Jurisdiction D News from Noridian Administrative Services, LLC.

Happenings

September 2008
Issue No. 15

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

In This Issue…

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

COMPETETIVE BIDDING

ACCREDITATION

CERT

FORMS

BILLING

CODING

COVERAGE

OXYGEN

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

FYI

Holiday Schedule

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

Holiday	Date
Columbus Day *	October 13, 2008
Veteran's Day *	November 11, 2008
Thanksgiving Day	November 27, 2008
Thanksgiving Holiday	November 28, 2008
Christmas Eve**	December 24, 2008
Christmas Day	December 25, 2008
** Partial day closure	

Summary of Supplier Manual Updates

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

Chapter 16	Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC)	Changed SADMERC references to PDAC	08/15/08
Chapter 16	HCPCS K Codes	Changed SADMERC references to PDAC	08/15/08
Chapter 15	Coding Assistance	Changed SADMERC references to PDAC	08/15/08
Chapter 9	LCD Development Process	Changed SADMERC references to PDAC	08/15/08

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

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."

New Supplier Manual Format

NAS is launching a new look to the supplier manual! The updated chapters will be added in stages, a chapter at a time. Per requests from the supplier community, a PDF version of the supplier manual will be also be available. The PDF version will be updated on a quarterly basis, while the HTML or Web version will continue to be updated real time.

We welcome your feedback on our manual. Please provide comments or suggestions by sending an email to dme@noridian.com, and use Supplier Manual as the subject line.

Change in Jurisdiction D Medical Director

Effective August 18, the Medical Director for Jurisdiction D has changed from Dr. Robert Szczys, who transferred to the position of Medical Director for the Medicare Pricing, Data Analysis, and Coding (PDAC) contract, to Richard W. (Dick) Whitten, MD, MBA, FACP. Dr. Whitten will be involved with the development and revision of LCDs coordinating with the three other DME MAC medical directors. Dr. Whitten is an internist, who has worked at NAS for eight years as a Part B Medical Director.

Prior to this, he was Medical Director of the Washington State Health Care Authority and its Basic Health Plan. He is a member of the CPT Assistant Editorial Panel and a former member and Vice Chair of the AMA/Specialty Society Relative Value System Update Committee ("RUC") and Chair of the Healthcare Professions Advisory Committee (both are advisory bodies to CMS on provider coding and billing).

Effective 8/18/08-SADMERC Transition to NAS PDAC

Noridian Administrative Services, LLC (NAS) has been named the Pricing, Data Analysis and Coding (PDAC) Contractor by the Centers for Medicare & Medicaid Services. By August 18, 2008, NAS will perform the following activities that Palmetto GBA, as the Statistical Analysis DME Regional Carrier (SADMERC), currently performs:

- Provide data analysis support to the DME Program Safeguard Contractors (PSCs)
- Guide manufacturers and suppliers on the proper use of the Healthcare Common Procedure Coding System (HCPCS) for Medicare billing purposes, through product reviews and decisions, the DMECS system and the HCPCS Helpline
- Conduct national pricing functions for DMEPOS services
- Assist CMS with DMEPOS fee schedules

Visit the PDAC Web site at www.dmepdac.com.

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

Implementation of New Provider Authentication Requirements for Medicare Contractor Provider Telephone and Written Inquiries

MLN Matters Number: MM6139 Revised
Related Change Request (CR) #: 6139
Related CR Release Date: August 8, 2008
Related CR Transmittal #: R22COM
Effective Date: March 1, 2009
Implementation Date: January 5, 2009

Note: This article was revised on August 13, 2008, to change the title to more accurately reflect the Change Request requirements. Additionally, changes were made to further clarify the authentication requirements. In particular, the note on page 2 was changed to show that you will only be allowed three attempts to correctly provide your NPI, PTAN, **AND** last 5-digits of your TIN.

Provider Types Affected

CR 6139 impacts all physicians, providers, and suppliers (or their staffs) who make inquiries to Medicare contractors (carriers, Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), Medicare Administrative Contractors (A/B MACs), or Durable Medical Equipment Medicare Administrative Contractors (DME MACs)). Inquiries include written inquiries or calls made to Medicare contractor provider contact centers, including calls to Interactive Voice Response (IVR) systems.

What You Need to Know

CR 6139, from which this article is taken, addresses the necessary provider authentication requirements to complete IVR transactions and calls with a Customer Service Representative (CSR).

Effective March 1, 2009, when you call either the IVR system, or a CSR, the Centers for Medicare & Medicaid Services (CMS) will require you to provide three data elements for authentication: 1) Your National Provider Identifier (NPI); 2) Your Provider Transaction Access Number (PTAN); and 3) The last 5-digits of your tax identification number (TIN).

Make sure that your staffs are aware of this requirement for provider authentication.

Background

In order to comply with the requirements of the Privacy Act of 1974 and of the Health Insurance Portability and Accountability Act, customer service staff at Medicare fee-for-service provider contact centers must properly authenticate callers and writers before disclosing protected health information.

Because of issues with the public availability of previous authentication elements, CMS has addressed the current provider authentication process for providers who use the IVR system or call a CSR. To better safeguard providers' information before sharing information on claims status, beneficiary eligibility, and other provider related questions, CR 6139, from which this article is taken, announces that CMS has added the last 5-digits of the provider's TIN as an additional element in the provider authentication process. Your Medicare contractor's system will verify that the NPI, PTAN, and last 5-digits of the TIN are correct and belong to you before providing the information you request.

Note: You will only be allowed three attempts to correctly provide your NPI, PTAN, and last 5-digits of your TIN.

As a result of CR 6139, the *Disclosure Desk Reference* for Provider Contact Centers, which contains the information Medicare contractors use to authenticate the identity of callers and writers, is updated in the *Medicare Contractor Beneficiary and Provider Communications Manual,* Chapter 3 (Provider Inquiries), Section 30 (Disclosure of Information) and Chapter 6 (Provider Customer Service Program), Section 80 (Disclosure of Information) to reflect these changes.

New information in these manual chapters also addresses other authentication issues. This new information is summarized as follows:

- **Authentication of Providers with No NPI**

  Occasionally, providers will never be assigned an NPI (for example providers who are retired/terminated), or inquiries may be made about claims submitted by a provider who has since deceased.

  Most IVRs use the NPI crosswalk to authenticate the NPI and PTAN. The NPI is updated on a daily basis and does not maintain any history about deactivated NPIs or NPI/PTAN pairs. Therefore, if a provider enters an NPI or NPI/PTAN pair that is no longer recognized by the crosswalk, the IVRs may be unable to authenticate them; or if the claim was processed using a different NPI/PTAN pair that has since been deactivated, the IVR may not be able to find the claim and return claims status information.

  Since these types of inquiries are likely to result in additional CSR inquiries, before releasing information to the provider, CSRs will authenticate using at least two other data elements available in the provider's record, such as provider name, TIN, remittance address, and provider master address.

- **Beneficiary Authentication**

  Before disclosing beneficiary information (whether from either an IVR or CSR telephone inquiry), and regardless of the date of the call, four beneficiary data elements are required for authentication: 1) last name, 2) first name or initial, Health Insurance Claim Number (HICN), 3) and either date of birth (eligibility, next eligible date), and 4) Durable Medical Equipment Medicare Administrative Contractor Information Form (DIF) (pre-claim) or date of service (claim status, CMN/DIF (post-claim.)).

- **Written Inquiries**

  In general, three data elements (NPI, PTAN, and last 5-digits of the TIN) are required for authenticating providers' written inquiries. This includes inquiries received without letterhead (including hardcopy, fax, email, pre-formatted inquiry forms or inquiries written on Remittance Advice (RAs) or Medicare Summary Notices (MSNs)).

FYI CONT'D

The exception to this requirement is written inquiries received on the provider's official letterhead (including emails with an attachment on letterhead). In this case, provider authentication will be met if the provider's name and address are included in the letterhead and clearly establish their identity. Therefore, the provider's practice location and name on the letterhead must match the contractor's file for this provider. (However, your Medicare contractor may use discretion if the file does not exactly match the letterhead, but it is clear that the provider is one and the same.) In addition, the letterhead information on the letter or email needs to match either, the NPI, PTAN, or last 5-digits of the TIN. Providers will also include on the letterhead either the NPI, PTAN, or last 5-digits of the TIN. Medicare contractors will ask you for additional information, if necessary.

- **Overlapping Claims**

  When claims overlap (that is, multiple claims with the same or similar dates of service or billing periods), the contractor that the provider initially contacts will authenticate that provider by verifying his/her name, NPI, PTAN, last 5-digits of the TIN, beneficiary name, HICN, and date of service for post-claim information, or date of birth for pre-claim information.

Additional Information

You can find more information about the new provider authentication requirements for Medicare inquiries by going to CR 6139, located at http://www.cms.hhs.gov/Transmittals/downloads/R22COM.pdf on the CMS web site.

New Report Shows CMS Pilot Program Saving Nearly $700 Million in Improper Medicare Payments

The Centers for Medicare & Medicaid Services (CMS) today released a new report offering fresh evidence that the recovery audit contractors (RACs) pilot program is successfully identifying improper payments. The findings will also help the agency improve the program as it is expanded nationwide within two years, officials say.

The evaluation report shows that $693.6 million in improper Medicare payments was returned to the Medicare Trust Funds between 2005 and March 2008. The funds returned to the Medicare Trust Funds occurred after taking into account the dollars repaid to health care providers, the money overturned on appeal and the costs of operating the RAC demonstration program.

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

To view the RAC Evaluation Report:
http://www.cms.hhs.gov/RAC

Quarterly Provider Updates

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

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

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

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

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

EDUCATIONAL

DME CD Available

NAS created an educational CD-ROM that was mailed to suppliers on June 20th, 2008. This educational tool contains many great tools for suppliers, especially for training new staff. Suppliers will find many useful documents and links on this CD including billing guidelines, forms, helpful hints for submitting appeals, financial information, resources and contacts. The *What NAS Does for You* section highlights each NAS department and how we serve and assist suppliers.

The CD-ROMs were mailed to the payee address on file in our claims processing system. Please watch your mailbox for your interactive NAS Jurisdiction D DME CD-ROM if you have not already received this or check with the staff at your payee address to verify receipt of this CD. If you received a damaged CD or it will not load, please call the Supplier Contact Center at 866-243-7272 to request a new CD.

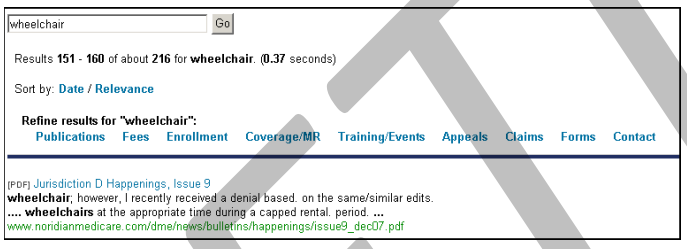
Disclaimer: The information provided on the CD-ROM is current as early June when the CDs were created. To keep up-to-date on the latest Medicare and DME information, please visit the NAS DME Web site and sign up for our email list.

Search Engine Enhancements for DME

NAS has launched the Google™ search engine on our www.noridianmedicare.com/dme Web site. This will allow suppliers to more easily access and sort DME news, fees, policies, and related information. A search guide is available that provides techniques to assist you in conducting searches that offer the most precise results.

There are a number of changes suppliers should be aware of when using the Google™ search engine.

