Jurisdiction D News from Noridian Administrative Services, LLC.

Happenings

November 2008
Issue No. 16

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

In This Issue…

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EDUCATIONAL

CEDI

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

ACCREDITATION

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Alphabetical Listing...

Jurisdiction D DME MAC Supplier Contacts and Resources

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

Web site: www.noridianmedicare.com

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

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

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

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

Other Resources		
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
Veteran's Day *	November 11, 2008
Thanksgiving Day	November 27, 2008
Thanksgiving Holiday	November 28, 2008
Christmas Eve**	December 24, 2008
Christmas Day	December 25, 2008
** Partial day closure	

Sources for "Jurisdiction D Happenings" Articles

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

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

Medicare Learning Network Matters Disclaimer Statement

Below is the Centers for Medicare & Medicaid Services (CMS) Medicare Learning Network (MLN) Matters Disclaimer statement that applies to all MLN Matters articles in this bulletin.

"This article was prepared as a service to the public and is not intended to grant rights or impose obligations. MLN Matters articles may contain references or links to statutes, regulations or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents."

CMS Announces Medicare Premiums, Deductibles for 2009

The standard Medicare Part B monthly premium will be $96.40 in 2009, the same as the Part B premium for 2008. This is the first year since 2000 that there was no increase in the standard premium over the prior year.

The 2009 Part B premium of $96.40 is the same as the amount projected in the 2008 Medicare Trustees Report issued in March. This monthly premium paid by beneficiaries enrolled in Medicare Part B covers a portion of the cost of physicians' services, outpatient hospital services, certain home health services, durable medical equipment, and other items.

By law, the standard premium is set to cover approximately one-fourth of the average cost of Part B services incurred by beneficiaries aged 65 and over. The remaining Part B costs are financed by Federal general revenues. The income to the program from premiums and general revenues are paid into the Part B account of the Supplementary Medical Insurance trust fund, and Part B expenditures are drawn from this account.

Normally, the Part B premium increases at the same rate as average Part B expenditures from year to year. A number of factors explain why the premium can be kept level for 2009.

Growth is expected in 2009 for most areas of the Medicare Part B program, including growth in the cost and use of physician and outpatient hospital care, home health services, physician-administered drugs, ambulatory surgical center services, durable medical equipment, independent lab and physician's office lab services, as well as growth in the Medicare Advantage program. In most years, this would result in the need for an increase in the Part B premium and general revenue financing.

To view this Fact Sheet in its entirety go to: http://www.cms.hhs.gov/apps/media/fact_sheets.asp

What is the Difference Between the PDAC and the DME MACs?

Function of the PDAC

One function of the Pricing Data Analysis and Coding Contractor is to determine an appropriate Healthcare Common Procedure Coding System (HCPCS) code to use when submitting claims to Medicare. A HCPCS code identifies the durable medical equipment, prosthetics, orthotics, and/or supplies (DMEPOS) being billed.

PDAC Responsibilities

- Operate a Contact Center to provide coding advice and guidance.
- Maintain DMECS, a web-based interactive tool that provides HCPCS coding assistance and national fee schedule information. (PDAC Contact Center)
- Respond to written inquiries requesting HCPCS coding assistance
- Coordinate and participate in requests for HCPCS Coding Verification Reviews

- Maintain a NDC/HCPCS crosswalk applicable for DME MAC billing.

Who is Calling the PDAC?

- Suppliers
- Manufacturers
- Distributors
- OIG (Office of Inspector General)
- CMS (Centers for Medicare & Medicaid Services)
- Consultants
- Attorneys
- Doctor Offices
- Pharmacies
- Billing Services
- Other Insurance Carriers
- DME MACS
- Medicaid
- Attorney General Office

PDAC Can:

- Provide HCPCS coding determinations
- Provide allowables for items that are on the DMEPOS Fee Schedule

PDAC Cannot:

- Provide codes for items that are not billable to the DME MACS
- Answer coverage or policy questions including the use of modifiers
- Address claim inquiries
- Provide beneficiary eligibility
- Assist with questions concerning claim form(s)
- Address required documentation for claims submission
- Provide allowables for items that are not on the DMEPOS Fee Schedule
- Provide publications such as the Supplier Manual, bulletins or DMEPOS Fee Schedules
- Address CMN or DIF Information
- Assist with Type of Service or Place of Service codes
- Provide Diagnosis Codes

Type of Calls Referred to the DME MAC:

- Coverage and Utilization Questions
- Eligibility
- Claim Inquiries
- Claim Form(s)
- Required Documentation
- Allowables for items priced by reasonable charge and individually considered items
- Publications: Supplier Manual, bulletins and Fee Schedules
- CMN/DIF Information
- Type of Service and Place of Service Codes

Medicare Providers Remain Satisfied with Fee-for-Service Contractors

The Centers for Medicare & Medicaid Services (CMS) reported today that Medicare health care providers continue to be satisfied with services provided by Medicare fee-for-service contractors showing a relatively smooth transition to the new Medicare Administrative Contractors (MACs).

The average score based on a satisfaction survey across all contractors was 4.51 on a scale of 1 to 6. This year's average score was comparable to last year's average score of 4.56.

The Medicare Contractor Provider Satisfaction Survey (MCPSS), conducted by CMS for the third year, is designed to gather and report objective, quantifiable data on provider satisfaction with the fee-for-service contractors who process and pay Medicare claims. In 2007, more than one billion claims were processed and paid to approximately one million health care providers who provided medically necessary items and services to 44 million beneficiaries.

The survey is mandated by the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003. Specifically, the law calls for CMS to develop contract performance requirements, including measuring provider satisfaction with Medicare contractors. The MCPSS enables CMS to make valid comparisons of provider satisfaction between contractors and, over time, improvements to Medicare.

The summary report of the survey findings is available on the CMS Web site in the MCPSS section at www.cms.hhs.gov/MCPSS.

The CMS press release issued today can be viewed at: http://www.cms.hhs.gov/apps/media/press_releases.asp

Iowa and Indiana Waivers Expire

In June 2008, the Centers for Medicare & Medicaid Services (CMS) issued guidance which addressed Medicare's Skilled Nursing Facility (SNF) benefit's statutory requirement of a 3-day prior hospital stay and the inability of beneficiaries who were evacuated or transferred as a result of the serious flooding in the States of Iowa and Indiana to meet this requirement. This guidance provided temporary emergency coverage of SNF services that are not post-hospital SNF services under our authority in section 1812(f) of the Social Security Act (the Act), for those beneficiaries who are evacuated, transferred, or otherwise dislocated as a result of the flooding.

In addition, for beneficiaries who, prior to the flooding, had been recently discharged from a SNF after utilizing some or

all of their available SNF benefit days, guidance was issued to address the inability to meet the requirement to end an existing Medicare benefit period (or "spell of illness") before renewing SNF benefits. Under the authority of section 1812(f) of the Act, this policy enabled such beneficiaries to receive up to an additional 100 days of SNF Part A benefits for care needed as a result of the flooding, without first having to end a spell of illness by being discharged to custodial or non-institutional care for a 60-day period.

Unlike the general waivers issued in response to the Iowa and Indiana flooding under the authority of section 1135 of the Act, these two SNF-related policies were not limited to States designated as emergency areas. Rather, they would apply to all beneficiaries who were evacuated from an emergency area as a result of the flooding, regardless of where the "host" SNF providing post-flood care was located. In addition, these two SNF-related policies would remain in effect until such time as CMS issued a notification that normal procedures would resume.

We have terminated these SNF-related policies concurrently with the general flood-related waivers issued under the section 1135 authority, which expire on September 12, 2008. Accordingly, effective with SNF admissions occurring on and after September 13, 2008, the Internet-Only Manual instructions for determining compliance with the SNF benefit's prior hospitalization and benefit period requirements shall apply.

Finally, beginning September 13, 2008, all program policies and Questions and Answers that implemented modifications to program requirements under the section 1135 waiver authority for the Iowa/Indiana floods are no longer applicable. Therefore, claims with dates of service September 13, 2008, and later will follow all normal program requirements.

Beneficiaries Call 1-800-MEDICARE

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

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

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

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

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

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

- View claim status (excluding Part D claims)
- Order a duplicate Medicare Summary Notice (MSN) or replacement Medicare card
- View eligibility, entitlement and preventive services information
- View enrollment information including prescription drug plans
- View or modify their drug list and pharmacy information
- View address of record with Medicare and Part B deductible status
- Access online forms, publications and messages sent to them by CMS

Healthcare Provider Taxonomy Codes Update for October 2008

This article provides notice to Medicare providers of modifications, additions and deletions to the Healthcare Provider Taxonomy Codes (HPTC) maintained by the National Uniform Claim Committee (NUCC) for standardized classification of healthcare providers. The NUCC updates the code set twice a year with changes effective April 1 and October 1.

Background

The HPTC list is available from the Washington Publishing Company (WPC) www.wpc-edi.com/codes/taxonomy in

FYI CONT'D

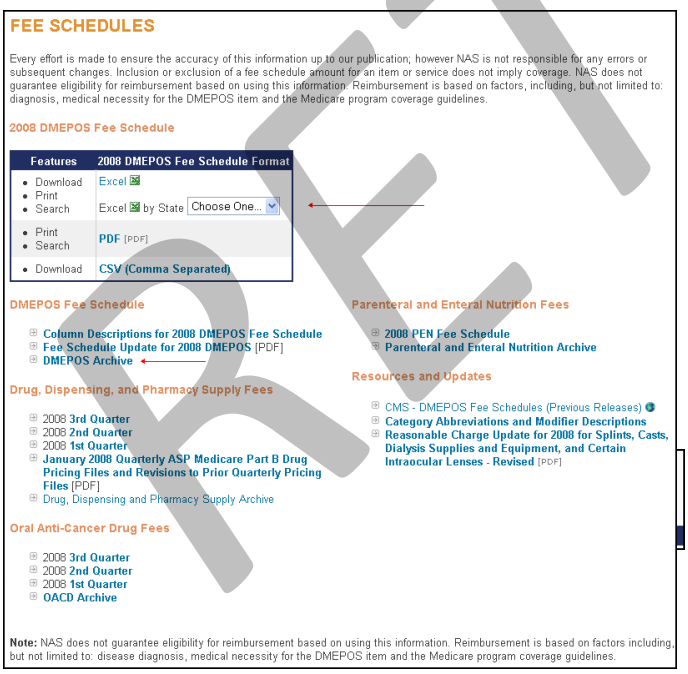
two forms. The first form is a free Adobe PDF download. The second form, available for purchase, is an electronic representation of the code set that facilitates automatic loading of the codes.

Policy

The Health Insurance Portability and Accountability Act (HIPAA) requires that covered entities comply with the requirements in the electronic transaction format implementation guides adopted as national standards. The institutional and professional claim electronic standard implementation guides (X12 837-I and 837-P) each require use of valid codes contained in the HPTC set when there is a need to report provider type or physician, practitioner, or supplier specialty for a claim.

Valid HPTCs are those codes approved by the NUCC for current use. Terminated codes are not approved for use after a specific date and newly approved codes are not approved for use prior to the effective date of the code set update in which each new code first appears. Although the NUCC generally posts their updates on the WPC Web page three months prior to the effective date, changes are not effective until April 1 or October 1 as indicated in each update.

Specialty and/or provider type codes issued by any entity other than the NUCC are not valid and Medicare would be guilty of non-compliance with HIPAA if Medicare contractors accepted claims that contain invalid HPTCs. Taxonomy code changes are to be applied to claims processed on and after the implementation date of this change request.



As always, NAS appreciates all supplier feedback through the ForeSee Results survey and the Web site Feedback link at the bottom of each NAS DME Web page.

Ask the Contractor Teleconference for Small Suppliers – November 12, 2008

NAS will conduct the next DME Ask the Contractor Teleconference to assist **small suppliers on November12, 2008**. CMS has defined a small supplier as a supplier with ten or fewer full time equivalent employees. During this teleconference, knowledgeable NAS staff representing a variety of functions will be available to answer your questions. If we cannot answer your question during the teleconference, we will research the issue and then call you with the answer.

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

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

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

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

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

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

EDUCATIONAL

Update to a Medicare Learning Network Educational Product: CMS Form 1500 Web-Based Training Course

The CMS Form 1500 Web-based Training (WBT) course has been updated (July 2008) and is now available from the Centers for Medicare & Medicaid Services **Medicare Learning Network**. This WBT course provides information that will allow you to file Medicare Part B claims accurately and reduce your chances of receiving unprocessable rejections.

To access this WBT, visit http://www.cms.hhs.gov/mlngeninfo/ , scroll down to "Related Links Inside CMS" and select "Web-based training Modules", scroll down to "Office Management Information" to select this training.

Change to the CEDI B108 Error Message on October 1, 2008

On October 1, 2008, the B108 Warning Message on the CEDI GenResponse (GENRPT) Report will become a rejection.

The Common Electronic Data Interchange (CEDI) currently provides a B108 warning message on the CEDI GenResponse (GENRPT) Report when the NPI is not linked to the Trading Partner (Submitter) ID. At this time, this is a warning message and does not reject claims submitted. Accepted claims with the B108 warning message are being forwarded to the appropriate DME MAC where front end edits will continue to be performed. These edits will validate the supplier is authorized for EDI transactions and perform NPI validation.

The CEDI edit B108 will be changed from a warning to a rejection on October 1, 2008. At that time claims that do not have an NPI matched to the Trading Partner (Submitter) ID will be rejected by CEDI and will not be forwarded to the DME MACs. It is important that electronic trading partners complete the steps below to correct the B108 warning message now and avoid future rejection of claims on October 1, 2008.

