were submitted to a DME MAC or to CEDI. This allows a trading partner/submitter to submit claims to a DME MAC on one day and to move to CEDI the next day with the ability to receive all Front End Edit Reports and ERAs. CEDI maintains 45 days of reports and ERAs under each CEDI login for retrieval by the trading partners/submitters.

CEDI Listserv
To stay informed of all CEDI updates, visit the CEDI Web site at http://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.

Express Plus Users Must Remove NSC Numbers and UPINs from Software to Avoid NPI Rejections

Effective May 23, 2008, all Medicare claims must include ONLY the NPI in the primary and secondary provider fields. Express Plus users must follow the instructions below to ensure that only the NPI is submitted on claims sent on/after May 23, 2008.

To remove the National Supplier Clearinghouse (NSC)/ Provider Transaction Access Number (PTAN) number from the Express Plus software for the primary provider field:

7. Go to the File Maintenance Menu.
8. Click on Provider Maintenance.
9. Select a Provider and then click on Edit.
10. Make sure the supplier's NPI number is listed under the field titled "NPI."
11. Add the Tax ID or Social Security Number associated with the NPI. The Tax ID will be entered into the field titled "Tax ID". The Social Security Number will be entered into the field titled "SSN".

Note: The corresponding Tax ID or SSN *must be* entered for the NPI listed on this screen.

12. Remove the NSC supplier number listed under the field titled "Medicare ID."
13. Click on "Save" and your information will be updated.

Complete the steps above for **each** provider listed under Provider Maintenance.

To remove the UPIN number from the Express Plus software for the secondary provider field:

1. Go to the File Maintenance Menu.
2. Click on Ordering Physician Maintenance.
3. Select a Provider and then click on Edit.
4. Make sure the ordering physician's NPI number is listed under the field titled "NPI."
5. Remove the UPIN number listed under the field titled "UPIN ID."
6. Click on "Save" and your information will be updated.

Complete the steps above for **each** provider listed under Ordering Physician Maintenance.

Express Plus users should complete these instructions and then transmit a few claims to make sure there are not any problems with their NPI number. If the claims are accepted, the Express Plus users should continue submitting claims as normal.

CEDI Change to B108 Rejection

The Common Electronic Data Interchange (CEDI) has been rejecting claims with a B108 error message on the CEDI GenResponse Report when the NSC supplier number and/or NPI are not linked to the Trading Partner (Submitter) ID. **Effective *May 23, 2008*, the B108 rejection is now set as a warning edit and will *no* longer reject the claims** at CEDI. Claims accepted by CEDI will be forwarded to the appropriate DME MAC where front-end edits will continue to be performed. These edits will validate the supplier is authorized for EDI transactions and perform NPI validation.

CEDI edit B108 will be turned on in the future. At that time, claims that do not have an NSC and NPI match with the Trading Partner (Submitter) ID will be rejected by CEDI and not forwarded to the DME MACs. It is important that electronic trading partners complete the steps below to correct the B108 warning message and avoid future rejection of claims.

DME MAC Electronic Trading Partners that received the B108 rejection from CEDI *prior to* May 23, 2008, can now resubmit those claims. When those claims are resubmitted, the electronic trading partner will see the B108 warning message, but the claims will not be rejected by CEDI. As stated above, claims accepted by CEDI will be forwarded to the appropriate DME MAC where front-end edits will continue to be performed. These edits will validate the supplier is authorized for EDI transactions and perform NPI validation.

All DME MAC Electronic Trading Partners that receive the B108 warning message should complete the following steps. (If a Supplier Authorization Form has previously been submitted to CEDI for the Submitter ID and supplier NSC number/NPI receiving the B108 warning message, please do not complete the steps below.)

7. The supplier must complete the Supplier Authorization Form by clicking on the following link: www.ngscedi.com/forms/formsindex.htm
8. Once complete, click on the submit button at the bottom of the form
9. Print the form
10. Sign the form on the last page where it indicates "Authorized DME Supplier Signature"
11. List the title of the signer and the date signed
12. Fax the form to CEDI at 315-442-4299
13. Retain a copy for your records

Note: The Supplier Authorization Form cannot be signed by a third party. This form MUST be signed by the supplier.

The CEDI Enrollment Team is processing all enrollment requests in the order they are received and will respond once your setup is complete.

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.

Addition of Accreditation Standards 22-25

Recently, JSMTDL-08250 announced a revised version of the 855S Medicare enrollment form for DMEPOS suppliers. The revised enrollment form added Supplier Standards 22-25. The additional standards require 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.

Suppliers who were enrolled with the National Supplier Clearinghouse (NSC) for the first time between January 1, 2008, and February 29, 2008, must obtain and submit an approved accreditation to the NSC by January 1, 2009. DMEPOS suppliers enrolled in the Medicare program prior to January 1, 2008, are required to obtain and submit approved accreditation to the NSC by September 30, 2009. Suppliers enrolling in the Medicare program after March 1, 2008, must already be accredited by an approved organization.

Under the instruction of CMS, the NSC will reject/revoke supplier billing privileges for failure to obtain and submit supporting accreditation documentation in accordance with the aforementioned schedule.

Suppliers are reminded that the NSC and the accrediting organizations are completely autonomous. Compliance with one entity does not guarantee compliance with the other. The full and abbreviated lists of DMEPOS supplier standards are available on the NSC web site.

For more information on accreditation or to view the quality standards, suppliers are encouraged to visit the accreditation pages of the CMS Web site.

CMS Announces Contract Suppliers for Round 1 of DMEPOS Competitive Bidding!

The Centers for Medicare & Medicaid Services (CMS) has announced the contract suppliers for Round 1 of the DMEPOS Competitive Bidding Program.

Please visit the CMS web site at www.cms.hhs.gov/DMEPOSCompetitiveBid to view additional information.

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

Revised ACCREDITATION Deadlines FOR DMEPOS Competitive Bidding!

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

1. Suppliers must be accredited or have applied for accreditation by July 21, 2008 (change from May 14, 2008) to submit a bid for the second round of competitive bidding. CMS cannot accept a bid from any supplier that is not accredited or that has not applied for accreditation by July 21, 2008.
2. Suppliers will need to be accredited to be awarded a contract. The accreditation deadline for the second round of competitive bidding is January 14, 2009 (change from October 31, 2008). Suppliers must be accredited before this date to be awarded a contract. Suppliers should apply for accreditation immediately to allow adequate time to process their applications.

CMS has extended these deadlines because a significant number of suppliers in the 70 metropolitan statistical areas (MSAs) included in Round Two of the DMEPOS Competitive Bidding Program have not yet applied for accreditation. Suppliers in these MSAs that do not meet these accreditation deadlines cannot become DMEPOS competitive bidding contract suppliers and will therefore be unable to furnish competitively bid items to any beneficiary residing in any part of the competitive bidding area during the contract period.

Suppliers can determine if they are serving beneficiaries in a Round 2 MSA by visiting the following web site: www.census.gov/population/www/estimates/metrodef.html and looking up their MSAs in the section called "counties with metropolitan and micropolitan statistical area codes". (In this file, MSAs are called CBSAs). For example, the Los Angeles-Long Beach-Santa Ana, CA MSA is comprised of two counties: Los Angeles and Orange.

We urge all suppliers serving Medicare beneficiaries in the 70 Round Two MSAs to apply for accreditation now.

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

Payment for Complex Rehabilitative PMD Services that Span the Implementation Date of DMEPOS Competitive Bidding Programs in CBAs

CMS will be issuing instructions in the near future about a one-time DMEPOS competitive bidding transition policy for suppliers of purchased Group 3 single or multiple power option power mobility devices (PMDs) furnished to beneficiaries in competitive bidding areas (CBAs). In specific cases described below, suppliers who, prior to July 1, 2008, begin furnishing services related to providing these devices, but do not deliver the final PMD product until July 1, 2008 or later, will be paid based on the 2008 fee schedule amounts for furnishing these PMDs to beneficiaries residing in Round One CBAs. This transition policy applies to both contract and noncontract suppliers.

The HCPCS codes subject to the transition policy include PMD codes K0856 thru K0864 and related accessories provided at the time the PMD is delivered to a beneficiary who resides in a Round One CBA. The specific claims subject to the transition policy are items that are delivered for use in the beneficiary's home on or after July 1, 2008, for which the supplier has:

- **A signed order from the physician that is dated between April 1, 2008 and May 31, 2008; and**
- **Documentation that the face-to-face beneficiary examination by the physician that is necessary to determine medical necessity for the PMD occurred before July 1, 2008.**

This documentation should be maintained by the supplier, but does not need to be submitted at the time the claim for the PMD is submitted. However, it should be made available upon request.

Suppliers should use the date of the physician order as the date of service on the claim (other than this limited, one-time exception, suppliers should be aware that the date of service that is recorded on a DMEPOS claim is the date that the item is delivered). In addition, suppliers should include on the claim for the PMD all accessories provided with the PMD and should use the same date of service used for the PMD for these items. Suppliers should report the date the PMD and related accessories were delivered for use in the beneficiary's home in the narrative section of the claim.

Important MLN Matters Articles and ABN Reminders for Upcoming DMEPOS Competitive Bidding Program

Three MLN Matters Articles Now Available!
This is an important reminder that the Centers for Medicare & Medicaid Services (CMS) has now issued three articles through the Medicare Learning Network (MLN) to educate and prepare you for the July 1, 2008, implementation of the Medicare for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program. These Special Edition MLN Matters articles are:

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

MLN Matters Special Edition Article # SE0806 entitled "Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program: Grandfathering, Repair and Replacement, Mail Order Diabetic Supplies and Advanced Beneficiary Notices (ABNs) - the second in a series of articles on the new DMEPOS Competitive Bidding Program." This article is

posted on the CMS Website at http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0806.pdf.