- The most noticeable change is the ability to search the DME site and then narrow the search results by category.
- Some misspelled words can still be searched, i.e., searching for the misspelled term 'whelchair' will provide the results for the correctly spelled term 'wheelchair'.
- If there are exact duplicates of the same search result, those will be removed from the initial search result listing; but offered as a link on the last page of the results listing.
- The look of the results should be familiar to those who commonly use the www.google.com search engine.
- Partial word searches or 'wildcard' searches using the first few letters of a word followed by an asterisk (*) are no longer used.
- NAS does not control the frequency in which Google™ reviews new content on our site to be included in the search results (known as indexing). To view the latest news on your search term, reference the "What's New" section of our Web site.



Most search engine changes will not be noticeable. You will still be able to do the following with your search result:

- Identify the file type (PDF, Excel)
- Identify the title, which is also a hyperlink to the content
- View an excerpt of the content containing the searched term/phrase
- View the full web address for each result
- View how many total results were available for your search
- Page through the result listings
- Sort the results by relevance of the term/phrase used within the content or by the date published

The change was made in response to the feedback received through the Web site satisfaction survey. Suppliers are encouraged to complete the survey as often as it is displayed to allow NAS to see the trend in our customer's Web usage and satisfaction.

Three New OLC Lessons Available

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

Documentation Prior to DME Claim Submission

In this lesson we discuss what documention you need prior to submitting DME claims. Documentation to support medical necessity begins at the point of intake and having a thorough intake process is key. NAS encourages suppliers to ask the right questions up front in order to gather all the appropriate documentation necessary, such as the Advance Beneficiary Notice of Noncoverage, Certificate of Medical Necessity or DME Information Form. This lesson also outlines the elements for orders, proof of delivery and obtaining the beneficiary's authorization.

Claim Submission

Are you new to Medicare or are you looking for a refresher course? This lesson is a great resourse for all suppliers who submit claims on the CMS-1500 claim form. All fields specific to DME claim submission are discussed. NAS explains the Administrative Simplification Compliance Act and benefits to electonic data interchange. Come find the key to successful claim submission!

Refractive Lenses

Are you having difficulty getting your claims paid by the DME MAC? Are you unsure of how to complete the claim form for deluxe frames or lenses? Are you perplexed by the coverage requirements? If your answer to any of these questions was yes, or you just need a refresher course, then this is the lesson for you. Refractive Lenses if the first lesson offered within our **DME Coverage and Specialty** course. This self-pace lesson includes information on:

- Claim submission
- Coverage
- Coding for lenses
- Documentation

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

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

Top Ten Telephone Inquiries and Solutions

The purpose of this article is to assist suppliers with solutions to the "Top Ten" telephone inquiries that our Supplier Contact Center received from April - June 2008. Our Web site, www.noridianmedicare.com/dme, contains excellent information to assist with supplier inquiries. The IVR At-A-Glance is a new resource guide that can help navigate through the functions of the IVR. This handy reference tool can be found on our Web site under Contacts.

1. DME Same or Similar Equipment

Since the implementation of the IVR enhancements for same or similar equipment in June, calls to the Contact Center have dropped dramatically, from an average of 2,000 inquires per day in April to an average of 500 calls per day. The same or similar functionality was added to the IVR to address the higher call volume.

To access same or similar information from the IVR Main Menu, use the voice activation option by saying "same or similar" or press 6 on the phone keypad. The IVR will determine the HCPCS on file that is considered same/similar, initial date of the equipment on file, recertification date, last day equipment was billed, and the name and phone number of the supplier who billed the paid equipment. The IVR will also provide information on CMNs that are posted to the Common Working File. To access CMNs on file, say "CMN" or press 4 on the phone keypad.

Suppliers should also have a very thorough intake assessment to assist with determining whether a beneficiary currently has or previously had an identical or similar piece of equipment. A Suggested Intake Form can be accessed on our Web Site under Forms.

2. Frequency/Dollar Amount Limitation

Utilization guidelines can be found in the Indications and Limitations of Coverage and/or Medical Necessity section of most medical policies. Quantities of supplies greater than the allowable amount must have documentation supporting the medical necessity, as outlined in the Documentation section of the policy. There must be clear documentation in the patient's medical record that corroborates the order and any additional documentation that pertains to the medical necessity of the items and quantities billed. This supporting information should be reported in Item 19 on the CMS-1500 or the narrative field of an electronic claim.

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

3. Entitlement

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

4. **CWF Rejects**

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

- Does the beneficiary live in a skilled nursing facility?
- Has the beneficiary recently been hospitalized? If so, ask for admission and discharge dates. Refer to Chapter 5 of the Supplier Manual for specifics on consolidated billing.
- Does the beneficiary have home health services? Ask if anyone is coming into the home to aid the beneficiary. A list of items included in a covered home health episode can be found at www.cms.hhs.gov/HomeHealthPPS/03_coding&billing.asp. These items cannot be billed to the DME MAC during a Part A covered home health episode.
- Verify the beneficiary is not covered under a Medicare Advantage (HMO) Plan. Verify the beneficiary's Medicare name and HICN on the Medicare card. Make a copy of their Medicare card for reference. Always submit claims with the beneficiary's name exactly as it is listed on their Medicare card, i.e., include the middle name or initial of the middle name, Jr or Sr, if listed on the Medicare card.

5. Claim Not on File

Claims that are incomplete or have invalid information will not be processed or the supplier may receive an education status letter which outlines the errors on the claims. These claims are considered unprocessable. Claims must be corrected and submitted as new claims. If the IVR states no claim is on file, verify the claim form was completed appropriately by checking the following items:

- Item 1A - Verify the HICN is correct. Most HICNs have 9 digits and either leading or ending alpha character(s).
- Item 11 - Completed with the word "NONE" if Medicare is primary. If Medicare is secondary, enter the policy or group number.
- Items 17 and 17b - Name of the referring or ordering physician and physician's NPI.
- Item 21 - Diagnosis is coded to the highest specificity.
- Item 24E - Claim has only one diagnosis code pointer per claim line (1, 2, 3 or 4).
- Item 33a - NPI of supplier.

References:

- Refer to the CMS 1500 claim form tutorial located on our Web site under Claims.

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

6. Payment Explanation/Calculation

Most DMEPOS are paid based on a fee schedule established by CMS for each state or territory. The beneficiary's permanent address will determine the amount allowed by Medicare for a particular service. Drugs, however, have the same allowance regardless of where the beneficiary resides. Medicare pays 80% of the allowed amount for DMEPOS and drugs and biologicals. Access the NAS DME Web site for:

- Fee schedules located under News/Publications.
- Remittance advice codes located under Claims.

7. **Certification Requirements**

Suppliers should be knowledgeable in the medical policies for items that require a CMN or DIF. Refer to the Web site for:

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

Reminders:

- If a claim denies due to a CMN missing, verify through the IVR, under the CMN option, if there is a CMN on file for the billed item.
- If there was a break in service in the item being billed, enter the reason for the break with "BIS" in Item 19 on the CMS-1500 claim form or the NTE segment, 2400 loop for electronic claims. A comment of BIS allows claims processing staff to ensure that a new rental period begins and to enter the "new" initial CMN. This will prevent claim denials and the need for requesting a redetermination on denied claims.

8. Eligibility

It is the supplier's responsibility to determine whether the patient is entitled to receive Medicare benefits and to report the Medicare number as shown on the patient's Medicare Health Insurance card. The claim must be submitted with the patient's name exactly as it is shown on the Medicare card. Utilize the IVR to verify Part B entitlement, possible HMO coverage or possible Date of Death information.

9. Duplicate Remittance Advice (RA)

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

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

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

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

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

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

10. Status/Explanation/Resolution

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

Refer to our Web site for:

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

Stay up-to-date with Medicare changes!

- Log onto www.noridianmedicare.com to keep abreast of Medicare changes.
- The latest news regarding policy changes, claim filing issues and other important information is found in the "What's New" section of our Web site.

Subscribe to the NAS DME E-Mail List to receive emails with the latest news and information.

Top Ten Written Inquiries

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

1. Medical Review

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

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

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

If you receive a medical necessity denial due to a minor error such as forgetting to append the KX modifier, you can do a reopening. Please read further in the article for more examples of reopenings versus redeterminations.

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

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

2. Issue Not Identified/Incomplete Information Provided

When sending inquiries to NAS, clearly state the question. This will ensure NAS has all of the information needed to answer the request. If information is submitted without a specific request, the written correspondence staff will reply with a letter indicating the inquiry was incomplete, causing a delay in receiving a response.

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

3. Claim Information Change

This is a reminder to send in the CMN, when needed, with claim submission. Uploading CMNs after claim submission will delay the process of your claim. Double check the information you are providing is correct including the date of service, procedure code, modifiers, etc. Remember to have all pertinent information with your claim at the time of submission to avoid having to request a reopening or redetermination.

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

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

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

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

4. Misrouted Written Correspondence

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

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

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

5. Claim Processing Error

Be sure your claim denied inappropriately prior to sending a written inquiry stating it was denied in error. There has been an increase in written inquiries for this reason when in fact the claim was denied appropriately. Please refer to the LCDs for specific coverage criteria.

6. Benefits/Exclusions/Coverage Criteria/Rules

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

The DME MAC Jurisdiction D Online Supplier Manual is also a great resource for information regarding Medicare. The following outlines the chapters:

Chapter 1 – Introduction
Chapter 2 – Supplier Enrollment
Chapter 3 – Documentation Requirements
Chapter 4 – Certificates of Medical Necessity
Chapter 5 – DMEPOS
Chapter 6 – Claim Submission
Chapter 7 – Crossover Claims
Chapter 8 – Electronic Data Interchange (EDI)
Chapter 9 – Local Coverage Determinations (LCD) and Policy Articles
Chapter 10 – Indian Health Services (IHS)
Chapter 11 – Medicare Secondary Payer (MSP)
Chapter 12 – Pricing and Overpayments
Chapter 13 – Inquiries and Appeals
Chapter 14 – Fraud and Abuse
Chapter 15 – Resources

Chapter 16 – Coding

Chapter 17 – System Outputs

Appendix – Acronyms/Abbreviations

7. Provider Demographic Information Changes

NAS has been seeing an increase in requests for change of address or Medicare enrollment applications for suppliers. Keep in mind this information cannot be changed by the DME MAC. This information must be sent to the National Supplier Clearinghouse (NSC). The NSC is contracted by CMS to issue Medicare billing privileges to suppliers of DMEPOS and to maintain a supplier file containing information collected via the CMS 855S enrollment form.

The following are ways to contact the NSC:

Address

National Supplier Clearinghouse
Palmetto GBA * AG-495
PO Box 100142
Columbia SC 29202-3142

Overnight Mailing Address

National Supplier Clearinghouse
Palmetto GBA * AG-495
2300 Springdale Drive Bldg. 1
Camden SC 29020

Telephone
1-866-238-9652 9 am – 4 pm EST

8. Other Issues

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

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

9. Statutes and Regulations

A great resource for finding benefits, exclusions, coverage criteria, rules and regulations is the Internet Online Manual (IOM) on the CMS Web site. Information regarding documentation, claims processing, ABNs, appeals information, the Medicare Program Integrity Manual, as well as other pertinent information can be found here.

10. Filling/Billing Instructions

Sending in a copy of an invoice or returning an education status letter, asking for NAS to make payment, is not the appropriate procedure in getting your claims paid timely. If you bill electronically, please visit the CEDI Web site for further information. If you are exempt from billing electronically and bill on a paper CMS-1500 claim form, please reference the Claims tab on our Web site for appropriate information.