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

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

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

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

Changes to Electronic Front-End Report Effective October 6, 2008

Effective October 6, 2008, the following changes will occur on 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: A CEDI Error Code Manual will be published soon. Once available, a CEDI Listserv announcement will be distributed.
- 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 working closely with the DME MAC software vendors to provide information about the front-end report changes. Updates are currently being made to the report documentation available on the CEDI Web site at www.ngscedi.com. When the updated materials are available a Listserv will be distributed.

Out of Balance ERAs will Become Available on October 6, 2008

Beginning, October 6, 2008, CEDI will begin returning Out of Balance (OOB) Electronic Remittance Advices (ERAs) to all electronic trading partners when an OOB ERA is created by a DME MAC.

In the past, OOB ERAs were not returned to electronic trading partners. Due to the many requests from DME MAC suppliers and software vendors to receive this information, the OOB ERA's will be returned beginning October 6, 2008.

OOB ERAs are normally created when Medicare Secondary Payer (MSP) claims exists in the file and the reason and remark code on the ERA was valid when the claim was paid, but is no longer valid when the ERA is created. OOB ERAs are seldom created and will not balance with the amounts paid and adjusted.

CEDI has notified software vendors of this change and worked closely with them to determine the best method of returning this information.

On October 6, 2008, Electronic trading partners can determine when an OOB ERA is created by the naming convention of the ERA file. An OOB ERA will begin with "OOB835" in the file name. When an OOB ERA file is received, please contact your software vendor to determine how to view and post the file correctly.

Support for Electronic Trading Partners using a Clearinghouse or Billing Service

Electronic trading partners/submitters using a clearinghouse or billing service to send claims to CEDI should work directly with their clearinghouse or billing service concerning the following items:

- **Assistance with an Electronic Report** – Electronic reports are returned to the submitter of the electronic file (Clearinghouse or Billing Service). As the submitter, the clearinghouse or billing service will contact the CEDI Help Desk to resolve any issues with the electronic reports.
- **Electronic Remittance Advices(ERA)** – If the DME MAC supplier elects to have a Clearinghouse or Billing Service retrieve their Electronic Remittance Advice (ERA), the Clearinghouse or Billing Service will contact the CEDI Help Desk for ERA support (i.e., to recreate an ERA).

When the Clearinghouse or Billing Service is exchanging electronic transactions on behalf of a DME MAC supplier, the Clearinghouse or Billing Service will contact the CEDI Help Desk directly for assistance with the items listed above. The CEDI Help Desk can be contacted by calling 1-866-311-9184 or via e-mail at ngs.cedihelpdesk@wellpoint.com.

New CEDI Front-End Report Manual

National Government Services, CEDI has developed a new *Front-End Report Manual* to include all of the electronic report changes that will occur effective, October 6, 2008. The CEDI *Front-End Report Manual* can be accessed using the following link: www.ngscedi.com/outreach_materials/outreachindex.htm

All DME MAC electronic trading partners, suppliers, software vendors, billing services and clearinghouses should download this manual ("CEDI Front-End Reports Manual") and use it to interpret the front-end reports created by CEDI.

As a reminder, the list of the changes effective, October 6, 2008 on the electronic front-end reports returned to trading partners from CEDI are listed below:

- Additional front-end edits will be added to the current CEDI GenResponse (GENRPT) report.
- 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.
- IMPORTANT: 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.
- CEDI is working closely with the DME MAC software vendors to provide information about the front-end report changes.

DME MACs will continue to produce the CMN Reject and this report will be returned to Trading Partners through CEDI.

COBA and Affiliated NPI Process Modifications

Attention: Medicare Part A, Part B, and DME MAC electronic submitters, software vendors, billing services, and clearinghouses.

Effective October 6, 2008, Medicare will reject all incoming Medicare electronic claims that contain any legacy provider identifiers (qualifiers) other than the following:

- NPI (NM109 segment using the qualifier "XX")
- EIN/Federal Tax ID (using the qualifiers "EI" or "TJ" within the secondary provider REF loops)
- SSN (using the qualifier "SY" within the secondary provider REF loops)

The secondary provider REF loops in American National Standards Institute (ANSI) are: 2010AA, 2010AB, 2310A, 2310B, 2310C, 2310D, 2310E, 2330D, 2330E, 2330F, 2330G, 2330H, 2420A, 2420B, 2420C, 2420D, 2420E and 2420F. Medicare will not accept qualifiers other than "EI", "TJ" or "SY" in these secondary provider loops beginning with electronic claims accepted on or after October 6, 2008.

Note: The secondary provider REF loops listed above should only be used for Medicare claims when appropriate for the line of business submitted. The qualifiers ("EI", "TJ" and "SY") should only be used when valid for the loop submitted.

All loops and qualifiers referenced are part of the ANSI format. Providers and suppliers that have questions regarding these loops and/or qualifiers should contact their software vendor for further details.

Note: This article is written in reference to CMS Change Request 6024, Transmittal 1507, titled, "Coordination of Benefits Agreement (COBA) and Affiliate National Provider Identifier (NPI) Process Modifications."

CEDI Companion Documents Available on www.ngscedi.com

National Government Services, Common Electronic Data Interchange (CEDI) has the following Companion Documents loaded to the CEDI Web site:

- ANSI X12 276/277 Version 4010A1 (Claim Status and Response)
- ANSI X12 835 Version 4010A1 (Remittance Advice)
- ANSI X12 837 Version 4010A1 (Claims)
- NCPDP Companion Document

These documents serve only as a companion document to the HIPAA implementation guides. These companion documents supplement, but do not contradict any requirements in HIPAA implementation guides. The use of these documents is solely for the purpose of clarification. The information in these documents is subject to change. Changes will be communicated on the National Government Services CEDI Web site at www.ngscedi.com and through the CEDI Listserv. The CEDI Companion Documents can be accessed using the following link http://www.ngscedi.com/TechnicalSpec/techindex.htm.

CEDI NCPDP Error Code Manual is Now Available

National Government Services, Common Electronic Data Interchange (CEDI) is announcing the availability of the *NCPDP Error Code Manual* on the CEDI Web site. The National Council for Prescription Drug Programs (NCPDP) format is used by DME MAC suppliers to submit retail pharmacy drug claims. DME MAC suppliers using this format will use the *NCPDP Error Code Manual* to resolve front end edits received on their NCPDP electronic reports.

The *NCPDP Error Code Manual* provides a listing of all NCPDP edit numbers, descriptions, element/segment ID references, edit explanations and report examples. To access this manual use the following link www.ngscedi.com/outreach_materials/outreachindex.htm

The Level I report reference document, titled "CEDI Front End Reports Reference Document" and the Level II Manual, titled "DME MAC Front End Edit Error Code Manual" are both available using the same link referenced above.

It is essential that all trading partners/electronic submitters download and review all front end reports returned by CEDI. Trading partners/electronic submitters should use the edit error manuals available to resolve rejections prior to contacting the CEDI Help Desk.

CEDI Electronic Front-End Reports and Top Rejections for July 2008

It is essential that all Trading Partners/Electronic Submitters download and review all front end reports returned by Common Electronic Data Interchange (CEDI).

Level I Reports

National Government Services CEDI creates and delivers the following Level I reports for each claim file that is submitted:

- TA1 (NOTE: Some systems may generate a TA1 report for accepted and rejected files., Others will only generate a TA1 if the file rejects. Check with your software vendor to determine if your system generates both an accepted and/or rejected TA1.)
- TRN
- 997
- GenResponse (GENRPT)

For more information on the Level I reports, access the **CEDI Front End Reports Reference Document** under the Resource Materials section of the CEDI Web site at: www.ngscedi.com/outreach_materials/outreachindex.htm

Questions regarding rejections on the TA1, TRN and/or 997 should be directed to your software vendor. Your software vendor will know what needs to be corrected in order to pass these edits.

CEDI will provide support for the GenResponse (GENRPT) report.

Level II Reports

Electronic trading partners/submitters will also receive a Level II report from each DME MAC that received claims in the file(s) sent to CEDI. These Level II reports are created by the DME MACs, but delivered by CEDI.

Electronic Trading Partners/Submitters should first review the **DME MAC Front End Edit Error Code Manual** to identify the cause of the error before contacting the CEDI Help Desk. For more information on the DME MAC Level II errors, descriptions and report examples, access the **DME MAC Front End Edit Error Code Manual** under the Resource Materials section of the CEDI Web site at: www.ngscedi.com/outreach_materials/outreachindex.htm

The edit codes below were the top rejections received by CEDI electronic trading partners/submitters in July 2008. These edits are included in the **DME MAC Front End Edit Error Code Manual**. The information included below provides the description from the DME MAC Front End Edit Error Code Manual as well as additional information that can be used to resolve these rejections.

Edit #	Edit Description	ANSI reference	Edit Explanation
20359	ORDERING PROVIDER SECONDARY ID INVALID	2420E. REF01	**DME MAC Front End Edit Code Manual states:** As of May 23, 2008, the qualifier "1C" (Medicare Provider Number) or "1G" (Provider UPIN Number) will no longer be allowed. **Additional Information:** This REF segment should not be sent and should be removed from the electronic file. The NPI for the Ordering Provider must be reported in the NM109 only, with an "XX" qualifier in the NM108. This would apply to all loops with a REF segment for DME MAC electronic claims. NOTE: The REF segment was used prior to May 23, 2008 to report legacy identification numbers. Express Plus Users: See instructions below titled "Express Plus Users – Steps to ensure the software program is only transmitting NPI numbers" PC-ACE Pro32 Users: See instructions below titled "PC-ACE Pro32 Users – Steps to ensure the software program is only transmitting NPI numbers" Suppliers using a software vendor, billing service or clearinghouse: Contact your vendor, billing service or clearinghouse for assistance.
40014	ORDERING PROV INFO MISSING	2420E. REF01 or 2420E NM108	**DME MAC Front End Edit Code Manual states:** The ordering provider information is missing. This loop must be present for each service line of a DME MAC claim. **Additional Information:** Due to the NPI implementation on May 23, 2008, all legacy ID numbers are no longer accepted on any Medicare claims. Electronic claims must be submitted with an NPI number for the ordering provider. In the ANSI format, NM108 must equal qualifier "XX". The "XX" qualifier identifies that an NPI is being submitted. The NM109 must contain the 10-digit NPI. Express Plus Users: See instructions below titled "Express Plus Users – Steps to ensure the software program is only transmitting NPI numbers" PC-ACE Pro32 Users: See instructions below titled "PC-ACE Pro32 Users – Steps to ensure the software program is only transmitting NPI numbers" Suppliers using a software vendor, billing service or clearinghouse: Contact your vendor, billing service or clearinghouse for assistance.

Edit #	Edit Description	ANSI reference	Edit Explanation
40022	PROCEDURE CODE MODIFIER INVALID	2400. SV101-2	**DME MAC Front End Edit Code Manual states:** The procedure code or modifier is invalid. Verify the HCPCS and modifier combination is valid. Make sure the first position does not contain a space. **Additional Information:** Suppliers should check the validity of the procedure code/ modifier combination by using the Pricing, Data Analysis and Coding (PDAC) Web site https://www.dmepdac.com/. The supplier should check the Local Coverage Determination (LCD) at the DME MACs for guidelines on procedure codes and modifier usage specific for that LCD. Jurisdiction A: www.medicarenhic.com/dme Jurisdiction B: www.NGSMedicare.com Jurisdiction C: www.cignagovernmentservices.com/jc Jurisdiction D: www.noridianmedicare.com/dme The supplier can reference the supplier manual at the DME MAC Jurisdiction where they received the front end rejection. Jurisdiction A: www.medicarenhic.com/dme Jurisdiction B: www.NGSMedicare.com Jurisdiction C: www.cignagovernmentservices.com/jc Jurisdiction D: www.noridianmedicare.com/dme If the supplier cannot determine what is wrong with their HCPCS code and modifier combination, they should contact the Customer Care department at the Jurisdiction where they received the front end rejection. Jurisdiction A: 1-866-590-6731 Jurisdiction B: 1-866-590-6727 Jurisdiction C: 1-866-270-4909 Jurisdiction D: 1-866-243-7272
40068	QUESTION NUMBER/ LETTER INVALID	2440. FRM01	**DME MAC Front End Edit Code Manual states:** If edits 40066, 40067, and 40068 are present on one charge line, verify the procedure code actually requires the attached CMN. If 40022 is also present as a rejection on the charge line, these edits may all be caused by an invalid procedure code/modifier combination. If the procedure code does require the attached CMN, the question number entered is not valid for the DME MAC CMN sent with this claim line. **Additional Information:** Most of the time this edit (40068) fires with 40066 and 40067 because the HCPCS code submitted on the charge line does not require a CMN.

40068	QUESTION NUMBER/ LETTER INVALID	2440. FRM01	**DME MAC Front End Edit Code Manual states:** If edits 40066, 40067, and 40068 are present on one charge line, verify the procedure code actually requires the attached CMN. If 40022 is also present as a rejection on the charge line, these edits may all be caused by an invalid procedure code/modifier combination. If the procedure code does require the attached CMN, the question number entered is not valid for the DME MAC CMN sent with this claim line. **Additional Information:** Most of the time this edit (40068) fires with 40066 and 40067 because the HCPCS code submitted on the charge line does not require a CMN.
20269	POINTER 1 DIAG INVALID	2400. SV107.1	**DME MAC Front End Edit Code Manual states:** The diagnosis code pointed to by Diagnosis Code Pointer 1 (SV107-1) is invalid for the claim line date of service. **Additional Information:** Use this diagnosis pointer for the first diagnosis code pointer (primary diagnosis for this service line). Acceptable values for DME MAC are 1, 2, 3 or 4.