MLN Matters Special Edition Article # SE0807 entitled "Important Exceptions and Special Circumstances that Occur Under the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program: - The third in a series of articles on the new DMEPOS Competitive Bidding Program." This Article is posted on the CMS Website at http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0807.pdf.

Additional educational materials will be made available to you as we approach the **July 1, 2008**, implementation date.

Advance Beneficiary Notice (ABN) Information
We would also like to take this opportunity to highlight the importance of using an Advance Beneficiary Notice under the Medicare DMEPOS Competitive Bidding Program. Given the range of situations wherein Medicare may or may not pay for a specific item of DMEPOS, it is imperative that non-contract suppliers understand the significance of issuing or not issuing an ABN to beneficiaries to whom they are furnishing a competitively bid item. More information on this subject can be found in the MLN Matters Special Edition article #SE0806.

Also, please be aware that a revised Advance Beneficiary Notice (ABN) of Noncoverage (CMS-R-131) was released on March 3, 2008, and providers (including independent laboratories), physicians, practitioners, and suppliers are authorized to begin using the notice immediately for all situations where Medicare payment is expected to be denied. The revised ABN replaces the existing ABN-G (Form CMS-R-131G), ABN-L (Form CMS-R-131L), and NEMB (Form CMS-20007). CMS will allow a 6-month transition period from the date of implementation for use of the revised form and instructions. Thus, all providers and suppliers must begin using the revised ABN (CMS-R-131) **no later than September 1, 2008**. Revised manual instructions will be published within the next few weeks and a MLN Matters article will also be released at that time. The revised ABN and form instructions can be accessed at the following URL: http://www.cms.hhs.gov/BNI/02_ABNGABNL.asp#TopOfPage

DMEPOS Competitive Bidding Provider Cover Note

Information You Need: New Medicare-Covered Equipment and Supplies Program In Certain Designated Areas

If you order, refer or supply certain medical equipment and supplies, such as oxygen or power wheelchairs, you should know about a new Medicare program that may change the suppliers your patients will need to use.

The new program will begin July 1, 2008, in 10 geographic areas around the country, including Charlotte-Gastonia-Concord, NC-SC; Cincinnati-Middletown, OH-KY-IN; Cleveland-Elyria-Mentor, OH; Dallas-Fort Worth-Arlington, TX; Kansas City, MO-KS; Miami-Fort Lauderdale-Miami Beach, FL; Orlando-Kissimmee, FL; Pittsburgh, PA; Riverside-San Bernardino-Ontario, CA; San Juan-Caguas-Guaynabo, PR. The program will expand to 70 additional areas in 2009 and to additional areas thereafter.

If your patient lives in or travels to one of these 10 designated areas and you order, refer or supply any medical equipment or supplies that fall within the 10 product categories listed below, the patient must now get the equipment or supplies from a Medicare-contracted supplier.

The 10 product categories that are included in the program are:

1. Oxygen supplies and equipment;*
2. Standard power wheelchairs, scooters and related accessories;
3. Complex rehabilitative power wheelchairs and related accessories;*
4. Mail-order diabetic supplies;
5. Enteral nutrients, equipment, and supplies;*
6. Continuous Positive Airway Pressure (CPAP) devices and Respiratory Assist Devices (RADs) and related supplies;
7. Hospital beds and related accessories;*
8. Negative pressure wound therapy pumps and related supplies and accessories;
9. Walkers and related accessories; and
10. Support surfaces, including group 2 mattresses and overlays (in Miami-Fort Lauderdale-Miami Beach, FL only).*

(* Indicates product category is NOT included in San Juan-Caguas-Guaynabo, PR)

To ensure that his or her medical products and services will be covered by Medicare, we encourage you to help your patient find out which suppliers are Medicare contract suppliers. After the suppliers are announced in May, you can find out if a supplier is included in the program by visiting www.cms.hhs.gov/CompetitiveAcqforDMEPOS.

For the latest provider information on this new program, CMS has released 3 MLN Matters educational articles, which can be found at:

http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0805.pdf

http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0806.pdf

http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0807.pdf

Once again, **if your patient lives in or travels to one of the 10 designated areas** and you order, refer or supply any medical equipment or supplies that fall within the 10 product categories, please **discuss the new program requirements with your patient**, and provide them with the Medicare fact sheet entitled "What You Should Know if You Need Medicare-covered Equipment or Supplies." http://www.medicare.gov/Publications/Pubs/pdf/11307.pdf

Important Exceptions and Special Circumstances that Occur Under DMEPOS Competitive Bidding Program

MLN Matters Number: SE0807

Provider Types Affected
The following providers may be affected by this program:

- Physicians and other treating practitioners who are Medicare enrolled DMEPOS suppliers;
- Physicians and others who order or refer DMEPOS items or services for their patients;
- Skilled nursing facilities (SNFs) and nursing facilities (NFs); and
- Physical therapists and occupational therapists in private practice who are Medicare enrolled DMEPOS suppliers.

Many Medicare Fee-for-Service (FFS) providers may be in a position of ordering, referring, or supplying DMEPOS to a Medicare beneficiary. This includes physicians (including podiatric physicians), other treating practitioners (nurse practitioners, physician assistants, and clinical nurse specialists), physical and occupational therapists, and institutional providers (especially skilled nursing facilities and their social workers or care coordinators, hospitals and their discharge planners, home health agencies and pharmacists).

Provider Action Needed
Understand these special program rules that may affect you. This article is especially important if you are a Medicare enrolled DMEPOS supplier of items governed by the new program, even if you are not located in a competitive bidding area (CBA). It is important to understand that the program affects any beneficiaries who permanently reside in or travel to CBAs. Some program requirements apply to beneficiaries who reside in CBAs even if these beneficiaries travel outside their CBAs. Thus, it is important for you to be familiar with this program.

While the first phase of the competitive bidding program only affects ten CBAs in the country as of July 1, 2008, the second phase will expand to 70 additional geographic areas in 2009. See MLN article SE0805 for information about CBAs and items governed by this new program and for information about how the program applies to traveling beneficiaries.

Background
MLN Matters article SE0805 that is entitled, "Overview of New Medicare Competitive Bidding Program for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)," which is available at http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0805.pdf on the CMS website, summarizes information on competitive bidding that may impact your patients. Article SE0805 contains the list of competitive bidding areas for the first phase of competitive bidding as well as a list of the DMEPOS product categories that are included in the program's initial implementation.

MLN Matters article SE0806 that is entitled, "Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program: Grandfathering, Repair and Replacement, Mail Order Diabetic Supplies and Advanced Beneficiary Notices (ABNs)," which is available at http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0806.pdf on the CMS website, provides an overview of the rules regarding grandfathered suppliers, repair and replacement of beneficiary-owned equipment, mail order diabetic supplies under the program, and ABNs.

In this, the third in a series of articles on the new DMEPOS competitive bidding program, we provide information on some special circumstances and exceptions of particular interest to physicians and other treating practitioners, SNFs and NFs , and physical and occupational therapists in independent practice.

Note: It is important to note that the Competitive Bidding Program does not affect your patients' choice of physician or treating practitioner.

In using this series of DMEPOS articles, remember that in most instances, beneficiaries maintaining a permanent residence in one of the Competitive Bidding Areas (CBAs) must obtain competitive bidding items from a contract supplier. There are also program requirements that apply to beneficiaries who reside in CBAs but travel outside of those CBAs and to beneficiaries who do not live in CBAs but travel to them.

Physicians and Other Treating Practitioners Who are Enrolled Medicare DMEPOS Suppliers

Medicare physicians and treating practitioners who have also enrolled as Medicare DMEPOS suppliers via the 855S enrollment form have the option to furnish certain types of competitively bid items to their own patients without submitting a bid or being awarded a competitive bid contract, provided the following requirements are met:

- For the first phase of the program being implemented July 1 2008, the item furnished must be a walker. In the future, the items will be limited to crutches, canes, walkers, folding manual wheelchairs, blood glucose monitors, and infusion pumps that are DME;
- The items must be furnished by the physician or treating practitioner DMEPOS supplier **to his or her own patients as part of his or her professional service**; and
- The items must be billed to a DME MAC using the DMEPOS billing number that is assigned to the physician, the treating practitioner (if possible), or a group practice to which the physician or treating practitioner has reassigned the right to receive Medicare payment.

Where the furnished item is a bid item and the beneficiary resides in a CBA, the physician or treating practitioner will be paid the single payment amount established by this program for the item. This exception does not affect the applicability of the physician self-referral (Stark law) provisions in section 1877 of the Act. All provisions of the physician self-referral law remain fully in effect.

COMPETITIVE BIDDING CONT'D

Physicians and Other Treating Practitioners Who Prescribe Specific Brand or Mode of Delivery to Avoid an Adverse Medical Outcome
A physician (including a podiatric physician) or treating practitioner may prescribe, in writing, a particular brand of DMEPOS bid item or mode of delivery for an item if he or she determines that the particular brand or mode of delivery would avoid an adverse medical outcome for the beneficiary. The physician or treating practitioner must document in the beneficiary's medical record the reason why the specific brand or mode of delivery is necessary to avoid an adverse medical outcome.

In these cases, the contract supplier under the Competitive Bidding Program must:

- Furnish the particular brand or mode of delivery as prescribed by the physician or treating practitioner;
- Consult with the physician or treating practitioner to find another appropriate brand of item or mode of delivery for the beneficiary and obtain a revised written prescription from the physician or treating practitioner; or
- Assist the beneficiary in locating a contract supplier that can furnish the particular brand of item or mode of delivery prescribed by the physician or treating practitioner.

Any change in the prescription requires a revised written prescription. A contract supplier is prohibited from submitting a claim to Medicare if it furnishes an item different from that specified in the written prescription received from the beneficiary's physician or treating practitioner.

