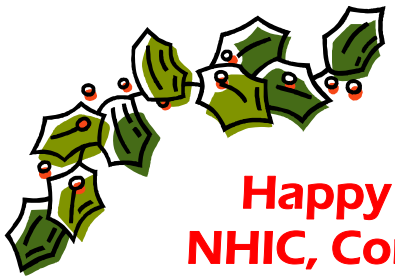
DME MAC Jurisdiction A Resource

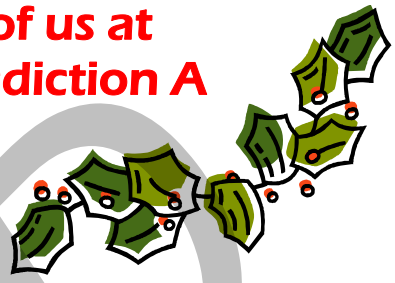
FOCUSED INFORMATION for MEDICARE DME MAC SUPPLIERS in CT, DE, DC, ME, MD, MA, NH, NJ, NY, PA, RI, & VT

December 2008
Number 10

Table of Contents



Happy Holidays from all of us at NHIC, Corp. DME MAC Jurisdiction A



Billing / Finance

General Information

This bulletin should be shared with all healthcare practitioners and managerial members of the physician/supplier staff. Bulletins are available at no cost from our web site at **www.medicarenhic.com/dme/**

CMS CENTERS for MEDICARE & MEDICAID SERVICES

NHIC, Corp.

TMP-EDO-0058 Ver. 1
06 / 25 / 2008

Table of Contents

Medical Review

Outreach & Education

Legend

DRU Drugs	**O&P** Orthotics & Prosthetics	**SPE** Specialty Items
GEN General	**OXY** Oxygen	**VIS** Vision
MOB Mobility/Support Surfaces	**PEN** Parenteral/Enteral Nutrition	

***MLN Matters* Disclaimer**
These articles were prepared as a service to the public and are not intended to grant rights or impose obligations. These 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.

Claims Jurisdiction and Enrollment Procedures for Suppliers of Certain Prosthetics, Durable Medical Equipment (DME) and Replacement Parts, Accessories and Supplies (MM5917) (GEN)

MLN Matters Number: MM5917
Related CR Release Date: September 26, 2008
Related CR Transmittal #: R1603CP
Related Change Request (CR) #: 5917
Effective Date: October 27, 2008
Implementation Date: October 27, 2008

Provider Types Affected
Suppliers, including manufacturers, billing Medicare Carriers and Medicare Administrative Contractors (A/B MACs) for certain DME products provided to Medicare beneficiaries.

Provider Action Needed
Impact to You
The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 5917 to alert suppliers, including manufacturers, enrolled with the National Supplier Clearinghouse (NSC) as a Durable Medical Equipment Prosthetic, Orthotics, and Supplies (DMEPOS) supplier, that they may now enroll with and bill the Medicare carrier or A/B MAC for replacement parts, accessories and supplies for prosthetic implants and surgically implanted DME items that are not required to be billed to the Medicare fiscal intermediary.

What You Need to Know
Such suppliers may bill the carrier/MAC for these items only, unless the entity separately qualified as a supplier for items and/or services in another benefit category.

What You Need to Do
Make certain that you use your National Provider Identifier (NPI) and do not include your NSC number on claims submitted to carriers/MACs for replacement parts, accessories, and supplies for prosthetic implants and surgically implanted DME.

Key Points
- CR5917 reinstates the Part B carrier/MAC jurisdiction for suppliers of replacement parts, accessories and supplies for prosthetic implants and surgically implanted DME only, including manufacturers of such items.
- Suppliers that wish to bill the carrier/MAC for these items must enroll with the NSC as a DMEPOS supplier prior to enrolling with, and billing these items to, the Part B carrier/MAC.
- All suppliers must meet the enrollment standards of the NSC and qualify as a DMEPOS supplier. (A DMEPOS supplier must meet certain requirements and enroll with the NSC as described in Chapter 10 of the *Program Integrity Manual*, which may be reviewed at **http://www.cms.hhs.gov/manuals/downloads/pim83c10.pdf** on the CMS web site.
- When submitting claims to the carrier or A/B MAC, be sure to use your National Provider Identifier (NPI), rather than the NSC number.

Additional Information
CR 5917 contains the list of HCPCS codes that may be billed to the carrier/MAC as a replacement part, accessory, or supply for prosthetic implants and surgically implanted DME. That list is attachment A of CR 5917 and it is available at **http://www.cms.hhs.gov/Transmittals/downloads/R1603CP.pdf** on the CMS web site. Also, the full 2008 jurisdiction list of DMEPOS HCPCS is attached to CR6062, which is at **http://www.cms.hhs.gov/Transmittals/downloads/R1605CP.pdf** on the CMS web site.

If you have questions, please contact your Medicare Carrier or A/B 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.

Clarification of Medicare Payment for Routine Costs in a Clinical Trial (SE0822) (SPE)

MLN Matters Number: SE0822
Related CR Release Date: N/A
Related CR Transmittal #: N/A

Related Change Request (CR) #: N/A
Effective Date: N/A
Implementation Date: N/A

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

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

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

"40 No Legal Obligation to Pay for or Provide Services

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

Key Points of SE0822
There are three concerns addressed in this article regarding "Payment for Routine Costs in a Clinical Trial" and they are addressed in the following questions and answers:

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

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

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

   Answer: If the routine costs of the clinical trial are not billed to indigent non-Medicare patients because of their inability to pay (but are being billed to all the other patients in the clinical trial who have the financial means to pay even when his/her private insurer denies payment for the routine costs), then a legal obligation to pay exists. Therefore, Medicare payment may be made and the beneficiary (who is not indigent) will be responsible for the applicable Medicare deductible and coinsurance amounts.

As noted at **http://www.cms.hhs.gov/AcuteInpatientPPS/downloads/FAQ_Uninsured.pdf**, "nothing in the Centers for Medicare & Medicaid Services' (CMS') regulations or Program Instructions prohibit a hospital from waiving collection of charges to any patients, Medicare or non-Medicare, including low-income, uninsured or medically indigent individuals, if it is done as part of the hospital's indigency policy. By "indigency policy" we mean a policy developed and utilized by a hospital to determine patients' financial ability to pay for services. By "medically indigent," we mean patients whose health insurance coverage, if any, does not provide full coverage for all of their medical expenses and that their medical expenses, in relationship to their income, would make them indigent if they were forced to pay full charges for their medical expenses. In addition to CMS' policy, the Office of Inspector General (OIG) advises that nothing in OIG rules or regulations under the Federal anti-kickback statute prohibits hospitals from waiving collection of charges to uninsured patients of limited means, so long as the waiver is not linked in any manner to the generation of business payable by a Federal health care program - a highly unlikely circumstance

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

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

   Answer: If a research sponsor offers to pay cost-sharing amounts owed by the beneficiary, this could be a fraud and abuse problem. In addition to CMS' policy, the Office of Inspector General (OIG) advises that nothing in OIG rules or regulations under the Federal anti-kickback statute prohibits hospitals from waiving collection of charges to uninsured patients of limited means, so long as the waiver is not linked in any manner to the generation of business payable by a Federal health care program.

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

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

If you have any questions, please contact your Medicare contractor at their toll-free number, which may be found at **http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip** on the CMS web site.

Limitation on Recoupment (935) for Provider, Physicians and Suppliers Overpayments (MM6183) (GEN)

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

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

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

What You Need to Know
CR 6183, from which this article is taken, announces changes to the physician, provider, and supplier overpayment recoupment process, as required by Section 935 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) which

amended Title XVIII of the Social Security Act to add to Section 1893 a new paragraph (f) addressing this process. The important points of interest for providers are as follows:

- For overpayments subject to this limitation on recoupment, Medicare will not begin overpayment collection of debts (or will cease collections that have started) when it receives notice that the provider has requested a Medicare contractor redetermination (first level of appeal) or a reconsideration by a Qualified Independent Contractor (QIC).

- As appropriate, Medicare will resume overpayment recoveries with interest if the Medicare overpayment decision is upheld in the appeals process.

- If the ALJ level process reverses the Medicare overpayment determination, Medicare will refund both principal and interest collected, and also pay 935 interest on any recouped funds that Medicare took from ongoing Medicare payments. (If a provider has any other outstanding overpayments, Medicare will apply the amount collected first to those overpayments and any excess monies will then be refunded back to the provider.)

- Payment of 935 interest is only applicable to overpayments recovered under the limitation on recoupment provisions. Interest is only payable on the principal amount recouped.

- Providers must note that when Medicare sends a demand letter notifying a provider of Medicare's intent to collect an overpayment, the provider may submit a letter of rebuttal that disputes the debt. The rebuttal letter will not necessarily stop Medicare from beginning the process of recouping that debt. Only a provider's timely and valid request for a redetermination or reconsideration will halt the recoupment.

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

Background

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

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

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

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

Overpayments that ARE subject to Limitation on Recoupment

- Determined post-pay denial of claims for benefits under Medicare Part A for which a written demand letter was issued (a letter informing the provider of the overpayment determination as a result of a post payment review of the medical record, claim, or billing records is subject to this provision);

- Determined post-pay denial of claims for benefits under Medicare Part B for which a written demand letter was issued;

- Medicare Secondary Payer (MSP) recovery where the provider or supplier received a duplicate primary payment and for which a written demand letter was issued (a letter informing the provider of the overpayment determination as a result of a post payment review of claim or billing records is subject to this provision); or

- Medicare Secondary Payer (MSP) recovery based on the provider's or supplier's failure to file a proper claim with the third party payer plan, program, or insurer for payment for Part A or B (a letter informing the provider of the overpayment determination as a result of a post payment review of claim or billing records is subject to this provision).

- The final Claims associated with a Home Health Agency (HHA) Request for Anticipated Payment (RAP) under Home Health Prospective Payment System (HH PPS), but not the RAP itself (see Table 2, below).

Overpayments that ARE NOT Subject to Limitation on Recoupment

- All other Medicare Secondary Payer recoveries except those identified in the preceding section of this article;
- Beneficiary overpayments;
- Overpayments that arise from a cost report determination;
- Overpayments that are appealed under the Provider Reimbursement Payment (PRB) process of 42 CFR parts 405 subpart R-Provider /Reimbursement Determinations and appeals;
- HHA Requests for Anticipated Payment (RAP) under HH PPS;
  Note: While a RAP is not considered a claim for purposes of Medicare appeals regulations, it is submitted using the same format as Medicare claims. RAPs under the HH PPS do not have appeal rights during: 1) the 120 days from the start of the episode; or 2) 60 days from the payment date of the RAP to submit the final claim. Rather, appeals rights are tied to the claims that represent all services delivered for the entire HH PPS episode. (Refer to the *Medicare Claims Processing Manual*, Chapter 10 (Home Health Agency Billing), Sections 10.1.10 (Provider Billing Process Under HH PPS), 10.1.11 (Payment, Claim Adjustments and Cancellations), 10.1.12 (Request for Anticipated Payment (RAP)), 40.1 (Request for Anticipated Payment (RAP)), and 50 (Beneficiary-Driven Demand Billing Under HH PPS). This manual is available at **http://www.cms.hhs.gov/Manuals/IOM/list.asp** on the CMS web site.)
- Hospice Caps calculations;
- Provider initiated adjustments;
- Accelerated/Advanced Payments; and
- Certain claims adjustments at the contractors' discretion that will not be subject to Section 935 (this requires approval by CMS).

The Rebuttal Process

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

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

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

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

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

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

- States that the provider may submit a rebuttal statement (which is not an appeal request) to any proposed recoupment action and the Medicare contractor will review it and consider whether to proceed or stop the offset (remember that they may elect to continue recoupment);

- States that in order to stop recoupment under the provisions of Section 935 of the MMA; providers must request a valid appeal (redetermination) of the overpayment within 30 days from the date of the demand letter;

- Explains how the overpayment arose, the amount of the overpayment, how the overpayment was calculated, and why the original payment was not correct;

- Explains why the provider knew or should have known the items or services would not be covered, as well as the regulatory and statutory references for the 1879 determination, or (when appropriate) why the provider was not found to be without fault in causing the overpayment.

- Explains that recoupment will begin on the 41st day from the date of the first demand letter if: 1) payment is not received in full, or 2) an acceptable request for an extended repayment schedule, or 3) a valid request for a contractor redetermination is not date stamped in the Medicare contractor's mailroom by day 30 from the date of the demand letter. However, if the appeal is filed later than 30 days, the contractor will also stop recoupment at whatever point that an appeal is received and validated, but Medicare may not refund any recoupment already taken.

Notes:

1. Timeliness of this request is important because if you don't send this request within 30 days, Medicare can begin to recoup on the 41st day from the date of the Medicare demand letter.

2. In addition, during this appeal process, while the Medicare contractor cannot recoup or demand the debt, it continues to age (its interest continues to accrue); and, once both levels of appeal are completed, if the appeal decision results in an affirmation of the overpayment decision, collection activities may resume within the designated timeframes.

3. If you have filed a bankruptcy petition or are involved in a bankruptcy proceeding, Medicare financial obligations will be resolved in accordance with the applicable bankruptcy process. You should immediately notify your Medicare contractor about this bankruptcy so that they can coordinate with both CMS and the Department of Justice to assure that your particular situation is handled properly.

Step Three - How to Stop Recoupment:

First Level Appeal (Redetermination)

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

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

Table 1
Timeframe for Medicare Recoupment Process After the First Demand Letter

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

Redetermination or Reconsideration (Appeals) Requests

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

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

A Redetermination can have three possible outcomes:

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

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

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

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

Table 2
Timeframe for Medicare Recoupment Process After Redetermination

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

Second Level Appeal (Reconsideration)

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

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

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

A QIC Reconsideration can have three possible outcomes:

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

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

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

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

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

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

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

Additional Details of CR6183

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

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

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

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

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

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

pay interest on interest; (mirroring the manner in which interest against providers is assessed). Monies recouped and applied to interest would be refunded and not included in the "amount recouped" for purposes of calculating any interest due the provider.

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

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

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

If you have any questions, please contact your Medicare contractor at their toll-free number, which may be found at **http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip** on the CMS web site.

October 2008 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files (MM6175) (DRU)

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

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

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

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

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

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

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

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

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

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

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

ASP Methodology

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

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

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

Exceptions are summarized as follows:

- The payment allowance limits for blood and blood products (other than blood clotting factors) that are not paid on a prospective payment basis are determined in the same manner that the payment allowance limits were determined on October 1, 2003. Specifically, the payment allowance limits for blood and blood products are 95 percent of the average wholesale price (AWP) as reflected in the published compendia. The payment allowance limits are updated on a quarterly basis. Blood and blood products furnished in the hospital outpatient department are paid under OPPS at the amount specified for the Ambulatory Payment Classification (APC) to which the product is assigned.

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

- The payment allowance limits for influenza, Pneumococcal and Hepatitis B vaccines are 95 percent of the AWP as reflected in the published compendia except when the vaccine is furnished in a hospital outpatient department. When furnished in a hospital outpatient department, the vaccine is paid at reasonable cost.

- The payment allowance limits for drugs and biologicals that are not included in the ASP Medicare Part B Drug Pricing File or NOC Pricing File, other than new drugs and biologicals that are produced or distributed under a new drug application (or other application) approved by the FDA, are based on the published wholesale acquisition cost (WAC) or invoice pricing, except under OPPS where the payment allowance limit is 95 percent of the published AWP. In determining the payment limit based on WAC, Medicare contractors follow the methodology specified in the *Medicare Claims Processing Manual*, Chapter 17, Drugs and Biologicals, for calculating the AWP; but substitute WAC for AWP. The payment limit is 100 percent of the lesser of the lowest-priced brand or median generic WAC. For 2006, the blood clotting furnishing factor of $0.146 per I.U. is added to the payment amount for the blood clotting factor when the blood clotting factor is not included on the ASP file. For 2007, the blood clotting furnishing factor of $0.152 per I.U. is added to the payment amount for the blood clotting factor when the blood clotting factor is not included on the ASP file. **For 2008, the blood clotting furnishing factor of $0.158 per**

I.U. is added to the payment amount for the blood clotting factor when the blood clotting factor is not included on the ASP file.

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

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

- The payment allowance limits for radiopharmaceuticals are not subject to the ASP payment methodology. In the case of radiopharmaceuticals furnished in other than the hospital outpatient department, Medicare contractors determine payment limits for radiopharmaceuticals based on the methodology in place as of November 2003. Radiopharmaceuticals furnished in the hospital outpatient department are paid charges reduced to cost by the hospital's overall cost to charge ratio.

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

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

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

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

Drugs Furnished During Filling or Refilling an Implantable Pump or Reservoir

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

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

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

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

If you have any questions, please contact your Medicare contractor at their toll-free number, which may be found at **http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip** on the CMS web site.

Reasonable Charge Update for 2008 for Splints, Casts, Dialysis Supplies, Dialysis Equipment, and Certain Intraocular Lenses (MM5740) (GEN)

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

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

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

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

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

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

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

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

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

Dialysis Supplies Billed With AX Modifier

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

Dialysis Supplies Billed Without AX Modifier

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

Dialysis Equipment Billed With AX Modifier

E0210NU	E1632	E1637	E1639

Dialysis Equipment Billed Without AX Modifier

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

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

Additional Information
Detailed instructions for Calculating:

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

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

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

If you have questions, please contact your Medicare FI, carrier, DME MAC, or A/B 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.

Attachment A

2008 Payment Limits for Splints and Casts

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

Reasonable Charge Update for 2009 for Splints, Casts, Dialysis Supplies, Dialysis Equipment, and Certain Intraocular Lenses (MM6221) (GEN)

MLN Matters Number: MM6221
Related CR Release Date: October 3, 2008
Related CR Transmittal #: R1613CP

Related Change Request (CR) #: 6221
Effective Date: January 1, 2009
Implementation Date: January 5, 2009

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

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

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

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

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

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

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

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

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

Table 1
Dialysis Supplies Billed With AX Modifier

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

Table 2
Dialysis Supplies Billed Without AX Modifier

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

Table 3
Dialysis Equipment Billed With AX Modifier

E0210NU	E1632	E1637	E1639

Table 4
Dialysis Equipment Billed Without AX Modifier

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

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

Additional Information
Detailed instructions for calculating:

- **Reasonable charges** are located in the *Medicare Claims Processing Manual*, Chapter 23 (Fee Schedule Administration and Coding Requirements), Section 80 (Reasonable Charges as Basis for Carrier/DMERC Payments);

- **Customary and prevailing charges** are located in *Medicare Claims Processing Manual*, Chapter 23 (Fee Schedule Administration and Coding Requirements), Sections 80.2 (Updating Customary and Prevailing Charges) and 80.4 (Prevailing Charge); and

- The **IIC** are located in *Medicare Claims Processing Manual*, Chapter 23 (Fee Schedule Administration and Coding Requirements), Sections 80.6 (Inflation Indexed Charge (IIC) for Nonphysician Services).

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

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

If you have any questions, please contact your FI, carrier, 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.

