Jurisdiction D News from Noridian Administrative Services, LLC.

Happenings

November 2008
Issue No. 17

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

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Jurisdiction D DME MAC Supplier Contacts and Resources

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

Web site: www.noridianmedicare.com

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

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

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

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

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

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
Christmas Eve**	December 24, 2008
Christmas Day	December 25, 2008
** Partial day closure Supplier Contact Center open from 8:00 am - 12:00 pm CT.	

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."

Same and Similar Inquiries to the Contact Center

Effective November 3, 2008, the process of checking same and similar through the contact center telephone line will be changing. Suppliers must provide the HCPCS they intend to bill before information on same or similar equipment will be released. This is being changed to be consistent with the functionality of the Interactive Voice Response (IVR) system.

To request same or similar information from the contact center, the following information will be needed:

- Supplier's National Provider Identifier (NPI)
- Supplier's Provider Transaction Access Number (PTAN)
- Patient's Medicare number
- Patient's first and last name
- Patient's date of birth
- HCPCS of equipment being provided

CMS requires all contractors to use self service technology such as the IVR to respond to suppliers inquiries. By utilizing this automated system, the Supplier Contact Center can be available to help you with questions that require more detailed personal assistance.

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 6 am - 6 pm CT, whereas the contact center hours are 8 am - 5:30 pm CT.

For more information regarding same and similar inquires on the IVR, see Interactive Voice Response Enhancements posted to What's New on May 19, 2008.

For more information regarding same and similar inquiries on the IVR, see Interactive Voice Response Enhancements, posted to What's New on May 19, 2008.

Quarterly Provider Updates

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

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

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

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

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

SCAM ALERT-Arthritis Kits-From SafeGuard Services LLC

It has come to our attention that a few unscrupulous suppliers of Durable Medical Equipment Prosthetic, Orthotics, and Supplies (DMEPOS) are advertising "Medicare Approved Arthritis Kits" at no charge to the beneficiaries. **THIS IS A SCAM!** Medicare has not approved "Arthritis Kits" nor has Medicare approved an unconditional waiver of the 20% co-payment.

If you are approached by any person requesting that you sign a prescription for an "Arthritis Kit" or multiple braces (orthotics), or if hear that this has occurred, contact the Jurisdiction D DME Supplier Contact Center by one of the following methods:

- By Phone: 1-866-243-7272
- By Mail: Noridian Administrative Services
  PO Box 6736
  Fargo ND 58108-6736

These kits are advertised as consisting of multiple upper and lower limb orthotics, a spinal orthotic, and sometimes a heating pad or heat lamp. These advertisements claim these kits are designed to eliminate or reduce the pain that arthritis sufferers may have in all areas of their body, such as the hands, wrists, elbows, shoulders, back and knees. There have been advertisements geared to solicit independent contractors to promote the arthritis kits by offering $100 to $300 for each kit billed to and paid by Medicare. These advertisers claim that 80% to 85% of the physicians WILL sign the prescriptions, which is needed to bill Medicare.

In order for an orthosis to be covered by Medicare, it must be a rigid or semi-rigid device that is used for the purpose of supporting a weak or deformed body member or restricting or eliminating motion in a diseased or injured part of the body. An orthosis can be either prefabricated or custom fabricated. Covered orthotics must be reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member. Payment is prohibited for medical services that are for prevention, palliation, research or experimentation. For more information on Medicare's coverage guidelines for orthotics please visit www.noridianmedicare.com/dme/coverage/lcd.html.

Thank you for your care of Medicare beneficiaries and your cooperation in protecting the Medicare Trust Fund.

Influenza Pandemic Emergency -- Policies Concerning the Medicare Program

MLN Matters Number: MM6164 Revised
Related Change Request (CR) #: 6164
Related CR Release Date: September 26, 2008 Related CR Transmittal #: R379OTN
Effective Date: October 27, 2008 (for preparedness)
Implementation Date: October 27, 2008 (for preparedness)

Note: This article was rescinded on October 20, 2008. It was replaced by a Special Edition (SE) article SE0836, which may be found at www.cms.hhs.gov/MLNMattersArticles/downloads/SE0836.pdf on the CMS Web site.

Influenza Pandemic Emergency - The Medicare Program Prepares

MLN Matters Number: SE0836

Provider Types Affected

In the event of a pandemic flu, all physicians and providers who submit claims to Medicare Part C or Part D plans or to Medicare contractors (Medicare Administrative Contractors (A/B MACs), fiscal intermediaries (FIs), Durable Medical Equipment Medicare Administrative Contractors (DME MACs), carriers or Regional Home Health Intermediaries (RHHIs)) for services provided to Medicare beneficiaries.

Impact on Providers

This article is informational only and is alerting providers that the Centers for Medicare & Medicaid Services (CMS) has begun preparing emergency policies and procedures that may be implemented in the event of a pandemic or national emergency.

Background

As part of its preparedness efforts for influenza pandemic, CMS has begun developing certain emergency policies and procedures that **may** be implemented for the Medicare program in the event of a pandemic or other emergency.

Decision to implement would occur if:

1. The President declares an emergency or disaster under the National Emergencies Act or the Stafford Act; and
2. The Secretary of the Department of Health and Human Services declares – under Section 319 of the Public Health Service Act – that a public health emergency exists; and
3. The Secretary elects to waive one or more requirements of Title XVIII of the Social Security Act (Act) pursuant to Section 1135 of such Act.

In the event of a pandemic or other national emergency, CMS will issue communications to Medicare providers to specify which policies and procedures will be implemented and other relevant information.

This article includes links to policy documents that have been released by CMS. As additional policy becomes available,

FYI CONT'D

CMS will revise this article to include links to all available influenza pandemic policy documents.

Dedicated CMS Web Page Now Available

Providers should be aware that all relevant materials will be posted on a CMS dedicated "Pandemic Flu" Web page at www.cms.hhs.gov/Emergency/10_PandemicFlu.asp on the CMS Web site. That page will contain all important information providers need to know in the event of an influenza pandemic, including the policy documents discussed above.

Additional Information

Existing CMS Influenza Pandemic Policy Documents:

CR 6164 can be found at www.cms.hhs.gov/Transmittals/downloads/R379OTN.pdf on the CMS Web site.

EDUCATIONAL

Ask the Contractor Teleconference – December 10, 2008

NAS is pleased to announce the next Ask the Contractor Teleconference on December 10, 2008. We will be continuing with our current format of brief opening remarks followed by the question and answer (Q&A) session.

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

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

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

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

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

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

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

Top Ten Written Inquiries

The top written inquiries for July through September 2008 are listed below along with tips and reminders about submitting these requests. The NAS DME Web site is a great tool to keep you informed as well as our email list. Sign up today!

1. **Medical Review**

   Pay close attention to the denial on your remittance advice. If the denial is not for medical necessity, you are unable to appeal the decision and must do a reopening. However, if you receive a medical necessity denial on a claim, you have the option to submit a written signed request to appeal the decision. If you make this choice, NAS recommends using the "DME Inquiry/Redetermination" interactive form located on our Web site and submitting it along with the appropriate medical documentation supporting the need for the item to:

   Noridian Administrative Services
   Attn: DME Redeterminations
   PO Box 6727
   Fargo ND 58108-6727

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

   If you receive a medical necessity denial due to a minor error, such as forgetting to append the KX modifier, you can do a reopening.

   For a complete list of remittance advice remark codes, please visit the Washington Publishing Company (WPC) Web site.

   If you need help understanding the remittance advice, reference the Remittance Advice Guide.

2. **Issue not Identified/Incomplete Information**

   When sending inquiries to NAS, clearly state the question. This will ensure we have all of the information needed to answer the request. If information is submitted without a specific request, a letter will be sent indicating the inquiry was incomplete, causing a delay in receiving your response.

   NAS also receives letters stating an item is medically necessary with no Health Insurance Claim Number (HICN), no appeals request, Date of Service (DOS), etc. We also receive Certificates of Medical Necessity (CMN) with nothing else included. Please ensure you provide the appropriate information so the inquiry can be completed. Lack of required information may also cause a delay in processing.

3. **Claim Documentation**

   Be sure to use the most current version of the CMN if it is required for your HCPCS code. When a new version of the CMN is effective, the old form is unable to be submitted electronically.

4. **Claim Information Change**

   This is a reminder to send in the CMN, when needed, with claim submission. Uploading CMNs after claim submission will delay the process of your claim.

Double check the information you are providing is correct including the date of service, procedure code, modifiers, etc. Remember to have all pertinent information with your claim at the time of submission to avoid having to request a reopening or redetermination.

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

- Date of Service (within same year)
- Place of Service
- HCPCS Codes
- Diagnoses
- Modifiers (with the exception of GA, GY or GZ which changes liability)
- Number of Services
- Billed Amount

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

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

5. Misrouted Written Correspondence

Supplier enrollment information as well as proof of insurance must be sent directly to the National Supplier Clearinghouse.

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

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

If you submit claims or send correspondence to Part B, use the appropriate Part B PO Box for those items. DME items and Part B items should never be intermixed. If you are not aware of the correct Part B PO Box numbers, they can be located on the NAS Web site under Part B and whichever state for which you have an interest. Also, we have been seeing suppliers submit refunds using either the Part B Refunds to Medicare form or the DME Inquiry / Redetermination form. Please make sure you are submitting the correct form so processing is not delayed.

6. Other Issues

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

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

7. Filing/Billing Instructions

If you are unsure how to bill or file your claim, sending in a copy of an invoice or returning an education status letter asking for NAS to make payment, is not the appropriate procedure in getting your claims paid timely.

If you bill electronically, please visit the CEDI Web site for further information.

If you are exempt from billing electronically and bill on a paper CMS-1500 claim form, please reference the Claims tab on our Web site for appropriate information.

8. Benefits/Exclusions/Coverage Criteria Rules

Suppliers are encouraged to reference the LCD and Policy Article for specific policy coverage criteria. The LCDs can be accessed from the Coverage/MR page on our DME Web site. Select "Local Coverage Determinations (LCDs)" followed by Current LCDs or Current Articles.

The following Web sites are also great resources for information regarding Medicare:

- DME MAC Jurisdiction D Online Supplier Manual
- Internet Only Manuals (IOMs)
- Medical Coding Database

9. Duplicate Remittance

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

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

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

For additional information on downloading MREP, contact the CEDI Help Desk. The CEDI Help Desk will provide support for electronic transactions exchanged with CEDI including claims, reports, ERAs and 276/277 transactions.

E-mail: NGS.CEDIHelpdesk@wellpoint.com
Phone: 866-311-9184
CEDI Web site: www.ngscedi.com

Many electronic claim billing software programs will have a feature that allows for an electronic remittance advice to be received electronically, printed and/or posted the payment information to each beneficiary's account. Contact your software vendor for the availability of these features.

Remember that CEDI only keeps a copy of remittance advices for 45 days so ensure that you are pulling remittance advices timely from your electronic mailbox.

10. Approved to Pay Amount/Check Information

Requests are being received at NAS for payment of claims (reopening or redetermination) that have already been paid. Ensure the claim has not been paid before sending a reopening or redetermination request by calling the IVR at 877-320-0390 for claim status.

MLN Products Catalog

The Medicare Learning Network (MLN) is the brand name for official CMS national FFS health care professional education products. The MLN is designed to promote national consistency of Medicare information developed for CMS initiatives. Most importantly, it is available to help you!

The MLN Products Catalog is now an interactive downloadable document that lists all MLN products by media format. The catalog has been revised to provide new customer-friendly links that are embedded within the document. All product titles and the word "download", when selected, will link you to the online version of the product. The word "hard copy", when selected, will automatically link you to the MLN Product Ordering page.

The Catalog is updated quarterly and the latest version is now available for download at www.cms.hhs.gov/MLNProducts/downloads/MLNCatalog.pdf on the CMS Web site.

Each quarter the MLN will send out information on the latest products available to order. Please be on the lookout for those updates!

For more information on The Medicare Learning Network, please visit www.cms.hhs.gov/MLNGenInfo on the Internet.

CMS Announces MLN Learning Management System Now Available

The Medicare Learning Network's (MLN) Learning Management System (LMS) that hosts our web-based training courses and product ordering page is now available and has a new look. All of your certificates and product ordering history is still available and you can use your same user id and password. There is no need to register again. If you have any questions, please send them to MLN@cms.hhs.gov.

To access the system go to www.cms.hhs.gov/MLNProducts and click on web-based training modules or MLN product ordering page at the bottom of the page.

Thank you for your patience while CMS was upgrading the system.

Revised Medicare Physician Guide

The revised **Medicare Physician Guide: A Resource for Residents, Practicing Physicians, and Other Health Care Professionals** (October 2008), which offers general information about the Medicare Program, becoming a Medicare provider or supplier, Medicare reimbursement, Medicare payment policies, evaluation and management services, protecting the Medicare Trust Fund, inquiries, overpayments, and appeals, is now available in downloadable format from the Centers for Medicare & Medicaid Services **Medicare Learning Network** at www.cms.hhs.gov/MLNProducts/downloads/physicianguide.pdf.

Updated CEDI Approved Vendor List is Now Available

National Government Services, Common Electronic Data Interchange (CEDI) updated the Approved Vendor List located on the CEDI Web site. The Approved Vendor List provides contact information for all software vendors, billing services, clearinghouses and network service vendors that have completed testing with CEDI. The updated list is available on the Resource Materials page and can be accessed using the following link www.ngscedi.com/outreach_materials/outreachindex.htm.

As a reminder, the following documents are also available on the Resource Materials page:

CEDI Frequently Asked Questions - This document includes frequently asked questions received by CEDI from the DME MAC supplier community.

CEDI Front End Reports Manual - Provides a description of the CEDI reports, instructions on what to do when the report is received and report examples. CEDI reports include the TA1, TRN, 997 and GenResponse.

DME MAC Front End Edit Error Code Manual - Provides all DME MAC Level II (RPT Reports) front-end error codes, including the edit number, description, segment ID and edit explanations. This manual also includes information on the CMN Reject Report.

NCPDP Error Code Manual – Provides the NCPDP error codes, including the edit number, description, segment ID and edit explanations.

DME MAC Express Plus Manual – Detailed instructions on how to use the Express Plus software program.

PC-ACE Pro32 User Guide – Detailed instructions on how to use the PC-ACE Pro32 software program.

Claims (837) Transaction Flows – Provides a layout of what happens to ANSI X12 837 formatted electronic claims submitted to CEDI. (The lifecycle of an ANSI 837 electronic claim.)

Claims (NCPDP) Transaction Flows – Provides a layout of what happens to an electronic NCPDP formatted claim submitted to CEDI. (The lifecycle of an NCPDP electronic claim.)

276/277 Transaction Flows – Provides a layout of what happens to a 276 claim status inquiry transaction submitted to CEDI and the 277 claim status response returned from the DME MAC Jurisdiction through CEDI. (The lifecycle of an ANSI 276 claim status transaction.)

The Resource Materials page and can be accessed using the following link www.ngscedi.com/outreach_materials/outreachindex.htm.

CEDI Front End Update – No Longer Experiencing Delays

As of October 14, 2008 the Common Electronic Data Interchange (CEDI) system is no longer experiencing delays in processing inbound files received from trading partners.

All inbound files received since October 6, 2008 have been processed, delivered to the DME MACs and all front-end reports have been delivered back to the Trading Partner's CEDI mailbox. All claim files delivered were stamped with the receipt date of the file at CEDI. Any delay in the delivery of the files to the DME MACs did not affect the date of receipt on the claims submitted and will not affect the payment floor of these claims.