Skilled Nursing Facilities (SNFs) and Nursing Facilities (NFs) Specialty Suppliers
The DMEPOS Competitive Bidding Program applies to SNFs and NFs to the extent that their residents receive competitively bid items under Medicare Part B. Unlike most suppliers, SNFs and NFs have the option to bid for, and be awarded, contracts to be "specialty suppliers" **that only furnish competitively bid items to their own residents.** SNFs and NFs that become specialty suppliers may not furnish competitively bid items and services to Medicare beneficiaries outside their facilities for purposes of Medicare payment. SNFs and NFs can also become regular contract suppliers that furnish competitively bid items to beneficiaries throughout a CBA.

If a SNF or NF is not a contract supplier (either a specialty contract supplier or a regular contract supplier), it must use a contract supplier for its CBA to furnish competitively bid items to its residents.

Physical Therapists and Occupational Therapists in Private Practice Who are Enrolled Medicare DMEPOS Suppliers
Physical therapists and occupational therapists in private practice who are enrolled DMEPOS suppliers may eventually have the option to furnish certain types of competitively bid items to their own patients and be paid the single payment amount for such items without being contract suppliers, provided the following requirements are met:

- The items are limited to off-the-shelf (OTS) orthotics; and
- The items must be furnished only to their own patients as part of the physical or occupational therapy service.

Note: OTS orthotics are not included in the first phase of competitive bidding, this exception is not relevant in the first phase of the DMEPOS Competitive Bidding program beginning July1, 2008.

Additional Information
If you have concerns, questions, or complaints about the quality of an item or the service that a patient received from a contract supplier please call the Competitive Bidding Program helpline at 1-877-577-5331.

For more information about the Competitive Bidding Program, call 1-877-577-5331. TTY users call 1-877-486-2048. Stay tuned for additional articles in this series. You can also visit http://dmecompetitivebid.com/palmetto/cbic.nsf/DocsCat/Home on the Internet and at http://www.cms.hhs.gov/CompetitiveAcqforDMEPOS/ on the CMS website for more details.

CERT

Comprehensive Error Rate Testing Documentation Submission

The Centers for Medicare & Medicaid Services (CMS) uses the Comprehensive Error Rate Testing (CERT) program to measure and improve the quality and accuracy of Medicare claims submission, processing and payment. Under this program, numerous randomly selected claims are reviewed each year. The results of these reviews are used to characterize and quantify local, regional and national error rate patterns. CMS uses this information to address the error rate through appropriate educational programs.

The primary reasons for CERT errors are:

- Services incorrectly coded
- Medically unnecessary service or supply
- No documentation

When suppliers receive a request from the CERT contractor, they need to submit the requested supporting documentation within the time frame outlined in the request. Suppliers do not need to obtain additional beneficiary authorization to forward medical records to the designated CERT contractor. Be assured that forwarding specifically requested records to the designated CERT contractor does not violate privacy provisions under the Health Insurance Portability and Accountability Act (HIPAA).

Suppliers should maintain documentation required prior to dispensing equipment/supplies and submitting a claim. This documentation will be needed for audits, medical review, appeal requests and for the CERT for supporting documentation of the equipment or supplies issued. Suppliers should maintain all documentation in the beneficiary's file for review.

There are certain DME items that require a Certificate of Medical Necessity (CMN) or DME Information Form (DIF) to help document medical necessity. Portions of CMNs

are completed by the supplier and other sections by the ordering physician. DIFs can be completed by the supplier. Both CMNs and DIFs must be completed prior to claim submission and must accompany the initial claim. Proof of Delivery must also be available upon request.

DMEPOS requiring a CMN:

- Oxygen
- Pneumatic Compression Device
- Osteogenesis Stimulator
- Transcutaneous Electrical Stimulator (for purchase only)
- Seat Lift Mechanism

DMEPOS requiring a DIF:

- External Infusion Pump
- Parenteral Nutrition
- Enteral Nutrition

Most DME items may be dispensed based on a verbal order, however some items require a written order prior to delivery (WOPD) as listed below:

- Support Surfaces
- Transcutaneous Nerve Stimulators (TENS)
- Seat Lift Mechanisms
- Negative Pressure Wound Therapy (NPWT)
- Power Mobility Devices
- Wheelchair Seating

Suppliers must document the verbal order with the following elements:

- Description of the item
- Name of the beneficiary
- Name of the physician
- Start date of the order

A written order is required prior to claim submission, even if item is dispensed based on a verbal order. A CMN can be used as the written order if section C is sufficiently detailed with all the written order requirements.

Elements that are required on all written orders are:

- Beneficiary's name
- Detailed description of the item that can either be a narrative description or a brand name/model name
- All options or additional features which will be separately billed or which will require an upgraded code
- Signature of the treating physician and the date the order is signed
- Initial date of need or start date

Accessories or supplies may require:

- Quantity used
- Specific frequency of change or use (this must be specific; "as needed" or "prn" is not acceptable)
- Length of need

Covered drugs require:

- Name of the drug
- Concentration, if applicable
- Frequency of administration
- Route of administration
- Duration of infusion, if applicable

The requested documentation is due as soon as possible after receipt of the initial request. If the requested information is not received within 75 days, CERT staff must assume that the services were not rendered. Be sure that your medical records department places a high priority on responding to requests.

Please adhere to the following directions when faxing:

- Send the specific documents listed on the Bar Coded Cover Sheet to support the services of each claim identified on the Medical Records/ Documentation Pull List.
- Place the bar coded cover sheet in front of the medical records/documentation being submitted for review
- Make sure all pages are complete, legible and include both sides where applicable.

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

- Send the specific records listed on the Bar Coded Cover Sheet to support the services of each claim identified on the Medical Records/Documentation Pull List.
- Photocopy each record. Make sure all copies are complete, legible and include both sides of each page.
- Place the bar coded cover sheet in front of the medical records/documentation being submitted for review.

CERT reviews of documentation can result in identification of overpayments, as well as underpayments. Suppliers may file an appeal with your Medicare contractor on any claim reviewed by CERT. If no documentation is provided on consistent basis, the supplier may be referred to the Office of Inspector General.

The NAS DME website, www.noridianmedicare.com/dme, is a good resource for finding information on what documentation is needed for DMEPOS items. Look in the Coverage/Medical Review section to search the Local Coverage Determinations and policy articles.

CERT Documentation

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

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

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

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

Mail all requested documentation to:

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

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

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

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

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

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

Advance Beneficiary Notice of Noncoverage

On Monday, March 3, 2008, CMS implemented use of the revised Advance Beneficiary Notice of Noncoverage (ABN) (CMS-R-131). This form replaces the following existing forms:

- ABN-G (Form No. CMS-R-131G) - Advance Beneficiary Notice (General)
- NEMB (Form No. CMS-20007) - Notice of Exclusion from Medicare Benefits

This revised ABN form is for providers, physicians, practitioners, and suppliers for all situations where Medicare payment is expected to be denied. Both the form and notice instructions have been posted on the Beneficiary Notice Initiative web page at www.cms.hhs.gov/bni.

Some key features of the new form are that it:

- Has a new official title, the "Advance Beneficiary Notice of Noncoverage (ABN)", in order to more clearly convey the purpose of the notice;
- May also be used for voluntary notifications, in place of the Notice of Exclusion from Medicare Benefits (NEMB);
- Has a mandatory field for cost estimates of the items/services at issue; and
- Includes a new beneficiary option, under which an individual may choose to receive an item/service, and pay for it out-of-pocket, rather than have a claim submitted to Medicare.

CMS is allowing a six-month transition period from the date of implementation for use of the revised form and instructions. All providers and suppliers must begin using the new ABN (CMS-R-131) no later than September 1, 2008.

The new form, CMS-R-131, is available on the NAS DME web site under Forms.

Updated CMS 1500 Instructions for NPI

The CMS 1500 (08-05) instructions have been updated to reflect NPI changes which are going into effect May 23, 2008. The instructions can be located under the Claims section of our web site.

Reminder: As of May 23, Medicare FFS will require and send NPI-Only in ALL provider identifier fields for all HIPAA and paper transactions where a provider identifier is required. **If you send Medicare a transaction with a Medicare legacy identifier in any of the provider fields, your claim will be rejected.**

More information and education regarding NPI can be found on the CMS NPI page of the CMS web site.

Clarification of Glucose Monitors and Related Accessories and Supplies

NAS is providing the following clarification of glucose monitoring supplies in response to supplier inquiries and an assessment of recently submitted claims.

NAS posted Glucose Monitors and Related Accessories and Supplies to our web site on March 12, 2008, reminding suppliers of the LCD and Policy Article requirements. In our assessment of recently submitted claims, NAS is finding it necessary for suppliers to provide more specific information in the narrative when the prescribed frequency of testing is more often than the LCD utilization. To support the medical necessity of the testing frequency, the narrative (Item 19 for paper submitters or the NTE segment for electronic billing) should include:

- The treating physician's prescribed frequency (from the physician's order)

Example of a valid narrative: Testing 2x a day

Example of insufficient narrative: poor control, high frequency, fluctuating levels

If you have received denials for which supporting documentation is available to substantiate additional payment, **a reopening or a redetermination may be requested**.

A telephone reopening may be requested for claims denied for no narrative or insufficient narrative, provided the needed information is made available to the reopenings staff. Suppliers may be referred to follow the redeterminations process based on the testing frequency of the beneficiary or the information maintained by the supplier from the physician's written order.

Redetermination requests may be submitted along with medical documentation to support testing in excess of the policy frequency limitations. Medical documentation may include written orders, progress notes and blood glucose logs.

Eliminating Duplicate Denials

Did you know that approximately 15% of all claims submitted in January/February 2008 resulted in duplicate denials? Submitting duplicate claims is not cost effective and may delay the processing of other claims. One submission is all that is required.