Express Plus Users – Steps to ensure the software program is only transmitting NPI numbers

Reminder: Effective May 23, 2008, electronic claims should list a National Provider Identifier (NPI) ONLY. If a legacy number is listed, the claim will reject on the electronic front end.

To ensure that only the NPI is submitted on claims, Express Plus users must complete the following instructions:

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

1. Go to the File Maintenance Menu
2. Click on Provider Maintenance
3. Select a Provider and then click on Edit
4. Make sure the supplier's NPI number is listed under the field titled "NPI"
5. Add the Tax ID or Social Security Number associated with the NPI. The Tax ID number will be entered into the field titled "Tax ID". The Social Security Number will be entered into the field titled "SSN". NOTE: The corresponding Tax ID or SSN must be entered for the NPI listed on this screen.
6. Remove the NSC supplier number listed under the field titled "Medicare ID"
7. Click on "Save" and your information will be updated

Complete the steps above for each Provider listed under Provider Maintenance in the Express Plus software.

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

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

Complete the steps above for each Provider listed under the Ordering Physician Maintenance Menu in the Express Plus software.

PC-ACE Pro32 Users - Steps to ensure the software program is only transmitting NPI numbers

CEDI CONT'D

Reminder: Effective May 23, 2008, electronic claims should list a National Provider Identifier (NPI) ONLY. If a legacy number is listed, the claim will reject on the electronic front end.

To ensure that only the NPI is submitted on claims, PC-ACE Pro32 users must complete the following instructions:

1. Make sure you are using PC-ACE Pro32 Version 1.94. PC-ACE Pro32 Version 1.94 and download instructions are available at the CEDI Web site www.ngscedi.com.
2. Verify that your Billing Provider's NPI and Tax ID numbers are located in the Provider (Professional) tab under Reference File Maintenance. This will also require an entry for the PTAN/legacy number in the Provider field, but PC-ACE Pro 32 will not send the PTAN/legacy number in the claims file.
3. Verify that your Ordering Provider's NPI is located in the Physicians area of the Codes/Misc tab. This tab is found under Reference File Maintenance. PC-ACE Pro32 only requires the NPI under this tab, so the first entry (formerly used for the UPIN number) can be left blank. If the UPIN is included in this first entry field, PC-ACE Pro32 will not send it in the claims file.

ACCREDITATION

CMS Announces Accreditation Exemptions

CMS has announced that as of September 3, 2008, several supplier types are now exempt from all accreditation requirements. Among this supplier group are:

- Physicians
- Orthotists
- Prosthetists
- Pedorthists
- Opticians
- Optometrists
- Audiologists
- Occupational Therapists
- Physical Therapists

Suppliers that fall in this subset are reminded that if they provide other durable medical equipment outside of their specialty, they will be required to be accredited to bill Medicare.

In addition, suppliers that provide drugs and pharmaceuticals ONLY are exempt from the accreditation requirement. If the supplier provides equipment to administer drugs or pharmaceuticals, the supplier must be accredited.

As an exempted supplier, if your enrollment application was returned previously for non-accreditation, you must resubmit your 855S to the NSC. **Billing privileges will not be retroactive due to new accreditation exemptions**. All other suppliers that require accreditation to obtain/maintain Medicare billing privileges must submit accreditation documentation to the NSC by the following deadlines.

Suppliers enrolled with the NSC January 1, 2008 - February 29, 2008, must submit accreditation documentation to the NSC no later than January 1, 2009.

Active suppliers enrolled prior to January 1, 2008, must submit accreditation documentation to the NSC no later than September 30, 2009.

As of March 1, 2008, all DMEPOS suppliers with the exception of the exemptions listed above are required to be accredited prior to enrolling with the National Supplier Clearinghouse.

Response to FQHC Question Raised on the September 3, 2008 Special ODF: DMEPOS Accreditation - MIPPA 2008 Guidance

DME is not covered within the Medicare Federally Qualified Health Clinic (FQHC) benefit. All FQHC's would need to have a DMEPOS supplier number in order to bill for those separately, and go through the same process as any other DME supplier. Thus, all FQHC's billing for the products covered under the DME quality standards would be subject to the accreditation deadline of September 30, 2009, in order to continue to bill for these supplies. If you would like a list of those supplies, please go to the web site at: www.cms.hhs.gov/medicareprovidersupenroll there is a link on the upper left hand side of the page for DMEPOS Accreditation. Once in that site, you will find the 10 accreditation organizations, the quality standards and a Fact Sheet listing all of the covered items.

COMPETETIVE BIDDING

Delay of DMEPOS Competitive Bidding Program

MLN Matters Number: MM6203
Related Change Request (CR) #: 6203
Related CR Release Date: September 5, 2008
Related CR Transmittal #: R375OTN
Effective Date: July 1, 2008
Implementation Date: September 12, 2008

Provider Types Affected

Providers and suppliers submitting claims to Medicare Durable Medical Equipment Medicare Administrative Contractors (DME MACs) and/or Regional Home Health Intermediaries (RHHIs) for DMEPOS provided to Medicare beneficiaries residing in the 10 areas previously designated as competitive bidding areas.

Provider Action Needed

This article is based on Change Request (CR) 6203, which implements instructions related to **delaying the DMEPOS Competitive Bidding Program, reprocessing DMEPOS Competitive Bidding claims under regular fee-for-service**

(FFS) rules, and educating suppliers about the delay. Make certain your billing staffs are aware of these changes.

Background

Section 154 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) delays the DMEPOS Competitive Bidding Program and terminates all Round I Competitive Bid contracts. Therefore, in the 10 areas where competitive bidding was initiated, **Medicare has resumed paying for DMEPOS items using the standard DMEPOS fee schedule amounts that were in place as of June 30, 2008**.

Key Points

Effective immediately, the Centers for Medicare & Medicaid Services (CMS) has instructed the DME MACs and RHHIs to **cease all implementation activities related to the DMEPOS Competitive Bidding Program**. Your Medicare Contractors will process all DMEPOS claims under standard FFS rules. Note the following requirements issued by CMS and make certain your billing staffs are aware of the changes.

- Your Medicare Contractors have begun to process all new incoming DMEPOS claims under standard FFS rules.
- Your Medicare Contractors will process all previously-held DMEPOS Competitive Bidding Program claims under standard FFS rules and they should have completed such processing as soon as possible.
- Your Medicare Contractors will automatically reprocess claims that were denied based solely on DMEPOS Competitive Bidding Program rules under standard FFS rules and complete such reprocessing by September 30, 2008.
- Your Medicare Contractors should identify and automatically reprocess under standard FFS rules any claim adjudicated under DMEPOS Competitive Bidding Program rules and pay any difference that may be owed on such claims to affected suppliers and complete these activities by September 30, 2008.
- Your Medicare Contractors should adjust any claims they are unable to automatically reprocess if you bring such claims to their attention.
- Home health agencies (HHA) should be aware that any claims returned to the provider as subject to DMEPOS Competitive Bidding may be resubmitted.
- Your Medicare Contractors will not initiate any redeterminations on claims where the application of one or more DMEPOS Competitive Bidding rule is the only issue in controversy. Rather than issuing redeterminations your contractors will reprocess such claims and issue substitute initial determinations with full appeal rights.
- Providers should ignore the instructions contained in Chapter 36 of the Medicare Claims Processing Manual, as communicated via CRs 5978, 6007 and 6119, until further notice from CMS.

Additional Information

The official instruction (CR6203) issued to your Medicare DME MAC or RHHI may be viewed by going to http://www.cms.hhs.gov/Transmittals/downloads/R375OTN.pdf on the CMS web site.

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 http://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.

NPI for Secondary Providers

MLN Matters Number: MM6093
Related Change Request (CR) #: 6093
Related CR Release Date: September 12, 2008
Related CR Transmittal #: R267PI
Effective Date: May 23, 2008
Implementation Date: September 26, 2008

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.

NPI CONT'D

Additional Information

For complete details regarding this Change Request (CR) please see the official instruction (CR6093) issued to your Medicare carrier, DME/MAC, MAC or FI. That instruction may be viewed by going to http://www.cms.hhs.gov/Transmittals/downloads/R267PI.pdf on the CMS web site.

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.

OVERPAYMENTS

Limitation on Recoupment (935) for Provider, Physicians and Suppliers Overpayments

MLN Matters Number: MM6183 Revised
Related Change Request (CR) #: 6183
Related CR Release Date: September 12, 2008
Related CR Transmittal #: R141FM
Effective Date: September 29, 2008
Implementation Date: September 29, 2008

Note: This article was revised on September 18, 2008, to make minor clarifying changes on page 2 and to delete some unnecessary language on pages 5 and 9. All other information remains the same.

Provider Types Affected

Physicians, providers, and suppliers (collectively referred to as providers) who submit claims to Medicare contractors (fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), carriers, Medicare Administrative Contractors (A/B/MAC), or Durable Medical Equipment Medicare Administrative Contractors (DME MAC)) for services provided or supplied to Medicare Beneficiaries.

What You Need to Know

CR 6183, from which this article is taken, announces changes to the physician, provider, and supplier overpayment recoupment process, as required by Section 935 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) which amended Title XVIII of the Social Security Act to add to Section 1893 a new paragraph (f) addressing this process. The important points of interest for providers are as follows:

- For overpayments subject to this limitation on recoupment, Medicare will not begin overpayment collection of debts (or will cease collections that have started) when it receives notice that the provider has requested a Medicare contractor redetermination (first level of appeal) or a reconsideration by a Qualified Independent Contractor (QIC).
- As appropriate, Medicare will resume overpayment recoveries with interest if the Medicare overpayment decision is upheld in the appeals process.
- If the ALJ level process reverses the Medicare overpayment determination, Medicare will refund both principal and interest collected, and also pay 935 interest on any recouped funds that Medicare took from ongoing Medicare payments. (If a provider has any other outstanding overpayments, Medicare will apply the amount collected first to those overpayments and any excess monies will then be refunded back to the provider.)
- Payment of 935 interest is only applicable to overpayments recovered under the limitation on recoupment provisions. Interest is only payable on the principal amount recouped.
- Providers must note that when Medicare sends a demand letter notifying a provider of Medicare's intent to collect

an overpayment, the provider may submit a letter of rebuttal that disputes the debt. The rebuttal letter will not necessarily stop Medicare from beginning the process of recouping that debt. Only a provider's timely and valid request for a redetermination or reconsideration will halt the recoupment.

This article provides more detail on these general points and clarifies which overpayments are subject to this limitation on recoupment and which types of overpayments are not subject to this limitation. Make sure that your billing staffs are aware of these changes as described below.

Background

Before the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) was enacted, a provider's electing to appeal an overpayment determination did not affect Medicare's prerogative to recover the debt. However, through an amendment of Title XVIII of the Social Security Act (the Act); MMA Section 935 changed this process, by adding a new paragraph (f) to section 1893 of the Act.

This amendment requires the Centers for Medicare & Medicaid Services (CMS) to change: 1) the way it recoups certain overpayments to providers, physicians and suppliers; and 2) how it pays interest to a provider, physician or supplier whose overpayment is reversed at subsequent administrative (Administrative Law Judge (ALJ)) or judicial levels of appeal.

CR 6183 describes these changes to the providers, physicians and suppliers overpayment recoupment process. Specifically, Section 1893 (f)(2)(a) of the Social Security Act protects providers physicians, and suppliers during the initial stages of the appeal process (both first level appeal – contractor redetermination, and second level appeal -- Qualified Independent Contractor (QIC) reconsideration) by limiting the recoupment process for Medicare overpayments while the appeals process is underway.

It requires that when a valid first or second level appeal is received from a provider on an overpayment, subject to certain limitations (see below), CMS and its Medicare contractors may not recoup the overpayment until the decision on the redetermination and/or reconsideration has been rendered.

Overpayments that ARE subject to Limitation on Recoupment

- Determined post-pay denial of claims for benefits under Medicare Part A for which a written demand letter was issued (a letter informing the provider of the overpayment determination as a result of a post payment review of the medical record, claim, or billing records is subject to this provision);
- Determined post-pay denial of claims for benefits under Medicare Part B for which a written demand letter was issued;
- Medicare Secondary Payer (MSP) recovery where the provider or supplier received a duplicate primary payment and for which a written demand letter was issued (a letter informing the provider of the overpayment determination as a result of a post payment review of claim or billing records is subject to this provision); or
- Medicare Secondary Payer (MSP) recovery based on the provider's or supplier's failure to file a proper claim with the third party payer plan, program, or insurer for payment for Part A or B (a letter informing the provider of the overpayment determination as a result of a post payment review of claim or billing records is subject to this provision).
- The final Claims associated with a Home Health Agency (HHA) Request for Anticipated Payment (RAP) under Home Health Prospective Payment System (HH PPS), but not the RAP itself (see Table 2, below).