Sign Up for the CEDI Listserv Today

All entities participating with CEDI, including electronic trading partners, DME MAC suppliers submitting electronic claims, software vendors, billing services and/or clearinghouses should sign up for the CEDI listserv.

The CEDI listserv will keep you informed of all CEDI updates and changes. Currently many of the CEDI listserves are submitted through the listserves provided by the DME MAC Jurisdictions. Eventually CEDI listserv will only be sent through the CEDI listserv, so sign up today.

To sign up for the CEDI listserv, click on the following link: www.ngscedi.com/listserv/subscribe.htm

CEDI Front End Reports

It is essential that all Trading Partners/Electronic Submitter download and review all front end reports returned by CEDI.

National Government Services, Common Electronic Data Interchange (CEDI) creates and delivers the following Level I reports for each claim file 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 generated 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 vendor will know what needs to be corrected in order to pass these edits. CEDI will provide support for the GenResponse (GENRPT) report.

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

Note: Common Front End Edits (i.e. 20004, 20011, 20322, 40014 and many more) are listed in the DME MAC Front End Edit Error Code Manual. This manual provides the edit number/code, edit descriptions and edit explanations. Examples of these reports are included in the back of the manual.

CEDI CONT'D

Commonly asked questions on the Electronic Front End Reports are located in the CEDI Frequently Asked Questions (FAQ) document and can be accessed using the following link: www.ngscedi.com/outreach_materials/outreachindex.htm.

CEDI created the resources referenced above to assist DME MAC electronic trading partners with understanding the electronic reports delivered by CEDI.

CEDI Listserv

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

CEDI Passwords and Logging Into CEDI

Changing or Resetting a CEDI Password

The following CEDI password guidelines will assist DME MAC suppliers when changing their initial or expired passwords. All CEDI initial passwords will expire immediately and require the user to establish a confidential, unique password. **Passwords will expire every 90 days.** Password configuration requirements for changing and initial or expired password are as follows:

- Passwords must be eight (8) characters in length. No more and no less.
- Passwords must contain a combination of number and alpha characters.
- Passwords must contain one of these three special characters (@, #, $). No other special characters will be accepted.
- Passwords are only good for 90 days, at which time the user must reset it.
- Passwords cannot be changed by the user more than once per day.
- After three incorrect login attempts, the ID will be revoked. Please disconnect and re-try prior to the third attempt.
- The ID history retains the last 12 passwords the user has used. These cannot be reused.
- Must not be stored in scripts, files, or applications unless compensating controls are in place

Note: Trading Partner IDs will automatically suspend after 365 days of inactivity.

There are two options available to request a CEDI password reset:

- E-mail the CEDI Help Desk at ngs.cedihelpdesk@wellpoint.com (This option is recommended and will provide a faster response)
- Contact the CEDI Help Desk at 1-866-311-9184 and select option 3.

Logging into CEDI

CEDI Login IDs and Passwords are case sensitive. Login IDs start with an uppercase (i.e. A08 and not a08). After three incorrect login attempts, the Login ID will be revoked. Please disconnect and re-try prior to the third attempt to avoid having your ID revoked.

To request a Login ID reset for a revoked ID:

- E-mail the CEDI Help Desk at ngs.cedihelpdesk@wellpoint.com (This option is recommended and will provide a faster response)
- Contact the CEDI Help Desk at 1-866-311-9184 and select option 3.

ERA Files Only Kept for 45 Days

The CEDI have seen an increase in requests for Electronic Remittance Advices (ERAs) older than 45 days. The CEDI only keeps reports and files in the customer's mailboxes for retrieval for 45 days after which they are no longer available.

If you are sending in a request for an ERA after 45 days, a paper remittance must be requested from the DME MAC.

Updated Express Plus Manual Available

National Government Services, Common Electronic Data Interchange (CEDI) recently updated the Express Plus Manual. The July 2008 Express Plus Manual includes updates related to the implementation of the National Provider Identifier (NPI). The updated manual is available on the CEDI Web site, www.ngscedi.com, under Resource Materials or Software Downloads.

Update to CEDI FAQs

National Government Services Common Electric Data Interchange (CEDI) has made changes to the Frequently Asked Questions (FAQs) for the July 24th update.

These changes are highlighted and are available at www.ngscedi.com/outreach_materials/072408faq.pdf.

NPI

Sole Proprietors with Multiple PTANs

Due to the fact that DME suppliers who are Sole Proprietors can have multiple PTANs linked to their NPI number, a letter is sent by our claims processing staff asking which PTAN (NSC number) should be used for paying the claim. To avoid receiving these letters for every claim and to speed up claims processing, NAS is encouraging suppliers to include the corresponding PTAN in Item 19 on the CMS 1500 claim form or the NTE segment for electronic claims. Please precede the PTAN number with the letters "PTAN" so we know what the number in the narrative field represents.

Delay of the Medicare DMEPOS Competitive Bidding Program

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

Delay of National DMEPOS Competitive Bidding Program: Claims Processing

Section 154 of the Medicare Improvements for Patients and Providers Act of 2008 delays the DMEPOS Competitive Bidding Program. Therefore, in the 10 areas where competitive bidding was initiated, Medicare will pay for DMEPOS items, retroactive to June 30, 2008, using the standard DMEPOS fee schedule amounts.

CMS will begin processing all incoming claims under standard FFS rules, no later than July 28, 2008. Any claims that were held will be processed no later than August 4, 2008.

To the extent possible, CMS will also automatically reprocess claims that were paid under the Competitive Bidding Program and those claims denied based solely due to DMEPOS Competitive Bidding Program rules.

Note that in some instances suppliers will need to alert the contractor to claims that should be adjusted.

CMS will soon issue contractor instructions and issue accompanying MLN Matters articles with more information.

Important Information on New Medicare Law – The Medicare Improvements for Patients and Providers Act of 2008

MLN Matters Number: SE0826

This article contains a compilation of messages that were issued on July 16, 2008.

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 MACs (DME MACs)) for services provided to Medicare beneficiaries.

Provider Action Needed

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) was enacted on July 15, 2008. This legislation alters a number of Medicare policies, which have been the subject of a number of change requests (CRs) and MLN Matters articles published in recent months. The Centers for Medicare & Medicaid Services (CMS) is in the process of revising these previously issued CRs and MLN Matters articles as a result of this legislation. However, CMS feels it is important that physicians, providers and suppliers be aware of five critical issues immediately.

These five issues are:

- New 2008 Medicare Physician Fee Schedule (MPFS) payment rates effective for dates of service July 1, 2008 through December 31, 2008;
- Extension of the exceptions process for the therapy caps;
- A delay in the Medicare durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive bidding program;
- Reinstatement of the moratorium that allows independent laboratories to bill for the technical component (TC) of physician pathology services furnished to hospital patients; and
- Extension of the payment rule for Brachytherapy and Therapeutic Radiopharmaceuticals.

Be sure your billing staff is aware of these changes.

Background

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) was enacted on July 15, 2008. While MIPPA calls for numerous changes to the Medicare program, this special edition article covers five key provisions as noted above.

1. **New 2008 Medicare Physician Fee Schedule (MPFS) Payment Rates Effective for Dates of Service July 1, 2008 through December 31, 2008**

As a result of this legislation, the mid-year 2008 MPFS rate of -10.6 percent has been replaced with the January-June 2008 0.5 percent update, retroactive to July 1, 2008.

Physicians, non-physician practitioners and other providers of services paid under the MPFS should begin to receive payment at the 0.5 % update rates in approximately 10 business days, or less, for claims with dates of service on or after July 1, 2008. Medicare contractors are currently working to update their payment system with the new rates.

In the meantime, to avoid a disruption to the payment of claims for physicians, non-physician practitioners and other providers of services paid under the MPFS, Medicare contractors will continue to process the claims with dates of service on or after July 1, 2008, that have been on hold. These claims will be processed on a rolling basis (first in/first out) for payment at the -10.6% update level. After your Medicare contractor begins to pay claims at the new 0.5% rate, to the extent possible, the contractor will begin to automatically reprocess any claims paid at the lower rates.

Under the Medicare statute, Medicare pays the lower of submitted charges or the Medicare fee schedule amount. Claims with dates of service July 1 and later billed with

a submitted charge at least at the level of the January 1 – June 30, 2008, fee schedule amount will be automatically reprocessed. Any lesser amount will require providers to contact their local contractor for direction on obtaining adjustments. Non-participating physicians who submitted unassigned claims at the reduced nonparticipation amount also will need to request an adjustment.

Medicare contractor web sites are being updated with the new rates and these should be available shortly. Be aware that any published MLN Matters articles affected by the new law will be revised or rescinded as appropriate.

2. Extension of Therapy Cap Exceptions

Another key provision of the MIPPA legislation extends the effective date of the exceptions process to the therapy caps to December 31, 2009. Outpatient therapy service providers may now resume submitting claims with the KX modifier for therapy services that exceed the cap furnished on or after July 1, 2008.

For physical therapy and speech language pathology services combined, the limit on incurred expenses is $1810 for calendar year 2008. For occupational therapy services, the limit is $1810. Deductible and coinsurance amounts applied to therapy services count toward the amount accrued before a cap is reached. Services that meet the exceptions criteria and report the KX modifier will be paid beyond this limit.

Before this legislation was enacted, outpatient therapy service providers were previously instructed to not submit the KX modifier on claims for services furnished on or after July 1, 2008. The extension of the therapy cap exceptions is retroactive to July 1, 2008. As a result, providers may have already submitted some claims without the KX modifier that would qualify for an exception.

Providers submitting these claims using the 837 institutional electronic claim format or the UB-04 paper claim format would have had these claims rejected for exceeding the cap. These providers should resubmit these claims appending the KX modifier so they may now be processed and paid. Providers submitting these claims using the 837 professional electronic claim format or the CMS-1500 paper claim format would have had these claims denied for exceeding the cap. These providers should request to have their claims adjusted in order to have the contractor pay the claim.

In all cases, if the beneficiary was notified of their liability and the beneficiary made payment for services that now qualify for exceptions, any such payments should be refunded to the beneficiary.

3. Delay in the DMEPOS Competitive Bidding Program

This new law also has delayed the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program. Items that had been included in the first round of the DMEPOS Competitive Bidding Program can be furnished by any enrolled DMEPOS supplier in accordance with existing Medicare rules. Payment for these items will be made under the fee schedule. Additional guidance regarding the new law's impact on this program will be forthcoming.

4. Reinstatement of the Moratorium That Allows Independent Laboratories to Bill for the TC of Physician Pathology Services Furnished to Hospital Patients

In the final physician fee schedule regulation published in the Federal Register on November 2, 1999, CMS stated that it would implement a policy to pay only the hospital for the technical component (TC) of physician pathology services furnished to hospital patients. Prior to this proposal, any independent laboratory could bill the carrier under the MPFS for the TC of physician pathology services for hospital patients. At the request of the industry, to allow independent laboratories and hospitals sufficient time to negotiate arrangements, the implementation of this rule was administratively delayed. Subsequent legislation formalized a moratorium on the implementation of the rule. As such, during this time, Medicare contractors have continued to pay for the TC of physician pathology services when an independent laboratory furnishes this service to an inpatient or outpatient of a covered hospital.

The most recent extension of the moratorium, established by the Medicare, Medicaid, and SCHIP Extension Act (MMSEA), Section 104, expired on June 30, 2008. A new extension of the moratorium has been established by Section 136 of MIPPA, retroactive to July 1, 2008.