Tips to avoid duplicate denials:

- Do not automatically rebill claims at preset intervals.
- Check the EDI reports to verify claims were received and accepted or rejected.
- Verify claim status using the Interactive Voice Response (IVR) system by dialing 1-877-320-0390 if you have not received payments after 30 days. Remember that payment for electronic claims will be issued 14 days after receipt, whereas paper claims cannot be paid until at least 29 days after receipt.
- Do not resubmit medical necessity denials; these should be appealed if you do not agree with Medicare's initial decision.
- Items billed on separate lines with the same HCPCS code may cause the second line to deny as a duplicate. If there is a valid explanation for the second line with the same HCPCS, please include this explanation in Item 19 on the CMS-1500 claim form or the NTE segment for electronic claims.
- All charges and number of services for the same HCPCS codes should be billed on one line with the charges combined and total units indicated, i.e., two different kinds of ostomy supplies with the same HCPCS or two different nutrient products with the same HCPCS should be combined on one line.

  Exceptions to billing one line item for the same HCPCS:

  - Rented or purchased items with RT/LT modifiers may be billed on two lines.
  - When billing for back-up equipment, bill two lines with an explanation for the second item.

Appealing a Duplicate Denial

The redeterminations staff cannot give appeal rights to those services that are denying duplicate, unless the appeal request specifically states that the service(s) was not a duplicate charge and documentation shows the service was distinct and separate.

Remember, submitting duplicate claims:

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

Updated Medicare Remit Easy Print Brochure

The Medicare Remit Easy Print brochure has been updated and is now available to order print copies or to download as a PDF file. This brochure provides an overview of free software that enables physicians and suppliers to view and print remittance information. To view the PDF file, go to http://www.cms.hhs.gov/MLNProducts/downloads/MedicareRemit_0408.pdf. Print copies may be ordered by visiting the MLN Product Ordering Page at http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5 on the CMS Website.

Medicare Shared Systems Modifications Necessary to Accept and Crossover to Medicaid NDC and Corresponding Quantities Submitted on CMS-1500 Paper Claims

MLN Matters Number: MM5835
Related Change Request (CR) #: 5835
Related CR Release Date: December 21, 2007
Related CR Transmittal #: R1401CP
Effective Date: April 7, 2008
Implementation Date: April 7, 2008

Provider Types Affected
All physicians, providers, and suppliers who submit paper claims using Form CMS-1500 to Medicare contractors (carriers, Medicare Administrative Contractors (A/B MACs), and durable medical equipment Medicare Administrative Contractors (DME/MACs)) for certain physician administered drugs provided to Medicare beneficiaries

Provider Action Needed
The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 5835 that notifies physicians and suppliers who use Claim Form CMS-1500 (those providers who qualify for a waiver from the Administrative Simplification Compliance Act (ASCA)) that changes are being made to Medicare systems to conform with instructions for submitting NDC drug code and quantity information on Form CMS-1500.

This article only applies to those providers eligible to submit paper claims and who do so for patients who are dually eligible for Medicaid and Medicare. Such claims need to include NDCs and corresponding quantity amounts for physician-administered drugs. The Key Points section of this CR outlines the changes required in the Form CMS-1500.

Background
The Deficit Reduction Act (DRA) of 2005 required State Medicaid agencies to provide for the collection of National Drug Codes (NDC) on all claims for certain physician-administered drugs for the purpose of billing manufacturers for Medicaid drug rebates. Prior to the DRA, physicians' offices, outpatient hospital departments and clinics generally used Healthcare Common Procedure Coding System (HCPCS) codes to bill Medicaid for drugs dispensed to Medicaid patients. However, because State Medicaid agencies are required to invoice manufacturers for rebates using NDCs for drugs for which the States have made payments, often States were not able to fulfill the rebate requirements for physician-administered drugs. The requirements for the collection of NDCs became effective beginning January 1, 2007. In addition, beginning January 1, 2008, in order for Federal financial participation (FFP) to be available for these drugs, State Medicaid agencies must be in compliance with the requirements. These requirements were implemented in a final rule published on July 17, 2007.

Also, the quantity field of the CMS-1500 paper claim should be captured on all crossover claims for Medicaid billing, as provided for by the National Uniform Claims Committee (NUCC). Information regarding the quantities of physician-administered drugs billed to Medicaid is also necessary for States to bill manufacturers for Medicaid drug rebates.

Key Points
When required to submit NDC drug number and quantity information for Medicaid rebates on the CMS-1500 paper claim be aware of the following:

- Submit the NDC code in the red shaded portion of the detail line item in positions 01 through position 13.
- The NDC is to be preceded with the qualifier N4 and followed immediately by the 11digit NDC code (e.g. N499999999999).
- Report the NDC quantity in positions 17 through 24 of the same red shaded portion. The quantity is to be preceded by the appropriate qualifier: UN (units), F2 (international units), GR (gram) or ML (milliliter). There are six positions available for quantity. If the quantity is less than six positions, the entry should be left justified with spaces filling the remaining positions.

Additional Information
To see the official instruction (CR5835) issued to your Medicare Carrier, DME/MAC, or A/B MAC refer to http://www.cms.hhs.gov/Transmittals/downloads/R1401CP.pdf on the CMS website.

Reporting of Hematocrit or Hemoglobin Levels on All Claims for the Administration of ESAs

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

Note: This article was revised on May 16, 2008, to delete the words "decimal implied" in the third bullet item on page 3 that discusses reporting of the MEA segment. The values for the most recent numeric test result should be reported with decimals. All other information remains the same.

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

Impact on Providers
Effective for services on or after January 1, 2008, you must report the most recent hemoglobin or hematocrit levels on any claim for a Medicare patient receiving: (1) ESA administrations, or (2) Part B anti-anemia drugs other than ESAs used in the treatment of cancer that are not self-administered. In addition, non-ESRD claims for the administration of ESAs must also contain one of three new Healthcare Common Procedure Coding System (HCPCS)

modifiers effective January 1, 2008. Failure to report this information will result in your claim being returned as unprocessed. **(Note that renal dialysis facilities are already reporting this information on claim types 72X, so CR5699 applies to providers billing with other types of bills.)** See the rest of this article for reporting details.

Background

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

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

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

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

What You Need to Know

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

1. Effective January 1, 2008, all claims billing for the administration of an ESA with HCPCS codes J0881, J0882, J0885, J0886 and Q4081 must report the most recent hematocrit or hemoglobin reading available when the billed ESA dose was administered. Facilities should bill at a frequency that allows for the reporting of the most recent hematocrit or hemoglobin reading prior to the start of the billing period that is applicable to the administrations billed on the claim. For new patients this would be the most recent reading prior to the onset of treatment. Note that a provider may have to submit more than one claim for the month if there were multiple readings that were applicable to the administrations given during the month. Claims submitted prior to the publication of change request 5699 that were not completed per the instructions in change request 5699 should be re-submitted.

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

    Examples: If the most recent hemoglobin test results are 10.50, providers should enter: TR/R1/10.5, or, if the most recent hematocrit results are 32.3, providers would enter: TR/R2/32.3.

    - Effective for dates of service on and after January 1, 2008, contractors will return to provider paper and electronic professional claims, or return as unprocessable paper and electronic institutional claims for ESAs when the most recent hemoglobin or hematocrit test results are not reported.
    - When Medicare returns a claim as unprocessable for ESAs with HCPCS codes J0881, J0882, J0885, J0886, or Q4081 for failure to report the most recent hemoglobin or hematocrit test results, it will include Claim Adjustment Reason Code 16 (Claim/service lacks information which is needed for adjudication.) and Remittance Advice Code MA130 (Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with complete/correct information.)

2. Effective January 1, 2008, all non-ESRD ESA claims billing HCPCS J0881 and J0885 must begin reporting one **(and only one)** of the following three modifiers on the same line as the ESA HCPCS:

    - EA: ESA, anemia, chemo-induced;
    - EB: ESA, anemia, radio-induced; or
    - EC: ESA, anemia, non-chemo/radio
    - Non-ESRD ESA institutional claims that do not report one of the above three modifiers along with HCPCS J0881 or J0885 will be returned to the provider.

- Non-ESRD ESA professional claims that are billed without one of the three required modifiers as line items along with HCPCS J0881 or J0885 will be returned as unprocessable with reason code 4 and remark code MA130. If more than one modifier is reported, the claim will be returned with reason code 125 and remark code N63.

3. Effective January 1, 2008, all non-ESRD, non-ESA claims billing for the administration of Part B anti-anemia drugs used in the treatment of cancer that are not self-administered must report the most recent hematocrit or hemoglobin reading. Facilities should bill at a frequency that allows for the reporting of the most recent hematocrit or hemoglobin reading prior to the start of the billing period that is applicable to the administrations billed on the claim. For new patients this would be the most recent reading prior to the onset of treatment. Note that a provider may have to submit more than one claim for the month if there were multiple readings that were applicable to the administrations given during the month.

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

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

CR 5550 Clarification - Signature Requirements

MLN Matters Number: MM5971
Related Change Request (CR) #: 5971
Related CR Release Date: March 28, 2008
Related CR Transmittal #: R248PI
Effective Date: September 3, 2007
Implementation Date: April 28, 2008

Provider Types Affected
Physicians and other providers who bill Medicare Contractors (Carriers, Fiscal Intermediaries, Regional Home Health Intermediaries, Part A/B Medicare Administrative Contractors, including Durable Medical Equipment Medicare Administrative Contractors) for care provided to Medicare beneficiaries in hospice.

What You Need to Know
CR 5971, from which this article is taken, clarifies the instructions on signature requirements for the certification of terminal illness for hospice. It provides that Medicare contractors will accept a facsimile of an original written or electronic signature in documenting the certification of terminal illness for hospice.