Overpayments that ARE NOT Subject to Limitation on Recoupment

- All other Medicare Secondary Payer recoveries except those identified in the preceding section of this article;
- Beneficiary overpayments;
- Overpayments that arise from a cost report determination;
- Overpayments that are appealed under the Provider Reimbursement Payment (PRB) process of 42 CFR parts 405 subpart R-Provider /Reimbursement Determinations and appeals;
- HHA Requests for Anticipated Payment (RAP) under HH PPS;

  Note: While a RAP is not considered a claim for purposes of Medicare appeals regulations, it is submitted using the same format as Medicare claims. RAPs under the HH PPS do not have appeal rights during: 1) the 120 days from the start of the episode; or 2) 60 days from the payment date of the RAP to submit the final claim. Rather, appeals rights are tied to the claims that represent all services delivered for the entire HH PPS episode. (Refer to the *Medicare Claims Processing Manual*, Chapter 10 (Home Health Agency Billing), Sections 10.1.10 (Provider Billing Process Under HH PPS), 10.1.11 (Payment, Claim Adjustments and Cancellations), 10.1.12 (Request for Anticipated Payment (RAP)), 40.1 (Request for Anticipated Payment (RAP)), and 50 (Beneficiary-Driven Demand Billing Under HH PPS). This manual is available at http://www.cms.hhs.gov/Manuals/IOM/list.asp on the CMS web site.)
- Hospice Caps calculations;
- Provider initiated adjustments;
- Accelerated/Advanced Payments; and
- Certain claims adjustments at the contractors' discretion that will not be subject to Section 935 (this requires approval by CMS).

The Rebuttal Process

Here is how the rebuttal process with the limitation on recoupment works.

You are given an opportunity to rebut any proposed recoupment action submitting a statement within 15 days of the notice of an impending recoupment action. **These rebuttal procedures occur prior to the appeals process and are separate from the requirements of the limitation on recoupment**.

The rebuttal process gives you a vehicle to indicate why the proposed recoupment should not take place; but you should remember that, as opposed to the limitations that CR 6183 describes, your Medicare contractor may (based on the rebuttal statement) determine to either stop, or proceed with, recoupment.

Step One -- Overpayments

Part A

As a result of post-pay reviews or MSP recoveries and during the Part A claim adjustment process (including Part B of A claims), Medicare FIs, RHHIs, and/or MACs, will determine if the limitations apply to the claim and annotate the system of the MMA Section 935 adjustment. If the adjustment results in a refund to the provider, they will follow existing underpayment policies; however, if the adjustment is deemed an overpayment and the 935 rules apply, they will mark the claim as being available for the limitation on recoupment protections.

Part B

As a result of post-pay reviews or MSP recoveries and during the Part B claim adjustment process, Medicare carriers and MACs, including DME MACs, will adjust claims in the normal manner.

Step Two -- Demand Letter

These adjustments will trigger the creation of the first demand letter (unless previously issued) which (in addition to the requirements listed in the *Medicare Financial Management Manual,* Chapter 3 (Overpayments), and Chapter 4 (Debt Collection)) will:

- States that the provider may submit a rebuttal statement (which is not an appeal request) to any proposed recoupment action and the Medicare contractor will review it and consider whether to proceed or stop the offset (remember that they may elect to continue recoupment);
- States that in order to stop recoupment under the provisions of Section 935 of the MMA; providers must request a valid appeal (redetermination) of the overpayment within 30 days from the date of the demand letter;
- Explains how the overpayment arose, the amount of the overpayment, how the overpayment was calculated, and why the original payment was not correct;
- Explains why the provider knew or should have known the items or services would not be covered, as well as the regulatory and statutory references for the 1879 determination, or (when appropriate) why the provider was not found to be without fault in causing the overpayment.
- Explains that recoupment will begin on the 41st day from the date of the first demand letter if: 1) payment is not received in full, or 2) an acceptable request for an extended repayment schedule, or 3) a valid request for a contractor redetermination is not date stamped in the Medicare contractor's mailroom by day 30 from the date of the demand letter. However, if the appeal is filed later than 30 days, the contractor will also stop recoupment at whatever point that an appeal is received and validated, but Medicare may not refund any recoupment already taken.

Notes:

1. Timeliness of this request is important because if you don't send this request within 30 days, Medicare can begin to recoup on the 41st day from the date of the Medicare demand letter.
2. In addition, during this appeal process, while the Medicare contractor cannot recoup or demand the debt, it continues to age (its interest continues to accrue); and, once both levels of appeal are completed, if the appeal decision results in an affirmation of the overpayment decision, collection activities may resume within the designated timeframes.
3. If you have filed a bankruptcy petition or are involved in a bankruptcy proceeding, Medicare financial obligations will be resolved in accordance with the applicable bankruptcy process. You should immediately notify your Medicare contractor about this bankruptcy so that they can coordinate with both CMS and the Department of Justice to assure that your particular situation is handled properly.

Step Three -- How to Stop Recoupment:

First Level Appeal (Redetermination)

Recoupment can proceed on day 41 from the first demand letter unless you submit a request for a redetermination by the 30th day following the date of the first demand letter, in which case recoupment will stop.

Table 1, below displays the time frame for the recoupment process after the first demand letter.

Table 1

Timeframe for Medicare Recoupment Process After the First Demand Letter

Timeframe	Medicare Contractor	Provider
Day 1	Date of Demand Letter (Date demand letter mailed)	Provider receives notification by first class mail of overpayment determination
Day 1-15	Day 15 deadline for Rebuttal request. No recoupment occurs	Provider must submit a statement within 15 days from the date of demand letter.
Day 1-40	No recoupment occurs	Provider can appeal and potentially limit recoupment from occurring
Day 41	Recoupment begins	Provider can appeal and potentially stop recoupment

OVERPAYMENTS CONT'D

Redetermination or Reconsideration (Appeals) Requests

Upon receiving your valid request for a redetermination of an overpayment, your Medicare contractor will take the following actions:

- Cease recoupment of the overpayment that is the subject of the appeal, or will not initiate recoupment if it has not yet started;
- Retain any amounts recouped, if they had already recouped funds before receiving the request for redetermination, and apply them first to interest and then to principal; and
- Will continue to collect any other debts that you might owe, but will not withhold or place in suspense any monies related to this debt, while it is in the appeal status.

A Redetermination can have three possible outcomes:

1. Full reversal of the overpayment decision.

   In this instance, Medicare contractors may need to adjust the overpayment and amount of interest charged (they may apply these funds to any other debt that you might owe and then release any excess to you).

2. Partial reversal (Partially Favorable) of the overpayment decision

   In this instance (in which the debt is reduced below the initial stated amount) Medicare contractors will recalculate the correct amounts of both the underpayment and the overpayment, make appropriate payments to you if due; or, if necessary, issue a revised demand letter for the newly calculated overpayment amount. This letter will state that the contractor can begin recoupment no earlier than the 61st day from the date of the revised overpayment determination if they have not been notified by the QIC that you have requested a reconsideration. It will also state that in order to stop recoupment under the provisions of Section 935 of the MMA, you must request a valid appeal (reconsideration) of the overpayment within 60 days from the date of the notice. It will also remind you that you have an opportunity to rebut the proposed recoupment action (but keep in mind that a rebuttal does not mandate that recoupment will stop).

3. Full Affirmation of the overpayment decision

   With this "unfavorable" decision that upholds the overpayment determination, the Medicare contractor will issue the 2nd or 3rd demand letter (as appropriate), which will state that they can begin to recoup no earlier than 61st calendar day from the Medicare redetermination notice, it they have not been notified by the QIC that you have requested a reconsideration.

Table 2, below displays the time frame for the recoupment process after redetermination.

Table 2

Timeframe for Medicare Recoupment Process After Redetermination

Timeframe	Medicare Contractor	Provider
Day 60 following revised notice of overpayment following redetermination	Date Reconsideration request is Stamped in Mailroom, or Payment Received from the revised overpayment notice	Provider Must Pay Overpayment or Must have submitted request for 2nd level appeal
Day 61- 75	Recoupment could begin on the 61st day	Provider appeals or pays
Day 76	Recoupment Begins or Resumes	Provider Can Still Appeal. Recoupment stops on date receipt of appeal

Second Level Appeal (Reconsideration)

You can also stop Medicare from recouping any payments at a second point in the recoupment process by filing a valid request for reconsideration with the QIC within 60 days of the appropriate notice/letter.

When your Medicare contractor receives notification from the QIC of your valid and timely request for a reconsideration, they will:

- Cease recoupment of the overpayment, or not initiate recoupment if it has not yet begun;
- Retain the amount recouped, and apply it first to interest and then to principal (if the recoupment process had begun before the reconsideration request was received);
- Will continue to collect other debts that you might owe, if an overpayment is appealed and recoupment stopped; but will not withhold or place in suspense any monies related to this debt, while it is in the appeal status.

A QIC Reconsideration can have three possible outcomes:

1. Full Reversal

   In this instance, Medicare contractors may need to adjust the overpayment and amount of interest charged (the amount held may be applied to any other debt that you might owe and any excess refunded to you);

2. Partial Reversal

   In this instance, this reduces the overpayment. Medicare contractors effectuate the redetermination decision and if necessary issue a revised demand letter to the provider of the revised overpayment amount or make appropriate payments if due of the underpayment amount. Medicare contractors may apply the excess to any other debt (including interest) that you might owe before releasing payment to you.

They will issue you a notice of the revised overpayment amount, which will also state that they can begin to recoup on the 30th day, from the date of notice of the revised overpayment. This is to give you an opportunity to make payment arrangements or to rebut the recoupment as described above.

3. Affirmation

   If the QIC reconsideration results in an "unfavorable" overpayment decision, recoupment may be resumed on the 30th calendar day after the date of the notice of the reconsideration. This gives you time to make payment or to request a repayment plan.

Note: Medicare Contractors can initiate (or resume) recoupment immediately upon receipt the QIC's decision or dismissal notice of a physician's, provider's, or supplier's request for reconsideration, regardless of a subsequent appeal to the ALJ (third appeal level) and all further levels of appeal (see below).

Third Level of Appeal (Administrative Law Judge (ALJ))

Whether or not the provider, physician or supplier subsequently appeals the overpayment to the ALJ, the Medicare Appeals Council, or Federal court, the Medicare contractor will continue to recoup until the debt is satisfied in full.

Additional Details of CR6183

CR 6183 also provides some additional specific payment details, i.e.:

1. If you have been granted an extended repayment schedule (ERS) and have submitted a valid and timely request for a redetermination or reconsideration to the Medicare contractor, you will not be considered in default if your payments were not made. The appeal would supersede the ERS agreement.

   Further, Payments that you make under an ERS are not recoupment for the limitation provision and are not subject to Section 935 interest, if reversed at the ALJ appeal or above. However, if you default on the ERS schedule and recoupment begins before a valid and timely request has been received, those recoupment are subject to payment of interest under the Section 935 interest requirements.

2. Suspended funds involving providers who have been put on payment suspension are not a "recoupment" for purposes of the limitation on recoupment. Medicare is not restricted from applying suspended funds to reduce or dispose of an overpayment. However, if the suspended payments are insufficient to fully eliminate any overpayment, and the provider or supplier meets the requirements of 42 CFR, Section 405.379 "Limitation on Recoupment," provision under section 1893(f)(2) of the Social Security Act, Section 935 of the MMA Act will be applicable to any remaining balance still owed to CMS.

3. Payments made by a provider in response to a demand are not recoupments. Recoupment is the recovery by Medicare of any outstanding Medicare debt by reducing present or future Medicare payments and applying the amount withheld to the indebtedness. Therefore, payments made in response to a demand are not subject to Section 935 interest.

4. Lastly, CR 6183 amends the way interest is to be paid to a provider or supplier whose overpayment determination is overturned in administrative or judicial appeals subsequent to the second level of appeal (QIC reconsideration). This is called Section 935 interest, which is payable on an underpayment when the reversal occurs at the ALJ level or subsequent levels of administrative appeal, when that decision results in a full or partial reversal of the prior decision and contractors retained recouped funds (based on the period that Medicare recouped the provider's or supplier's funds). Payment of 935 interest is only applicable to overpayments recovered under the limitation on recoupment provisions, and is only payable on the principal amount recouped. In these instances, Medicare will pay simple interest rather than compound interest, and **will not pay interest on interest; (mirroring the manner in which interest against providers is assessed)**. Monies recouped and applied to interest would be refunded and not included in the "amount recouped" for purposes of calculating any interest due the provider.

   The periods of recoupment will be calculated in full 30-day periods; and interest will not be payable for any periods of less than 30 days in which Medicare had possession of the recouped funds; and will be calculated for each 30-day period using the interest Rate in Effect on the ALJ decision Date or the (revised written Final Determination Date).

Finally, please be aware that CR 6183 does not change the rebuttal process for this recovery, nor the appeal process including the appeal levels, the time a provider or supplier has to file a request for appeal, or the decision making time frames.

Additional Information

You can find the official instruction, CR6183, issued to your carrier, FI, RHHI, A/B MAC, or DME MAC by visiting http://www.cms.hhs.gov/Transmittals/downloads/R141FM.pdf on the CMS web site. You will find the updated *Medicare Financial Management Manual*, Chapter 3 (Overpayments), as an attachment to CR 6183.

FORMS

Updated Security Request Form

The Medicare Claims Processing System (MCPS) request form used to request Claims Status Inquiry (CSI) access has been updated on the NAS Medicare Web site on the Forms tab. Effective August 15, 2008, only version 1.1 of the form will be accepted and all prior versions will be returned.

Be sure to complete ALL fields and sections on the request form or the form 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. Forms without signatures or dates cannot be processed and will be returned.