Attachment A

Code	Payment Limit	Code	Payment Limit
A4565	$7.75	Q4025	$34.07
Q4001	$44.11	Q4026	$106.37
Q4002	$166.75	Q4027	$17.04
Q4003	$31.69	Q4028	$53.19
Q4004	$109.71	Q4029	$26.05
Q4005	$11.68	Q4030	$68.58
Q4006	$26.33	Q4031	$13.03
Q4007	$5.86	Q4032	$34.28
Q4008	$13.17	Q4033	$24.30
Q4009	$7.80	Q4034	$60.44
Q4010	$17.56	Q4035	$12.15
Q4011	$3.90	Q4036	$30.23
Q4012	$8.78	Q4037	$14.83
Q4013	$14.20	Q4038	$37.14
Q4014	$23.95	Q4039	$7.43
Q4015	$7.10	Q4040	$18.56
Q4016	$11.97	Q4041	$18.02
Q4017	$8.21	Q4042	$30.77
Q4018	$13.09	Q4043	$9.02
Q4019	$4.11	Q4044	$15.39
Q4020	$6.55	Q4045	$10.46
Q4021	$6.07	Q4046	$16.83
Q4022	$10.96	Q4047	$5.22
Q4023	$3.06	Q4048	$8.42
Q4024	$5.48	Q4049	$1.91

Revised Form CMS-R-131 Advance Beneficiary Notice of Noncoverage (MM6136) (GEN)

MLN Matters Number: MM6136
Related CR Release Date: September 5, 2008
Related CR Transmittal #: R1587CP

Related Change Request (CR) #: 6136
Effective Date: March 3, 2008
Implementation Date: March 1, 2009

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

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

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

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

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

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

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

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

1. The revised ABN is the new CMS-approved written notice that physicians, providers, practitioners, suppliers, and laboratories issue to beneficiaries enrolled in the Medicare Fee-For-Service (FFS) program for items and services that they provide under Medicare Part A (hospice and religious non-medical healthcare institutions only) and Part B. It may not be used for items or services provided under the Medicare Advantage (MA) Program, or for prescription drugs provided under the Medicare Prescription Drug Program (Part D).

2. The revised ABN (which replaces the ABN-G (CMS-R-131-G), ABN-L (CMS-R-131-L), and Notice of Exclusion from Medicare Benefits (NEMB) (CMS-20007)) will now be used to fulfill both mandatory and voluntary notice functions.

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

3. The following situations require by statute that an ABN be issued:
   - Care is not reasonable and necessary;
   - There was a violation of the prohibition on unsolicited telephone contacts;
   - Medical equipment and supplies supplier number requirements not met;
   - Medical equipment and/or supplies denied in advance;

- Custodial care; and
- A hospice patient who is not terminally ill.

4. In the following situations ABN use is voluntary

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

   Additionally, the ABN can also be issued voluntarily in place of the Notice of Exclusion from Medicare Benefits (NEMB) for care that is never covered such as:
   - Care that fails to meet the definition of a Medicare benefit as defined in Section 1861 of the Social Security Act;
   - Care that is explicitly excluded from coverage under Section 1862 of the Social Security Act. Examples include:
     - Services for which there is no legal obligation to pay;
     - Services paid for by a government entity other than Medicare (this exclusion does not include services paid for by Medicaid on behalf of dual-eligibles);
     - Services required as a result of war;
     - Personal comfort items;
     - Routine physicals (except the initial preventive physical or "Welcome to Medicare" physical examination) and most screening tests;
     - Routine eye care;
     - Dental care; and
     - Routine foot care.

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

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

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

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

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

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

If you have any questions, please contact your carrier, FI, RHHI, 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.

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

Update to Medicare Deductible, Coinsurance and Premium Rates for 2009 (MM6258) (GEN)

MLN Matters Number: MM6258 - Revised
Related CR Release Date: November 17, 2008
Related CR Transmittal #: R56GI
Related Change Request (CR) #: 6258
Effective Date: January 1, 2009
Implementation Date: January 5, 2009

Note: *This article was revised on November 18, 2008, to reflect changes made to CR6258, which was re-issued on November 17. The CR transmittal number and release date (see above) were revised and the Web address for accessing CR6258 was changed. All other information remains the same.*

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

Impact on Providers
This article is based on Change Request (CR) 6258, which provides the Medicare rates for deductible, coinsurance and premium payment amounts for calendar year (CY) 2009.

2009 Part A - Hospital Insurance (HI)
A beneficiary is responsible for an inpatient hospital deductible amount, which is deducted from the amount that the Medicare program pays the hospital for inpatient hospital services it furnishes in an illness episode. When a beneficiary receives such services for more than 60 days during an illness encounter, he or she is responsible for a coinsurance amount that is equal to one-fourth of the inpatient hospital deductible per-day for the 61st-90th day spent in the hospital.

Please note that an individual has 60 lifetime reserve days of coverage, which they may elect to use after the 90th day in a spell of illness. The coinsurance amount for these days is equal to one-half of the inpatient hospital deductible.

In addition, a beneficiary is responsible for a coinsurance amount equal to one-eighth of the inpatient hospital deductible per day for the 21st through the 100th day of Skilled Nursing Facility (SNF) services furnished during an illness episode. The 2009 deductible and coinsurance amounts are in the following table.

Table 1

2009 Part A - Hospital Insurance (HI)			
Deductible	**$1,068.00**		
Coinsurance	**Hospital**		**Skilled Nursing Facility**
	Days 61-90	**Days 91-150 (Lifetime Reserve Days)**	**Days 21-100**
	$267.00	$534.00	$133.50

Most individuals age 65 and older (and many disabled individuals under age 65) are insured for Health Insurance (HI) benefits without a premium payment. In addition, the Social Security Act provides that certain aged and disabled persons who are not insured may voluntarily enroll, but are subject to the payment of a monthly Part A premium.

Since 1994, voluntary enrollees may qualify for a reduced Part A premium if they have 30-39 quarters of covered employment. When voluntary enrollment takes place more than 12 months after a person's initial enrollment period, a 2-year 10% penalty is assessed for every year they had the opportunity to (but failed to) enroll in Part A. The 2009 Part A premiums are listed in table 2, below.

Table 2

Voluntary Enrollees Part A Premium Schedule	
Base Premium (BP)	$443.00 per month
Base Premium with 10% Surcharge	$487.30 per month
Base premium with 45% Reduction	$244.00 per month (for those who have 30-39 quarters of coverage)
Base premium with 45% Reduction and 10% surcharge	$268.40 per month

2009 Part B - Supplementary Medical Insurance (SMI)

Under Part B, the Supplementary Medical Insurance (SMI) program, all enrollees are subject to a monthly premium. In addition, most SMI services are subject to an annual deductible and coinsurance (percent of costs that the enrollee must pay), which are set by statute. Further, when Part B enrollment takes place more than 12 months after a person's initial enrollment period, there is a permanent 10% increase in the premium for each year the beneficiary had the opportunity to (but failed to) enroll.

For 2009, the standard premium for SMI services is $96.40 a month; the deductible is $135.00 a year; and the coinsurance is 20%. The Part B premium is influenced by the beneficiary's income and can be substantially higher based on income. The higher premium amounts and relative income levels for those amounts are contained in CR 6258, which is available at **http://www.cms.hhs.gov/Transmittals/downloads/R56GI.pdf** on the CMS web site.

Additional Information

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

Be sure that you have the most updated version of the IVR Guide and IVR Call Flow in your office, both can be found at **http://www.medicarenhic.com/dme/contacts.shtml**

Also remember to have your supplier number and the beneficiary's HIC and DOB ready when you call customer service.

2008 - 2009 Influenza (Flu) Season Resources for Health Care Professionals (SE0838) (GEN)

MLN Matters Number: SE0838
Related CR Release Date: N/A
Related CR Transmittal #: N/A
Related Change Request (CR) #: N/A
Effective Date: N/A
Implementation Date: N/A

Provider Types Affected
All Medicare fee-for-service (FFS) physicians, non-physician practitioners, providers, suppliers, and other health care professionals who bill Medicare for flu vaccines and vaccine administration provided to Medicare beneficiaries

Provider Action Needed

- Keep this Special Edition *MLN Matters* article and refer to it throughout the 2008 - 2009 flu season.
- Take advantage of each office visit as an opportunity to encourage your patients to protect themselves from the flu and serious complications by getting a flu shot.
- Continue to provide the flu shot as long as you have vaccine available, even after the new year.
- Don't forget to immunize yourself and your staff - **Get the Flu Shot - Not the Flu!**

Introduction
Historically the flu vaccine has been an under-utilized benefit by Medicare beneficiaries. Yet, of the nearly 36,000 people who, on average, die every year in the United States from seasonal flu and complications arising from the flu, the majority of deaths occur in persons 65 years of age and older. People with chronic medical conditions such as diabetes and heart disease are considered to be at high risk for serious complications from the flu, as are people in nursing homes and other long-term care facilities. Complications of flu can include bacterial pneumonia, ear infections, sinus infections, dehydration, and worsening of chronic medical conditions, such as congestive heart failure, asthma, or diabetes.

The Centers for Medicare & Medicaid Services (CMS) reminds health care professionals that Medicare Part B reimburses health care providers for flu vaccines and their administration. (*Medicare provides coverage of the flu vaccine without any out-of-pocket costs to the Medicare patient. No deductible or copayment/coinsurance applies.*) All adults 65 and older should get flu and pneumococcal immunizations. People with Medicare who are under 65 but have chronic illness, including heart disease, lung disease, diabetes or end-stage renal disease should get a flu shot.

Prevention is Key to Public Health!

While flu season can begin as early as October and last as late as May the optimal time to get a flu vaccine is in October or November. However, protection can still be obtained if the flu vaccine is given in December or later. The flu vaccine continues to be the most effective method for preventing flu virus infection and its potentially severe complications. You can help your Medicare patients reduce their risk for contracting seasonal flu and serious complications by using every office visit as an opportunity to recommend they take advantage of the annual flu shot benefit covered by Medicare. And don't forget, health care providers and their staff can spread the highly contagious flu virus to their patients. Don't forget to immunize yourself and your staff. **Protect yourself, your patients, your staff, and your family and friends. Get Your Flu Shot - Not the Flu!**

The following educational products have been developed by CMS to be used by Medicare FFS health care professionals and are not intended for distribution to Medicare beneficiaries.

Educational Products for Health Care Professionals
CMS has developed a variety of educational resources to help Medicare FFS health care professionals understanding coverage, coding, billing, and reimbursement guidelines for flu vaccines and their administration.

1. MLN Matters Articles

- **MM6153:** Influenza Vaccine and the Pneumococcal Vaccine Payment Allowances Based on 95 Percent of the Average Wholesale Price (AWP) at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6153.pdf** on the CMS web site.

- **MM6121:** 2008 Reminder for Roster Billing and Centralized Billing for Influenza and Pneumococcal Vaccinations at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6121.pdf** on the CMS web site.

- **MM6079:** Pneumococcal Pneumonia, Influenza Virus, and Hepatitis B Vaccines at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6079.pdf** on the CMS web site.

- **MM5511:** Update to *Medicare Claims Processing Manual*, Chapter 18, Section 10 for Part B Influenza Billing at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5511.pdf** on the CMS web site.

- **MM4240:** Guidelines for Payment of Vaccine (Pneumococcal Pneumonia Virus, Influenza Virus, and Hepatitis B Virus) Administration at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4240.pdf** on the CMS web site.

- **MM5037:** Reporting of Diagnosis Code V06.6 on Influenza Virus and/or Pneumococcal Pneumonia Virus (PPV) Vaccine Claims and Acceptance of Current Procedural Terminology (CPT) Code 90660 for the Reporting of the Influenza Virus Vaccine at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5037.pdf** on the CMS web site.

2. MLN Influenza Related Products for Health Care Professionals

- **Quick Reference Information: Medicare Part B Immunization Billing** - This two-sided laminated chart provides Medicare FFS physicians, providers, suppliers, and other health care professionals with quick information to assist with filing claims for the influenza, pneumococcal, and hepatitis B vaccines and their administration. Available in print and as a downloadable PDF at **http://www.cms.hhs.gov/MLNProducts/downloads/qr_immun_bill.pdf** on the CMS web site.

- **The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals, Second Edition** - This updated comprehensive guide to Medicare-covered preventive services and screenings provides Medicare FFS physicians, providers, suppliers, and other health care professionals information on coverage, coding, billing, and reimbursement guidelines of preventive services and screenings covered by Medicare. The guide includes a chapter on influenza, pneumococcal, and hepatitis B vaccines and their administration. Also includes suggestions for planning a flu clinic and information for mass immunizers and roster billers. Available as a downloadable PDF file at **http://www.cms.hhs.gov/MLNProducts/downloads/mps_guide_web-061305.pdf** on the CMS web site.

- **Medicare Preventive Services Adult Immunizations Brochure** - This two-sided tri-fold brochure provides health care professionals with an overview of Medicare's coverage of influenza, pneumococcal, and hepatitis B vaccines and their administration. Available in print and as a downloadable PDF file at **http://www.cms.hhs.gov/MLNProducts/downloads/Adult_Immunization.pdf** on the CMS web site.

- **Medicare Preventive Services Series: Part 1 Adult Immunizations Web-based Training (WBT) Course** - This WBT course contains four modules that include information about Medicare's coverage of influenza, pneumococcal, and hepatitis B vaccines. Module Four includes lessons on mass immunizers, roster billing, and centralized billing. To register, free of charge, to take this course go to the *MLN* Products web page **http://www.cms.hhs.gov/MLNProducts/** and select "Web-Based Training Modules" from Related Links Inside CMS at the bottom of the web page.

- **Quick Reference Information: Medicare Preventive Services** - This two-sided laminated chart gives Medicare FFS physicians, providers, suppliers, and other health care professionals a quick reference to Medicare's preventive services and screenings, identifying coding requirements, eligibility, frequency parameters, and copayment/coinsurance and deductible information for each benefit. This chart includes influenza, pneumococcal, and hepatitis B vaccines. Available in print or as a downloadable PDF file at **http://www.cms.hhs.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf** on the CMS web site.

- **Medicare Preventive Services Bookmark** - This bookmark lists the preventive services and screenings covered by Medicare (including influenza) and serves as a handy reminder for health care professionals of the many preventive benefits covered by Medicare. Appropriate for use as a give away at conferences and other provider related gatherings. Available in print or as a downloadable PDF file at **http://www.cms.hhs.gov/MLNProducts/downloads/medprevsrvcesbkmrk.pdf** on the CMS web site.

- **MLN Preventive Services Educational Products Web Page** - This *Medicare Learning Network (MLN)* web page provides descriptions of all *MLN* preventive services related educational products and resources designed specifically for use by Medicare FFS health care professionals. PDF files provide product ordering information and links to all downloadable products, including those related to the influenza vaccine and its administration. This web page is updated as new product information becomes available. Bookmark this page (**http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp#TopOfPage**) for easy access.

3. Other CMS Resources

- **CMS Adult Immunizations Web Page** is at **http://www.cms.hhs.gov/AdultImmunizations/** on the CMS web site.
- **CMS Frequently Asked Questions** are available at **http://questions.cms.hhs.gov/cgi-bin/cmshhs.cfg/php/enduser/std_alp.php?p_sid=I3ALEDhi** on the CMS web site.
- ***Medicare Benefit Policy Manual* - Chapter 15, Section 50.4.4.2 - Immunizations** available at **http://www.cms.hhs.gov/manuals/downloads/bp102c15.pdf** on the CMS web site.
- ***Medicare Claims Processing Manual* - Chapter 18, Preventive and Screening Services** available at **http://www.cms.hhs.gov/manuals/downloads/clm104c18.pdf** on the CMS web site.
- **Medicare Part B Drug Average Sales Price Payment Amounts** Influenza and Pneumococcal Vaccines Pricing found at **http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/01_overview.asp** on the CMS web site.

4. Other Resources

The following non-CMS resources are just a few of the many available in which clinicians may find useful information and tools to help increase flu vaccine awareness and utilization during the 2008 - 2009 flu season:

- **Advisory Committee on Immunization Practices** are at **http://www.cdc.gov/vaccines/recs/acip/default.htm** on the Internet.
- **American Lung Association's Influenza (Flu) Center** is at **http://www.lungusa.org** on the Internet. This web site provides a flu clinic locator at **http://www.flucliniclocator.org** on the Internet. Individuals can enter their zip code to find a flu clinic in their area. Providers can also obtain information on how to add their flu clinic to this site.
- **Other sites with helpful information include:**
- **Centers for Disease Control and Prevention** - **http://www.cdc.gov/flu**;
- **Food and Drug Administration** - **http://www.fda.gov/**;
- **Immunization Action Coalition** - **http://www.immunize.org**;
- **Immunization: Supporting a Healthy Life Throughout the Lifespan** - **http://www.nfid.org/pdf/publications/naiaw08.pdf**;
- **Indian Health Services** - **http://www.ihs.gov/**;
- **Medicare Quality Improvement Community** - **http://www.QualityNet.org/MedQIC**;
- **National Alliance for Hispanic Health** - **http://www.hispanichealth.org/**;
- **The National Center for Immunization and Respiratory Diseases (NCIRD)** - **http://www.cdc.gov/ncird/**;
- **National Foundation For Infectious Diseases** - **http://www.nfid.org/influenza**;

- **National Library of Medicine and NIH Medline Plus** - **http://www.nlm.nih.gov/medlineplus/immunization.html**;
- **National Network for Immunization Information** - **http://www.immunizationinfo.org**;
- **National Vaccine Program** - **http://www.hhs.gov/nvpo**;
- **Office of Disease Prevention and Promotion** - **http://odphp.osophs.dhhs.gov**;
- **Partnership for Prevention** - **http://www.prevent.org**; and
- **World Health Organization** - **http://www.who.int/en/** on the Internet.

Beneficiary Information
For information to share with your Medicare patients, please visit **http://www.medicare.gov** on the Internet.

2008 Jurisdiction List for Durable Medical Equipment Prosthetics, Orthotics, and Supply (DMEPOS) Healthcare Common Procedure Coding System (HCPCS) Codes (MM6062) (GEN)

MLN Matters Number: MM6062
Related CR Release Date: September 26, 2008
Related CR Transmittal #: R1605CP

Related Change Request (CR) #: 6062
Effective Date: October 27, 2008
Implementation Date: October 27, 2008

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

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

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

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

2009 Annual Update of Healthcare Common Procedure Coding System (HCPCS) Codes for Skilled Nursing Facility (SNF) Consolidated Billing (CB) for the Common Working File (CWF), Medicare Administrative Contractors (MACs), Medicare Carriers and Fiscal Intermediaries (FIs) (MM6220) (GEN)

MLN Matters Number: MM6220
Related CR Release Date: October 3, 2008
Related CR Transmittal #: R1608CP

Related Change Request (CR) #: 6220
Effective Date: January 1, 2009
Implementation Date: January 5, 2009

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

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

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

What You Need to Do
See the *Background* and *Additional Information* Sections of this article for further details regarding these changes.

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

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

Annual Update of Healthcare Common Procedure Coding System (HCPCS) Codes Used for Home Health Consolidated Billing Enforcement (MM6262) (GEN)

MLN Matters Number: MM6262
Related CR Release Date: November 7, 2008
Related CR Transmittal #: R1633CP

Related Change Request (CR) #: 6262
Effective Date: January 1, 2009
Implementation Date: January 5, 2009

Provider Types Affected
Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, DME Medicare Administrative Contractors (DME MACs), Fiscal Intermediaries (FIs), Part A/B Medicare Administrative Contractors (A/B MACs), and/or Regional Home Health Intermediaries (RHHIs)) for services provided to Medicare beneficiaries during an episode of home health care.

Provider Action Needed
Impact to You
The Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of Healthcare Common Procedure Codes System (HCPCS) codes subject to the consolidated billing provision of the Home Health Prospective Payment System (HH PPS).

What You Need to Know
This article is based on Change Request (CR) 6262 which provides the annual HH consolidated billing update effective January 1, 2009.

What You Need to Do
See the Background and Additional Information Sections of this article for further details regarding these changes.