Make sure that your billing staffs are aware that, to document the certification of terminal illness for hospice, a facsimile of an original written or electronic signature is acceptable

Background
CR 5971, from which this article is taken, clarifies the instructions in *Medicare Program Integrity Manual* Chapter 3 (Verifying Potential Errors and Taking Corrective Actions), Subsection 3.4.1.1B (Signature Requirements) that address the signature requirements for the certification of terminal illness for hospice, that were provided in CR 5550 (Various Medical Review Clarifications).

Subsection 3.4.1.1B of the manual notes that Medicare contractors require a legible identifier for services provided/ordered. It further requires that when this documentation is for medical review purposes, the only acceptable method of documenting the provider signature is by written or an electronic signature. Stamp signatures are not acceptable to sign an order or other medical record documentation for medical review purposes.

CR 5971 provides that there is an exception to this requirement.

It announces that a facsimile of an original written or electronic signature is acceptable for the certification of terminal illness for hospice. Please be sure to note however, that while a signature facsimile is acceptable in this instance, **hard copies of a physician's electronic signature** must be present in the patient's medical record.

Additional Information
You can find more information about the signature requirements for the certification of terminal illness for hospice by going to CR 5971, located at http://www.cms.hhs.gov/Transmittals/downloads/R248PI.pdf on the CMS website. You will find updated *Medicare Program Integrity Manual* Chapter 3 (Verifying Potential Errors and Taking Corrective Actions), Subsection 3.4.1.1B (Signature Requirements) as an attachment to this CR.

New HCPCS Codes for the April 2008 Update

MLN Matters Number: MM5981
Related Change Request (CR) #: 5981
Related CR Release Date: April 18, 2008
Related CR Transmittal #: R1492CP
Effective Date: April 1, 2008
Implementation Date: April 7, 2008

Provider Types Affected
Physicians, 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 services provided to Medicare beneficiaries.

Provider Action Needed
This article is based on Change Request (CR) 5981, which instructs Medicare Contractors to implement Healthcare Common Procedure Coding System (HCPCS) code changes effective April 1, 2008. Make sure that your billing staffs are aware of these changes.

Background
The Centers for Medicare & Medicaid Services (CMS) updates the Healthcare Common Procedure Coding System (HCPCS) code set on a quarterly basis.

Effective for claims with dates of service on or after April 1, 2008, the following HCPCS codes will no longer be payable for Medicare:

HCPCS Code	Short Description	Long Description
J7602	Albuterol inh non-comp con	ALBUTEROL, ALL FORMULATIONS INCLUDING SEPARATED ISOMERS, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, CONCENTRATED FORM, PER 1 MG (ALBUTEROL) OR PER 0.5 MG (LEVALBUTEROL)
J7603	Albuterol inh non-comp u d	ALBUTEROL, ALL FORMULATIONS INCLUDING SEPARATED ISOMERS, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, UNIT DOSE, PER 1 MG (ALBUTEROL) OR PER 0.5 MG (LEVALBUTEROL)
J1751	Iron dextran 165 injection	INJECTION, IRON DEXTRAN 165, 50 MG
J1752	Iron dextran 267 injection	INJECTION, IRON DEXTRAN 267, 50 MG

Effective for claims with dates of service on or after April 1, 2008, the following HCPCS codes will be payable for Medicare:

HCPCS Code	Short Description	Long Description
J7611	Albuterol non-comp con	ALBUTEROL, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, CONCENTRATED FORM, 1MG
J7612	Levalbuterol non-comp con	LEVALBUTEROL, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, CONCENTRATED FORM, 0.5 MG
J7613	Albuterol non-comp unit	ALBUTEROL, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTEREDTHROUGH DME, UNIT DOSE, 1MG
J7614	Levalbuterol non-comp unit	LEVALBUTEROL, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, UNIT DOSE, 0.5 MG
Q4096	VWF complex, NOS	INJECTION, VON WILLEBRAND FACTOR COMPLEX, HUMAN, RISTOCETIN COFACTOR (NOT OTHERWISE SPECIFIED), PER I.U. VWF:RCO

Q4097	Inj IVIG Privigen 500 mg	INJECTION, IMMUNE GLOBULIN (PRIVIGEN), INTRAVENOUS, NON-LYOPHILIZED (E.G., LIQUID), 500 MG
Q4098	Inj iron dextran	INJECTION, IRON DEXTRAN, 50MG
Q4099	Formorterol fumarate, inh	FORMORETOL FUMARATE, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, UNIT DOSE FORM, 20 MICROGRAMS

Currently, Alphanate® is the only product that should be billed using code Q4096. J7190 should continue to be billed when Alphanate® is furnished for purposes of administering Factor VIII. The blood clotting furnishing fee is payable when payment is allowed for Q4096. When a payment allowance limit for Q4096 is included on the quarterly Part B drug pricing files, the payment allowance limit will include payment for the blood clotting furnishing fee.

Effective for dates of service on or after April 1, 2008, the requirements under CR 5713 (See the MLN Matters article for CR5713, which is at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5713.pdf on the CMS website) are being updated by CR 5981 to apply to claims that bill Intravenous Immunoglobulins (IVIG) using Q4097 as follows:

- Effective for dates of service on or after April 1, 2008, Medicare Contractors will:
  - Only pay a claim for preadministration-related services (G0332) associated with IVIG administration if G0332, the drug (IVIG, HCPCS codes: J1566, J1568, J1569, J1561, J1572 and/or Q4097), and the drug administration service are all billed on the same claim for the same date of service;
  - Return institutional claims for G0332 to the provider if J1566, J1568, J1569, J1561, J1572 and/or Q4097 and a drug administration service are not also billed for the same date of service on the same claim;
  - Reject professional claims as unprocessable for G0332 if J1566, J1568, J1569, J1561, J1572 and/or Q4097 and a drug administration service are not billed for the same date of service on the same claim; and
  - Use the appropriate reason/remark messages such as: M67 "Missing other procedure codes" and/or 16 "Claim/service lacks information" which are needed for adjudication when claims are returned/rejected.

Additional Information
The official instruction, CR 5981, issued to your carrier, FI, RHHI, A/B MAC, and DME MAC regarding these changes may be viewed at http://www.cms.hhs.gov/transmittals/downloads/R1492CP.pdf on the CMS website.

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

MLN Matters Number: MM6009
Related Change Request (CR) #: 6009
Related CR Release Date: May 9, 2008
Related CR Transmittal #: R1501CP
Effective Date: January 1, 2008
Implementation Date: July 7, 2008

Provider Types Affected
Providers submitting claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs), and/or Part A/B Medicare Administrative Contractors (A/B MACs)) for services provided to Medicare beneficiaries in Skilled Nursing Facilities.

Provider Action Needed
This notification provides updates to the lists of Healthcare Common Procedure Coding System (HCPCS) codes that are subject to the consolidated billing provision of the SNF Prospective Payment System (PPS). **CR 6009 adds HCPCS code J9303 (Injection, Panitumumab, 10MG)** to the Major Category III.A. Chemotherapy services FI/A/B MAC **Exclusion List** retroactive to January 1, 2008.

Background
The Social Security Act (Section 1888) codifies the Skilled Nursing Facility (SNF) Prospective Payment System (PPS) and Consolidated Billing (CB). The new coding identified in each update describes the same services that are subject to SNF PPS payment by law. No additional services are added by these routine updates; that is, new updates are required by changes to the coding system, not because the services subject to SNF CB are being redefined. Other regulatory changes beyond code list updates will be noted when and if they occur.

CODING CONT'D

The Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of HCPCS codes that are not subject to the consolidated billing provision of the SNF PPS. Services not appearing on this list submitted on claims to FIs/A/B MACs and carriers/A/B MACS, including DME MACs, will not be paid by Medicare to providers, other than a 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 will edit for services provided to SNF beneficiaries both included and excluded from SNF CB.

CR 6009 adds HCPCS code J9303 to the Major Category III.A. Chemotherapy services FI/A/B MAC **Exclusion List retroactive to January 1, 2008.**

Medicare contractors will reopen and reprocess claims affected by this instruction when providers bring such claims to their contractor's attention.

Additional Information
The official instruction, CR 6009, issued to your carrier, FI, and A/B MAC regarding this change may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R1501CP.pdf on the CMS website.

REIMBURSMENT

Do Not Forward

NAS places a Do Not Forward (DNF) flag on a supplier's account to protect the supplier's future Medicare payments after a check or remittance advice (RA) is returned to NAS as undeliverable by the United States Postal Service or when an Electronic Funds Transfer (EFT) is declined by the supplier's bank. Holding payments until the supplier can update their address and/or bank routing information avoids funds being lost or misdirected.

Check/Remittances Returned by Postal Service
CMS requires contractors to use "Return Service Requested" envelopes for all checks and RAs that are mailed to suppliers. The postal service will return to NAS any checks or RAs that cannot be delivered to the address on the envelope. The postal service may include the new forwarding address with the returned mail, but CMS contractors may NOT resend the check or RA based on only that information (Medicare Claims Processing Manual, Chapter 1, Section 80.5.1).

To protect suppliers, checks and RAs from NAS are mailed only to the address on file with the National Supplier Clearinghouse (NSC). The Medicare Supplier Standards (42 C.F.R. 424.57(c)) state that it is the supplier's responsibility to notify the NSC within 30 days of the change. If the postal service determines that an address is not valid and returns the mail to NAS, a DNF flag is placed on the supplier's record and NAS notifies the NSC. The NSC, in turn, attempts to contact the supplier to request updated information.

The supplier must verify their address information in writing. This means completing and mailing the CMS 855S Enrollment Application form to verify that the address on file with the NSC is correct or to submit a change of address. The supplier must include a copy of their National Provider Identifier (NPI) notification letter from the NPI Enumerator each time the CMS 855S form is submitted.