Revised Form CMS-R-131 Advance Beneficiary Notice of Noncoverage

MLN Matters Number: MM6136
Related Change Request (CR) #: 6136
Related CR Release Date: September 5, 2008
Related CR Transmittal #: R1587CP
Effective Date: March 3, 2008
Implementation Date: March 1, 2009

Provider Types Affected

Physicians, providers and suppliers who bill Medicare contractors (carriers, fiscal intermediaries (FI), Medicare Administrative Contractors (A/B MAC), or Durable Medical Equipment Medicare Administrative Contractors (DME MAC)) for services provided to Medicare beneficiaries.

What You Need to Know

CR 6136, from which this article is taken announces that, effective March 3, 2008, the Centers for Medicare & Medicaid Services (CMS) implemented use of the revised Advance Beneficiary Notice of Noncoverage (ABN); which combines the general Advance Beneficiary Notice (ABN-G) and laboratory Advance Beneficiary Notice (ABN-L) into a single form, with form number (CMS R-131).

You should be aware that beginning March 3, 2008 and prior to March 1, 2009, your contractors will accept either the current ABN-G and ABN-L or the revised ABN as valid notification. **However, beginning March 1, 2009, Medicare contractors will accept only a properly executed revised ABN (CMS R-131) as valid notification**.

Make sure that your billing staffs are aware of these ABN form changes.

Background

Prior to March 3, 2008, physicians, providers, practitioners, and suppliers paid under Part B, and hospice providers and religious non-medical health care institutions paid under Part A; were instructed to use the general Advance Beneficiary Notice (ABN-G) or laboratory Advance Beneficiary Notice (ABN-L) to inform beneficiaries of their potential liability in accordance with the limitation on liability provisions set forth in Section 1879 of the Social Security Act.

Beginning on March 3, 2008, however, CMS implemented use of the revised Advance Beneficiary Notice of Noncoverage (ABN). This revised ABN combines the ABN-G and the ABN-L into a single notice, with the same form number (CMS R-131).

The *Medicare Claims Processing Manual* Chapter 30 (Financial Liability Protections), Section 50 (Form CMS-R-131 Advance Beneficiary Notice of Noncoverage (ABN)) has been substantially updated to reflect these changes. 85 subsections have been deleted from this chapter, and 47 are either new or have been revised. Attached to CR6136 is the updated Chapter 30 and the Web address for viewing CR6136 is contained in the "Additional Information" section of this article.

Some key points from the updated Chapter 30 are as follows:

1. The revised ABN is the new CMS-approved written notice that physicians, providers, practitioners, suppliers, and laboratories issue to beneficiaries enrolled in the Medicare Fee-For-Service (FFS) program for items and services that they provide under Medicare Part A (hospice and religious non-medical healthcare institutions only) and Part B. It may not be used for items or services provided under the Medicare Advantage (MA) Program, or for prescription drugs provided under the Medicare Prescription Drug Program (Part D).
2. The revised ABN (which replaces the ABN-G (CMS-R-131-G), ABN-L (CMS-R-131-L), and Notice of Exclusion from Medicare Benefits (NEMB) (CMS-20007)) will now be used to fulfill both mandatory and voluntary notice functions.

Note: Once the revised SNFABN is implemented, Skilled Nursing Facilities must use the revised SNFABN for all items and services billed to Part A and Part B.

3. The following situations require by statute that an ABN be issued:

- Care is not reasonable and necessary;
- There was a violation of the prohibition on unsolicited telephone contacts;
- Medical equipment and supplies supplier number requirements not met;
- Medical equipment and/or supplies denied in advance;
- Custodial care; and
- A hospice patient who is not terminally ill.

4. In the following situations ABN use is voluntary

   ABNs are not required for care that is either statutorily excluded from coverage under Medicare (i.e. care that is never covered) or fails to meet a technical benefit requirement (i.e. lacks required certification).

   Additionally, the ABN can also be issued voluntarily in place of the Notice of Exclusion from Medicare Benefits (NEMB) for care that is never covered such as:

   - Care that fails to meet the definition of a Medicare benefit as defined in Section 1861 of the Social Security Act;
   - Care that is explicitly excluded from coverage under Section 1862 of the Social Security Act. Examples include:
     - Services for which there is no legal obligation to pay;
     - Services paid for by a government entity other than Medicare (this exclusion does not include services paid for by Medicaid on behalf of dual-eligibles);
     - Services required as a result of war;
     - Personal comfort items;
     - Routine physicals (except the initial preventive physical or "Welcome to Medicare" physical examination) and most screening tests;
     - Routine eye care;
     - Dental care; and
     - Routine foot care.

5. ABN issuers (who may be physicians, practitioners, providers (including laboratories), suppliers, Medicare contractors, or utilization review committees for the care provider) are collectively known as "notifiers". Be aware that the notifier may direct an employee or a subcontractor to actually deliver an ABN, however, the notifier remains ultimately responsible for its effective delivery.

   Notifiers are required to issue ABNs whenever limitation on liability applies. This typically occurs at three "**triggering events**" during a course of treatment (initiation, reduction, and termination).

   Notifiers must give an ABN to "**recipients**" (FFS Medicare beneficiaries or their representatives), including beneficiaries who have Medicaid coverage in addition to Medicare (i.e. dual-eligible). You should note that notifiers' inability to give notice to a beneficiary or his/her representative does not allow them to shift financial liability to the beneficiary, unless they have exhausted all attempts to issue the notice and such attempts are clearly documented in the patient's record and undisputed by the beneficiary.

Medicare Claims Processing Manual Chapter 30 (Financial Liability Protections), Section 50 (Form CMS-R-131 Advance Beneficiary Notice of Noncoverage (ABN)) also contains specific information about ABN Preparation Requirements such as the number of pages, fonts and form reproduction, completion and retention of the form, delivery requirements; and what to do in particular situations such as emergencies, or if a beneficiary changes his/her mind or refuses to complete or sign the notice.

It also discusses potential beneficiary and provider liability; requirements for advance coverage determinations; the collection of funds and refunds; and issues specific to durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS), hospice, and Comprehensive Outpatient Rehabilitation Facility (CORF).

Additional Information

You can find more information about the revised ABN Form (CMS-R-131) by going to CR 6136, located at http://www.cms.hhs.gov/Transmittals/downloads/R1587CP.pdf on the CMS web site. There you will find the updated *Medicare Claims Processing Manual* Chapter 30(Financial Liability Protections), Section 50 (Form CMS-R-131 Advance Beneficiary Notice of Noncoverage (ABN)) as an attachment to that CR.

Additional information on the revised ABN and other limitation of liability notices can be found on the Beneficiary Notice Initiatives web site at http://www.cms.hhs.gov/bni on the CMS web site. Questions regarding the revised ABN can be emailed to RevisedABN_ODF@cms.hhs.gov.

P O Box for DME Overpayment Redeterminations – Reminder

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

The overpayment redetermination address is:

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

When requesting an overpayment redetermination, mark the overpayment box to alert NAS staff that this is an appeal for an overpayment.

What Can and Cannot be Completed as a Reopening - Clarification

Reopenings are separate and distinct from the appeals process. Reopenings are a discretionary action on the part of the contractor to correct a clerical error or omission. A contractor's decision to reopen a claim is not an initial determination and is therefore not appeallable.

What Can be Done as a Reopening

The following is a list of clerical errors and omissions that can be completed as a telephone or written reopening. This list is not all-inclusive.

- Diagnosis changes/additions
- Date of service changes (except for the year)
- Procedure code changes
- CMN/DIF Updates (with the exception of PEN and enteral nutrition, which must be done as a written redetermination and oxygen BIS which can only be done as a written reopening)
- Certain modifier changes/additions (not all inclusive list)
  - KH – DMEPOS item, initial claim, purchase or first month
  - KI – DMPOS item, second or third month rental
  - KJ – DMEPOS item, parenteral enteral nutrition (PEN) pump or capped rental, months four to fifteen
  - KX – Specific required documentation on file
  - RR – Rental
- Surgical Dressing (when number of services are within the policy, if the request is to allow over the policy amount, these must go to written redeterminations)
- Wheelchairs/Power Mobility Devices – HCPCS K0004 and lower

APPEALS CONT'D

Disclaimer: If any of the above changes, upon research, are determined to be too complex, the requestor will be notified that the request needs to be sent in writing, with the appropriate documentation, as a redetermination.

What Cannot be Done as a Reopening

The following issues must be requested and completed as a redetermination rather than a telephone or written reopening.

- Negative Pressure Wounds
- Surgical Dressings (number of units is over the policy amount)
- Wound Covers/Compression Stockings
- Parenteral and Enteral CMN/DIF issues
- Oxygen BIS
- Wheelchairs/Power Mobility Devices – HCPCS K0005 and higher
- Recoupment/Reduction of payment – Complete Refunds to Medicare Form
- Medicare Secondary Payer (MSP)-send inquiry to MSP Department
- Timely Denials
- Late Files
- Requests that require documentation
- ABN Issues
- GA/GY/GZ Modifiers
- Liability Issues
- Repairs to equipment
- Miscellaneous codes

Claims with remittance message MA130 can never be submitted as a reopening. Claims with message MA130 are considered unprocessable. The claim is missing information that is needed for processing the claim or the claim information is invalid. Unprocessable claims do not have reopening or redetermination rights and must be corrected and submitted as a new claim.

Email Available for Redetermination and Reopening Questions

Suppliers can email questions and concerns regarding reopenings and redeterminations to dmeredeterminations@noridian.com. Communication with suppliers is important to NAS so we want to provide an additional avenue of communication for redetermination and reopening questions.

Questions and concerns may include but are not limited to:

- Timely Filing Inquiries
- Appeal Regulations
- Coverage Questions
- Appeal Rights
- Documentation Requirements for Redeterminations
- Redetermination/Reopening Request Forms
- Redetermination Letter Wording
- Social Security Laws
- Interpretation of Denial Messages
- Policies

Confidential information cannot be e-mailed. This includes Protected Health Information (PHI), such as patient names, claim information, Health Insurance Claim (HIC) numbers, Social Security numbers, Claim Control numbers (CCNs) or supplier numbers. This type of information cannot be e-mailed because it may be possible for others to view the contents. If you have a question that would contain PHI, please call our Contact Center at 1-866-243-7272.

The Centers for Medicare & Medicaid Services (CMS) state that PHI cannot be transmitted via e-mail, therefore, NAS will not respond to any requests that contain PHI. Those requests that do not contain PHI will be answered within two business days.

This e-mail option is for suppliers only and is not to be used by beneficiaries. All beneficiary inquiries should be directed to 1-800-MEDICARE (1-800-633-4227).

BILLING

Warranties for DMEPOS

Suppliers are reminded that any item or labor provided under a manufacturer's warranty cannot be billed to Medicare. Medicare makes payment only for reasonable and necessary maintenance and servicing of beneficiary owned oxygen and capped rental equipment for parts and labor not covered by the supplier's or manufacturer's warranty.

NAS is seeing claims billed for labor for repairs and replacement parts for "almost" new (those purchased or rented as new a few months ago or have been in use for less than a year) power mobility devices and other DME items. Below is additional information on DME warranties.

Modifier MS is submitted on codes to represent maintenance and servicing of a capped rental item that the patient chose to rent for 15 months for capped rental periods that began before January 1, 2006 (under the previous capped rental rules). Modifier MS states "Six month maintenance and servicing fee for reasonable and necessary parts and labor which are not covered under any manufacturer or supplier warranty."

The Model Warranty Information Form available in the Forms section of our DME Web site, www.noridianmedicare.com/dme, addresses supplier standard number six, which requires the supplier to inform Medicare beneficiaries about the warranty coverage of any piece of equipment or any supply provided. This standard states:

> "A supplier honors all warranties expressed and implied under applicable State law. A supplier must not charge the beneficiary or the Medicare program for the repair or replacement of Medicare covered items or for services covered under warranty. This standard applies to all purchased and rented items, including capped rental items, as described in Sec. 414.229 of this subchapter. The supplier must provide, upon request, documentation that it has provided beneficiaries with information about Medicare covered items covered under warranty, in the form of copies of letters, logs, or signed notices."

There may be times when suppliers will need to furnish a letter from the manufacturer that indicates why a specific item is not covered by warranty during the warranty period under the warranty agreement. Some DMEPOS items may be covered for parts up to five years. This is common for oxygen equipment.

Suppliers are also reminded that Medicare allows for labor and parts to repair equipment as long as repairing the equipment is more cost effective than replacing the item. If the parts are covered under warranty, then Medicare will only allow for the labor. Labor is billed under HCPCS code E1340 (1 unit=15 minutes). **Reminder**: If the warranty allows for labor, then labor cannot be billed to Medicare.

Per the *Medicare Benefit Policy Manual*, Chapter 15, Section 110.2.C, cases suggesting malicious damage, culpable neglect, or wrongful disposition of equipment will be investigated and denied where the DME MAC determines that it is unreasonable to make program payment under the circumstances. DME MACs refer such cases to the program safeguard contractor for further research.

Sources: *Medicare Benefit Policy Manual*, Chapter 15, Section 110.2 and *Medicare Claims Processing Manual*, Chapter 20, Sections 40.1, 40.2, 50 and 130.7

Nebulizer Drugs-Date Span Narrative

Nebulizer drugs are usually billed once a month or every three months, however, a date span is not required on the claim. It is helpful for claims processing if the date span is provided on the claim.