Note: DME MAC suppliers may receive duplicate claim denials on some of the electronic claims submitted to CEDI from October 6 through October 13, 2008. If CEDI was in the process of re-batching claims to deliver to the DME MACs and the re-batch did not complete properly, all claims were re-batched and delivered again. This would cause some claims to be delivered to a DME MAC twice and suppliers would see duplicate claims denials. We apologize for any inconvenience this may cause.

Most of the additional front end edits added to CEDI on October 6 have been turned off. The DME MACs will continue to perform their Level II edits and these will continue to be returned on the "RPT" report delivered by CEDI to the Trading Partners.

Please note the following edits are still in place at CEDI on the GenResponse (GENRPT) report:

NGS005	C007	C065	C087	C125	C143
NGS006	C015	C072	C088	C131	C147
NGS008	C055	C077	C089	C137	C154
B108	C060	C086	C090	C141	

* More detailed information on the edits listed above is available in the CEDI Front End Reports Manual on the CEDI Web site (www.ngscedi.com) under Resource Materials.

National Government Services has also identified the following CEDI edits to be modified before they are put back into production on the CEDI front end.

A215	C011	C124
A525	C017	C171
A549	C044	C182
C003	C111	C187
C008	C122	C190

If you received any of the edits above during the week of October 6 – 10, 2008, you can resubmit those claims. If the claim passes the CEDI front end edits, it will be delivered to the DME MACs for processing against the DME MAC Level II edits.

CEDI Front End Edit Update – Changes Effective October 6, 2008 and Mid-November

Effective October 6, 2008, the following changes are in effect for the electronic front-end reports returned to Trading Partners from CEDI:

- Additional front-end edits will be added to the current CEDI GenResponse (GENRPT) report.
  Note: The CEDI *Error Code Manual* is available from the CEDI Web site at: www.ngscedi.com/outreach_materials/CEDIFrontEndReportsManual.pdf
- Claims accepted on the CEDI GenResponse Report will be delivered to the appropriate DME MAC.
- Claims delivered to the DME MAC will continue to edit against the DME MAC Level II edits as they do currently.
- Claims accepted on the DME MAC Level II reports will be assigned a Claim Control Number (CCN) that will be attached to the claim as it enters the DME MAC for processing.
- Level II reports created by the DME MACs will continue to be delivered back to the Trading Partners through CEDI.
- Most, if not all, claims that reject will be returned on the GenResponse Report. It will be extremely important for Trading Partners to monitor the GenResponse Report for rejected claims in order to correct and resubmit the claims to CEDI.

Effective Mid-November 2008 the following changes will occur:

- All electronic front-end claim editing will be done through CEDI and all front end rejections will be returned on the CEDI GenResponse (GENRPT) Report.
- The additional GenResponse edits that were implemented on October 6, 2008 will replace the DME MAC Level II edits and Trading Partners will no longer receive Level II reports from the DME MACs.
- Claims accepted on the GenResponse Report will be assigned a Claim Control (CCN) and these will be indicated on a report that will go back to the Trading Partner from CEDI. This CCN will be attached to the claim as it enters the appropriate DME MAC for processing.
- DME MACs will continue to produce the CMN Reject and this report will be returned to Trading Partners through CEDI.

CEDI is monitoring the DME MAC Level II reports to identify any claims that should have rejected with the new

CEDI CONT'D

CEDI front end edits and make any modifications to the CEDI front end edits.

CEDI is also monitoring the CEDI front end rejections to identify any situations where a CEDI front end edit has inappropriately caused a claim to reject. As part of this monitoring, CEDI has identified an issue with the edits listed below and turned off these edits so that they did not go into effect on October 6, 2008.

Claims that would have rejected at CEDI with an edit below will receive the rejection on the DME MAC Level II report, if the claim does not reject at CEDI with other edits. CEDI is currently planning to have the updated logic implemented and will turn on these edits on Sunday, October 19, 2008.

The following are the CEDI edits and the related DME MAC edit number:

CEDI	DME MAC
C172	40022
C173	40023
C174	40024
C175	40094
C177	40026
C178	40095
C179	40036
C180	40037
C181	40073
C183	40052
C184	40086
C185	40087
C186	40093
C188	40066

Only CEDI On-Line Enrollment Forms Accepted for Setup Requests and Additional CEDI Form Information

Effective October 1, 2008, National Government Services, Common Electronic Data Interchange (CEDI) will only accept the on-line CEDI enrollment forms for all EDI setup requests handled by CEDI. Any EDI enrollment forms developed and used by the DME MAC Jurisdictions prior to the CEDI transition will not be accepted by CEDI on or after October 1, 2008 and will be returned.

Note: This does not apply to Claim Status Inquiry (CSI) and Electronic Funds Transfer (EFT) setups. CSI and EFT setups are accepted and processed by the DME MAC Jurisdictions. All other EDI setup requests go to CEDI.

CEDI Enrollment Instructions:

CEDI enrollment documents are completed and submitted online. To comply with CMS requirements, these documents must also be printed, signed, and faxed to the CEDI electronic fax system. After completing any of the online forms, click on the "Submit" button, print, sign and fax the form to the number located on the printed form.

The following documents are required and must be completed for every new DME MAC Electronic Data Interchange (EDI) Trading Partner (Submitter).

- CMS EDI Enrollment Agreement
- Supplier Submitter Action Request Form

All CEDI online enrollment forms can be accessed using the following link: www.ngscedi.com/forms/formsindex.htm.

The fax number is: 315-442-4299

The CEDI Submitter Action Request Form is to request a Trading Partner ID for a new submitter and indicate the transactions the Trading Partner will be exchanging with CEDI. The form is then faxed to CEDI for processing.

Existing Trading Partners will use the Submitter Action Request Form to request the addition of a new transaction. For example, if a supplier is currently only submitting electronic claims and wants to begin receiving an electronic remittance advice, the CEDI Submitter Action Request form is completed by filling in the requested information and checking the box for the 835 Electronic Remittance Advice (ERA). The form is then faxed to CEDI for processing.

The CEDI Submitter Action Request Form should also be used to order the Express Plus software program. To order the Express Plus software, click on the box under Section II, titled, "Order the CEDI Free Software Program (Express Plus)."

The Supplier Authorization Form must be completed for any supplier who will be using a Clearinghouse, Billing Service or other Third Party to exchange any transactions with CEDI. This includes claims, 835 Electronic Remittance Advice (ERA), and/or the 276/277 transactions.

CEDI Publishes Two New Articles

National Government Services has important CEDI News to share. Please view the CEDI News item(s) listed at www.ngscedi.com and select "News" from the bulleted list of links.

The new article(s) is/are entitled:

- The Online CEDI Enrollment Forms are Now Available
- Updated FAQ Document Available on the CEDI Web Site

ACCREDITATION

CMS Provides Guidance on DMEPOS Accreditation for Pharmacy Suppliers

On September 3, 2008, the Centers for Medicare & Medicaid Services (CMS) announced a list of Durable Medical Equipment Prosthetics/Orthotics, and Supplies (DMEPOS) providers that were exempt from meeting the quality standards for DMEPOS accreditation. CMS would like to clarify that pharmacists and pharmacies were not included in this provider exemption and do need to obtain accreditation. For example, if a pharmacy is providing DMEPOS supplies to Medicare beneficiaries, such as diabetic supplies and enteral/parenteral nutrition, they would need to be accredited by the September 30, 2009 deadline. For more information about DMEPOS Accreditation, please visit the web page at www.cms.hhs.gov/medicareprovidersupenroll/.

COMPETETIVE BIDDING

Medicare Solicits Nominees for Advisory Panel for Next Phase of DME Competitive Bidding Program

Members to Provide Guidance on Operational Issues

The Centers for Medicare & Medicaid Services (CMS) is soliciting nominations for individuals to serve on the Program Advisory and Oversight Committee (PAOC) that advises CMS on various issues relating to the competitive bidding program for durable medical equipment, prosthetics, orthotics and supplies (DMEPOS).

The PAOC was initially established in 2004, as required by the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), to advise CMS on the design and implementation of a competitive bidding program for DMEPOS that would build on the successes of two pilot projects that had shown that competitive bidding could reduce prices of DMEPOS without adversely affecting beneficiary access or compromising quality.

Because the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) delayed implementation of and made certain changes to the competitive bidding program, and extended the PAOC for two years through December 31, 2011, CMS is ending the term of service for current PAOC members.

The PAOC will be comprised of 10 and 12 members from the following broad categories:

- Beneficiary/consumer representatives;
- Physicians and other practitioners;
- Suppliers;
- Professional standards organizations;
- Financial standards specialists (that is, economist/certified public accountant); and
- Association representatives.

CMS may consider nominees for additional categories if it finds that their expertise will help to ensure the successful implementation of the program

Nominations are due to CMS by November 3, 2008. For more information, please see the CMS Web site at: www.cms.hhs.gov/center/dme.asp

To read the CMS press release issued on October 1, 2008, click here: www.cms.hhs.gov/apps/media/press_releases.asp

RAC

CMS Enhances Program Integrity Efforts to Fight Fraud, Waste and Abuse in Medicare

The Centers for Medicare & Medicaid Services (CMS) announced aggressive new steps to find and prevent waste, fraud and abuse in Medicare. CMS is working closer with beneficiaries and providers; consolidating its fraud detection efforts; strengthening its oversight of medical equipment suppliers and home health agencies; and launching the national recovery audit contractor (RAC) program.

"Because Medicare pays for medical services and items without looking behind every claim, the potential for waste, fraud and abuse is high," said CMS Acting Administrator Kerry Weems. "By enhancing our oversight efforts we can better ensure that Medicare dollars are being used to pay for equipment or services that beneficiaries actually received while protecting them and the Medicare trust fund from unscrupulous providers and suppliers."

As part of these enhanced efforts, CMS is consolidating its efforts with new program integrity contractors that will look at billing trends and patterns across Medicare. They will focus on companies and individuals whose billings for Medicare services are higher than the majority of providers and suppliers in the community. CMS is also shifting its traditional approach to fighting fraud by working directly with beneficiaries by ensuring they received the durable medical equipment or home health services for which Medicare was billed and that the items or services were medically necessary.

Furthermore, CMS will be taking additional steps to fight fraud and abuse in home health agencies in Florida and suppliers of durable medical equipment, prosthetics and orthotics (DMEPOS) in Florida, California, Texas, Illinois, Michigan, North Carolina and New York. Those additional steps include:

- Conducting more stringent reviews of new DMEPOS suppliers' applications including background checks to ensure that a principal, owner or managing owner has not been suspended by Medicare;
- Making unannounced site visits to double check that suppliers and home health agencies are actually in business;
- Implementing extensive pre- and post-payment review of claims submitted by suppliers, home health agencies and ordering or referring physicians;
- Validating claims submitted by physicians who order a high number of certain items or services by sending follow-up letters to these physicians;
- Verifying the relationship between physicians who order a large volume of DMEPOS equipment or supplies or home health visits and the beneficiaries for whom they ordered these services;
- Identifying and visiting high risk beneficiaries to ensure they are appropriately receiving the items and services for which Medicare is being billed.

The additional reviews that will be focused on DMEPOS equipment and supplies with high expenditures and high growth rates expect to identify items such as oxygen supplies

and equipment, power mobility devices or power wheelchairs, and diabetic test strips.

For those claims not reviewed before payment is made, CMS is implementing further medical review of submitted DMEPOS claims by one of the new RACs. The RACs review paid claims for all Medicare Part A and B providers to ensure their claims meet Medicare statutory, regulatory and policy requirements and regulations. If the RACs find that any Medicare claim was paid improperly it will then request repayment from the provider if an overpayment was found or request that the provider is repaid if the claim was underpaid. The new national RACs can be found at www.cms.hhs.gov/RAC.

The new RACs were selected under a full and open competition and will begin to educate and inform providers later in October and November about the program. The RACs will be paid on a contingency fee basis on both the overpayments and underpayments they find. The selection of these new contractors was based on a best value determination that included a sound technical approach for the level and quality of claim analysis and detail to exceptional customer service, conflict of interest reviews and lowest contingency fee. The 3-year RAC demonstration program in California, Florida, New York, Massachusetts, South Carolina and Arizona collected over $900 million in overpayments and nearly $38 million in underpayments returned to health care providers.

Finally, CMS is consolidating the work of Medicare's program safeguard contractors (PSCs), and the Medicare Drug Integrity Contractors (MEDICs) with new Zone Program Integrity Contractors (ZPICs). The new contractors will eventually be responsible for ensuring the integrity of all Medicare-related claims under Parts A and B (hospital, skilled nursing, home health, provider and durable medical equipment claims), Part C (Medicare Advantage health plans), Part D (prescription drug plans) and coordination of Medicare-Medicaid data matches (Medi-Medi). The first two ZPIC contracts were awarded to Health Integrity, LLC for Zone 4 which encompasses Texas, New Mexico, Colorado and Oklahoma and SafeGuard Services LLC for Zone 7 which encompasses Florida, Puerto Rico and US Virgin Islands.

"We are continuing to build on our fraud fighting and program integrity efforts by identifying high risk areas and trends to better focus our limited funds and resources," said Weems.

Medicare is required by law to pay claims to health care providers for services provided to beneficiaries within 30 days after the claim is submitted, as long as the claim meets Medicare's rules. After the claim is paid, CMS or its contractors can review the claim to ensure that the items or services were actually provided or the services were medically necessary. If the claim was not submitted under Medicare's rules, CMS checks to see if the claim was submitted in error or may be potentially fraudulent. Those claims that could be fraudulent are referred to law enforcement for further investigation.

For more information about CMS RAC Web site, please visit: www.cms.hhs.gov/RAC/Downloads/RAC%20Expansion%20Schedule%20Web.pdf

To read the CMS Press release click here: www.cms.hhs.gov/apps/media/press_releases.asp

CMS Announces New Development Guidelines

As of October 6, 2008, DMEPOS suppliers will be required to respond to development requests made by the National Supplier Clearinghouse (NSC) within 30 days. Previously, a supplier had 60 days to return requested information or documentation that was missing for the continued processing of the CMS-855S. This change in the development time frame is in accordance with the Centers for Medicare & Medicaid Service publishing a final rule titled, "Appeals of CMS or CMS Contractor Determinations When a Provider or Supplier Fails to Meet the Requirements for Medicare Billing Privileges (CMS 6003-F)" in the Federal Register. This final rule directs Medicare contractors to reject an enrollment application when a provider or supplier fails to provide missing information or documentation within 30 days of a contractor's request for additional information. All applications/ changes of information that are received at the NSC prior to October 6, 2008 are subject to the 60-day development time frame. If a supplier's application is closed or the Medicare billing privileges are deactivated due to non-response of a development request, the supplier does not have appeal rights and must reapply to the NSC for Medicare billing privileges using the CMS-855S enrollment application.

DMEPOS Supplier Revocation Bar

On June 27, 2008, the Centers for Medicare & Medicaid Service published a final rule titled, "Appeals of CMS or CMS Contractor Determinations When a Provider or Supplier Fails to Meet the Requirements for Medicare Billing Privileges (CMS 6003-F)" in the Federal Register. This final rule establishes an enrollment bar for those providers and suppliers whose billing privileges are revoked. The enrollment bar will require that providers and suppliers whose billing privileges are revoked wait from **one to three years before reapplying to participate** in the Medicare program depending on the severity of the infraction. The National Supplier Clearinghouse is enforcing this rule. DMEPOS suppliers are reminded to adhere to the guidelines as outlined in the 25 Supplier Standards to ensure compliance and to avoid revocation. Specific information regarding debarment infractions will be provided as released by CMS.