Background
The Social Security Act (Section 1842(b)(6); see **http://www.ssa.gov/OP_Home/ssact/title18/1842.htm** on the Internet) requires that payment for home health services provided under a home health plan of care is made to the home health agency (HHA). This requirement is found in Medicare regulations at 42 CFR 409.100 (see **http://edocket.access.gpo.gov/cfr_2005/octqtr/42cfr409.100.htm** on the Internet and in the *Medicare Claims Processing Manual* (Chapter 10, Section 20.1), available at **http://www.cms.hhs.gov/manuals/IOM/list.asp** on the CMS web site.

The home health consolidated billing code lists are updated annually, to reflect the annual changes to the HCPCS code set itself. Additional updates may occur as frequently as quarterly in order to reflect the creation of temporary HCPCS codes (i.e., 'K' codes) throughout the calendar year.

The following HCPCS code is <u>added</u> to the home health consolidated billing supply code list, and it is a new code that does not replace any prior HCPCS code on the list:

Added HCPCS Code	Descriptor
A6545	Gradient compression wrap, non-elastic, below knee, 30-50 mmHg, each.

The following HCPCS code is <u>deleted</u> from the home health consolidated billing supply code list, and this code is being removed because it is non-covered by Medicare statute.

Deleted HCPCS Code	Descriptor
A6413	Adhesive Bandage, First-Aid Type, any size, each

Additional Information
The official instruction, CR 6262, issued to your carrier, FI, A/B MAC, RHHI, and DME MAC regarding this change may be viewed at **http://www.cms.hhs.gov/Transmittals/downloads/R1633CP.pdf** on the CMS web site.

If you have any questions, please contact your carrier, FI, A/B MAC, RHHI, 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.

Changes in Medicare Payment for Oxygen and Oxygen Equipment (SE0840) (OXY)

MLN Matters Number: SE0840
Related CR Release Date: N/A
Related CR Transmittal #: N/A
Related Change Request (CR) #: N/A
Effective Date: N/A
Implementation Date: N/A

Provider Types Affected
Providers and suppliers submitting claims to Durable Medical Equipment Medicare Administrative Contractors (DME MACs) and/or Regional Home Health Intermediaries (RHHIs)) for oxygen and oxygen equipment provided to Medicare beneficiaries.

Provider Action Needed
This article alerts suppliers and providers that the Centers for Medicare & Medicaid Services (CMS) is implementing new oxygen payment rules and supplier responsibilities as a result of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) in the Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2009 as displayed in the Federal Register on October 30, 2008. These changes are effective for services provided on or after January 1, 2009. Be sure billing staff are aware of these changes.

Background
CMS is making these changes to comply with the new MIPPA requirements for oxygen and oxygen equipment while safeguarding beneficiaries who rely on life sustaining oxygen services. This Special Edition article supplements the information provided in *MLN Matters* 6296 and 6297 (or MM6296 and MM6297) which, when issued, outline instructions regarding repair, maintenance and servicing of oxygen equipment, and other changes resulting from implementation of section 144(b) of MIPPA. Once issued, MM6296 may be reviewed at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6296.pdf** on the CMS web site. Once issued, MM6297 may be reviewed at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6297.pdf** on the CMS web site.

Key Points
Payment and Billing Issues

- Oxygen and oxygen equipment are paid on a fee schedule basis. The beneficiary pays coinsurance and deductibles.
- The oxygen rental payment covers the equipment, contents, maintenance, and supplies and accessories such as tubing or a mouthpiece, and other services necessary for furnishing oxygen and oxygen equipment.
- The Deficit Reduction Act of 2005 (DRA) limited monthly payments for oxygen and oxygen equipment to 36 months of continuous use after which the equipment title transferred to the beneficiary. Section 144(b) of the **MIPPA repeals the transfer of ownership provision and permits suppliers to retain ownership of the oxygen equipment following the 36-month rental cap**.
- Section 414.226(g)(1) of CMS regulations requires the supplier who furnished the oxygen equipment in the first month to continue furnishing the oxygen equipment for the entire 36 month period with certain exceptions such as when the beneficiary relocates outside the service area, when the beneficiary elects to obtain oxygen equipment from another supplier, or in certain cases granted by the carrier/DME MAC or CMS such as emergency situations.
- Section 414.226(g)(2) of the regulations prevent suppliers from switching oxygen equipment modalities during the 36 month period (e.g., from liquid oxygen to a concentrator). There are special exceptions to this rule in the event the physician orders different equipment based on medical necessity or where the beneficiary chooses newer technology and signs an Advance Beneficiary Notice (ABN) acknowledging potential financial liability for the newer technology.
- Section 414.226(g)(1) also requires the supplier to disclose its intentions for accepting assignment of claims during the 36 month rental period.

- **Be aware that after the 36 month cap the following requirements apply:**

  - The supplier is required to continue furnishing the equipment, supplies and accessories for any period of medical need for the remainder of the reasonable useful lifetime of the equipment. This requirement includes use of equipment following temporary breaks of in-home oxygen services (e.g., due to a hospital or other facility stay) of any duration after the 36-month rental cap.

  - The supplier who furnished the liquid or gaseous oxygen equipment during the 36-month rental period is responsible for furnishing the oxygen contents used with the supplier-owned oxygen equipment for any period of medical need following the 36-month rental cap for the remainder of the reasonable useful lifetime of the equipment. Medicare will pay for oxygen contents for any gaseous or liquid oxygen equipment. Suppliers should continue to use HCPCS codes **E0441** through **E0444** in order to bill and receive payment for furnishing oxygen contents. Medicare can pay for a general maintenance-and-servicing visit for concentrators or transfilling equipment in 2009, which must take place 6 months after the end of the 36-month rental period.

  - Other than this general maintenance and servicing payment, payment is not allowable for any repair or maintenance and servicing of supplier-owned oxygen equipment, including any replacement part furnished as part of any repair or maintenance and servicing of oxygen equipment.

  - The supplier is responsible for furnishing all of the same items **and** services after the 36-month rental period as they furnished during the 36-month rental period. With the exception of oxygen contents and the general maintenance and servicing visit in 2009, the supplier must furnish these items and services without charging Medicare or the beneficiary.

  - Payment is not allowable for supplier pickup or disposal of oxygen tanks or cylinders that are no longer needed.

Beneficiary Relocation Issues

- If the beneficiary relocates before the end of the 36-month rental period, he/she should work with his or her supplier to make arrangements to continue receiving oxygen and oxygen equipment from a new supplier at his or her new place of residence.

- If the beneficiary relocates after the 36-month rental period, the supplier is required to continue furnishing oxygen and oxygen equipment, and therefore, must make arrangements for the beneficiary to continue receiving oxygen services at his or her new place of residence.

Take Note: *Suppliers that are found to be out of compliance with existing regulations and these new requirements are subject to significant administrative remedies, including removal of billing privileges.*

Beneficiary Issues of Importance to Providers

- Beneficiaries are entitled to change suppliers at any time during their period of medical need. **A word of caution, finding new suppliers after the 36 month cap may be difficult because the new supplier would receive no monthly payments except for maybe the maintenance and servicing visit.**

- If beneficiaries choose to purchase their own oxygen equipment instead of renting, they need to understand that **Medicare does not pay a lump-sum purchase for oxygen equipment.** Medicare pays on a rental basis up to a 36-month rental period.

Additional Information
If you have questions, please contact your Medicare DME MAC or RHHI at their toll-free number which may be found at **http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip** on the CMS web site.

Questions and answers regarding changes in payment for oxygen and oxygen equipment are posted at **http://questions.medicare.gov/cgi-bin/medicare.cfg/php/enduser/std_alp.php?p_sid=AUyrW7ij&p_lva=&p_li=&p_accessibility=0&p_redirect=&p_page=1&p_cv=1.33&p_pv=&p_prods=&p_cats=33&p_hidden_prods=&cat_lvl1=33** on the Internet.

Compendia as Authoritative Sources for Use in the Determination of a "Medically Accepted Indication" of Drugs and Biologicals Used Off-Label in an Anti-Cancer Chemotherapeutic Regimen (MM6191) (DRU)

MLN Matters Number: MM6191
Related CR Release Date: October 24, 2008
Related CR Transmittal #: R96BP
Related Change Request (CR) #: 6191
Effective Date: June 5, June 10, and July 2, 2008 (see below)
Implementation Date: November 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 Part A/B Medicare Administrative Contractors (A/B MACs)) for services provided to Medicare beneficiaries.

Provider Action Needed
Impact to You
This article is based on Change Request (CR) 6191 which updates the list of compendia recognized as authoritative sources of information for the determination of drugs and biologicals used off-label in anti-cancer chemotherapeutic regimens.

What You Need to Know
The Centers for Medicare & Medicaid Services (CMS) is recognizing the following as authoritative compendia and listing them in the *Medicare Benefit Policy Manual* (Chapter 15,Section 50.4.5) for use in the determination of a "medically-accepted indication" of drugs and biologicals used off-label in an anti-cancer chemotherapeutic regimen:

- American Hospital Formulary Service-Drug Information (AHFS-DI), (existing)
- National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium, (effective June 5, 2008)
- Thomson Micromedex DrugDex, (effective June 10, 2008) and
- Clinical Pharmacology (effective July 2, 2008).

What You Need to Do
See the *Background* and *Additional Information* Sections of this article for further details regarding these changes.

Background
In the past, the following three compendia were recognized as authoritative sources for use in the determination of a "medically-accepted indication" of drugs and biologicals used off-label in an anti-cancer chemotherapeutic regimen (unless the Secretary of the Department of Health and Human Services determined that the use was not medically appropriate or the use was identified as not indicated in one or more such compendia):

1. American Medical Association Drug Evaluations (AMA-DE),
2. United States Pharmacopoeia-Drug Information (USP-DI) or its successor publication, and
3. American Hospital Formulary Service-Drug Information (AHFS-DI).

Because the AMA-DE and the USP-DI are no longer published (due to changes in the pharmaceutical reference industry), the AHFS-DI became the only remaining statutorily-named compendia available for the CMS to use as a reference. Consequently, CMS received requests from the stakeholder community for a process to revise the list of recognized authoritative compendia.

In the Medicare Physician Fee Schedule final rule for calendar year 2008, CMS established:

- A process for revising the list of compendia. (Section 1861(t)(2) of the Social Security Act; [**http://www.ssa.gov/OP_Home/ssact/title18/1861.htm**], and
- A definition for "compendium." (72 FR 66222 [**http://edocket.access.gpo.gov/2007/07-5506.htm**], 72 FR 66303-66306 [**http://www.cms.hhs.gov/CoverageGenInfo/Downloads/compendiapreamble.pdf**], and 72 FR 66404 [**http://www.cms.hhs.gov/CoverageGenInfo/Downloads/compendiareg.pdf**].

A compendium is defined "as a comprehensive listing of FDA-approved drugs and biologicals or a comprehensive listing of a specific subset of drugs and biologicals in a specialty compendium, for example, a compendium of anti-cancer treatment." (42 CFR 414.930(a) [**http://edocket.access.gpo.gov/2007/pdf/07-3274.pdf**].

In addition, a compendium:

(1) Includes a summary of the pharmacologic characteristics of each drug or biological and may include information on dosage, as well as recommended or endorsed uses in specific diseases; and,

(2) Is indexed by drug or biological. (42 CFR 414.930(a) [**http://edocket.access.gpo.gov/2007/pdf/07-3274.pdf**], 72 FR 66222 [**http://edocket.access.gpo.gov/2007/07-5506.htm**], and 72 FR 66404 [**http://www.cms.hhs.gov/CoverageGenInfo/Downloads/compendiareg.pdf**].

During a public meeting on March 30, 2006, the Medicare Evidence Development and Coverage Advisory Committee (MedCAC) generated a list of desirable characteristics to use when reviewing a compendium. Subsequently, the MedCAC advised CMS of their findings and recommendations regarding the desirable characteristics of compendia for use in the determination of medically-accepted indications of drugs and biologicals in anti-cancer therapy.

After CMS conducted a review of specific compendia and compared their characteristics with the MedCAC list of desirable characteristics, CMS determined the following are recognized as authoritative compendia and is listing them in the *Medicare Benefit Policy Manual* (Chapter 15,Section 50.4.5) for use in the determination of a "medically-accepted indication" of drugs and biologicals used off-label in an anti-cancer chemotherapeutic regimen:

- American Hospital Formulary Service - Drug Information (AHFS-DI),
- National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium,
- Thomson Micromedex DrugDex, and
- Clinical Pharmacology.

The above listed compendia employ various rating and recommendation systems that may not be readily cross-walked from compendium to compendium. In general, a use is identified by a compendium as **medically accepted** if the:

- Indication is a Category 1 or 2A in NCCN, or Class I, Class IIa, or Class IIb in DrugDex; or,
- Narrative text in AHFS-DI or Clinical Pharmacology is supportive.

A use is **not medically accepted** by a compendium if the:

- Indication is a Category 3 in NCCN or a Class III in DrugDex; or,
- Narrative text in AHFS or Clinical Pharmacology is "not supportive."

The complete absence of narrative text on a use is considered neither supportive nor non-supportive.

Medicare contractors may also identify off-label uses that are supported by clinical research under the conditions identified in Section 50.4.5 of the *Medicare Benefits Policy Manual*, as amended by CR6191. Peer-reviewed medical literature may appear in scientific, medical, and pharmaceutical publications in which original manuscripts are published, only after having been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.

In-house publications of entities whose business relates to the manufacture, sale, or distribution of pharmaceutical products are excluded from consideration. Abstracts (including meeting abstracts) are excluded from consideration.

In determining whether an off-label use is supported, Medicare contractors will evaluate the evidence in published, peer-reviewed medical literature listed in the revised Section 50.4.5.C, which is attached to CR6191. When evaluating this literature, Medicare contractors will consider (among other things) the following:

- Whether the clinical characteristics of the beneficiary and the cancer are adequately represented in the published evidence.
- Whether the administered chemotherapy regimen is adequately represented in the published evidence.
- Whether the reported study outcomes represent clinically meaningful outcomes experienced by patients.
- Whether the study is appropriate to address the clinical question.

Additional Information

The official instruction, CR 6191, 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/R96BP.pdf** on the CMS web site. The revised sections of the *Medicare Benefit Policy Manual* are attached to CR 6191.

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.

Continuous Positive Airway Pressure (CPAP) Therapy for Obstructive Sleep Apnea (OSA) (MM6048) (SPE)

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

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

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

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

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

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

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

Key Points of CR6048

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

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

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

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

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

   As previously stated, the AHI is equal to the average number of episodes of apnea and hypopnea per hour of sleep. The RDI is equal to the average number of respiratory disturbances per hour of continuous monitoring. However, there is variability in the published medical literature about the definition of the events that constitute a respiratory disturbance. The technology assessment that supported this NCD recognized this variability and defined RDI in the context of the specific sleep test technology under review. For the purposes of this NCD, a respiratory disturbance is defined in the context of the sleep test technology of interest and does not require direct measurement of airflow. Local contractors will, as needed, determine, based on their review of the published, peer-reviewed medical literature, the equivalent test result criteria corresponding to the required AHI or RDI for Type IV devices measuring 3 or more channels that do not measure AHI or RDI directly.

4. The AHI or RDI is calculated on the average number of events of per hour. If the AHI or RDI is calculated based on less than 2 hours of continuous recorded sleep, the total number of recorded events to calculate the AHI or RDI during sleep testing is at least the number of events that would have been required in a 2-hour period.

5. CMS is deleting the distinct requirements that an individual have moderate to severe OSA and that surgery is a likely alternative.

6. CPAP based on clinical diagnosis alone or using a diagnostic procedure other than PSG or Type II, Type III, or a Type IV HST measuring at least 3 channels is covered only when provided in the context of a clinical study and when that study meets the standards outlined in the *NCD manual* revision attached to CR6048. Medicare will process claims according to Coverage with Evidence Development (CED)/clinical trials criteria at Section 310.1 of the *NCD Manual* and Chapter 32 and Sections 69.6-69.7 (Pub 100-04) of the *Medicare Claims Processing Manual*. These manuals are available at **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/R96NCD.pdf** on the CMS web site.

If you have questions, please contact your Medicare A/B MAC, FI, carrier, 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.

Delay of the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program (MM6203) (GEN)

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

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

Provider Action Needed
This article is based on Change Request (CR) 6203, which implements instructions related to **delaying the DMEPOS Competitive Bidding Program, reprocessing DMEPOS Competitive Bidding claims under regular fee-for-service (FFS) rules**, and educating suppliers about the delay. Make certain your billing staffs are aware of these changes.

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

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

- Your Medicare Contractors have begun to process all new incoming DMEPOS claims under standard FFS rules.
- Your Medicare Contractors will process all previously-held DMEPOS Competitive Bidding Program claims under standard FFS rules and they should have completed such processing as soon as possible.
- Your Medicare Contractors will automatically reprocess claims that were denied based solely on DMEPOS Competitive Bidding Program rules under standard FFS rules and complete such reprocessing by September 30, 2008.
- Your Medicare Contractors should identify and automatically reprocess under standard FFS rules any claim adjudicated under DMEPOS Competitive Bidding Program rules and pay any difference that may be owed on such claims to affected suppliers and complete these activities by September 30, 2008.
- Your Medicare Contractors should adjust any claims they are unable to automatically reprocess if you bring such claims to their attention.
- Home health agencies (HHA) should be aware that any claims returned to the provider as subject to DMEPOS Competitive Bidding may be resubmitted.

- Your Medicare Contractors will not initiate any redeterminations on claims where the application of one or more DMEPOS Competitive Bidding rule is the only issue in controversy. Rather than issuing redeterminations your contractors will reprocess such claims and issue substitute initial determinations with full appeal rights.
- Providers should ignore the instructions contained in Chapter 36 of the *Medicare Claims Processing Manual*, as communicated via CRs 5978, 6007 and 6119, until further notice from CMS.

Additional Information
If you have questions, please contact your Medicare DME MAC or RHHI at their toll-free number which may be found at **http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip** on the CMS web site.

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

Durable Medical Equipment, Prosthetics, Orthotics And Supplies (DMEPOS) Accreditation Fact Sheet (GEN)

Overview
The Centers for Medicare & Medicaid Services (CMS) issued guidance regarding Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) furnished by certain health care professionals and persons. The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) required all DMEPOS suppliers to meet quality standards for Medicare accreditation by September 30, 2009. In addition, MIPPA stated that certain professionals and persons do not have to meet this deadline unless quality standards are developed specific to these professionals and persons.

Background Information
Section 302 of the Medicare Modernization Act of 2003 (MMA) added a new paragraph 1834(a)(20) to the Social Security Act (the Act). This paragraph required the Secretary to establish and implement quality standards for suppliers of DMEPOS. All suppliers that furnish such items or services set out at subparagraph 1834(a)(20)(D) as the Secretary determines appropriate must comply with the quality standards in order to receive Medicare Part B payments and to retain a supplier billing number. Pursuant to subparagraph 1834(a)(20)(D) of the Act, the covered items and services are defined in section 1834 (a) (13), section 1834 (h) (4) and section 1842 (s) (2) of the Act. The covered items include:

- DME
- Medical supplies;
- Home dialysis supplies and equipment;
- Therapeutic shoes;
- Parenteral and enteral nutrient, equipment and supplies;
- Transfusion medicine; and
- Prosthetic devices, prosthetics, and orthotics.