Providing a comment of "30 day supply," "60 day supply" or "90 day supply," in the claim narrative, Item 19 on the CMS-1500 claim form or the NTE segment in the 2400 loop (line level) for an electronic claim, will help our claims staff determine the number of units/doses to pay. This information is especially helpful if a supplier switches from monthly billing of nebulizer drugs to two or three months or vice versa. We are not always able to determine the intent of the supplier even after reviewing the claims previously billed for the beneficiary.

Note: Nebulizer drugs will not be denied if this narrative is not submitted on the claim.

Infusion Therapy Denial Reminders

Suppliers are reminded that when billing for an infusion drug or supply that is not administered through a pump, a GY modifier is required to receive a claim denial that is patient responsibility. In addition, a comment on the claim, such as "not administered with a pump" is required in Item 19 on the CMS-1500 claim form or the electronic equivalent, the NTE segment. If the comment is not submitted, the claim will deny as supplier liable. NAS cannot assume why the GY modifier is being billed, especially if a pump has been billed previously for the patient around the same timeframe of the current date of service.

Suppliers are also reminded that anytime a drug is administered with a durable infusion pump (E0779-E0791, K0455) that does not meet coverage criteria, an Advance Beneficiary Notice of Non-coverage (ABN) must be obtained. This is true even if the drug is not covered. A GY modifier should not be used in this situation.

For more information on this topic, see the Infusion Therapy Billing for Denial article posted on What's New on September 4, 2007.

Billing Hospital Beds

Hospital beds 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 Determination (LCD) for Hospital Beds and Accessories.

Therefore, NAS would like to remind suppliers of the payment criteria for hospital beds to aid in lowering the error rate for these items. This information is also found in the LCD for Hospital Beds and Accessories (L11572). Documentation supporting the payment criteria must be available upon request.

If the patient is being provided a fixed height hospital bed (E0250, E0251, E0290, E0291, and E0328), the patient must meet **one or more** of the following criteria:

1. The patient has a medical condition, which requires positioning of the body in ways not feasible with an ordinary bed. Elevation of the head/upper body less than 30 degrees does not usually require the use of a hospital bed, or
2. The patient requires positioning of the body in ways not feasible with an ordinary bed in order to alleviate pain, or
3. The patient requires the head of the bed to be elevated more than 30 degrees most of the time due to congestive heart failure, chronic pulmonary disease, or problems with aspiration. Pillows or wedges must have been considered and ruled out, or
4. The patient requires traction equipment, which can only be attached to a hospital bed.

A variable height hospital bed (E0255, E0256, E0292 and E0293) is covered if the patient meets one of the criteria for a fixed height hospital bed and requires a bed height different than a fixed height hospital bed to permit transfers to chair, wheelchair or standing position.

A semi-electric hospital bed (E0260, E0261, E0294, E0295, and E0329) is covered if the patient meets one of the criteria for a fixed height bed and requires frequent changes in body position and/or has an immediate need for a change in body position.

A heavy duty extra wide hospital bed (E0301, E0303) is covered if the patient meets one of the criteria for a fixed height hospital bed and the patient's weight is more than 350 pounds, but does not exceed 600 pounds.

An extra heavy-duty hospital bed (E0302, E0304) is covered if the patient meets one of the criteria for a hospital bed and the patient's weight exceeds 600 pounds.

A total electric hospital bed (E0265, E0266, E0296 and E0297) is not covered; the height adjustment feature is a convenience feature. Total electric beds will be paid as the least costly medically appropriate alternative for the comparable semi-electric bed (E0260, E0261, E0294 and E0295).

Suppliers must also remember to add a KX modifier to a hospital bed code **only** if the payment criteria noted above have been met.

Sources: Hospital Beds and Accessories Local Coverage Determination (L11572)

Hospital Beds and Accessories Policy Article (A37079)

ICD-9 & Rules are on Display

HHS Proposes Adoption of ICD-10 Code Sets and Updated Electronic Transaction Standards

Proposed Changes Would Improve Disease Tracking and Speed Transition to an Electronic Health Care Environment

The Department of Health and Human Services (HHS) announced Friday a long-awaited proposed regulation that would replace the ICD-9-CM code sets now used to report health care diagnoses and procedures with greatly expanded ICD-10 code sets, effective October 1, 2011. In a separate proposed regulation, HHS has proposed adopting the updated X12 standard, Version 5010, and the National Council for Prescription Drug Programs standard, Version D.0, for electronic transactions, such as health care claims. Version 5010 is essential to use of the ICD-10 codes.

In 2000, under authority provided by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the ICD-9-CM code sets were adopted for use in the administrative transactions by both the public and private sectors to report diagnoses and inpatient hospital procedures. Covered entities required to use the ICD-9-CM code sets include health plans, health care clearinghouses, and health care providers who transmit any electronic health information in connection with a transaction for which a standard has been adopted by HHS.

Developed almost 30 years ago, ICD-9 is now widely viewed as outdated because of its limited ability to accommodate new procedures and diagnoses. ICD-9 contains only 17,000 codes and is expected to start running out of available codes next year. By contrast, the ICD-10 code sets contain more than 155,000 codes and accommodate a host of new diagnoses and procedures. The additional codes will help to enable the implementation of electronic health records because they will provide more detail in the electronic transactions.

Comments on the ICD-10 code sets proposed rule are due by 5:00pm Eastern time on October 21, 2008.

Comments on the updated transaction standards proposed are due by 5:00pm Eastern time on October 21, 2008.

Both regulations may be viewed at www.cms.hhs.gov/TransactionCodeSetsStands/02_TransactionsandCodeSetsRegulations.asp#TopOfPage

To read the HHS press release issued please click here or see attached: http://www.hhs.gov/news/press/2008pres/2008.html

Fact sheets describing both proposed rules will be forthcoming at http://www.cms.hhs.gov/apps/media/fact_sheets.asp.

Implementation of a New Claim Adjustment Reason Code No.213: "Non-compliance with the physician self-referral prohibition legislation or payer policy"

MLN Matters Number: MM6131
Related Change Request (CR) #: 6131
Related CR Release Date: August 15, 2008
Related CR Transmittal #: R1578CP
Effective Date: January 1, 2009
Implementation Date: January 5, 2009

Provider Types Affected

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

What You Need to Know

CR 6131, from which this article is taken, instructs carriers, FIs, A/B MACs, RHHIs, and DME MACs (effective January 1, 2009) to use the new Claim Adjustment Reason Code (CARC) #213 when denying claims based on non-compliance with the physician self-referral prohibition.

Make sure that your billing staffs are aware of this new CARC code.

Background

Unless an exception applies (as referenced below), Section 1877 of the Social Security Act (the Act), prohibits a physician from referring a Medicare patient for certain designated health services (DHS) to an entity with which the physician (or his/her immediate family member(s)) has a financial relationship. A "financial relationship" includes both ownership/investment interests and compensation arrangements (for example, contractual arrangements).

The following services are DHS:

- Clinical laboratory services;
- Radiology and certain other imaging services (including MRIs, CT scans and ultrasound);
- Radiation therapy services and supplies;
- Durable medical equipment and supplies;

- Orthotics, prosthetics, and prosthetic devices;
- Parenteral and enteral nutrients, equipment and supplies;
- Physical therapy, occupational therapy, speech-language pathology services;
- Outpatient prescription drugs;
- Home health services and supplies; and
- Inpatient and outpatient hospital services.

Section 1877 of the Act also prohibits the DHS entity from submitting to Medicare, the beneficiary, or any entity for DHS, claims that are furnished as a result of a prohibited referral.

Note: Violations of this statute are punishable by: 1) Denial of payment for all DHS claims; 2) Refunds of amounts collected for DHS claims; and 3) Civil money penalties for knowing violations of the prohibition.

Prior to the publication of the new CARC #213 ("Non-compliance with the physician self-referral prohibition legislation or payer policy"), there was no specific code to describe claims that are denied based on "Stark" (the physician self-referral statute at Section 1877 of the Act). Therefore, so that both the DHS providers and the industry will know that claims are being denied because of non-compliance with the physician self-referral prohibitions; CR 6131, from which this article is taken, instructs carriers, FIs, A/B MACs, RHHIs, and DME MACs to use the new CARC No. 213 (effective January 1, 2009) when denying claims based on non-compliance with the physician self-referral prohibition.

Your Medicare contractors will use this code any time they deny a claim because a physician (or one or more of their immediate family members) has a financial interest in a DHS provider and fails to meet one of the exceptions referenced below.

Exceptions

Please note that the statute enumerates various exceptions, including exceptions for physician ownership or investment interest in hospitals and rural providers. You can read these exceptions in Section 1877 of the Social Security Act Sec. 1877 which you can find at http://www.cms.hhs.gov/PhysicianSelfReferral/Downloads/section_1877.pdf on the CMS Web site; and in 42 C.F.R. Part 411, Subpart J.) (42 U.S.C. Section 1395nn).

Additional Information

You can find more information about CARC #213 by going to CR 6131, located at http://www.cms.hhs.gov/Transmittals/downloads/R1578CP.pdf on the Centers for Medicare & Medicaid Services (CMS) web site. You will find the updated Medicare Claims Processing Manual Chapter 1 (General billing requirements Section 180 (Denial of Claims Due to Violations of Physician Self-Referral Prohibition) as an attachment to that CR.

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

MLN Matters Number: MM6175
Related Change Request (CR) #: 6175
Related CR Release Date: September 12, 2008
Related CR Transmittal #: R1595CP
Effective Date: October 1, 2008
Implementation Date: October 6, 2008

Provider Types Affected

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

What You Need to Know

CR 6175, from which this article is taken, instructs Medicare contractors to download and implement the October 2008 Average Sales Price (ASP) drug pricing file for Medicare Part B drugs; and if released by the Centers for Medicare & Medicaid Services (CMS), also the revised July 2008, April 2008, January 2008, and October 2007 files.

Background

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

The ASP methodology is based on quarterly data that drug manufacturers submit to CMS, which CMS then provides (quarterly) to Medicare contractors (carriers, DME MACs, FIs, A/B MACs, and/or RHHIs) through the ASP drug pricing files for Medicare Part B drugs. Please note that payment allowance limits under the Outpatient Prospective Payment System (OPPS) are incorporated into the Outpatient Code Editor (OCE) through separate instructions.

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

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

- The Food and Drug Administration (FDA) approval;
- Therapeutic equivalents as determined by the FDA; and
- The date of first sale in the United States.

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

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

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

ASP Methodology

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

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

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

Exceptions are summarized as follows:

- The payment allowance limits for blood and blood products (other than blood clotting factors) that are not paid on a prospective payment basis are determined in the same manner that the payment allowance limits were determined on October 1, 2003. Specifically, the payment allowance limits for blood and blood products are 95 percent of the average wholesale price (AWP) as reflected in the published compendia. The payment allowance limits are updated on a quarterly basis. Blood and blood products furnished in the hospital outpatient department are paid under OPPS at the amount specified for the Ambulatory Payment Classification (APC) to which the product is assigned.
- Payment allowance limits for infusion drugs furnished through a covered item of durable medical equipment on or after January 1, 2005, will continue to be 95 percent of the AWP reflected in the published compendia as of October 1, 2003, unless the drug is compounded or the drug is furnished incident to a professional service. **The payment allowance limits are not being updated**. The payment allowance limits for infusion drugs furnished through a covered item of durable medical equipment that were not listed in the published compendia as of October 1, 2003, (i.e., new drugs) are 95 percent of the first published AWP unless the drug is compounded or the drug is furnished incident to a professional service.
- The payment allowance limits for influenza, Pneumococcal and Hepatitis B vaccines are 95 percent of the AWP as reflected in the published compendia except when the vaccine is furnished in a hospital outpatient department. When furnished in a hospital outpatient department, the vaccine is paid at reasonable cost.
- The payment allowance limits for drugs and biologicals that are not included in the ASP Medicare Part B Drug Pricing File or NOC Pricing File, other than new drugs and biologicals that are produced or distributed under a new drug application (or other application) approved by the FDA, are based on the published wholesale acquisition cost (WAC) or invoice pricing, except under OPPS where the payment allowance limit is 95 percent of the published AWP. In determining the payment limit based on WAC, Medicare contractors follow the methodology specified in the *Medicare Claims Processing Manual*, Chapter 17, Drugs and Biologicals, for calculating the AWP; but substitute WAC for AWP. The payment limit is 100 percent of the lesser of the lowest-priced brand or median generic WAC. For 2006, the blood clotting furnishing factor of $0.146 per I.U. is added to the payment amount for the blood clotting factor when the blood clotting factor is not included on the ASP file. For 2007, the blood clotting furnishing factor of $0.152 per I.U. is added to the payment amount for the blood clotting factor when the blood clotting factor is not included on the ASP file. **For 2008, the blood clotting furnishing factor of $0.158 per I.U. is added to the payment amount for the blood clotting factor when the blood clotting factor is not included on the ASP file**.

Note: At their discretion, Medicare contractors may contact CMS to obtain payment limits for drugs and biologicals that are not included in the quarterly ASP or NOC files, or otherwise made available on the CMS Web site. If the payment limit is available from CMS, contractors will substitute CMS-provided payment limits for pricing based on WAC or invoice pricing.