Definition of Operational

Operational means the provider or supplier has a qualified physical practice location that remains open to the public and properly staffed during posted business hours for the purpose of providing health care related services. Further, the practice location must be prepared to submit valid Medicare claims, and equipped or stocked to furnish these items or services. The Centers for Medicare & Medicaid Services (CMS) does not consider the business to be operational if no one is available at the place of business during routine deliveries or off-site maintenance of supplies or products to Medicare beneficiaries.

OVERPAYMENTS

Submitting an Overpayment Rebuttal

A supplier may submit a rebuttal when they have good cause to believe that the Medicare contractor should not withhold claims payments to offset a recouped account receivable. A rebuttal is a request that the contractor not withhold claim payments: It is NOT an appeal of the overpayment itself.

Common reasons to submit a rebuttal may include, but are not limited to:

- A check has already been submitted for payment.
- The overpayment was created in error.
- The overpayment was created for a full, instead of a partial claim adjustment, and a clarification is included with the rebuttal statement.

The Recoupment team will review the rebuttal and respond to the supplier in writing.

Currently, there is no rebuttal form. A rebuttal may be requested as a business letter or memo. To ensure correct processing:

- Clearly indicate "Rebuttal" in the subject line or first sentence of the document and on the envelope.
- Clearly state the reason for the rebuttal and included any supporting documentation, i.e., cashed checks.
- Include a copy of the original overpayment letter with the rebuttal statement. If the original overpayment letter is not available, the following information may be included in the rebuttal itself:
  - Supplier's name;
  - NPI or PTAN number;
  - Account receivable number (also known as the DCN);
  - Beneficiary's HICN;
  - Date of service.

Mail rebuttals to:

Noridian Administrative Services
Attention: Rebuttals
PO Box 6728
Fargo ND 58108-6727

CERT

CERT Documentation

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

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

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

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

Mail all requested documentation to:

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

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

Suppliers may call the CDC at (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.

NPI

NPPES - Keeping It Safe and Keeping It Updated

This message is for health care providers, particularly physicians and other practitioners, who have obtained National Provider Identifiers (NPIs) and have records in the National Plan and Provider Enumeration System (NPPES). The Centers for Medicare & Medicaid Services (CMS) recommends that each health care provider, including individual physicians and non-physician practitioners:

- Know and maintain their NPPES User Ids and passwords.
- Reset their NPPES passwords at least once a year. See the NPPES Application Help page regarding the 'Reset Password' rules. Those rules indicate the length, format, content and requirements of NPPES passwords.
- Review their NPPES records in order to ensure that the information reflects current and correct information.

Maintaining NPPES Account Information for Safety and Accessibility

Health care providers, including physicians and non-physician practitioners, should maintain their own NPPES account information (i.e., User ID, Password, and Secret Question/Answer) for safety and accessibility purposes.

Viewing NPPES Information

Health care providers, including physicians and non-physician practitioners, can view their NPPES information in one of two ways:

1. By accessing the NPPES record at https://nppes.cms.hhs.gov/NPPES/Welcome.do and following the NPI hyperlink and selecting Login. The user will be prompted to enter the User ID and password that he/she previously created. *

   * If the health care provider has forgotten the password, enter the User ID and click the "Reset Forgotten Password" button to navigate to the Reset Password Page. If the health care provider enters an incorrect User ID and Password combination three times, the User ID will be disabled. Please contact the NPI Enumerator at 1-800-465-3203 if the account is disabled or if the health care provider has forgotten the User ID.

   OR

2. By accessing the NPI Registry at https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do. The NPI Registry gives the health care provider an online view of Freedom of Information Act (FOIA)-disclosable NPPES data. The health care provider can search for its information using the name or NPI as the criterion.

Updating NPPES Information

Health care providers, including physicians and non-physician practitioners, can correct, add, or delete information in their NPPES records by accessing their NPPES records at https://nppes.cms.hhs.gov/NPPES/Welcome.do and following the NPI hyperlink and selecting Login. The user will be prompted to enter the User ID and password that he/she previously created.

Please note: Required information cannot be deleted from an NPPES record; however, required information can be changed/updated to ensure that NPPES captures the correct information. Certain information is inaccessible via the web, thus requiring the change/update to be made via paper application. The paper NPI Application/Update Form can be downloaded and printed at www.cms.hhs.gov/cmsforms/downloads/CMS10114.pdf.

Need More Information?

Providers can apply for an NPI online at https://nppes.cms.hhs.gov or can call the NPI enumerator to request a paper application at 1-800-465-3203. Having trouble viewing any of the URLs in this message? If so, try to cut and paste any URL in this message into your web browser to view the intended information.

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

Non-acceptance of Legacy Provider Numbers on Incoming Medicare Claims

MLN Matters Number: SE0835

Provider Types Affected

Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs), including Regional Home Health Intermediaries (RHHIs), Part A/B Medicare Administrative Contractors (A/B MACs), and/or durable medical equipment MACs (DME MACs)) services provided to Medicare beneficiaries.

Provider Action Needed

With the implementation of the National Provider Identifier (NPI) on May 23, 2008, Medicare ceased accepting legacy provider numbers, qualified by 1C and 1G within the secondary provider REF segments, on incoming Medicare American National Standards Institute (ANSI) X12N 837 4010A1 claims. Effective October 6, 2008, providers should note that, with one qualified exception, as highlighted below, Medicare will reject all incoming Medicare X12N 837 4010A1 claims that contain legacy identifiers. The following qualifiers within the secondary provider REF loops are acceptable:

- For 837 institutional claims, the Employer Identification Number (EIN)/Federal Tax ID, qualified by "EI" or "TJ," will be accepted; and
- For 837 professional claims, the provider's EIN/Tax ID, qualified by "EI" or "TJ," or social security number, as qualified by "SY," will be accepted.

The secondary provider REF loops encompass all of the following loops within the HIPAA ANSI X12N 837 4010A1 institutional or professional format: 2010AA, 2010AB, 2310A, 2310B, 2310C, 2310D, 2310E, 2330D, 2330E, 2330F, 2330G, 2330H, 2420A, 2420B, 2420C, 2420D, 2420E and 2420F.

Therefore, providers that bill Medicare should only be including the above referenced values within the indicated secondary provider REF loops as appropriate for the line of business submitted. In addition, providers should only use values qualified by "EI," "TJ," and "SY" when valid for the loop submitted.

Exception: Providers that bill Veterans Administration (VA) demonstration claims to TrailBlazer Health Enterprises, LLC, are permitted to include Medicare legacy provider numbers, qualified by 1C and 1G, within the secondary REF fields highlighted above. In addition, Medicare does **not** require NPI qualifiers and values within the NM108 and NM109 segments of the above referenced loops for incoming VA demonstration code claims (also known as the VA Medicare Remittance Advice [VA MRA] project claims).

Providers and suppliers that have questions regarding these loops and/or qualifiers should contact their software vendor for further details.

Background

The Centers for Medicare & Medicaid Services (CMS) implemented the NPI as the primary provider identifier to

be used on Medicare claims effective May 23, 2008. Through the systematic actions that CMS is implementing on October 6, 2008, CMS will ensure that its objective of not accepting legacy provider numbers will be realized.

NPI for Secondary Providers

MLN Matters Number: MM6093 Revised
Related Change Request (CR) #: 6093
Related CR Release Date: October 15, 2008
Related CR Transmittal #: R270PI
Effective Date: May 23, 2008
Implementation Date: September 26, 2008
(FISS implementation date is November 3, 2008)

Note: This article was revised on October 19, 2008, to reflect changes to CR 6093, which CMS revised on October 15, 2008, to include the FISS in the business requirements. The FISS implementation date was also added. The CR release date, transmittal number, and the Web address for accessing CR6093 were also revised. All other information remains the same.

Provider Types Affected

All Medicare providers who submit claims to Medicare Carriers, Medicare Administrative Contractors (MACs), Durable Medical Equipment Medicare Administrative Contractors (DME MACs) and/or Fiscal Intermediaries (FIs) in which a secondary provider must be identified.

Provider Action Needed

This article is based on CR 6093 and outlines the need to use NPIs to identify secondary providers in Medicare claims beginning May 23, 2008.

Background

The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandate the adoption of a standard unique health identifier for each health care provider. The NPI final rule, published on January 23, 2004, establishes the NPI as this standard. All health care providers and entities covered under HIPAA must comply with the requirements of the NPI final rule (45 CFR Part 162, CMS- 0045-F).

Effective May 23, 2008, paper and electronic Medicare claims must contain NPIs to identify health care providers in their role as health care providers. (NPIs do not replace Taxpayer Identification Numbers, which identify health care providers in their role as taxpayers.)

Medicare claims always identify primary providers. Primary providers are the Billing and Pay-to Providers and, for non-institutional and non-pharmacy claims, the Rendering Provider.

Some Medicare claims also need to identify one or more secondary providers. A secondary provider could be a health care provider who ordered services for a Medicare patient or who referred a Medicare patient to another health care provider (ordering/referring providers); an attending, operating, supervising, purchased service, other, or service facility provider; or a prescriber (the latter only in retail pharmacy drug claims).

Prior to May 23, 2008, health care providers who ordered/referred were identified by Unique Physician Identification Numbers (UPINs). UPINs were assigned to physicians as defined in section 1861(r) of the Social Security Act, and to nurse practitioners, clinical nurse specialists, physician assistants, licensed clinical social workers, clinical psychologists, and certified nurse midwives—the only practitioners who are permitted by law to order/refer in the Medicare program. Medicare ceased assigning UPINs in June 2007 as part of the implementation of the NPI.

Note: CR6093 does not alter existing requirements for capturing the name and address, when required, of secondary providers or instructions that address the specific practitioner types that must be reported in certain referral and "incident to" situations. CR6093 instruction addresses only the reporting of the identifier for secondary providers, when required.

Key Points of CR6093

- When an identifier is reported on a paper or electronically submitted claim for a secondary provider (ordering, referring, attending, operating, supervising, purchased service, other, or service facility provider [in the X12N 837 claims transactions] or for prescriber [in the NCPDP 5.1 retail drug claim transactions]), that **identifier must be an NPI**.
- If the secondary provider (the ordering, referring, attending, operating, supervising, purchased service, other, or service facility provider [in the X12N 837 claims transactions] or for prescriber [in the NCPDP 5.1 retail drug claim transactions]) **does not furnish** its NPI at the time of the order/, referral, purchase, prescription, or time of service, **YOU as the billing provider need to know that NPI in order to use it in your claim**.
- You may use the NPI Registry or you may need to contact the ordering, referring, attending, operating, supervising, purchased service, other, service facility, or prescriber in order to obtain that 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, the Centers for Medicare & Medicaid Services (CMS) does not believe you will be successful in having secondary providers disclose their SSNs.
- If you are **unable to obtain the NPI of the entity** to be identified as the **service facility provider, or if that entity has not obtained an NPI, NO identifier is to be reported in that loop**.
- If you are unable to obtain the NPI of the ordering, referring, attending, operating, supervising, purchased service, other, or prescriber, **you (the Billing Provider) must use YOUR NPI as the identifier for that secondary provider**.
- Claims will not be paid if the secondary providers (with the exception of the service facility provider) are not identified by NPIs. No NPI is necessary for the service facility provider.

Additional Information

For complete details regarding this Change Request (CR) please see the official instruction (CR6093) issued to your

NPI CONT'D

Medicare Carrier, DME MAC, MAC or FI. That instruction may be viewed by going to www.cms.hhs.gov/Transmittals/downloads/R270PI.pdf on the CMS Web site.

FORMS

CMN and DIF Denials Cost Suppliers

Recent analysis of claim denials show a high number of claims denied for Certification of Medical Necessity (CMN) or DME Information Form (DIF) issues. The percentage of claims being appealed for these denials is estimated at 35% of the appeals workload or 18,233 appeals. The average cost of these denials for one year is approximately $1.4 million. NAS estimates that the total cost to the Medicare Trust Fund for these appeals is $1.4 million/year.

These denials are for services that include, but are not limited to, parenteral and enteral nutrition, infusion pumps and oxygen equipment. A CMN or a DIF is required for these services for the initial claim and for revision and recertification situations.

Tips to insure that your claims will not deny for CMN or DIF issues:

- ALWAYS check beneficiary history to see if another supplier already has a CMN or a DIF on file by asking the beneficiary if another supplier has previously provided the services in question or by calling the Interactive Voice Recognition (IVR) system to research this information.
- ALWAYS submit the CMN or DIF with the initial claim.
- Verify the initial claim is correctly processed before submitting subsequent claims.
- Make sure all necessary information is present on the CMN or DIF.
- Make sure the ordering physician or medical professional has signed and dated the CMN.
- Submit claims in chronological order.

Failure to follow these tips may result in a CMN or DIF related denial. When a CMN/DIF is not filed with the initial claim, it will cause denials for subsequent claims. Not only do the claims deny, suppliers spend a great amount of money requesting appeals. NAS estimates that it costs suppliers on the average $36.74 to do an appeal. This amount includes, but is not limited to, preparation of appeal and pulling supporting documentation, mailing/faxing costs and the employee wages to request and track appeals.

The CMNs and DIFs can be found in the Forms section of www.noridianmedicare.com/dme

- CMS 484 CMN - Oxygen
- CMS 846 CMN - Pneumatic Compression Devices
- CMS 847 CMN - Osteogenesis Stimulators
- CMS 848 CMN - Transcutaneous Electrical Nerve Stimulator (TENS)
- CMS 849 CMN - Seat Lift Mechanisms
- CMS 10125 DIF - External Infusion Pumps
- CMS 10126 DIF - Enteral and Parenteral Nutrition

FORMS CONT'D

CSI: Updated MCPS – DDE/CSI User ID Form and New Fax Number

The Medicare Claims Processing System (MCPS) DDE/CSI User ID Form and Instructions used to request Claims Status Inquiry (CSI) access has been updated on the Noridian Medicare Web site. Effective November 10, 2008, only version 1.2 (dated 10/15/2008) of the form will be accepted and all prior versions will be returned.

The fax number for submitting the MCPS DDE/CSI User ID Forms has changed. Forms should now be faxed to 866-442-6987. This new fax number is also indicated on the instructions page of the request form.

The MCPS DDE/CSI User ID Form is now an interactive form, in which content can be entered within the form and then printed prior to signing and submitting to NAS. To access to form on the NAS Web site, please follow the steps below:

1. Navigate to the NAS Web site at www.noridianmedicare.com
2. Select the "Forms" link from the "DME Quick Links …" dropdown box.
3. Scroll down and select the file "DDE/CSI User ID Form and Instructions" under the "Miscellaneous" subtitle.

Be sure to complete ALL fields and sections on the request form or the form cannot be processed and will be returned.

Forms without signatures or dates cannot be processed and will be returned. When requesting removal of access for a user who is no longer available to sign the form, a supervisor or an authorized official of the facility MUST sign the form.

APPEALS

Appeal Rights for Duplicate Claim Denials

The remittance advice remark code N111 addresses duplicate claim submissions. If we have previously processed a charge and receive a duplicate claim submission, the following message will appear on the remittance advice:

> "This service was included in a claim that was previously billed and adjudicated. No appeal rights attached except with regard to whether the service/item is a duplicate."

The *Medicare Claims Processing Manual,* Publication 100-04, Chapter 29, Section 200.C states, "Duplicate items and services are not afforded appeal rights, unless the supplier is appealing whether or not the service was, in fact, a duplicate."

As indicated in the *Medicare Claims Processing Manual*, appeal rights will only be afforded on requests where the provider is appealing the fact that the charge is not a duplicate service (bilateral items, more than one unit, etc.).