The quality standards are published on the CMS web site at: **http://www.cms.hhs.gov/medicareprovidersupenroll**

Guidance on the Medicare Improvements for Patients and Providers Act of 2008
The MIPPA, section 154(b), added a new subparagraph (F). This subparagraph states that eligible professionals and other persons (defined below) are exempt from meeting the ***September 30, 2009*** accreditation deadline unless CMS determines that the quality standards are specifically designed to apply to such professionals and persons. CMS will work in collaboration with the medical and professional groups to develop specific quality standards. Those providers that were accredited prior to the enactment of MIPPA will not have to undergo a re-accreditation process.

The eligible professionals (as defined in section 1848(k)(3)(B)) include the following practitioners:

- Physicians (as defined in section 1861(r) of the Act),
- Physical Therapists,
- Occupational Therapists,
- Qualified Speech-Language Pathologists,

- Physician Assistants,
- Nurse Practitioners,
- Clinical Nurse Specialists,
- Certified Registered Nurse Anesthetists,
- Certified Nurse-Midwives,
- Clinical Social Workers,
- Clinical Psychologists,
- Registered Dietitians, and
- Nutritional professionals.

Additionally, section 154(b) of MIPPA allows the Secretary to specify "other persons" that are exempt from meeting the accreditation deadline unless CMS determines that the quality standards are specifically designed to apply to such other persons. At this time, "such other persons" are only defined as the following practitioners:

- Orthotists,
- Prosthetists,
- Opticians, and
- Audiologists.

MIPPA also states that CMS may exempt such professionals and persons from the quality standards based on their licensing, accreditation or other mandatory quality requirements that may apply. At the present, CMS is not exercising their statutory authority to exempt suppliers based on their licensing, accreditation or other mandatory quality requirements.

Accreditation Deadlines for DMEPOS Suppliers

Existing DMEPOS suppliers, with the exception of those eligible professionals and other persons mentioned above, that are enrolled in the Medicare program are required to obtain and submit proof of accreditation to the National Supplier Clearinghouse (NSC) by ***September 30, 2009***. The NSC will revoke a DMEPOS supplier's billing privileges on ***October 1, 2009***.

The accreditation process may take up to 9 months to complete for an enrolled DMEPOS supplier that submits a complete application to the Accreditation Organizations (AOs) and has no deficiencies to correct post onsite-survey. Therefore, all enrolled DMEPOS suppliers, except those eligible professionals and other persons mentioned above, will need to submit a complete accreditation application to the accreditation organizations (AOs) by ***January 31, 2009***. This is to ensure that the DMEPOS supplier will receive an accreditation decision (provided that they meet the all the accreditation requirements) by ***September 30, 2009***.

If an enrolled DMEPOS supplier does not submit a complete accreditation application to the AOs by ***January 31, 2009***, CMS cannot ensure that the AOs will be able to accredit them by the ***September 30, 2009*** deadline.

Since March 1, 2008, new DMEPOS suppliers submitting an enrollment application to the NSC (excepting those eligible professionals and other persons mentioned above) must be accredited prior to submitting the application. The NSC will not approve any DMEPOS supplier's enrollment application if the enrollment package does not contain an approved accreditation upon receipt or in response to a developmental request. The NSC shall reject the enrollment application unless the DMEPOS supplier provides supporting documentation that demonstrates that the supplier has an approved accreditation.

Fee Schedule Update for 2009 for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) (MM6270) (GEN)

MLN Matters Number: MM6270 - Revised
Related CR Release Date: November 7, 2008
Related CR Transmittal #: R1630CP

Related Change Request (CR) #: 6270
Effective Date: January 1, 2009
Implementation Date: January 5, 2009

Note: *This article was revised on December 3, 2008 to clarify language in the second paragraph of page 5. The revised language more completely explains the rationale for the revised 2009 monthly national payment rate for stationary oxygen equipment. All other information remains the same.*

Provider Types Affected
Providers and suppliers submitting claims to Medicare contractors (carriers, DME Medicare Administrative Contractors (DME MACs), Fiscal Intermediaries (FIs), Part A/B Medicare Administrative Contractors (A/B MACs), and/or Regional Home Health Intermediaries (RHHIs)) for DMEPOS provided to Medicare beneficiaries.

Provider Action Needed
This article is based on Change Request (CR) 6270 and alerts providers that the Centers for Medicare & Medicaid Services (CMS) has issued instructions for implementing and/or updating the DMEPOS fee schedule payment amounts on a semiannual basis (January and July), with quarterly updates as necessary (April and October). Be sure your billing staffs are aware of these changes.

Background
The update process for the DMEPOS fee schedule is contained in section 60, Chapter 23 of the *Medicare Claims Processing Manual*, which is located at **http://www.cms.hhs.gov/manuals/downloads/clm104c23.pdf** on the CMS web site. Other information on the fee schedule, including access to the DMEPOS fee schedules is at **http://www.cms.hhs.gov/DMEPOSFeeSched/01_overview.asp** on the CMS web site. The key points of CR6270 are as follows:

- The following codes are being deleted from the Healthcare Common Procedure Coding System (HCPCS) effective January 1, 2009, and are therefore being removed from the DMEPOS fee schedule files:

L5993	L5994	L5995	L7611	L7612	L7613
L7614	L7621	L7622			

- For gap-filling purposes, the 2008 deflation factors by payment category are:

0.500 for Oxygen	0.504 for Capped Rental	0.505 for Prosthetics and Orthotics	0.641 for Surgical Dressings	0.697 for Parental and Enteral Nutrition

- The fee schedule amounts for HCPCS code **K0672** (Addition to Lower Extremity Orthosis, Removable Soft Interface, All Components, Replacement Only, Each) are added to the fee schedule file on January 1, 2009, and are effective for claims submitted with dates of service on or after January 1, 2009.

- HCPCS code E2295 (Manual wheelchair accessory, for pediatric size wheelchair, dynamic seating frame, allows coordinated movement of multiple positioning features) is added to the HCPCS file on January 1, 2009. Due to low claims volumes expected, your Medicare contractor will establish local fee schedule amounts to pay claims for E2295.

- Fee schedule amounts for L3905, L3806, and L3808 were revised in the July 2008 Quarterly Update. However, CMS has determined that the gap-filled fees originally established for these three codes were correct and the fee amounts will revert back to what was in place prior to the July update. Claims already processed for dates of service on or after July 1, 2008, through December 31, 2008 will not be adjusted.

2009 Fee Schedule Updates following the Enactment of the Medicare Improvements for Patients and Providers Act (MIPPA)

- MIPPA of 2008 mandates a fee schedule covered item **update of -9.5% for 2009 for items included in round 1 of the DMEPOS Competitive Bidding Program**. The reduction applies to items furnished on or after January 1, 2009, in any geographical area.

- Items selected for competitive bidding in 2008 will receive a **-9.5%** update for 2009 with the **exception of HCPCS codes E1392, K0738, E0441, E0442, E0443 and E0444**. These 6 oxygen generating portable equipment (OGPE) and oxygen contents codes will receive a 0% update for 2009 as the fees for these items are not adjusted by the covered item update specified in 1834(a)(14), and are not reduced by the -9.5%, even though they are competitive bid items.

- Non-competitive bid items will receive a 5.0% covered item update for 2009.

New KE Modifier and the KL Modifier

A new HCPCS modifier was added to the HCPCS on January 1, 2009, and is effective for claims with dates of service on or after January 1, 2009. The new modifier is KE (Bid Under Round One of the DMEPOS Competitive Bidding Program for use with Non-Competitive Bid Base Equipment).

To accommodate the fee schedule updates required per the MIPPA, CMS is adding the KE modifier to the fee schedule for all power mobility device (PMD) accessory items selected for competitive bidding in 2008 as part of this update. The KE modifier is a pricing modifier that suppliers must use to identify when the same accessory HCPCS code can be furnished in multiple competitive and non-competitive bidding product categories. For example, HCPCS code E0981 Wheelchair Accessory, Seat Upholstery, Replacement Only, Each can be used with both competitively bid standard and complex rehabilitative power wheelchairs (K0813 thru K0829 and K0835 thru K0864), as well as with non-competitively bid manual wheelchairs (K0001 thru K0009) or a miscellaneous power wheelchair (K0898).

All fee schedules for PMD accessory codes with the KE modifier will receive a 5% covered item update for 2009, whereas the fee schedules for the PMD accessory codes without the KE modifier will receive the MIPPA-required 9.5% reduction for 2009. Suppliers need to know that if a competitively bid PMD accessory code is used with a competitively bid standard PMD base code (K0813 thru K0829) or complex rehabilitative PMD base code (K0835 thru K0864), claims for the PMD accessory code should be submitted without the KE modifier. If such claims are submitted with the KE modifier, they will be rejected with message M78 (Missing/incomplete/invalid HCPCS modifier) and 125 (Submission/billing error (s)).

Suppliers should bill the accessory code with the KE modifier when the accessory is used in conjunction with a non-competitively bid manual wheelchair (K0001 through K0009) or a miscellaneous PMD (K0898). In the case of the complex rehabilitative only PMD accessory code E2373 KC, suppliers should bill for the replacement only of E2373 without the KE modifier, but with the KC modifier when the accessory is used with a competitively bid complex rehabilitative PMD base code (K0835 thru K0864). When the replacement only code E2373 is used with a non-competitively bid manual or miscellaneous wheelchair, suppliers should bill code E2373 without the KC modifier, but with the KE modifier.

For the aforementioned reasons, CMS is also adding the KE modifier to the fee schedule for the following competitively bid HCPCS codes: A4636, A4637, A7000, and E0776. If codes A4636 and A4637 are used in conjunction with a competitively bid walker code (E0130, E0135, E0140, E0141, E0143, E0144, E0147, E0148, and E0149), claims for the replacement handgrip (A4636) or tip (A4637) should be submitted without the KE modifier. Suppliers should bill codes A4636 and A4637 with the KE modifier when the codes are used with non-competitively bid cane or crutch codes. Likewise, suppliers should bill the disposable canister code A7000 without the KE modifier when this code is used in conjunction with the competitively bid negative pressure wound therapy pump code E2402. When code A7000 is used with a non-competitively bid respiratory or gastric suction pump, suppliers should bill code A7000 with the KE modifier. Similarly when an IV pole (E0776) is used in conjunction with competitively bid enteral nutrient codes (B4149, B4150, and B4152 thru B4155), suppliers should bill code E0776 with the BA modifier, but without the KE modifier. When code E0776 is used with non-competitively bid parenteral nutrient codes, suppliers should bill code E0776 without the BA modifier, but with the KE modifier.

Further instruction on the use of the KE modifier with codes competitively bid in 2008 is available in Attachment B of CR 6270, which is available at **http://www.cms.hhs.gov/Transmittals/downloads/R1630CP.pdf** on the CMS web site.

Note: *Suppliers should not use the KE modifier on any claims for payment for items that were included under Round 1 such as an accessory for a standard power wheelchair.*

With CR 6270, CMS is also adding the KL modifier to the fee schedule for the following diabetic supply HCPCS codes: A4233, A4234, A4235, A4236, A4253, A4256, A4258, and A4259. As indicated in CR 5641 (July Quarterly Update for 2007 DMEPOS Fee Schedule, discussed in *MLN Matters* article MM5641 at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5641.pdf**), suppliers began using the KL modifier as an informational modifier to identify diabetic supplies (HCPCS codes A4233-A4236, A4253, A4256, A4258 and A4259) furnished via mail order on or after July 1, 2007. Effective January 1, 2009, the KL modifier has been changed from an informational modifier to a pricing modifier in the HCPCS file. Suppliers must use the KL modifier on all claims for the aforementioned diabetic supply codes that are furnished via mail order to beneficiaries. The KL modifier is not used with diabetic supply codes that are not delivered to the beneficiary's residence and are obtained from local supplier storefronts.

Note: *Inappropriate use of a competitive bidding modifier on a competitive bidding claim is in violation of the law and may lead to claims denial and/or other corrective actions. The use of a competitive bidding modifier does not supersede existing Medicare modifier use requirements for a particular code, but rather should be used in addition, as required.*

Competitive Bidding Items from 2008 Impacted by 2009 Pricing

The following product lists of the HCPCS codes that were selected for competitive bidding in 2008 are subject to the - 9.5% covered item update for 2009. The detailed descriptions of the listed HCPCS codes (for product categories 1-10) are not repeated in this article, but are available in ***Attachment A*** of CR 6270, which is available at **http://www.cms.hhs.gov/Transmittals/downloads/R1630CP.pdf** on the CMS web site.

Product Category 1 - Oxygen, Supplies and Equipment (for the detailed product description of each HCPCS code see ***Attachment A***)

E1390	E1391	E0424	E0439	E0431
E0434	A4608	A4615	A4616	A4617
A4620	E0560	E0580	E1353	E1355

As part of this update, CMS is implementing the 2009 national monthly payment rates for stationary oxygen equipment (HCPCS codes E0424, E0439, E1390 and E1391), effective for claims with dates of service on or after January 1, 2009. CMS is revising the fee schedule file to include the new national 2009 monthly payment rate of $175.79 for stationary oxygen equipment. This revised 2009 monthly payment rate of $175.79 is reduced by 11.8% from the 2008 monthly payment rate. This reduction includes the 9.5% covered item reduction ascribed to items selected for competitive bidding in 2008 as required by section 154(a)(2)(A) of MIPPA and the 2.53% budget neutrality reduction as required by section 1834(a)(9)(D)(ii) of the Social Security Act and discussed in a final rule published in the Federal Register on November 9, 2006. The previously announced payment amount for 2009 of $193.21 did not include the 9.5% reduction and assumed a higher shift to oxygen generating portable equipment (OGPE).

As a result of the above adjustments, CMS is also revising the fee schedule amounts for HCPCS codes E1405 and E1406 as part of this update. Since 1989, the fees for codes E1405 and E1406 have been established based on a combination of the Medicare payment amounts for stationary oxygen equipment and nebulizer codes E0585 and E0570, respectively.

Product Category 2 - Standard Power Wheelchairs, Scooters, and Related Accessories (for the detailed product description of each HCPCS code see ***Attachment A***)

E0950	E0951	E0952	E0955	E0956	E0957	E0960	E0973
E0978	E0981	E0982	E0990	E0995	E1016	E1020	E1028
E2208	E2209	E2210	E2361	E2363	E2365	E2366	E2367
E2368	E2369	E2370	E2371	E2381	E2382	E2383	E2384
E2385	E2386	E2387	E2388	E2389	E2390	E2391	E2392
E2394	E2395	E2396	E2601	E2602	E2603	E2604	E2605
E2606	E2607	E2608	E2611	E2612	E2613	E2614	E2615
E2616	E2619	E2620	E2621	K0015	K0017	K0018	K0019
K0020	K0037	K0038	K0039	K0040	K0041	K0042	K0043
K0044	K0045	K0046	K0047	K0050	K0051	K0052	K0053
K0098	K0195	K0733	K0734	K0735	K0736	K0737	K0800
K0801	K0802	K0806	K0807	K0808	K0813	K0814	K0815
K0816	K0820	K0821	K0822	K0823	K0824	K0825	K0826
K0827	K0828	K0829					

Product Category 3 - Complex Rehabilitative Power Wheelchairs and Related Accessories (for the detailed product description of each HCPCS code see ***Attachment A***)

E0950	E0951	E0952	E0955	E0956	E0957	E0960	E0973
E0978	E0981	E0982	E0990	E0995	E1002	E1003	E1004
E1005	E1006	E1007	E1008	E1010	E1016	E1020	E1028
E1029	E1030	E2208	E2209	E2210	E2310	E2311	E2321
E2322	E2323	E2324	E2325	E2326	E2327	E2328	E2329
E2330	E2351	E2361	E2363	E2365	E2366	E2367	E2368
E2369	E2370	E2371	E2373 KC	E2374	E2375	E2376	E2377
E2381	E2382	E2383	E2384	E2385	E2386	E2387	E2388
E2389	E2390	E2391	E2392	E2394	E2395	E2396	E2601
E2602	E2603	E2604	E2605	E2606	E2607	E2608	E2611
E2612	E2613	E2614	E2615	E2616	E2619	E2620	E2621
K0015	K0017	K0018	K0019	K0020	K0037	K0038	K0039
K0040	K0041	K0042	K0043	K0044	K0045	K0046	K0047
K0050	K0051	K0052	K0053	K0098	K0195	K0733	K0734
K0735	K0736	K0737	K0835	K0836	K0837	K0838	K0839
K0840	K0841	K0842	K0843	K0848	K0849	K0850	
K0851	K0852	K0853	K0854	K0855	K0856	K0857	K0858
K0859	K0860	K0861	K0862	K0863	K0864		

Product Category 4 - Mail-Order Diabetic Supplies (for the detailed product description of each HCPCS code see ***Attachment A***)

A4233 KL	A4234 KL	A4235 KL	A4236 KL	A4253 KL	A4256 KL	A4258 KL	A4259 KL

Product Category 5 - Enteral Nutrients, Equipment, and Supplies (for the detailed product description of each HCPCS code see ***Attachment A***)

B4034	B4035	B4036	B4081	B4082	B4083	B4087	B4088
B4149	B4150	B4152	B4153	B4154	B4155	B9000	B9002
E0776							

Product Category 6 - Continuous Positive Airway Pressure Devices, Respiratory Assist Devices, and Related Supplies and Accessories (for the detailed product description of each HCPCS code see ***Attachment A***)

A4604	A7030	A7031	A7032	A7033	A7034	A7035	A7036
A7037	A7038	A7039	A7044	A7045	A7046	E0470	E0471
E0472	E0561	E0562	E0601				

Product Category 7 - Hospital Beds and Related Supplies (for the detailed product description of each HCPCS code see ***Attachment A***)

E0250	E0251	E0255	E0256	E0260	E0261	E0265	E0266
E0271	E0272	E0280	E0290	E0291	E0292	E0293	E0294
E0295	E0296	E0297	E0300	E0301	E0302	E0303	E0304

E0305	E0310	E0316	E0910	E0911	E0912	E0940	

Product Category 8 - Negative Pressure Wound Therapy Pumps and Related Supplies and Accessories (for the detailed product description of each HCPCS code see ***Attachment A***)

A6550	A7000	E2402

Product Category 9 - Walkers and Related Supplies (for the detailed product description of each HCPCS code see ***Attachment A***)

A4636	A4637	E0130	E0135	E0140	E0141	E0143	E0144	E0147
E0148	E0149	E0154	E0155	E0156	E0157	E0158	E0159	

Product Category 10 - Support Surfaces (for the detailed product description of each HCPCS code see ***Attachment A***)

E0193	E0277	E0371	E0372	E0373

Billing Instructions for Power Wheelchair Harness (HCPCS code E2313)
The April Quarterly Update for the 2007 DMEPOS Fee Schedule included instructions for suppliers to submit claims for the electronics necessary to **upgrade from a non-expandable controller to an expandable controller at initial issue using HCPCS code E2399. This instruction was intended as a temporary measure** until a new code could be added to describe the electronics/cables/junction boxes used when upgrading from a non-expandable controller at initial issue.

- HCPCS code E2313 (Power Wheelchair Accessory, Harness For Upgrade to Expandable Controller, Including all Fasteners, Connectors and Mounting Hardware, Each) was added to the HCPCS effective January 1, 2008, for use in paying claims for the electronics furnished when upgrading from a non-expandable controller at initial issue.

- Suppliers may submit claims for the electronics provided at initial issue using HCPCS code E2313 for dates of service on or after January 1, 2008, and must no longer use code E2399 for submission of such items.