A previous communication (MLN Matters article MM6088) indicated that the moratorium had ended and that independent laboratories may no longer bill Medicare for the TC of physician pathology services furnished to patients of a covered hospital, regardless of the beneficiary's hospitalization status (inpatient or outpatient) on the date that the service was performed. This prohibition is rescinded and the moratorium will continue effective for claims with dates of service on and after July 1, 2008, but prior to January 1, 2010.

5. Extension of Payment Rule for Brachytherapy and Therapeutic Radiopharmaceuticals

MIPPA extends the use of the cost to charge payment methodology for Brachytherapy and Therapeutic Radiopharmaceuticals through January 1, 2010. This change is retroactive to July 1, 2008. Some claims have already been processed, however, using the Outpatient Prospective Payment System (OPPS) rates that were in effect until MIPAA enactment. To avoid a disruption in payment while the cost to charge payment methodology is re-implemented, impacted claims will continue to be paid based on the OPPS rates. Contractors will mass adjust all impacted OPPS claims with dates of service beginning July 1, 2008, as soon as the cost to charge payment methodology has been implemented. Reprocessing of affected claims will be complete by September 30, 2008.

Additional Information

Be on the alert for more information about other legislative provisions which may affect you.

If you have any questions, please contact your carrier, FI, A/B MAC, or DME MAC at their toll-free number, which may be found at http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip on the CMS web site.

Manual Revisions to Reflect Special Billing Instructions for DMEPOS Items as a Result of the DMEPOS Competitive Bidding Program

MLN Matters Number: MM6007 Revised
Related Change Request (CR) #: 6007
Related CR Release Date: June 26, 2008
Related CR Transmittal #: R1544CP
Effective Date: July 1, 2008
Implementation Date: July 7, 2008

Note: This article is impacted by the Medicare Improvements for Patients and Providers Act of 2008, which was enacted on July 15, 2008. That legislation delays the implementation of the DMEPOS competitive bidding program until 2009 and makes other changes to the program. This article will be further revised and/or replaced as more details of the modified program are available.

Provider Types Affected

Physicians, providers, and suppliers who bill Medicare Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for DMEPOS provided to Medicare beneficiaries.

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 6007 so suppliers are aware of the information provided in the **new section 50 of chapter 36 of the Medicare Claims Processing Manual** highlighted in the *Key Points* section of this CR and attached to CR6007.

Background

Change Request 6007 explains that currently Medicare payment for most DMEPOS is based on fee schedules. However, section 302(b) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), which amended section 1847 of the Social Security Act (Act), mandates a competitive bidding program to replace the current DMEPOS methodology. The statute also mandates that the competitive bidding program be phased-in beginning in 2007. CMS has issued the regulation for the competitive bidding program, which was published on April 10, 2007 (72 Federal Register 68 (10 April 2007) pp. 17991-18090).

Key Points of CR6007

- Claims for DMEPOS items subject to the DMEPOS Competitive Bidding Program should be submitted under the general DMEPOS claims billing guidelines specified in Chapter 20, section 110 of the Medicare Claims Processing Manual, which may be viewed by referring to http://www.cms.hhs.gov/manuals/downloads/clm104c20.pdf on the CMS web site, **with the following exceptions as described below**.
- Under the DMEPOS Competitive Bidding Program, all claims should be submitted electronically (except for certain claims with multiple Medicare Secondary Payer situations, which may be sent via paper claims) and claims are subject to mandatory assignment. Mandatory assignment denotes that a supplier must accept Medicare payment as payment in full with the beneficiary's liability limited to any applicable deductible and 20 percent coinsurance.
- New modifiers will be in use for the DMEPOS Competitive Bidding Program and the following Table 1 below describes these modifiers.

Modifier	Effective Date	Definition
KG	7/1/07	DMEPOS Item Subject to DMEPOS Competitive Bidding Program Number 1
KK	7/1/07	DMEPOS Item Subject to DMEPOS Competitive Bidding Program Number 2
KU	7/1/07	DMEPOS Item Subject to DMEPOS Competitive Bidding Program Number 3
KL	7/1/07	DMEPOS Item Delivered Via Mail
KT	7/1/07	Beneficiary Resides in a Competitive Bidding Area and Travels Outside that Competitive Bidding Area and Receives a Competitive Bid Item
KV	1/1/08	DMEPOS Item Subject to DMEPOS Competitive Bidding Program that is Furnished as Part of a Professional Service
KW	1/1/08	DMEPOS Item Subject to DMEPOS Competitive Bidding Program Number 4
KY	1/1/08	DMEPOS Item Subject to DMEPOS Competitive Bidding Program Number 5

- New HCPCS modifiers were developed to facilitate implementation of various policies that apply to certain competitive bidding items. The KG, KK, KU, KW, and KY modifiers are pricing modifiers that suppliers must use to identify when the same supply or accessory HCPCS code is furnished in multiple competitive bidding product categories. For example, HCPCS code E0981 (Wheelchair Accessory, Seat Upholstery, Replacement Only, Each) is found in both the standard and complex rehabilitative power wheelchair competitive bidding product categories. Contract suppliers for the standard power wheelchair product category shall submit E0981 claims using the KG modifier, whereas contract suppliers for the complex rehabilitative power wheelchair product category shall use the KK modifier. All suppliers, including grandfathered suppliers, shall submit claims for competitive bid items using the aforementioned competitive bidding modifiers. The KG and KK modifiers are used in Round I of the competitive bidding program and the KU, KW and KY modifiers are reserved for future program use.
- Claims for non-mail order competitive bid items furnished to beneficiaries who maintain a permanent residence in a CBA, but who are traveling outside of their CBA when

they obtain the item, must be submitted with a "KT" modifier to indicate a traveling beneficiary. **Claims for items subject to national competitive bidding (NCB) furnished to beneficiaries traveling outside of their CBA that do not have a "KT" modifier will be denied**. Jurisdiction for these claims remains with DME MAC with jurisdiction for the beneficiary based on the beneficiary's permanent residence. Claims for mail order competitively bid items that have the "KT" modifier will be denied.

- For purposes of claims adjudication under DMEPOS Competitive Bidding, **beneficiaries who are maintain a permanent residence within a CBA and, while a resident of a skilled nursing facility (SNF) or nursing facility (NF) facility outside of a CBA, obtain a competitively bid item from that SNF or NF**, will be treated as traveling beneficiaries when their permanent address is within a CBA. Suppliers should submit a "KT" modifier on any claims for DMEPOS items provided to beneficiaries while in a SNF or a NF, under these circumstances. For all such claims, suppliers should submit the claim using place of service "31" to indicate that the beneficiary resides in a SNF or "32" to indicate that the beneficiary resides in a nursing home, as applicable.
- **The "KL" modifier has been established for use for mail order DMEPOS Competitive Bidding items (e.g. diabetic supplies)**. Beneficiaries who maintain a permanent residence in CBAs that include mail order for diabetic supplies may choose to obtain their diabetic supplies through mail order or at a storefront. If such a beneficiary chooses to obtain their diabetic supplies through mail order, they should obtain these supplies from a contract supplier for mail order items in their CBA. Claims for mail order diabetic supplies provided to beneficiaries who maintain a permanent residence in a CBA should be billed with the modifier "KL".
- **Under DMEPOS Competitive Bidding, physicians and treating practitioners may furnish certain competitively bid items without submitting a bid and being awarded a contract**. This exception requires that the items be furnished by the physician or treating practitioner to his or her own patients as part of his or her professional service. The professional service must be furnished on the same date as the date that the DME item is initially furnished. In addition, physicians and treating practitioners must submit their office visit claim on the same day that they submit the DME claim to ensure timely and accurate claims processing. Physicians and treating practitioners who provide DME items in their offices should continue to be paid even though they did not submit or win a bid for the items. Physicians and treating practitioners that are located in a CBA should submit the "KV" modifier on claims for DME items and related accessories that are appropriately furnished in accordance with this exception to receive payment for these items at the contracted bid amount for the applicable CBA. **Physician/practitioner-submitted claims for competitively bid items that do not have an accompanying office visit will be denied**. Physicians and practitioners located outside a CBA who furnish DME items and/or related accessories as part of a professional service to traveling beneficiaries who maintain a permanent residence in a CBA must also affix the "KV" modifier to claims submitted for these items.
- **Non-contract suppliers of oxygen and oxygen equipment may elect to become "grandfathered suppliers" and continue to provide these items and services to their existing beneficiaries, if the beneficiary agrees to the arrangement**. These suppliers are considered "grandfathered" and the grandfathering process only applies to suppliers that began furnishing the oxygen and oxygen equipment to beneficiaries in a CBA prior to the implementation of the competitive bidding program for that area and chooses to continue to furnish the grandfathered oxygen equipment to beneficiaries in the CBA. If a non-contract supplier does not want to continue furnishing oxygen and oxygen equipment to its existing customers/beneficiaries, the beneficiaries must use a contract supplier to obtain the oxygen and oxygen equipment. Ordinarily, the title to the oxygen equipment would transfer to the beneficiary after rental payments have been made for 36 months of continuous use. However, Medicare allows for a minimum of 10 months of payments to be made to a contract supplier for oxygen and oxygen equipment furnished to a beneficiary who changes suppliers under the DMEPOS Competitive Bidding Program because the current supplier chose not to become a grandfathered supplier. Therefore, under the DMEPOS Competitive Bidding Program, up to 45 continuous payments could be made for the oxygen and oxygen equipment. The beneficiary is liable for co-payments for all paid oxygen and oxygen equipment claims.
- **Non-contract suppliers of capped rental equipment may elect to become "grandfathered suppliers" and continue to provide their equipment to their existing beneficiaries, if the beneficiary agrees to the arrangement**. This grandfathering process only applies to suppliers that began furnishing the capped rental item to beneficiaries in a CBA prior to the implementation of the competitive bidding program for that area and chooses to continue to furnish the grandfathered item to beneficiaries in the CBA. The payment for these services will be made at the fee schedule amount. If a non-winning supplier does not want to continue providing capped rental equipment to its existing beneficiaries at the bid amount (chooses not to become a "grandfathered supplier" under DMEPOS Competitive Bidding), the beneficiary should obtain a new piece of capped rental equipment from a winning supplier. Under normal circumstances, the title to the capped rental item would transfer to the beneficiary after 13 payments have been made. However, for beneficiaries that should obtain a new piece of equipment under DMEPOS Competitive Bidding, the 13 month capped rental period starts over again. Medicare allows for a minimum of 13 months of payments to be made to a winning supplier for capped rental items provided to a beneficiary who should change suppliers under DMEPOS Competitive Bidding because their current supplier chooses not to become a grandfathered supplier. Therefore, under DMEPOS Competitive Bidding, up to 25 payments could be made for the capped rental item. The beneficiary is liable for co-payments for capped rental equipment claims for up to 25 months, regardless of when the title transferred.

COMPETETIVE BIDDING CONT'D

- Suppliers are not required to obtain a new Certificate of Medical Necessity (CMN) for situations in which a beneficiary who was receiving a capped rental item prior to the implementation of DMEPOS Competitive Bidding goes to a new supplier after the implementation of NCB (e.g., the previous supplier decides not to become a grandfathered supplier), unless the beneficiary's medical necessity for the item has changed. Notwithstanding this situation, the **new supplier should bill using the appropriate modifiers for their first rental month (KH), the second and third rental months (KI), and all subsequent rental months (KJ)**.

Additional Information

For complete details regarding this CR please see the official instruction (CR6007) issued to your Medicare DME MAC. That instruction may be viewed by going to http://www.cms.hhs.gov/Transmittals/downloads/R1544CP.pdf on the CMS web site. The new manual sections are attached to CR6007. You may also wish to DMEPOS Competitive Bidding Web Page, which contains a wide array of resources relating to this program. That page is at http://www.cms.hhs.gov/DMEPOSCompetitiveBid on the CMS web site.