- The payment allowance limits for new drugs and biologicals that are produced or distributed under a new drug application (or other new application) approved by the FDA and that are not included in the ASP Medicare Part B Drug Pricing File or NOC Pricing File are based on 106 percent of the WAC, or invoice pricing if the WAC is not published, except under OPPS where the payment allowance limit is 95 percent of the published AWP. This policy applies only to new drugs and biologicals that were first sold on or after January 1, 2005.
- The payment allowance limits for radiopharmaceuticals are not subject to the ASP payment methodology. In the case of radiopharmaceuticals furnished in other than the hospital outpatient department, Medicare contractors

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determine payment limits for radiopharmaceuticals based on the methodology in place as of November 2003. Radiopharmaceuticals furnished in the hospital outpatient department are paid charges reduced to cost by the hospital's overall cost to charge ratio.

On or after September 16, 2008, the October 2008 ASP file will be available for download along with revisions to prior ASP payment files, if CMS determines that revisions to these prior files are necessary. On or after September 16, 2008, the October 2008 ASP NOC files will be available for retrieval from the CMS ASP webpage along with revisions to prior ASP NOC files, if CMS determines that revisions to these prior files are necessary.

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

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

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

Drugs Furnished During Filling or Refilling an Implantable Pump or Reservoir

Physicians (or a practitioner described in Section 1842(b)(18)(C) of the Social Security Act) may be paid for filling or refilling an implantable pump or reservoir when it is medically necessary for the physician (or other practitioner) to perform the service. Medicare contractors must find the use of the implantable pump or reservoir medically reasonable and necessary in order to allow payment for the professional service to fill or refill the implantable pump or reservoir and to allow payment for drugs furnished incident to the professional service.

If a physician (or other practitioner) is prescribing medication for a patient with an implantable pump, a nurse may refill the pump if the medication administered is accepted as a safe and effective treatment of the patient's illness or injury; there is a medical reason that the medication cannot be taken orally; and the skills of the nurse are needed to infuse the medication safely and effectively. Payment for drugs furnished incident to the filling or refilling of an implantable pump or reservoir is determined under the ASP methodology as described above, except that pricing for compounded drugs is done by your local Medicare contractor.

Please be aware that your contractors will not search and adjust claims that have already been processed unless you bring them to their attention.

Additional Information

You can find the official instruction, CR6175, issued to your carrier, FI, RHHI, A/B MAC, or DME MAC by visiting http://www.cms.hhs.gov/Transmittals/downloads/R1595CP.pdf on the CMS web site.

COVERAGE

Positive Airway Pressure Devices LCD - Revised

The recently released PAP policy has been revised. The following is a summary of the changes:

INDICATIONS AND LIMITATIONS OF COVERAGE:

- Revised: Coverage criteria for documentation of initial evaluation and moved to Documentation section
- Revised: Clarified extrapolation of AHI and RDI results
- Revised: Definition of Type IV device
- Revised: Extended implementation dates for credentialing of physicians interpreting home sleep tests and facility-based polysomnograms.
- Revised: Requirement for beneficiary education by entity conducting home sleep test
- Revised: Expanded dates during which patients must be re-evaluated for documenting benefit from PAP therapy.
- Revised: Expanded dates for patients switched from CPAP to RAD with less than 30 days remaining in initial trial period
- Added: Requalifying after failed initial 12 week trial of PAP therapy

DOCUMENTATION:

- Revised: Expanded dates for documentation of benefit from PAP therapy.
- Revised: Documentation of adherence to PAP therapy to allow visual inspection of usage data.

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

FAQs – Positive Airway Pressure Devices

1. **Who is responsible for ensuring that the initial clinical evaluation and re-evaluation were conducted and who must retain documentation of that evaluation?**

   Answer: The treating physician is responsible for documenting the elements of the clinical evaluation and re-evaluation and must maintain that documentation as they would with any patient. Suppliers are responsible for ensuring that the coverage criteria have been met before applying the KX modifier to the code for PAP devices and accessories. Suppliers have the option of either requesting the information from the physician prior to dispensing the PAP device or waiting until requested to submit the information to the DME MAC.

2. **Will phone-in compliance satisfy the requirement for demonstrating that the patient must be compliant with therapy for 4 or more hours a night for 70% of the nights in a consecutive 30-day period within the first 90 days of therapy?**

   Answer: Yes, this is acceptable. The policy allows for either direct download or visual inspection of adherence information.

3. **Does the equipment provided to the patient during the initial 90-day therapy trial period have to be new?**

   Answer: No, it does not have to be new but must be in good working condition.

4. **Is ICD-9 diagnosis code 327.23 the only code acceptable for PAP device claims and when does its use become mandatory?**

   Answer: Yes, ICD-9 code is the only code acceptable for PAP and is the code that should have been used on claims since becoming effective in January 2006. Prior to the creation of code 327.23, other ICD-9 codes were allowed because there was no ICD-9 code specific to obstructive sleep apnea. Suppliers should always use the ICD-9 code that accurately and specifically reflects the condition for which the equipment is covered. ICD-9 code 327.23 should be used on all claims at this time for patients with obstructive sleep apnea.

5. **Does a new order need to be obtained reflecting diagnosis code 327.23 for beneficiaries already in the capped rental cycle?**

   Answer: No, as long as the supplier of the PAP device has information from the treating physician that the patient has obstructive sleep apnea.

6. **What happens if a RAD device is put on a patient at a point in time where it is now impossible to meet the compliance requirement for 70% of the nights in a consecutive 30-day period within that first 90 days? Say for example, the patient changes over from a CPAP to a RAD device on day 75?**

   Answer: Patients will be given until the 120th day after initiation of CPAP to document adherence to therapy.

7. **What happens if all of the documentation needed to continue therapy beyond the first 90 days is not received/available to the supplier before the end of the 90 day trial period but does become available later - possibly at 120 or 150 days, for example?**

   Answer: The supplier has two options:

   1. Submit the claims without the KX modifier; or,
   2. Hold claims until the proper documentation has been received. If the documentation confirms that the beneficiary was adherent to therapy and had a face-to-face re-evaluation between the 31st and 91st day, the claims being held may be submitted with the KX modifier.

7b. **What if the beneficiary did not have the required re-evaluation within the 31st to 91st day window?**

   Answer: If the documentation shows that the beneficiary was adherent to therapy and demonstrated improvement in symptoms but *did not* have a face-to-face re-evaluation between the 31st and 91st day but rather was re-evaluated at a later date, claims may be submitted with the KX modifier from the date of the re-evaluation.

8. **If a patient fails to meet the requirements for additional coverage of PAP therapy beyond the 90-day trial period, when is that patient eligible for a new trial?**

   Answer: In order to requalify for PAP therapy, the patient must undergo another face-to-face clinical evaluation and facility-based sleep test to assist in discerning the reasons for failure to demonstrate improvement in obstructive sleep apnea symptoms during the initial 90 day trial period.

9. **Titration, either in-home or in-lab, is not addressed in the LCD. Will there be any opportunity for in-home titration? When? How? Under what circumstances?**

   Answer: Titration may be performed either in-home or in-lab. Titration conducted in a facility-based setting is addressed in LCDs from other contractors. Titration conducted in the unattended home setting is not addressed in the PAP policy because there is no additional payment from the DME MAC for this procedure. If auto-titrating PAP devices are used for home titration, they should be billed using HCPCS code E0601.

10. **Has there been any consideration to paying for A9279 - Compliance monitoring equipment or component of equipment, to compensate for the additional work on the part of the supplier associated with compliance in the initial 90-day trial period?**

    Answer: This was considered; however, it has been decided that A9279 will continue to be non-covered by Medicare.

11. **G0398, G0399 and G0400 were created for portable testing. How frequently can those be billed/paid and used to qualify a patient for PAP therapy?**

    Answer: These are not codes payable by the DME MAC. Billing frequencies and payment amounts are established by other contractors.

12. **Why are there several different effective dates in the PAP Device policy?**

Answer: The national coverage determination (NCD) became effective on March 13, 2008. The NCD required a clinical evaluation and demonstration of improvement in OSA symptoms in the first 12 weeks of PAP use. It also allowed the use of home sleep tests to qualify the patient for a PAP device. As is often the case, the NCD requirements needed further definition and explanation; therefore, those additional guidelines for coverage, coding and payment were included in the DME MAC LCD. A prospective effective date was given to allow compliance with those criteria.

13. Who is allowed to interpret sleep studies?

Answer: The PAP policy requirements for interpreting physicians allows for sleep study interpretation by one of the following:

- Board certified in sleep medicine by the American Academy of Sleep Medicine (AASM); or,
- Board certified in sleep medicine by member board of the American Board of Medical Specialties (ABMS); or,
- Physician who has completed training in an ABMS member board specialty and is awaiting the next sleep medicine certification exam; or,
- Physician who is an active staff member of an AASM or Joint Commission-accredited sleep center or laboratory.

For home sleep tests, interpreting physicians must meet one of these 4 criteria by November 1, 2008. For physicians interpreting facility-based sleep tests, the timeline to meet one of these 4 criteria is January 1, 2010.

14. How can suppliers find out if a physician is board-certified?

Answer: Suppliers may contact the physician directly or search the certification records of the ABMS (www.abms.org) member boards or AASM certification information (www.aasmnet.org/ABMS.aspx).

15. Does a change from an E0601 to E0470 after the 91st day require a physician face-to-face evaluation?

Answer: Changing devices from a CPAP to RAD in the first 90 days can occur without a repeat face-to-face evaluation. It is anticipated that the physician and/or DME supplier is actively engaged with the patient to ensure that they are adherent to therapy and that any factors impacting the successful improvement in their OSA symptoms are being addressed. However once past the initial 90 days, changing from CPAP to RAD is often necessitated by complicating factors and must be done in conjunction with another face-to-face evaluation by the treating physician.

Positive Airway Pressure (PAP) Devices for Obstructive Sleep Apnea – Revised Policy – Important Information for the Ordering Physician

On March 13, 2008, CMS released a revised National Coverage Determination (NCD) for Continuous Positive Airway Pressure (CPAP) devices. The major change was allowing the results of specified home sleep tests to be used to qualify beneficiaries for coverage of CPAP devices. The Durable Medical Equipment Medicare Administrative Contractors (DME MACs) have released revised Local Coverage Determinations (LCDs) which incorporate the provisions of the NCD but also include additional coverage criteria. The policies also apply to bi-level positive airway pressure devices (respiratory assist devices, RADs) when they are used to treat obstructive sleep apnea (OSA). CPAP and bi-level devices have been combined into a single LCD - Positive Airway Pressure (PAP) Devices for Obstructive Sleep Apnea.

The major requirements for coverage of a PAP device for OSA that pertain to the ordering physician are:

1. There must be a face-to-face visit with the physician prior to ordering the sleep test. This should generally include the following elements:

- Sleep history and symptoms which may be caused by OSA
- Epworth Sleepiness Scale (a standardized patient questionnaire which helps to assess the likelihood of sleep apnea) or other validated sleep inventory
- Pertinent physical examination – e.g., body mass index, neck circumference, upper airway exam, and cardiopulmonary exam

2. If a home sleep study is performed, it must be one which **directly** measures airflow and at least two other pertinent physiological parameters (e.g., respiratory movement/effort, oxygen saturation, ECG/heart rate, etc.) and therefore allows determination of apneas and hypopneas used to calculate an apnea-hypopnea index (AHI) or respiratory disturbance index (RDI).
3. If a home sleep study is performed, it must be interpreted by a physician who holds either:

- Current certification in Sleep Medicine by the American Board of Sleep Medicine (ABSM); or
- Current subspecialty certification in Sleep Medicine by a member board of the American Board of Medical Specialties (ABMS); or
- Completed residency or fellowship training by a program approved by an ABMS member board and has completed all the requirements for subspecialty certification in sleep medicine except the examination itself and only until the time of reporting of the first examination for which the physician is eligible; or
- Active staff membership of a sleep center or laboratory accredited by the American Academy of Sleep Medicine or the Joint Commission.

Note: Physicians interpreting polysomnograms will be required to meet this requirement for coverage of PAP devices provided after January 1, 2010.

4. The sleep study results are:

- AHI or RDI is greater than or equal to 15 events per hour, with a minimum of 30 events; or
- AHI or RDI is 5-14 events per hour (minimum of 10 events) with documentation of excessive daytime sleepiness, impaired cognition, mood disorders, insomnia, hypertension, ischemic heart disease, or history of stroke.

(Note: For purposes of this policy, the RDI includes only apneas and hypopneas.)

5. To continue coverage for the PAP device (CPAP or RAD) beyond an initial 3 month trial period, there must be:

- A face-to-face visit with the physician during the second or third month of the trial that documents an improvement of the beneficiary's symptoms; and
- A data report from the PAP device which documents use the PAP device for at least 4 hours per night on 70% of nights for a 30 consecutive day period during the trial.

Additional coverage and payment rules for sleep tests may be found in the local coverage determinations (LCDs) for the applicable Medicare Part A or Part B contractor. There may be differences between those LCDs and the DME MAC LCD. For the purposes of coverage of PAP therapy, the DME MAC coverage criteria take precedence.

The complete medical policy may be viewed on the DME MACs' individual web sites or in the CMS Medicare Coverage Database. The Epworth Sleepiness Scale may be found in the Appendices section of the LCD. Note that the formal title of the policy is Positive Airway Pressure (PAP) Devices for the Treatment of Obstructive Sleep Apnea. The web address of the Medicare Coverage Database is: http://www.cms.hhs.gov/mcd/search.asp

Physicians are reminded that in order for these items to be reimbursed for your patients, the DME supplier will need to collect medical documentation including copies of your initial evaluation, the report of the sleep study, your re-evaluation during the PAP trial, and the data report from the PAP device indicating patient compliance during the trial. Please cooperate with them so they can provide the device you have ordered for your patient.