The CMS 855S Enrollment Application form can be found at: www.cms.hhs.gov/cmsforms/downloads/cms855s.pdf.

If the supplier is unable to locate the NPI notification, they may contact the National Plan and Provider Enumeration System (NPPES) at (800)-465-3203 or send an e-mail to customerservice@npienumerator.com to request a copy of the notification.

For more information about completing the 855S form, see the NSC website www.palmettogba.com/nsc.

Change of Address Requires Suppliers to Change to EFT Payments
CMS requires suppliers who have been receiving payments via a paper check to change to EFT payments when updating their address information. If a supplier's check has been returned to NAS as undeliverable, the supplier must complete the CMS 588 – Electronic Funds Transfer Authorization form and send it to the NSC with the 855-S Enrollment Application form. The 588 must be accompanied by a voided check, deposit slip or confirmation of account information on bank letterhead.

The CMS 588 – Electronic Funds Transfer Authorization form can be found at:
www.cms.hhs.gov/cmsforms/downloads/cms588.pdf

The CMS 855-S and CMS 588 forms must contain original signatures. Stamped signatures, photocopies and faxes are unacceptable. These documents must be mailed to the NSC at the following address.

National Supplier Clearinghouse
PO Box 100142
Columbia SC 29202-3142

Declined Electronic Fund Transfers
As of April 14, 2008, Medicare contractors are no longer allowed to automatically reissue payment in the form of a paper check after an EFT payment is declined by a bank (Change Request 5952, Transmittal 246). Instead, a DNF flag will be place on the supplier's account to prevent payments from being misdirected until the EFT information is updated by the supplier. If an EFT is declined due to incorrect or changed banking or routing numbers, NAS will notify the supplier in writing that the EFT has been declined.

The supplier is responsible to send a completed CMS 588-Electronic Funds Transfer Authorization form to NAS. The CMS 588 form must be accompanied by a voided check, deposit slip or account information on bank letterhead. Each section of the 588 form must be completed, including the NPI number in Part II – Provider or Supplier Information and "Noridian Administrative Services" or "NAS" as the fee-for-service contractor in Part V - Authorization.

REIMBURSMENT CONT'D

The CMS 588 form must contain an original signature. Stamped signatures, photocopies and faxes are unacceptable. These documents must be mailed to Noridian Administrative Services at the address below.

Noridian Administrative Services
PO Box 6728
Fargo ND 58108-6728

Failure to complete any part of the CMS 588 form or failure to include a voided check, deposit slip or account information from the bank will result in a delay in processing the EFT request as NAS attempts to contact the supplier to complete the requirements. EFT processing generally takes at least two weeks from the time the request is received by the EFT staff, as most banks requires at least one weekend cycle to update their records and NAS needs a subsequent weekend to test transmissions with the bank.

Any questions about a supplier's Do Not Forward status may be directed to the Supplier Contact Center at 1-866-243-7272.

COVERAGE

Urological Supplies – Policy Changes FAQ

The March 2008 revision of the Urological Supplies LCD removed references to "Clean Intermittent Catheterization" and removed the requirement for re-use of intermittent catheters with that technique. This FAQ addresses some issues associated with the policy revision.

Q1. The policy on intermittent catheterization has been revised. The criteria for coverage of sterile kits, A4353, are slightly different from the previous criteria. The previous criteria required two infections while using "clean technique". This revision requires two infections while using sterile, single-use catheters (A4351, A4352). Are current A4353 patients that qualified under clean technique grandfathered under this new policy?
A1. Beneficiaries who were using A4353 sterile catheter kits prior to April 1, 2008, and who met the requirements for A4353 in the previous version of the Urological Supplies LCD continue to be eligible to receive sterile intermittent catheterization kits. The medical record must contain sufficient information to demonstrate that the applicable coverage criteria were met.

Q2. We are working with patients who have a history of urinary tract infections (UTI) but are currently washing and reusing their catheters (A4351, A4352) – i.e., they are using clean technique. We are just waiting for their doctors to send the lab results along with the UTI dates. Sometimes it takes 3 to 4 weeks for the doctors to respond to our requests. Are sterile catheter kits (A4353) covered for these patients?
A2. No. If the beneficiary was not using sterile catheter kits (A4353) prior to 4/1/2008, he/she must meet the current criteria in order to be eligible for reimbursement. Beneficiaries

COVERAGE CONT'D

who have been reusing intermittent catheters (A4351, A4352) with clean technique at the rate of one catheter per week are eligible to use a sterile catheter (A4351, A4352) and a packet of sterile lubricant (A4332) for each catheterization. The number of items needed must be determined by the treating physician and information in the medical record must justify the need for the number of items prescribed.

Q3. The policy contains a table describing the usual maximum number of supplies. Does this mean that every beneficiary should get 200 per month?
A3. No. The usual maximum number represents a determination of the number of items that beneficiaries with extreme utilization requirements will actually need. The typical beneficiary will require a much lower amount. The beneficiary's utilization should be determined by the treating physician based upon the patient's medical condition. There must be sufficient information in the medical record to justify the amount ordered.

A beneficiary or their caregiver must specifically request refills of urological supplies before they are dispensed. The supplier must not automatically dispense a quantity of supplies on a predetermined regular basis, even if the beneficiary has "authorized" this in advance. The supplier should check with the patient or caregiver prior to dispensing a new supply of intermittent catheters to determine that previous supplies are nearly exhausted.

Q4. In an audit, what information must be contained in the medical record to justify payment for both the type and quantity of urological supplies ordered by the treating physician?
A4. For urological supplies to be covered by Medicare, the patient's medical record must contain sufficient documentation of the patient's medical condition to substantiate the necessity for the type and quantity of items ordered and for the frequency of use or replacement. The information should include the patient's diagnosis and other pertinent information including, but not limited to, duration of the patient's condition, clinical course (worsening or improvement), prognosis, nature and extent of functional limitations, other therapeutic interventions and results, past experience with related items, etc. Neither a physician's order nor a supplier-prepared statement nor a physician attestation by itself provides sufficient documentation of medical necessity, even though it is signed by the treating physician. There must be clinical information in the patient's medical record that supports the medical necessity for the item and substantiates the information on a supplier-prepared statement or physician attestation.

For intermittent catheterization, in addition to the general information described above, the patient's medical record must contain a statement from the physician specifying how often the patient (or caregiver) performs catheterizations.

The patient's medical record is not limited to the physician's office records. It may include hospital, nursing home, or home health agency (HHA) records, and records from other professionals including, but not limited to, nurses, physical or occupational therapists, prosthetists, and orthotists.

Erythropoiesis Stimulating Agents in Cancer and Related Neoplastic Conditions

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

Note: This article was April 25, 2008, to correct the bullet on page 3 regarding the "Maintenance of ESA therapy" (See bullet in **bold**). It should have stated that the "starting dose if the hemoglobin level remains below 10 g/dL (or hematocrit is < 30%) 4 weeks after initiation of therapy and the rise in hemoglobin is ≥ 1g/dL (hematocrit ≥ 3%)." All other information remains the same.

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

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

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

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

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

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

- The hemoglobin level immediately prior to the first administration is < 10 g/dL (or the hematocrit is < 30%) and the hemoglobin level prior to any maintenance administration is < 10g/dL (or the hematocrit is < 30%.);
- The starting dose for ESA treatment is up to either of the recommended Food and Drug Administration (FDA) approved label starting doses for cancer patients receiving chemotherapy, which includes the, 150 U/kg/3 times weekly or the 40,000 U weekly doses for epoetin alfa and the 2.25 mcg/kg/weekly or the 500 mcg once every three week dose for darbepoetin alpha;
- **Maintenance of ESA therapy is the starting dose if the hemoglobin level remains below 10 g/dL (or hematocrit is < 30%) 4 weeks after initiation of therapy and the rise in hemoglobin is ≥ 1g/dL (hematocrit ≥ 3%);**
- For patients whose hemoglobin rises < 1 g/dl (hematocrit rise < 3%) compared to pretreatment baseline over 4 weeks of treatment and whose hemoglobin level remains < 10 g/dL after 4 weeks of treatment (or the hematocrit is < 30%), the recommended FDA label starting dose may be increased once by 25%. Continued use of the drug is not reasonable and necessary if the hemoglobin rises < 1 g/dl (hematocrit rise < 3%) compared to pretreatment baseline by 8 weeks of treatment;
- Continued administration of the drug is not reasonable and necessary if there is a rapid rise in hemoglobin > 1 g/dl (hematocrit > 3%) over any 2 week period of treatment unless the hemoglobin remains below or subsequently falls to < 10 g/dL (or the hematocrit is < 30%). Continuation and reinstitution of ESA therapy must include a dose reduction of 25% from the previously administered dose; and
- ESA treatment duration for each course of chemotherapy includes the 8 weeks following the final dose of myelosuppressive chemotherapy in a chemotherapy regimen.

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

- Any anemia in cancer or cancer treatment patients due to folate deficiency (diagnosis code 281.2), B-12 deficiency (281.1 or 281.3), iron deficiency (280.0-280.9), hemolysis (282.0, 282.2, 282.9, 283.0, 283.2, 283.9, 283.10, 283.19), bleeding (280.0 or 285.1), or bone marrow fibrosis;

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- Anemia associated with the treatment of acute and chronic myelogenous leukemias (CML, AML) (205.00-205.21, 205.80-205.91), or erythroid cancers (207.00-207.81);
- Anemia of cancer not related to cancer treatment;
- Any anemia associated only with radiotherapy;
- Prophylactic use to prevent chemotherapy-induced anemia;
- Prophylactic use to reduce tumor hypoxia;
- Erythropoietin-type resistance due to neutralizing antibodies; and
- Anemia due to cancer treatment if patients have uncontrolled hypertension.