ACCREDITATION

Cancelled - Accreditation Deadlines FOR DMEPOS Competitive Bidding

The Medicare Improvements for Patients and Providers Act of 2008 was enacted on July 15, 2008. This new law has delayed the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program. As a result of this delay, the special accreditation deadlines previously established for the second round of the program have been cancelled. Specifically, prior to enactment of this new law, suppliers must have been accredited or have applied for accreditation by July 21, 2008 to be eligible to submit a bid for the second round of competitive bidding and must have obtained accreditation by January 14, 2009 to be eligible for a second round contract. Both of these deadlines have been cancelled and no longer apply.

The deadline of September 30, 2009, that was previously established by which all DMEPOS suppliers must be accredited is still in effect.

CERT

CERT Newsletter

The June 2008 CERT Newsletter contains information suppliers may find helpful, including what to do when there has been a loss of records due to natural disasters, submitting medical records on CD and communicating CERT review results.

CERT CONT'D

Natural Disasters and the Loss of Records

The staff members at CMS and CERT wish to express their deepest concerns for all who suffered and were affected by the recent flooding and tornado disasters in the mid-west. We would like to remind you that CERT is able to grant relief to providers affected by disaster. Providers may submit an attestation letter to be used to verify that records are missing or destroyed. The letter is available on our web site at www.certcdc.com/certproviderportal/.

Submitting Medical Records Electronically on CDs: Another Option for the Provider Community

While the majority of the medical records requested by the CDC are transmitted to us via fax, we recognize that the volume of pages contained in some medical records can be voluminous. In these situations, the CDC encourages submission of the requested records electronically on a CD. This CD must contain each medical record saved as a .tif file. By submitting records electronically, providers can save money in copying and postage and reduce the turnaround time of receipt.

Communicating CERT Review Results to Providers

Frequently, the CDC receives inquiries from providers asking for the status of their reviews. Although we are able to verify whether the review has occurred, we cannot communicate the results of the review. Inquiries regarding the results of the review are referred to the AC or MAC. The ACs or MACs will be able to assist the providers by accessing the CERT Web site.

The complete June 2008 Newsletter is available on the CERT Provider Web site at www.certcdc.com/certproviderportal/default.aspx.

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.

CERT CONT'D

Mail all requested documentation to:

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

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

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

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

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

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

FORMS

Redeterminations Form Now Fillable and Savable

The Inquiry/Redetermination form is now available as a fillable and savable form.

To improve efficiency, suppliers may now save this form to their computer instead of accessing it from the NAS DME Web site. Information completed each time the form is filled out can also be saved.

To assist with thorough completion, a valuable function, Highlight Fields, is located in the top right corner of the form. By clicking on Highlight Fields, the mandatory items that must be completed on this form are highlighted.

The DME Inquiry/Redetermination form, along with supporting documentation, may be mailed or faxed to NAS.

Mail:

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

Fax: 888-408-7405

To keep up-to-date with changes and future announcements on additional forms becoming savable, sign up for our email updates.

Joint Signature Memorandum Announces Extended Use of 2006 Version of CMS-855S Application Form

JSM/TDL-08378 recently announced that DMEPOS suppliers/providers may continue to use the 2006 version of the CMS 855S application form through September 2008. Earlier this year, a revised CMS-855S application form, version (02/08) was introduced in JSM/TDL-08250 to include four additional supplier standards to the list of which suppliers must comply in order to receive and maintain Medicare billing privileges. The additional measures, standards 22-25, pertain to supplier accreditation requirements. While not required until September 2008, suppliers are encouraged to use the revised version of the application form for initial enrollment, re-enrollment, and reactivation of Medicare billing privileges.

The Centers for Medicare & Medicaid Services (CMS) has placed the revised enrollment application on the CMS Provider Enrollment Web site. The application version appears bottom left in the footer of the application form.

New DDE/CSI Security Request Form

A new DDE/CSI security request form has been developed for providers to use when requesting Claim Status Inquiry access. This new streamlined form will allow for faster processing of requests for new, updated, or termination of Medicare Claims Processing System (MCPS) access.

This form (and instructions for completion) can be found on the Claims page of our Web site. Effective August 1, 2008 old versions of the security request form will not be accepted and will be returned.

BILLING

Billing Upgrades

When billing for an upgraded item, use the full charge on the claim for both the non-upgraded and the upgraded items. Do not calculate the difference between the non-upgraded item and the upgraded item. The claims processing system will determine the corrected allowed amounts for each line of the claim. This will cause an unprocessable denial, which cannot be appealed.

Incorrect:

E0265RRKHGZ $10 (upgrade)

E0260RRKHGK $140 (medically necessary)

Correct:

E0265RRKHGZ $200 (upgrade)

E0260RRKHGK $140 (medically necessary)

For more information regarding upgrades, please refer to the "DME upgrades, ABNs and Claims Modifiers" article posted to the What's New section of our Web site on 5/2/07.

Billing for Repairs and Labor

Per the Medicare Benefit Policy Manual, Chapter 15, Section 110.2 and Chapter 5 of the Supplier Manual, to repair means to fix or mend and put the equipment back in good condition after damage or wear. Repairs to equipment the beneficiary owns that is currently being used are covered when necessary to make the item serviceable. If the expense for repair exceeds the estimated expense of purchasing or renting another item for the remaining period of medical need, no payment can be made for the amount of the excess.

Repairs of rented equipment are not covered. This includes items in the frequent and substantial servicing, oxygen equipment, capped rental and inexpensive or routinely purchased payment categories. In addition, if the DME item was denied, Medicare will not cover repairs to that item.

The following are a few things to remember in regards to billing for repairs and the related labor:

- The labor time for repairs should be submitted as E1340, with 15 minutes representing one unit. A modifier is not needed with E1340.
- E1340 requires the skill of a technician. Replacing batteries or other simple adjustments that do not require the skill of a technician are not covered by Medicare.
- E1340 cannot be paid without an explanation of what is being repaired.
- When billing for repairs, the following information is required in the claim narrative (Item 19 on the CMS-1500 claim form or NTE segment for electronic claims):
    - Manufacturer's name (if billing for parts, give manufacturer's name for **each** part)
- Product name
- Part number
- Suggested retail price or manufacturer's invoice price
- Date of purchase
- Justification of patient's medical necessity for the item
- Labor and the parts being replaced or repaired should be billed on the same claim.
    - **Exception:** Most DMEPOS warranties will cover parts, but not labor. If the part is under warranty, the labor can be billed with a narrative stating the part was obtained under warranty.
- E1340 should not be billed on the same date as a purchase of a power mobility device. Per the Power Mobility Devices policy article, the reimbursement of a wheelchair code includes all labor charges with the assembly of the chair, as well as, all support services such as delivery, set-up and education. This same guideline applies to all items of DME when initially issued.
- Repairs will only be paid up to the cost of replacing the item.
- A new order and/or CMN or DIF, are not required for repairs.
- The modifier RP should be used when billing for replacement parts for a DME item. If the entire DME item needs to be replaced, the RP modifier is not reported. In this situation, the "replaced" item is considered a "new" initial purchase or rental and the appropriate NU, UE and/or rental modifiers should be submitted on the claim.

See repair and replacement for additional FAQs.

KX Modifier Usage

Currently there are 54 Local Coverage Determinations (LCDs) in effect for DMEPOS. Listed below are 31 polices that make reference to using the KX modifier. The KX modifier states: Specific required documentation on file.

- L13577: Automatic External Defibrillators
- L15300: Cervical Traction Devices
- L11486: Commodes
- L171: CPAP (PAP)
- L11452: Epoetin
- L11570 : External Infusion Pumps
- L196 : Glucose Monitors
- L12739: High Frequency Chest Wall Oscillation Devices
- L11487: Home Dialysis Supplies and Equipment
- L11572: Hospital Beds
- L68: Immunosuppressive Drugs
- L27058: Knee Orthoses
- L11454: Manual Wheelchair Bases
- L11488: Nebulizers
- L11489: Negative Pressure Wound Therapy Pumps
- L11575: Oral Antiemetic Drugs
- L11456: Orthopedic Footwear
- L11577: Patient Lifts
- L23598: Power Mobility Devices
- L11578: Pressure Reducing Support Surfaces â€“ Group 1
- L11579: Pressure Reducing Support Surfaces â€“ Group 2
- L11580: Pressure Reducing Support Surfaces â€“ Group 3
- L51: Refractive Lenses
- L11493: Respiratory Assistive Devices
- L108: Speech Generating Devices
- L157: Therapeutic Shoes for Persons with Diabetes
- L11495: Transcutaneous Electrical Nerve Stimulators (TENS)
- L11581: Urological Supplies
- L11461: Walkers
- L11462: Wheelchair Options/ Accessories
- L15670: Wheelchair Seating

Suppliers should be aware that NAS is monitoring the usage of the KX modifier and is continuing to establish edits that will deny claims when this modifier is not reported on the claim. Therefore, if the KX modifier is referenced in an LCD, and the item being billed meets the coverage criteria, the KX must be appended to the HCPCS code or the code may be denied as not reasonable and necessary. This denial will be the supplier's liability unless the supplier has the beneficiary sign an Advance Beneficiary Notice of Noncoverage (ABN) explaining why Medicare will likely deny the item and appends the GA modifier to all HCPCS at issue.

The LCDs are housed in the Medicare Coverage Database which can be accessed in the Coverage/MR section on our DME Web site.

Pick-up Information for Wheelchairs and Power Mobility Devices-Correction

NAS is correcting the example in this article regarding a change in wheelchairs to reflect current HCPCS codes. Below is the entire article with this correction:

Our claims processing area sees many claims for wheelchairs and power mobility devices where it has been less than five years since the beneficiary received a similar piece of equipment, but there is no comment on the claim to explain why a new piece of equipment is being billed. This leads to the claim being denied as same and similar due to existing equipment being on file. These denied claims will have remark code M3 on the remittance advice. The wording for M3 is "Equipment is the same or similar to equipment already being used".

It is important when billing for a purchase or rental of a DME item when it has been less than five years since the beneficiary received a similar piece of equipment to include the pick up date and the reason for the pick-up of the previous equipment in the claim narrative. Without this information, the current claim will be denied as same and similar due to existing equipment being on file.

For example, if a beneficiary is renting a K0001 wheelchair and his/her condition worsens to the point that only a different wheelchair such as a K0823 will meet his/her medical need, coverage will be allowed for the K0823 and the K0001 will be denied as same or similar equipment.

The statutory basis for denial of such same and similar claims is medical necessity; therefore, the limitation on liability provision under Section 1879 of the Social Security Act applies. If an ABN has not been obtained, stating there is similar equipment on file, the supplier will be liable for this denial. If an ABN is obtained and the GA modifier reported on the claim, the beneficiary will be liable.

Medicare regulation specifically forbids payments for multiple claims for rental of same or similar equipment from either the same or a different supplier during the same rental month.

A pick-up slip should be on file showing that the previous equipment is no longer being used by the beneficiary. A pick-up slip is written confirmation, provided by a supplier, that the supplier has removed an item of DME from the beneficiary's home.

Sources: Chapter 3, Supplier Manual and *Medicare Program Integrity Manual*, Chapter 5, Section 5.12

Clarification on Billing Diabetic Testing Supplies - Updated

The utilization guidelines for insulin treated patients were changed from 300 test strips and 300 lancets per month to 100 test strips and 100 lancets per month. All other information remains the same.