Medicare Publishes Billing Edits to Reduce Payment Errors

The Centers for Medicare & Medicaid Services today announced that, beginning October 1, 2008, it will publish most of the edits utilized in its Medically Unlikely Edit (MUE) program to improve the accuracy of claims payments.

"It is always our aim to ensure that CMS pays for appropriate services, at the same time protecting the Medicare Trust funds and the American taxpayer," said CMS Acting Administrator Kerry Weems. "This program is going to help us dramatically reduce costly payment errors."

CMS established the MUE program to reduce payment errors for Medicare Part B claims. Claims processing contractors utilize these edits to assure that providers and suppliers do not report excessive services. The edits are applied during the electronic processing of all claims.

These edits check the number of times a service is reported by a provider or supplier for the same patient on the same date of service. Providers and suppliers report services on claims using HCPCS/CPT codes along with the number of times (i.e., units of service) that the service is provided.

Prior studies, including one by the U.S Department of Health and Human Services' Office of the Inspector General in May 2006, identified significant Medicare overpayments because provider or supplier claims sometimes report services with too many units of service. These errors may be caused by numerous factors, including clerical errors and coding errors.

CMS first implemented the MUE program January 1, 2007, with edits for about 2,600 HCPCS/CPT codes. There have been quarterly updates adding additional codes.

The October 1, 2008, version of MUE will contain edits for about 9,700 HCPCS/CPT codes that have been assigned unit values for MUEs. MUEs are cumulative for each quarter. However, CMS will not publish all MUEs on October 1, 2008.

CMS has not yet determined if there have been any savings in the MUE program since it was implemented.

The edits were developed by CMS with the cooperation and participation of national health care organizations representing physicians, hospitals, non-physician practitioners, laboratories, and durable medical equipment suppliers. CMS also utilized claims data in its analysis of MUE.

The edits will be published on the CMS Web site at www.cms.hhs.gov/NationalCorrectCodInitEd/08_MUE.asp#TopOfPage.

At the start of each calendar quarter, CMS will publish most MUEs active for that quarter. Although the October 1, 2008, publication will contain most MUEs, additional ones will be published on January 1, 2009. CMS is not able to publish all active MUEs because some are primarily designed to detect and deter questionable payments rather than billing errors. Publishing those MUEs would diminish their effectiveness.

Repair and Replacement Reminders

Repair

To repair means to fix or mend and to put the equipment back in good condition after damage or wear. Repairs to medically necessary beneficiary owned equipment may be covered up to the cost of replacement when necessary to make the equipment serviceable. If the expense for repairs exceeds the estimated expense of purchasing or renting another item of equipment for the remaining period of medical need, no payment can be made for the amount of the excess.

Since renters of equipment recover from the rental charge the expenses they incur in maintaining the equipment they rent out, separately itemized charges for repair of rented equipment are not covered. This includes items in the frequent and substantial servicing, capped rental and inexpensive or routinely purchased payment categories during a rental period. A new Certificate of Medical Necessity (CMN) and/or physician's order is not needed for repairs to an item.

Replacement

Replacement refers to the provision of an identical or nearly identical item. Situations involving the provision of a different item because of a change in medical condition are not addressed in this document. Replacement of DME may occur in cases of loss, irreparable damage or irreparable wear.

Irreparable Damage

Irreparable damage means the damage has been caused by a specific accident (such as a wheelchair falling from a vehicle) or natural disaster (such as a fire or flood). In cases where loss or irreparable damage has occurred, replacement may be reimbursed. A physician's order and/or a new CMN, when required, is needed to reaffirm the medical necessity of the item. This rule applies to both beneficiary owned equipment and capped rental equipment.

Irreparable Wear

Irreparable wear refers to deterioration sustained from day-to-day usage over time and a specific event cannot be identified. Replacement of equipment due to irreparable wear takes into consideration the reasonable useful lifetime of the equipment. If the item of equipment has been in continuous use by the patient on either a rental or purchase basis for the equipment's useful lifetime, the beneficiary may elect to obtain a new piece of equipment, if that piece of equipment remains medically reasonable and necessary. Replacement may be reimbursed when a new physician order and/or new CMN, when required, is needed to reaffirm the medical necessity of the item.

In cases involving irreparable wear, the reasonable useful lifetime of the equipment is taken into consideration, and in no case can it be less than five years. Computation of the useful lifetime is based on when the equipment is delivered to the beneficiary, not the age of the equipment. If the item of equipment has been in continuous use for the equipment's useful lifetime and irreparable wear is involved, Medicare may cover a new piece of equipment. A new physician's order and/or a new CMN, when required, is needed to reaffirm the

medical necessity of the item. The replacement of a product before the five-year life expectancy can only be done if the item is irreparably damaged, for example by a natural disaster such as fire, flood, etc. **Replacement due to wear and tear before the five-year useful lifetime is not covered.** During the reasonable useful lifetime, Medicare does cover repair up to the cost of replacement (but not actual replacement) for medically necessary equipment owned by the beneficiary.

Cases suggesting malicious damage, culpable neglect, or wrongful disposition of equipment may be investigated and denied if NAS determines that it is unreasonable to make program payment under the circumstances.

Note: If an item of DME reaches its five-year life expectancy, is in good working order, and meets the beneficiary's medical needs, it should not automatically be replaced.

Source: *Medicare Benefit Policy Manual*, 100-02, Chapter 15, Section 100.2 Supplier Manual, Chapter 5

Inexpensive and Routinely Purchased Item Payments

Suppliers are reminded that Inexpensive or Other Routinely Purchased (IRP) items are processed as either a lump sum purchase or on a rental basis. Claims for rentals (with the exception of TENS) are paid up to the Medicare purchase allowable for the item. Claims for rental beyond the purchase allowable will deny as contractual obligation because Medicare has already paid up to the Medicare purchase allowable. The beneficiary may not be billed for these charges. If you have previously billed the beneficiary, a refund is owed to them.

Source: *Medicare Claims Processing Manual*, Chapter 20, Section 30.1

Medicare Remit Easy Print Version 2.5 Available

Medicare Remittance Easy Print (MREP) version 2.5 is available for download and includes the following changes:

- Updated Codes.ini file.
- Label updated from "FCN" to "FCN/Other Identifier" on the Remit Summary tab and the Entire Remittance.
- Functionality has been enhanced to be compatible with text-to-speech screen reading programs.

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

2008 Jurisdiction List for DMEPOS HCPCS Codes

MLN Matters Number: MM6062
Related Change Request (CR) #: 6062
Related CR Release Date: September 26, 2008
Related CR Transmittal #: R1605CP
Effective Date: October 27, 2008
Implementation Date: October 27, 2008

Provider Types Affected

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

Impact on Providers

This article is informational and is based on Change Request (CR) 6062 that notifies providers that the spreadsheet containing an updated list of the HCPCS codes for DME MAC and Part B local carrier or A/B MAC jurisdictions is updated annually to reflect codes that have been added or discontinued (deleted) each year. The spreadsheet is helpful to billing staff by showing the appropriate Medicare contractor to be billed for HCPCS appearing on the spreadsheet. The spreadsheet for the 2008 Jurisdiction List is attached to CR6062 at www.cms.hhs.gov/Transmittals/downloads/R1605CP.pdf on the CMS Web site.

Additional Information

To see the official instruction (CR6062) issued to your Medicare DME MAC, carrier, or A/B MAC visit www.cms.hhs.gov/Transmittals/downloads/R1605CP.pdf on the CMS Web site.

HCPCS	DESCRIPTION	JURISDICTION
A0021 - A0999	Ambulance Services	Local Carrier
A4206 - A4209	Medical, Surgical, and Self-Administered Injection Supplies	Local Carrier if incident to a physician's service (not separately payable). If other DME MAC.
A4210	Needle Free Injection Device	DME MAC
A4211	Medical, Surgical, and Self-Administered Injection Supplies	Local Carrier if incident to a physician's service (not separately payable). If other DME MAC.
A4212	Non Coring Needle or Stylet with or without Catheter	Local Carrier
A4213 - A4215	Medical , Surgical, and Self-Administered Injection Supplies	Local Carrier if incident to a physician's service (not separately payable). If other DME MAC.
A4216 - A4218	Saline	Local Carrier if incident to a physician's service (not separately payable). If other DME MAC.
A4220	Refill Kit for Implantable Pump	Local Carrier
A4221 - A4250	Medical, Surgical, and Self-Administered Injection Supplies	Local Carrier if incident to a physician's service (not separately payable). If other DME MAC.
A4252 - A4259	Diabetic Supplies	DME MAC
A4261	Cervical Cap for Contraceptive Use	Local Carrier
A4262 - A4263	Lacrimal Duct Implants	Local Carrier
A4265	Paraffin	Local Carrier if incident to a physician's service (not separately payable). If other DME MAC.
A4266 - A4269	Contraceptives	Local Carrier
A4270	Endoscope Sheath	Local Carrier
A4280	Accessory for Breast Prosthesis	DME MAC
A4281 - A4286	Accessory for Breast Pump	DME MAC
A4290	Sacral Nerve Stimulation Test Lead	Local Carrier
A4300 - A4301	Implantable Catheter	Local Carrier
A4305 - A4306	Disposable Drug Delivery System	Local Carrier if incident to a physician's service (not separately payable). If other DME MAC.
A4310 - A4358	Incontinence Supplies/ Urinary Supplies	If provided in the physician's office for a temporary condition, the item is incident to the physician's service & billed to the Local Carrier. If provided in the physician's office or other place of service for a permanent condition, the item is a prosthetic device & billed to the DME MAC.
A4359 (deleted 12/31/06)	Incontinence Supplies/ Urinary Supplies	See description above.
A4361 - A4434	Urinary Supplies	If provided in the physician's office for a temporary condition, the item is incident to the physician's service & billed to the Local Carrier. If provided in the physician's office or other place of service for a permanent condition, the item is a prosthetic device & billed to the DME MAC.
A4450 - A4455	Tape;Adhesive Remover	Local Carrier if incident to a physician's service (not separately payable). If other DME MAC.
A4458	Enema Bag	DME MAC
A4461-A4463	Surgical Dressing Holders	Local Carrier if incident to a physician's service (not separately payable). If other DME MAC.
A4465	Non-elastic Binder for Extremity	DME MAC

A4470	Gravlee Jet Washer	Local Carrier
A4480	Vabra Aspirator	Local Carrier
A4481	Tracheostomy Supply	Local Carrier if incident to a physician's service (not separately payable). If other DME MAC.
A4483	Moisture Exchanger	DME MAC
A4490 - A4510	Surgical Stockings	DME MAC
A4520	Diapers	DME MAC
A4550	Surgical Trays	Local Carrier
A4554	Disposable Underpads	DME MAC
A4556 - A4558	Electrodes; Lead Wires; Conductive Paste	Local Carrier if incident to a physician's service (not separately payable). If other DME MAC.
A4559	Coupling Gel	Local Carrier if incident to a physician's (not separately payable).
A4561 - A4562	Pessary	Local Carrier
A4565	Sling	Local Carrier
A4570	Splint	Local Carrier
A4575	Topical Hyperbaric Oxygen Chamber, Disposable	DME MAC
A4580 - A4590	Casting Supplies & Material	Local Carrier
A4595	TENS Supplies	Local Carrier if incident to a physician's service (not separately payable). If other DME MAC.
A4600	Sleeve for Intermittent Limb Compression Device	DME MAC
A4601	Lithium Ion Battery for Non-Prosthetic Use	DME MAC
A4604	Tubing for Positive Airway Pressure Device	DME MAC
A4605	Tracheal Suction Catheter	DME MAC
A4606	Oxygen Probe for Oximeter	DME MAC
A4608	Transtracheal Oxygen Catheter	DME MAC
A4611 - A4613	Oxygen Equipment Batteries and Supplies	DME MAC
A4614	Peak Flow Rate Meter	Local Carrier if incident to a physician's service (not separately payable). If other DME MAC.
A4615 - A4629	Oxygen & Tracheostomy Supplies	Local Carrier if incident to a physician's service (not separately payable). If other DME MAC.
A4630 - A4640	DME Supplies	DME MAC
A4641 - A4642	Imaging Agent; Contrast Material	Local Carrier
A4648	Tissue Marker, Implanted	Local Carrier
A4649	Miscellaneous Surgical Supplies	Local Carrier if incident to a physician's service (not separately payable) or if supply for implanted prosthetic device or implanted DME. If other DME MAC.
A4650	Implantable Radiation Dosimeter	Local Carrier
A4651 - A4932	Supplies for ESRD	DME MAC

A5051 - A5093	Additional Ostomy Supplies	If provided in the physician's office for a temporary condition, the item is incident to the physician's service & billed to the Local Carrier. If provided in the physician's office or other place of service for a permanent condition, the item is a prosthetic device & billed to the DME MAC.
A5102 - A5200	Additional Incontinence and Ostomy Supplies	If provided in the physician's office for a temporary condition, the item is incident to the physician's service & billed to the Local Carrier. If provided in the physician's office or other place of service for a permanent condition, the item is a prosthetic device & billed to the DME MAC.
A5500 - A5513	Therapeutic Shoes	DME MAC
A6000	Non-Contact Wound Warming Cover	DME MAC
A6010-A6024	Surgical Dressing	Local Carrier if incident to a physician's service (not separately payable) or if supply for implanted prosthetic device or implanted DME. If other DME MAC.
A6025	Silicone Gel Sheet	Local Carrier if incident to a physician's service (not separately payable) or if supply for implanted prosthetic device or implanted DME. If other DME MAC.
A6154 - A6411	Surgical Dressing	Local Carrier if incident to a physician's service (not separately payable) or if supply for implanted prosthetic device or implanted DME. If other DME MAC.
A6412	Eye Patch	Local Carrier if incident to a physician's service (not separately payable) or if supply for implanted prosthetic device or implanted DME. If other DME MAC.
A6413	Adhesive Bandage	Local Carrier if incident to a physician's service (not separately payable) or if supply for implanted prosthetic device or implanted DME. If other DME MAC.
A6441 - A6512	Surgical Dressings	Local Carrier if incident to a physician's service (not separately payable) or if supply for implanted prosthetic device or implanted DME. If other DME MAC.
A6513	Compression Burn Mask	DME MAC
A6530 - A6549	Compression Gradient Stockings	DME MAC
A6550	Supplies for Negative Pressure Wound Therapy Electrical Pump	DME MAC
A7000 - A7002	Accessories for Suction Pumps	DME MAC
A7003 - A7039	Accessories for Nebulizers, Aspirators and Ventilators	DME MAC
A7040 - A7041	Chest Drainage Supplies	Local Carrier
A7042 - A7043	Pleural Catheter	Local Carrier
A7044 - A7046	Respiratory Accessories	DME MAC
A7501-A7527	Tracheostomy Supplies	DME MAC
A8000-A8004	Protective Helmets	DME MAC
A9150	Non-Prescription Drugs	Local Carrier
A9152 - A9153	Vitamins	Local Carrier
A9155	Artificial Saliva	Local Carrier
A9180	Lice Infestation Treatment	Local Carrier
A9270	Noncovered Items or Services	DME MAC
A9274 - A9278	Glucose Monitoring	DME MAC