CPAP Therapy for Obstructive Sleep Apnea

MLN Matters Number: MM6048 Revised
Related Change Request (CR) #: 6048
Related CR Release Date: August 29, 2008
Related CR Transmittal #: R94NCD
Effective Date: March 13, 2008
Implementation Date: August 4, 2008

Note: This article was revised on September 2, 2008, to reflect changes to CR 6048, which CMS revised on August 28, 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 http://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.

Note: 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.

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 http://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 http://www.cms.hhs.gov/Transmittals/downloads/R94NCD.pdf on the CMS web site.

LCD and Policy Article Revisions - Summary for September 2008

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

High Frequency Chest Wall Oscillation Devices	
LCD	Revision Effective Date: 10/01/2008
INDICATIONS AND LIMITATIONS OF COVERAGE	Added: Coverage for specified neuromuscular diseases Added: Statement about concurrent use of mechanical in-exsufflation device
ICD-9 CODES THAT SUPPORT MEDICAL NECESSITY	Added: ICD-9 codes for neuromuscular diseases

Lower Limb Prostheses	
LCD	Revision Effective Date: 10/01/2008
INDICATIONS AND LIMITATIONS OF COVERAGE	Moved: Noncoverage statement for user adjustable heel heights from Policy Article
Policy Article	Revision Effective Date: 10/01/2008
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES	Moved: Noncoverage statement for user adjustable heel heights to LCD

COVERAGE CONT'D

CODING GUIDELINES	Revised: Coding guidance for microprocessor controlled knees Substituted: PDAC for SADMERC

Wheelchair Options/Accessories	
LCD	Revision Effective Date: 04/01/2008
INDICATIONS AND LIMITATIONS OF COVERAGE	Revised: Statements about the requirements for ATS or ATP involvement in the selection of power tilt and/or recline seating systems

Note: The information contained in this article is only a summary of revisions to LCDs and Policy Articles. For complete information on any topic, you must review the policy and/or article.

Screening DNA Stool Test for Colorectal Cancer

MLN Matters Number: MM6145 Revised
Related Change Request (CR) #: 6145
Related CR Release Date: July 25, 2008
Related CR Transmittal #: R93BP and R92NCD
Effective Date: April 28, 2008
Implementation Date: August 25, 2008

Note: This article was revised on August 11, 2008, to reflect changes made to CR6145. The transmittal number, release date, and Web address for accessing the NCD portion of CR6145 were revised. All other information remains the same.

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 6145 which announces the Centers for Medicare & Medicaid Services (CMS) decision regarding a request for reconsideration of the current national coverage determination (NCD) for colorectal cancer screening.

CMS will not expand the colorectal cancer screening benefit to include coverage of PreGen-Plus™, a commercially available screening DNA stool test; because the Food and Drug Administration (FDA) determines that this test requires pre-market review and approval. A subsequent request for reconsideration will be considered once FDA approval is obtained.

Background

Congress specifically authorized coverage of certain screening tests under Part B of the Medicare program and made necessary conforming changes in order to ensure that payments are made. As a result, CMS currently covers colorectal cancer screening for average-risk individuals ages 50 years and older using fecal occult blood testing, sigmoidoscopy, colonoscopy, and barium enema.

Neither the law nor regulations identify screening DNA stool tests as a possible coverage option under the colorectal cancer screening benefit. However, under the Code of Federal Regulations (42 CFR 410.37(a)(1)(v)) at http://www.access.gpo.gov/nara/cfr/waisidx_02/42cfr410_02.html and the Social Security Act (section 1861(pp)(1)(D)) http://www.ssa.gov/OP_Home/ssact/title18/1861.htm on the internet), CMS is allowed to use the NCD process to determine coverage of other types of colorectal cancer screening tests not specifically identified in the law or regulations as it determines to be appropriate, and in consultation with appropriate organizations.

Following a request for reconsideration of the current NCD at Section 210.3 of the Medicare NCD Manual for colorectal cancer screening, CMS will not expand the colorectal cancer screening benefit to include coverage of PreGen-Plus™, a commercially available screening DNA stool test, as an alternative to a screening colonoscopy or a screening flexible sigmoidoscopy.

The FDA determined that this test is a medical device that requires pre-market review and approval prior to marketing, which, to date, has not been obtained. In the absence of an FDA determination, CMS believes that there may be unresolved questions regarding the safety and effectiveness of the stool DNA test. Therefore, CMS does not believe that identification of stool DNA mutations is an appropriate colorectal cancer screening test at this time.

Additional Information

The official instruction, CR 6145, issued to your carrier, FI, A/B MAC, and DME MAC regarding this change, is reflected in two transmittals, one for the *Medicare Benefit Policy Manual* and one for the *National Coverage Determinations Manual*. These two transmittals are at http://www.cms.hhs.gov/Transmittals/downloads/R93BP.pdf and http://www.cms.hhs.gov/Transmittals/downloads/R92NCD.pdf, respectively, on the CMS web site.

WHEELCHAIR/POWER MOBILITY DEVICE

Corrections to the Manual Wheelchair Bases LCD

It was recently brought to NAS' attention that the Manual Wheelchair Bases Local Coverage Determination (LCD) L11454 contained erroneous information. Upon researching, it was found that when the January 1, 2007, revision to the policy was done four lines were omitted from the policy that described the criteria needed for coverage for a K0003 and a K0004 manual wheelchair base. The policy should read as follows:

> A lightweight wheelchair (K0003) is covered when a patient:

a) Cannot self-propel in a standard wheelchair in the home; and

b) The patient can and does self-propel in a lightweight wheelchair.

A high strength lightweight wheelchair (K0004) is covered when a patient meets the criteria in (1) and/or (2):

1) The patient self-propels the wheelchair while engaging in frequent activities in the home that cannot be performed in a standard or lightweight wheelchair.

2) The patient requires a seat width, depth, or height that cannot be accommodated in a standard, lightweight or hemi-wheelchair, and spends at least two hours per day in the wheelchair.

A high strength lightweight wheelchair is rarely medically necessary if the expected duration of need is less than three months (e.g., post-operative recovery).

In addition, it was found that the policy did not clarify the home assessment criteria and the KX modifier usage. Those clarifications should have also been done with the January 1, 2007, revision.

NAS has corrected those errors and apologizes for any inconvenience this may have caused.

Wheelchair Headrests

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 (LCDs) for Wheelchair Options and Accessories and Wheelchair Seating.

Therefore, NAS would like to provide suppliers with some basic information and to remind suppliers of the payment criteria regarding wheelchair headrests to aid in lowering the error rate for this item. Suppliers should also remember that documentation to support the payment criteria must be available if requested by any entity associated with Medicare.

A wheelchair headrest is an integral part of a wheelchair seating system and serves many purposes to allow the user the most optimal function and safe position. These purposes include:

- Supporting the head and neck
- Promoting correct posture
- Preventing neck and spine deformities
- Preventing possible neck, back, or arm discomfort and/or injury
- Promoting easier breathing
- Keeping the head in a mid-line position for optimum vision for wheelchair operation
- Improving socialization and interaction with others
- Allowing the use of assistive technology such as head array, switches, and environmental controls
- Promoting an optimal and safe eating position

The beneficiary most in need of a headrest is one with weak neck muscles who is unable to hold his/her head upright or with postural asymmetries that need support for safe and functional use. A headrest can also be used for support by the patient who becomes fatigued throughout the day and loses functional ability. The beneficiary with weak neck muscles or postural asymmetries requires a complex headrest system with additional support points and padding. Suppliers should remember, however, that if the neck strength and/or posture is good, the medical necessity for a complex headrest system would need justification.

In addition to those beneficiaries with weak neck muscles or with postural asymmetries, there are beneficiaries who need their headrests only while tilting or reclining and not when they are in an upright position because they have the ability to hold and/or control posture and head movement. In this instance, when the wheelchair is tilted or reclined, the user is able to rest his/her head against the headrest in a comfortable, well-supported position so the neck muscles can relax and the user can get the full benefit of tilting/ reclining the chair without hyper extending the neck causing discomfort and/or injury. In this instance, the individual would only require a simple headrest system.

A headrest is also an alternative for the individual who is unable to use a standard joystick to move the power wheelchair. With a head array device, head movement activates switches and sensors inside the headrest's padding, signaling the chair to move forward, backward, left or right. In this instance, switches in the headrest can also control seat functions such as tilting and reclining.

A headrest is versatile and can be attached to almost any solid back chair. It is adjustable in the vertical and horizontal planes, as well as rotational for precise positioning with the straight bar adjusting horizontally, the offset bar adjusting vertically, and the offset block swiveling on a ball for rotation.

It also comes in different shapes and sizes to ensure a perfect fit for maximum comfort, support and control. The differing shapes offer different amounts of support in the back, side, or front of the head. Where support is needed depends on which muscles are weak. There are also a variety of headrest attachments available such as facial pads for added support.

Medicare will allow for a headrest if the patient meets the following two criteria:

1. The patient has a manual wheelchair or a power wheelchair with a sling/solid seat/back and the patient meets Medicare coverage criteria for the wheelchair; and
2. The patient has any significant muscle weakness or postural asymmetries of the neck or head that may be due to one of the following or has one of the following diagnoses:

WHEELCHAIR/POWER MOBILITY DEVICE CONT'D

- A spinal cord injury resulting in quadriplegia or paraplegia (344.00-344.1)
- Other spinal cord disease (336.0-336.3)
- Multiple sclerosis (340)
- Other demyelinating disease (341.0-341.9)
- Cerebral palsy (343.0-343.9)
- Anterior horn cell diseases including amyotrophic lateral sclerosis (335.0-335.21, 335.23-335.9)
- Post polio paralysis (138)
- Traumatic brain injury resulting in quadriplegia (344.09)
- Spina bifida (741.00-741.93)
- Childhood cerebral degeneration (330.0-330.9)
- Alzheimer's disease (331.0)
- Parkinson's disease (332.0)
- Muscular dystrophy (359.0, 359.1)
- Hemiplegia (342.00-342.92, 438.20-438.22) due to stroke, traumatic brain injury, or other etiology
- Torsion dystonias (333.4, 333.6, 333.71)
- Spinocerebellar disease (334.0-334.9).

Medicare will also cover a headrest when the patient has a covered manual tilt-in-space wheelchair, manual semi or fully reclining back on a manual wheelchair, a manual fully reclining back on a power wheelchair, or a power tilt and/or recline power seating system.

Suppliers should remember that if the patient has a power operated vehicle (POV) or a power wheelchair with a captain's chair seat, a headrest or other positioning accessory will be denied as not medically necessary.

The HCPCS code to use when billing for either a simple or a complex headrest is E0955 – Wheelchair accessory, headrest, cushioned, any type including fixed mounting hardware. If the patient meets the criteria for a headrest, as noted above, the KX modifier should also be appended to the code. If the KX modifier is not appended to the code, the headrest may be denied as not a medical necessity.

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

Wheelchair Leg Rests

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.

Leg rests/footrests are designed to support the lower leg and foot in a comfortable position. Optimal positioning of the leg and foot will minimize back, lower extremity and foot discomfort; reduce the risk of skin breakdown; reduce strain on lower extremity joints; assist in maintaining good posture; thus giving the user adequate lower extremity support for safe operation of the wheelchair.

A standard wheelchair comes with fixed, swing-away or removable flip-up foot rests. The only possible adjustment is the height of the footrest. This is done at the initial seating and is accomplished with a wrench and is not easily/quickly changed.

Elevating leg rests allow the user to have his/her lower extremities elevated to a desired position other than 90/90 (hips and knees bent at 90 degrees). There are many reasons for this, including the user may have a musculoskeletal condition or the presence of a cast or brace which prevents 90 degree flexion at the knee; the user has significant edema of the lower extremities that requires an elevating leg rest; or the user meets the criteria for and has a reclining back on the wheelchair. Leg rests also help with changing position when the user becomes uncomfortable.

Standard elevating leg rests have a ratcheting device that brings the leg rest upward. The leg length is again adjusted at initial seating and does not change. This causes the foot to push against the footplate as the leg is raised. This restricts the knee from straightening.

Calf pads are added to elevating leg rests which may be padded or hard. The calf pad has minimal adjustability up and down but is mostly for supporting the lower leg (calf area) when the leg is elevated. The calf pad can flip up out of the way.

An articulating leg rest will lengthen as the leg rest is raised. This will provide enough length for the leg to extend and the foot will not push against the footplate thus maintaining proper support and fit during the entire raising and lowering of the leg.

A mechanically linked leg elevation feature includes a push rod connecting the leg rest to a manual or power recline seating system which elevates the leg rest when the back reclines and lowers the leg rest when the back rises.

A power leg elevation feature allows the leg rest to be raised and lowered independently of the recline and / or tilt of the seating system and includes the following: articulating or non-articulating leg-rests, dedicated motor and related

WHEELCHAIR/POWER MOBILITY DEVICE CONT'D

electronics with or without variable speed programmability and switch control which may or may not be integrated with the power tilt and / or recline control(s).

When combined with power tilt, the leg rests will help reduce lower extremity edema. Power elevating leg rests need to be articulating leg rests, which means that the length of the leg rest increases as it elevates in order to maintain correct position.

Coverage criteria for elevating leg rests include:

1. The patient has a musculoskeletal condition or the presence of a cast or brace which prevents 90 degree flexion at the knee; or
2. The patient has significant edema of the lower extremities that requires an elevating leg rest; or
3. The patient meets the criteria for and has a reclining back on the wheelchair

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.