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

HCPCS

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

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

Modifiers

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

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

Utilization Guidelines

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

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

CMN and DIF Denials-Correction

This article has been corrected to reflect a change in the claim adjustment reason code used when CMN or DIF forms are required and are not submitted. Below is the corrected article in its entirety.

Recent analysis of claim denials show a high number of claims being denied for Certification of Medical Necessity (CMN) or DME Information Form (DIF) issues. These denials are for services that include, but are not limited to, parenteral and enteral nutrition, infusion pumps and oxygen. A CMN or a DIF is required for these services.

If a CMN or DIF is not on file or the length of need has expired, the claim will be denied with claim adjustment reason code 176 and the remittance advice remark code M60.

176: Prescription is not current:

M60: Missing Certificate of Medical Necessity

Below are some tips to prevent denials for CMN issues:

1. Submit the initial CMN/DIF with the first claim for that service.
2. After the initial CMN/DIF has been submitted, there is no need to continue submitting that same CMN/DIF for each subsequent claim.
3. Submit claims in chronological order.

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

- CMS 484 CMN - Oxygen
- CMS 846 CMN - Pneumatic Compression Devices
- CMS 847 CMN - Osteogenesis Stimulators
- CMS 848 CMN - Transcutaneous Electrical Nerve Stimulator (TENS)
- CMS 849 CMN - Seat Lift Mechanisms
- CMS 854 CMN - "Section C" Continuation Form
- CMS 10125 DIF - External Infusion Pumps
- CMS 10126 DIF - Enteral and Parenteral Nutrition

Transcutaneous Electrical Nerve Stimulators

To process the purchase of TENS device claims, HCPCS E0720, E0730 and E0731 correctly and efficiently, the following information is required on the CMN form CMS-848:

- Initial date for the purchase of the TENS unit (Section A). The initial date should not be the same date that the TENS rental started.
- Sections A, B and C filled out in their entirety.
- Section D signed and dated by the ordering physican.

For more information, see MLN Matters MM5107, located at www.cms.hhs.gov/MLNMattersArticles/downloads/MM5107.pdf.

Although a CMN is not required for the rental of a TENS, all other documentation requirements still apply:

- A written order prior to delivery of the TENS must be kept on file and available upon request.
- Code E0731, conductive garment for delivery of TENS, requires the brand name and model number within the narrative section of the claim and documentation supporting medical necessity within the supplier's file. The KX modifier must be added to this code if coverage requirements per the Local Coverage Determination have been met.
- Over-utilization of supplies exceeding the usual maximum amounts as described in the Local Coverage Determination must be clearly documented in the patient's medical record. Documentation must corroborate the medical necessity and be made available upon request.
- Refer to Chapter 3 of the Jurisdiction D Supplier Manual and the TENS LCD and policy article for more information on documentation requirements.

If a beneficiary owns their own TENS unit and the unit was purchased and/or approved by Medicare, when a claim is submitted for accessories, the following information is required in Item 19 of the 1500 form or in the NTE segment (2400 loop) for electronic claims:

- Date of purchase
- Serial number of unit
- Who purchased unit

Failure to include the date of purchase, serial number and who purchased the equipment will result in accessories being denied.

Important Reminders

- TENS can only be rented for a maximum of two months, then a purchase is required for Medicare to continue coverage.
- If rentals have been billed, before any accessories will be paid, a TENS purchase claim and CMN must be submitted and paid.

Medicare Secondary Payer Electronic Claim Submission

This article discusses Medicare Secondary Payer (MSP) electronic claims submission and describes the information required for successful MSP claims processing.

The Administrative Simplification and Compliance Act (ASCA) requires Medicare providers to submit all initial Medicare claims for reimbursement electronically, unless granted an ASCA waiver. This includes MSP claims.

An MSP claim may be submitted to Medicare for payment only after the primary insurer has processed the claim and provided an Explanation of Benefits (EOB) or payment notice. It is the supplier's responsibility to determine if Medicare is the primary or secondary payer for each beneficiary. Please see the Medicare Secondary Payer Fact Sheet located at www.cms.hhs.gov/MLNProducts/downloads/MSP_Fact_Sheet.pdf for information on determining whether Medicare is primary or secondary.

For supplier convenience, NAS provides an example of an intake form at www.noridianmedicare.com/dme/forms/docs/intake_form.pdf

This form contains questions that may help suppliers obtain information relevant to the beneficiary's insurance coverage when the beneficiary begins receiving DME.

EOB Formats

There is no standard format for how insurance companies report payment information on their EOBs. Insurers may report information in a manner that requires the supplier to perform calculations to find the correct amounts to submit on the MSP claim. Suppliers are encouraged to contact the

primary insurer with any questions about how to interpret the EOB.

Software vendors may also have different ways of allowing for entry of MSP information in electronic claim submission software or billing software, even though the claims must be submitted using the HIPAA mandated ANSI specifications. Suppliers looking for software that supports MSP electronic claims submission are encouraged to visit the National Government Services Common Electronic Data Interchange (CEDI) Web site at www.ngscedi.com for more information.

Because of the lack of these EOB reporting standards, the information provided in this article will be general rather than specific to one EOB format or one claims billing software format.

Submitting MSP Claims

Once a claim has been paid by the primary insurer and an EOB is sent to the supplier, the MSP claim can be submitted to Medicare. There are key pieces of information contained on the EOB that must be entered on an MSP electronic claim. MSP payments cannot be determined without this information:

1. Allowed Amount
2. Paid Amount
3. Obligation to Accept Payment in Full Amount (OTAF)

All software that supports MSP electronic claims submission will allow for this information to be entered and submitted to Medicare. In addition, some claims submission software also contains fields for Deductible and Co-Insurance amounts. Please include those amounts when possible. There is no need to provide a paper copy of the EOB when submitting an MSP claim electronically.

Definitions:

1. **Allowed Amount**-maximum amount the primary insurer will pay for an item or service based on the insurer's contract with the beneficiary.
2. **Paid Amount**-actual amount paid by the insurer for the item or service, after co-insurance and deductibles are factored in.
3. **OTAF Amount**-amount that the supplier agreed to accept as payment in full for the item or service (the amount the primary payer paid plus the amount that is patient responsibility).
4. **Deductible Amount**-amount the beneficiary must pay for health care before the insurer begins to make payments.
5. **Co-Insurance Amount**-amount that is the beneficiary's responsibility to pay for each item or service. This is usually a percentage of the allowed amount.

In most claims processing software products, the Allowed Amount, Paid Amount, and OTAF Amount are entered at the claim level. These amounts may also be entered at the line level and we encourage this when possible.

Suppliers should be aware that when only claim level information is provided, if any line on the claim denies, NAS must deny the entire claim. Therefore, when there are multiple lines on a single claim, it is in the suppliers' best interest to submit these amounts at the line level. This provides NAS enough information to process payments on the lines of the claim that were not denied and can provide the supplier with at least partial payment.

MSP claims must balance at the claim level. The formula used to ensure balancing is:

> Amount Paid by the Primary Payer + Submitted Claim Level or Line Level Adjustment Amounts Must = Submitted Charges

Out-of-balance MSP claims will be denied or suspended, requiring additional time to process. Incorrect or incomplete MSP claims submissions may be denied or suspended, requiring additional time to process.

Other reminders for submitting MSP claims are:

- Medicare is primary over supplemental insurance, such as Medicaid and Tricare.
- MSP claims related to auto and liability and workers compensation are generally diagnosis driven.
- When Medicare is secondary, claims should be submitted first to the primary insurer and then to Medicare.
- Medicare Advantage plans sold by private insurers are a type of managed care. Medicare may not coordinate benefits if the beneficiary has a managed care plan.
- If the billed amount is different than the primary allowed, indicate whether the beneficiary or the supplier is liable.
- EOBs may identify a "Submitted Amount." This is the amount the supplier submitted on the original request for payment (the price of the item/service). The submitted amount should not be used as the allowed Amount, unless the two amounts are exactly equal.
- If the beneficiary's benefits have been exhausted, there should be no amount listed in the primary allowed field.
- If the beneficiary is liable, there is no OTAF.
- Using the correct forms speeds processing of requests:
    - Use the MSP Inquiry and Refunds Form to request any MSP-related changes to payment (i.e., Medicare paid primary and should have paid secondary and vice versa). www.noridianmedicare.com/dme/forms/docs/msp_inq_dme.pdf
    - Use the DME Inquiry/Redetermination form to request further review when a claim is denied for reasons other than MSP (i.e., insufficient documentation, medical necessity), even if there is a primary insurer. www.noridianmedicare.com/dme/forms/docs/nas_redeterm_dme.pdf

CR 5971 Clarification - Signature Requirements

MLN Matters Number: SE0829

Provider Types Affected

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

What You Need to Know

The purpose of this notice is to provide guidance to providers/suppliers and Medicare contractors on the use of stamped signatures. **Note that stamped signatures are not acceptable on any medical record**.

Background

The Centers for Medicare & Medicaid Services (CMS) has taken this step to ensure accurate application of Medicare's program requirements throughout the nation. CMS has identified problems of noncompliance with existing statutes, regulations, rules, and other systematic problems relating to standards of practice for a valid physician's signature on medical orders and related medical documents.

CR 5971 (Transmittal #248) was issued to prohibit the use of stamped signatures. These requirements are intended to apply all providers/suppliers. *Stamped signatures are not acceptable on any medical record*. Medicare will accept hand written, electronic signatures or facsimiles of original written or electronic signatures.

In addition, the Medicare Conditions of Participation (CoP) are requirements for ensuring health and safety. The CoPs define specific quality standards that providers must meet to participate in the Medicare program. A provider's compliance with the CoPs is ultimately determined by the CMS regional office based on the State survey agency recommendation (per the Medicare Program Integrity Manual, Publication 100-8, chapter 3, section 3.4.2.1, which is available at http://www.cms.hhs.gov/manuals/downloads/pim83c03.pdf on the CMS web site). Compliance with the CoPs and any related policies does not necessarily ensure that certain requirements for payment are being met.

Additional Information

The official instruction, CR 5971, issued to your carrier, FI, A/B MAC, and DME MAC regarding this change may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R248PI.pdf on the CMS web site.

Medicare Contractor Annual Update of ICD-9-CM

MLN Matters Number: MM6107
Related Change Request (CR) #: 6107
Related CR Release Date: July 29, 2008
Related CR Transmittal #: R1566CP
Effective Date: October 1, 2008
Implementation Date: October 6, 2008

Provider Types Affected

Physicians, suppliers, and providers billing Medicare contractors (carriers, Part A/B Medicare Administrative Contractors (A/B MACs), Durable Medical Equipment Medicare Administrative Contractors (DMACs), and fiscal intermediaries (FIs) including regional home health intermediaries (RHHIs)).

Impact on Providers

This article is based on Change Request (CR) 6107 and reminds the Medicare contractors and providers that the annual ICD-9-CM update will be effective for dates of service on and after October 1, 2008 (for institutional providers, effective for discharges on or after October 1, 2008). You can see the new, revised, and discontinued ICD-9-CM diagnosis codes on the Centers for Medicare & Medicaid Services (CMS) web site at http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/07_summarytables.asp#TopOfPage, or at the National Center for Health Statistics (NCHS) web site at http://www.cdc.gov/nchs/icd9.htm in June of each year.

Background

The ICD-9-CM codes are updated annually as stated in the Medicare Claims Processing Manual, Chapter 23 (Fee Schedule Administration and Coding Requirements), Section 10.2 (Relationship of ICD-9-CM Codes and Date of Service).