- Claims submitted for the electronics necessary to upgrade from a non-expandable controller to an expandable controller using HCPCS code E2399 are invalid and will be denied as contractor/supplier responsibility. When such claims are denied, CMS will use message codes of M20 (Missing/incomplete/invalid HCPCS), 189 (Not otherwise classified or unlisted procedure code (CPT/HCPCS) was billed when there is a specific procedure code for this procedure/service.), N211 (Alert: You may not appeal this decision.), and MA13 (You may be subject to penalties if you bill the patient for amount not reported with the PR (patient responsibility) group code.). These denials are made as CO-Contractual Obligation denials.

Additional Information
If you have questions, please contact your Medicare contractor at their toll-free number which may be found at **http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip** on the CMS web site.

For complete details regarding this Change Request (CR) please see the official instruction (CR6270) issued to your Medicare A/B MAC, DME/MAC, carrier, FI or RHHI. That instruction may be viewed by going to **http://www.cms.hhs.gov/Transmittals/downloads/R1630CP.pdf** on the CMS web site.

Influenza Pandemic Emergency - The Medicare Program Prepares (SE0836) (GEN)

MLN Matters Number: SE0836 - Revised
Related CR Release Date: N/A
Related CR Transmittal #: N/A
Related Change Request (CR) #: N/A
Effective Date: N/A
Implementation Date: N/A

Note: *This article was revised on November 26, 2008, to include Web revised links to recently-reissued CR6174, CR 6146, and CR 6164, all of which were recently revised by CMS. All other information remains the same.*

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

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

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

Decision to implement would occur if:

1. The President declares an emergency or disaster under the National Emergencies Act or the Stafford Act; **and**

2. The Secretary of the Department of Health and Human Services declares - under § 319 of the Public Health Service Act - that a public health emergency exists; **and**

3. The Secretary elects to waive one or more requirements of Title XVIII of the Social Security Act (Act) pursuant to § 1135 of such Act.

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

This article includes links to policy documents that have been released by CMS. As additional policy becomes available, CMS will revise this article to include links to all available influenza pandemic policy documents.

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

Additional Information
Additional CMS influenza pandemic policy documents include:

- CR 6146, which can be found at **http://www.cms.hhs.gov/Transmittals/downloads/R404OTN.pdf** on the CMS web site;

- CR 6164, which can be found at **http://www.cms.hhs.gov/Transmittals/downloads/R402OTN.pdf** on the CMS web site; and

- CR 6174, which can be found at **http://www.cms.hhs.gov/Transmittals/downloads/R403OTN.pdf** on the CMS web site.

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

Medicare Providers Remain Satisfied with Fee-For-Service Contractors (CMS Message 2008-08-29) (GEN)

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

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

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

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

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

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

MEDICARE NEWS: Medicare Publishes Billing Edits to Reduce Payment Errors (CMS Message 2008-10-01) (GEN)

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

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

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

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

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

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

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

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

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

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

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

National Provider Identifier (NPI) for Secondary Providers (MM6093) (GEN)

MLN Matters Number: MM6093 - Revised
Related CR Release Date: October 15, 2008
Related CR Transmittal #: R270PI

Related Change Request (CR) #: 6093
Effective Date: May 23, 2008
Implementation Date: September 26, 2008
(FISS implementation date is November 3, 2008)

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

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

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

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

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

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

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

TMP-EDO-0058 Ver. 1
06 / 25 / 2008

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

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

Key Points of CR6093

- When an identifier is reported on a paper or electronically submitted claim for a secondary provider (ordering, referring, attending, operating, supervising, purchased service, other, or service facility provider [in the X12N 837 claims transactions] or for prescriber [in the NCPDP 5.1 retail drug claim transactions]), that **identifier must be an NPI**.

- If the secondary provider (the ordering, referring, attending, operating, supervising, purchased service, other, or service facility provider [in the X12N 837 claims transactions] or for prescriber [in the NCPDP 5.1 retail drug claim transactions]) **does not furnish** its NPI at the time of the order/, referral, purchase, prescription, or time of service, **YOU as the billing provider need to know that NPI in order to use it in your claim.**

- You may use the NPI Registry or you may need to contact the ordering, referring, attending, operating, supervising, purchased service, other, service facility, or prescriber in order to obtain that NPI. While the Implementation Guides for the X12N claims transactions permit the reporting of the Social Security Number (SSN) for some secondary providers if there is no NPI, the Centers for Medicare & Medicaid Services (CMS) does not believe you will be successful in having secondary providers disclose their SSNs.

- If you are **unable to obtain the NPI of the entity** to be identified as the **service facility provider, or if that entity has not obtained an NPI, NO identifier is to be reported in that loop.**

- If you are unable to obtain the NPI of the ordering, referring, attending, operating, supervising, purchased service, other, or prescriber, **you (the Billing Provider) must use YOUR NPI as the identifier for that secondary provider.**

- Claims will not be paid if the secondary providers (with the exception of the service facility provider) are not identified by NPIs. No NPI is necessary for the service facility provider.

Additional Information

If you have questions, please contact your Medicare carrier, DME MAC, FI or A/B 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.

For complete details regarding this Change Request (CR) please see the official instruction (CR6093) issued to your Medicare Carrier, DME MAC, MAC or FI. That instruction may be viewed by going to **http://www.cms.hhs.gov/Transmittals/downloads/R270PI.pdf** on the CMS web site.

Non-acceptance of Legacy Provider Numbers on Incoming Medicare Claims (SE0835) (GEN)

MLN Matters Number: SE0835
Related CR Release Date: N/A
Related CR Transmittal #: N/A

Related Change Request (CR) #: N/A
Effective Date: N/A
Implementation Date: N/A

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

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

- For 837 institutional claims, the Employer Identification Number (EIN)/Federal Tax ID, qualified by "EI" or "TJ," will be accepted; and

- For 837 professional claims, the provider's EIN/Tax ID, qualified by "EI" or "TJ," or social security number, as qualified by "SY," will be accepted.

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

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

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

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

Background
The Centers for Medicare & Medicaid Services (CMS) implemented the NPI as the primary provider identifier to be used on Medicare claims effective May 23, 2008. Through the systematic actions that CMS is implementing on October 6, 2008, CMS will ensure that its objective of not accepting legacy provider numbers will be realized.

Additional Information
If you have any questions, please contact your intermediary, carrier, A/B MAC, or DME MAC at its toll-free number found at **http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip** on the CMS web site.

Remittance Advice Remark Code (RARC) and Claim Adjustment Reason Code (CARC) Update (MM6229) (GEN)

MLN Matters Number: MM6229
Related CR Release Date: November 14, 2008
Related CR Transmittal #: R1634CP

Related Change Request (CR) #: 6229
Effective Date: January 1, 2009
Implementation Date: January 5, 2009

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

Provider Action Needed
This article is based on Change Request (CR) 6229 which updates Remittance Advice Remark Codes (RARCs) and Claim Adjustment Reason Codes (CARCs). If you use the Medicare Remit Easy Print software, note that Medicare will update that software as a result of implementing CR6229. Be sure billing staff are aware of these updates.

Background
The Health Insurance Portability and Accountability Act (HIPAA) of 1996 instructs health plans to be able to conduct standard electronic transactions adopted under HIPAA using valid standard codes. Medicare policy states that Claim Adjustment Reason Codes (CARCs) are required in the remittance advice and coordination of benefits transactions. Medicare policy further states that appropriate Remittance Advice Remark Codes (RARCs) that provide either supplemental explanation for a monetary adjustment or policy information are required in the remittance advice transaction.

X12N 835 Health Care Remittance Advice Remark Codes
The Centers for Medicare & Medicaid Services (CMS) is the national maintainer of the remittance advice remark code list. This code list is used by reference in the ASC X12 N transaction 835 (Health Care Claim Payment/Advice) version 004010A1 Implementation Guide (IG). Under HIPAA, all payers, including Medicare, are required to use reason and remark codes approved by X12 recognized code set maintainers instead of proprietary codes to explain any adjustment in the claim payment. CMS, as the X12 recognized maintainer of RARCs, receives requests from Medicare and non-Medicare payers for new codes and modification/deactivation of existing codes. Additions, deletions, and modifications to the code list resulting from non-Medicare requests may or may not impact Medicare.

Note: *The complete list of remark codes is available at* ***http://www.wpc-edi.com/codes*** *on the Internet.*

Medicare contractors will use the latest approved and valid codes in the 835, corresponding Standard Paper Remittance (SPR) advice, and coordination of benefits transactions.

CMS has developed a new Web site to help navigate the RARC database more easily. A tool is provided to help search if you are looking for a specific category of codes. At this site you can find some other information that is also available from the WPC Web site. The Web site address is **http://www.cmsremarkcodes.info/** on the Internet.

NOTE I: *This Web site is not replacing the WPC Web site as the official site where the most current RARC list resides. If there is any discrepancy, always use the list posted at the WPC Web site.*

NOTE II: *Some remark codes may only provide general information that may not necessarily supplement the specific explanation provided through a reason code and in some cases another/other remark code(s) for a monetary adjustment. Codes that are "Informational" will have "Alert" in the text to identify them as informational rather than explanatory codes. These "Informational" codes may be used without any CARC explaining a specific adjustment.*

An example of an informational code:

N369 Alert: Although this claim has been processed, it is deficient according to state legislation/regulation.

The above information is sent per state regulation, but does not explain any adjustment.

These informational codes are used only if specific information about adjudication (like appeal rights) needs to be communicated but not as default codes when a RARC is required with a CARC -16, 17, 96, 125, and A1.

Remittance Advice Remark Code Changes

New Codes:

Code	Current Narrative	Medicare Initiated
N434	Missing/Incomplete/Invalid Present on Admission indicator. Start: 7/1/2008	
N435	Exceeds number/frequency approved /allowed within time period without support documentation. Start: 7/1/2008	
N436	The injury claim has not been accepted and a mandatory medical reimbursement has been made. Start: 7/1/2008	
N437	Alert: If the injury claim is accepted, these charges will be reconsidered. Start: 7/1/2008	
N438	This jurisdiction only accepts paper claims. Start: 7/1/2008	
N439	Missing anesthesia physical status report/indicators. Start: 7/1/2008	
N440	Incomplete/invalid anesthesia physical status report/indicators. Start: 7/1/2008	
N441	This missed appointment is not covered. Start: 7/1/2008	
N442	Payment based on an alternate fee schedule. Start: 7/1/2008	
N443	Missing/incomplete/invalid total time or begin/end time. Start: 7/1/2008	
N444	Alert: This facility has not filed the Election for High Cost Outlier form with the Division of Workers' Compensation. Start: 7/1/2008	
N445	Missing document for actual cost or paid amount. Start: 7/1/2008	
N446	Incomplete/invalid document for actual cost or paid amount. Start: 7/1/2008	
N447	Payment is based on a generic equivalent as required documentation was not provided. Start: 7/1/2008	
N448	This drug/service/supply is not included in the fee schedule or contracted/legislated fee arrangement. Start: 7/1/2008	
N449	Payment based on a comparable drug/service/supply. Start: 7/1/2008	
N450	Covered only when performed by the primary treating physician or the designee. Start: 7/1/2008	

N451	Missing Admission Summary Report. Start: 7/1/2008	
N452	Incomplete/invalid Admission Summary Report. Start: 7/1/2008	
N453	Missing Consultation Report. Start: 7/1/2008	
N454	Incomplete/invalid Consultation Report. Start: 7/1/2008	
N455	Missing Physician Order. Start: 7/1/2008	
N456	Incomplete/invalid Physician Order. Start: 7/1/2008	
N457	Missing Diagnostic Report. Start: 7/1/2008	
N458	Incomplete/invalid Diagnostic Report. Start: 7/1/2008	
N459	Missing Discharge Summary. Start: 7/1/2008	
N460	Incomplete/invalid Discharge Summary. Start: 7/1/2008	
N461	Missing Nursing Notes. Start: 7/1/2008	
N462	Incomplete/invalid Nursing Notes. Start: 7/1/2008	
N463	Missing support data for claim. Start: 7/1/2008	
N464	Incomplete/invalid support data for claim. Start: 7/1/2008	
N465	Missing Physical Therapy Notes/Report. Start: 7/1/2008	
N466	Incomplete/invalid Physical Therapy Notes/Report. Start: 7/1/2008	
N467	Missing Report of Tests and Analysis Report. Start: 7/1/2008	
N468	Incomplete/invalid Report of Tests and Analysis Report. Start: 7/1/2008	
N469	Alert: Claim/Service(s) subject to appeal process, see section 935 of Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). Start: 7/1/2008	YES
N470	This payment will complete the mandatory medical reimbursement limit. Start: 7/1/2008	
N471	Missing/incomplete/invalid HIPPS Rate Code. Start: 7/1/2008	

N472	Payment for this service has been issued to another provider. Start: 7/1/2008	
N473	Missing certification. Start: 7/1/2008	
N474	Incomplete/invalid certification Start: 7/1/2008	
N475	Missing completed referral form. Start: 7/1/2008	
N476	Incomplete/invalid completed referral form Start: 7/1/2008	
N477	Missing Dental Models. Start: 7/1/2008	
N478	Incomplete/invalid Dental Models Start: 7/1/2008	
N479	Missing Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer). Start: 7/1/2008	
N480	Incomplete/invalid Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer). Start: 7/1/2008	
N481	Missing Models. Start: 7/1/2008	
N482	Incomplete/invalid Models Start: 7/1/2008	
N483	Missing Periodontal Charts. Start: 7/1/2008	
N484	Incomplete/invalid Periodontal Charts Start: 7/1/2008	
N485	Missing Physical Therapy Certification. Start: 7/1/2008	
N486	Incomplete/invalid Physical Therapy Certification. Start: 7/1/2008	
N487	Missing Prosthetics or Orthotics Certification. Start: 7/1/2008	
N488	Incomplete/invalid Prosthetics or Orthotics Certification Start: 7/1/2008	
N489	Missing referral form. Start: 7/1/2008	
N490	Incomplete/invalid referral form Start: 7/1/2008	
N491	Missing/Incomplete/Invalid Exclusionary Rider Condition. Start: 7/1/2008	

N492	Alert: A network provider may bill the member for this service if the member requested the service and agreed in writing, prior to receiving the service, to be financially responsible for the billed charge. Start: 7/1/2008	
N493	Missing Doctor First Report of Injury. Start: 7/1/2008	
N494	Incomplete/invalid Doctor First Report of Injury. Start: 7/1/2008	
N495	Missing Supplemental Medical Report. Start: 7/1/2008	
N496	Incomplete/invalid Supplemental Medical Report. Start: 7/1/2008	
N497	Missing Medical Permanent Impairment or Disability Report. Start: 7/1/2008	
N498	Incomplete/invalid Medical Permanent Impairment or Disability Report. Start: 7/1/2008	
N499	Missing Medical Legal Report. Start: 7/1/2008	
N500	Incomplete/invalid Medical Legal Report. Start: 7/1/2008	
N501	Missing Vocational Report. Start: 7/1/2008	
N502	Incomplete/invalid Vocational Report. Start: 7/1/2008	
N503	Missing Work Status Report. Start: 7/1/2008	
N504	Incomplete/invalid Work Status Report. Start: 7/1/2008	

Modified Codes:

Code	Current Modified Narrative	Last Modified
M29	Missing operative note/report.	7/1/08
N10	Payment based on the findings of a review organization/professional consult/manual adjudication/medical or dental advisor.	7/1/08
N26	Missing itemized bill/statement.	7/1/08
N40	Missing radiology film(s)/image(s).	7/1/08
N130	Alert: Consult plan benefit documents/guidelines for information about restrictions for this service.	7/1/08
N209	Missing/incomplete/invalid taxpayer identification number (TIN).	7/1/08
N232	Incomplete/invalid itemized bill/statement.	7/1/08
N233	Incomplete/invalid operative note/report.	7/1/08
N242	Incomplete/invalid radiology film(s)/image(s).	7/1/08

N350	Missing/incomplete/invalid description of service for a Not Otherwise Classified (NOC) code or for an Unlisted/By Report procedure.	7/1/08
N367	Alert: The claim information has been forwarded to a Consumer Spending Account processor for review; for example, flexible spending account or health savings account.	7/1/08
N390	This service/report cannot be billed separately	7/1/08
N393	Missing progress notes/report	7/1/08
N394	Incomplete/invalid progress notes/report.	7/1/08

Deactivated Codes:
There are no newly deactivated codes with CR 6229. Lists of all deactivated and scheduled to be deactivated RARCs are available at the WPC Web site at **http://www.wpc-edi.com/codes** on the Internet.

X12 N 835 Health Care Claim Adjustment Reason Codes
A national code maintenance committee maintains the health care Claim Adjustment Reason Codes (CARCs). The Committee meets at the beginning of each X12 trimester meeting (January/February, June and September/October) and makes decisions about additions, modifications, and retirement of existing reason codes. The updated list is posted 3 times a year around early November, March, and July.

The list is available at **http://www.wpc-edi.com/codes** on the Internet.

New Codes:

Code	Current Narrative	Implementation Date
222	Exceeds the contracted maximum number of hours/days/units by this provider for this period. This is not patient specific. Start Date: 6/1/2008	1/5/2009
223	Adjustment code for mandated federal, state or local law/regulation that is not already covered by another code and is mandated before a new code can be created. Start Date: 6/1/2008	1/5/2009
224	Patient identification compromised by identity theft. Identity verification required for processing this and future claims. Start Date: 6/1/2008	1/5/2009
225	Penalty or Interest Payment by Payer (Only used for plan to plan encounter reporting within the 837) Start Date: 6/1/2008	1/5/2009

Note: *Codes 223 and 224 are Medicare initiated*

Modified Code(s):

Code	Modified Narrative	Implementation Date
60	Charges for outpatient services with this proximity to inpatient services are not covered. This change to be effective 1/1/2009: Charges for outpatient services are not covered when performed within a period of time prior to or after inpatient services.	1/5/2009

Deactivated Code(s):

Code	Current Narrative	Implementation Date
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. Start: 01/27/2008 | Stop: 01/01/2009	1/1/2009

NOTE: *The Code Committee also reactivated CARC 207*

Additional Information
The official instruction, CR6229, issued to your carrier, FI, A/B MAC, RHHI, and DME MAC regarding this change may be viewed at **http://www.cms.hhs.gov/Transmittals/downloads/R1634CP.pdf** on the CMS web site.

If you have any questions, please contact your carrier, FI, A/B MAC, RHHI, 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.

Screening DNA Stool Test for Colorectal Cancer (MM6145) (SPE)

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

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

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

Provider Action Needed
Impact to You
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.

What You Need to Know
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.

What You Need to Do
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)) at **http://www.access.gpo.gov/nara/cfr/waisidx_02/42cfr410_02.html** and the Social Security Act (section 1861(pp)(1)(D)) **http://www.ssa.gov/OP_Home/ssact/title18/1861.htm** on the internet), CMS is allowed to use the NCD process to determine coverage of other types of colorectal cancer screening tests not specifically identified in the law or regulations as it determines to be appropriate, and in consultation with appropriate organizations.

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

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

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

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.

The ICD-10 Clinical Modification/Procedure Coding System (CM/PCS) - The Next Generation of Coding (SE0832) (GEN)

MLN Matters Number: SE0832 - Revised
Related CR Release Date: N/A
Related CR Transmittal #: N/A
Related Change Request (CR) #: N/A
Effective Date: N/A
Implementation Date: N/A

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

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

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

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

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

- United Kingdom (1995);
- France (1997);

- Australia (1998);
- Germany (2000); and
- Canada (2001).