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

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

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

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

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

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

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

CODING

Establish Pre-Payment Auto-Denial Edits in Applicable States for DMEPOS Suppliers of Oxygen and Oxygen Equipment (DME MACs Only)

MLN Matters Number: MM5929 Revised
Related Change Request (CR) #: 5929
Related CR Release Date: April 18, 2008
Related CR Transmittal #: R1493CP
Effective Date: April 1, 2008
Implementation Date: April 7, 2008

Note: This article was revised on April 21, 2008, to amend the last bullet point in the "Key Points" section. All other information remains the same.

Provider Types Affected
Medicare Durable Medical Equipment Prosthetic, Orthotics & Supplies (DMEPOS) suppliers who submit claims for Medicare payment for oxygen and/or oxygen related equipment to DME Medicare Administrative Contractors (DME MACs).

Key Points
Presently, 38 states require licensure and/or certification to provide oxygen and/or oxygen related equipment. A table listing the licensure/certification requirements, if any, is at the end of this article.

- CR 5929 clarifies that Medicare DMEPOS suppliers who submit claims for Medicare payment for oxygen and/or oxygen related equipment must notify the National Supplier Clearinghouse (NSC) via the supplier enrollment process (using the CMS 855S application) and provide a copy of their state license and/or certification to the NSC.
- DME MACs are currently processing these claims from enrolled and approved DMEPOS suppliers without regard to the specialty identified and services to be provided on the enrollment application form (CMS-855S).
- CR5929 **requires** the National Supplier Clearinghouse (NSC) to **assign an oxygen specialty code** to all suppliers who have indicated they will be providing oxygen and/or oxygen related services on their CMS 855S enrollment application.
- In addition, this instruction requires DME MACs to **edit claims to look for the oxygen specialty code**, which will assure that those suppliers specifying the provision of oxygen and/or oxygen related products on their enrollment application and supplying the license/certification are the **only entities that will receive Medicare payment for such supplies in the applicable states**. The DME MACs will establish a **claims processing pre-payment auto-denial edit** in place to deny claims in those states where oxygen and/or oxygen related equipment must be provided by a supplier with oxygen specific licensure and/or certification and where Medicare files do not reflect such license/certification.
- The effective date for the specialty code annotation in Medicare files will be the date the NSC assigns the specialty code for newly enrolled DMEPOS suppliers or the date a DMEPOS supplier initially adds the specialty to their file via a CMS 855S Change of Information submission providing all required licensure/certification is valid. The effective date of the specialty code for existing DMEPOS suppliers will be the date the DMEPOS supplier added or enrolled the specialty with the NSC, providing all required licensure/certification is valid.
- DMEPOS suppliers who are on file with the NSC prior to April 1, 2008 as providing oxygen and/or oxygen related equipment do not need to submit a CMS 855S Change of Information as a result of this instruction.
- Any future oxygen and/or oxygen equipment claims submission by a DMEPOS supplier in a state where licensure/certification is required, where the DMEPOS supplier does not have the oxygen and/or oxygen equipment specialty code on file with the NSC will result in an investigation by the NSC.

Background

In the absence of national Medicare policy regarding who may bill and be paid for oxygen and/or oxygen related equipment, the National Supplier Clearinghouse (NSC) looks to state requirements. The Center for Medicare & Medicaid Services (CMS) regulations (see 42 CFR Section 424.57(c)) require all DMEPOS suppliers wishing to bill Medicare meet all supplier standards. The standard in Section 424.57(c)(1) requires suppliers to operate their business and furnish Medicare-covered items in compliance with all applicable Federal and State licensure and regulatory requirements. This claims processing edit will ensure that suppliers in the (currently) 38 states are in compliance with this requirement.

Additional Information

CR5929 is the official instruction issued to your DME MAC. That instruction may be viewed by going to http://www.cms.hhs.gov/transmittals/downloads/R1493CP.pdf on the CMS website.

The following is the list of the (currently) 38 states that have licensure requirements for oxygen and oxygen related equipment.

State	DME Supplier License	Oxygen License	Other	Notes
AK				
AL		X		
AR	X			
AZ		X		
CA	X		X	"Drug Manufacturing License" issued by CA Department of Health; if wholesaler, permit from Board of Pharmacy is required
CO				
CT		X		
DC	X			"Certificate of Occupancy" issued by the Dept. of Consumer and Regulatory Affairs, Building and Land Regulation Administration Zoning Division, and if operating business from a principal residence, a "Home Occupation Permit" is also required, issued by the Dept. of Consumer and Regulatory Affairs, Building and Land Regulation Administration Zoning Division

DE				
FL	X	X		
GA				
HI		X		Pharmacy license – HI Dept. of Commerce and Consumer Affairs
IA		X		
ID	X			
IL	X			
IN				
KS		X	X	Distributor License required if supplying item/drug classified by FDA as a prescription device, issued by KS Board of Pharmacy
KY		X		
LA		X		
MA			X	"Controlled Substances" license, issued by MA Dept. of Public Health, Division of Food and Drugs
MD	X	X		
ME		X		
MI				
MN		X		
MO	X			
MS	X			
MT				
NC	X			
ND		X		
NE	X	X		
NH		X	X	"Home Health Care Provider" license if respiratory therapy or services provided in patient's residence, issued by NH DHHS, Division of Public Health Services
NJ				
NM				
NV	X	X	X	Must have physician or respiratory therapist on staff, with "Medical License" or respiratory therapist license, both issued by NV State Board of Medical Examiners
NY				
OH	X	X		
OK		X	X	If transfilling oxygen, company must be registered and listed with the FDA and have validated registration letter on file
OR		X		
PA	X			
PR		X		
RI		X		

SC		X		Oxygen license not needed if supplier has "SC Pharmacy Permit"
SD				
TN		X		
TX	X	X		
UT			X	"Retail Pharmacy" license required if supplying oxygen
VA	X	X		
VT				
WA				
WI		X		
WV				
WY		X		

WHEEL CHAIR/POWER MOBILITY DEVICE

Power Mobility Devices – FAQ – ATS/ATP Requirements

The Power Mobility Devices (PMD) LCD states that wheelchairs, classified as Group 2 with a single power option (SPO) or multiple power option (MPO), Group 3, Group 4, Group 5 and Push Rim Activated Power Assist for manual wheelchairs, must be provided by a supplier that employs a RESNA-certified Assistive Technology Supplier (ATS) or Assistive Technology Practitioner (ATP) who specializes in wheelchairs and has direct, in-person involvement in the wheelchair selection for the patient. This requirement was published in November 2006 with a prospective implementation date for PMDs delivered on or after April 1, 2008.

This FAQ will refer to both ATP and ATS credentials as ATS.

1. **Clarify "employ" as it relates to an ATS within this policy.**
   The ATS must be employed by a supplier in a full-time, part-time, or contracted capacity as is acceptable by state law. The ATS, if part-time or contracted, must be under the direct control of the supplier.
2. **If a supplier has a part time or contracted ATS on staff, what type of special documentation would be needed in an audit to prove the credential?**
   A supplier must show that the employee was working under the supplier's control and guidance. The supplier should also be able to provide evidence of the ATS certification upon request.
3. **Would a supplier be asked to provide employment records in a medical review (MR) audit?**
   Yes, employment records, contracting agreements or credential records could be requested. These types of records do not need to be routinely submitted with a claim but must be available upon request.
4. **In the draft Supplier Standards, CMS is proposing that a RESNA certified ATS be employed FULL-TIME by the supplier. Will the LCD be in conflict with the proposed standards?**
   No, there would be no conflict between the proposed supplier standards and the DME MAC policy. The proposed supplier standards specify that the supplier must employ a full time ATS, but do not require that the individual have direct, in-person involvement with each patient. If that person did have direct involvement, that would satisfy the requirements of the DME MAC LCD. However, if the supplier wanted to hire additional part-time or contracted staff, that would meet the requirements of the LCD.
5. **What does it mean for the ATS to have direct, in-person involvement in the wheelchair selection process?**
   It means to physically see and interact with the patient face-to-face. It is important that the record show how the ATS was involved and that medical personnel drove the process.
6. **Can the ATS sign off on the licensed/certified medical professional (LCMP) evaluation, detailed product description or some other attestation to demonstrate compliance with the requirement or would an ATS/ATP log be appropriate?**
   The medical directors have not mandated how suppliers document compliance with the ATS/ATP requirement. There must be evidence in the supplier's file of direct in-person interaction with the patient by the ATS in the wheelchair selection process. Suppliers must document how the ATS is involved with the patient. The documentation must be complete and detailed enough so a third party would be able to understand the nature of the ATS involvement and to show that the standard was

met. Just "signing off" on a form completed by another individual would not adequately document direct, in-person involvement.

7. **If an ATS is involved, in person, at the time of the face-to-face (medical) assessment and communicates with the referring clinician during development of the specifications, does that meet the requirement?**
Yes, the requirement would be met if the medical record documents their level of involvement. The ATS should also document this participation in a manner that can be verified in the event of an audit.

8. **Must the supplier's ATS be present for the delivery, fitting, and/or patient training for the wheelchair provided?**
The policy states the credentialed ATS must have direct, in-person involvement with equipment selection process. The policy does not require that the ATS be present for delivery, fitting, and/or patient training for the wheelchair.

9. **A company employs an ATS, as well as a number of non-credentialed staff who have direct, in-person involvement with the selection process. Is it permissible for the ATS to review the staff's recommendations and sign concurrence to meet the requirement?**
Only a RESNA credentialed ATS who specializes in wheelchairs and who has direct in-person involvement with the wheelchair selection process may provide certain chairs as described in the PMD LCD as of April 1, 2008. An ATS cannot simply "review" and "sign off" on non-credentialed staff work in order to meet the requirement.