CMS issued CR 6107 as a reminder that the annual ICD-9-CM coding update will be effective for dates of service on or after October 1, 2008 (for institutional providers, effective for discharges on or after October 1, 2008).

Remember that an ICD-9-CM code is required for all professional claims (including those from physicians, non-physician practitioners, independent clinical diagnostic laboratories, occupational and physical therapists, independent diagnostic testing facilities, audiologist, ambulatory surgical centers (ASCs)), and for all institutional claims; but is not required for ambulance supplier claims.

Additional Information

The official instruction (CR 6107) issued to your Medicare contractor is available at http://www.cms.hhs.gov/Transmittals/downloads/R1566CP.pdf on the CMS web site.

As mentioned, you can find the new, revised, and discontinued ICD-9-CM diagnosis codes at http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/07_summarytables.asp#TopOfPage on the CMS web site or at the National Center for Health Statistics (NCHS) Web site at http://www.cdc.gov/nchs/icd9.htm , in June of each year. The annual ICD-9-CM code changes are also included in a CD-ROM, which you can purchase for $25.00 from the Government Printing Office (GPO), stock number 017-022-01573-1.

To learn more about ICD-9-CM codes, you might want to read Medicare Claims Processing Manual, Chapter 23 (Fee Schedule Administration and Coding Requirements), Section 10.2 (Relationship of ICD-9-CM Codes and Date of Service); or look at the information provided at http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/01_overview.asp#TopOfPage on the CMS web site.

Remittance Advice Remark Code and Claim Adjustment Reason Code Update

MLN Matters Number: MM6109
Related Change Request (CR) #: 6109
Related CR Release Date: July 25, 2008
Related CR Transmittal #: R1563CP
Effective Date: October 1, 2008
Implementation Date: October 6, 2008

Provider Types Affected

Physicians, providers, and suppliers who submit claims to Medicare contractors (carriers, fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), Part A/B Medicare Administrative Contractors (A/B MACs), and Durable Medical Equipment Medicare Administrative Contractors (DME MACs)) for services.

Impact on Providers

CR 6109, from which this article is taken, announces the latest update of Remittance Advice Remark Codes (RARC) used in electronic and paper remittance advice, and Claim Adjustment Reason Codes (CARC) used in electronic and paper remittance advice and coordination of benefits (COB) claim transactions. These changes will be effective October 1, 2008.

Be sure that your billing staffs are aware of these changes.

Background

Two code sets—the reason and remark code sets—must be used to report payment adjustments in remittance advice transactions. The reason codes are also used in coordination-of-benefits (COB) transactions.

The RARC list is maintained by the Centers for Medicare & Medicaid Services (CMS), and used by all payers; and additions, deactivations, and modifications to it may be initiated by any health care organization. The CARC list is maintained by a national Code Maintenance committee that meets when X12 meets for their trimester meetings to make decisions about additions, modifications, and retirement of existing reason codes.

Both code lists are updated three times a year and are posted on the Washington Publishing Company (WPC) web site at http://www.wpc-edi.com/Codes on the Internet. The tables at the end of this article (right after the "Additional Information" section) summarize the latest changes to these lists, as announced in CR6109.

CMS has also developed a tool to help you search for a specific category of RARC code and that tool is available at http://www.cmsremarkcodes.info on the Internet. Note that this web site does not replace the WPC site and, should there be any discrepancies in what is posted at this site and the WPC site, consider the WPC site to be correct.

Additional Information

To see the official instruction (CR 6109) issued to your Medicare Carrier, RHHI, DME/MAC, FI and/or A/B MAC refer to http://www.cms.hhs.gov/Transmittals/downloads/R1563CP.pdf on the CMS web site.

For additional information about Remittance Advice, please refer to Understanding the Remittance Advice (RA): A Guide for Medicare Providers, Physicians, Suppliers, and Billers at http://www.cms.hhs.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf on the CMS web site.

The changes that are effective on October 1, 2008 are as follows:

Remittance Advice Remark Code changes

New Codes

Code	Current Narrative	Medicare Initiated
N433	Resubmit this claim using only your National Provider Identifier (NPI)	Y

Modified Codes

Code	Current Modified Narrative	Last Modified
MA97	Missing/incomplete/invalid Medicare Managed Care Demonstration contract number or clinical trial registry number.	2/29/08
N175	Missing review organization approval.	2/29/08
N241	Incomplete/invalid review organization approval.	2/29/08
N421	Claim payment was the result of a payer's retroactive adjustment due to a review organization decision.	2/29/08

Deactivated Codes

Code	Current Narrative	Last Modified
None		

Health Care Claim Adjustment Reason Codes

New Codes

Code	Current Narrative	Effective Date (per WPC web site)
213	Non-compliance with the physician self referral prohibition legislation or payer policy.	1/27/2008

214	Workers' Compensation claim adjudicated as non-compensable. This Payer not liable for claim or service/treatment. (Note: To be used for Workers' Compensation only)	1/27/2008
215	Based on subrogation of a third party settlement	1/27/2008
216	Based on the findings of a review organization	1/27/2008
217	Based on payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement. (Note: To be used for Workers' Compensation only)	1/27/2008
218	Based on entitlement to benefits (Note: To be used for Workers' Compensation only)	1/27/2008
219	Based on extent of injury (Note: To be used for Workers' Compensation only)	1/27/2008
220	The applicable fee schedule does not contain the billed code. Please resubmit a bill with the appropriate fee schedule code(s) that best describe the service(s) provided and supporting documentation if required. (Note: To be used for Workers' Compensation only)	1/27/2008
221	Workers' Compensation claim is under investigation. (Note: To be used for Workers' Compensation only. Claim pending final resolution)	1/27/2008
D22	Reimbursement was adjusted for the reasons to be provided in separate correspondence. (Note: To be used for Workers' Compensation only) - Temporary code to be added for timeframe only until 01/01/2009. Another code to be established and/or for 06/2008 meeting for a revised code to replace or strategy to use another existing code	1/27/2008

Modified Codes

Code	Modified Narrative	Effective Date (per WPC web site.
151	Payment adjusted because the payer deems the information submitted does not support this many/ frequency of services.	1/27/2008

Deactivated Codes

Code	Current Narrative	Effective Date (per WPC web site)
D22	Reimbursement was adjusted for the reasons to be provided in separate correspondence. (Note: To be used for Workers' Compensation only) - Temporary code to be added for timeframe only until 01/01/2009. Another code to be established and/ or for 06/2008 meeting for a revised code to replace or strategy to use another existing code	1/1/2009

Revisions to Chapter 14 of Medicare Program Integrity Manual

MLN Matters Number: MM6036
Related Change Request (CR) #: 6036
Related CR Release Date: July 25, 2008
Related CR Transmittal #: R263PI
Effective Date: May 23, 2008
Implementation Date: August 8, 2008

Provider Types Affected

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

Provider Action Needed

This article is informational only and is based on Change Request (CR) 6036 which reminds providers that the Centers for Medicare & Medicaid Services (CMS) no longer issues, updates, or uses the Unique Physician Identification Number (UPIN) in claims processing. CR 6036 also provides information on how to access the National Plan and Provider Enumeration System (NPPES) and UPIN data.

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. CMS published the National Provider Identifier (NPI) final rule, which established the NPI as this standard.

CR 6036 updates Medicare's Program Integrity Manual, Chapter 14, Sections 14.1 -14.4) by removing information related to the issuance and maintenance of UPINs and replacing this information with information about obtaining NPI and UPIN data. CR 6036 includes the updated Chapter 14 as an attachment.

Information about the NPI can be found on the National Provider Identifier Standard web page at http://www.cms.hhs.gov/NationalProvIdentStand/ on the CMS web site.

Since the UPIN Registry is no longer available, a copy of the UPIN file can be obtained by writing to:

CMS Public Use Files
7500 Security Boulevard, N1-15-03
Baltimore, MD 21244-1850

The following information is releasable for physicians and non-physician practitioners:

- Full name,
- Credentials (e.g., MD),
- UPIN,
- State,
- ZIP Code, and
- Specialty code.

Additional Information

The official instruction, CR 6036, issued to your carrier, FI, A/B MAC, and DME MAC regarding this change may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R263PI.pdf on the CMS web site.

CODING

Coding Instructions – Microprocessor Controlled Knee Prostheses

Recently coding instructions were provided for the Otto Bock C-Leg® and the billing of miscellaneous code L5999 for two functions, "continuous gait assessment, computerized MKP prosthesis" and "electronically controlled static stance regulator, adjustable." There are additional products with microprocessor control of stance and swing phase (Endolite Adaptive® knee and Ossur Rheo® knee), swing phase only (Endolite Smart IP®, Endolite IP+®) or stance phase only (Otto Bock Compact® knee) to which the coding guidance previously published for the Otto Bock C-Leg® applies.

Use of miscellaneous code L5999 reflecting either "continuous gait assessment, computerized microprocessor controlled knee prosthesis" or "electronically controlled static stance regulator, adjustable" is incorrect. Since these functions are included in the payment for L5856, L5857 or L5858, the correct coding is L9900 (Orthotic and prosthetic supply, accessory and/or service component of another HCPCS "L" code).

CODING CONT'D

For the Otto Bock C-Leg®, the following are considered unbundled from code L5856:

- L5999 – Electronically controlled static stance regulator, adjustable
- L5999 – Continuous gait assessment, computerized microprocessor knee prosthesis

For the Endolite Adaptive® knee and Ossur Rheo® knee, the following is considered unbundled from code L5856:

- L5999 – Continuous gait assessment, computerized microprocessor knee prosthesis

For the Endolite Smart IP®, Endolite IP+®, the following is considered unbundled from code L5857:

- L5999 – Continuous gait assessment, computerized microprocessor knee prosthesis

For the Otto Bock Compact® knee, the following is considered unbundled from code L5858:

- L5999 – Continuous gait assessment, computerized microprocessor knee prosthesis

For all of the products listed above, if a supplier chooses to bill for those functions shown as L5999, code L9900 must be used and will be denied as unbundled.

COVERAGE

Positive Airway Pressure Devices LCD – Delayed Implementation

In July, the DME MACs published a Local Coverage Determination (LCD) on Positive Airway Pressure (PAP) Devices for Obstructive Sleep Apnea. Some criteria in that policy were to take effect for dates of service on or after September 1. All criteria with a September 1, 2008, implementation date are being delayed. A revised LCD will be published in the near future and will include a new effective date for those criteria.

See below for the original publication.

CPAP LCD Revised

****All criteria with a September 1, 2008, implementation date are being delayed. See above.**

The Continuous Positive Airway Pressure (CPAP) System policy has been revised to reflect the Centers for Medicare & Medicaid Services (CMS) national coverage determination (NCD) on the use of home sleep tests to qualify patients with obstructive sleep apnea (OSA) for Positive Airway Pressure (PAP) devices. Certain provisions of the policy are effective

for dates of service on or after March 13, 2008, the effective date of the NCD; however, certain requirements will be prospectively implemented for dates of service on or after September 1, 2008.

Since some LCD provisions have differing effective dates, the criteria that apply for coverage are dependent on the date the PAP device was dispensed. There are 3 critical dates:

1. If the PAP device was dispensed prior to March 13, 2008, the initial coverage criteria and coverage criteria for use beyond the first 3 months must meet the CPAP policy requirements that were effective January 1, 2008.
2. If the PAP device was dispensed after March 13, 2008, but before September 1, 2008, the initial coverage criteria and the criteria for coverage after the first 3 months must meet the requirements in this revised PAP policy that reflect the CMS NCD requirements outlined in CMS Internet-Only Manual Pub. 100-03, Medicare National Coverage Determinations Manual, Chapter 1, Part 4, Section 240.1.
3. If the PAP device is dispensed on or after September 1, 2008, all requirements in this revised PAP policy must be met.