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

- ICD-10-CM - The diagnosis classification system was developed by the Centers for Disease Control and Prevention for use in all United States of America health care treatment settings. Diagnosis coding under this system uses a different number of digits and some other changes, but the format is very much the same as International Classification of Diseases, 9th Edition, Clinical Modification (ICD-9-CM); and

- ICD-10-PCS - The procedure classification system was developed by CMS for use in the U.S. for inpatient hospital settings ONLY. The new procedure coding system uses 7 alpha or numeric digits while the ICD-9-CM coding system uses 3 or 4 numeric digits.

ICD-10-CM/PCS:

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

Structural Differences Between the Two Coding Systems

1. Diagnoses Codes

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

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

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

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

2. Procedure Codes

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

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

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

- 0FB03ZX - Excision of Liver, Percutaneous Approach, Diagnostic; and
- 0DQ107Z - Repair, esophagus, upper, open with autograft.

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

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

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

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

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

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

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

Fee Schedule Updates (GEN)

The 2008 fee schedules and subsequent updates are available via the "Fee Schedules" section of the Jurisdiction A Durable Medical Equipment Medicare Administrative Contractor (DME MAC A) Web site, **http://www.medicarenhic.com/dme/dmfees.shtml**. The following notices have been posted:

- **There are no October Updates to the 2008 Jurisdiction A DME MAC Fee Schedule**
- October 2008 Quarterly Average Sales Price Medicare Part B Drug Pricing File
- 4th Quarter 2008 Oral Anticancer Drug Fees

Note: *The January 1 fees for the current calendar year are posted as the "Jurisdiction A DME MAC Fee Schedule" for that particular year, and these files are not changed throughout the year. Rather, separate notices are posted as fee revisions/updates become available. Please be sure you are viewing the appropriate file/notice for the item and date of service.*

Inclusion or exclusion of a fee schedule amount for an item or service does not imply any health insurance coverage.

CMS News Flash (GEN)

The Office of the Inspector General in the Department of Health and Human Services has issued a policy statement that assures Medicare providers, practitioners, and suppliers affected by retroactive increases in payment rates under the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 that they will not be subject to OIG administrative sanctions if they waive retroactive beneficiary cost-sharing amounts attributable to those increased payment rates, subject to the conditions noted in the policy statement. To view the document, go to
http://oig.hhs.gov/fraud/docs/alertsandbulletins/2008/MIPPA_Policy_Statement.PDF

A new *MLN Matters* provider education article is now available at
http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0837.pdf on the CMS web site. This Special Edition article assists all providers who will be affected by Medicare Administrative Contractor (MAC) implementations. It provides information to make you aware of what to expect as your FI or carrier transitions its work to a MAC. This article alerts providers as to what to expect and how to prepare for the MAC implementations and will help to minimize any disruption in your Medicare business.

The July 2008 version of the *Evaluation & Management Services Guide*, which provides evaluation and management services information about medical record documentation, International Classification of Diseases and Current Procedural Terminology codes, and key elements of service, is now available on the Centers for Medicare & Medicaid Services Medicare Learning Network at **http://www.cms.hhs.gov/MLNProducts/downloads/eval_mgmt_serv_guide.pdf** on the CMS web site.

Your Medicare Payments Could Be Reduced If The Internal Revenue Service (IRS) Needs To Collect Overdue Taxes That You Owe - The Taxpayer Relief Act of 1997, Section 1024, authorizes the IRS to reduce certain federal payments, including Medicare payments, to allow collection of overdue taxes. Should you owe such taxes and your payments are reduced, your remittance advice will reflect a provider level adjustment code (PLB) of "WU" in the PLB03-1 data field. For more information, please see *MLN Matters* Article #MM6125 available at
http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6125.pdf on the CMS web site.

Flu Shot Reminder - Flu Season Is Here! It's not too early to start vaccinating as soon as you receive vaccine. Encourage your patients to get a flu shot as it is still their best defense against the influenza virus. (Medicare provides coverage of the flu vaccine without any out-of-pocket costs to the Medicare patient. No deductible or copayment/coinsurance applies.) And don't forget, health care workers also need to protect themselves. **Get Your Flu Shot - Not the Flu.** *Remember* - Influenza vaccine plus its administration are covered Part B benefits. Note that influenza vaccine is NOT a Part D covered drug. For information about Medicare's coverage of the influenza virus vaccine and its administration as well as related educational resources for health care professions and their staff, visit **http://www.cms.hhs.gov/MLNProducts/Downloads/flu_products.pdf** on the CMS web site. To order, free of charge, a quick reference chart on Medicare Part B Immunization Billing, go to **http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5** on the CMS web site. To download the Medicare Part B Immunization Billing quick reference chart, go to **http://www.cms.hhs.gov/MLNProducts/downloads/qr_immun_bill.pdf** on the CMS web site. A copy of this quick reference chart can be ordered, free of charge, by going to the *MLN* Products web page and clicking on "MLN Product Ordering Page" in the Related Links Inside CMS section of the web page.

On September 3, 2008, the Centers for Medicare & Medicaid Services (CMS) announced those Durable Medical Equipment Prosthetics/Orthotics, and Supplies (DMEPOS) providers that are exempt from meeting the quality standards for DMEPOS accreditation. *CMS, at that time, stated that Orthotists, Prosthetists, and Pedorthotists are included in that exemption.* CMS will issue a notice of proposed rulemaking in 2009 that will define quality standards designed specifically for anyone furnishing or providing orthotics and prosthetics in order to be reimbursed for such supplies and services under Medicare Part B. For more information about DMEPOS Accreditation, please visit the web page at **http://www.cms.hhs.gov/medicareprovidersupenroll/** on the CMS web site.

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

Medicare is starting a new program to encourage physicians to adopt e-prescribing systems. Incentive payments will be made in mid-2010 for physicians who are successful e-prescribers during the 2009 reporting period which is January 1, 2009 through December 31, 2009. The initiative is part of the Administration's broader efforts to accelerate the adoption of health IT and the establishment of a health care system based on value. To read more, see the entire HHS Fact Sheet at **http://www.hhs.gov/news/facts/eprescribing.html** on the CMS web site.

The 2nd Edition of *The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals* is now available in downloadable format from the Centers for Medicare & Medicaid Services, **Medicare Learning Network (MLN)**. This comprehensive guide provides fee-for-services health care providers and suppliers with coverage, coding, billing and reimbursement information for preventive services and screenings covered by Medicare. This guide gives clinicians and their staff the information they need to help them in recommending Medicare-covered preventive services and screenings that are right for their Medicare patients and provides information needed to effectively bill Medicare for services furnished. To view online, go to **http://www.cms.hhs.gov/MLNProducts/downloads/mps_guide_web-061305.pdf** on the CMS web site.

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

Would you like to stay informed of the educational products from the **Medicare Learning Network (MLN)**? If so, you can join the *MLN Education Products* mailing list, which will deliver the latest information about new and revised *MLN* products, right to your inbox. To join, visit **https://list.nih.gov/cgi-bin/wa?SUBED1=mln_education_products-l&A=1** ; then enter your email address and full name. Click "Join the List". Follow the instructions in the confirmation email you will receive to confirm your subscription to the list. (Note that the sender of this email will appear as "NIH LISTSERV SERVER".)

November is American Diabetes Month® ~ The American Diabetes Association has designated American Diabetes Month® as a time to communicate the seriousness of diabetes and the importance of proper diabetes control. Left undiagnosed, diabetes can lead to serious complications such as heart disease, stroke, blindness, kidney damage, lower-limb amputations and premature death. The Centers for Medicare & Medicaid Services (CMS) reminds health care professionals that Medicare provides coverage of diabetes screening tests for beneficiaries at risk for diabetes or those diagnosed with pre-diabetes. Medicare also provides coverage for services to help beneficiaries effectively manage their diabetes. Coverage of these services is subject to certain eligibility and other limitations. For more information about Medicare's coverage of diabetes screening services, diabetes self-management training, and medical nutrition therapy services, including coverage, coding, billing, and reimbursement guidelines, visit the CMS *Medicare Learning Network (MLN)* Preventive Services Educational Products web page at **http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp** on the CMS web site.

CMS has established a dedicated National Provider Identifier web page that houses all NPI outreach information that CMS has prepared. Please visit **http://www.cms.hhs.gov/NationalProvIdentStand** for more information. (JSM 06536)

DME MAC Jurisdiction A Local Coverage Determinations (GEN)

The LCDs can be found on the DME MAC A Web site at: **http://www.medicarenhic.com/dme/medical_review/mr_index.shtml**

LCDs can also be found on the CMS Web site within the Medicare Coverage Database (MCD), which is accessible by going to: **http://www.cms.hhs.gov/mcd/overview.asp**

Ankle-Foot Orthoses - Arizona-Type - Correct Coding (O&P)

Arizona AFO is a company that manufactures a line of custom fabricated ankle-foot orthoses. Other companies manufacture similar products. The Pricing, Data Analysis, and Coding (PDAC) contractor has recently reviewed the Arizona AFO line of products and determined the appropriate HCPCS codes to be used when billing for these and similar items.

For the Arizona Short, Arizona Tall, Arizona Extended, Arizona Unweighting, and similar custom fabricated braces, only the following codes should be used:

L1940 Ankle foot orthosis, plastic or other material, custom fabricated
L2330 Addition to lower extremity, lacer molded to patient model, for custom fabricated orthosis only
L2820 Addition to lower extremity orthosis, soft interface for molded plastic below knee section

L2330 is used whether the closure is a lacer closure or a velcro closure. L2820 is used only if a soft interface, either leather or other material, is provided.

The following codes must not be used for these braces:

L1960 Ankle foot orthosis, posterior solid ankle, plastic, custom fabricated
L2275 Addition to lower extremity, varus/valgus correction, plastic modification, padded/lined
L2280 Addition to lower extremity, molded inner boot

For the Arizona Partial Foot model or similar orthosis, use codes L1940, L2330, L2820, and L5000 (Partial foot, shoe insert with longitudinal arch, toe filler).

Questions concerning the coding of other orthoses should be referred to the Pricing, Data Analysis, and Coding (PDAC) contractor.

Suppliers who have incorrectly coded these orthoses should submit a voluntary refund to the DME MAC.

Budesonide (J7626) - Coding and Coverage (DRU)

A recent review of claims for the inhalation medication, budesonide, has identified problems with the coding and coverage of this drug.

Coding Issues
The descriptor for HCPCS code J7626 reads:

J7626 Budesonide, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose form, up to 0.5mg

Budesonide is supplied by the manufacturer as Pulmicort Respules® in 0.25, 0.5 and 1.0 mg unit dose vials. The HCPCS code descriptor indicates one unit of service (UOS) = up to 0.5 mg. Therefore, for the 0.25 mg or 0.5 mg unit dose forms, one UOS is billed for each vial dispensed. For the 1.0 mg unit dose form, one vial = two UOS.

When billing code J7626, suppliers should use the following examples:

Example 1: Dispensing 0.5 mg vials
Order is for budesonide 0.5 mg vials, administer 0.5 mg BID
0.5 mg x 2x/day = 1 mg/day x 31 days = 31 mg/month
1 vial x 2x/day = 2 vials/day x 31 days = 62 UOS/ month
Claim filed for 62 UOS of code J7626

Example 2: Dispensing 0.25 mg vials
Order is for budesonide 0.25 mg vials, administer 0.25 mg BID
0.25 mg x 2x/day = 0.5 mg/day x 31 days = 15.5 mg/month
1 vial x 2x/day = 2 vials/day x 31 days = 62 UOS/ month
Claim filed for 62 UOS of code J7626

Example 3: Dispensing 0.25 mg vials
Order is for budesonide 0.25 mg vials, administer 0.25 mg TID
0.25 mg x 3x/day = 0.75 mg/day x 31 days = 23.25 mg
1 vial x 3x/day = 3 vials/day x 31 days = 93 UOS/ month
Claim filed for 93 UOS of code J7626

Coverage Issues
Budesonide is commonly provided as Pulmicort Respules® (AstraZeneca) which has an FDA indication for the maintenance and treatment of asthma and as a prophylactic therapy in children 12 months to 8 years old. Use for chronic obstructive pulmonary disease (COPD) is considered "off-label" use and therefore subject to the Centers for Medicare & Medicaid Services (CMS) policy on unlabeled use of medications found in the *Benefits Policy Manual*, Internet Only Manual Pub. 100-2, Chapter 15, Section 50.4.2.

There is nothing in the medical literature supporting the use of budesonide at a frequency greater than twice per day (regardless of whether 0.5 mg or 0.25 mg dose is used) or a cumulative dose greater than 1 mg/day. Therefore, according to the local coverage determination (LCD) for Nebulizers, the maximum allowed amount is 62 units of service per month. Billing for quantities greater than 62 UOS per month will be denied as not medically necessary.

In example #3, even though the total mg administered (23.25 mg/mo) is within the policy guidelines (31 mg/mo), the 93 units of service exceeds the guidelines. If 0.75 per day is ordered, there is no medical necessity for three times per day administration. Administration of one 0.5 mg dose and one 0.25 dose per day would be appropriate. The excess units of service will be denied as not medically necessary.

Suppliers should refer to the Nebulizers LCD for additional guidance on the coverage, coding and documentation requirements.

FAQ: Order (Prescription) Requirements (GEN)

Q. May a supplier furnish a DMEPOS item based on a verbal or preliminary written order?

A. Yes, unless the LCD states otherwise. Most DMEPOS items can be dispensed based on a verbal or preliminary order, provided that a supplier has a detailed written order in its files prior to submitting a claim for the item. The dispensing order must include the beneficiary's name, a description of the item, the physician's name and the start date of the order. If the elements of the preliminary order are documented in different parts of the beneficiary's medical record, e.g. discharge summary and the hospital medical record, the supplier must nonetheless be able to show documentation for each of the requirements for preliminary orders.

Q. May a supplier submit a claim for reimbursement of a DMEPOS item prior to obtaining a detailed written order from the treating physician?

A. No. If a supplier does not have a faxed, photocopied, electronic or pen and ink signed detailed written order in its records before submitting a claim, the claim will be denied.

A detailed written order must be sufficiently detailed, including all options or additional features that will be separately billed or that will require an upgrade code. If the order is for supplies that will be used on a periodic basis, the detailed written order should include information on the quantity used, frequency of change, and duration of need. The detailed description of the item can either be a narrative description or a brand and model number. Someone other than the physician may complete the detailed description of the item. However, the treating physician must review the detailed description and personally sign and date the order.

For example, a detailed written order for a manual wheelchair must specify the start date of the order, the beneficiary's name and must be sufficiently detailed, so as to include all options or additional features that will be separately billed or that will require an upgraded code. The description can be either a narrative description (e.g., lightweight wheelchair base) or a brand name/model number.

A claim may be submitted to secure a denial for COB purposes when billing for DMEPOS items dispensed without a written order. The item must be billed with the EY modifier. If the supplier has obtained a written order for some, but not all, of the items provided to a particular beneficiary, the supplier must submit a separate claim for the items dispensed without a written order.

Q. Are there any DMEPOS items that require a supplier to obtain a detailed written order prior to delivery (WOPD)?

A. Yes. A detailed WOPD is required for:

- group 1,2 and 3 pressure reducing support surfaces
- seat lift mechanisms
- TENS units
- power operated vehicles
- power wheelchairs
- negative pressure wound therapy
- wheelchair seating
- wheelchair options and accessories provided for power wheelchairs

The DME MACs may identify other items for which they will require a detailed WOPD. For these items, the supplier must have received a detailed written order that has been both signed and dated by the treating physician and that complies in all respects with the requirements applicable to detailed written orders before dispensing the item.

Refer to the applicable LCD for the specific HCPCS codes that are included in this requirement.

If a supplier bills for an item that requires a detailed WOPD prior to obtaining the written order, the item will be denied as excluded by statute; even if the supplier subsequently obtains a detailed WOPD.

Q. Is a supplier required to obtain a detailed WOPD in order to receive Medicare payment for a manual or semi electric hospital bed?

A. No. The requirement for a detailed WOPD applies to support surfaces and beds identified in the LCDs for Group I, Group II and Group III support surfaces.

Q. May a supplier furnish an item requiring a detailed WOPD such as a pressure reducing mattress overlay, a power wheelchair or a TENS unit to a Medicare beneficiary on the basis of a detailed WOPD that has been electronically signed and date stamped?

A. Yes. A valid detailed WOPD must meet all the requirements applicable to detailed written orders. This means that the detailed WOPD must clearly specify the start date of the order, identify the beneficiary, and include a description of the item

that is sufficiently detailed, including all options or additional features that will be separately billed or that will require an upgrade code. A detailed WOPD that has a secure, authenticated electronic signature and date stamp and that meets all of the requirements applicable to detailed written orders, is valid for furnishing and billing of these items.

Functional Electrical Stimulators - New Code (SPE)

A new HCPCS code been established for electrical stimulators, effective for claims with dates of service on or after January 1, 2009.

E0770 Functional electrical stimulator, transcutaneous stimulation of nerve and/or muscle groups, any type, complete system, not otherwise specified

A functional electrical stimulator provides a current which results in the movement of a body part to accomplish a specific task - e.g., walking, grasping, etc. Products in this category can have a variety of electrical parameters such as current, voltage ranges, and waveforms.

The only products that may be billed with code E0770 are those which are listed in the DMECS Product Classification List on the Pricing, Data Analysis, and Coding Contractor (PDAC) Web site. Currently, the only products that are coded E0770 are the WalkAide device manufactured by Innovative Neurotronics and the NESS L300 device manufactured by Bioness.

Questions concerning the coding of other products should be directed to the PDAC, Noridian Administrative Services Contact Center at 877.735.1326.

The CMS IOM Pub. 100-03 *National Coverage Determination (NCD) Manual*, section 160.12, addresses coverage criteria for functional electrical stimulators. Coverage is limited to those devices which enhance the ability to walk and are used by spinal cord injury patients (ICD-9 diagnosis codes 806.00-806.9, 907.2, 952.00-952.9) with all of the following characteristics:

1. Persons with intact lower motor neuron units (L1 and below)(both muscle and peripheral nerve); and
2. Persons with muscle and joint stability for weight bearing in their upper and lower extremities who can demonstrate balance and control to maintain an upright support posture independently; and
3. Persons who demonstrate brisk muscle contraction to neuromuscular electrical stimulation and have sensory perception of electrical stimulation sufficient for muscle contraction; and
4. Persons who possess high motivation, commitment, and cognitive ability to use such devices for walking; and
5. Persons who can transfer independently and can demonstrate independent standing tolerance for at least 3 minutes; and
6. Person who can demonstrate hand and finger function to manipulate controls; and
7. Persons who are at least 6 months post spinal cord injury and restorative surgery; and
8. Persons with hip and knee degenerative disease and no history of long bone fracture secondary to osteoporosis; and
9. Persons who have demonstrated a willingness to use the device long term; and
10. Persons who have completed a one-on-one training program with a physical therapist which consists of at least 32 physical therapy sessions with the device over a period of 3 months. The training program must be conducted in an inpatient hospital, outpatient hospital, or outpatient rehabilitation facility.

If a patient meets all of these requirements, a KX modifier must be added to code E0770. If any requirement is not met, the KX modifier may not be added.

Claims without a covered diagnosis code and/or without a KX modifier will be denied as not medically necessary.

Knee Orthoses LCD - Revised (O&P)

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

INDICATIONS AND LIMITATIONS OF COVERAGE:

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

ICD-9 CODES THAT SUPPORT MEDICAL NECESSITY:

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

DOCUMENTATION:

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

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

LCD and Policy Article Revisions - Summary for December 2008 (GEN)

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

External Infusion Pumps

LCD

Revision Effective Date: 01/01/2009

INDICATIONS AND LIMITATIONS OF COVERAGE:

Added ICD-9 codes 249.00-249.91 to range for insulin pumps. (effective 10/01/2008)

Changes the physician assessment interval for insulin pumps from every 3 months to every 6 months.