A9279	Monitoring Feature/Device	DME MAC
A9280	Alarm Device	DME MAC
A9281	Reaching/Grabbing Device	DME MAC
A9282	Wig	DME MAC
A9283	Foot Off Loading Device	DME MAC
A9300	Exercise Equipment	DME MAC
A9500 - A9700	Supplies for Radiology Procedures	Local Carrier
A9900	Miscellaneous DME Supply or Accessory	Local Carrier if used with implanted DME. If other, DME MAC.
A9901	Delivery	DME MAC
A9999	Miscellaneous DME Supply or Accessory	Local Carrier if used with implanted DME. If other, DME MAC.
B4034 - B9999	Enteral and Parenteral Therapy	DME MAC
D0120 - D9999	Dental Procedures	Local Carrier
E0100 - E0105	Canes	DME MAC
E0110 - E0118	Crutches	DME MAC
E0130 - E0159	Walkers	DME MAC
E0160 - E0175	Commodes	DME MAC
E0181 - E0199	Decubitus Care Equipment	DME MAC
E0200 - E0239	Heat/Cold Applications	DME MAC
E0240 - E0248	Bath and Toilet Aids	DME MAC
E0249	Pad for Heating Unit	DME MAC
E0250 - E0304	Hospital Beds	DME MAC
E0305 - E0326	Hospital Bed Accessories	DME MAC
E0328 - E0329	Pediatric Hospital Beds	DME MAC
E0350 - E0352	Electronic Bowel Irrigation System	DME MAC
E0370	Heel Pad	DME MAC
E0371 - E0373	Decubitus Care Equipment	DME MAC
E0424 - E0484	Oxygen and Related Respiratory Equipment	DME MAC
E0485 - E0486	Oral Device to Reduce Airway Collapsibility	DME MAC
E0500	IPPB Machine	DME MAC
E0550 - E0585	Compressors/Nebulizers	DME MAC
E0600	Suction Pump	DME MAC
E0601	CPAP Device	DME MAC
E0602 - E0604	Breast Pump	DME MAC
E0605	Vaporizer	DME MAC
E0606	Drainage Board	DME MAC
E0607	Home Blood Glucose Monitor	DME MAC
E0610 - E0615	Pacemaker Monitor	DME MAC
E0616	Implantable Cardiac Event Recorder	Local Carrier

E0617	External Defibrillator	DME MAC
E0618 - E0619	Apnea Monitor	DME MAC
E0620	Skin Piercing Device	DME MAC
E0621 - E0636	Patient Lifts	DME MAC
E0637 - E0642	Standing Devices/Lifts	DME MAC
E0650 - E0676	Pneumatic Compressor and Appliances	DME MAC
E0691 - E0694	Ultraviolet Light Therapy Systems	DME MAC
E0700	Safety Equipment	DME MAC
E0701 (deleted 12/31/06)	Protective Helmet	DME MAC
E0705	transfer Board	DME MAC
E0710	Restraints	DME MAC
E0720 - E0745	Electrical Nerve Stimulators	DME MAC
E0746	EMG Device	Local Carrier
E0747 - E0748	Osteogenic Stimulators	DME MAC
E0749	Implantable Osteogenic Stimulators	Local Carrier
E0755	Reflex Stimulator	DME MAC
E0760	Ultrasonic Osteogenic Stimulator	DME MAC
E0761	Electromagnetic Treatment Device	DME MAC
E0762	Electrical Joint Stimulation Device	DME MAC
E0764	Functional Neuromuscular Stimulator	DME MAC
E0765	Nerve Stimulator	DME MAC
E0769	Electrical Wound Treatment Device	DME MAC
E0776	IV Pole	DME MAC
E0779 - E0780	External Infusion Pumps	DME MAC
E0781	Ambulatory Infusion Pump	Billable to both the local carrier and the DME MAC. This item may be billed to the DME MAC whenever the infusion is initiated in the physician's office but the patient does not return during the same business day.
E0782 - E0783	Infusion Pumps, Implantable	Local Carrier
E0784	Infusion Pumps, Insulin	DME MAC
E0785 - E0786	Implantable Infusion Pump Catheter	Local Carrier
E0791	Parenteral Infusion Pump	DME MAC
E0830	Ambulatory Traction Device	DME MAC
E0840 - E0900	Traction Equipment	DME MAC
E0910 - E0930	Trapeze/Fracture Frame	DME MAC
E0935 - E0936	Passive Motion Exercise Device	DME MAC
E0940	Trapeze Equipment	DME MAC
E0941	Traction Equipment	DME MAC
E0942 - E0945	Orthopedic Devices	DME MAC
E0946 - E0948	Fracture Frame	DME MAC
E0950 - E1298	Wheelchairs	DME MAC

E1300 - E1310	Whirlpool Equipment	DME MAC
E1340	Repair or Non-routine Service	Local Carrier if repair of implanted DME. If other, DME MAC.
E1353 - E1392	Additional Oxygen Related Equipment	DME MAC
E1399	Miscellaneous DME	Local Carrier if implanted DME. If other, DME REGIONAL Carrier.
E1405 - E1406	Additional Oxygen Equipment	DME MAC
E1500 - E1699	Artificial Kidney Machines and Accessories	DME MAC
E1700 - E1702	TMJ Device and Supplies	DME MAC
E1800 - E1841	Dynamic Flexion Devices	DME MAC
E1902	Communication Board	DME MAC
E2000	Gastric Suction Pump	DME MAC
E2100 - E2101	Blood Glucose Monitors with Special Features	DME MAC
E2120	Pulse Generator for Tympanic Treatment of Inner Ear	DME MAC
E2201 - E2399	Wheelchair Accessories	DME MAC
E2402	Negative Pressure Wound Therapy Pump	DME MAC
E2500 - E2599	Speech Generating Device	DME MAC
E2601 - E2621	Wheelchair Cushions	DME MAC
E8000 - E8002	Gate Trainers	DME MAC
G0008 - G0332	Misc. Professional Services	Local Carrier
G0333	Dispensing Fee	DME MAC
G0337 - G0368	Misc. Professional Services	Local Carrier
G0372	Misc. Professional Services	Local Carrier
G0375 - G0376	Misc. Professional Services	Local Carrier
G0378 - G9140	Misc. Professional Services	Local Carrier
J0120 - J3570	Injection	Local Carrier if incident to a physician's service or used in an implanted infusion pump. If other, DME MAC.
J3590	Unclassified Biologics	Local Carrier
J7030 - J7130	Miscellaneous Drugs and Solutions	Local Carrier if incident to a physician's service or used in an implanted infusion pump. If other, DME MAC.
J7187 - J7195	Antihemophilic Factor	Local Carrier
J7197	Antithrombin III	Local Carrier
J7198	Anti-inhibitor; per I.U.	Local Carrier
J7199	Other Hemophilia Clotting Factors	Local Carrier
J7300 - J7307	Intrauterine Copper Contraceptive	Local Carrier
J7308	Aminolevulinic Acid HCL	Local Carrier
J7310	Ganciclovir, Long-Acting Implant	Local Carrier
J7311	Fluocinolone Acetonide, intravitrea implant	Local Carrier
J7317 (deleted 12/31/06)	Sodium Hyaluronate	Local Carrier

J7319 (deleted 12/31/07)	Hyaluronan	Local Carrier
J7320 (deleted 12/31/06)	Hylan	Local Carrier
J7321 - J7324	Hyaluronan	Local Carrier
J7330	Autologous Cultured Chondrocytes Implant	Local Carrier
J7340 - J7349	Dermal and Epidermal Tissue	Local Carrier
J7350 (deleted 12/31/06)	Dermal and Epidermal Tissue	Local Carrier
J7500 - J7599	Immunosuppressive Drugs	Local Carrier if incident to a physician's service or used in an implanted infusion pump. If other, DME MAC.
J7602 - J7699	Inhalation Solutions	Local Carrier if incident to a physician's service. If other, DME MAC.
J7799	NOC, Other than Inhalation Drugs through DME	Local carrier if incident to a physician's service. If other, DME MAC.
J8498	Anti-emetic Drug	DME MAC
J8499	Prescription Drug, Oral, Non Chemotherapeutic	Local carrier if incident to a physician's service. If other, DME MAC.
J8501 - J8999	Oral Anti-Cancer Drugs	DME MAC
J9000 - J9999	Chemotherapy Drugs	Local Carrier if incident to a physician's service or used in an implanted infusion pump. If other, DME MAC.
K0001 - K0108	Wheelchairs	DME MAC
K0195	Elevating Leg Rests	DME MAC
K0455	Infusion Pump used for Uninterrupted Administration of Epoprostenal	DME MAC
K0462	Loaner Equipment	DME MAC
K0552	External Infusion Pump Supplies	DME MAC
K0553 - K0555 (deleted 12/31/07)	Accessories for CPAP and Ventilators	DME MAC
K0601 - K0605	External Infusion Pump Batteries	DME MAC
K0606 - K0609	Defibrillator Accessories	DME MAC
K0669	Wheelchair Cushion	DME MAC
K0730	Inhalation Drug Delivery System	DME MAC
K0733	Power Wheelchair Accessory	DME MAC
K0734 - K0737	Power Wheelchair Seat Cushions	DME MAC
K0738	Oxygen Equipment	DME MAC
K0800 - K0899	Power Mobility Devices	DME MAC
L0100 (deleted 12/31/06)	Orthotics	DME MAC
L0110 (deleted 12/31/06)	Orthotics	DME MAC
L0112 - L2090	Orthotics	DME MAC
L2106 - L2116	Orthotics	DME MAC
L2126 - L4398	Orthotics	DME MAC

L5000 - L5999	Lower Limb Prosthetics	DME MAC
L6000 - L7499	Upper Limb Prosthetics	DME MAC
L7500 - L7520	Repair of Prosthetic Device	Local Carrier if repair of implanted prosthetic device. If other, DME MAC.
L7600	Prosthetic Donning Sleeve	DME MAC
L7611 - L7622	Prosthetic Terminal Devices	DME MAC
L7900	Vacuum Erection System	DME MAC
L8000 - L8485	Prosthetics	DME MAC
L8499	Unlisted Procedure for Miscellaneous Prosthetic Services	Local Carrier if implanted prosthetic device. If other, DME MAC.
L8500 - L8501	Artificial Larynx; Tracheostomy Speaking Valve	DME MAC
L8505	Artificial Larynx Accessory	DME MAC
L8507 - L8515	Voice Prosthesis	DME MAC
L8600 - L8699	Prosthetic Implants	Local Carrier
L9900	Miscellaneous Orthotic or Prosthetic Component or Accessory	Local Carrier if used with implanted prosthetic device. If other, DME MAC.
M0064 - M0301	Medical Services	Local Carrier
P2028 - P9615	Laboratory Tests	Local Carrier
Q0035	Influenza Vaccine; Cardiokymography	Local Carrier
Q0081	Infusion Therapy	Local Carrier
Q0083 - Q0085	Chemotherapy Administration	Local Carrier
Q0091	Smear Preparation	Local Carrier
Q0092	Portable X-ray Setup	Local Carrier
Q0111 - Q0115	Miscellaneous Lab Services	Local Carrier
Q0144	azithromycin dihydrate	Local Carrier if incident to a physician's service. If other, DME MAC.
Q0163 - Q0181	Anti-emetic	DME MAC
Q0480 - Q0505	Ventricular Assist Devices	Local Carrier
Q0510 - Q0514	Drug Dispensing Fees	DME MAC
Q0515	Sermorelin Acetate	Local Carrier
Q1003 - Q1005	New Technology IOL	Local Carrier
Q2004	Irrigation Solution	Local Carrier
Q2009	Fosphenytoin	Local Carrier
Q2017	Teniposide	Local Carrier
Q3001	Radio Elements for Brachytherapy	Local Carrier
Q3014	Telehealth Originating Site Facility Fee	Local Carrier
Q3025 - Q3026	Vaccines	Local Carrier
Q3031	Collagen Skin Test	Local Carrier
Q4001 - Q4051	Splints and Casts	Local Carrier
Q4080	Inhalation Drug	Local Carrier if incident to a physician's service. If other, DME MAC.
Q4081	Epoetin	DME MAC for method II home dialysis. If other, Local Carrier.

Q4082	Drug Subject to Competitive Acquisition Program	Local Carrier
Q4083 - Q4086 (deleted 12/31/07)	Hyaluronan	Local Carrier
Q4087 - Q4092 (deleted 12/31/07)	Injection	Local Carrier if incident to a physician's service or used in an implanted infusion pump. If other DME MAC.
Q4093 - Q4094 (deleted 12/31/07)	Inhalation Solutions	Local Carrier if incident to a physician's service or used in an implanted infusion pump. If other DME MAC.
Q4095 (deleted 12/31/07)	Injection	Local Carrier if incident to a physician's service or used in an implanted infusion pump. If other DME MAC.
Q4096 - Q4098	Injection	Local Carrier if incident to a physician's service or used in an implanted infusion pump.
Q4099	Inhalation Solutions	DME MAC
Q5001 - Q5009	Hospice Services	Local Carrier
Q9945 - Q9950 (deleted 12/31/07)	Imaging Agents	Local Carrier
Q9951 - Q9954	Imaging Agents	Local Carrier
Q9955 - Q9957	Microspheres	Local Carrier
Q9958 - Q9967	Imaging Agents	Local Carrier
R0070 - R0076	Diagnostic Radiology Services	Local Carrier
V2020 - V2025	Frames	DME MAC
V2100 - V2513	Lenses	DME MAC
V2520 - V2523	Hydrophilic Contact Lenses	Local Carrier if incident to a physician's service. If other, DME MAC.
V2530 - V2531	Contact Lenses, Scleral	DME MAC
V2599	Contact Lens, Other Type	Local Carrier if incident to a physician's service. If other, DME MAC.
V2600 - V2615	Low Vision Aids	DME MAC
V2623 - V2629	Prosthetic Eyes	DME MAC
V2630 - V2632	Intraocular Lenses	Local Carrier
V2700 - V2780	Miscellaneous Vision Service	DME MAC
V2781	Progressive Lens	DME MAC
V2782 - V2784	Lenses	DME MAC
V2785	Processing--Corneal Tissue	Local Carrier
V2786	Lense	DME MAC
V2787 - V2788	Intraocular Lenses	Local Carrier
V2790	Amniotic Membrane	Local Carrier
V2797	Vision Supply	DME MAC
V2799	Miscellaneous Vision Service	DME MAC
V5008 - V5299	Hearing Services	Local Carrier
V5336	Repair/Modification of Augmentative Communicative System or Device	DME MAC
V5362 - V5364	Speech Screening	Local Carrier

The ICD-10 CM/PCS - The Next Generation of Coding

MLN Matters Number: SE0832 Revised

Note: This article was revised on October 9, 2008, to update the Web site addresses and other information in the "Additional Information" section of this article. All other information remains the same.

Provider Types Affected

This article is informational only for all physicians, providers, and suppliers who submit claims to Medicare contractors (carriers, Medicare Administrative Contractors (A/B MACs), durable medical equipment Medicare Administrative Contractors (DME MACs), fiscal intermediaries (FIs), and regional home health intermediaries (RHHIs)) for services provided to Medicare beneficiaries.

Provider Action Needed

This Special Edition article (SE0832) outlines general information for providers detailing the International Classification of Diseases, 10th Edition (ICD-10) classification system. Compared to the current ICD-9 classification system, ICD-10 offers more detailed information and the ability to expand specificity and clinical information in order to capture advancements in clinical medicine. Providers may want to become familiar with the new coding system.

The system is not yet implemented in Medicare's fee-for-service (FFS) claims processes so no action is needed at this time.

Background

A number of other countries already use ICD-10, including:

- United Kingdom (1995);
- France (1997);
- Australia (1998);
- Germany (2000); and
- Canada (2001).