If the PAP device was dispensed prior to September 1, 2008, the KX modifier may be added to the claim if:

1. The initial coverage criteria in effect at the time were met; and,
2. The criteria for coverage after the first 3 months that were in effect at the time were met; and,
3. The patient continues to compliantly use the device.

It should also be noted that the name of the policy has changed to Positive Airway Pressure (PAP) Devices for the Treatment of Obstructive Sleep Apnea. The change reflects the addition of coverage criteria for respiratory assist devices (E0470 and E0471) when used to treat OSA. With the addition of these coverage criteria to the PAP policy, provisions related to the use of codes E0470 and E0471 for OSA were removed from the Respiratory Assist Device (RAD) policy. A revision of the RAD policy reflecting this change will be published in the near future.

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

CPAP Therapy for Obstructive Sleep Apnea

MLN Matters Number: MM6048 Revised
Related Change Request (CR) #: 6048
Related CR Release Date: July 25, 2008
Related CR Transmittal #: R91NCD
Effective Date: March 13, 2008
Implementation Date: August 4, 2008

Note: This article was revised on July 28, 2008, to reflect changes to CR 6048, which CMS revised on July 25, 2008. The CR release date, transmittal number, and the Web address for accessing CR6048 were revised. 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).

COVERAGE CONT'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) is met:

- AHI or RDI greater than or equal to 15 events per hour, or
- AHI or RDI greater than or equal to 5 and less than or equal to 14 events per hour 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. The RDI is equal to the average number of respiratory disturbances per hour.

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/R91NCD.pdf on the CMS web site.

Ostomy Supplies Policy Article Update - July 2008 Publication

The Policy Article for Ostomy Supplies, effective 01/01/08 (July 2008 Publication), has been updated to add HCPCS code A5120 to the list that requires use of the AU modifier for payment when billing for ostomy supplies.

Refer to the LCD for Ostomy Supplies and the related Policy Article for additional information on the coding, coverage, and documentation requirements.

Respiratory Assist Devices LCD Revision – July 2008

The Respiratory Assist Devices (RAD) policy has been revised to reflect the Centers for Medicare & Medicaid Services (CMS) national coverage determination (NCD) on the use of home sleep tests to qualify patients with obstructive sleep apnea (OSA) for Positive Airway Pressure (PAP) devices. Effective with dates of service on or after March 13, 2008, the effective date of the NCD, the Obstructive Sleep Apnea section (Indication IV) in the LCD for Respiratory Assist Devices was moved to the LCD for Positive Airway Pressure (PAP) Devices for the Treatment of Obstructive Sleep Apnea, formally the LCD for Continuous Positive Airway Pressure System.

Suppliers should review the entire RAD and PAP policies for additional information on the coding, coverage and documentation requirements for these devices.ion – July 2008 in the LCD for Respiratory Assist DevicesRAD LCDLCD for Obstructive Sleep Apnea Apnea LCDLCD for System Devices LCDs

Enteral Nutrition CERT Error Rates High

Enteral nutrition has a high CERT provider compliance error rate in Jurisdiction D. NAS would like to review the indications, limitations of coverage and the medical necessity required for enteral nutrition.

Enteral nutrition is covered for patients with one of the following two situations:

- A permanent non-function or disease of the structures that normally permit food to reach the small bowel. Permanence does not require a determination that there is no possibility that the patient's condition may improve sometime in the future. If the judgment of the attending physician, substantiated in the medical record, is that the condition is of long and indefinite duration (ordinarily at least 3 months), the test of permanence is considered met.

  NOTE: Enteral nutrition will be denied as non-covered in situations involving temporary impairments.

- A disease of the small bowel, which impairs digestion, and absorption of an oral diet, either of which requires tube feedings to provide sufficient nutrients to maintain weight and strength commensurate with the patient's overall health status. Some examples of this would be:

  - Obstruction due to head and neck cancer
  - Reconstructive surgery
  - A motility disorder, like dysphagia, following a stroke

  NOTE: Enteral nutrition is non-covered for patients with a functioning gastrointestinal tract whose need for enteral nutrition is due to reasons such as anorexia or nausea associated with mood disorder, end-stage disease, etc.

Please keep in mind the following:

- A DME Information Form (DIF) must accompany and support initial claims for enteral nutrition to establish whether coverage criteria are met and to ensure that the enteral therapy provided is consistent with the attending or ordering physician's prescription. Coverage for enteral nutrition is determined by information provided by the treating physician and the enteral supplier.
- Enteral formulas consisting of semi-synthetic intact protein/protein isolates (B4150 or B4152) are appropriate for the majority of patients requiring enteral nutrition.
- For special enteral formulas (B4149, B4153-B4157, B4161, and B4162) the medical necessity will need to be justified for each patient as to why this special formula is needed versus the semi-synthetic enteral formula.
- If a pump (B9000-B9002) is ordered, there must be sufficient documentation in the patient's medical record to justify its use. Examples of statements showing medical necessity would be "gravity feeding is not satisfactory due to reflux"; "aspiration"; "severe diarrhea"; "dumping syndrome"; "administration rate less than 100ml/hr"; "blood glucose fluctuations"; "circulatory overload; or "gastrostomy/jejunostomy tube used for feeding".

  NOTE: If the medical necessity of the pump is not documented, the pump will be denied.

- The feeding supply kit (B4034-B4036) must correspond to the method of administration indicated in question 5 on the DIF. This question specifies the method of administration: syringe, gravity, pump, or oral. If the supply kit does not correspond, payment for the code will be based on the allowance for the code relating to the method of administration specified on the DIF or the billed code, whichever is less.
- If a pump supply kit is ordered (B4035), the medical necessity of the pump must be documented or the payment will be based on the allowance for the least costly medically appropriate alternative, B4036.
- Feeding supply kits (B4034-B4036) are specific to the route of administration and the submission of a claim for more than one type of kit code delivered on the same date or provided on an ongoing basis will be denied as not medically necessary.
- More than three nasogastric tubes (B4081-B4083) or one gastrostomy/jejunostomy tube (B4087-B4088) every three months is rarely medically necessary and would require extensive documentation for approval.
- If the coverage requirements for enteral nutrition are met, medically necessary nutrients, administration supplies and equipment are covered.
- If two enteral nutrition products, which are described by the same HCPCS code, are being provided at the same time, they should be billed on a single claim line with the units of service reflecting the total calories of both nutrients.
- Food thickeners (B4100), baby food, and other regular grocery products that can be blenderized and used with the enteral system will be denied as noncovered.
- Codes B4102 and B4103 describe electrolyte-containing fluids that are noncovered by Medicare.
- Self-blenderized formulas are noncovered by Medicare.
- Code B4104 is an enteral formula additive and is denied as not separately payable as the enteral formula codes include all nutrient components, including vitamins, minerals, and fiber.

In relation to the DIF:

- A new initial DIF for enteral nutrients is required when:
  - A formula billed with a different code, which has not been previously certified, is ordered, **or**
  - Enteral nutrition services are resumed after they have not been required for two consecutive months.
- A new Initial DIF for a pump (B9000 or B9002) is required when:
  - Enteral nutrition services involving use of a pump are resumed after they have not been required for two consecutive months, or

  - A patient receiving enteral nutrition by the syringe or gravity method is changed to administration using a pump.
- A revised DIF for enteral nutrients is required when:
  - The number of calories per day is changed, **or**
  - The number of days per week administered is changed, **or**
  - The method of administration (syringe, gravity, pump) changes, **or**
  - The route of administration is changed from tube feedings to oral feedings (if billing for denial).

In relation to supplies:

- Payment for a catheter/tube-anchoring device is considered included in the allowance for enteral feeding supply kits (B4034-B4036). Code A5200 should not be billed separately and is not paid in addition to the supplies for enteral nutrition.
- The codes for feeding supply kits (B4034-B4036) include all supplies, other than the feeding tube itself, required for the administration of enteral nutrients to the patient for one day.
- Supplies include but are not limited to bags, tubing, syringes, irrigation solution, dressings (any type), tape, etc. Individual items may differ from patient to patient and from day to day.
- Only one unit of service may be billed for any one day. Units of service in excess of one per day will be denied as not separately payable.

Specific documentation requirements include:

- An order for each item billed must be signed and dated by the treating physician.
- The patient's medical record must contain sufficient documentation of the patient's medical condition to substantiate the necessity for the type and quantity of items ordered and for the frequency of use or replacement (if applicable).
- Please remember that neither a physician's order nor a DIF nor a supplier prepared statement nor a physician attestation by itself provides sufficient documentation of medical necessity, even though the treating physician or supplier signs it.

Sources:

- Enteral Nutrition LCD (L11568)
- Enteral Nutrition Policy Article (A25361)
- *Medicare Program Integrity Manual* (MPIM), Chapter 5, Sections 5.3 and 5.3.1

NCD for Colorectal Cancer Screening Tests Remains Unchanged – Implementation Date Correction

The Implementation Date on the Business Requirements was erroneously stated as August 25, 2005. The correct Implementation Date is August 25, 2008. All other material remains the same.

Following reconsideration of the current national coverage determination (NCD) for colorectal cancer screening, CMS proposes not to expand the colorectal cancer screening benefit to include coverage of PreGen-Plus, a commercially available screening DNA stool test. The FDA determines that this test requires premarket review and approval.

For complete information, see Change Request 6145: Screening DNA Stool Test for Colorectal Cancer http://www.cms.hhs.gov/transmittals/downloads/R92NCD.pdf

Screening DNA Stool Test for Colorectal Cancer

MLN Matters Number: MM6145
Related Change Request (CR) #: 6145
Related CR Release Date: July 25, 2008
Related CR Transmittal #: R93BP and R89NCD
Effective Date: April 28, 2008
Implementation Date: August 25, 2008

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.

See the *Background* and *Additional Information* Sections of this article for further details regarding these changes.

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)) http://frwebgate1.access.gpo.gov/cgi-bin/waisgate.cgi?WAISdocID=30235324 0525+88+0+0&WAISaction=retrieve 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/R89NCD.pdf, respectively, on the CMS web site.

Oxygen and Oxygen Equipment Denials

Recent analysis shows a 10% claims denial rate for oxygen claims due to the supplier not being identified as having an oxygen license. The claim adjustment reason code for these denials is 172: *Payment is adjusted when performed/billed by a provider of this specialty.* The remittance advice remark code for these denials is M143: *The provider must update license information with the payer.*

According to Change Request (CR) 5929, 38 states require licensure and/or certification to provide oxygen and/or oxygen related equipment. The CR also states that Medicare suppliers who submit claims for Medicare payment for oxygen and/or oxygen related equipment must provide the National Supplier Clearinghouse (NSC) via the supplier enrollment process (using the CMS 855S application) a copy of their state license and/or certification.

The DME Medicare Administrative Contractors (DME MACs) are required to edit claims to look for the oxygen specialty code. This assures that those suppliers specifying the provision of oxygen and/or oxygen related products on their enrollment application and supplying the license/certification are the only entities that will receive Medicare payment for oxygen and related products in the applicable states.

For a copy of the CMS 855S application, click on the CMS 855S Medicare Enrollment Application located under the Enrollment tab on our Web site.

A copy of the MedLearn Matters (MLN) article which includes the table of 38 states that require oxygen licensure and/or certification requirements can be found at www.cms.hhs.gov/MLNMattersArticles/downloads/MM5929.pdf.