10. **If the ATS is not present at the face-to-face examination with the therapist or physiatrist, but does assess the patient "in-person" prior to or following the evaluation by the LCMP, such as during the home evaluation, does this fulfill the requirement for "involvement with the selection process"?**
If the ATS has direct contact with the patient and has taken part in the wheelchair selection process, the requirement is met, providing the ATS interaction is clearly documented within the patient's file. If the ATS has not had direct in-person involvement in the wheelchair selection process and simply delivers the ordered product, the requirement is not met and the KX modifier must NOT be added to the code.

    Since the purpose of the ATS role is to assure that the equipment selected is appropriate to address the medical needs identified during the face-to-face examination process, it would be inappropriate to begin product selection prior to completion of the face-to-face examination. Any in-person ATS/beneficiary interactions prior to the face-to-face examination would not be considered sufficient to meet the LCD requirement.

11. **An ATS candidate has taken the RESNA exam but as of April 1, 2008, has not yet received the credential. In the event of an audit, will the pending receipt of the ATS credential, retroactively dated to the day the test was taken, be considered compliant?**
For a rehab power WC that is delivered on or after April 1, 2008, there must have been an evaluation by a properly credentialed, supplier-employed ATS. The ATS must have been certified as of the date he/she performed the in-person evaluation of the patient. The ATS is not a credentialed ATS until receipt of the credential from RESNA. RESNA document will specify the effective date of the credential.

    - Example #1 - PT takes ATS exam on March 1, 2008. PT evaluates patient on March 15, 2008. PMD is delivered on April 2, 2008. RESNA notifies PT on April 15, 2008, that he/she passed exam and was credentialed as an ATP as of March 1, 2008 (the date of the exam). If the supplier submits the claim prior to April 15, 2008, then a KX modifier must not be used because the result of the credentialing exam was not yet known. However, if the supplier files the claim after April 15, 2008, then the KX modifier may be added to the code (if all other criteria are also met).
    - Example #2 - PT evaluates patient on March 1, 2008. PT takes the exam on March 15, 2008. Even if the PT is notified that he/she passed the exam and was credentialed as of March 15, 2008, the KX modifier cannot be added to the claim line because the PT was not credentialed by RESNA as of the date of the evaluation (March 1, 2008).

12. **Will a supplier, that does not have an ATS on staff as of April 1, 2008, who provides a PMD requiring this credential, be in compliance with the LCD?**
No. As outlined in the Power Mobility Devices LCD, claims for Group 2 SPO or MPO, Group 3, Group 4, Group 5 and push-rim activated power assist chairs with dates of service (DOS) on or after April 1, 2008, must meet the requirement that a RESNA certified ATS has direct in-person involvement in the wheelchair selection process. In this scenario, the wheelchair would not meet coverage criteria and a KX modifier must NOT be added to the code.

13. **If an ATS employed by a supplier who has had direct in-person involvement in the wheelchair selection process for a patient leaves a company before the wheelchair is delivered, will the claim be considered compliant?**
Leaving the company employment would not invalidate what that person did while working as a RESNA certified ATS. The patient's record must illustrate the previously employed ATS had in-person involvement with the wheelchair selection process.

14. **Can an ATP involved in the face-to-face examination process required for all PMDs or the specialty evaluation required for rehab power wheelchairs also perform the functions of the ATS for the supplier of Group 2 SPO or MPO, Group 3, Group 4, Group 5 and push-rim activated power assist chairs?**
For an ATP involved in the face-to-face examination or specialty evaluation process, it would be a conflict-of-interest to perform functions that meet the supplier requirements for an ATS to have direct in-person involvement in the Group 2 SPO or MPO, Group 3, Group 4, Group 5, and push-rim activated power assist chairs selection process.

15. **Will the ATS have to do the evaluation in person or can an evaluation be videotaped? Alternatively, if the ATS participated in the evaluation by means of a live video feed, would that be acceptable?**
Review of a live video feed or videotaped "evaluation" would NOT meet the requirements of the policy. The "direct, in-person involvement" requirement means just that - a live, in-person, interaction between the ATS and the beneficiary addressing the selection of the actual equipment to be provided is required. The goal is to assure that the items selected are those that are most appropriate to address the beneficiary's needs. Remote or indirect interactions are not considered sufficient to meet the requirement.

Documentation Requirements for Power Wheelchair Advance Determination of Medicare Coverage

The Medical Review Department has noted that some suppliers are not providing complete information when submitting Advance Determination of Medicare Coverage (ADMC) requests. It is helpful when all the documentation as outlined in the Power Mobility Devices' (PMD) Local Coverage Determination (L23598) and Policy Article (A41127), is submitted with an ADMC request to prevent a negative determination related to missing information.

Face-To-Face Examination:
Physicians shall document the face-to-face in a detailed narrative note in their charts in the format that they use for other entries. The note must clearly indicate that a major reason for the visit was a mobility examination.

The treating physician must conduct a face-to-face examination of the patient before writing the order. The face-to-face examination should answer the following questions:

- What is this patient's mobility limitation and how does it interfere with the performance of activities of daily living?
- Why can't a cane or walker meet this patient's mobility needs in the home?
- Why can't a manual wheelchair meet this patient's mobility needs in the home?
- Does this patient have the physical and mental abilities to transfer into a Power Operated Vehicle (POV) and to operate it safely in the home?
- Does this patient have the physical and mental abilities to operate a power wheelchair safely in the home?
- Why can't a POV meet this patient's mobility needs in the home?

The face-to-face should provide information about the following elements. Each element would not have to be addressed in every evaluation, however, please keep in mind that the more information provided with the ADMC request the more efficiently and timely the request can be completed.

- Symptoms
- Related diagnoses
- History
- How long the condition has been present
- Clinical progression
- Interventions that have been tried and the results
- Past use of walker, manual wheelchair, POV, or power wheelchair (PWC) and the results
- Physical exam
- Beneficiary's height and weight
- Impairment of strength, range of motion, sensation, or coordination of arms and legs
- Presence of abnormal tone or deformity of arms, legs, or trunk
- Neck, trunk, and pelvic posture and flexibility
- Sitting and standing balance
- Functional assessment – any problems with performing the following activities including the need to use a cane, walker, or the assistance of another person
    - Transferring between a bed, chair, and PMD
    - Walking around their home – to bathroom, kitchen, living room, etc. – provide information on distance walked, speed and balance

If the POV or PWC is a replacement during the five-year useful lifetime of an item in the same performance group that was previously covered by Medicare, a face-to-face examination is not required per the Policy Article.

The physician may refer the patient to a licensed/certified medical professional (LCMP), such as a physical therapist (PT) or occupational therapist (OT), which has experience and training in mobility evaluations to perform **part** of the face-to-face examination. Once the physician has received and reviewed the written report of this examination, the physician **must see the patient** and perform any additional examination that is needed. The report of the physician's visit shall state concurrence or any disagreement with the LCMP examination.

A LCMP completes part of the face-to-face and there must be a signed and dated attestation by the supplier that the LCMP has no financial relationship with the supplier.

Many suppliers have created forms, which they send to physicians and ask them to complete. Even if the physician completes this type of form and puts it in the patient's chart, it is **not** a substitute for the comprehensive medical record or written order as noted above.

Order:
The supplier must receive a written order from the treating physician for a wheelchair of any kind. For a PWC an order must be completed within 45 days after completion of the face-to-face examination. The order must contain all of the following elements:

- Beneficiary's name
- Description of the item that is being ordered. This may be general (e.g., power operated vehicle, power wheelchair, or power mobility device, or may be more specific)
- Date of the face-to-face examination
- Pertinent diagnoses/conditions that relate to the need for the POV or power wheelchair
- Length of need
- Physician's signature
- Date of physician signature

The supplier needs to use a date stamp or equivalent to document receipt date of the physician's order.

A detailed product description created by the supplier and signed by the physician cannot be considered the order. Suppliers cannot create, prescribe or write orders for wheelchairs.

Detailed Product Description:
Once the supplier has determined the power mobility device that is appropriate for the patient based on the physician's order, the supplier must prepare a written detailed product description that needs to contain the following information:

- Specific base (HCPCS) code and codes for each accessory
- Narrative description of the item or the manufacturer name/model
- List of options and accessories that will be separately billed. (The supplier needs to include each charge and the Medicare fee schedule allowance for each separately billed item; if there is no fee schedule allowance, the supplier must enter "not applicable").

The physician must sign and date this detailed product description. Once the supplier receives the signed product description, a date stamp or equivalent shall be placed on the document, prior to delivery of the PWC or POV.

Specialty Evaluation:
A specialty evaluation, performed by a PT, OT or rehab specialist, **is required, in addition to** the requirement for the face-to-face examination by the physician, for patients who receive:

- Group 2 Single Power Option PWC
- Group 2 Multiple Power Options PWC
- Any Group 3 or Group 4 PWC
- Push-rim activated power assist device

The specialty evaluation needs to provide the following information and accompany the ADMC request:

- How the option or accessory will assist the patient in their mobility needs
- Medical necessity for each accessory requested
- Detailed information explaining why each specific option or accessory (i.e., elevating leg rests, multi axis head rest, tilt/recline, height adjustable arm rests, or push-rim activated power assist) is needed to address the patient's mobility limitation

Home Assessment:
The supplier or practitioner must perform an on-site evaluation of the patient's home prior to or at the time of delivery of a POV or PWC. The home assessment needs to provide the following information.

Can the patient adequately maneuver the device that is provided considering physical layout, doorway width, doorway thresholds, and surfaces?

Attestation Statement:
This statement confirms that the supplier has no financial relationship with the PT, OT, rehab specialist, or medical personnel involved.