ICD-10-CM/PCS consists of two parts:

- ICD-10-CM – The diagnosis classification system was developed by the Centers for Disease Control and Prevention for use in all United States of America health care treatment settings. Diagnosis coding under this system uses a different number of digits and some other changes, but the format is very much the same as International Classification of Diseases, 9th Edition, Clinical Modification (ICD-9-CM); and
- ICD-10-PCS – The procedure classification system was developed by CMS for use in the U.S. for inpatient hospital settings ONLY. The new procedure coding system uses 7 alpha or numeric digits while the ICD-9-CM coding system uses 3 or 4 numeric digits.

ICD-10-CM/PCS:

- Incorporates much greater specificity and clinical information, which results in:
  - Improved ability to measure health care services;
  - Increased sensitivity when refining grouping and reimbursement methodologies;
  - Enhanced ability to conduct public health surveillance; and
  - Decreased need to include supporting documentation with claims.
- Includes updated medical terminology and classification of diseases.
- Provides codes to allow comparison of mortality and morbidity data.
- Provides better data for:
  - Measuring care furnished to patients;
  - Designing payment systems;
  - Processing claims;
  - Making clinical decisions;
  - Tracking public health;
  - Identifying fraud and abuse; and
  - Conducting research.

Structural Differences Between the Two Coding Systems

1. Diagnoses Codes

   ICD-9-CM diagnoses codes are 3 – 5 digits in length with the first digit being alpha (E or V) or numeric and digits 2 – 5 being numeric. For example:

   - 496 – Chronic airway obstruction not elsewhere classified (NEC);
   - 511.9 – Unspecified pleural effusion; and
   - V02.61 – Hepatitis B carrier.

   ICD-10-CM diagnoses are 3 – 7 digits in length with the first digit being alpha, digits 2 and 3 being numeric and digits 4 – 7 are alpha or numeric. The alpha digits are not case sensitive. For example:

   - A66 – Yaws;
   - A69.21 – Meningitis due to Lyme disease; and
   - S52.131a – Displaced fracture of neck of right radius, initial encounter for closed fracture.

2. Procedure Codes

   ICD-9-CM procedures are 3 – 4 digits in length and all digits are numeric. For example:

   - 43.5 – Partial gastrectomy with anastomosis to esophagus; and
   - 44.42 – Suture of duodenal ulcer site.

   ICD-10-PCS procedures are 7 digits in length with each of the 7 digits being either alpha or numeric. The alpha digits are not case sensitive. Letters O and I are not used to avoid confusion with the numbers 0 and 1. For example:

   - 0FB03ZX – Excision of Liver, Percutaneous Approach, Diagnostic; and

0DQ107Z – Repair, esophagus, upper, open with autograft.

Note that ICD-10-CM/PCS would not affect physicians, outpatient facilities, and hospital outpatient departments' usage of Current Procedural Terminology (CPT) codes on Medicare FFS claims as CPT use would continue.

Additional Information

The Centers for Medicare & Medicaid Services (CMS) has developed a dedicated Web page for ICD-10 information. That page is at www.cms.hhs.gov/ICD10 on the CMS Web site.

Details on the ICD-10-PCS Coding System, mappings, and a related training manual may be found at www.cms.hhs.gov/ICD10/02_ICD-10-PCS.asp#TopOfPage on the CMS Web site.

The ICD-10 Notice of Proposed Rulemaking is available at http://edocket.access.gpo.gov/2008/pdf/E8-19298.pdf on the Internet.

Details on the ICD-10-CM Coding system, mappings, and guidelines may be found at www.cdc.gov/nchs/about/otheract/icd9/abticd10.htm on the Internet and also at www.cms.hhs.gov/ICD10/03_ICD_10_CM.asp#TopOfPage on the CMS Web site.

Many private sector professional organizations and businesses have resources available that may help with ICD-10-CM/PCS implementation planning.

Please note that the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) is published by the United States Government. A CD-ROM, which may be purchased through the Government Printing Office, is the only official Federal government version of the ICD-9-CM. ICD-9-CM is an official Health Insurance Portability and Accountability Act (HIPAA) standard. The dedicated CMS ICD-10 page also has links to these resources in the "Related Links Outside of CMS" at the bottom of the page.

ICD-10-Clinical Modification/ Procedure Coding System Fact Sheet

The ICD-10-Clinical Modification/ Procedure Coding System Fact Sheet, which provides general information about the International Classification of Diseases, 10th Edition, Clinical Modification/ Procedure Coding System (ICD-10-CM/PCS) including benefits of adopting the new coding system, structural differences between ICD-9-CM and ICD-10-CM/PCS, and implementation planning recommendations, is now available in downloadable format from the Centers for Medicare & Medicaid Services **Medicare Learning Network** at www.cms.hhs.gov/MLNProducts/downloads/ICD-10factsheet2008.pdf.

ICD-10-Clincal Modification/ Procedure Coding System Bookmark

The ICD-10-Clinical Modification/Procedure Coding System Bookmark is now available from the Centers for Medicare & Medicaid Services Medicare Learning Network. This bookmark explains the ICD-10-Clinical Modification/ Procedure Coding System (CM/PCS) including the benefits of adopting the system, recommended steps to be taken in order to plan and prepare for implementation of the system, and where additional information about the system can be found. To place your order, visit www.cms.hhs.gov/MLNProducts/01_Overview.asp, scroll down to "Related Links Inside CMS" and select "MLN Product Ordering Page." If you have problems accessing this hyperlink, please copy and paste the URL into your Internet browser.

REIMBURSEMENT

Reasonable Charge Update for 2009 for Splints, Casts, Dialysis Supplies, Dialysis Equipment, and Certain Intraocular Lenses

MLN Matters Number: MM6221
Related Change Request (CR) #: 6221
Related CR Release Date: October 3, 2008
Related CR Transmittal #: R1613CP
Effective Date: January 1, 2009
Implementation Date: January 5, 2009

Provider Types Affected

Physicians, providers, and suppliers billing Medicare contractors (carriers, Fiscal Intermediaries, (FIs), Medicare Administrative Contractors (MACs), and Durable Medical Equipment Medicare Administrative Contractors (DME MACs)) for splints, casts, dialysis equipment, and certain intraocular lenses.

What You Need to Know

CR 6221, from which this article is taken, instructs your carriers, FIs, MACs, and DME MACs how to calculate reasonable charges for the payment of claims for splints, casts, dialysis supplies, dialysis equipment, and intraocular lenses furnished in calendar year 2009. CR6221 also announces that the 2009 Inflation-Indexed Charge IIC update factor is 5.0 percent.

Background

Payment on a reasonable charge basis is required for splints, casts, dialysis supplies, dialysis equipment, and intraocular lenses by regulations contained in 42 CFR 405.501.

For calendar year 2009, Medicare will continue to pay for splints, casts, dialysis supplies, dialysis equipment and intraocular lenses on a reasonable charge basis.

In addition, please note that: 1) Payment for intraocular lenses is only made on a reasonable charge basis for lenses implanted in a physician's office; and 2) You should use the Q-codes for splints and casts, when supplies are indicated for cast and splint purposes. This payment is in addition to the

payment made under the Medicare physician fee schedule for the procedure for applying the splint or cast.

The 2009 payment limits for splints and casts will be based on the 2008 limits that were announced in CR 5740 last year, increased by 5.0 percent (the percentage change in the consumer price index for all urban consumers for the 12-month period ending June 30, 2008). (The MLN Matters article related to CR 5740 can be viewed at www.cms.hhs.gov/MLNMattersArticles/downloads/MM5740.pdf on the CMS Web site.)

Change Request 6221 instructs your carrier or MAC to: 1) Compute 2009 customary and prevailing charges for the V2630, V2631, and V2632 (Intraocular Lenses Implanted in a Physician's Office) using actual charge data from July 1, 2007, through June 30, 2008; and 2) Compute 2009 Inflation-Indexed Charge (IIC) amounts for these codes that were not paid using gap-filled payment amounts in 2008.

The 2009 Inflation-Indexed Charge IIC update factor is 5.0 percent.

For codes identified in the following four tables, CR 6221 instructs DME MACs to compute 2009 customary and prevailing charges using actual charge data from July 1, 2007 through June 30, 2008; and will compute 2009 IIC amounts for the codes that were not paid using gap-filled amounts in 2008.

Table 1
Dialysis Supplies Billed With AX Modifier

A4215	A4216	A4217	A4244	A4245	A4246	A4247	A4248
A4450	A4452	A4651	A4652	A4657	A4660	A4663	A4670
A4927	A4928	A4930	A4931	A6216	A6250	A6260	A6402

Table 2
Dialysis Supplies Billed Without AX Modifier

A4653	A4671	A4672	A4673	A4674	A4680	A4690	A4706	A4707
A4708	A4709	A4714	A4719	A4720	A4721	A4722	A4723	A4724
A4725	A4726	A4728	A4730	A4736	A4737	A4740	A4750	A4755
A4760	A4765	A4766	A4770	A4771	A4772	A4773	A4774	A4802
A4860	A4870	A4890	A4911	A4918	A4929	E1634		

Table 3
Dialysis Equipment Billed With AX Modifier

E0210NU	E1632	E1637	E1639

Table 4
Dialysis Equipment Billed Without AX Modifier

E1500	E1510	E1520	E1530	E1540	E1550
E1560	E1570	E1575	E1580	E1590	E1592
E1594	E1600	E1610	E1615	E1620	E1625
E1630	E1635	E1636			

Your contractors will make payment for splints and casts furnished in 2009 based on the lower of the actual charge or the payment limits established for these codes. They will use the 2009 reasonable charges or the attached 2009 splints and casts payment limits to pay claims for items furnished from January 1, 2009 through December 31, 2009. **Please refer to Attachment A, at the end of this article for a detailed list of the applicable HCPCS codes and 2009 payment limits.**

Additional Information

Detailed instructions for calculating:

- Reasonable charges are located in the *Medicare Claims Processing Manual*, Chapter 23 (Fee Schedule Administration and Coding Requirements), Section 80 (Reasonable Charges as Basis for Carrier/DMERC Payments);
- Customary and prevailing charges are located in *Medicare Claims Processing Manual*, Chapter 23 (Fee Schedule Administration and Coding Requirements), Sections 80.2 (Updating Customary and Prevailing Charges) and 80.4 (Prevailing Charge); and
- The IIC are located in *Medicare Claims Processing Manual*, Chapter 23 (Fee Schedule Administration and Coding Requirements), Sections 80.6 (Inflation Indexed Charge (IIC) for Nonphysician Services).

The *Medicare Claims Processing Manual* is available at www.cms.hhs.gov/manuals/IOM/list.asp on the CMS Web site.

For complete details regarding this Change Request (CR) please see the official instruction (CR 6221) issued to your Medicare FI, carrier, MAC, or DME MAC. That instruction may be viewed by going to www.cms.hhs.gov/Transmittals/downloads/R1613CP.pdf on the CMS Web site.

Attachment A

Code	Payment Limit	Code	Payment Limit
A4565	$7.75	Q4025	$34.07
Q4001	$44.11	Q4026	$106.37
Q4002	$166.75	Q4027	$17.04
Q4003	$31.69	Q4028	$53.19
Q4004	$109.71	Q4029	$26.05
Q4005	$11.68	Q4030	$68.58
Q4006	$26.33	Q4031	$13.03
Q4007	$5.86	Q4032	$34.28
Q4008	$13.17	Q4033	$24.30
Q4009	$7.80	Q4034	$60.44
Q4010	$17.56	Q4035	$12.15
Q4011	$3.90	Q4036	$30.23
Q4012	$8.78	Q4037	$14.83
Q4013	$14.20	Q4038	$37.14
Q4014	$23.95	Q4039	$7.43
Q4015	$7.10	Q4040	$18.56
Q4016	$11.97	Q4041	$18.02
Q4017	$8.21	Q4042	$30.77

Q4018	$13.09	Q4043	$9.02
Q4019	$4.11	Q4044	$15.39
Q4020	$6.55	Q4045	$10.46
Q4021	$6.07	Q4046	$16.83
Q4022	$10.96	Q4047	$5.22
Q4023	$3.06	Q4048	$8.42
Q4024	$5.48	Q4049	$1.91

Clarification of Medicare Payment for Routine Costs in a Clinical Trial

MLN Matters Number: SE0822

Provider Types Affected

All physicians, providers, and suppliers who submit claims to Medicare contractors (carriers, Medicare Administrative Contractors (A/B MACs), durable medical equipment Medicare Administrative Contractors (DME MACs), fiscal intermediaries (FIs), and regional home health intermediaries (RHHIs)) for services provided to Medicare beneficiaries in clinical trials.

Provider Action Needed

This Special Edition article provides clarification regarding Medicare payment of routine costs associated with clinical trials. Be sure your billing staff is aware of this information.

Background

The Centers for Medicare & Medicaid Services (CMS) reminds providers that the policies for payment of the routine costs of the clinical trial are outlined in chapter 16, section 40 of the *Medicare Benefit Policy Manual*. The policy in the manual states:

"**40 No Legal Obligation to Pay for or Provide Services**

Program payment may not be made for items or services which neither the beneficiary nor any other person or organization has a legal obligation to pay for or provide. This exclusion applies where items and services are furnished gratuitously without regard to the beneficiary's ability to pay and without expectation of payment from any source, such as free x-rays or immunizations provided by health organizations. However, Medicare reimbursement is not precluded merely because a provider, physician, or supplier waives the charge in the case of a particular patient or group or class of patients, as the waiver of charges for some patients does not impair the right to charge others, including Medicare patients. The determinative factor in applying this exclusion is the reason the particular individual is not charged."

Key Points of SE0822

There are three concerns addressed in this article regarding "Payment for Routine Costs in a Clinical Trial" and they are addressed in the following questions and answers:

1. **Question**: If a research sponsor says in writing that they will pay for routine costs if there is no reimbursement from any insurance company (including Medicare), does that fall into the "free of charge" category?

   Answer: If the routine costs of the clinical trial are furnished gratuitously (i.e., without regard to the beneficiary's ability to pay and without expectation of payment from any other source), then Medicare payment cannot be made and the beneficiary cannot be charged. If private insurers deny the routine costs and the provider of services does not pursue the non-Medicare patients for payment after the denials (even though the non-Medicare patient has the ability to pay), Medicare payment cannot be made and the beneficiary cannot be charged for the routine costs.

2. **Question:** If the research sponsor pays for the routine costs provided to an indigent non-Medicare patient (the provider has determined that the patient is indigent due to a valid financial hardship) may Medicare payment be made for Medicare beneficiaries?

   Answer: If the routine costs of the clinical trial are not billed to indigent non-Medicare patients because of their inability to pay (but are being billed to all the other patients in the clinical trial who have the financial means to pay even when his/her private insurer denies payment for the routine costs), then a legal obligation to pay exists. Therefore, Medicare payment may be made and the beneficiary (who is not indigent) will be responsible for the applicable Medicare deductible and coinsurance amounts. As noted at www.cms.hhs.gov/AcuteInpatientPPS/downloads/FAQ_Uninsured.pdf, "nothing in the Centers for Medicare & Medicaid Services' (CMS') regulations or Program Instructions prohibit a hospital from waiving collection of charges to any patients, Medicare or non-Medicare, including low-income, uninsured or medically indigent individuals, if it is done as part of the hospital's indigency policy. By "indigency policy" we mean a policy developed and utilized by a hospital to determine patients' financial ability to pay for services. By "medically indigent," we mean patients whose health insurance coverage, if any, does not provide full coverage for all of their medical expenses and that their medical expenses, in relationship to their income, would make them indigent if they were forced to pay full charges for their medical expenses. In addition to CMS' policy, the Office of Inspector General (OIG) advises that nothing in OIG rules or regulations under the Federal anti-kickback statute prohibits hospitals from waiving collection of charges to uninsured patients of limited means, so long as the waiver is not linked in any manner to the generation of business payable by a Federal health care program – a highly unlikely circumstance.