Removed word “Subcutaneous” from paragraph describing use of epoprostenol/treprostinil.

Revised denial for pumps other than E0779 for administration of subcutaneous immune globulin to allow payment at least costly alternative.

HCPCS CODES AND MODIFIERS:

Narrative changes for codes J9000, J9040, J9100, J9110, J9190, J9200, and J9360.

ICD-9 CODES THAT SUPPORT MEDICAL NECESSITY:

Added ICD-9 codes 249.00-249.91 to range for insulin pumps. (effective 10/01/2008)

Policy Article

Revision Effective Date: 01/01/2009

CODING GUIDELINES:

Replaced SADMERC reference with PDAC.

Glucose Monitors

LCD

Revision Effective Date: 10/01/2008

INDICATIONS AND LIMITATIONS OF COVERAGE:

Added: Delivery timeframe for shipping of refills.

ICD-9 CODES THAT SUPPORT MEDICAL NECESSITY:

Added: 249.00 – 249.91 ICD-9 diagnosis codes.

Policy Article

Revision Effective Date: 10/01/2008

CODING GUIDELINES:

Deleted: Moved ICD-9 code range to LCD.

Revised: Changed SADMERC to PDAC.

Intravenous Immune Globulin

LCD

Revision Effective Date: 01/01/2009

HCPCS CODES AND MODIFIERS:

Added J1459.

Changed code descriptor for J1572.

Deleted Q4097.

Policy Article

Revision Effective Date: 01/01/2009

CODING GUIDELINES:

Replaced SADMERC reference with PDAC.

Lower Limb Prostheses

LCD

Revision Effective Date: 01/01/2009

HCPCS CODES AND MODIFIERS:

Deleted: L5993 – L5995.

Nebulizers

LCD

Revision Effective Date: 01/01/2009

INDICATIONS AND LIMITATIONS OF COVERAGE:

Deleted: Least costly alternative statement for albuterol/ipratropium combination (J7620) scheduled to become effective November 1, 2008.

Revised: Statement about denial of coverage when more than one beta-adrenergic agent is provided.

Added: Maximum amount for albuterol/ipratropium combination.

Added: Delivery timeframe for shipping of refills.

HCPCS CODES AND MODIFIERS:

Added: Code J7606 (formoterol fumarate).

Deleted: Code Q4099 (formoterol fumarate).

Policy Article

Revision Effective Date: 01/01/2009

CODING GUIDELINES:

Deleted: References to trademarked name DuoNeb.

Revised: Changed SADMERC to PDAC.

Ostomy Supplies

LCD

Revision Effective Date: 01/01/2009

INDICATIONS AND LIMITATIONS OF COVERAGE:

Revised: Usual maximum quantity for A5083.

Policy Article

Revision Effective Date: 01/01/2009

CODING GUIDELINES:

Changed: References from SADMERC to PDAC.

ICD-9 CODES:

Added: 569.60

Oxygen and Oxygen Equipment

LCD

Revision Effective Date: 01/01/2009

HCPCS CODES AND MODIFIERS:

Added HCPCS Codes E1354, E1356, E1357, and E1358.

Pneumatic Compression Devices

LCD

Revision Effective Date: 01/01/2009

INDICATIONS AND LIMITATIONS OF COVERAGE:

Added: Statement regarding appliances for the chest and trunk.

HCPCS CODES AND MODIFIERS:

Added: E0656 and E0657.

Policy Article

Revision Effective Date: 01/01/2009

CODING GUIDELINES:

Changed: References from SADMERC to PDAC. References from DMERC to DME MAC.

Power Mobility Devices

LCD

Revision Effective Date: 01/01/2009

INDICATIONS AND LIMITATIONS OF COVERAGE:

Changed: Terminology from Assistive Technology Supplier/Practitioner to Assistive Technology Professional.

Changed: References from SADMERC to PDAC.

HCPCS CODES AND MODIFIERS:

Revised: K0899

DOCUMENTATION REQUIREMENTS:

Revised: Guidance concerning the content of the face-to-face examination.

Policy Article

Revision Effective Date: 01/01/2009

CODING GUIDELINES:

Changed: References from SADMERC to PDAC.

Pressure Reducing Support Surfaces - Group 2

LCD

Revision Effective Date: 01/01/2009

APPENDICES:

Revised: Definitions of pressure ulcer stages.

SOURCES OF INFORMATION AND BASIS FOR DECISION:

Added: Reference to NPUAP guidelines for pressure ulcer staging.

Policy Article

Revision Effective Date: 01/01/2009

CODING GUIDELINES:

Revised: Changed SADMERC to PDAC.

Pressure Reducing Support Surfaces - Group 3

LCD

Revision Effective Date: 01/01/2009

INDICATIONS AND LIMITATIONS OF COVERAGE:

Added : ICD-9 codes 707.23 and 707.24.

ICD-9 CODES:

Added: 707.23 & 707.24 – Pressure ulcers, stages III and IV.

APPENDICES:

Revised: Definitions of pressure ulcer stages.

SOURCES OF INFORMATION AND BASIS FOR DECISION:

Added: Reference to NPUAP guidelines for pressure ulcer staging.

Policy Article

Revision Effective Date: 01/01/2009

CODING GUIDELINES:

Revised: Changed SADMERC to PDAC.

Surgical Dressings

LCD

Revision Effective Date: 01/01/2009

INDICATIONS AND LIMITATIONS OF COVERAGE:

Added: Frequency of replacement for compression wrap (A6545).

HCPCS CODES AND MODIFIERS:

Added: A4490-A4510, A6545.

Revised: A6010-A6024, A6196-A6199, A6203-A6215, A6219-A6248, A6251-A6266, A6407.

APPENDICES:

Revised: Definitions of pressure ulcer stages.

SOURCES OF INFORMATION AND BASIS FOR DECISION:

Added: Reference to NPUAP guidelines for pressure ulcer staging.

Policy Article

Revision Effective Date: 01/01/2009

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Clarified: Allowance for HCPCS codes which use the term “kit”.

Added: Coverage statements for compression wraps (A6545).

Added: Noncoverage statement for surgical stockings (A4490-A4510).

CODING GUIDELINES:

Added: Requirement for PDAC Coding Verification Review for non-elastic compression wraps (A6545).

Revised: Changed SADMERC to PDAC.

Therapeutic Shoes for Persons with Diabetes

Policy Article

Revision Effective Date: 10/01/2008

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Added: Additional diagnosis codes for diabetes.

CODING GUIDELINES:

Replaced: References to SADMERC with PDAC.

ICD-9 CODES THAT ARE COVERED:

Added: 249.00-249.91.

Wheelchair Seating

LCD

Revision Effective Date: 01/01/2009

INDICATIONS AND LIMITATIONS OF COVERAGE:

Replaced: Reference to SADMERC with PDAC.

HCPCS CODES AND MODIFIERS:

Added: E2231

Revised: K0669

Policy Article

Revision Effective Date: 01/01/2009

CODING GUIDELINES:

Revised: Guidelines for solid seat support base for manual wheelchair.

Replaced: References to SADMERC with PDAC.

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

LCD and Policy Article Revisions - Summary for September 2008 (GEN)

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

High Frequency Chest Wall Oscillation Devices

LCD

Revision Effective Date: 10/01/2008

INDICATIONS AND LIMITATIONS OF COVERAGE:

Added: Coverage for specified neuromuscular diseases.

Added: Statement about concurrent use of mechanical in-exsufflation device.

ICD-9 CODES THAT SUPPORT MEDICAL NECESSITY:

Added: ICD-9 codes for neuromuscular diseases.

Lower Limb Prostheses

LCD

Revision Effective Date: 10/01/2008

INDICATIONS AND LIMITATIONS OF COVERAGE:

Moved: Noncoverage statement for user adjustable heel heights from Policy Article.

Policy Article

Revision Effective Date: 10/01/2008

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Moved: Noncoverage statement for user adjustable heel heights to LCD.

CODING GUIDELINES:

Revised: Coding guidance for microprocessor controlled knees.

Substituted: PDAC for SADMERC.

Wheelchair Options/Accessories

LCD

Revision Effective Date: 04/01/2008

INDICATIONS AND LIMITATIONS OF COVERAGE:

Revised: Statements about the requirements for ATS or ATP involvement in the selection of power tilt and/or recline seating systems.

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

Nebulizers - Policy Revision (DRU)

The local coverage determination (LCD) for Nebulizers is being revised. The provision related to the application of least costly alternative to the combination drug albuterol/ipratropium (e.g. DuoNeb®) that was scheduled to be implemented on November 1, 2008 is being withdrawn. Other provisions of the policy remain in effect. This change will be included in an upcoming revision of the LCD for Nebulizers.

Positive Airway Pressure (PAP) Devices for Obstructive Sleep Apnea - FAQ (SPE)

Q1. Who is responsible for ensuring that the initial clinical evaluation and re-evaluation were conducted and who must retain documentation of that evaluation?

A1. The treating physician is responsible for documenting the elements of the clinical evaluation and re-evaluation and must maintain that documentation as they would with any patient. Suppliers are responsible for ensuring that the coverage criteria have been met before applying the KX modifier to the code for PAP devices and accessories. Suppliers have the option of either requesting the information from the physician prior to dispensing the PAP device or waiting until requested to submit the information to the DME MAC.

Q2. Will phone-in compliance satisfy the requirement for demonstrating that the patient must be compliant with therapy for 4 or more hours a night for 70% of the nights in a consecutive 30-day period within the first 90 days of therapy?

A2. Yes, this is acceptable. The policy allows for either direct download or visual inspection of adherence information.

Q3. Does the equipment provided to the patient during the initial 90-day therapy trial period have to be new?

A3. No, it does not have to be new but must be in good working condition.

Q4. Is ICD-9 diagnosis code 327.23 the only code acceptable for PAP device claims and when does its use become mandatory?

A4. Yes, ICD-9 code is the only code acceptable for PAP and is the code that should have been used on claims since becoming effective in January 2006. Prior to the creation of code 327.23, other ICD-9 codes were allowed because there was no ICD-9 code specific to obstructive sleep apnea. Suppliers should always use the ICD-9 code that accurately and specifically reflects the condition for which the equipment is covered. ICD-9 code 327.23 should be used on all claims at this time for patients with obstructive sleep apnea.

Q5. Does a new order need to be obtained reflecting diagnosis code 327.23 for beneficiaries already in the capped rental cycle?

A5. No, as long as the supplier of the PAP device has information from the treating physician that the patient has obstructive sleep apnea.

Q6. What happens if a RAD device is put on a patient at a point in time where it is now impossible to meet the compliance requirement for 70% of the nights in a consecutive 30-day period within that first 90 days? Say for example, the patient changes over from a CPAP to a RAD device on day 75?

A6. Patients will be given until the 120th day after initiation of CPAP to document adherence to therapy.

Q7a. What happens if all of the documentation needed to continue on therapy beyond the first 90 days is not received/available to the supplier before the end of the 90 day trial period but does become available later - possibly at 120 or 150 days, for example?

A7a. The supplier has two options:

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

Q7b. What if the beneficiary did not have the required re-evaluation within the 31st to 91st day window?

A7b. If the documentation shows that the beneficiary was adherent to therapy and demonstrated improvement in symptoms but did not have a face-to-face re-evaluation between the 31st and 91st day but rather was re-evaluated at a later date, claims may be submitted with the KX modifier from the date of the re-evaluation.

Q8. If a patient fails to meet the requirements for additional coverage of PAP therapy beyond the 90-day trial period, when is that patient eligible for a new trial?

A8. In order to re-qualify for PAP therapy, the patient must undergo another face-to-face clinical evaluation and facility-based sleep test to assist in discerning the reasons for failure to demonstrate improvement in obstructive sleep apnea symptoms during the initial 90 day trial period.

Q9. Titration, either in-home or in-lab, is not addressed in the LCD. Will there be any opportunity for in-home titration? When? How? Under what circumstances?

A9. Titration may be performed either in-home or in-lab. Titration conducted in a facility-based setting is addressed in LCDs from other contractors. Titration conducted in the unattended home setting is not addressed in the PAP policy because there is no additional payment from the DME MAC for this procedure. If auto-titrating PAP devices are used for home titration, they should be billed using HCPCS code E0601.

Q10. Has there been any consideration to paying for A9279 - Compliance monitoring equipment or component of equipment, to compensate for the additional work on the part of the supplier associated with compliance in the initial 90-day trial period?

A10. This was considered; however, it has been decided that A9279 will continue to be non-covered by Medicare.

Q11. G0398, G0399 and G0400 were created for portable testing. How frequently can those be billed / paid and used to qualify a patient for PAP therapy?

A11. These are not codes payable by the DME MAC. Billing frequencies and payment amounts are established by other contractors.

Q12. Why are there several different effective dates in the PAP Device policy?

A12: The national coverage determination (NCD) became effective on March 13, 2008. The NCD required a clinical evaluation and demonstration of improvement in OSA symptoms in the first 12 weeks of PAP use. It also allowed the use of home sleep tests to qualify the patient for a PAP device. As is often the case, the NCD requirements needed further definition and explanation; therefore, those additional guidelines for coverage, coding and payment were included in the DME MAC LCD. A prospective effective date was given to allow compliance with those criteria.

Q13. Who is allowed to interpret sleep studies?

A13: The PAP policy requirements for interpreting physicians allows for sleep study interpretation by one of the following:

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

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

Q14. How can suppliers find out if a physician is board-certified?

A14. Suppliers may contact the physician directly or search the certification records of the ABMS (**http://www.abms.org**) member boards or AASM certification information (**http://www.aasmnet.org**).

Q15. Does a change from an E0601 to E0470 after the 91st day require a physician face-to-face evaluation?

A15. Changing devices from a CPAP to RAD in the first 90 days can occur without a repeat face-to-face evaluation. It is anticipated that the physician and/or DME supplier is actively engaged with the patient to ensure that they are adherent to therapy and that any factors impacting the successful improvement in their OSA symptoms are being addressed. However, once past the initial 90 days, changing from CPAP to RAD is often necessitated by complicating factors and must be done in conjunction with another face-to-face evaluation by the treating physician.

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

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

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

1) There must be a face-to-face visit with the physician prior to ordering the sleep test. This should generally include the following elements:
   a) Sleep history and symptoms which may be caused by OSA
   b) Epworth Sleepiness Scale (a standardized patient questionnaire which helps to assess the likelihood of sleep apnea) or other validated sleep inventory
   c) Pertinent physical examination - e.g., body mass index, neck circumference, upper airway exam, and cardiopulmonary exam

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

3) If a home sleep study is performed, it must be interpreted by a physician who holds either:
   a) Current certification in Sleep Medicine by the American Board of Sleep Medicine (ABSM); or
   b) Current subspecialty certification in Sleep Medicine by a member board of the American Board of Medical Specialties (ABMS); or
   c) Completed residency or fellowship training by a program approved by an ABMS member board and has completed all the requirements for subspecialty certification in sleep medicine except the examination itself and only until the time of reporting of the first examination for which the physician is eligible; or
   d) Active staff membership of a sleep center or laboratory accredited by the American Academy of Sleep Medicine or the Joint Commission.

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

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

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

5) To continue coverage for the positive airway pressure (PAP) device (CPAP or RAD) beyond an initial 3 month trial period, there must be:
   a) A face-to-face visit with the physician during the second or third month of the trial that documents an improvement of the beneficiary's symptoms; and
   b) A data report from the PAP device which documents use the PAP device for at least 4 hours per night on 70% of nights for a 30 consecutive day period during the trial.

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

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

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

Positive Airway Pressure (PAP) Devices LCD - Revised (SPE)

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

INDICATIONS AND LIMITATIONS OF COVERAGE:

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

DOCUMENTATION:

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

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

Power Wheelchairs and Power Operated Vehicles – Documentation Requirements (October 30, 2008) (MOB)

Dear Physician,

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

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

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

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

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

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

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

History of the present condition(s) and past medical history that is relevant to mobility needs

- Symptoms that limit ambulation
- Diagnoses that are responsible for these symptoms
- Medications or other treatment for these symptoms
- Progression of ambulation difficulty over time
- Other diagnoses that may relate to ambulatory problems
- How far the patient can walk without stopping
- Pace of ambulation
- What ambulatory assistance (cane, walker, wheelchair, caregiver) is currently used
- What has changed to now require use of a power mobility device
- Ability to stand up from a seated position without assistance
- Description of the home setting and the ability to perform activities of daily living in the home

Physical examination that is relevant to mobility needs

- Weight and height
- Cardiopulmonary examination
- Musculoskeletal examination
  - Arm and leg strength and range of motion
- Neurological examination
  - Gait
  - Balance and coordination

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

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

You may elect to refer the patient to another medical professional, such as a physical therapist or occupational therapist, to perform part of the evaluation – as long as that individual has no financial relationship with the wheelchair supplier. However, you do have to

personally see the patient before or after the PT/OT evaluation. You must review the report, indicate your agreement in writing on the report, and sign and date the report. If you do not see the patient after the PT/OT evaluation, the date that you sign the report is considered to be the date of completion of the face-to-face examination.

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

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

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

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

This information is not intended to serve as a substitute for the complete DME MAC local coverage determination on Power Mobility Devices. It is only a synopsis detailing the highlights of documentation. Refer to the complete LCD and Policy Article on the CMS Web site at **http://www.cms.hhs.gov/mcd/overview.asp** for additional information.

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

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

Sincerely,

Paul J. Hughes, M.D.
Medical Director, DME MAC, Jurisdiction A

Adrian M. Oleck, M.D.
Medical Director, DME MAC, Jurisdiction B

Robert D. Hoover, Jr., MD, MPH, FACP
Medical Director, DME MAC, Jurisdiction C

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

Be sure to visit the "What's New" section of our Web site at
http://www.medicarenhic.com/dme/dme_whats_new.shtml
for the latest information and updates regarding the Medicare program and DME MAC A.

2009 DME MAC Jurisdiction A Call Center Holiday Schedule (GEN)

The Jurisdiction A Durable Medical Equipment Medicare Administrative Contractor (DME MAC A) call center will be observing the following holidays in 2009:

New Year's Day	Thursday, January 1
Martin Luther King, Jr. Day	Monday, January 19
Presidents Day	Monday, February 16
Memorial Day	Monday, May 25
Independence Day	Friday, July 3
Labor Day	Monday, September 7
Columbus Day	Monday, October 12
Veteran's Day	Wednesday, November 11
Thanksgiving	Thursday, November 26
Day after Thanksgiving	Friday, November 27
Christmas Day	Friday, December 25

Third Quarter 2008 - Top Claim Submission Errors (GEN)

A claim submission error (CSEs) is an error made on a claim that would cause the claim to reject upon submission to the Jurisdiction A Durable Medical Equipment Medicare Administrative Contractor (DME MAC). The top ten American National Standards Institute (ANSI) Claim Submission Errors for July through September 2008, are provided in the following table.

Top Ten Claims Submission Errors	Number Received	Reason For Error
20359 - Ordering Provider Secondary ID Invalid	58,327	The ordering provider secondary ID is invalid.
40022 - Procedure Code/Modifier Invalid	47,606	The procedure code and/or modifier used on this line is invalid.
40014 - Ordering Provider Information Missing	46,166	The ordering provider information is missing.
20269 - Pointer 1 Diagnosis Invalid	14,173	Diagnosis pointer is invalid in first diagnosis field.
40068 - Invalid/Unnecessary CMN Question	12,711	The question number entered is not valid for the DME MAC CMN you are sending.
20364 - Rendering Provider Secondary ID Invalid	10,623	The rendering provider secondary ID is invalid.
20110 - Procedure Code Invalid	9,069	Procedure code is invalid or discontinued.
40073 - Dates of Service Invalid with Procedure Code	7,205	The procedure code used is not valid for the dates of service used.