   Thus, the provider of services should bill the beneficiary for co-payments and deductible, but may waive that payment for beneficiaries who have a valid financial hardship.

3. **Question:** May a research sponsor pay Medicare copays for beneficiaries in a clinical trial.

   Answer: If a research sponsor offers to pay cost-sharing amounts owed by the beneficiary, this could be a fraud and abuse problem. In addition to CMS' policy, the Office of Inspector General (OIG) advises that nothing in OIG rules or regulations under the Federal

anti-kickback statute prohibits hospitals from waiving collection of charges to uninsured patients of limited means, so long as the waiver is not linked in any manner to the generation of business payable by a Federal health care program.

The citations include 42 U.S.C. 1320a-7(a)(i)(6); OIG Special Advisory Bulletin on Offering Gifts to Beneficiaries (http://oig.hhs.gov/fraud/docs/alertsandbulletins/SABGiftsandInducements.pdf) and OIG Special Fraud Alert on Routine Waivers of Copayments and Deductibles (http://oig.hhs.gov/fraud/docs/alertsandbulletins/121994.html).

Additional Information

Chapter 16, Section 40 of the *Medicare Benefit Policy Manual* is available at www.cms.hhs.gov/manuals/Downloads/bp102c16.pdf on the CMS Web site.

Reasonable Charge Update for 2008 for Splints, Casts, Dialysis Supplies, Dialysis Equipment, and Certain Intraocular Lenses

MLN Matters Number: MM5740
Related Change Request (CR) #: 5740
Related CR Release Date: September 28, 2007
Related CR Transmittal #: R1344CP
Effective Date: January 1, 2008
Implementation Date: January 7, 2008

Note: This article was revised on November 7, 2007 to change the title to the chart showing the payment limits. That chart should have read "2008" and not "2007". All other information is unchanged.

Provider Types Affected

Physicians, providers, and suppliers billing Medicare contractors (carriers, Fiscal Intermediaries, (FIs), Medicare Administrative Contractors (A/B MACs), and Durable Medical Equipment Medicare Administrative Contractors (DME MACs)) for splints, casts, dialysis equipment, and certain intraocular lenses.

Provider Action Needed

Affected providers may want to be certain their billing staffs know of these changes.

Background

For calendar year 2008, Medicare will continue to pay on a reasonable charge basis for splints, casts, dialysis supplies, dialysis equipment and intraocular lenses. For intraocular lenses, payment is only made on a reasonable charge basis for lenses implanted in a physician's office. For splints and casts, the Q-codes are to be used when supplies are indicated for cast and splint purposes. This payment is in addition to the payment made under the Medicare physician fee schedule for the procedure for applying the splint or cast.

Change Request (CR) 5740 provides instructions regarding the calculation of reasonable charges for payment of claims for splints, casts, dialysis supplies, dialysis equipment, and intraocular lenses furnished in calendar year 2008. Payment on a reasonable charge basis is required for these items by regulations contained in 42 CFR 405.501 at: www.gpoaccess.gov/cfr/retrieve.html on the Internet. The 2008 payment limits for splints and casts will be based on the 2007 limits that were announced in CR 5382 last year, increased by 2.7 percent, the percentage change in the consumer price index for all urban consumers for the 12-month period ending June 30, 2007. The MLN Matters article related to CR 5382 can be viewed at www.cms.hhs.gov/MLNMattersArticles/downloads/MM5382.pdf on the CMS Web site.

For intraocular lenses, payment is made only **on a reasonable charge basis for lenses implanted in a physician's office**. Change Request 5740 instructs your carrier, or A/B MAC to compute 2008 customary and prevailing charges for the V2630, V2631, and V2632 (Intraocular Lenses Implanted in a Physician's Office) using actual charge data from July 1, 2006, through June 30, 2007.

Carriers and A/B MACs will compute 2008 Inflation-Indexed Charge (IIC) amounts for the V2630, V2631, and V2632 that were not paid using gap-filled payment amounts in 2007.

DME MACs will compute 2008 customary and prevailing charges for the codes identified in the following tables using actual charge data from July 1, 2006, through June 30, 2007. For these same codes, they will compute 2008 IIC amounts for the codes identified in the following tables that were not paid using gap-filled amounts in 2007. These tables are:

Dialysis Supplies Billed With AX Modifier

A4216	A4217	A4248	A4244	A4245	A4246
A4247	A4450	A4452	A6250	A6260	A4651
A4652	A4657	A4660	A4663	A4670	A4927
A4928	A4930	A4931	A6216	A640	

Dialysis Supplies Billed Without AX Modifier

A4653	A4671	A4672	A4673	A4674	A4680
A4690	A4706	A4707	A4708	A4709	A4714
A4719	A4720	A4721	A4722	A4723	A4724
A4725	A4726	A4728	A4730	A4736	A4737
A4740	A4750	A4755	A4760	A4765	A4766
A4770	A4771	A4772	A4773	A4774	A4802
A4860	A4870	A4890	A4911	A4918	A4929
E1634					

Dialysis Equipment Billed With AX Modifier

E0210NU	E1632	E1637	E1639

Dialysis Equipment Billed Without AX Modifier

E1500	E1510	E1520	E1530	E1540	E1550
E1560	E1570	E1575	E1580	E1590	E1592
E1594	E1600	E1610	E1615	E1620	E1625
E1630	E1635	E1636			

REIMBURSEMENT CONT'D

Carriers and A/B MACs will make payment for splints and casts furnished in 2008 based on the lower of the actual charge or the payment limits established for these codes. **Contractors** will use the 2008 reasonable charges or the attached 2008 splints and casts payment limits to pay claims for items furnished from January 1, 2008 through December 31, 2008. **Those 2008 payment limits are in Attachment A at the end of this article**.

Additional Information

Detailed instructions for Calculating:

- Reasonable charges are located in Chapter 23 (Section 80) of the *Medicare Claims Processing Manual*;
- Customary and prevailing charge are located in Section 80.2 and 80.4 of Chapter 23 of the *Medicare Claims Processing Manual*; and
- The IIC (Inflation Indexed Charge) are located in Section 80.6 of Chapter 23 of the *Medicare Claims Processing Manual*. The IIC update factor for 2008 is 2.7 percent.

You can find Chapter 23 of the *Medicare Claims Processing Manual* at www.cms.hhs.gov/manuals/downloads/clm104c23.pdf on the CMS Web site.

For complete details regarding this Change Request (CR) please see the official instruction (CR5740) issued to your Medicare FI, carrier, DME MAC, or A/B MAC. That instruction may be viewed by going to www.cms.hhs.gov/transmittals/downloads/R1344CP.pdf on the CMS Web site.

Attachment A
2008 Payment Limits for Splints and Casts

Code	Payment Limit	Code	Payment Limit
A4565	$7.38	Q4025	$32.45
Q4001	$42.01	Q4026	$101.30
Q4002	$158.81	Q4027	$16.23
Q4003	$30.18	Q4028	$50.66
Q4004	$104.49	Q4029	$24.81
Q4005	$11.12	Q4030	$65.31
Q4006	$25.08	Q4031	$12.41
Q4007	$5.58	Q4032	$32.65
Q4008	$12.54	Q4033	$23.14
Q4009	$7.43	Q4034	$57.56
Q4010	$16.72	Q4035	$11.57
Q4011	$3.71	Q4036	$28.79
Q4012	$8.36	Q4037	$14.12
Q4013	$13.52	Q4038	$35.37
Q4014	$22.81	Q4039	$7.08
Q4015	$6.76	Q4040	$17.68
Q4016	$11.40	Q4041	$17.16
Q4017	$7.82	Q4042	$29.30
Q4018	$12.47	Q4043	$8.59
Q4019	$3.91	Q4044	$14.66
Q4020	$6.24	Q4045	$9.96
Q4021	$5.78	Q4046	$16.03
Q4022	$10.44	Q4047	$4.97
Q4023	$2.91	Q4048	$8.02
Q4024	$5.22	Q4049	$1.82

CODING

ERMI Knee Flexinator

The ERMI knee/ankle flexinator device should be billed using HCPCS code E1811, for dates of service in 2008. For dates of service prior to January 1, 2008, use code E1399, as indicated in the DME Coding System (DMECS).

The ERMI knee/ankle flexinator is a patient-actuated serial stretch device [PASS] in the category of mechanical stretching devices. E1811 is described as a static progressive stretch knee device, extension and/or flexion, with or without range of motion adjustment, includes all components and accessories. This device is similar to a continuous passive motion device (CPM) used on knees, but is not a CPM device.

If an ERMI knee/ankle flexinator device is billed as code E1399 for dates of service in 2008, the claim will be denied as unprocessable, as a code for this device exists. This follows the guidelines in the Billing Unlisted HCPCS Codes article, published on 3/13/07.

When billing for DME items, select the HCPCS code that accurately identifies the equipment. Only when a code does not exist may the appropriate unlisted HCPCS code be billed.

2009 Annual Update of HCPCS Codes for SNF Consolidated Billing for Common Working File, MACs, Medicare Carriers and Fiscal Intermediaries

MLN Matters Number: MM6220
Related Change Request (CR) #: 6220
Related CR Release Date: October 3, 2008
Related CR Transmittal #: R1608CP
Effective Date: January 1, 2009
Implementation Date: January 5, 2009

Provider Types Affected

Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, DME Medicare Administrative Contractors (DME MACs), Fiscal Intermediaries (FIs), and/or Part A/B Medicare Administrative Contractors (A/B MACs) for services provided to Medicare beneficiaries who are in a Part A covered SNF stay.

CODING CONT'D

Provider Action Needed

This article is based on Change Request (CR) 6220 which provides the 2009 annual update of Healthcare Common Procedure Coding System (HCPCS) Codes for Skilled Nursing Facility Consolidated Billing (SNF CB) and how the updates affect edits in Medicare claims processing systems.

Physicians and providers are advised that, by the first week in December 2008, new code files will be posted at www.cms.hhs.gov/SNFConsolidatedBilling/ on the Centers for Medicare & Medicaid Services (CMS) Web site. Institutional providers note that this site will include new Excel® and PDF format files. It is **important and necessary** for the provider community to view the "General Explanation of the Major Categories" PDF file located at the bottom of each year's FI update listed at www.cms.hhs.gov/SNFConsolidatedBilling/ on the CMS Web site in order to understand the Major Categories including additional exclusions not driven by HCPCS codes.

Background

Medicare's claims processing systems currently have edits in place for claims received for beneficiaries in a Part A covered SNF stay as well as for beneficiaries in a non-covered stay. Changes to Healthcare Common Procedure Coding System (HCPCS) codes and Medicare Physician Fee Schedule designations are used to revise these edits to allow carriers, A/B MACs, DME MACs, and FIs to make appropriate payments in accordance with policy for Skilled Nursing Facility Consolidated Billing (SNF CB) contained in the *Medicare Claims Processing Manual* (Chapter 6, Section 110.4.1 for carriers and Chapter 6, Section 20.6 for FIs). (This manual is available at www.cms.hhs.gov/Manuals/IOM/list.asp on the CMS Web site.) These edits only allow services that are excluded from CB to be separately paid by Medicare contractors.

Additional Information

The official instruction, CR 6220, issued to your carrier, FI, A/B MAC, and DME MAC regarding this change may be viewed at www.cms.hhs.gov/Transmittals/downloads/R1608CP.pdf on the CMS Web site.

COVERAGE

Frequency Edits on LCDs

NAS is required to monitor the utilization patterns of suppliers and determine medical necessity and proper coding practices.

Many of the Local Coverage Determinations (LCDs) specify frequencies that define the limit of reasonable and necessary care. Suppliers are reminded to review the LCDs for frequency limitations prior to claims submission. To access LCDs and Policy Articles, see the Local Coverage Determinations page on the NAS DME Web site under Coverage/MR.

NAS has implemented, and will continue to implement, frequency of service limitations edits based on the LCDs.

Local Coverage Determination Number	Local Coverage Determination Title
L142	Ankle-Foot/Knee-Ankle-Foot Orthosis
L11568	Enteral Nutrition
L11569	External Breast Prostheses
L11570	External Infusion Pumps
L194	Eye Prostheses
L196	Glucose Monitors
L27058	Knee Orthoses
L11488	Nebulizer
L11489	Negative Pressure Wound Therapy Pumps
L11453	Lower Limb Prostheses
L11491	Ostomy Supplies
L11576	Parenteral Nutrition
L171	Positive Airway Pressure (PAP) Devices for the Treatment of Obstructive Sleep Apnea (Formerly CPAP)
L51	Refractive Lenses
L11493	Respiratory Assist Devices
L108	Speech Generating Device
L11494	Suction Pumps
L11460	Surgical Dressings
L157	Therapeutic Shoes for Persons with Diabetes
L166	Tracheostomy Care Supplies
L11495	Transcutaneous Electrical Nerve Stimulators (TENS)
L11581	Urological Supplies

Nebulizers – Policy Revision

The local coverage determination (LCD) for Nebulizers is being revised. The provision related to the application of least costly alternative to the combination drug albuterol/ipratropium (e.g. DuoNeb®) that was scheduled to be implemented on November 1 is being withdrawn. Other provisions of the policy remain in effect. This change will be included in an upcoming revision of the LCD for Nebulizers.

Knee Orthoses LCD - Revised

The Knee Orthoses local coverage determination (LCD) has been revised. The changes will be incorporated into a future publication of the policy. The following is a summary of the changes effective for dates of service on or after July 1, 2008:

Indications and Limitations of Coverage:

Added: ICD-9 diagnosis codes 844.0 - 844.2 and 996.40 - 996.49 to range of codes for L1830, L1832, L1834, L1843, L1844, L1845 and L1846

ICD-9 Codes That Support Medical Necessity:

Added: ICD-9 diagnosis codes 844.0 - 844.2 and 996.40 - 996.49 to range of codes for L1830, L1832, L1843, L1844, L1845 and L1846.

Documentation:

Added: Clarified that use of KX modifier is applicable to both the base and any addition codes.

Suppliers should review the entire Knee Orthoses policy for additional information on the coding, coverage and documentation requirements for these devices.

CPAP Therapy for Obstructive Sleep Apnea

MLN Matters Number: MM6048 Revised
Related Change Request (CR) #: 6048
Related CR Release Date: October 15, 2008
Related CR Transmittal #: R96NCD
Effective Date: March 13, 2008
Implementation Date: August 4, 2008

Note: This article was revised on October 16, 2008, to reflect changes to CR 6048, which CMS revised on October 15, 2008. The CR release date, transmittal number, and the Web address for accessing CR6048 were revised. In addition, some language in item 3, on page 3 was clarified. All other information remains the same.

Provider Types Affected

Physicians, providers and suppliers submitting claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs), Part A/B Medicare Administrative Contractors (A/B MACs), and/or Durable Medical Equipment (DME) MACs) for OSA-related services provided to Medicare beneficiaries.

Impact on Providers

Providers need to be aware that effective for claims with dates of service on and after March 13, 2008, Medicare will allow for coverage of CPAP therapy based upon a positive diagnosis of OSA by home sleep testing (HST), subject to the requirements of CR6048.

Background

The Centers for Medicare & Medicaid Services (CMS) reconsidered its 2005 National Coverage Determination (NCD) for CPAP Therapy for OSA to allow for coverage of CPAP based upon a diagnosis of OSA by HST.

Medicare previously covered the use of CPAP only in beneficiaries who had been diagnosed with moderate to severe OSA when ordered and prescribed by a licensed treating physician and confirmed by polysomnography (PSG) performed in a sleep laboratory in accordance with Section 240.4 of the *Medicare NCD Manual* (see the Additional Information section of this article for the official instruction and the revised section of the NCD). Following the reconsideration of its coverage policy, CMS is revising the existing NCD on CPAP therapy for OSA as well as allowing coverage of CPAP based on a positive diagnosis of OSA by HST, subject to all the requirements of the new NCD, as outlined in CR6048. (Note that billing guidelines for capped rental equipment are contained in the *Medicare Claims Processing Manual*, Chapter 20, Section 30.5, which is available at www.cms.hhs.gov/manuals/downloads/clm104c20.pdf on the CMS Web site.)

As part of the NCD, apnea is defined as a cessation of airflow for at least 10 seconds. Hypopnea is defined as an abnormal respiratory event lasting at least 10 seconds with at least a 30% reduction in thoracoabdominal movement or airflow as compared to baseline, and with at least a 4% oxygen desaturation. The apnea hypopnea index (AHI) is equal to the average number of episodes of apnea and hypopnea per hour. The respiratory disturbance index (RDI) is equal to the average number of respiratory disturbances per hour.

Key Points of CR6048

1. Coverage of CPAP is initially limited to a 12-week period for beneficiaries diagnosed with OSA as described below. CPAP is subsequently covered for those beneficiaries diagnosed with OSA whose OSA improves as a result of CPAP during this 12-week period.

Note: DME Prosthetics, Orthotics, and Supplies (DMEPOS) suppliers are required to provide beneficiaries with necessary information and instructions on how to use Medicare-covered items safely and effectively (42 CFR 424.57(c)(12)). Failure to meet this standard may result in revocation of the DMEPOS supplier's billing privileges (42 CFR 424.57(d)).

2. CPAP for adults is covered when diagnosed using a clinical evaluation and a positive:
   - Polysomnography (PSG) performed in a sleep laboratory; or
   - Unattended home sleep monitoring device of Type II; or
   - Unattended home sleep monitoring device of Type III; or
   - Unattended home sleep monitoring device of Type IV, measuring at least 3 channels

Note: In general, pursuant to 42 CFR 410.32(a), diagnostic tests that are not ordered by the beneficiary's treating physician are not considered reasonable and necessary. Pursuant to 42 CFR 410.32(b), diagnostic tests payable under the Medicare physician fee schedule that are furnished without the required level of supervision by a physician are not reasonable and necessary.

3. A positive test for OSA is established if either of the following criteria using the Apnea-Hypopnea Index (AHI) or Respiratory Disturbance Index (RDI) are met:
   - AHI or RDI greater than or equal to 15 events per hour of sleep or continuous monitoring, or
   - AHI or RDI greater than or equal to 5 and less than or equal to 14 events per hour of sleep or continuous monitoring with documented symptoms of excessive daytime sleepiness, impaired cognition, mood disorders or insomnia, or documented hypertension, ischemic heart disease, or history of stroke.

As previously stated, the AHI is equal to the average number of episodes of apnea and hypopnea per hour of sleep. The RDI is equal to the average number of respiratory disturbances per hour of continuous monitoring. However, there is variability in the published medical literature about the definition of the events that constitute a respiratory disturbance. The technology assessment that supported this NCD recognized this variability and defined RDI in the

context of the specific sleep test technology under review. For the purposes of this NCD, a respiratory disturbance is defined in the context of the sleep test technology of interest and does not require direct measurement of airflow. Local contractors will, as needed, determine, based on their review of the published, peer-reviewed medical literature, the equivalent test result criteria corresponding to the required AHI or RDI for Type IV devices measuring 3 or more channels that do not measure AHI or RDI directly.

4. The AHI or RDI is calculated on the average number of events of per hour. If the AHI or RDI is calculated based on less than 2 hours of continuous recorded sleep, the total number of recorded events to calculate the AHI or RDI during sleep testing is at least the number of events that would have been required in a 2-hour period.
5. CMS is deleting the distinct requirements that an individual have moderate to severe OSA and that surgery is a likely alternative.
6. CPAP based on clinical diagnosis alone or using a diagnostic procedure other than PSG or Type II, Type III, or a Type IV HST measuring at least 3 channels is covered only when provided in the context of a clinical study and when that study meets the standards outlined in the NCD manual revision attached to CR6048. Medicare will process claims according to Coverage with Evidence Development (CED)/clinical trials criteria at Section 310.1 of the NCD Manual and Chapter 32 and Sections 69.6-69.7 (Pub 100-04) of the Medicare Claims Processing Manual. These manuals are available at www.cms.hhs.gov/manuals/IOM/list.asp on the CMS Web site.

Note: The following HST portable monitoring G codes effective March 13, 2008, are provided for your information only, are not included in the CPAP for OSA NCD at section 240.4 of the *NCD Manual*, and do not necessarily convey coverage, which is determined at local contractor discretion.

G0398 Home sleep study test (HST) with type II portable monitor, unattended; minimum of 7 channels: EEG, EOG, EMG, ECG/heart rate, airflow, respiratory effort and oxygen saturation.

G0398 Short Descriptor: Home sleep test/type 2 Porta

G0399 Home sleep test (HST) with type III portable monitor, unattended; minimum of 4 channels: 2 respiratory movement/airflow, 1 ECG/heart rate and 1 oxygen saturation

G0399 Short Descriptor: Home sleep test/type 3 Porta

G0400: Home sleep test (HST) with type IV portable monitor, unattended; minimum of 3 channels

G0400 Short Descriptor: Home sleep test/type 4 Porta

Additional Information

To see the official instruction (CR6048) issued to your Medicare A/B MAC, FI , carrier, or DME MAC visit www.cms.hhs.gov/Transmittals/downloads/R96NCD.pdf on the CMS Web site.

Changes in Medicare Payment for Oxygen and Oxygen Equipment

The Centers for Medicare & Medicaid Services (CMS) has announced new oxygen payment rules and supplier responsibilities required by the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA). These final rules are found in the regulation titled "Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B (CMS-1403-FC)," which is now on display at the Office of the Federal Register.

Visit the CMS website at www.cms.hhs.gov/center/dme.asp to view the rule and obtain additional information.

Reminder Regarding Physician Orders for Manual Wheelchairs

It has come to NAS' attention that suppliers are providing physicians with a detailed product description of a manual wheelchair with accessories, having the physician sign and date this detailed product description, and naming this the detailed written order. Suppliers should remember this is appropriate only if the supplier received a verbal dispensing order or a preliminary written order from the physician prior to seeing the patient and determining what type of manual wheelchair would best suit the beneficiary's medical needs. A detailed product description may be completed and sent to the physician for approval only after the supplier receives a verbal or preliminary written order and sees the patient. Also, remember that a detailed product description, as described in the Power Mobility Devices LCD, is not a requirement for a manual wheelchair; the physician can provide his/her own detailed written order.

If the manual wheelchair is dispensed based on a verbal or preliminary written order, the supplier must maintain, in addition to the detailed written order, this preliminary written order or written documentation of the verbal order that must include: the beneficiary's name, a description of the item, the physician's name, and the start date of the order. This documentation must be available to the DME MACs, DME PSCs, ZPICs, or CERT contractor upon request. The preliminary written order or written documentation of the verbal dispensing order, if utilized, must be included when submitting a request for Advanced Determination of Medicare Coverage (ADMC) for a manual wheelchair.

Source: *Program Integrity Manual*, Chapter 5, Section 5.2 and Supplier Manual, Chapter 3

Wheelchair Armrests

Wheelchair options and accessories have a high Comprehensive Error Rate Testing (CERT) provider compliance error rate in Jurisdiction D. This determination was based upon review of medical documentation, which showed claims being billed for patients who did not meet the coverage criteria as noted in the Local Coverage Determinations (LCD) for Wheelchair Options and Accessories and Wheelchair Seating L11462. Therefore, NAS would like to provide suppliers with some basic information and to remind suppliers of the payment criteria regarding wheelchair leg rest to aid in lowering the error rate for this item.

Options and accessories for wheelchairs are covered if the patient has a wheelchair that meets Medicare coverage criteria and the option/accessory itself is medically necessary.

An arm trough (E2209) is covered if the patient has quadriplegia, hemiplegia, or uncontrolled arm movements.

Adjustable arm height option (E0973, K0017, K0018, K0020) is covered if the patient requires an arm height that is different than that available using nonadjustable arms and the patient spends at least 2 hours per day in the wheelchair.

Armrests can be fixed, adjustable, swing-back, swing-away or detachable. Their purpose is to support the arms in a comfortable, resting position and is essential for correct alignment of posture and decreasing strain on shoulder and neck joints/muscles. The user shouldn't have to lean forward to rest his elbows and the armrests should not be pushing his upper arms into his shoulders. It is important for the arms to be positioned with equal amount of pressure from the elbow to the hand to avoid pressure points. The surface of the arm rest must also be considered for prevention of skin breakdown. Armrests also serve as a base for attachments such as arm troughs, upper extremity orthoses and trays.

For options and accessories provided at the time of initial issue of a power wheelchair, once the supplier has determined the specific power mobility device that is appropriate for the patient based on the physician's order, the supplier must prepare a written document (termed a detailed product description) that lists the specific base (HCPCS code and either a narrative description of the item or the manufacturer name/model) and all options and accessories that will be billed separately. The supplier must list their 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 and the supplier must receive it prior to delivery of the power wheelchair. A date stamp or equivalent must be used to document receipt date. The detailed product description must be available upon request.

Accessories to the wheelchair base must be billed on the same claim as the wheelchair base itself.

When billing option/accessory codes as a replacement (modifier RP), documentation of the medical necessity for the item, make and model name of the wheelchair base it is being added to, and the date of initial issue of the wheelchair must be available upon request.

Refer to the Supplier Manual for more information on documentation requirements.

The medical necessity criteria noted above are found in the LCD for Wheelchair and Accessories located in the CMS Medicare Coverage Database

Suppliers may use this letter to assist in obtaining documentation from physicians for power wheelchairs and power operated vehicles.

NORIDIAN Administrative Services LLC
901 40th St S, Suite 1
Fargo, ND 58103-2146

Medicare

October 30, 2008

Dear Physician,

In order for Medicare to provide reimbursement for a power wheelchair (PWC) or power operated vehicle (POV) (scooter), there are several statutory requirements that must be met:

1. There must be an in-person physician-patient encounter.
2. The physician must perform a medical examination for the specific purpose of assessing the beneficiary's mobility limitation and needs. The results of this exam must be recorded in the patient's medical record.
3. The prescription must only be written AFTER the in-person visit has occurred and the medical evaluation is completed. This prescription has seven required elements.
4. The prescription and medical records documenting the in-person visit and examination report must be sent to the equipment supplier within 45 days of the completion of the examination.

The in-person visit and medical examination together are often referred to as the "face-to-face" exam.

You should record the visit and examination in your usual medical record-keeping format. Many suppliers provide forms for you to complete. Suppliers often try to create the impression that these documents are a sufficient record of the in-person visit and medical evaluation. Based upon our auditing experience, most of them are not. This is usually because these documents do not record a complete medical examination and thus do not provide enough detailed information to adequately describe the medical necessity for the power mobility device in the patient's home.

There are numerous sources that have developed forms. Many are home-grown by the individual supplier, some have been created by equipment manufacturers or other industry sources, and some have even been developed by medical groups, e.g., the Texas Academy of Family Physicians and Florida Academy of Family Physicians.

While there is no specific prohibition against the use of a form to facilitate record-keeping, any instrument you choose must be a complete and comprehensive record of your in-person visit and the examination that was performed. Documents such as the Texas or Florida Academy of Family Physicians forms that are designed to simply gather selected bits of information to be used for reimbursement purposes are insufficient to meet the statutory requirements. Even if you complete this type of form and include it in the patient's chart, it does not provide sufficient documentation of a comprehensive assessment of a patient's mobility needs.

You should perform a complete examination and document the results of the face-to-face examination in the same format that you use for other entries in your patient records. This assessment typically includes:

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A CMS Contracted Carrier/Intermediary

- History of the present condition(s) and past medical history that is relevant to mobility needs
  - Symptoms that limit ambulation
  - Diagnoses that are responsible for these symptoms
  - Medications or other treatment for these symptoms
  - Progression of ambulation difficulty over time
  - Other diagnoses that may relate to ambulatory problems
  - How far the patient can walk without stopping
  - Pace of ambulation
  - What ambulatory assistance (cane, walker, wheelchair, caregiver) is currently used
  - What has changed to now require use of a power mobility device
  - Ability to stand up from a seated position without assistance
  - Description of the home setting and the ability to perform activities of daily living in the home
- Physical examination that is relevant to mobility needs
  - Weight and height
  - Cardiopulmonary examination
  - Musculoskeletal examination
    - Arm and leg strength and range of motion
  - Neurological examination
    - Gait
    - Balance and coordination

The evaluation should be tailored to the individual patient's conditions. The history should paint a picture of your patient's functional abilities and limitations on a typical day. It should contain as much objective data as possible. The physical examination should be focused on the body systems that are responsible for the patient's ambulatory difficulty or impact on the patient's ambulatory ability.

It is important to keep in mind that because of the way that the Social Security Act defines durable medical equipment, a power mobility device is covered by Medicare only if the beneficiary has a mobility limitation that significantly impairs his/her ability to perform activities of daily living **within the home**. If the wheelchair/POV is needed in the home, the beneficiary may also use it outside the home. However, in your evaluation you must clearly distinguish your patient's mobility needs within the home from their needs outside the home.

You may elect to refer the patient to another medical professional, such as a physical therapist or occupational therapist, to perform part of the evaluation – as long as that individual has no financial relationship with the wheelchair supplier. However, you do have to personally see the patient before or after the PT/OT evaluation. You must review the report, indicate your agreement in writing on the report, and sign and date the report. If you do not see the patient after the PT/OT evaluation, the date that you sign the report is considered to be the date of completion of the face-to-face examination.

You may write the prescription for these items ONLY after the visit and examination are complete. This prescription must contain the following seven elements:

1. Beneficiary's name
2. Description of the item that is ordered. This may be general – e.g., "power operated vehicle", "power wheelchair", or "power mobility device"– or may be more specific.
3. Date of completion of the face-to-face examination
4. Pertinent diagnoses/conditions that relate to the need for the POV or power wheelchair
5. Length of need
6. Physician's signature
7. Date of physician signature

You must forward a copy of the face-to-face record and your seven-element prescription to the supplier within 45 days from the completion of the face-to-face. You should also include copies of previous notes, consultations with other physicians, and reports of pertinent laboratory, x-ray, or other diagnostic tests if they will help to document the severity of your patient's ambulatory problems.

After the supplier receives your order and the face-to-face information, they will prepare a detailed product description that describes the item(s) being provided including all options and accessories. You should review it and, if you agree with what is being provided, sign, date and return it to the supplier. If you do not agree with any part of the detailed product description, you should contact the supplier to clarify what you want the beneficiary to receive.

This information is not intended to serve as a substitute for the complete DME MAC local coverage determination on Power Mobility Devices. It is only a synopsis detailing the highlights of documentation. Refer to the complete LCD and Policy Article for additional information.

Medicare does provide you additional reimbursement (HCPCS code G0372) to recognize the additional time and effort that are required to provide this documentation to the supplier. This code is payable in addition to the reimbursement for your E&M visit code.

Your participation in this process and cooperation with the supplier will allow your patient to receive the most appropriate type of mobility equipment. We appreciate all your efforts in providing quality services to your Medicare patients.

Sincerely,

Richard W. Whitten, MD, MBA
Medical Director, DME MAC, Jurisdiction D