40021 - Capped Rental K Modifier	6,820	Missing required capped rental K modifier is missing from the claim.
40037 - Service Date Greater Than Receipt Date	5,458	Service date is after the date the claim was received.

The following information is provided in an effort to reduce other initial claim denials. The information represents the top ten (10) return/reject denials for the third quarter of 2008. Claims denied in this manner are considered to be unprocessable and have no appeal rights. An unprocessable claim is any claim with incomplete or missing, required information, or any claim that contains complete and necessary information, however, the information provided is invalid. Such information may either be required for all claims or required conditionally.

The below table reflects those claims that were accepted by the system and processed; however, were denied with a return/reject action code, which could have been prevented upon proper completion of claim information. This table represents the top errors for claims processed from July through September 2008.

Claims Submission Errors (Return/Reject Denials)	CMS 1500 Form (or electronic equivalent) Entry Requirement	Number Received
CO 4 The procedure code is inconsistent with the modifier used or a required modifier is missing.	**Item 24D** - Enter the procedures, services or supplies using the Healthcare Common Procedure Coding System (HCPCS). When applicable, show HCPCS modifiers with the HCPCS code.	4405
CO 16 N64 Claim/service lacks information which is needed for adjudication. The "from" and "to" dates must be different.	**Item 24A** - Enter the precise eight-digit date (MMDDCCYY) for each procedure, service, or supply in Item 24A.	3,032
CO 16 M51 Claim/service lacks information which is needed for adjudication. Missing / incomplete / invalid procedure codes(s) and/or rates.	**Item 24D** - Enter the procedures, services, or supplies using the HCPCS. When applicable show HCPCS modifiers with the HCPCS code.	2,999
CO 16 MA130 Claim/service lacks information which is needed for adjudication. Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable.	**Item 11** - If other insurance is primary to Medicare, enter the insured's policy or group number. If no insurance primary to Medicare exists, enter "NONE." (Paper Claims Only).	2,887
CO 16 N265, N286 Claim/service lacks information which is needed for adjudication. Missing / incomplete / invalid ordering provider primary identifier.	**Item 17** - Enter the name of the referring or ordering physician, if the service or item was ordered or referred by a physician.	1,810
CO 16 MA114 Claim/service lacks information which is needed for adjudication. Missing / incomplete / invalid information on where the services were furnished.	**Item 32** - Enter the name, address, and ZIP code of the facility if the services were furnished in a hospital, clinic, laboratory, or facility other than the patient's home or physician's office.	1,644
CO 16 M51, N225, N29 Claim/service lacks information which is needed for adjudication. Missing / incomplete / invalid procedure code(s) and/or dates. Missing incomplete / invalid documentation.	**Item 24D** - Enter the procedures, services or supplies using the Healthcare Common Procedure Coding System (HCPCS). NOC (Not Otherwise Classified) codes billed and a narrative description was not entered.	966

CO 16 N280 Claim/service lacks information which is needed for adjudication. Missing / incomplete / invalid pay to provider primary identifier.	**Item 33** - NPI bypass logic rejection - Invalid NPI/PTAN (National Provider Identifier/Provider Transaction Access Number) pair on the crosswalk file. **Note:** *Effective May 23, 2008, only the NPI must be submitted.*	514
CO 16 M77 Claim/service lacks information which is needed for adjudication. Missing / incomplete / invalid place of service.	**Item 24B** - Invalid place of service submitted. Must indicate place of service where the equipment/supplies will be used.	173
CO 109 N127 This claim/service is not payable under our claims jurisdiction. We have notified your provider to send your claim for these services to the United Mine Workers of America (UMWA) for processing.	**Misdirected Claim** - This is a misdirected claim/service for a United Mine Workers of America (UMWA) beneficiary. Please submit claims there.	120

Make it a goal to reduce the number of CSEs by taking the extra time to review your claims before submission to ensure that all the required information is on each claim. DME MAC Jurisdiction A will continue to provide information to assist you in reducing these errors and increasing claims processing efficiency. Please take advantage of the information in the above tables and share it with your colleagues.

DME MAC A ListServes (GEN)

The Jurisdiction A Durable Medical Equipment Medicare Administrative Contractor (DME MAC A) ListServes are used to notify subscribers via email of important and time-sensitive Medicare program information and other important announcements or messages. All you need is Internet access and an email address.

What are the benefits of joining the DME MAC A ListServes? By joining, you will be the first to learn about upcoming educational opportunities and training events. You will also be the first to know when our quarterly Bulletins and *Supplier Manual* revisions become available on our Web site. Additionally, there are specialty/area of interest ListServes that enable DME MAC A to send targeted information to specific supplier/provider audiences when the information is posted on our Web site. If you are a specialty supplier/provider, we encourage you to join the appropriate ListServe(s).

Signing up for the DME MAC A ListServes gives you immediate email notification of important information on Medicare changes impacting your business. Subscribe today by visiting the DME MAC A Web site at **http://www.medicarenhic.com/dme/**

Supplier Manual News (GEN)

The 2008 Edition of the *Jurisdiction A Durable Medical Equipment Medicare Administrative Contractor (DME MAC A) Supplier Manual* is available via the "Publications" section of our Web site at **http://www.medicarenhic.com/dme/dme_publications.shtml**. After accepting the CPT License Agreement, suppliers can access the entire *DME MAC A Supplier Manual*, including revised chapters and archived revisions. The 2008 Edition is available via the DME MAC A Web site only, and newly-enrolled suppliers will continue to receive initial hard copy manuals, as mandated by the Centers for Medicare & Medicaid Services (CMS). The option to request additional copies for a fee is not available to anyone at this time.

Updates/Corrections Made:
In December of 2008 chapters 2, 3, 9, 10, 11 and 12 of the *DME MAC A Supplier Manual* were updated. Suppliers who maintain hard copy manuals at their place of business need to discard the previously published pages and replace them with the revised ones.

DME MAC A Webinar Schedule Announcement (GEN)

The DME MAC Jurisdiction A Outreach & Education Team is pleased to announce the schedule for our Winter educational Webinars. The topics for this round of sessions include DME MAC Essentials I & II, Advance Beneficiary Notice of Noncoverage (ABN), Troubleshooting Claim Submission Errors (CSEs) and Denials, Positive Airway Pressure (PAP) Device Billing, Oxygen and Oxygen Equipment Billing, Urological Billing and Hospital Bed Billing.

For further details including registration information, visit the "Events/Seminars" section of the DME MAC Jurisdiction A Web site at **http://www.medicarenhic.com/dme/dmerc_seminars.shtml**

DME MAC A's Gift Policy (GEN)

During the holiday season, people often like to show their appreciation with gifts. Occasionally, we at the Jurisdiction A Durable Medical Equipment Medicare Administrative Contractor (DME MAC A) receive gifts such as candy, fruit baskets, and flowers from beneficiaries, providers, and their billing staffs, in appreciation and thanks for our customer service. While we greatly appreciate the generosity of such gifts, we are unable to accept them. As part of our Code of Conduct, DME MAC A has a zero tolerance policy regarding gifts - we cannot accept any. If you would like to express your thanks for service you have received from DME MAC A's representatives, we welcome notes or letters of appreciation in place of gifts.

Quarterly Provider Update (GEN)

The Quarterly Provider Update (QPU) is a comprehensive resource published by the Centers for Medicare & Medicaid Services (CMS) on the first business day of each quarter. It is a listing of all non-regulatory changes to Medicare including program memoranda, manual changes, and any other instructions that could affect providers. Regulations and instructions published in the previous quarter are also included in the update. The QPU can be accessed at **http://www.cms.hhs.gov/QuarterlyProviderUpdates/**. CMS encourages you to bookmark this Web site and visit it often for this valuable information. To receive notification when regulations and program instructions are added throughout the quarter, sign up for the QPU Listserve at: **https://list.nih.gov/cgi-bin/wa?SUBED1=cms-qpu&A=1**

Reminder-Support Income Tax Reporting (GEN)

This reminder article is based on Change Request (CR) 5816 which notified all DME MACs of the requirements to issue Internal Revenue Service (IRS) Form 1099-MISC to every supplier paid under contract and/or any other forms required for income tax and reporting purposes.

IRS instructions for completing form 1099-MISC states in part that Form 1099-MISC (Miscellaneous Income) should be filed for each person to whom one has paid during the year:

- At least $600 in rents, services (including parts and materials), prizes and awards, other income payments, medical and health care payments.

Note: *Contractors must issue Form 1099-MISC by January 31, 2009.*

The official instruction, CR 5816, issued to your DME MAC regarding this change may be viewed on the CMS Web site at: **http://www.cms.hhs.gov/Transmittals/downloads/R311OTN.pdf**

Revised Advance Beneficiary Notice of Noncoverage (ABN) Reminder (GEN)

Effective March 1, 2009, the ABN-G and ABN-L will no longer be valid. Suppliers are reminded to begin using the revised ABN (CMS-R-131) form.

Some key features include:

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

The ABN form and detailed instructions are available on the Beneficiary Notice Initiative web page at **http://www.cms.hhs.gov/BNI/02_ABNGABNL.asp**

The Advance Beneficiary Notice of Noncoverage (ABN) and Correct Use of Modifiers GA and GY (GEN)

Both Medicare beneficiaries and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers have certain rights and protections related to financial liability under the Fee-for-Service (FFS) Medicare program. These financial liability and appeal rights and protections are communicated to beneficiaries through Advance Beneficiary Notices of Noncoverage (ABN) given by suppliers.

An ABN is a written notice the supplier gives to a Medicare beneficiary before providing items and or services that are expected to be denied by Medicare based on one of the following statutory exclusions:

1. The item or service may be denied as "not reasonable and necessary" pursuant to Section 1862(a)(1) of the Social Security Act
2. The item or service may be denied due to an unsolicited telephone contact pursuant to Section 1834(a)(17)(B)
3. The supplier number requirements not being met pursuant to Section 1834(j)(1)
4. Denial of a request for Advance Determination of Medicare Coverage (ADMC) pursuant to Section 1834(a)(15)

When an item or service is provided to a Medicare beneficiary and is expected to be denied based on one of the four exclusions listed above, it is the responsibility of the supplier to notify the beneficiary in writing through the use of the ABN before the item or service is delivered or purchased. If the supplier issues a properly executed ABN with Option 1 selected by the beneficiary, the DMEPOS supplier must submit the claim to Medicare using the GA modifier on each Healthcare Common Procedural Coding System (HCPCS) code that is expected to be denied. The GA modifier indicates that the supplier has a waiver of liability statement on file.

Statutorily Excluded Items
The GY modifier indicates that an item or service is statutorily excluded or does not meet the definition of any Medicare benefit. Some local coverage determinations (LCD) require the use of the GY modifier when the item or service may be excluded from coverage. In this situation, suppliers are instructed to code the claim with the appropriate HCPCS code indicated in the LCD and append the GY modifier. Some examples of statutory exclusions where the GY modifier is required per policy would include:

- An infusion drug not administered using a durable infusion pump
- A wheelchair that is for use for mobility outside the home

To determine if an exclusion of Medicare benefits exist, suppliers must review the applicable LCD and policy article for the item or service being provided.

Suppliers are reminded that modifiers GA and GY should never be coded together on the same line for the same HCPCS code. It is important to distinguish situations in which an item is denied because it is **statutorily excluded or does not meet the definition of any Medicare benefit** from those situations in which at item is denied because it is not reasonable and necessary. Some examples of ***statutorily excluded items*** or situations include, but are not limited to:

- eyeglasses or contact lenses—except those provided following cataract removal or other cause of aphakia;
- Durable Medical Equipment and related accessories and supplies provided to patients in nursing facilities;
- personal comfort items; and
- orthopedic shoes or shoe inserts—other than those covered under the therapeutic shoes for diabetics benefit or those that are attached to a covered leg brace.

Some examples of items or situations which do not meet the definition of a Medicare benefit include, but are not limited to:

- Parenteral or enteral nutrients that are used to treat a temporary (rather than permanent) condition;
- Enteral nutrients that are administered orally;

- Infusion drugs that are not administered through a durable infusion pump;
- Surgical dressings that are used to cleanse a wound, clean intact skin, or provide protection to intact skin;
- Irrigation supplies that are used to irrigate the skin or wounds;
- Immunosuppressive drugs when they are used for conditions other than following organ transplants;
- Most oral drugs;
- Oral anticancer drugs when there is no injectable or infusion form of the drug;
- Nondurable items (that are not covered under any other benefit category);
  - e.g., compression stockings and sleeves;
- Durable items that are not primarily designed to serve a medical purpose;
  - e.g., exercise equipment.

To access the LCDs and policy articles, please visit the DME MAC A Web site at: **http://www.medicarenhic.com/dme** click on the LCDs/Medical Policies link in the left hand navigation under Medical Review.

Voluntary Notification
Under the new instruction for the revised ABN, the Centers for Medicare & Medicaid Services (CMS) advise that this form may be used to voluntarily notify Medicare beneficiaries of an expected noncovered denial of Medicare payment due to the statutory exclusion of an item or service, or the item or service not meeting the definition of any Medicare benefit.

Section 1848(g)(4) of the Social Security Act states that items that are categorically excluded from Medicare benefits (i.e. hearing aids, personal comfort items, etc.) are not required to be submitted to the Medicare program by the supplier. However, if the beneficiary requests the supplier to submit the claim to Medicare, the claim should be coded with the designated HCPCS, however, neither modifiers GA nor GY are required. The supplier and the Medicare beneficiary will receive a patient responsibility denial for the noncovered services.

For additional instruction regarding the proper execution of an ABN, suppliers are encouraged to review the CMS Internet-Only Manual *Medicare Claims Processing Manual*, Chapter 30, "Financial Liability Protections," Sections 50 and 60 at: **http://www.cms.hhs.gov/manuals**.

Please join the NHIC, Corp. DME MAC A ListServe!
Visit **http://www.medicarenhic.com/dme/** and select
"ListServe Sign-Up"

Remember that you can fax your immediate offset requests
http://www.medicarenhic.com/dme/forms/offsetrequest.pdf

For Your Notes

Reopenings are to correct processing or clerical errors. Medical necessity denials must be handled through the redetermination process

Customer Service Telephone

Interactive Voice Response (IVR) System: 866-419-9458
Customer Service Representatives: 866-590-6731
TTY-TDD: 888-897-7539

Outreach & Education

781-741-3950

Claims Submissions

DME - Drug Claims
P.O. Box 9145
Hingham, MA 02043-9145

DME - Mobility/Support Surfaces Claims
P.O. Box 9147
Hingham, MA 02043-9147

DME - Oxygen Claims
P.O. Box 9148
Hingham, MA 02043-9148

DME - PEN Claims
P.O. Box 9149
Hingham, MA 02043-9149

DME - Specialty Claims
P.O. Box 9165
Hingham, MA 02043-9165

DME - ADS
P.O. Box 9170
Hingham, MA 02043-9170

Written Inquiries

DME - Written Inquiries
P.O. Box 9146
Hingham, MA 02043-9146

Written Inquiry FAX: 781-741-3118

DME - MSP Correspondence
P.O. Box 9175
Hingham, MA 02043-9175

Overpayments

Refund Checks:
DME - Accounting (Refund Checks)
P.O. Box 9143
Hingham, MA 02043-9143

Payment Offset Fax Requests: 781-741-3916

Note: *Include both the demand letter or the remittance indicating the overpayment, and the Offset Request Form*

Appeals and Reopenings

Telephone Reopenings: 317-595-4371

Faxed Reopenings: 781-741-3914

Redeterminations:
DME - Redeterminations
P.O. Box 9150
Hingham, MA 02043-9150

Redetermination For Overnight Mailings:
NHIC, Corp. DME MAC Jurisdiction A
Appeals
75 William Terry Drive
Hingham, MA 02044

Redetermination Requests Fax: 781-741-3118

Reconsiderations:
RiverTrust Solutions, Inc.
P.O. Box 180208
Chattanooga, TN 37401-7208

Reconsiderations For Overnight Deliveries:
RiverTrust Solutions, Inc.
801 Pine Street
Chattanooga, TN 37402

Administrative Law Judge (ALJ) Hearings:
HHS OMHA Mid-West Field Office
BP Tower, Suite 1300
200 Public Square
Cleveland, OH 44114-2316

Local Coverage Determinations (LCDs)

Draft LCDs Comments Mailing Address:
Paul J. Hughes, MD
Medical Director
DME MAC Jurisdiction A
75 Sgt. William Terry Dr.
Hingham, MA 02043

Draft LCDs Comments Email Address:
NHICDMEDraftLCDFeedback@EXAMHUB.exch.eds.com

LCD Reconsiderations Mailing Address:
Same as Draft LCDs Comments

LCD Reconsiderations Email Address:
NHICDMELCDRecon@examhub.exch.eds.com

LCD Reconsiderations Fax: 781-741-3991

ADMC Requests

NHIC, Corp.
Attention: ADMC
P.O. Box 9170
Hingham, MA 02043-9170

ADMC Requests Fax:

Attention: ADMC
781-741-3991

Common Electronic Data Interchange (CEDI)

Help Desk: 866-311-9184

Email Address: ngs.CEDIHelpdesk@wellpoint.com

DME MAC Jurisdiction A Resource

INFORMATION for DME MAC SUPPLIERS in CT, DE, DC, ME, MD, MA, NH, NJ, NY, PA, RI & VT

December 2008
Number 10

Publication Information

NHIC, Corp. is the contractor for the Jurisdiction A DME MAC serving all of Connecticut, Delaware, District of Columbia, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island and Vermont.

Visit the following web sites for more information:

- NHIC, Corp.: www.medicarenhic.com/dme/
- TriCenturion: www.tricenturion.com
- CMS: www.cms.hhs.gov/

The *DME MAC Jurisdiction A Resource*, together with occasional special releases, serves as legal notice to physicians and suppliers concerning responsibilities and requirements imposed upon them by Medicare law, regulations, and guidelines.

If you have any comments about the *DME MAC Jurisdiction A Resource* or would like to make suggestions, please write to:

DME MAC Jurisdiction A Resource Coordinator
Outreach & Education Publications
NHIC, Corp.
75 Sgt. William B. Terry Drive
Hingham, MA 02043

NHIC, Corp.
A CMS Contractor

75 Sgt. William B. Terry Drive
Hingham, MA 02043

Additional Article added December 19, 2008:

Updated Healthcare Provider Taxonomy Code (HPTC) List Codes Effective October 1, 2008 (CR6190) (GEN)

A list of Healthcare Provider Taxonomy Codes (HPTCs), effective October 1, 2008, is available on the Washington Publishing Company (WPC) web site at: **http://www.wpc-edi.com/codes/taxonomy**

Use of the taxonomy code is not required on Medicare DME MAC Jurisdiction A claims. However, **if used, the code must be the correct code**. To avoid delays in the processing of your claims, please ensure you are using only the latest HPTC code list. New code values may not be used prior to the effective date and prior code may not be used after the new code effective date. Although updates may be posted on the WPC Web site up to 3 months prior to the effective date, changes are not effective until the date noted.

If you have any questions regarding the new HPTC list please contact CEDI at **866-311-9184** or **ngs.CEDIHelpdesk@wellpoint.com**